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COMMENTARY

Sustaining and Expanding Systems of Care to Provide Mental Health Services for Children, Youth and Families Across America

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Abstract The Substance Abuse and Mental Health Services Administration has been instrumental in supporting the development and implementation of systems of care to provide services to children and youth with serious mental health conditions and their families. Since 1993, 173 grants have been awarded to communities in all 50 states, Puerto Rico, Guam, the District of Columbia, and 21 American Indian/Alaska Native communities. The system of care principles of creating comprehensive, individualized services, family-driven and youth-guided care and cultural and linguistic competence, supported by a well-trained and competent workforce, have been successful in transforming the field of children's mental health and facilitating the integration of child-serving systems. This approach has achieved positive outcomes at the child and family, practice and system levels, and numerous articles have been published using data collected from system of care communities, demonstrating the effectiveness of this framework. This article will describe lessons learned from implementing the system of care approach, and will discuss the importance of expanding and sustaining systems of care across the country.

Keywords Children · Mental health · Systems of care · Youth · Family-driven · Public health

The purpose of this commentary is to address the ideas, lessons learned and recommendations identified in the articles contained in this Special Issue. When reviewed in their totality it is evident that concepts, values and principles of systems of care (SOC) have positively impacted the field of children's mental health. Communities, States, tribes and Territories that have implemented a system of care approach demonstrate improved outcomes across diverse populations and geographic areas. And, it is also clear that more work is needed to improve, expand, evolve and sustain the SOC approach for children and youth with serious mental health conditions and their families. This has been the cornerstone of the Comprehensive Community Mental Health Services for Children and their Families Program, and must continue to be the organizing framework for child, youth and family mental health in the future.

Childhood emotional and behavioral disorders are the most prevalent and costly of all chronic illnesses in children and youth (Soni 2009). In 2006, 8.9 billion dollars were spent for the treatment of mental disorders in children, representing the highest of any children's health care expenditures, exceeding asthma, trauma-related disorders (e.g., fractures, sprains, burns, and other physical injuries from accidents or violence), acute bronchitis, and infectious disease (Soni 2009). It is estimated that 20 % of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, and this costs the public $247 billion annually (National Research Council and Institutes of Medicine et al. 2009). Of children and youth in need of mental health services, 75–80 % of these youth do not receive services (Kataoka et al. 2002). It is also estimated that of the 2 million youth aged 12–17 in 2007 that met criteria for a major depressive episode, only 39 % actually received services (Substance Abuse Mental Health Services Administration Office of Applied Services 2009). Given the estimated prevalence of emotional and

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behavioral disorders, the limited access to appropriate services, and the costs associated with these conditions, it is critical to develop efficient and effective strategies for addressing what can legitimately be labeled as a public health crisis (Alegria et al. 2010; Stelk and Slaton 2010).

This issue of the *American Journal of Community Psychology* dedicated to systems of care in children's mental health provides a comprehensive review of what has been learned about the role of systems of care in achieving first-order improvements for children and families and impacting second-order change for the organizations and systems that serve them. This issue also provides a forum to take inventory of what is already known about systems of care, areas that require more research, and strategies to take this approach to scale for broader impact. The authors in this issue provide information on: the importance of implementing the principles of family-driven and youth-guided care; how services and systems can be culturally and linguistically competent; the need for an expert workforce that is trained to implement the SOC principles; the understanding that systems change is a slow process that benefits from ongoing monitoring and evaluation; the recognition that integration of services across the life span and disciplines is critical to long-term success; and the identification that the expansion and sustainability of systems of care must be the preferred approach to supporting children's mental health. Community psychology plays an important role in advancing and supporting systems of care. In fact, the community psychology orientation that embraces a person-in-environment philosophy and a focus on the community-at-large as the "identified client" are particularly consistent with the principles and values of the systems of care approach (see Cook and Kilmer 2012).

Background

The SOC framework is defined as a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life (Stroul et al. 2010). In 1992, Congress incorporated this model into Public Law 102-321 as amended, Part E, Sections 561-565, to create the *Comprehensive Community Mental Health Services for Children and Their Families Program* (i.e., Children's Mental Health Initiative or CMHI).

It is important to distinguish the definition of "SOC" from the concept. The definition serves to provide a framework and philosophy to guide service systems and service delivery in order to improve the lives of children with mental health challenges and their families. The definition was not to propose a "model" to be "replicated" or to be implemented in a model-adherence manner similar to a discrete, manualized treatment; nor was it intended to refer to a single "program" that operates according to this philosophy. Rather, a SOC as a concept is a coordinated network of services and supports across agencies to meet the multiple and complex needs of a particular population (Stroul and Blau 2010). More than 20 years into this initiative, some efforts have been made to update and expand the definition of a SOC, both in the literature and in practice; modifications that incorporate more of a public health approach are a natural outgrowth of the evolution of systems of care. While definitions are important, perhaps more significant is that, much like the youth and families they serve, systems of care are dynamic, individual to each community, and, if continually and actively maintained and evaluated, highly effective in meeting the needs of children and youth with serious emotional and behavioral difficulties and their families.

The concept has shaped the work of nearly all states, many communities, tribes, and territories to the extent that at least some elements of the SOC philosophy and approach can be found in nearly all communities across the nation. As of 2011, the CMHI has invested more than $1.6 billion in grants and cooperative agreements to 173 communities in all 50 states, Puerto Rico, Guam, the District of Columbia, and 21 American Indian/Alaska Native communities. The funding has increased from $4.9 million/year in fiscal year (FY) 1992 to $118 million/year in FY 2011.

Throughout its history, this program has achieved consistently positive results. Research and evaluation results have found that implementing a SOC approach improves the lives of children, youth and families, including improvements in clinical and functional outcomes, increases in behavioral and emotional strengths for both youth and caregivers, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reductions in reliance on inpatient care, and more stable living situations (Manteuffel et al. 2008). The SOC approach has had a positive impact on the structure, organization, and availability of services and has been shown to be a cost-effective way of investing resources, redirecting resources from restrictive services (inpatient and residential treatment) to home and community-based services and supports (Gruttadaro et al. 2009; Maine Department of Health and Human Services 2011; Manteuffel et al. 2008; Maryland Child and Adolescent Innovations Institute 2008). As a result of these positive outcomes, the SOC approach has been widely adopted by mental health systems as well as by child welfare, juvenile justice, education, and substance abuse

systems; early childhood programs; systems designed to serve youth in transition to adulthood; and even by many adult-serving systems.

The SOC program is highly consistent with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Theory of Change model (Hyde 2011) that takes the development of an innovation through the phases of demonstration, dissemination, implementation, and widespread adoption. The CMHI began as an innovative idea, has progressed through the stages, and is now ready to evolve and expand so that there is broader implementation of this approach.

Although CMHI has historically been identified and labeled as a "services" program, in reality this is a misnomer. The reason is that the majority of service dollars are provided by other sources—Medicaid; the Children's Health Insurance Program; third-party insurance; the child welfare, juvenile justice, and education systems; and other state and local funding streams. The CMHI dollars were never intended to provide all the services that are needed to care for children and youth with mental health conditions. Rather, these dollars were intended to create infrastructure, access, capacity, and the system changes necessary to develop and sustain the SOC approach. In order to expand and sustain the SOC values and principles, the move towards increasing infrastructure and creating more state involvement in establishing and supporting systems of care is the future direction of federal program policy.

In light of the ever-changing environment in which systems of care exist, and the move toward greater evolution and expansion of systems of care beyond the grant communities historically funded by SAMHSA, the articles in this issue provide an important springboard for further discussion, conceptualization, and evaluation. This commentary will highlight lessons learned and next steps across themes that are addressed in this special issue: Family-driven and Youth-guided Systems of Care, Cultural and Linguistic Competence (CLC), Workforce, Systems Change, and Integration. Each of these themes will be addressed separately and cumulatively, and lead to the final section on the importance of "Expanding and Sustaining the SOC Approach."

Family-Driven and Youth-Guided Systems of Care

Perhaps the most transformational principle of systems of care is that of providing services, supporting organizations, and systems that are family-driven and youth-guided. Family-driven care means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. Families assume a significant role in choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing and evaluating programs; monitoring outcomes; and partnering in funding decisions (National Federation of Families for Children's Mental Health 2010a).

Youth-guided services support the active participation of youth receiving services in the development and selection of their treatment plans while also providing input on which services meet their personal goals. Additionally, youth are encouraged and challenged to participate in governance activities that guide SOCs, such as advisory boards and evaluation activities.

There has been a shift from blaming parents for the mental health challenges of their children (being "causal agents") to considering families as "full partners in policy making, planning, and priority setting, and evaluating the overall SOC" (Stroul and Friedman 1994, p. 22). Researchers, policy makers, advocates, and providers in children's mental health have worked to enhance the role of families in decision making at all levels of service planning and delivery. Ultimately, these changes have significantly impacted how families are perceived by system partners and the level at which they are engaged within the mental health service system.

Research studies and grant communities' evaluations alike have documented that family-driven and youth-guided care produce positive results for individuals and the systems that serve them. Family engagement in general is a key factor in getting to positive outcomes in psychotherapy (Burns et al. 1999). Additionally, an individual's family is often the most direct influence in child development. Parents have the ability to serve as a catalyst to promote positive mental health development, and family involvement has been found to improve school and mental health outcomes and help reduce mental health disparities (Osher et al. 2008a, b; Spencer et al. 2010). Youth who are involved in SOCs report feeling greater control over their own lives, and that their involvement helped all youth in their community (Matarese et al. 2008). When youth and families have a commitment to treatment, it increases their role in making the primary decisions on their clinical services (Manteuffel 2010). The national evaluation of CMHI has found that, overall, SOC communities rate highly in the implementation of family-driven care, and the families' participation in service planning has improved over time (Brashears et al. 2012).

While great strides have been made in the ability of SOCs to implement family-driven and youth-guided services, there is still work to be done. Training continues to be an ongoing need for providers on how to engage and include families and youth in the treatment process. Such training should focus on how to deliver strengths-based assessments and interventions (McCammon 2012), and how to address the basic of needs of youth and families so

that they may meaningfully and actively participate in treatment and function in the community (Brashears et al. 2012). Training must also help providers effectively engage and support youth and families to take the lead in service delivery (Slaton et al. 2011), and build on the relationships that youth and families already have with peers, community partners, and faith-based organizations (Finello and Poulsen 2012). Additionally, training must be supported by consistent and meaningful supervision by supervisors and managers who are supportive of, and committed to, family-driven and youth-guided services.

Several of the articles in this issue highlighted the value of treating the whole family, rather than focusing on one individual or "patient" as the locus of care and intervention (Brashears et al. 2012; Finello and Poulsen 2012; Haber et al. 2012; Suarez et al. 2012). True family-driven care is when the focus of intervention is the whole family, and where the dichotomy between adult and child mental health systems is diminished. Certainly this approach is consistent with the ecological perspective of community psychology, as highlighted by Cook and Kilmer (2010): that the treatment of the adult, in which each of his/her roles in society (i.e., as worker, as citizen, as caregivers/parents, etc.) is attended to as part of the intervention, benefits the child with serious emotional or behavioral difficulties.

One of the greatest challenges to family-driven and youth-guided care is sustaining them on a long-term basis. Slaton et al. (2011) recommend several avenues for sustainability, including the horizontal placement of youth and family representatives on governance committees; advocating with legislators for funding; making effective use of data to support advocacy efforts and to communicate accomplishments; effective public relations; coalition-building with other groups; family- and youth-run organizations; and training efforts directed at providers and youth and families. Systems of care can also strive for sustainability by ensuring that policies, programs, and administrative functions (e.g., requests for contracts, contract language, and performance benchmarks, consumer review and approval) are reflective of the principles of family-driven and youth-guided care (Brashears et al. 2012; Haber et al. 2012). Further, working within existing payor structures (e.g., Medicaid, third party payors) to gain reimbursement for consumer provider activities, such as peer partners, will ensure a funding source for vital services.

In order to effectively support family leadership, agencies and systems must actively and continually support and promote these concepts in policies, programs, and administrative functions (Barksdale et al. 2012; Brannan et al. 2012). In addition, as the next section illustrates, inclusion of families into SOCs loses meaning unless cultural and linguistic context and needs are respected and addressed.

Cultural and Linguistic Competence

Cultural Competence is defined as the integration of knowledge, information, and data about individuals and groups of people into clinical standards, skills, service approaches and supports, policies, measures, and benchmarks that align with the individual's or group's culture and increases the quality, appropriateness, and acceptability of health care and outcomes (Cross et al. 1989). Linguistic competence is defined as the capacity within an organization and its personnel to deliver effective information in a manner that is easily understood by diverse audiences (Goode and Jones 2003). In the context of SOCs, this means that the values, customs, practices, and traditions of the child and family are inherently part of the service planning and delivery, and that the service systems with which the child and family interface are competent to incorporate these foundational elements.

Culture and language are ubiquitous and highly influential, as well as abstract and difficult to describe. Cultural, political, and historical beliefs shape all the perspectives of the individuals that are part of a SOC: agency staff, community partner staff, children, youth, and families. These beliefs impact how, when, and under what circumstances a child and family may seek services from a SOC, and continue to influence their participation in those services throughout the service encounter. Similarly, these same beliefs are present in the service providers themselves, and impact the helping relationship positively and negatively. Additionally, cultural and political influences also impact a system's interface with the community it serves. Culture and language exert forces on all of these levels, and each level impacts the other levels, thereby presenting challenges and opportunities for systems of care in emphasizing CLC.

What is typically and historically included under the category of "culture" is race and ethnicity, and these are most certainly important aspects of culture. One example provided by West et al. (2012) focuses on the experiences of urban American Indian (AI) youth and families. However, most of the broader implications of this article are also applicable to cultures beyond AI youth and families, such as honoring local definitions of mental health and wellness, community-based and culturally relevant services, and systems and policy changes.

It is also important to broaden the definition of culture beyond the typical notion. Recently, the culture of poverty has received additional attention (Barksdale et al. 2012; Brashears et al. 2012), and is particularly salient given the lengthy and pervasive recession that this country and its citizens have experienced. Youth culture is also important, particularly as SOCs work to become more youth-guided (Barksdale et al. 2012). Cultural differences between urban

and rural settings, and the other cultural indices, such as sexual orientation, must also be considered in the context of services and systems.

System of care communities implement the principle of CLC in different ways, and frequently experience challenges in doing so (Barksdale et al. 2012; Brannan et al. 2012). Brannan et al. (2012) found common difficulties across communities in the implementation of CLC. At the service delivery level, communities struggle to conduct outreach efforts that overcome cultural and linguistic barriers; staff often are not reflective of the population of focus; service arrays frequently do not include culturally appropriate options; culture is often not incorporated into the strengths and needs assessment, or the service planning and delivery process; and frequently language services are lacking. At the infrastructure level, governance boards generally are not reflective of the population of focus; and cultural competence training is limited, as is cultural competence quality monitoring. Additionally, communities tend to implement CLC at a service delivery level earlier on in the implementation of a SOC than at the infrastructure level (see Barksdale et al. 2012; Brashears et al. 2012).

Communities often struggle to implement the CLC principle more than other principles (Brashears et al. 2012), and they also experience the greatest gains in implementing culturally and linguistically competent services over time (Brannan et al. 2012). This may indicate that implementation of CLC is developmental in nature, and reflective of a trust-building process that takes time.

Each of the aforementioned challenges presents an opportunity for next steps, and is underscored further within the context of sustainability and expansion. Contributors to this issue highlight the need for, and importance of, effective outreach to historically underserved populations, followed closely by effective engagement strategies to envelope them into the SOC. Engagement of caregivers in service delivery is key to the effective implementation of CLC, and has been shown to have an impact on the implementation of other principles and values (Barksdale et al. 2012). Concurrently, a focus on training at all levels of the SOC on CLC is essential, and should focus on race, ethnicity, and other cultural elements; on how to integrate these elements into assessments, service planning, and delivery; and on monitoring these processes through evaluation of the interventions and the SOC (Brannan et al. 2012; Brashears et al. 2012).

Finally, as SOCs expand into the larger public mental health system, it will become increasingly challenging to maintain focus on CLC simply due to the expanded numbers and breadth of cultural and languages, and ongoing technical assistance and quality monitoring may be useful in sustaining the necessary attention to this principle, a recommendation also made by others (Barksdale et al. 2012). Community psychologists will likely be great resources to the field in this arena, as they can help agencies and systems understand and respond to the dynamics between the dominant society and different population groups (Isaacs et al. 2008).

Workforce Development

There are many challenges facing the children's mental health workforce today, including a limited number of professionals in the field, and the need to update training programs for mental health professionals to keep pace with the evolution of what has become the standard of care. The field of children's mental health continually struggles with having a workforce that is sufficient in size, appropriately trained, diverse enough in specializations, and committed to meeting the multiple complex and voluminous challenges children with serious emotional difficulties and their families encounter. Simply put, there are not enough psychologists, therapists, social workers, or child psychiatrists. What has become increasingly apparent is the need to expand the workforce beyond what we historically have considered professional providers in this field to include family support providers and youth support providers.

Several strategies need to be in place in order for this to happen, many of which were identified by Wenz-Gross et al. (2012), and supported by others (Brashears et al. 2012). First, the leadership and organization in which family and youth support providers will be employed must be supportive of such roles within the agency. Accordingly, family and youth support providers need supports in place that will allow them to build on their skills, compensate them for their work, and receive appropriate supervision so they can be successful in their roles. Additionally, the family and youth support providers themselves must have certain characteristics upon which professional skills can be built: strong engagement skills, the ability to collaborate with other organizations and individuals, and an understanding of both organizational and personal boundaries to ensure they balance system limitations with sharing their personal experience and conveying the family perspective in their work. Finally, policies and funding must support the professionalization of these roles within the organization. This includes reimbursement through Medicaid, linking to family-run organizations, and continued efforts in creating certification programs, such as has been developed by the Federation of Families for Children's Mental Health (National Federation of Families for Children's Mental Health 2010b).

In addition to broadening the workforce it is also important to update existing training programs for mental health professionals to reflect current standards of practice. By and large, universities that generate the professional

mental health workforce still operate programs that are stove-piped according to specialization, and that are steeped in traditional methods, such as deficit-based services in a generic outpatient setting. Unfortunately, this extrapolates to a workforce that does not make use of the most current and evidence-based practices. Considerable evidence suggests the workforce is uninformed and unengaged as it relates to health promotion and prevention activities (Hoge et al. 2007). The next phase of professional education must train individuals to approach mental health services from a strengths-based capacity, based on a SOC approach, and make use of data in developing and implementing evidence-based practices. One existing model that shows promise is that of the University of South Florida's Graduate Certificate in Behavioral Health Counseling. This certificate program trains its students in integrative approaches to health and well-being and emphasizes collaboration between counselors and other health care professionals to better assist clients in achieving and maintaining wellness (University of South Florida Department of Rehabilitation and Mental Health Counseling 2012). Mental health guilds and professional organizations play an integral role in changing the manner in which the profession is educated and in how the workforce can be further expanded and trained.

Quality Improvement Drives Change

As noted, the articles in this special issue, among others in the literature at large, poignantly capture the challenges currently facing the children's mental health field at the child and family, practice, and systems levels: Assessments of children often do not adequately account for cultural and linguistic issues; interventions frequently do not match the needs identified; clinicians often do not have sufficient training or supervision to effectively implement the most appropriate interventions; and limited financial and human resources do not effectively support the workforce training or development activities that are necessary to meet the complex needs of the children and youth served by the mental health field. Ongoing quality improvement activities will drive change at each of these levels, resulting in synergy in which there is a snowball effect of improvements. As Brashears et al. (2012) note, although many SOC communities engage in quality improvement practices, frequently those systems are directed at ensuring an activity is complete rather than effective.

Quality improvement practices benefit the individual and practice levels in ways that build upon one another. Progress in the implementation of evidence-based practices with fidelity usually results in improvement in clinical outcomes for children and families, which in turn builds more evidence for those practices and adaptations thereof for other populations (West et al. 2012). This inherently expands the number of mental health professionals qualified to implement evidence-based practices that are more effective, and are also more efficient.

Effective quality improvement processes must include an ongoing feedback mechanism at each level. At the individual level, that may be the child's case plan. Clinical supervision may be the mechanism at the practice level, and may also include using the child's case plan as an indicator of the effectiveness of the practice itself. At the systems level, the SOC Assessment tool (SOCA) is frequently used by SOC communities, although other types of needs or readiness assessments may be used. It is important to note that change at the systems level is very slow, sometimes taking years.

Ongoing assessment and feedback loops are important to track, maintain, and communicate progress (Brannan et al. 2012; Brashears et al. 2012). Taking a community-based, participatory approach empowers families and communities to support and promote their own indigenous practices, and to develop an evidence base to support their culturally-based methods of healing (West et al. 2012). Several models were presented in this special issue that may be of use when monitoring systems level change in particular, and typically take a systemic action research process approach, such as the "Above and Below the Line" process (Foster-Fishman and Watson 2012; see also, Armstrong et al. 2012).

Using a Public Health Approach: Integration Across Human Service Delivery Systems

Expanding the SOC framework to incorporate a public health model is a new and evolving context for systems of care (Holden and Blau 2006; Stroul et al. 2010). There are multiple definitions and frameworks for a public health approach, and federal policy is beginning to translate these ideas into action. Recently, with support from SAMHSA's Child, Adolescent and Family Branch, Georgetown University's Center for Child and Human Development developed a monograph entitled, "A Public Health Approach to Children's Mental Health: A Conceptual Framework" (Miles et al. 2010).

This re-conceptualization of children's mental health within a public health framework is strengths-based (see McCammon 2012) and calls for taking a population focus, incorporating both promotion (supporting optimal health) and prevention (addressing problems before they occur), and understanding the determinants of health (factors that contribute to positive and negative health outcomes). In addition, a new term, "Reclaiming," is used to reflect interventions and actions that optimize positive mental

health for children and youth with identified mental health problems. Reclaiming is broader than the concept of "recovery," and emphasizes the holistic striving for optimal health rather than just alleviating the suffering associated with mental illness.

This type of public health approach calls for a paradigm shift moving from the idea that any one system is responsible for children's mental health. Rather, multiple partners, disciplines, and sectors that touch children's lives must come together to advance the health of America's children. This requires a partnership between education, early child care providers, child welfare, juvenile justice, recreation programs, faith-based organizations, etc. to examine their role in children's mental health.

System Integration

Organizations and systems have historically maintained high levels of fragmentation. In the human services arena, this typically manifests in "silos" that are organized around specialized expertise: substance abuse, welfare, education (primary, secondary, and higher), justice, etc. While this indeed may be an efficient way of conducting business for the organizations and systems, it is frequently not the most effective—or cost-efficient—way to meet the complex needs of the people served by them, particularly those who require services from multiple agencies. Systems of care are designed to cross-sect these silos in order to meet such complex needs, and in doing so have been shown to redirect resources from costly inpatient and residential treatment services to home- and community-based services (Gruttadaro et al. 2009; Maine Department of Health and Human Services 2011; Manteuffel et al. 2008; Maryland Child and Adolescent Innovations Institute 2008).

Systems of care under the CMHI grant program are statutorily required to focus on children and/or adolescents with a serious emotional disturbance, also referred to as children and youth with "serious mental health needs" (Miles et al. 2010). As a result, systems of care are frequently assumed to be affiliated primarily with children's mental health. However, the SOC approach can be, and already has been, implemented to address other areas than children's mental health: child welfare, juvenile justice, education, and substance abuse services. This may be due, at least in part, to the fact that children with serious mental health needs are frequently served by these other child-serving systems at the same time they are receiving mental health services.

Collaboration between mental health and other child-serving systems has laid the groundwork for greater expansion of the system of care approach to impact populations beyond just children with serious mental health difficulties. Nonetheless, these large, bureaucratic systems continue to be challenged to break down institutional, fiscal, and political barriers to effectively serve children, youth, and their families. Two examples of such challenges are children and youth in the juvenile justice system who have mental health difficulties, and the intersection of mental health and substance abuse services in treating individuals with co-occurring mental health and substance abuse disorders.

Studies have found that 65–70 % of youth in contact with the juvenile justice system meet criteria for at least one mental health disorder (Erickson 2012; Shufelt and Cocozza 2006; Wasserman et al. 2004). For many of these youth, contact with the juvenile justice system stems from untreated mental health needs that manifest in negative or delinquent behaviors. The juvenile justice system, with a primary mission to maintain public safety, lacks the appropriate resources and expertise to become the mental health providers for these youth. Youths' mental health needs are frequently identified and addressed in service systems other than mental health, and these youth often are "involved with more than one specialized service system, including mental health, special education, child welfare…substance abuse, and health" (President's New Freedom Common on Mental Health 2003, p. 58). This frequently results in duplication of some services, gaps in other services, conflicting missions, different terms for similar concepts, varying regulatory mandates, and different funding streams.

In addition to the challenges inherent in coordinating care across systems are challenges in integrating treatment for mental health and substance abuse disorders. This type of treatment presents challenges to the youth and adult community alike. Co-occurring disorders are to be expected in all behavioral health settings, and system planning must address the need to serve people with co-occurring disorders in all policies, regulations, funding mechanisms, and programming. Approximately 8.9 million adults have co-occurring disorders. Only 7.4 % of individuals receive treatment for both conditions, with 55.8 % receiving no treatment at all. Every year approximately one million youth under the age of 18 in the United States come in contact with the juvenile justice system (Kamradt 2002). Of these children, an estimated 80 % have diagnosable mental health disorders, and many also have co-occurring substance use disorders (Kamradt 2002). Integrated treatment, or treatment that addresses mental health and substance use conditions at the same time, is associated with lower costs and better outcomes such as substance use reduction, improved psychiatric symptoms and functioning, decreased hospitalization, increased housing stability, fewer arrests, and improved

quality of life (Substance Abuse and Mental Health Services Administration 2011a).

The effective treatment of co-occurring mental and substance use disorders requires collaboration across disciplines. While evidence shows that the most effective services offer treatment for both disorders, practitioners are usually trained in separate fields, operate under distinct licenses with requirements that may restrict integrated care, and know relatively little about each other's organizational culture and operations. In order to work together effectively, practitioners need basic information on co-occurring disorders, common terms that are understood by all, and understanding and respect for each other's roles, responsibilities, and culture (Substance Abuse and Mental Health Services Administration 2011b).

These two examples underscore that, in order to establish an effective SOC, services must be available to all youth, regardless of the particular system in which their needs are identified, and that all involved child-serving systems—juvenile justice, mental health, child welfare, and education—collaborate and share responsibility for these services (Shufelt et al. 2010). This shift will focus on strengthening community mental health services and exploring the notion of "no wrong door" to services (i.e., accessible from multiple points of entry). This collaboration can result in improved system relationships and serve to build trust between the agencies; a reduction in the duplication of services; and engagement in coordinated needs assessments and planning efforts that allows limited resources to be used more efficiently (Macbeth 1993). Lastly, these changes can result in significant cost savings to the taxpayers, while at the same time ensuring a more comprehensive and effective SOC in the community (Shufelt et al. 2010).

In addition to the implementation of SOCs within a number of disciplines and sectors that serve children, the approach has also been implemented across the lifespan to address early childhood, youth in transition to adulthood, and adult-serving systems, perhaps to a lesser extent. Programs that target young children must also incorporate the strengths and needs of the caregivers, thereby necessitating integration between child- and adult-serving systems into their service approach. Similarly, programs focused on youth transitioning to adulthood require aiding the youth in transition from child-serving systems to the adult-serving systems. The ecological perspective offered by community psychology is useful when considering full integration of systems of care across disciplines and the lifespan. The impact of family and community factors is integral and allows for promotion of healthy systems in addition to healthy individuals, with a focus on wellness rather than illness. Such an approach would also result in reduced stigma, as the full integration of mental health services into existing mainstream activities normalizes the availability and use of such services (West et al. 2012). Several examples of successful efforts to integrate services across the lifespan include Home Visitation programs, Project LAUNCH, and the Healthy Transitions Initiative (HTI); the paragraphs that follow describe these briefly in turn.

Home visiting programs offer a variety of family-focused services to expectant parents and families with new babies and young children to address issues such as maternal and child health, positive parenting practices, safe home environments, and access to services (Child Welfare Information Gateway 2012). A comprehensive review and synthesis of home visiting models found that these models have favorable impacts on child development, school readiness, and positive parenting practice (Paulsell et al. 2011). Under the Affordable Care Act, the Maternal, Infant, and Early Childhood Home Visiting Program was created to support evidence-based home visiting programs focused on improving the well-being of families with young children. This program takes a multi-disciplinary and community-based approach to meeting young children's needs, including health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance (Olds et al. 1997).

Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a SAMHSA-funded grant program, seeks to promote the wellness of young children (ages birth to eight) by addressing the physical, social, emotional, cognitive and behavioral aspects of their development. Grants are awarded to states, territories, tribes and localities to improve collaboration and coordination across child-serving systems, and to increase access to evidence-based prevention and wellness promotion practices. Local communities promote healthy social and emotional development by integrating mental-health informed practices into child care centers and schools; primary care clinics; home visiting programs; and families. This includes increasing the use of screening and assessment for developmental and behavioral health issues across settings, and improving pathways to link children and families with appropriate services. In the first 3 years of the initiative, the 24 sites around the nation have brought mental health consultation into 152 early care and education centers, and 99 health care settings; have offered training and support to home visitors in 27 home visiting programs; and have educated over 10,000 community providers on issues related to behavioral health. Additionally, 4,800 families have participated in family strengthening/parent training programs supported by Project LAUNCH (2010).

Youth and young adults in transition often encounter many challenges along the road to adulthood.

Developmentally, the period of transition is particularly difficult for youth who experience mental health challenges and their sequelae which can include school dropout, under- and unemployment, contacts with the juvenile or criminal justice system, substance abuse disorders, early and unplanned pregnancy, and homelessness (Blau and Sondheimer 2009). Studies have shown that 50 % of all mental illnesses emerge by the age of 14, and by the age of 24 that number increases to 75 % (Blau and Sondheimer 2009). Young people who experience mental health challenges frequently face a difficult transition into adulthood and may face challenges when assuming various roles as adults, in comparison to peers with or without other disabilities (Blau and Sondheimer 2009). They face many challenges in completing high school, selecting post job training or higher education, securing and maintaining employment, managing finances, developing relationships, and living independently in adulthood (Arnett 2000).

In 2009, SAMHSA funded the HTI to seven grantees. The purpose of the HTI was to create developmentally-appropriate and effective youth-guided local systems of care to improve outcomes for youth and young adults ages 16–25 with serious mental health conditions. These grant communities assist the youth in areas such as education, employment, housing; attend to their mental health and co-occurring disorders; and to decrease their contacts with the juvenile and criminal justice system.

Home visiting programs, Project LAUNCH, and HTI exemplify that human service systems that are integrated across the lifespan is possible and can be more effective in achieving positive outcomes for those they serve than traditional approaches to service provision. An integrated human service system emphasizes continuity and quality and operates from shared vision of that system that guides the development of programs and policies and the allocation of scarce resources (Center for Substance Abuse Treatment 2007a, b). Efforts toward integration must always be conducted with the intent and goal of improving outcomes for the individual and family being served, and should contain several key elements (Center for Substance Abuse Treatment 2007a, b). Among these elements, the integrated SOC must be accessible from multiple points of entry, or through "no wrong door." Systematic screenings and assessments should be focused on a multitude of issues, including but not limited to trauma exposure, substance use, violence, and child maltreatment (Finello and Poulsen 2012; Suarez et al. 2012). Systems of care should not be limited to a single model or approach. Rather, interventions should be based on an assessment of individual needs and preferences, matched to appropriate levels of care, and provided or coordinated by a single treatment team or within a comprehensive treatment model (Center for Substance Abuse Treatment 2007a, b).

Perhaps the most accessible vehicle for effective systems integration and a public health approach to meeting children's mental health needs is through primary care. Pediatricians have access to providing services to children, and a movement is afoot to make those services more holistic in nature to include a focus on wellness as well as illness. Primary care visits frequently afford the opportunity to meet with the child and his/her caregiver simultaneously, which may not always be the case in other settings. A doctor's office visit also is a familiar and recurring event for most, making such visits viable outreach venues, while reducing stigma that is frequently associated with mental health services (West et al. 2012). Bright Futures and the American Academy of Pediatrics (2008) provide a periodicity schedule for well child visits, during which developmental and behavioral assessments should be conducted. This is a ready-built opportunity to conduct assessments and deliver services to children, youth and families in need in an integrated fashion that is community-based and sustainable. Pediatricians are often the first health care professional to address mental health issues, and more work is occurring to provide better training and consultation (Blau et al., in press).

Given the complexity of needs of children and youth with serious emotional difficulties, and the diverse families and communities on whom they rely, systems of care for this specific population are likely to be better served when the family unit is the focus of intervention, rather than the individual child, as was recommended by a number of the articles in this issue (Brashears et al. 2012; Finello and Poulsen 2012; Haber et al. 2012; Kilmer et al. 2008, 2010a, b; Suarez et al. 2012). Caregivers of children may have their own challenges that impact and are affected by the children's mental health difficulties: work obligations, health conditions, substance use, or their own mental health challenges, all of which must be incorporated into the development of a treatment plan. This presupposes a SOC that is not limited by age or mental health condition, but one that is individualized to the specific needs of the whole family and that meets these needs in the least restrictive, community-based setting; in short: a SOC with a public health focus.

Expanding and Sustaining the System of Care Approach

The intent of the SOC approach has always been to provide a framework and philosophy to guide services and systems that improve the lives of children and youth with serious mental health conditions and their families—not to create a special "program" in selected communities without the strong connection to state, tribal and territorial policy that is needed for widespread adoption of the approach. The

goal of CMHI is to use time-limited demonstration grants to produce system changes that are maintained after grant funding has ended and have a broader impact by expanding the SOC approach statewide and in territories and tribes.

SAMHSA took a step towards widespread adoption of systems of care in FY 2011 by issuing a Request for Application (RFA) for SOC Expansion Planning Grants. These grants are intended to develop a comprehensive strategic plan for improving and expanding services provided by systems of care and to expand the number of jurisdictions and locations within a state, political subdivision, territory or tribal entity that have adopted a SOC approach. However, planning grants alone will not ensure the widespread implementation of sustainable systems of care. And, while a planning process is certainly a necessary condition to advance and improve the lives of children and youth with serious mental health conditions and their families, planning alone will not be sufficient. What will be needed are subsequent ideas and resources to provide both financial and technical assistance to support the *implementation* of these strategic plans.

The "new vision" would support the expansion of systems of care by creating a sustainable infrastructure that will allow the values, principles, and practices comprising the SOC approach to become the primary way in which children's mental health services are delivered in the nation. The new vision creates options to assist states, tribes, and territories to implement systemic changes in policy, financing, services and supports, training and workforce development, and other areas that are necessary for sustaining and expanding the SOC approach, as well as to link with health reform implementation efforts.

The passage of two key pieces of legislation offers the opportunity to expand systems of care that further integrate human service systems, and that cross-cut specialty areas, age, and even funding streams: The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Patient Protection and Affordable Care Act (ACA). Both laws broaden the accessibility to, remove barriers from, and improve effectiveness of mental health care for Americans. Systems of care have already developed many processes and resources that can easily and expediently be applied to the implementation of ACA by States. Additionally, ACA provides a vehicle for the broader expansion of systems care as an approach to children's mental health services, as well as the broader human services field.

Provisions in the Affordable Care Act are consistent with the values and principles of SOCs and provide a unique and exciting opportunity to expand SOCs to a larger scale. Additionally, revised Federal reimbursement options for States under the expansion of Medicaid and CHIP will result in cost savings that can be redirected to further expand SOCs (Wotring and Stroul 2011). The following service and finance options could be used as strategies to build and sustain systems of care:

- Essential Benefits Package in Medicaid: A "benchmark benefit package" is being developed that will define the minimum benefits available to new Medicaid enrollees, which includes children and youth with serious mental challenges.
- Essential Benefits Package in Health Insurance Exchanges: States have wide discretion in developing health insurance plans that offer an array of benefits to individuals with incomes below specific thresholds and for small businesses.
- Medicaid and Children's Health Insurance Program (CHIP) Expansion: Medicaid and CHIP programs are anticipated to expand their enrollments by 33 % by 2019.
- Health Homes: As one option under Medicaid, health homes provide in one location an individual's primary care and other disability-specific services for individuals with chronic illnesses, serious mental health conditions, or addiction disorders. The health home also must provide care management and coordination for all services needed by the individual.
- 1915i State Medical Plan Amendments: Individuals below specific income thresholds and individuals with disabilities who receive specific levels of Supplemental Security income payments are eligible to receive Home and Community-Based Services under this provision of the law.
- Money Follows the Person: States may develop community-based, long-term care alternatives to institutional care; and state Medicaid programs may support ongoing, high-quality home and community-based care to individuals transitioning from institutions.

Several articles in this special issue, as well as other sources, provide important information on how financing strategies can be used to expand and sustain the SOC framework. However, systems change is a slow process and can be either facilitated or impeded by a wide variety of forces. Stroul and Friedman (2011) offer a number of specific strategies that can be used to expand systems of care:

- Incorporating SOC values and principles in requests for proposals, contracts, and regulations
- Providing training, technical assistance, and coaching on the SOC approach
- Creating or assigning clear focal points of management and accountability for SOC development and expansion at state and local levels
- Expanding the array of available services and supports, with particular focus on home- and community-based services

- Expanding an individualized, wraparound approach to service planning and delivery
- Expanding family and youth involvement in service planning and delivery
- Creating strong family organizations that can help to generate support for systems of care with important constituencies
- Increasing the use Medicaid to finance services and supports
- Using data on cost avoidance due to reductions in the use of costly residential placements to help build the case for systems of care
- Promoting CLC as an expansion strategy
- Using social marketing and strategic communications more effectively

Authors in this special issue also offer ideas that would help institutionalize a SOC approach. Brashears et al. discuss how Medicaid policy and regulations can be tailored to support community-based care services that are based on SOC values and principles. These authors also discuss options to blend or braid funding across child-serving systems. Finello and Poulsen describe how Medicaid's Early Periodic Screening Diagnosis and Treatment Program (EPSDT) could be aligned to better serve children and youth within a SOC approach. Hodges and colleagues (2012) recommend additional planning opportunities and identify the need to maintain a balance between statewide expansion of systems of care with the need to maintain services and supports at the community level. They call for a standardized needs assessment to determine readiness to expand and point to a number of lessons learned about how to create systems change, including the need to create champions who will adopt and translate shared beliefs into shared responsibility and shared action.

Concluding Statement

Enormous and rapid changes are occurring in the United States, changes that will invariably have significant implications for children with mental health conditions and their families. There are tremendous economic and budgetary challenges, a federal mental health parity law, health reform, a greater focus on prevention and public health approaches for children's mental health systems, and emerging efforts to expand systems of care. Many of these changes create important new opportunities, and some create new challenges that call for greater levels of collaboration and leadership in the future in order to build on the substantial progress that has been achieved over the last 25 years in addressing the mental health needs of children and their families, and to capitalize on new opportunities to continue this progress and focus on efforts in new directions. Toward these goals, the following considerations are offered:

- Provide more of a focus on how mental health agencies, providers and government policy officials can work together on organizing systems of care.
- Enhance or create infrastructure that supports family-driven and youth-guided care, including strategies to engage families and youth in policy and budget decisions. Develop strategies to include services and supports that are consistent with SOC values and principles in essential benefits packages under ACA. In particular, use structures that are already developed and in place—such as community child guidance agencies and other care management and provider entities – to become qualified and designated as health homes for children with behavioral health disorders.
- Identify mechanisms in other reform efforts, such as those that occur in child welfare, substance abuse, education and juvenile justice that will support efforts to expand and sustain systems of care. Also, use existing strategies such as the mental health block grant to ensure that SOC infrastructure, policy, services and supports are created and maintained.
- Continue to find ways to demonstrate cost effectiveness and focus on efforts to redirect high-end expenditures into community investments in systems of care.

The SOC approach has become the standard by which services and supports are provided for children and youth who have serious mental health conditions and their families. The approach has a rich history of helping to create positive outcomes and enjoys widespread support among providers, policy-makers, families and youth. The goal is to build on these lessons learned to create and implement a strategy that allow the SOC framework to grow and flourish so that children and youth with mental health challenges can reach their full potential and lead full and productive lives.

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