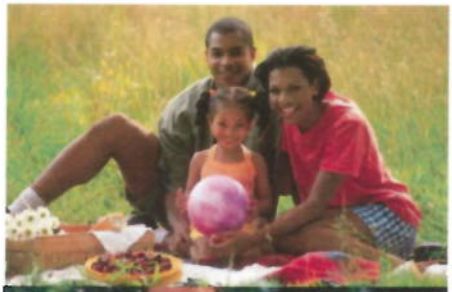

## Historical Background

A national study in 1982 found that two-thirds of all children with serious emotional disorders were not receiving appropriate services. These children were "unclaimed" by the public agencies responsible to serve them, and there was little coordination among the various child-serving systems (Knitzer, 1982). To address this need, Congress appropriated funds in 1984 for the Child and Adolescent Service System Program (CASSP), envisioned as a comprehensive mental health system of care for children, adolescents and their families.

Pennsylvania first received a federal CASSP grant in 1985 and began building a state and local infrastructure for a comprehensive system of care. Since the beginning of CASSP more than 20 years ago, the infrastructure has developed and now includes a Bureau of Children's Behavioral Health Services in the state Department of Public Welfare's Office of Mental Health and Substance Abuse Services, one or more mental health program specialists in each of the four regional field offices who focus primarily on children's issues, CASSP or children's mental health coordinators in each county or joinder, and the development of CASSP systems of care at the local level.

# PA CASSP

*Pennsylvania Child and Adolescent Service System Program*

## CASSP Principles

**Child-centered:** Services are planned to meet the individual needs of the child, rather than to fit the child into an existing service. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.

**Family-focused:** Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring and evaluation. A family may include biological, adoptive and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.

**Community-based:** Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious and cultural organizations and other natural community support networks.

**Multi-system:** Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.

**Culturally competent:** Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.

**Least restrictive/least intrusive:** Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.