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The Evolution of the System of Care Approach

for Children, Youth, and Young Adults with Mental Health Conditions and Their Families

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The system of care (SOC) approach was first introduced in the mid-1980s to address well-documented problems in mental health systems for children and youth with serious emotional disturbances (SEDs) and their families (Stroul & Friedman, 1986). Among these problems were significant unmet need for mental health care, overuse of excessively restrictive settings, limited home- and community-based service options, lack of cross-agency coordination, and a lack of partnerships with families and youth. The vision was to offer a comprehensive array of community-based services and supports that would be coordinated across systems; individualized; delivered in the appropriate, least restrictive setting; culturally competent; and based on full partnerships with families and young people (Stroul, 2002). The SOC approach has provided a framework for reforming child and youth mental health systems nationwide and has been implemented and adapted across many states, communities, tribes, and territories with positive results (Manteuffel et al., 2008; Pumariega et al., 2003; Substance Abuse and Mental Health Services Administration [SAMHSA], 2017; Stroul et al., 2010; Stroul, et al., 2012).

These efforts have resulted in significant strides across the United States in addressing youth mental health issues. However, notwithstanding this progress, there is a continuing need to improve SOCs based on environmental changes, changes in health and human service delivery, experience, and data from evaluations and research. As such, an update of the approach was published in 2010 (Stroul et al., 2010). This current document builds on the 2010 update and describes the further evolution of the SOC approach, and presents further updates in the philosophy, infrastructure, services, and supports that comprise the SOC framework. The revisions were based on extensive expert consultation and input from the field and reflect a consensus on the future directions of SOCs. (See Appendix A for a list of expert organizations consulted.)

The Need for Systems of Care

In the United States, annual prevalence estimates of mental disorders among children under 18 years of age range from 13 to 20 percent and cost health care systems approximately 247 billion dollars annually (Perou et al., 2013). Within this group are children and youth with SEDs, defined as a diagnosable mental health condition that results in significant functional impairment (SAMHSA, 1993).[1]

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[1] Serious emotional disturbance (SED) refers to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role in family, school, or community activities.

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Current prevalence estimates of SED range from 4.3 to 11.3 percent of children (Ringeisen et al., 2017; Williams et al., 2018). Youth and young adults from age 18 through age 25 may have a serious mental illness (SMI), similarly defined as a diagnosable mental health condition that substantially interferes with one or more major life activities (Interdepartmental Serious Mental Illness Coordinating Committee [ISMICC], 2017; SAMHSA, 1993).[2] Although the prevalence of SMI is estimated at 4.2 percent of all adults, the prevalence of SMI among this group of young adults is higher at approximately 5.9 percent (ISMICC, 2017). For young children birth to age 6, the prevalence of mental health problems is reportedly between 9.5 and 14.2 percent (Brauner & Stephens, 2006).

It has been estimated that 75 to 80 percent of children, youth, and young adults with SED or SMI do not receive adequate treatment, largely due to structural, financial, or personal barriers to accessing high-quality mental health services (Centers for Disease Control and Prevention [CDC], 2021; Howell & McFeeters, 2008; ISMICC, 2017; Kataoka et al., 2002). This represents a significant public health issue because of the negative impact of untreated symptoms on development, academic achievement, employment, physical health, involvement in the juvenile and criminal justice systems, substance use, and other quality of life indicators, as well as on the well-being of families and communities (Perou et al., 2013). Further, more than half of mental health conditions begin in childhood or adolescence, and mental health problems that manifest early in life are associated with poorer clinical and functional outcomes. This underscores the need for improved treatment for mental health conditions diagnosed in children and adolescents, as well as for better prevention and early intervention efforts (Kessler et al., 2005; McGorry et al., 2011).

From a historical context, Jane Knitzer's 1982 book, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, documented the inadequacies of mental health care for children and youth. This seminal study of the children's mental health service delivery system in the United States was instrumental in creating a broad consensus about the need for comprehensive, coordinated SOCs to meet the mental health needs of young people with SED and their families, and the systemic changes needed to implement them.

In response to Knitzer's study, Congress appropriated funds for the Child and Adolescent Service System Program (CASSP) in 1984 to help states and communities plan comprehensive, community-based SOCs for this population. Subsequently, to move from planning to implementation, Congress established the Comprehensive Community Mental Health Services for Children with SED Program, or the Children's Mental Health Initiative (CMHI), which is administered by SAMHSA's Center for Mental Health Services (CMHS) (U.S. Department of Health and Human Services, 2017; 2019). Through the CMHI, SAMHSA has provided funds and technical assistance to states, communities, tribes, and territories for the widespread implementation and expansion of SOCs to provide a broad array of effective, home- and community-based services and supports that are organized in a coordinated network, with the goal of helping these children and youth thrive at home, in school, and in the community (Stroul et al., 2010).

Components of the SOC Approach

The SOC concept was originally described as including overlapping dimensions to address the comprehensive needs of children and youth with mental health conditions and their families, rather than providing mental health treatment in isolation (**Figure 1**).

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[2] Serious mental illness (SMI) refers to individuals 18 or older, who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the diagnostic manual of the American Psychiatric Association and that has resulted in functional impairment that substantially interferes with or limits one or more major life activities.

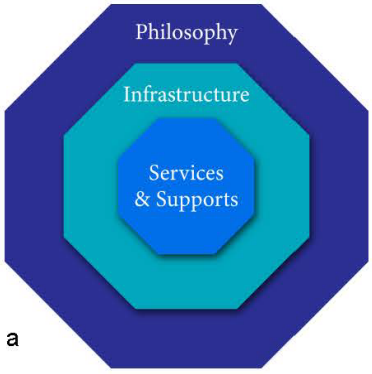
Figure 1. *Dimensions of the System of Care Framework (Adapted from Stroul et al., 2010)*

Figure 2 shows that the framework is currently conceptualized as comprising three components: 1) a comprehensive array of services and supports, 2) an infrastructure to fulfill essential functions, and 3) a clear philosophy intended to guide service delivery for young people with serious mental health conditions and their families.

Philosophy

The SOC philosophy is the foundation of service delivery and includes the core values of family- and youth-driven, community-based, and culturally and linguistically competent systems and services. The guiding principles emphasize a comprehensive service array, individualized care, providing services in least restrictive settings, interagency collaboration, and care coordination among others. The 2010 update added principles to explicitly include evidence-informed practices and practice-based evidence; linkage with mental health prevention and early identification; accountability; and developmentally appropriate services for both transition-age youth and young adults and infants and young children and their families (Stroul et al., 2010).

Figure 2. Elements of SOCs (Stroul et al., 2010)



Infrastructure

SOC infrastructure includes structures and processes for such functions as system management, data management and quality improvement, interagency partnerships, partnerships with youth and family organizations and leaders, financing, workforce development, and others (Pires, 2010; Stroul & Le, 2017).

Services and Supports

In the past, child/youth mental health services were often limited to individual therapy, medication therapy, inpatient psychiatric services, and residential treatment (Knitzer, 1982; Stroul & Friedman, 1986). The SOC approach delineated an array of services and supports that included these services and added others to create a broader array of services and supports for children, youth, and young adults with SED and their families, focusing on options that could be provided in home and community settings. Over time, this array of services has continued to expand to include a comprehensive range of home- and community-based treatment interventions along with inpatient and residential interventions with linkages to community services. The benefits of many of these services have been clearly established (CMCS & SAMHSA, 2013; SAMHSA, 2017).

The SOC philosophy emphasizes that the types and combination of services should be based on the unique needs of each young person and family. Accordingly, the service array includes individualized assessment and service planning processes in partnership with families and youth to determine the intensity and combination of services and supports that would be most beneficial.

In addition, central to SOCs are the principles that services should be high quality, evidence informed, and responsive to the culturally diverse populations served. As such, specific evidence-based practices and culture-specific interventions are included in each type or category of service. For example, outpatient therapy includes such practices as Cognitive Behavioral Therapy; family therapy includes Functional Family Therapy, Parent-Child Interaction Therapy, and others;

intensive in-home treatment includes interventions such as Multisystemic Therapy; and evidence-based practices for treatment in family homes include Treatment Foster Care Oregon. A modular approach to evidence-based practices can also be applied to each of the types of services to identify and train providers on the core components of multiple evidence-based practices, allowing services to be tailored to the unique needs of each individual child or youth (Chorpita et al., 2005; Weisz & Chorpita, 2012). A component of the SOC infrastructure is a structure and/or process to identify and implement evidence-informed and promising practices, as well as interventions supported by practice-based evidence that is derived from the experience of diverse communities, providers, families, and young people (Lieberman et al., 2010). Ongoing training for practitioners, fidelity monitoring, and quality improvement are essential to this process.

These services and supports are intended to be provided by a wide range of diverse providers who have the knowledge and skills necessary to meet the complex needs of young people with SED or SMI and their families. Providers include mental health professionals from all disciplines, paraprofessionals, peer support providers, staff from partner agencies, and individuals providing informal supports. The provider network is intended to be extensive given the broad array of services included in the array, and may include public and private agencies, various types of organizations, and individual practitioners. As called for in the SOC principles, the services are intended to be provided in the least restrictive, clinically appropriate environments including homes, schools, outpatient, primary health care, and community settings.

Outcomes of the SOC Approach

Some researchers have posited that evaluation of the efficacy of the SOC approach is challenging because of the variability in implementation across states and communities (Cook & Kilmer, 2004). Other experts have noted the complexity of evaluating SOCs because these frameworks necessitate provision of multiple services and supports rather than a single intervention (Stroul et al., 2010). Nonetheless, since its introduction, an extensive body of evaluation and research has documented the effectiveness of this approach (Cook & Kilmer, 2004; Manteuffel et al., 2008; Stroul et al., 2012; U.S. Department of Health and Human Services, 2015).

Several reviews summarize the evidence base for SOCs. Cook and Kilmer (2004) conducted a review of peer-reviewed literature and public reports on SOCs to evaluate the strengths of the framework and to identify areas that require continued research. They found that children enrolled in SOCs functioned better in school, engaged in less criminal activity, had more stable housing arrangements, and performed better on objective measures of child and adolescent functioning. They also found that SOCs offered more services and improved the ways in which services were administered. They concluded their review with recommendations for additional research to understand the “effective dose” of services provided through SOCs, the ways in which SOCs impact family members, other factors outside of services that contribute to child outcomes, and how SOCs could use the community to improve outcomes.

More recent reviews of multi-site evaluations and research have found that SOC implementation has resulted in both system and practices changes that led to positive outcomes for children and families served (Manteuffel et al., 2008; SAMHSA, 2017; Stroul et al., 2012). These include such outcomes as decreased behavioral and emotional symptoms, suicide rates, substance use, and juvenile justice involvement. Increased school attendance and grades, strengths, and stability of living situations have also been reported. Documented outcomes for families include reduced caregiver strain, improved family functioning, improved problem-solving skills, and better capacity to handle their child’s challenging behaviors. Findings also indicated that families had a greater ability to work and missed fewer days of work (U.S. Department of Health and Human Services, 2015).

In addition, multiple studies have shown a positive return on investment from implementation of the SOC approach. Cost savings result from decreased use of inpatent and residential treatment,

juvenile correction and other out-of-home placements, as well as decreased use of physical health and emergency room services (Stroul et al., 2015).

Updating the SOC Approach

As noted by Stroul (2020), the SOC approach evolved over time with significant changes in areas including the following:

- **Population** – Application and adaptation to 1) a broader population beyond those with the most serious and complex mental health conditions (e.g., youth with substance use or co-occurring disorders, youth in child welfare and juvenile justice systems); 2) different age groups with specialized, developmentally appropriate services (e.g., early childhood, youth and young adults of transition age); and 3) culturally and geographically diverse populations.
- **Services and Supports** – Inclusion of a broader array of services and supports; focus on a core set of services; and awareness of the importance and effectiveness of specific services (e.g., intensive care coordination with wraparound, mobile crisis and stabilization services, peer support).
- **Practice Approach** – Adoption of a practice approach grounded in intensive care coordination using a high-fidelity wraparound process.
- **Evidence Base** – Strengthened evidence base documenting the effectiveness of the approach both at the system and service delivery levels.
- **Widespread Adoption** – Shift from demonstration and evaluation of the approach to widespread implementation with flexibility, using a bi-directional process with partnerships between states and communities and integration with other systemic reforms such as those in Medicaid and partner child-serving systems.

There has been increasing awareness of the need to further update the SOC approach. Consensus among experts has emerged about changes needed to: 1) broaden the SOC approach to incorporate elements of a population-based public health framework, strategies for integrating health and mental health care, and approaches for achieving mental health equity; 2) incorporate a set of core component services. The significance of these revisions has increased further in the context of the COVID-19 pandemic, which has required intentional strategies for health-mental health integration, public health interventions, and equitable care, as well as innovative approaches to providing services and supports. Each of these areas is discussed below.

Incorporating Public Health, Care Integration, and Mental Health Equity

The importance of the public health approach and of integrating health and mental health care necessitates the need to incorporate aspects of these frameworks into the SOC approach. This better reflects the evolution in the field and the changing dynamics of health and human service delivery. This update of the approach incorporates mental health promotion, prevention, screening, early identification, and early intervention services in SOCs in addition to treatment for young people already identified with serious mental health conditions. In addition, the health-mental health care integration framework intersects with both the SOC and public health approaches and focuses on the need for coordination between primary health care and specialty mental health services. Both approaches are grounded in similar values and principles as SOCs and include cross-system collaboration at the system and service delivery levels that is a cornerstone of SOCs. The update also establishes the achievement of mental health equity as a priority and goal for the SOC approach.

The Public Health Approach

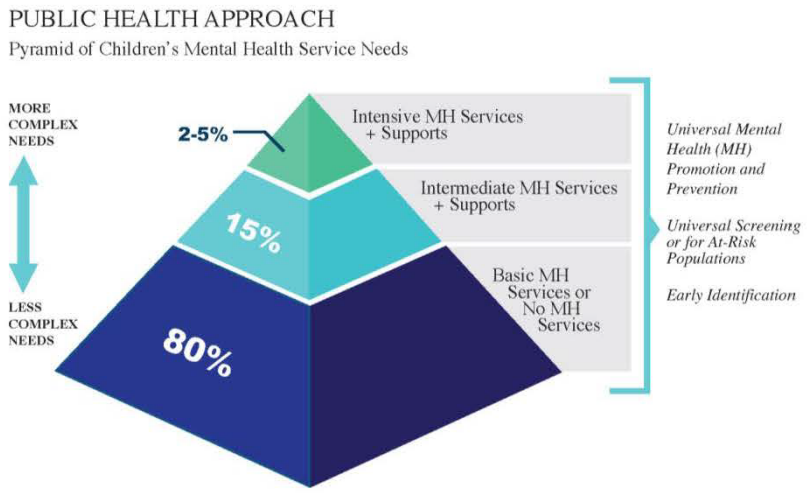
The Institute of Medicine (IOM) report *The Future of Public Health* defined public health as "what society does collectively to assure the conditions for people to be healthy" (IOM, 1988). Given the increasing demand for already overextended services and the high costs associated with

child/youth mental health care, some experts have advocated for the adoption of a public health approach that integrates prevention and health promotion into the mental health system.

The conventional public health framework includes primary, secondary, and tertiary prevention. An alternative framework for mental health was described in a 1994 IOM report (Mrazek & Haggerty, 1994) and includes four levels of intervention: universal, selective, and indicated prevention; and treatment. These intervention levels target upstream risk factors in the whole population, in high-risk or vulnerable populations, and in undiagnosed but symptomatic populations, respectively. The treatment level focuses on populations that have already been diagnosed.

Miles et al. (2010) applied the public health framework specifically to child/youth mental health, stating that this approach is based on concern about overburdened health care systems, high costs, and fragmented approaches to child/youth mental health care. They contended that SOCs should focus on both reducing mental health problems among children with identified problems and on a more holistic approach to optimize mental health for all young people. Their conceptual framework includes a foundation of core values derived from the SOC approach and a new "intervening model" that provides a range of services that includes promoting, preventing, treating, and reclaiming.

Figure 4. *Public Health Approach: Pyramid of Children and Service Needs (Pires, 2010).*



A related conceptualization of a public health approach developed specifically for child/youth mental health was described by Pires (2010). It is depicted as a pyramid of children and service needs, showing that universal mental health promotion and prevention, screening for at-risk youth, and early intervention apply to a total population of children, youth, and young adults. As mental health needs become more complex, additional services and supports are required, and intensive services and supports are needed for those young people with the most serious and complex conditions at the top of the pyramid (**Figure 4**). Pires noted that the types of services do not vary based on whether a child has moderate to complex service needs; rather, it is the intensity and duration of the services that vary.

Schools can play an important role in implementing a public health approach to address emotional and behavioral problems among children and youth. Comprehensive school mental health systems provide a full array of supports and services that promote positive school climate, social-emotional learning, mental health, and wellbeing, while reducing the prevalence and severity of mental illness (Hoover et al., 2008; NCSMH, 2019; SAMHSA-CMS, 2019). School-based interventions can address the total population, students at risk, and those with challenging problems. Examples include the Multi-Tiered System of Supports (MTSS) (Hoover Stephan et al., 2015) that is defined as a "practice of providing high-quality instruction and interventions matched to student need," with a focus on academic, social-emotional, and behavioral outcomes (Batsche et al., 2005). MTSS braids the evidence-based models of Response-to-Intervention (RIT) and Positive Behavior Intervention and Supports (PBIS) to create a comprehensive approach to meet the needs and improve outcomes for all students (Averill & Rinaldi, 2013).

Similar to the Pyramid of Children and Service Needs, MTSS is a three-tiered model for instruction and intervention that blends academic and behavioral supports. Tier 1 refers to universal interventions that address the needs of all students in a school; Tier 2 provides targeted interventions for students with identified needs; and Tier 3 provides intensive, individualized services to students with the most serious needs (University of South Florida, 2011). Much like the SOC approach, the framework also integrates system-level structures and processes that unite partners from child/youth- and family-serving systems to collaboratively plan and implement these interventions.

Health-Mental Health Care Integration Approach

Many children, youth, and young adults receive mental health services in primary care settings. More than half of annual visits for mental health care occur in the general medical sector, and 70 to 80 percent of prescriptions for medications related to mental health conditions for young people are written by pediatricians and general practitioners (National Institute of Mental Health [NIMH], 2017). Further, children with chronic medical conditions, such as asthma, are twice as likely to also have a mental health disorder (Center for Integrated Health Solutions [CIHS], 2016). Although mental health professionals are essential, it is likely that many young people will continue to access mental health services through primary care providers (PCPs) and that primary care will continue to be a gateway to mental health services (NIMH, 2017). Integrated care has been proposed as a solution, with the goal of systematically coordinating physical health and mental health services to improve outcomes for individuals with multiple needs.

The care integration framework addresses the role PCPs in providing mental health services and the importance of improving collaboration between primary care and mental health providers. The American Academy of Child & Adolescent Psychiatry (2010) outlined goals for this approach, such as promoting optimal social and emotional development, identifying mental health problems earlier, implementing effective psychopharmacologic services in primary care, improving care coordination, and increasing the ability of PCPs and behavioral health providers to better respond to both mental health and physical health problems.

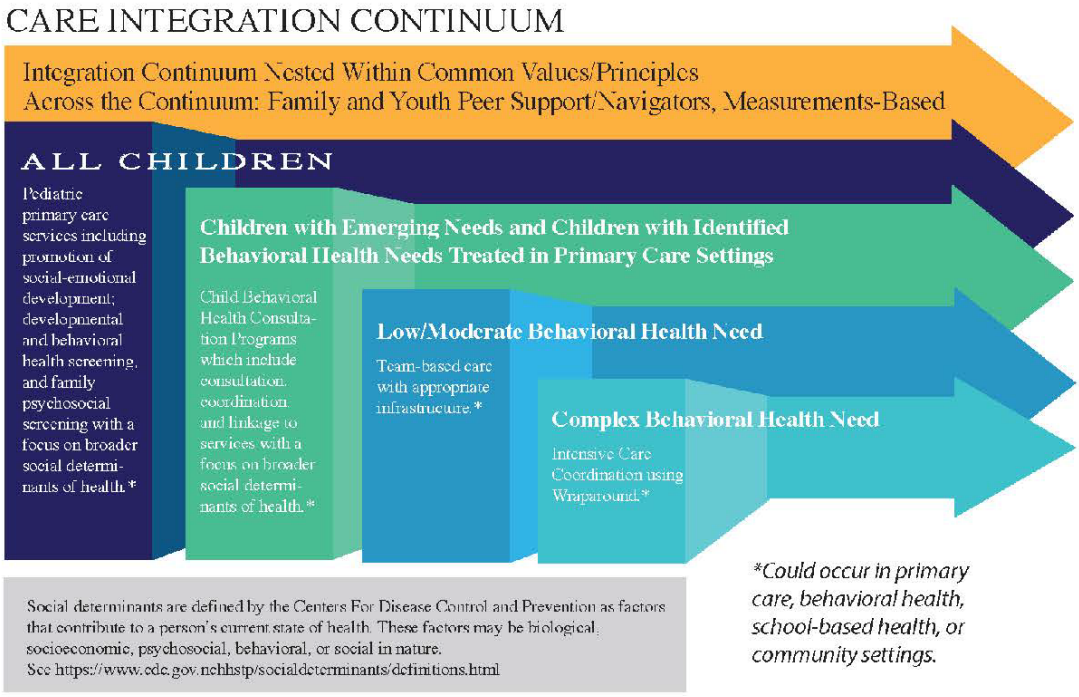
Various proposed definitions of health-mental health care integration share common characteristics (Pires et al., 2018). Integrated care has been defined as a framework that "encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative mental health and addiction services, according to their needs over time, and across different levels of the health system" (CIHS, n.d.). Recognizing the unique needs of children, youth, and young adults, care integration for this group has been described as "an approach and model of delivering care that comprehensively addresses the primary care, behavioral health, specialty care, and social support needs of children and youth with behavioral health issues in a manner that is continuous and family-centered" (CIHS, 2013).

The benefits of integrating physical health and mental health care were outlined by the American Academy of Pediatrics (2009) and include opportunities for building on potentially long-term and trusting relationships with PCPs, intervening earlier when signs of mental health issues are first identified, increasing access to specialty mental health care, increasing the receptiveness of families to mental health services, and improving the efficiency and outcomes of both health and mental health treatment. Recognizing the importance of integration, SAMHSA (2017) identified promising practices for integrating behavioral health into primary care settings for children based on results from Project LAUNCH (Linking Actions for Unmet Needs in Children's Health).

In 2017, the Institute for Innovation and Implementation at the University of Maryland School of Social Work convened a group of experts to explore care integration across primary care and behavioral health settings. The experts reached consensus on the elements of a continuum of care integration for children, youth, and young adults (Pires et al., 2018). Similar to the public health

approach, this continuum takes a population-based perspective and describes interventions for all young people with increasingly more intensive interventions for those with emerging, low/moderate, and complex behavioral health needs (**Figure 5**). They emphasized the importance of developmentally appropriate services and seamless transitions across the continuum.

Figure 5. Care Integration Continuum (Pires, Fields, & Schober, 2018



The expert panel agreed on common values and principles for the care integration framework that are similar to those comprising the SOC philosophy. The Center for Integrated Health Solutions (CIHS) also specified that the SOC approach is linked to care integration and that its integration framework is grounded in the core values of family-driven and youth-guided, community-based, and culturally and linguistically competent care. The CIHS framework uses SOC values and principles as part of the evaluation criteria for integrated systems (CIHS, 2016).

Mental Health Equity

Cultural and linguistic competence has been an integral element of the SOC philosophy from the outset. Many SOCs have used the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards) developed by the U.S. Department of Health and Human Services as a benchmark for providing culturally responsive services and eliminating health care disparities. The intent of the standards is to "advance health equity, improve quality, and help eliminate disparities by establishing a blueprint for health and health care organizations." Standards are provided for governance, leadership, and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

Moving beyond cultural competence, this update to the SOC approach incorporates an explicit focus on achieving equity in mental health care for young people and their families. Structural and systemic racism, implicit bias, and historical trauma impact the social determinants of health, such as economic stability, education, housing, health care, nutrition, and safety. Further, accessing high-quality, affordable services is challenging for children and families of color; youth who are

lesbian, gay, bisexual, transgender, or questioning (LGBTQ); other diverse populations; and children and families in underserved or disadvantaged rural, frontier, and urban areas. As attention to social justice and race equity has grown, so has recognition of the need for increased attention to issues of health equity. Strategies to address equity in mental health care are needed in multiple domains – research, policy, and practice (National Academies of Sciences, 2019).

According to Taylor and Goodman (2021), organizations and systems should build a culture of equity and inclusion and have the infrastructure, leadership, and capacity to collect and use data to engage in equity conversations, establish goals, and implement actions. As such, achieving equity in SOCs requires action across all system components, including mission and vision, policies, leadership, staff, partnerships, program design, services and supports, practice approach, desired outcomes at the system and service delivery levels, evaluation, and quality improvement.

Core Components of a Comprehensive Service Array in SOCs

As the SOC approach has evolved, the importance of a core set of services and supports for improving outcomes has been substantiated (Urpapilleta et al., 2012; U.S. Department of Health and Human Services, 2013). The core services were described in a Joint Informational Bulletin published by SAMHSA and the Center for Medicaid and CHIP Services (CMCS & SAMHSA, 2013) and include mobile crisis response and stabilization services, intensive care coordination using the wraparound approach, intensive in-home mental health treatment, respite care, parent and youth peer support, flex funds, and treatments addressing trauma. Although these services have primarily involved in-person care, telehealth approaches have been applied to many of them to provide treatment and support to young people and their families during the COVID-19 pandemic. Telehealth is also now included as a core SOC component.

Mobile Crisis Response and Stabilization Services (MRSS)

MRSS is provided to children and youth who are experiencing mental health emergencies and their families. It is designed to defuse and stabilize crises, maintain children and youth in their current living arrangements, prevent hospitalization, prevent disruption of child welfare placements, and improve functioning (Manley et al., 2018). The services are delivered by a single individual or a team of professionals or paraprofessionals trained in crisis intervention who typically provide on-site, face-to-face therapeutic responses in crisis situations. Although MRSS may include telephonic or video consultation with specialized providers as part of the intervention (e.g., psychiatric consultation for medication management), virtual approaches have been increasingly used during the pandemic. MRSS services are available 24 hours a day, seven days a week.

The initial intervention is typically short-term (72 hours or less), followed by a stabilization component that may span several weeks. The stabilization component may be provided in the home or in short-term residential placements. Following the initial stabilization, MRSS provides brief follow-up care to promote continued stabilization and linkage via warm handoff to ongoing services and supports in the community to improve access, child and family outcomes, and family satisfaction. Mobile crisis response teams often work collaboratively with law enforcement and other first responders (Manley et al., 2018; Rzucidlo & Campbell, 2009). A 2018 report by the National Association of State Mental Health Program Directors (NASMHPD) cited findings demonstrating that MRSS is instrumental in averting unnecessary emergency department visits, hospitalizations, out-of-home placements, and placement disruptions. In addition to improved outcomes for youth, MRSS services have been shown to reduce overall costs (Manley et al., 2018).

Intensive Care Coordination Using Wraparound

Intensive care coordination using the wraparound process is an approach to providing individualized care for children, youth, and young adults with complex mental health needs and their families (Schurer Coldiron et al., 2017; Walker & Baird, 2019). Wraparound is not a service per se; it is a structured approach to service planning and care coordination that is built on key SOC

values (e.g., family and youth driven, team based, collaborative, and outcomes based). The wraparound approach incorporates a dedicated full-time care coordinator working directly with small numbers of children and families. For each child served, the care coordinator creates a team comprised of the child and family, formal and informal service providers, peer support providers, and others. This team then creates, implements, and monitors an individualized, holistic service plan across all life domains. Zoom and other platforms have been used effectively as vehicles for team meetings during the pandemic.

In 2004, the National Wraparound Initiative further defined the model, including its principles, phases and activities, and staff roles (Bruns & Walker, 2008). Because fidelity to the model is considered key to achieving positive outcomes, a fidelity measurement system has also been developed. An increasing research base is documenting the effectiveness of intensive care coordination using wraparound, including its impact in areas such as reducing residential placements, improving mental health outcomes, improving school success, and decreasing juvenile justice recidivism (Bruns & Suter, 2010; Olson et al, 2021).

Intensive In-Home Mental Health Treatment Services

Intensive in-home mental health treatment services are interventions provided to improve child, youth, and family functioning and to prevent the need for out-of-home placement, inpatient hospitalization, or residential treatment. This is generally a comprehensive intervention that includes individual and family therapy, skills training, behavioral interventions, crisis response, and care coordination (English et al., 2016). The approach is typically collaborative, including the child/youth's family, school, mental health providers, health care providers, and other involved systems such as juvenile justice or child welfare (Barbot et al., 2016).

An effort to identify in-home mental health treatment services at the state-level found that these services exist in some form in most states (Bruns & Shepler, 2018). Results indicated that most of these services are required to be delivered in the home, school, or community, and that both individual and team models are used. Flexibility has allowed these services to also be provided virtually. The intensity of service averages at about 4 to 6 hours per week, and the typical duration ranges from 3 to 7 months. Caseloads are typically small, averaging at 4 to 6 cases for one staff person and 8 to 12 cases for two-person teams. Appointments are offered at times convenient to families, including evenings and weekends, and there is 24/7 on-call crisis availability. Family and youth partnerships are a central component of this approach. These services involve such interventions as crisis stabilization, safety planning, resource and support building, family/system therapy, behavior management/parenting, cognitive interventions, skill building, cross-system coordination, trauma-focused interventions, substance use treatment, and social services for basic needs.

There is an extensive body of research on in-home mental health treatment, much of which is related to the various manualized evidence-based practices that are relevant to this service, such as Multisystemic Therapy, Intensive Family Preservation Services, Homebuilders, Integrated Co-Occurring Treatment for mental health and substance use disorders, Intensive Home-Based Treatment, Multidimensional Family Therapy, and Functional Family Therapy. The outcomes demonstrated for these services include positive effects on psychiatric hospitalization, symptomatology, school functioning, juvenile justice and child welfare involvement, family functioning, substance use, and frequency and intensity of crises (Bruns & Shepler, 2018; Moffett et al, 2017).

Parent and Youth Peer Support

Peer support services are provided by individuals who have personal "lived" experience with mental health conditions and navigating service systems, either as a consumer or as a family member or caregiver (Fuhr et al., 2014). Peer support providers have personally faced the challenges of coping

with serious mental health conditions, and thus are uniquely qualified to assist others with similar challenges. Parent peer support serves families or caregivers of young people with mental health conditions, whereas youth peer support serves children, youth, and young adults with mental health conditions of varying ages, typically beginning with those in late childhood or early adolescence (Ansell & Insley, 2013; Center for Health Care Strategies, 2013).

Peer support involves providing services in ways that are both accessible and acceptable to families and youth. Services include providing one-on-one or group support, identifying and accessing natural supports, instilling confidence, assisting in goal development, serving as an advocate, teaching coping skills, providing social or emotional support, and providing intensive support during crises (Acri et al., 2017; Hoagwood et al., 2010; SAMHSA, 2017; Simons et al., 2016). Supporting community outreach, education, and advocacy for family and youth voices within agencies and systems may also be part of a peer support provider's role (Simons et al., 2016). Peer support providers may attend child and family team meetings and play a navigator role, helping youth or families navigate mental health and other child/youth- and family-serving systems (CMCS & SAMHSA, 2013). Youth peer support providers can also help youth and young adults in transition by collaborating across child/youth and adult mental health systems and other systems that serve them (Simons et al., 2016).

Reviews on the efficacy of peer-delivered family support services have reported promising impacts on improving knowledge, family functioning, and parenting skills, as well as in self-efficacy and empowerment to take action (Acri et al., 2017; Hoagwood et al., 2010; Kutash et al., 2011; Obrochta et al., 2011). Although studied less frequently, findings on youth peer support suggest that they have positive impacts on such indicators such as participation, appropriateness, and satisfaction with services; reduced hospitalizations; and improved functioning (Cené et al., 2016; Gopalan et al., 2017; Jackson, Walker, & Seibel, 2015; Ontario Centre of Excellence for Child and Youth Mental Health, 2016).

Respite Care

Respite care provides parents and other primary caregivers with planned or emergency short-term care for their child, enabling children and youth with mental health needs to remain in a safe and supportive environment, usually in their own homes (CMCS & SAMHSA, 2013). In addition to in-home support from trained individuals, respite care may be provided in the home of another family or in a facility such as a foster home or group home. In child welfare systems, the stated goals of respite care are to offer temporary relief to primary caregivers, reduce social isolation, improve family stability, and reduce the risk of neglect or abuse of the child or youth (Child Welfare Information Gateway, 2018). These services are provided by qualified caregivers who may be trained by child welfare or mental health systems, religious institutions, or formal respite care programs (Whitmore, 2017).

The ARCH National Respite Network (2012) noted that respite services for families of children and youth with SED are an important component of the service array by providing this temporary relief for families and caregivers and allowing them to renew their energies and reduce the stress associated with caregiving roles. Respite care also benefits other children in the family by providing an opportunity for them to spend quality time with their parents, and it benefits the child or youth by avoiding out-of-home placements and encouraging positive social experiences with caregivers other than their families. Early research on respite care found that the need is highest for families of children with significant functional impairment and that it promotes wellness in parents, enables them to better care for their children, and results in positive outcomes including fewer out-of-home placements and less caregiver stress (Boothroyd et al., 1998; Bruns & Burchard, 2000; Focal Point, 2001).

Flex Funds

Flex funds may be provided using financing mechanisms including state and grant funds and are also increasingly covered by Medicaid. Flex funds are typically used to purchase non-recurring goods or services that are procured to improve the family or caregivers' ability to meet the needs of a child or youth with SED that are not covered by other financing sources (CMCS & SAMHSA, 2013). The services may include education, coaching, recreational activities, membership in social clubs, or even expenses associated with transitioning from residential treatment to the family home or independent living. Some early literature described the benefit of flex funds in child/youth mental health and noted that families' ability to determine the best use of the money and the availability of the funds before crises occurred were critical to the success of this type of support (Dollard et al.,1994). Information derived from the national evaluation of the CMHI informed the development of a data collection tool to track how flex funds are used. The expenditure categories include items such as housing, utilities, environmental modification, food/groceries, clothing, activities, educational support, daycare, transportation, medical, mental health services for the child/youth or family member/caregiver, camp, and training for the child/youth or family member/caregiver (Peart Boyce et al., 2015).

Trauma-Specific Treatments and Trauma-Informed Systems

Children and youth with the most severe mental health needs have often experienced significant traumatic experiences. The connection between childhood adverse experiences such as trauma and later mental health needs was most notably highlighted by the Centers for Disease Control and Prevention (CDC)-Kaiser Permanente Adverse Childhood Experiences (ACE) study, which was originally conducted between 1995 and 1997 (Felitti et al., 1998). Since 2009, the CDC has collected data on ACEs through the Behavioral Risk Factor Surveillance System (BRFSS), an annual state-based survey of health among adults in the United States. On average, over 60 percent of adults reported at least one ACE in their lifetime, while approximately 20 percent reported three or more ACEs (CDC, 2016). There is wide consensus that neglecting to address trauma can significantly decrease the effectiveness of mental health treatment and may reduce positive long-term outcomes.

Considering the prevalence of childhood trauma, it is important to address this both with trauma-specific treatments and more globally with trauma-informed systems. There are numerous evidence-based practices that have been developed as trauma-specific treatments, such as Trauma-Focused Cognitive Behavioral Therapy, Trauma and Grief Component Therapy (TGCT) Integrative Treatment of Complex Trauma, and Parent Child Interaction Therapy (PCIT). These interventions directly address the impact and consequences of trauma to facilitate recovery and prevent re-traumatization. The National Child Traumatic Stress Network (NCTSN) described these interventions, including those that are evidence-based and evidence-supported, as well as promising and new emerging practices. The NCTSN also identified core components across trauma-focused interventions, such as risk screening, motivational interviewing, psychoeducation, emotional regulation, parenting skills and behavior management, safety skills, and relapse prevention skills.

Trauma-informed systems expand beyond specific treatments and involve system-wide policies and practices that address trauma (Marsac et al., 2016). Perez (2018) noted that "a program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for healing; recognizes the signs and symptoms of trauma in staff, clients, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings." Perez further pointed out that trauma-informed organizations and systems reflect the SOC values of being community based, family driven and youth guided, culturally responsive, and strength based. SAMHSA's Treatment Improvement Protocol on Trauma-Informed Care in Behavioral Health Services (2014) specifies the

strategies needed to become a trauma-informed system or organization, for example showing organizational and administrative commitment; using trauma-informed principles in strategic planning; creating trauma-informed oversight committees; conducting organizational self-assessments; developing policies and procedures to ensure trauma-informed practices and prevent re-traumatization; incorporating universal, routine trauma screening; and developing trauma-informed collaborations. Most experts advocate both trauma-specific treatments and trauma-informed systems.

Specific Evidence-Informed and Promising Practices

There is broad consensus across the literature and among experts consulted for this revision that providing evidence-based services is essential to ensuring treatment effectiveness (Hoagwood et al., 2001). Almost all the experts shared opinions about both the strengths and shortcomings of evidence-based practices as a standard for inclusion in a service array. However, opinions varied as to what constitutes sufficient evidence of efficacy (Hoagwood et al., 2001). Experts also emphasized the need to adapt evidence-based practices to be appropriate for culturally diverse populations (Green, 2008; Martinez, 2008: Outcomes Roundtable, 2011). Some cited challenges associated with the cost of implementing manualized evidence-based practices in public mental health systems, noting that some states, communities, tribes, and territories may not be able to purchase proprietary interventions or finance ongoing training and fidelity monitoring. Several recommended a modular approach that identifies and trains providers in the core components across multiple evidence-based practices, allowing for tailoring and adapting the intervention to the individual or population, as needed (Chorpita et al., 2005; Weisz & Chorpita, 2012).

Telehealth Services

The Health Resources Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration." HRSA identified technologies that can be used for telehealth services including videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communication. Telehealth is described as encompassing a broader scope of remote services than telemedicine, going beyond the clinical services provided by telemedicine to include such system functions as training, administrative meetings, and other activities (www.healthit.gov). The Centers for Medicare and Medicaid Services (CMS) defines telehealth for purposes of Medicaid as permitting two-way, real time interactive communication between service recipients and service providers at a distant site using electronic telecommunications equipment that includes, at a minimum, audio and video equipment (CMS, 2020).

The use of telehealth services in general and their application to mental health service delivery has expanded over time, particularly to provide care to underserved populations in rural, frontier, and urban areas. These services help to address shortages in mental health professionals, as well as geographic and other access barriers. Telehealth technologies are used to provide consultation to PCPs and other service providers. One of HRSA's Office for the Advancement of Telehealth (OAT) programs focuses on creating evidence-based tele-behavioral health networks to increase access to behavioral health care services. The importance and utilization of telehealth have increased dramatically to address the COVID-19 pandemic, both expanding the reach of services to those with limited access and minimizing exposure to the virus for clients and providers. CMS issued a toolkit for providers on telehealth and implemented flexibilities that expand coverage for telehealth services during the public health emergency, some of which may become permanent (CMS, 2020). Health care providers are authorized to use any audio or video remote communication technology that is available to communicate with clients, such as Zoom, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype. Commercial insurance carriers have also increased coverage for these services in the context of the pandemic. The surge in use of

telehealth has led to new resources to support the effective use of telehealth approaches, including Best Practices for Telehealth guidelines published by the National Council for Behavioral Health.

In a survey conducted by the National Association of State Mental Health Program Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD), state agencies reported that the use of telehealth has many benefits beyond providing services safely during the pandemic (Gordon et al., 2021). For example, transportation challenges for families are reduced, accessibility of services is increased in rural and urban areas with provider shortages, and some young people and their families feel more comfortable with virtual services. Reductions were reported in the stigma associated with mental health treatment, missed and cancelled appointments, and conflicts with work schedules and childcare. It was also noted that ER visits and psychiatric hospital admissions are reduced as a result of the ready availability of virtual interventions. Providers indicated that their capacity has increased, and that telehealth provides a valuable opportunity to observe and engage young people and families in their own environments. Based on these benefits and the cost-effectiveness of these services, it is likely that the more extensive use of telehealth technologies to provide mental health care will continue post-pandemic.

Revised SOC Approach

The information and consultation gathered through this project laid the groundwork for this current update to the SOC approach, with the goal of improving outcomes for children, youth, and young adults with SED or SMI and addressing the mental health and well-being of all young people. Updates are presented below for: 1) the definition of a SOC; 2) the values and principles that should guide SOCs; 3) the infrastructure elements needed to successfully organize, support, and provide services; and 4) the specific services and supports that should comprise the service array provided within the SOC framework. These updates reflect state-of-the-art thinking and state-of-the-art science, including:

- Incorporating elements of the public health approach, including comprehensive school-based mental health services
- Incorporating elements of the health-mental health care integration approach, including strategies for linking with PCPs
- Strengthening the service array to include the core set of essential services and supports outlined by SAMHSA and CMCS
- Including telehealth as an essential service
- Specifying services that meet the needs of young people across the age spectrum, including young children and youth and young adults of transition age
- Revising language to reflect youth-driven as well as family-driven care
- Emphasizing the need for equitable services in the core values and principles
- Adding an infrastructure component focusing on health equity and addressing disparities

Definition

System of Care
A system of care is a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults.

Philosophy

Philosophy: Values and Principles	
Core Values	**Systems of Care are:**
1. Family and Youth Driven	Family and youth driven, with families and young people supported in determining the types of treatment and supports provided (with increasing youth/young adult self-determination based on age and development), and their involvement in decision-making roles in system-level policies, procedures, and priorities.
2. Community Based	Community based, with services and supports provided in home, school, primary care, and community settings to the greatest possible extent, and with responsibility for system management and accountability resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community or regional level.
3. Culturally and Linguistically Competent	Culturally and linguistically responsive, with agencies, services, and supports adapted to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services.
Guiding Principles	**Systems of Care are Designed to:**
1. Comprehensive Array of Services and Supports	Ensure availability and access to a broad, flexible array of effective, high-quality treatment, services, and supports for young people and their families that address their emotional, social, educational, physical health, and mental health needs, including natural and informal supports.
2. Individualized, Strengths-Based Services and Supports	Provide individualized services and supports tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process and an individualized service plan developed in partnership with young people and their families.
3. Evidence-Based Practices and Practice-Based Evidence	Ensure that services and supports include evidence-informed, emerging evidence-supported, and promising practices to ensure the effectiveness of services and improve outcomes for young people and their families, as well as interventions supported by practice-based evidence provided by diverse communities, professionals, families, and young people.
4. Trauma-Informed	Provide services that are trauma-informed, including evidence-supported trauma-specific treatments, and implement system-wide policies and practices that address trauma.

Philosophy: Values and Principles	
5. Least Restrictive Natural Environment	Deliver services and supports within the least restrictive, most natural environments that are appropriate to the needs of young people and their families, including homes, schools, primary care, outpatient, and other community settings.
6. Partnerships with Families and Youth	Ensure that family and youth leaders and family- and youth-run organizations are full partners at the system level in policy, governance, system design and implementation, evaluation, and quality assurance in their communities, states, tribes, territories, and nation.
7. Interagency Collaboration	Ensure that services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (e.g., education, child welfare, juvenile justice, substance use, primary care) and with mechanisms for collaboration, system-level management, and addressing cross-system barriers to coordinated care.
8. Care Coordination	Provide care coordination at the service delivery level that is tailored to the intensity of need of young people and their families to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move throughout the system of services and supports in accordance with their changing needs and preferences.
9. Health-Mental Health Integration	Incorporate mechanisms to integrate services provided by primary health care and mental health service providers to increase the ability of primary care practitioners and behavioral health providers to better respond to both mental health and physical health problems.
10. Developmentally Appropriate Services and Supports	Provide developmentally appropriate services and supports, including services that promote optimal social-emotional outcomes for young children and their families and services and supports for youth and young adults to facilitate their transition to adulthood and to adult service systems as needed.
11. Public Health Approach	Incorporate a public health approach including mental health promotion, prevention, early identification, and early intervention in addition to treatment in order to improve long-term outcomes, including mechanisms in schools and other settings to identify problems as early as possible and implement mental health promotion and prevention activities directed at all children, youth, and young adults and their families.
12. Mental Health Equity	Provide equitable services and supports that are accessible to young people and families irrespective of race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; eliminate disparities in access and quality of services; and ensure that services are sensitive and responsive to all individuals.

Philosophy: Values and Principles	
13. Data Driven and Accountability	Incorporate mechanisms to ensure that systems and services are data-driven, with continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals; fidelity to SOC values and principles; the utilization and quality of clinical services and supports; equity and disparities in service delivery; and outcomes and costs at the child and family and system levels.
14. Rights Protection and Advocacy	Protect the rights of young people and families through policies and procedures and promote effective advocacy efforts in concert with advocacy and peer-led organizations.

Infrastructure

Infrastructure Elements	
Point of accountability structures for SOC policy and for system management and oversight	Structure and/or process for outreach, information, and referral
Financing for SOC infrastructure, services, and supports	Extensive provider network for comprehensive service array
Structure and/or process to manage care and costs for high-need populations (e.g., care management entity, health home)	Structure and/or process for training, technical assistance, coaching, and workforce development
Structure and/or process for interagency partnerships/agreements	Structure and/or process for implementing and monitoring evidence-informed and promising interventions
Structure and/or process for integrating primary health and mental health care	Structure and/or process for achieving mental health equity and eliminating disparities in access, quality of services, and outcomes for diverse populations
Structure and/or process for partnerships with family organizations and/or family leaders	Structure and/or process for accountability and quality improvement, including measuring and monitoring service utilization, quality, outcomes, equity, and cost, including utilization of psychotropic medications
Structure and/or process for partnerships with youth organizations and/or youth leaders	Structure and/or process for strategic communications
Defined access/entry points to care	Structure and/or process for strategic planning and identifying and resolving barriers

Array of Services and Supports

Array of Services and Supports	
Home- and Community-Based Treatment and Support Services	**Residential Interventions**
Screening	Treatment Family Homes
Assessment and Diagnosis	Therapeutic Group Homes
Outpatient Therapy – Individual, Family, and Group	Residential Treatment Services
Medication Therapies	Inpatient Hospital Services
Tiered Care Coordination	Residential Crisis and Stabilization Services
Intensive Care Coordination (e.g., Using Wraparound)	Inpatient Medical Detoxification
Intensive In-Home Mental Health Treatment	Residential Substance Use Interventions (Including Residential Services for Parents with Children)
Crisis Response Services – Non-Mobile (24 Hours, 7 Days)	**Promotion, Prevention, and Early Intervention**
Mobile Crisis Response and Stabilization	Mental Health Promotion Interventions
Parent Peer Support	Prevention Interventions
Youth Peer Support	Screening for Mental Health and Substance Use Conditions
Trauma-Specific Treatments	Early Intervention
Intensive Outpatient and Day Treatment	School-Based Promotion, Prevention, and Early Intervention
School-Based Mental Health Services	**Specialized Services for Youth and Young Adults of Transition Age**
Respite Services (Including Crisis Respite)	Supported Education and Employment
Outpatient Substance Use Disorder Services	Supported Housing
Medication Assisted Substance Use Treatment	Youth and Young Adult Peer Support
Integrated Mental Health and Substance Use Treatment	Specialized Care Coordination (Including Focus on Life and Self-Determination Skills)
Therapeutic Behavioral Aide Services	Wellness Services (e.g., Exercise, Meditation, Social Interaction)
Behavior Management Skills Training	**Specialized Services for Young Children and Their Families**
Youth and Family Education	Early Childhood Screening, Assessment, and Diagnosis
Mental Health Consultation (e.g., to Primary Care, Education)	Family Navigation
Therapeutic Mentoring	Home Visiting
Telehealth (Video and Audio)	Parent-Child Therapies
Adjunctive and Wellness Therapies (e.g., Creative Arts Therapies, Meditation)	Parenting Groups
Social and Recreational Services (e.g., After School Programs, Camps, Drop-In Centers)	Infant and Early Childhood Mental Health Consultation
Flex Funds	Therapeutic Nursery
Transportation	Therapeutic Day Care

Conclusion

These revisions to the SOC approach are intended to provide guidance to the field on how to best serve young people and their families. It is important to continue the process of revisiting and updating the approach, recognizing that the field is constantly evolving, and new approaches are continuously emerging over time. As a result, this update should be seen as dynamic, with flexibility to change and adapt to advances in the field based on experience and research.

Implementation and sustainability of the SOC approach involves significant change across systems serving young people and their families (Hodges et al., (2010). Five core strategy areas have been identified as essential for system change (Stroul & Friedman, 2011). Building effective SOCs requires multiple strategies in each of these areas, along with strategies to address implementation challenges:

- Implementing policy and partnership changes
- Developing or expanding services and supports
- Creating or improving financing strategies
- Providing training, technical assistance, and workforce development
- Strategic communications

Flexibility is essential in how the SOC approach is implemented across states, communities, tribes, and territories with different structures, geographical characteristics, cultures, resources, strengths, and challenges. This updated approach is comprehensive and represents the ideal philosophy, infrastructure and range of treatment and supports for children, youth, and young adults with SED or SMI. The goal is to develop the capacity to provide comprehensive, high-quality care, recognizing that jurisdictions will establish priorities based on environmental and resource factors. It is hoped that describing an evolving SOC approach and outlining these new updates will support efforts to improve service delivery and outcomes for young people and their families.

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Appendix A: List of Expert Organizations Consulted

Subject matter experts from the following organizations provided input and feedback at key junctures throughout this project:

- Center for Evaluation and Program Improvement, Vanderbilt University
- Center for Learning and Working During the Transition to Adulthood, Department of Psychiatry, University of Massachusetts Medical School
- Change Matrix
- Department of Child and Adolescent Psychiatry, New York University
- Family Run Executive Directors Leadership Association
- Georgetown University Center for Child and Human Development
- Human Service Collaborative
- Judge Baker Children's Center, Harvard University
- Management & Training Innovations
- National Alliance on Mental Illness
- National Association of State Mental Health Program Directors
- National Center for School Mental Health
- National Federation of Families for Children's Mental Health
- National Network to Eliminate Disparities in Behavioral Health
- National Wraparound Implementation Center
- National Wraparound Initiative
- Oklahoma Department of Mental Health and Substance Abuse Services
- Research and Training Center for Pathways to Positive Futures, Regional Research Institute, Portland State University
- SAMHSA Center for Substance Abuse Prevention
- SAMHSA Mental Health Promotion Branch
- SAMHSA Office of Behavioral Health Equity
- SAMHSA Office of Management, Technology, and Operations
- School Mental Health Assessment Research and Training (SMART) Center, University of Washington
- Technical Assistance Network for Children's Behavioral Health, Institute for Innovation and Implementation, University of Maryland School of Social Work
- University of Washington School of Medicine
- Utah Department of Human Services
- Youth MOVE National

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