Tow Youth Justice Institute
Making connections. Informing solutions.

May 20th, 2025
3:00 PM – 4:30 PM
System Infrastructure
ZOOM

TCB System Infrastructure May Workgroup Agenda

1. **Welcome & Introductions**
2. **TCB Updates (TYJI)**
    a. Workgroup Updates
    b. Legislative Updates
    c. 2025-2028 Strategic Plan
3. **Systems of Care Presentations**
    a. Judith Meyers, Ph.D.
    b. Gary Blau, Ph.D.
    c. Jeff Vanderploeg, Ph.D.
4. **Discussion/ Q&A**

Children's Behavioral Health System Infrastructure Workgroup

Judith Meyers, Ph.D.

May 20, 2025

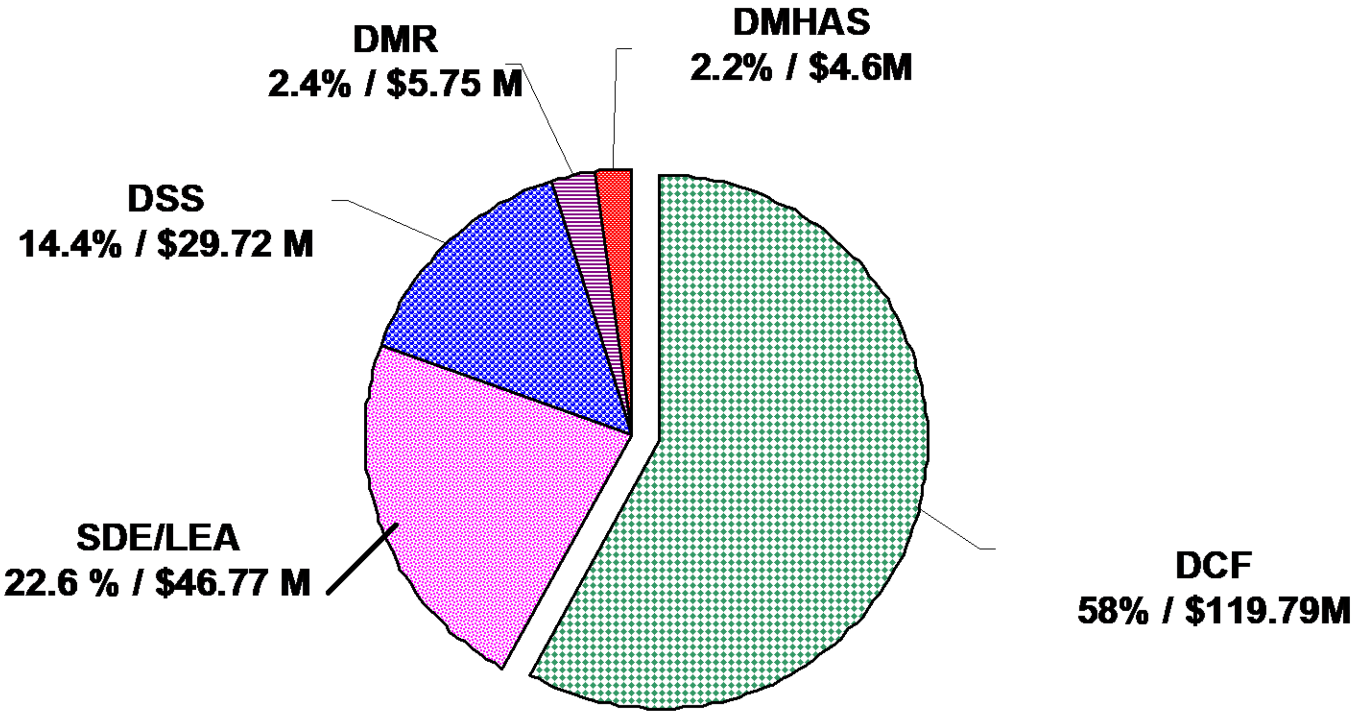
Milestones in Children's Mental Health Reform in Connecticut

1975	Established consolidated children's agency (DCF)
1997	P.L. 97-272 System of Care legislation
1999	State budget crisis/escalating costs for psychiatric hospital care resulting in P.A. 99-279 – calling for a study
2000	CHDI issued Delivering and Financing Children's Behavioral Health Services in CT
2000	Governor's Blue Ribbon Commission on Mental Health
2002	Connecticut Community Kidcare
2006	CT Behavioral Health Partnership
2014	Children's Behavioral Health Plan – PA 13-178 (Post Newtown)

Key Findings of Delivering and Financing Children's Behavioral Health Services in CT (2000)

- 184,000 children enrolled in HUSKY (now 366,000+)
- 22,300 (12%) used behavioral health services
- State spent $207 million per year in 5 state systems
- 70% of the dollars spent on 18% of the children served in psychiatric hospitals and residential treatment settings
- 30% spent on remaining 82% of children served in the community.
- 5% of children in HUSKY were in DCF custody yet accounted for 60% of expenditures
- Over half of youth in DCF custody who were hospitalized were no longer in need of this level of service – but limited discharge options
- No state advocacy and support network for families

Investment in Children's Behavioral Health Services: $207 Million in Public Investment



2000 Report Findings:
Problems in Service Systems

75-80% of children in need do not receive MH services

Services were:

- Categorical (silos)
- Crisis driven
- Over-reliant on residential and hospital care
- Fragmented
- Centralized
- Unresponsive to the needs of families
- Insensitive to variations in culture
- Limited array of services
- Limited integration of behavioral health with child welfare, juvenile justice, healthcare

2000 Report Recommendations

- Expand and enhance local systems of care
- Build a richer array of community-based services
- Develop a statewide family support network
- Develop and implement a blended funding approach
- Develop measurable outcomes
- Conduct training
- Improve information systems
- Conduct a thorough evaluation

Progress in System Reform
2001-2010

- Connecticut Community Kidcare
    - Carve out from Managed Care - Integrated funding streams
    - ASO – Value Options
    - Comprehensive benefits
- $23 Million annually allocated for KidCare Services
- New statewide services
    - Emergency mobile
    - Care coordination
    - Enhanced extended day treatment
    - Intensive home-based services – evidence-based
    - Crisis stabilization beds
- 27 Community Collaboratives (Systems of Care)
- Statewide Family Advocacy Organizations
- Better data systems and evaluation
- Addressing early childhood mental health

Newtown tragedy → Public Act 13-178- 2014

- Comprehensive in scope
- Integrated across public and private systems
- Inclusive of all children birth – 18
- Focus on key principles that support an effective system of mental health care:
    1) Family-driven; youth guided
    2) Developmentally appropriate
    3) Community-based
    4) Culturally and linguistically appropriate
    5) Trauma informed
    6) Data informed accountability

Behavioral Health Plan: Organizing Themes

- System Organization, Financing and Accountability
- Health Promotion, Prevention, Early Identification
- Access to Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Heath Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce

Key Goals/Strategies

- Create a Care Management Entity
- Implement evidence-based promotion and prevention models
- Universal standardized screening - part of comprehensive system of screening, assessment and referral
- Strengthen connections between primary care & behavioral health services
- Family support clearinghouse for mental health & substance abuse services
- Develop plan to address role of commercial insurers
- Develop and implement standards of culturally and linguistically appropriate care
- Finance expansion of services and supports where demonstrated gaps: *Crisis services, School-based services, Care Coordination, Suicide prevention*
- Workforce

Progress in System Reform
2014-2024

- Trauma-informed Systems and Care (i.e., TF-CBT)
- Expansion of Early Childhood Systems and Interventions – ECCP, screenings in primary care, CT-AIMH competencies
- EBTs – MATCH, ARC,
- Quality improvement systems – (e.g., mobile crisis)
- School mental health – SBDI, training
- New programs - Urgent crisis centers
- Integrated behavioral health and primary care
- ??

"We have learned to create the small exceptions that can change the lives of hundreds. But we have not learned how to make the exceptions the rule to change the lives of millions."

Lee Schorr

> ***"Systems are slow to change. It takes a commitment to a vision and values, patience, and a cadre of committed people who share in the cause. While the research is not yet conclusive, an accumulating body of evidence reinforces the work. Underlying all this is the experience of children and their families, who provide the passion and the reason to continue….We have come a long way. We have a long way to go."***
>
> *Judith Meyers, 2014*

Improving Child, Youth, and Family Mental Health Through Systems of Care

Gary M. Blau, PhD | May 20, 2025

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Agenda

- **The Case for Systems of Care**
  - What are Systems of Care
  - Impact of Systems of Care
  - Evolution of Systems of Care
- **Connecticut as a National Leader**
- **Systems of Care as part of Transformation**

The Data

It is estimated that nearly 20% of children and adolescents have a diagnosable mental, emotional, or behavioral disorder. And at least 1 in 10 young people has a SED at some time in their life (about 7.4 million children and youth).

2023 National Survey on Drug Use and Health (NSDUH):

- 9.1% of youth ages 12-17 had a substance use disorder (SUD; alcohol or illicit drugs) in 2023.
- Among the 1.9 million adolescents aged 12 to 17 in 2023 who had an SUD in the past year and did not receive substance use treatment in the past year, 96.8% (or 1.8 million people) did not seek treatment or think they should get it.
- Over half of children/youth with mental health needs do not receive services

Half of all mental illnesses emerge by the time a child turns 14, and 75% by the time a person is 24. And death by suicide is the second leading cause of death for individuals ages 10-14 and third for ages 15-24 in the United States (also second for ages 25-34). Mental Illness is a Pediatric Illness!

Addressing the Youth Mental Health Crisis

Across the nation, there are rising concerns about the mental health and well-being of young people.

- Emergency departments saw a 20% rise in children's mental distress and a 50% increase in suicide and self-injury cases from 2019 to 2022.
- The prevalence of depression and anxiety symptoms has been escalating for a decade, exacerbated by the stress and isolation of the COVID-19 pandemic, particularly impacting marginalized groups such as LGBTQ+ youth and youth of color.
- Emphasizing prevention and adopting a population health approach can enhance access to care and support resilience in youth.
- We must urgently address the issue at multiple levels: individual, community, and society.

Brief History of Systems of Care

1982: Jane Knitzer's book, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services,* led to the consensus that comprehensive, coordinated care was a necessity

1984: Congress appropriated funds for the Child and Adolescent Service System Program (CASSP) to help states and communities plan and implement comprehensive, community-based SOCs

Children's Mental Health Initiative (CMHI): planning → implementation

1986: Stroul, B. & Friedman, R. (1986). A system of care for children and youth with severe emotional disturbances. Washington, D.C.: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

1993: Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program

A System of Care (SOC)…

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

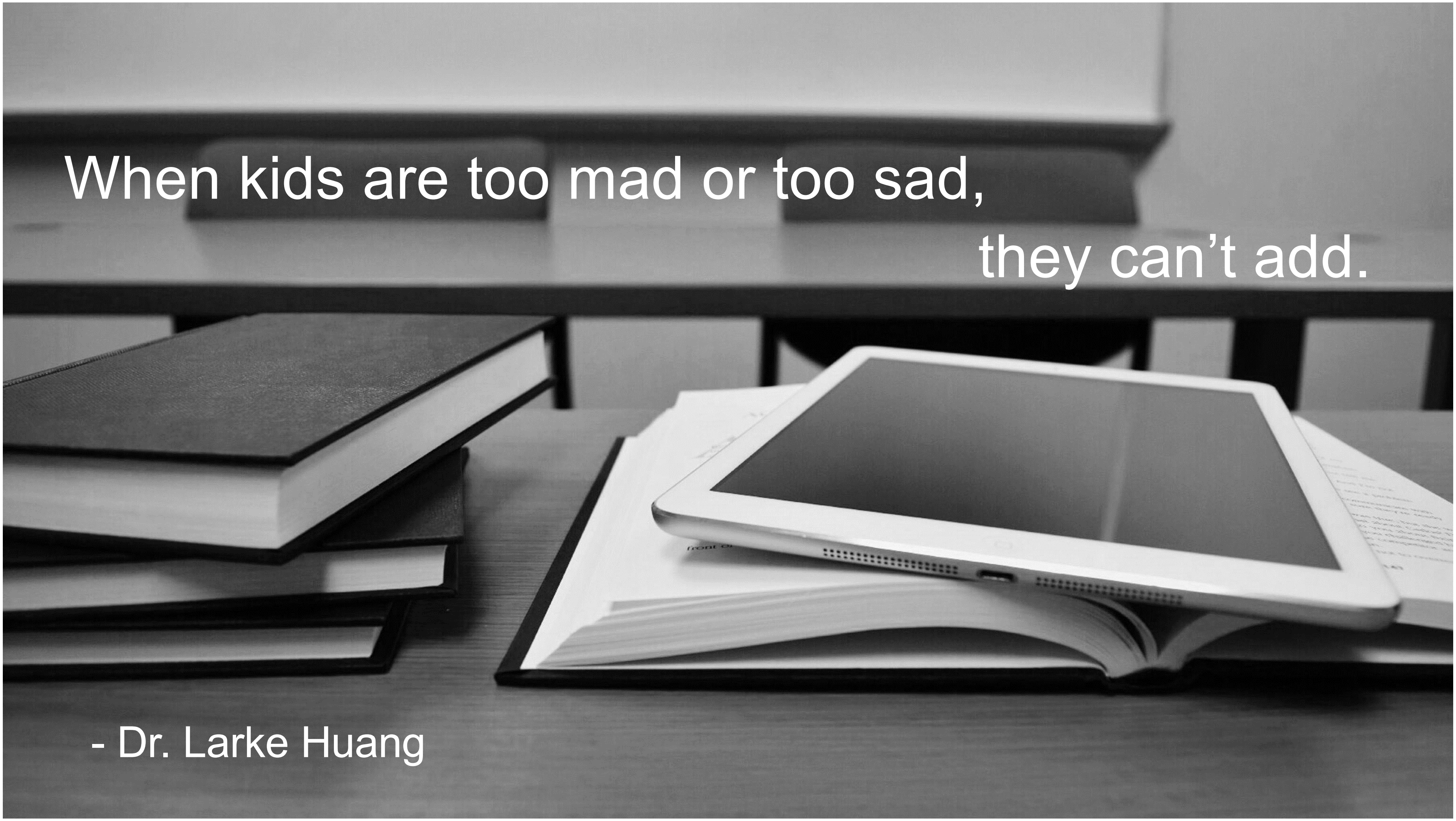
- …is organized into **coordinated networks**
- …builds meaningful **partnerships** with families and youth
- …addresses **cultural and linguistic needs**

…designed to help families function better at home, in school, in the community, and throughout life.

The System of Care Concept

- ✓ A framework and guide, not a prescription
- ✓ Flexible and creative
- ✓ Adaptive to community needs
- ✓ Consistent in philosophy

“Healthy at home, in school and out of trouble.”



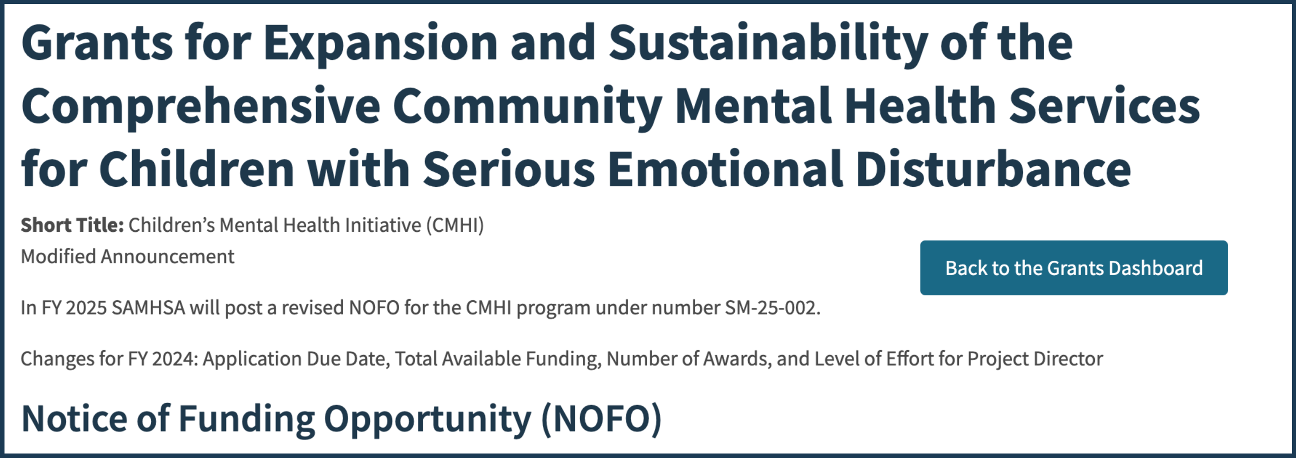
When kids are too mad or too sad,
they can’t add.

- Dr. Larke Huang

Components of a System of Care

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

The Evolution of the System of Care Approach



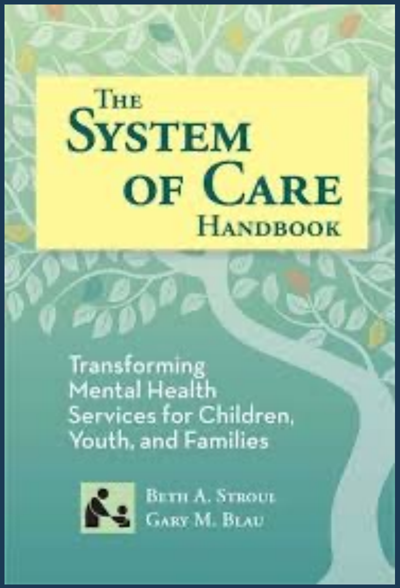
Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance

Short Title: Children's Mental Health Initiative (CMHI)
Modified Announcement

In FY 2025 SAMHSA will post a revised NOFO for the CMHI program under number SM-25-002.

Changes for FY 2024: Application Due Date, Total Available Funding, Number of Awards, and Level of Effort for Project Director

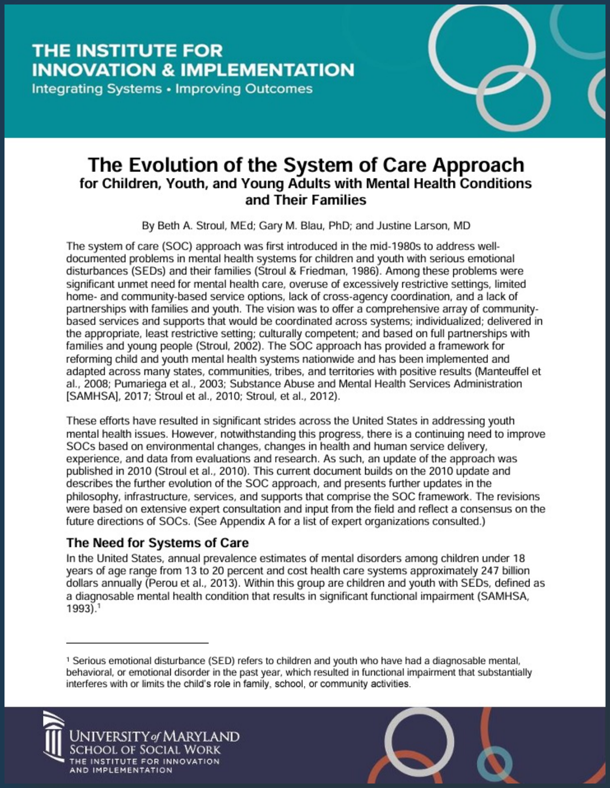
Notice of Funding Opportunity (NOFO)



The Evolution Continues…

“The Evolution of the System of Care” monograph traces the origins of the System of Care (SOC) approach, outlines the core values of SOC, and details the role of federal programs in providing grants and technical assistance that have been critical for SOC's implementation and sustainability.

It presents both the successes of the SOC model in improving care coordination and outcomes, and the ongoing challenges related to systemic integration, sustainability, and equitable access to services.



THE INSTITUTE FOR
INNOVATION & IMPLEMENTATION
Integrating Systems • Improving Outcomes

The Evolution of the System of Care Approach
for Children, Youth, and Young Adults with Mental Health Conditions and Their Families

By Beth A. Stroul, MEd; Gary M. Blau, PhD; and Justine Larson, MD

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]

---

[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.

UNIVERSITY of MARYLAND
SCHOOL OF SOCIAL WORK
THE INSTITUTE FOR INNOVATION
AND IMPLEMENTATION

https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf

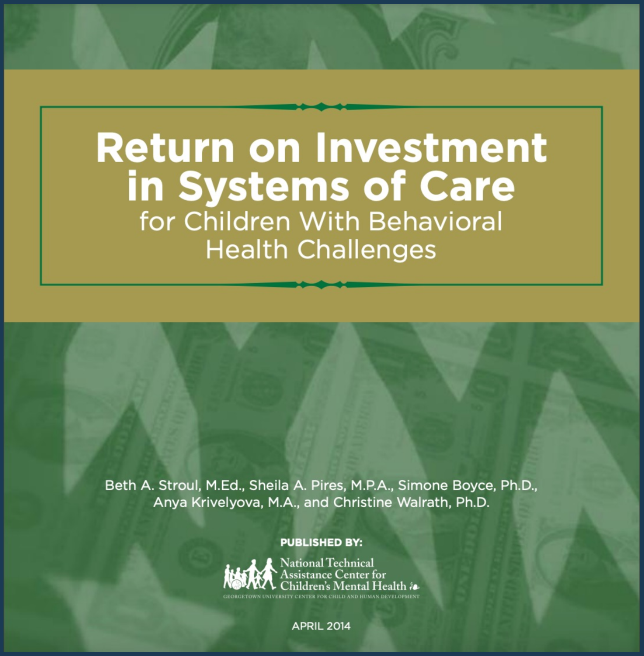
MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

The Impact of Systems of Care

- Reduced behavioral & emotional problems
- Improved functioning in school & the community
- Increased behavioral & emotional skills
- Reduced suicidal ideation & attempts
- Reduced substance use problems
- Improved ability to build relationships

National Return on Investment Study

- Youth served in systems of care are less likely to receive psychiatric inpatient services.
- From the 6 months prior to intake to the 12-month follow up, the average cost per child served for inpatient services decreased by 42%.
- Youth in systems of care are less likely to be arrested, resulting in a 55% reduction in average per-youth arrest-related costs.



Return on Investment in Systems of Care

for Children With Behavioral Health Challenges

Beth A. Stroul, M.Ed., Sheila A. Pires, M.P.A., Simone Boyce, Ph.D.,
Anya Krivelyova, M.A., and Christine Walrath, Ph.D.

PUBLISHED BY:

National Technical
Assistance Center for
Children's Mental Health
GEORGETOWN UNIVERSITY CENTER FOR CHILD AND HUMAN DEVELOPMENT

APRIL 2014

Connecticut as a National Leader

- Widespread Dissemination of Evidence Based Practices, including MST, FFT, MDFT, TFCBT, CBITS and BounceBack
- Crisis Services, including Mobile Crisis, Urgent Crisis Centers, 988
- Engagement with Families (e.g., FAVOR)
- DCF’s BH Data System, the Provider Information Exchange (PIE)

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Continuing to Transform

- Focus on Integration (e.g., Behavioral Health and Primary Care)
- Expand School-Based and School-Linked Services
- Fully Scale Systems of Care
- Expand Workforce Capacity, including youth and family peers
- Use Data for Measurement-Based & Outcome-Driven Care

CONNECTICUT CHILDREN'S BEHAVIORAL HEALTH PLAN

Annual Report October 2024

Executive Summary

This Annual Report is being submitted by the Children's Behavioral Health Plan Implementation Advisory Board (Advisory Board) as required by Connecticut General Statutes (CGS) Section 17a-22ff. Consistent with the collaborative efforts to *develop* the Children's Behavioral Health Plan (Plan), the Annual Report reflects the collective work of state agencies, family advocates, providers, and community partners to *implement* the Plan. The Advisory Board has worked to address the recommendations from its 2023 Annual Report, including substantial efforts to align and coordinate efforts among related advisory bodies. During this past year, there have been several accomplishments across the following components of the children's behavioral health system, consistent with the Plan:

- System Organization, Financing and Accountability
- Health Promotion, Prevention and Early Identification
- Access to a Comprehensive Array of Services and Supports
- Pediatric Primary Care and Behavioral Health Care Integration
- Disparities in Access to Culturally Appropriate Care
- Family and Youth Engagement
- Workforce

In spite of efforts made over the last year, there is an escalating need to address the significant workforce needs, insufficient funding structures, and lack of coordination across advisory bodies. *Continued failure to actively and adequately address the expanding workforce crisis is destabilizing the children's behavioral health system. Staffing shortages across programs and levels of care are exacerbated by inadequate pay for highly demanding work. At the same time, insufficient funding imperils the ability of providers to continue delivering services. The urgency of addressing these immediate system needs is heightened by the well-documented context of alarming and steadily escalating rates of children's behavioral health distress over the past several years. While there are many activities underway to identify additional services and system needs, Connecticut's children and families cannot afford further delay in making the investments needed to stem erosion of the progress made in our children's behavioral health system over years of thoughtful and purposeful implementation.*

The Advisory Board makes the following Recommendations for 2025:

1. **Address the Workforce Crisis**

The Advisory Board strongly encourages the state to implement the recommendations from the workforce strategic plan, *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut,* published last year. This report features 8 recommendations to provide Connecticut with a blueprint for supporting a diverse and competent workforce to meet the behavioral health needs of children and families. The Advisory Board wishes to highlight the following two recommendations from the report. *Recommendation 1: Increase reimbursement for children's behavioral health services to cover actual costs of high-quality care and establish a transparent and systematic rate-setting process*. This recommendation in particular has the potential to enable providers to effectively address workforce shortages. *Recommendation 7: Expand the youth and family peer support workforce*. Over the next year, the Advisory Board will directly address this recommendation through development of an action plan that advises the state as to how to expand the peer support workforce.

2. Develop optimal funding paradigms

In 2020 the Advisory Board worked with Carelon, as well as the Department of Children and Families (DCF) and the Department of Social Services (DSS), to complete a fiscal map of funding for children's behavioral health services across levels of care. The Advisory Board recommends that the fiscal map be completed again in 2025 and be inclusive of Medicaid, commercial insurance, and other payers.

3. Coordinate Efforts of Advisory Bodies

The Advisory Board made significant progress toward coordination across bodies, in particular with the Children's Behavioral Health Advisory Committee (CBHAC), the Statewide Advisory Council (SAC), and the Behavioral Health Partnership Oversight Council (BHPOC). However, more work is needed to strengthen alignment and coordination. In 2025 the Advisory Board will persist in its efforts to convene meetings with the remaining bodies and implement processes for collaboration identified over the last year.

Introduction

The Plan continues to serve as a comprehensive blueprint for promoting the emotional wellbeing of all children in our state (https://plan4children.org).

It reflects extensive input from multiple stakeholders including substantial contributions to the vision for our system from Connecticut families. The Plan development process featured:

- 6 open forums held across the state, facilitating input from parents, mental health experts, and community members;
- 5 meetings of the advisory committee focused on the Plan's development;
- 12 facilitated discussions on aspects of the children's behavioral health system; and
- 22 community conversations held across the state specifically to gather input from families and youth regarding the network of care in Connecticut.

The broad group of stakeholders who participated in the development of the Plan has subsequently been reflected in Advisory Board membership. The membership, most recently updated within Public Act 22-47, reflects the system's reliance on collaboration and coordination among state agencies, providers, advocates, family members, and other partners to provide comprehensive behavioral health services across the full continuum of care in home, community, school, and hospital settings. The full list of affiliations of Advisory Board members together with the membership of other related governing bodies can be found in Addendum 1.

The Plan's vision for Connecticut's behavioral health system is guided by the following core values. The system should be: ***family-driven and youth guided, community-based, culturally and linguistically appropriate*** and ***trauma informed***. More background on the development of the Plan can be found here. The framework and vision of the Plan remain relevant and constructive to the ongoing work to strengthen the systems and services that prevent, identify, and treat behavioral health needs for children and families within the state. Its organization around the following seven thematic areas of focus reflect the structure of the integrated approach to care:

- **System Organization, Financing and Accountability**
- **Health Promotion, Prevention and Early Identification**
- **Access to a Comprehensive Array of Services and Supports**
- **Pediatric Primary Care and Behavioral Health Care Integration**
- **Disparities in Access to Culturally Appropriate Care**
- **Family and Youth Engagement**
- **Workforce**

Each past annual report has provided an overview of work completed across the areas of focus and progress made toward the Plan's vision. The reports are available for review in full here. Highlights of accomplishments between 2015 and 2023 are attached as Addendum 2. This Addendum offers a high-level accounting of some of the most consequential work of the Advisory Board and its members, such as development of the state's Suicide Prevention Plan, the Assisted Intervention Matching Tool, Recommendations for Early Identification and Screening, adoption of Culturally and Linguistically Appropriate Standards, implementation of ACCESS Mental Health, and launch of the urgent crisis centers. The Advisory Board is dedicated to pursuing cross-utilization of resources, data, and tools so as to effectively and efficiently utilize existing resources and to direct current and future efforts toward quickly achieving system improvements. Each report also identified recommendations regarding key priorities for the system in the upcoming year. The 2023 Annual Report identified the following recommendations:

1. Align oversight and advisory efforts;
2. Aggressively address behavioral health workforce shortages; and
3. Develop and implement a sustainable model for funding and delivering children's behavioral health services.

The full Advisory Board met on the following dates in 2024: April 22nd, May 20th, June 17th, and October 21st. This Annual Report serves as an update on the progress made toward achieving the 2023 recommendations, and also highlights significant advances made by the various state agencies and other organizations serving on the Advisory Board in critical areas of the children's behavioral health system, as such advances are aligned with the Plan's areas of focus.

2023 Recommendation 1: Align oversight and advisory efforts

For the past several years, the Advisory Board has recommended the alignment of the six existing children's behavioral health oversight and advisory bodies (bodies), including:

- Children's Behavioral Health Plan Implementation Advisory Board (Advisory Board);
- Children's Behavioral Health Advisory Committee (CBHAC);
- Statewide Advisory Council (SAC);
- Child/Adolescent Quality, Access and Policy Committee (CAQAP) of the Behavioral Health Partnership Oversight Council (BHPOC);
- Transforming Children's Behavioral Health Policy and Planning Committee (TCB); and
- Juvenile Justice Policy and Oversight Committee (JJPOC).

The complexity of the children's behavioral health system is depicted in Addendum 3, and a crosswalk of the bodies are available in Addendum 4. Together with Addendum 1, the crosswalks offer a comparison of the legislative mandates, priorities, family engagement strategies, and memberships among these 6 groups.

The six bodies mentioned above are those most aligned in regard to the mandate to improve the children's behavioral health system. There are many other workgroups, task forces, and councils that have a relationship to children's behavioral health. As an example, at a recent TCB meeting, the Connecticut State Department of Education (CSDE) referenced 13 different children's behavioral health groups to which the department designates a member, and mentioned further that these 13 are among the *60* groups overall that maintain a member from CSDE. Similarly, at a meeting of the Mental Health Subcommittee of the Comptroller's Health Care Cabinet, the Department of Mental Health and Addiction Services (DMHAS) provided a list of *80* groups with designated participation from department staff. These examples further illustrates the need to eliminate redundancy in the respective missions of these bodies and to consider the possibility of eliminating or merging entities with related missions. Alignment and coordination among these bodies is essential to achieving efficiency, effectiveness, and overall system improvement.

On an individual level, the three Advisory Board Tri-Chairs as well as other members of the Advisory Board are purposeful in their participation on multiple bodies. For example, Ms. Smith and Dr. Cannata serve on workgroups of the JJPOC and intentionally cross-inform the work (bringing information discussed at the Advisory Board to JJPOC meetings, and vice-versa). All three Tri-Chairs participate in TCB workgroups and have been responsive to requests to provide presentations and information to the TCB Chairs and at TCB meetings. While this cross-participation is valuable for information sharing purposes, it does not serve to expedite concrete actions to achieve our shared goals. This year's Advisory Board meetings focused on making progress toward achieving such alignment as referenced in Recommendation 1. The Tri-Chairs of the Advisory Board extended invitations to the chairs and administrators of the other five bodies, offering each body an opportunity to meet with and present directly to Advisory Board members. The intent of this engagement was to identify unique roles, shared goals, and opportunities for collaboration, as well as to offer support from the Advisory Board to each of the other bodies.

The Advisory Board met with three of the other bodies. Unfortunately, and despite the vigorous efforts of administrators, the Advisory Board was unable to schedule the TCB and JJPOC presentations to the Advisory Board. Advisory Board Tri-Chairs met on two occasions with the TCB Tri-Chairs to discuss the shared goals and unique roles of the two bodies, and agreed to collaborate as their respective work moves forward. Advisory Board Tri-Chairs are also participating as members of the TCB's Strategic Planning Workgroup and the TCB subcommittees. Advisory Board Tri-Chairs will also present this Annual Report at an upcoming TCB meeting in November.

The following presentations occurred during in-person Advisory Board meetings (meeting materials available here):

- April 22, 2024
  Children's Behavioral Health Advisory Committee
  Chairs, Nan Arnstein and Gabrielle Hall

- May 20, 2024
  Statewide Advisory Council
  Chairs, Myke Halpin and Sarah Lockery

- June 17, 2024
  Child/Adolescent Quality, Access, and Policy Committee of the Behavioral Health Partnership Oversight Council
  Chairs, Melissa Green and Steve Girelli

Presenters were asked to address the following:

1. What are the most pressing concerns among your membership this year?
2. What work is underway or planned for this year (or the year ahead)?
3. How is family voice incorporated into your work?
4. What do you need from the Advisory Board to support your work?
5. What questions do you have of the Advisory Board members?

The presenters' responses to the first two questions identified above provided insight on where there are shared areas of focus among the bodies. For example, all groups included the following as priorities (identified either as a concern among membership or as work planned for the upcoming year):

- Addressing the workforce shortage;
- Increasing access of children and families to the full service array; and
- Strengthening racial equity in behavioral health services.

Other concerns identified were specific to the given body. For example, unique recommendations and member concerns included: participation in local collaboratives (CBHAC), access to non-emergency medical transportation (CAQAP), and information on the number of families with open DCF cases (SAC).

Family voice is incorporated within each body, with family members or youth with lived expertise participating as members as well as chairs. Engagement of families within CBHAC is particularly noteworthy, with families consisting of more than half of its members. The agendas and annual reports also directly reflect family-identified priorities.

In response to questions four and five above, the presenters asked that the Advisory Board support the work of the other bodies with the following:

- Assist with engaging legislators to appoint members to the given body per their statute;
- Support engagement of families across the bodies;
- Share Advisory Board recommendations to inform other bodies' reports; and
- Engage in coordination on shared priorities and goals.

2023 Recommendation 2: Aggressively address behavioral health workforce shortages

Behavioral health workforce shortages at every level of care are impairing the state's ability to provide timely and high-quality services during a time of heightened demand for services and increasing symptom acuity. In short, there are more children presenting with more acute and persistent behavioral health conditions, while the number of clinicians and direct care staff working with populations with high needs (in community, hospital, and home-based settings) has decreased to alarmingly low levels. This current crisis is a priority of the Advisory Board.

In November 2023 CHDI, in collaboration with the Advisory Board and with funding from DCF, published *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut*. The Workforce Strategic Plan was the culmination of a process involving extensive stakeholder engagement, advisement from a small group including Advisory Board representatives and those with lived expertise, and a comprehensive review of national and out-of-state initiatives. The plan includes recommendations for short- and long-term solutions to strengthen the pipeline, diversity, recruitment, retention, and competencies of the workforce.

At the June 17, 2024 Advisory Board meeting, CHDI presented an update on the workforce plan, and recent policy or system changes in the state that aligned with the Workforce Strategic Plan's recommendations. Progress is noted below.

1. Increase reimbursement rates for children's behavioral health services to cover actual costs of high-quality care and establish a transparent and systematic rate-setting process.
    - A Medicaid rate was established to reimburse urgent crisis center (UCC) services.
    - In response to a study of Medicaid rates for behavioral health services which found Connecticut's rates significantly short of those in comparable states (by approximately $48 million), $7 million was allocated to increase behavioral health Medicaid rates specifically for children's services. *The Advisory Board notes that although these increases are helpful to the system, the rates continue to fall short of the cost of delivering services and allowing agencies to pay competitive or even comparable wages to other states.*

2. Make immediate and significant investments in behavioral health workforce recruitment and retention.
    - The CGA appropriated $10 million in American Rescue Plan Act (ARPA) funds to DCF to be used in support of children's behavioral health. DCF prioritized this funding in support of behavioral health provider workforce recruitment and retention efforts. Funding was distributed in three ways: a portion of the funds was allocated to all DCF behavioral health contracts; an additional portion was allocated to behavioral health in-home treatment services contracts; and a third portion was allocated to Intensive In-home Child and Adolescent Psychiatric Services (IICAPS) providers. This represents a much-needed infusion of resources. These funds are one-time investments, however, and in the absence of an ability to annualize these increases their positive impact will be time limited.

3. Develop a children's behavioral health workforce center that can track and respond to trends in supply and demand and sustain workforce development efforts.
    - No significant progress noted.

4. Grow and diversify the children's behavioral health workforce pipeline.
    - The CT Health Horizons initiative has continued to provide tuition assistance to master's in social work students.
    - The Governor implemented a new student loan repayment program.

5. Increase behavioral health training across the child-serving workforce.
    - New asynchronous trainings available to providers at no cost were launched by CHDI as part of a new online platform with funding support from DCF.

6. Remove administrative barriers to workforce entry and retention.
    - Public Act 24-30 allows Connecticut to participate in a multistate social work licensure compact. While this may facilitate social workers considering transferring to Connecticut, this will only have impact if Connecticut is able to address the disincentives for practice in Connecticut such as salaries and reimbursement rates.

7. Expand the youth and family peer support workforce.
    - The Advisory Board endorsed work on this recommendation as a priority in the upcoming year as mentioned above (see more information below).

8. Expand the role and capacity of community-based organizations in prevention and early intervention.
    - Many state agencies and community-based partners engage in ongoing prevention and early intervention work. There has not been significant *additional* investment in the last year.

At the same Advisory Board meeting, the Tri-Chairs introduced an agenda item to advance new work in support of the Workforce Strategic Plan's recommendation regarding expanding peer support specialists within the children's behavioral health workforce. With support from

Advisory Board members, it was decided that the potential role of peer support specialists will be a priority for the next year. The Advisory Board has directed that CHDI, in its role supporting the Advisory Board's work through a contract with DCF, will lead development of recommendations and an associated action plan for Connecticut to increase the number of family and youth peer support specialists working within children's behavioral health services. The recommendations will address training, certification, roles, and career pathways, and will identify opportunities for reimbursement and other sustainable funding.

A Steering Committee inclusive of members of the Advisory Board, providers, current peer support specialists, and family members with lived expertise, will guide the process and development of recommendations. Methods will include a literature review, focus groups, interviews, and a scan of work already underway in Connecticut and best practices in implementation and funding across other states. The recommendations are expected to be released in the fall of 2025.

2023 Recommendation 3: Develop and Implement a Sustainable Model for Funding and Delivering Children's Behavioral Health Services

Addressing children's behavioral health needs requires a sustainable model of blended funding that covers actual costs of high-quality and timely care across the system. Efforts to strengthen funding this year included the following:

- During the 2024 legislative session unspent ARPA funding was reallocated including $7 million specifically to support higher Medicaid reimbursement rates for children's behavioral health services. The allocation is described in more detail in the updates below and came on the heels of the release of DSS' Phase 1 Report: Studies of Medicaid Rates of Reimbursement.

- Connecticut submitted an application for award of a federal Certified Community Behavioral Health Clinic (CCBHC) planning grant. During the planning period the state would select three programs for participation. CCBHCs provide comprehensive community-based behavioral health care for children, teens, adults, and seniors, and offer 24/7 crisis intervention services.

2024 Children's Behavioral Health Plan Implementation Updates

Implementation of the Children's Behavioral Health Plan is the responsibility of the various members of the Advisory Board. The highlights below reflect a sample of the accomplishments and investments from member organizations. These are illustrative of the interagency approach to children's behavioral health that is critical for a sustainable approach to timely high-quality care for children.

System Organization, Financing and Accountability

- Public Act 23-204, Sec. 15 appropriated $7,000,000 for FY 2025 to DSS for Medicaid rate increases (also noted above) for providers of behavioral health services to children. This will address a 15% increase for therapeutic behavioral health services, targeted case management, family psychotherapy that includes the patient, and adaptive behavioral health treatment by a technician using an established plan. It additionally will allow for a 3.75% increase on the remaining children's procedure codes with the exception of Autism Spectrum Disorder evaluations. Coverage is expanded to those up to 20 years of age.

- As follow up to recommendations from the Advisory Board's Data Integration Workgroup, DCF funded CHDI to conduct focus groups with family members with lived expertise, family advocates, providers, and DCF staff. The findings have been reflected within a report with recommendations regarding reporting of data related to children's behavioral health. The report findings will be shared with the Advisory Board and the Data Integration Workgroup members at upcoming meetings.

- CONNECTing Schools to Care IV Students (CONNECT IV) represents the fourth round of funding awarded to Connecticut from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen the system of care in the state. CONNECT IV is a four-year grant awarded to DCF, with CHDI serving as the statewide Coordinating Center. Other grant partners include Carelon Behavioral Health, FAVOR, Inc., and The Consultation Center at Yale. CONNECT IV will improve access to equitable and appropriate school- and community-based care using Connecticut's established framework for trauma-informed Comprehensive School Mental Health.

- DCF has contracted with CHDI to serve as the Performance Improvement Center (PIC) for the UCCs. CHDI will provide data analysis and hold associated quarterly meetings with providers to discuss trends in data. At this time, data includes episode-level data related to demographics, presenting problems (e.g., harm/risk of harm to self, disruptive behavior), referral source, implementation of model elements (e.g., medical clearance, crisis assessment), length of stay, and indicators related to discharge. Trainings for the UCC providers are being identified and will be a focus of the PIC in the coming months.

- Special Act 24-10 required that DPH convene a working group, and by January 1, 2026, develop a universal patient intake form based on the working group's requirements and guidelines. The Tri-Chairs of the Advisory Board will serve on the working group to support coordination. The universal patient intake form is intended to reduce the duplication of intake information collected across providers of behavioral health services for children. A report will be submitted to the joint standing committees of the General Assembly having cognizance of matters relating to children and public health, and shall include such recommendations, form requirements and guidelines.

Health Promotion, Prevention and Early Identification

- DMHAS, in collaboration with DCF and the Program for Specialized Treatment Early in Psychosis (STEP) at The Connecticut Mental Health Center (CMHC)/Yale University School of Medicine, developed a statewide plan for scaling the First Episode Psychosis (FEP) program statewide. STEP has been internationally recognized for Early Intervention Services (EIS) provided to individuals between the ages of 16 and 35 with recent onset schizophrenia spectrum disorders or first-episode psychosis within New Haven and surrounding towns. The statewide scale-up of FEP services includes Early

Detection and Assessment Coordinators (EDACs) in each of the five DMHAS regions. The EDACs are offering outreach to individuals experiencing a recent onset of schizophrenia spectrum disorders or first-episode psychosis, conducting screenings/assessments using specific scales, providing outreach and education to family members, and collaborating with treatment providers and connecting them with clinical consultation and trainings via STEP's Learning Collaborative.

- DMHAS Young Adult Services (YAS) finalized the outcomes in year four of a five-year federal SAMHSA grant, CT Stay Strong Healthy Transitions, to develop and implement an early intervention program for young people between the ages of 16 and 25 operated by the New Britain and East Hartford DMHAS Local Mental Health Authorities (LMHAs) which demonstrated statistically significant improvement in overall mental health ratings noted between baseline and six month follow up.

- The Office of Early Childhood (OEC) is implementing several integrated approaches to support young children's social and emotional wellbeing. The *Pyramid Model* is a framework that provides programs with guidance on how to promote social and emotional competence in all children and designing effective interventions that support young children with persistent challenging behavior. *ECCP* is a strength-based mental health consultation program designed to build capacity of caregivers by offering support, education, and consultation. *ECCP*'s purpose is to meet the social-emotional needs and/or developmental concerns of children birth to five; this includes promoting inclusion to mitigate exclusionary discipline practices. In recognition of the importance of promoting inclusion in early child care settings and the disproportionate rates of suspension and expulsion of children of color in preschool settings, OEC is proactively addressing the issue through educating staff and families.

- OEC supports a continuum of perinatal service delivery, including its *Doula* project and *Mind Over Mood*, an initiative that helps a mother transition from birth to postnatal care by addressing maternal mental health within early childhood home visitation programs.

- OEC also coordinates supports from services provided by Connecticut Association for Infant Mental Health and *Sparkler* to support the social and emotional development of children, while also heightening awareness of developmental milestones.

- DCF has funded CHDI to conduct a Comprehensive School Mental Health Landscape Analysis that will identify and catalog the many behavioral health services that occur within school settings.

Access to a Comprehensive Array of Services and Supports

- The Department of Developmental Services (DDS) has established a Children's Services Division to create a more centralized support system for families of our younger individuals. These services offer in-home supports, respite and other waivered services. The Division has also opened 2 respite centers (4 beds in each). The goal of this division is to maintain children within the family home while providing appropriate agency and community supports.

- OEC is working to increase awareness on how homelessness can be a traumatic experience potentially impacting children's development in lasting ways. *Insecure Housing Training and Support* provides training on homelessness and housing instability to increase awareness of the McKinney-Vento Homeless Assistance Act.

- Through funding from DCF, Carelon Behavioral Health's Community Pathways program, launched this year, is part of Connecticut's Family First Prevention Services Act Plan. The person-centered, strengths- and family-based approach promotes early intervention and upstream access to preventive services to ensure optimal results for children and their families. Parents and caregivers with a child under the age of 18 in need of a non-emergency referral can call Carelon Behavioral Health at 877-381-4193 and specialists will connect families to evidence-based interventions and community resources and will provide on-going support as needed. This program is available regardless of income or insurance.

- To expand prevention, identification, and treatment of substance use disorders (SUD), DCF has contracted with CHDI to provide training, professional development, and consultation for DCF contracted Outpatient Psychiatric Clinic for Children (OPCC) Providers on SUD. Additionally, through a federal SAMHSA grant, CHDI is coordinating comprehensive, family-based treatment, early intervention and recovery support services for transitional aged youth (TAY) ages 16-25 with SUD.

Pediatric Primary Care and Behavioral Health Care Integration

- School-Based Health Centers (SBHC) expanded the number of sites with behavioral health services. Services at SBHCs include screenings for mental health needs, including depression and trauma, at the time of a medical visit. Positive screenings can be followed up with referral for community services or to services directly by the SBHC. The most common mental health trends treated at SBHCs include anxiety and depression, and referrals self-harm, eating disorders, and trauma.

Disparities in Access to Culturally Appropriate Care

- Since 2015, Connecting to Care CT's Culturally and Linguistically Appropriate Services (CLAS) workgroup has trained a total of 2,591 participants in health equity related topics. Additionally, 65 organizations were trained using a six-month cohort process in the development of organizational Health Equity plans and creating internal DEI workgroups.

Family and Youth Engagement

- CSDE engaged families and youth through a variety of initiatives, including the Commissioner's Roundtable on Family and Community Engagement, and community stakeholder forums and surveys on Elementary and Secondary School Emergency Relief (ESSER) investments.

- Through CSDE's Voice4Change program, students were given the opportunity to propose and vote on how more than $1.5 million in federal relief funds should be invested to reimagine Connecticut's schools. Over 80% of Voice4Change submissions addressed the need for more social, emotional, and mental health supports for students and school staff.

- Through funding from DCF, CHDI has developed a new peer support model, *Students Supporting Students*, for schools based on best practices from across the country**.** It is currently being piloted with three Connecticut schools for the 2024-25 school year: Lebanon Middle School (Lebanon), Lyman Memorial High School (Lebanon), and Highville Charter School (New Haven). An additional school will be selected soon. Pilot schools will receive training, technical assistance, a financial stipend, and access to the Peer Support Guides.

- The Advisory Board has prioritized strengthening family member participation for the upcoming year. In response, DCF has identified funding to begin providing stipends to family members and offer simultaneous Spanish/English interpretation during meetings.

Workforce

- As part of OEC's Behavioral Health Initiatives, monthly webinars were held to highlight mental health. All webinars were accessible to the community at large and recorded; the recordings can be found on OEC's website under Behavioral Health Initiative, as well as on OEC's YouTube page. Webinars in FY23-24 included: Suspension & Expulsion, Insecure Housing Training and Support, Professional Development for Providers: Sharpening the Workplace Toolbox, Personal Development for Parents/Caregivers: Sharpening the Self-Care Toolbox, Women's History Month, Black Maternal Health - National Minority Health Month, National Mental Health Awareness Month, and Financial Literacy.

- CSDE is expanding the school-based mental health workforce. This includes funding of 21.5 FTE social workers across 20 school districts, grants to 73 school districts to hire behavioral health staff, and funding to support mental health services at schools during summer months.

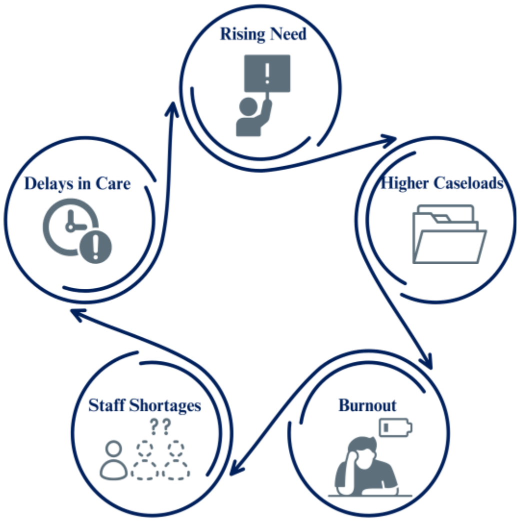
- With funding from DCF, CHDI has launched an asynchronous training platform, *Kids Mental Health Training*, to host trainings on children's behavioral health. Trainings on school refusal and substance use screening have been made available to staff within Mobile Crisis and Care Coordination programs, with expansion of training content and audience planned for the upcoming year.

Advisory Board Recommendations for 2025

1. Address the Workforce Crisis

The Advisory Board is tasked with implementation of the children's behavioral health plan. Connecticut is lauded nationally for its quality and scope of services, consistent with the vision outlined in the Plan. However, the strengths of our system are being undone by the severe shortages in the workforce, in particular within settings and services for the highest need populations. The system is experiencing a cycle of rising need, higher caseloads, clinician burnout, staff shortages, and delays in care (see Figure 1 on the next page). As time passes, the impact of this cycle intensifies, and is resulting not only in waitlists and delays in care, but also reduced quality of care (e.g., limited use of evidence-based treatments, reduced frequency of treatment sessions, less coordination of care, etc.).

Figure 1: Escalating Cycle of Workforce Needs



Connecticut has a plan for addressing the workforce's needs (*[Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut](#)*). Limited progress has been made on the recommendations to date. To ensure timely, equitable and high-quality services to children, it is critical that the state fully address those recommendations, and in particular, that it close the gap between the cost of care and the rates of reimbursement for services with attention to addressing pay for clinicians at rates that are aligned and competitive with salaries in neighboring states and the cost of living in Connecticut. The longer the state takes to fully address workforce needs, the greater the shortages, and the more challenging it will be to restore the system's critical infrastructure.

Over the next year, the Advisory Board will collaborate on the publication of recommendations for expanding family and youth peer support roles within the children's behavioral health workforce. Recommendations will identify opportunities for strengthening integration of lived expertise within the workforce and for addressing systemic workforce issues impacting access and quality of care.

2. Develop optimal funding paradigms

In 2020 Carelon, together with DCF and DSS, completed an expanded fiscal map of children's behavioral health services across levels of care that was initiated by the Advisory Board in 2018. The report assessed funding by Medicaid and DCF using data from 2015-2018. Given the changes that have occurred since that time period, including impacts of the pandemic, the Advisory Board recommends that the fiscal map be completed again in 2025, and that this report be inclusive of private insurance spending in addition to Medicaid. As in the work done in 2018, the children's behavioral health system included programming and services funded by the other state departments that are partners in the Children's Behavioral Health System (as represented by their inclusion of the Advisory Board). It will be important to ensure that the most current fiscal mapping includes attention to changes in funding of the other state departments that impacts children's behavioral health services, such as the expansion of school-based services, some with temporary ARPA funding and funding cuts to children's programming being implemented by Judicial Branch-Court Support Services Division.

3. Coordinate Efforts of Advisory Bodies

As follow up to their presentations, chairs of CBHAC, SAC and the Advisory Board met to identify specific next steps to strengthen alignment across the bodies. The meeting resulted in an agreement among the bodies' chairs to intentionally align efforts to address shared priorities. Beginning with FY 2024 annual reports, a summary of the three reports' recommendations will be provided as a supplement to the reports. During FY 2025 the chairs will continue to meet to coordinate progress on recommendations and will proactively address a collaborative approach to agenda setting and reporting in the upcoming year.

Looking ahead to 2025, the Advisory Board will persist in its efforts to convene meetings with the remaining bodies, including both JJPOC and TCB. The Advisory Board remains committed to pursuing alignment among these six bodies in order to achieve greater efficiency and effectiveness in working toward common priorities and a shared vision of wellbeing for children and families in Connecticut.

Respectfully submitted,

Elisabeth Cannata, Ph.D.
Carl Schiessl, JD
Ann R. Smith, JD, MBA

STATE AGENCY PARTNERS

Department of Children and Families (DCF)
Department of Developmental Services (DDS)
Department of Social Services (DSS)
Department of Public Health (DPH)
Department of Mental Health and Addiction Services (DMHAS)
Connecticut Insurance Department (CID)
Department of Corrections (DOC)
Department of Labor (DOL)
Office of the Governor
Office of Policy and Management (OPM)
Connecticut State Department of Education (CSDE)
Office of Early Childhood (OEC)
Office of the Child Advocate (OCA)
Office of the Healthcare Advocate (OHA)
Judicial Branch Court Support Services Division (JBCSSD)
Commission on Women, Children, Seniors, Equity and Opportunity (CWCSEO)

Addendum 1: Advisory Bodies' Membership Crosswalk

Member Affiliation[1]		Children's Behavioral Health Plan Implementation Advisory Board	Children's Behavioral Health Advisory Council	Behavioral Health Partnership Oversight Council	State Advisory Council	Transforming Children's Behavioral Health Policy and Planning Committee	Juvenile Justice Policy and Oversight Committee
Connecticut State Departments and Offices	Children & Families	X	X	X	X	X	X
	Child Advocate	X				X	X
	Comptroller			X			
	Corrections	X	X			X	X
	Developmental Srvcs	X	X	X		X	
	Education	X	X	X		X	X
	Early Childhood	X				X	
	Governor's Office	X					
	Healthcare Advocate	X		X		X	
	Health Strategy					X	
	Insurance	X				X	
	Judicial	X	X	X		X	X
	Dept of Labor	X					X
	Mental Health&Addiction	X	X	X		X	X
	Policy & Management	X		X		X	X
	Public Health	X		X		X	X
	Social Srvcs	X		X		X	X
	Victim Advocate						X
Lived Expertise[2]		X	X(≥51%)	X	X	X	X
Behavioral health providers		X	X	X	X	X	
Child care providers					X		
Family Advocates		X	X	X		X	X
General Assembly				X		X	X
Council on Medical Assistance..			X				
Cmsn on Women, Children…		X					
Medical Provider		X				X	
Police Chiefs' Assn		X		X	X		
Private Foundation		X					X
Regional Advisory Councils		X					
School-Based Health Centers		X					
School Superintendent					X		
Tskfc: Children's Needs		X				X	
Tskfc: MH Service Providers…		X					
United Way Infoline		X					

---

[1] Affiliation with department or organization (specific designee or representative may differ across committees)

[2] Member has lived experience with Connecticut behavioral health system (either self or family member)

Addendum 2: Children's Behavioral Health Plan Implementation Advisory Board Overview of Work 2015 - 2023

Below are *highlights* of work to date in implementing the Plan by members of the Advisory Board as documented in Annual Reports submitted between 2015 and 2023. They are organized in alignment with the Plan's seven thematic areas.

A. System Organization, Financing and Accountability

- Participation by all 12 state agency partners in fiscal mapping of the behavioral health system and contributions to Annual Reports
- Articulation of system of care and level of services
- Data Integration Workgroup report with recommendations for improved cross-agency use of data; system dashboard in development phase
- Alternative Payment Methodology Workgroup report with recommendations for a framework and phased implementation of a value-based payment system

B. Health Promotion, Prevention and Early Identification

- DCF training on Infant Mental Health for early childhood partners and expanded Circle of Security training for parents.
- Multiagency workgroup completed an extensive review to inform recommendations for adoption of screening tools to strengthen early identification of behavioral health needs
- Perinatal support services provided to young adults receiving services from DMHAS
- The State Suicide Prevention Plan developed in 2014 and updated for 2020-2025
- The Child Trauma Screen is implemented by multiple partners, including DCF and juvenile justice settings
- Release of the Gizmo's Pawesome Guide to Mental Health for elementary school students (also recently adapted for the preschool population)
- Federal approval of Connecticut's Families First Prevention Services Act (FFPSA) Plan in 2022 to support strengthening families and reducing out-of-home placement.
- Launch of the Assisted Intervention Matching Tool (AIM) to help providers, family members and others identify potential services for a child's needs

C. Access to a Comprehensive Array of Services and Supports

- Urgent Crisis Centers funded per model developed by the Behavioral Health Urgent Care and Crisis Stabilization Workgroup
- Funding and implementation of the School Based Diversion Initiative
- Signed MOUs between Youth Mobile Crisis and nearly all school districts in CT (schools now account for the highest proportion of referrals to the program)
- Coordination of 9-8-8 and Mobile Crisis services

D. Pediatric Primary Care and Behavioral Health Care Integration

- Expanded use of screening tools in pediatric primary care and added billing codes to track positive screenings
- Implementation of ACCESS Mental Health to increase pediatric knowledge of mental health and direct consultation for youth behavioral health needs for children, youth and young adults

E. Disparities in Access to Culturally Appropriate Care

- Adoption of the Culturally and Linguistically Appropriate Standards (CLAS), CT-developed inclusion of a racial justice framework, development of a CLAS Toolkit, and consultation to support implementation
- Health Equity Plans developed by agencies providing state-contracted behavioral health services
- Agencies, including DCF, CSSD and others engage in quality improvement efforts with behavioral health providers that include analyzing access and outcome data by race and ethnicity

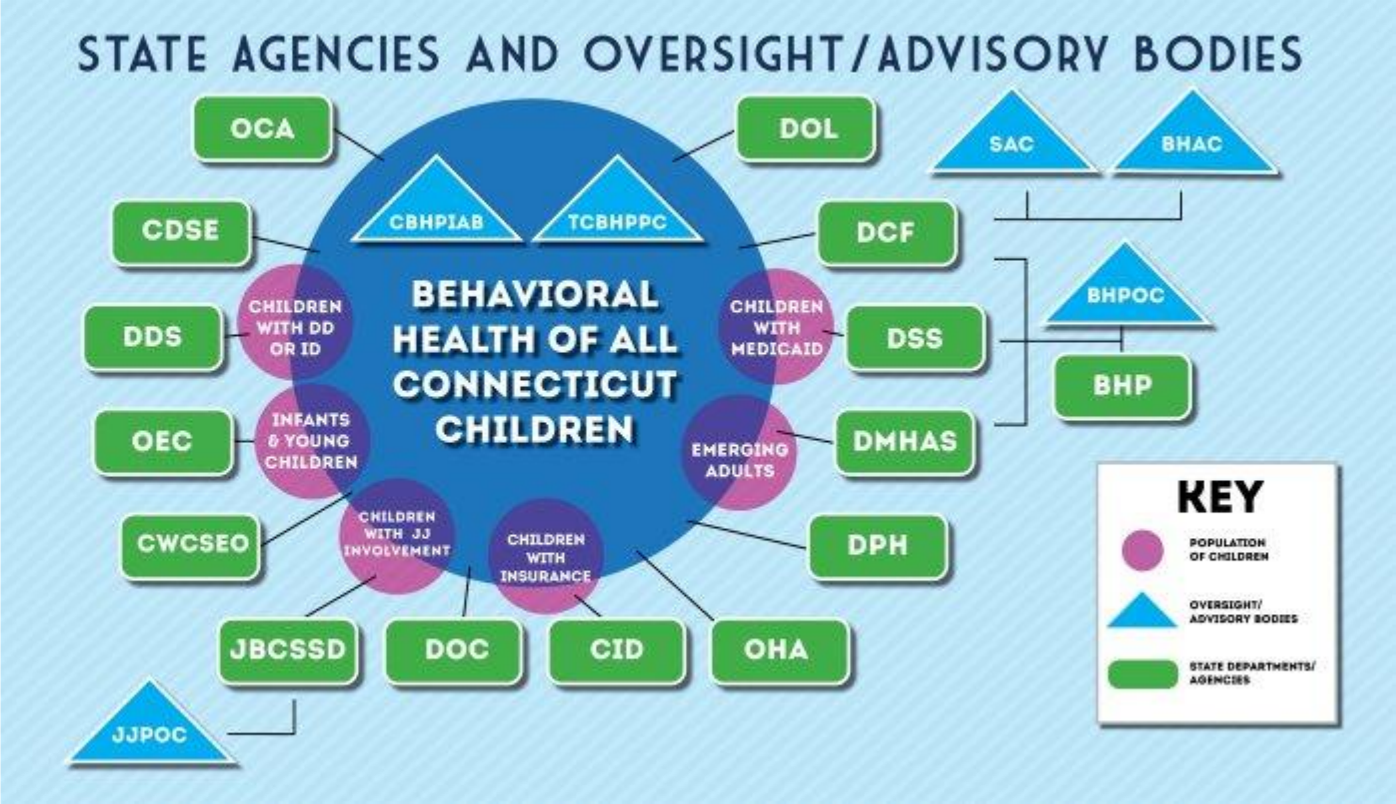
F. Family and Youth Engagement

- Mandated representation and strong participation of family members across policymaking bodies, including the Advisory Board, the Children's Behavioral Health Advisory Council, and the CONNECT Workgroups
- Development of the Connect4Families Toolkit
- Documenting and utilizing community conversations to include family voice in shaping the system
- Training for families on the behavioral health system of care

G. Workforce

- Training on home-, clinic- and school-based evidence-based treatments
- Learning collaboratives for providers to address recruitment and retention challenges
- Release of *Strengthening the Behavioral Health Workforce for Children, Youth, and Families: A Strategic Plan for Connecticut* by the Advisory Board in collaboration with the Child Health and Development Institute.

Addendum 3: Connecticut Children's Behavioral Health System: State Agencies and Oversight/Advisory Bodies



STATE AGENCIES

DCF - Department of Children and Families
DDS - Department of Developmental Services
DSS - Department of Social Services
DPH - Department of Public Health
DMHAS - Department of Mental Health and Addiction Services
CID - Connecticut Insurance Department
DOC - Department of Corrections
DOL - Department of Labor
CSDE - Connecticut State Department of Education
OEC - Office of Early Childhood
OCA - Office of the Child Advocate
OHA - Office of the Healthcare Advocate
JBCSSD - Judicial Branch Court Support Services Division
CWCSEO - Commission on Women, Children, Seniors, Equity and Opportunity
BHP – Behavioral Health Partnership (incudes DCF, DMHAS and DSS)

OVERSIGHT/ADVISORY BODIES

CBHPIAB – Children's Behavioral Health Plan Implementation Advisory Board
TCBHPPC – Transforming Children's Behavioral Health Policy and Planning Committee
JJPOC – Juvenile Justice Policy and Oversight Committee
BHPOC – Behavioral Health Partnership Oversight Council
SAC – State Advisory Council on Children and Families
CBHAC – Children's Behavioral Health Advisory Council

Addendum 4: Connecticut Children's Behavioral Health System: State Agencies and Oversight/Advisory Bodies

Leadership and Structure	Committee Charge Per Statute	Reporting Requirements	Family Engagement and Membership	FY24 Priorities
Children's Behavioral Health Plan Implementation Advisory Board **Target Population: all children in Connecticut**				
Tri-chairs selected by DCF Commissioner Quarterly mtgs Short-term workgroups are established and meet as needed to address specific needs in the system	**CGS Sec. 17a-22ff** **Established 2015** The board shall advise member agencies, service providers, advocates, and others regarding (a) execution of the behavioral health plan for all children in Connecticut developed pursuant to Connecticut law, (b) cataloguing the mental, emotional, and behavioral health services offered for families with children in the state by agency, service type, and funding allocations to reflect capacity and utilization of services, (c) adopting standard definitions and measurements for services that are delivered, when applicable, and (d) demonstrating the collaboration of such agencies, providers, advocates, and other stakeholders in implementing the Plan. (Home - Plan 4 Children). The Advisory Board meets quarterly and issues an annual report to the General Assembly each October. Subcommittees are convened to address aspects of the board's statutory charge.	Annual report to the joint standing committee of the General Assembly having cognizance of matters relating to children [Children's Committee] Report must address: the status of the Plan's execution; level of collaboration among agencies and stakeholders; recommendations for improvements in execution of the plan or collaboration among stakeholders; additional information as needed to reduce long-term impact of behavioral health needs on children.	At least 8 members must be families with lived expertise Beginning FY25, will provide Spanish/English translation and stipends to participating family members	(1) Coordinate Efforts of Advisory Bodies (2) Address the Workforce Crisis (3) Develop optimal funding paradigms
Children's Behavioral Health Advisory Committee **Target Population: all children in Connecticut**				

Two chairs: one family member and one provider Bimonthly mtgs required, but typically meet monthly	**CGS Sec. 17a-4a** **Established 2000** The committee shall promote and enhance the provision of behavioral health services for all children in this state. It shall meet at least bimonthly and submit a status report on local systems of care and practice standards for state-funded behavioral health programs to the commissioner of children and families and State Advisory Council on Children and Families.	Annual status report to the DCF Commissioner on local Systems of Care/Community Collaboratives and practice standards for state-funded behavioral health programs Biannual recommendations to the DCF Commissioner and the SAC on the provision of behavioral health services for all children in the state, including: assessment and benefit options for children with behavioral health needs; appropriateness and quality of care for children with behavioral health needs; the coordination of services provided under the HUSKY Health program with services provided by other publicly-funded programs; (4) performance standards for preventive services, family supports and emergency service training programs; (5) assessments of community-based and residential care programs; (6) outcome measurements by reviewing provider practice; and (7) a medication protocol and standards for the monitoring of medication and after-care programs.	At least 51% of members must be parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as children Family members receive a stipend for participation All meetings have live Spanish/English translation services	2022-2025 Priorities: (1) Pediatric Primary Care and Behavioral Health Care Integration (2) Disparities in Access to Culturally Appropriate Care (3) Access to a Comprehensive Array of Services and Supports More specific recommendations within annual reports
Behavioral Health Partnership Oversight Council and the Child/Adolescent Quality, Access, and Policy Committee **Target Population: Medicaid-insured**				
Tri-chairs: provider, family member, and Administrative support provided by the Joint	**CGA Sec. 17a-22j** **Established 2006** The council shall advise the commissioners of children and	Committees report on meeting content back to the Oversight Council and make recommendations to the Council about improvements in quality		CAQAP Key Topics: (1) Utilization of EDs and in-patient beds

Cmte on Legislative Management Council and committees meet monthly; committees are open to public without formal membership Committees: Child/Adolescent Quality, Access, and Policy; Adult Quality, Access, and Policy; Operations; Coordination of Care/Consumer Access	families, mental health and addiction services, and social services on the planning and implementation of the Behavioral Health Partnership (BHP) established on behalf of children and adults participating in the HUSKY Health Program members (Medicaid and CHIF services) and children enrolled in the voluntary services program operated by the Department of Children and Families.	and access in children's behavioral health		(2) Utilization/availability of intermediate levels of care (3) Urgent Crisis Center utilization and effectiveness and Medicaid funding (4) Non-Emergency Medical Transportation and its impact on access to care (5) Medicaid reimbursement levels and state response to study revealing inadequacy of current funding (6) Health equity within all of topics
State Advisory Council on Children and Families **Target Population: children served by DCF**				
Chair and Vice Chair Quarterly mtgs	[CGS Sec. 17a-4](#) **Established 1971** The council shall (a) recommend to the commissioner of children and families programs, legislation or other matters to improve services for children and youth, (b) annually review and advise the commissioner regarding the proposed budget, (c) interpret to the community at large the policies, duties and programs of the department, (d) issue reports to the Governor and commissioner, (e) assist in the development and review of strategic plans, (f) receive a quarterly status report from the commissioner, (g) independently	Annual progress report Review and comment on the annual DCF budget (annually) and the Child and Family Service Plan (every five years)	Positions designated for youth and caregivers Request youth and caregivers for agenda items Family advocate representatives Members of the Youth Advisory Board Meetings includes Regional Advisory Council updates representing family	(1) Access for services (2) Workforce shortage (3) Low Medicaid reimbursement rates and contracts without COLAs (4) Racial Justice (5) Foster family recruitment and retention

	monitor the department's progress in achieving its goals, and (h) provide an outside perspective to the department.		voices from the regions	
Transforming Children's Behavioral Health Policy and Planning Committee **Target Population: all children**				
Tri-chairs: OPM representative and two members of the General Assembly Monthly meetings Subcommittees include: Strategic Planning; Infrastructure; Services; Prevention; School-Based	**CGS Sec. 2-137** **Established 2022** The committee shall evaluate the availability and efficacy of prevention, early intervention, and behavioral health treatment services and options for children from birth to age eighteen and make recommendations to the General Assembly and executive agencies regarding the governance and administration of the behavioral health care system for children.		Statute does not require family or youth participation Family members are engaged within planning efforts and presentations	Workgroups defining priorities
Juvenile Justice Policy and Oversight Committee **Target Population: justice-involved youth**				
Chairs: Representatives from OPM and General Assembly Monthly mtgs Workgroups: Diversion; Incarceration; Cross Agency Data Sharing; Racial and Ethnic Disparities; Community Expertise Workgroup; Education Committee; Gender Responsiveness Workgroup	**CSG Sec. 46b-121n** **Established 2015** The committee shall evaluate policies related to the juvenile justice system and the expansion of juvenile jurisdiction to include persons sixteen and seventeen years of age.		Statute requires participation by youth and family members	

THE INSTITUTE FOR
INNOVATION & IMPLEMENTATION
Integrating Systems • Improving Outcomes

The Evolution of the System of Care Approach

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

By Beth A. Stroul, MEd; Gary M. Blau, PhD; and Justine Larson, MD

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]

---

[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.

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**).

---

[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.

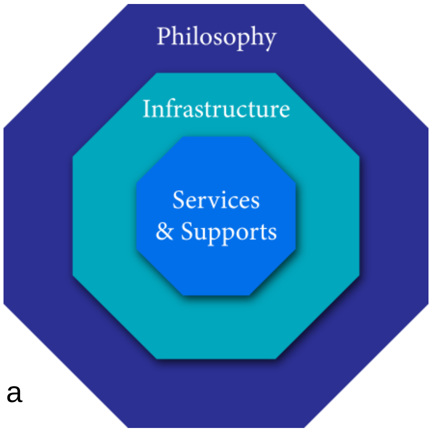
Philosophy

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).

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).

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



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.

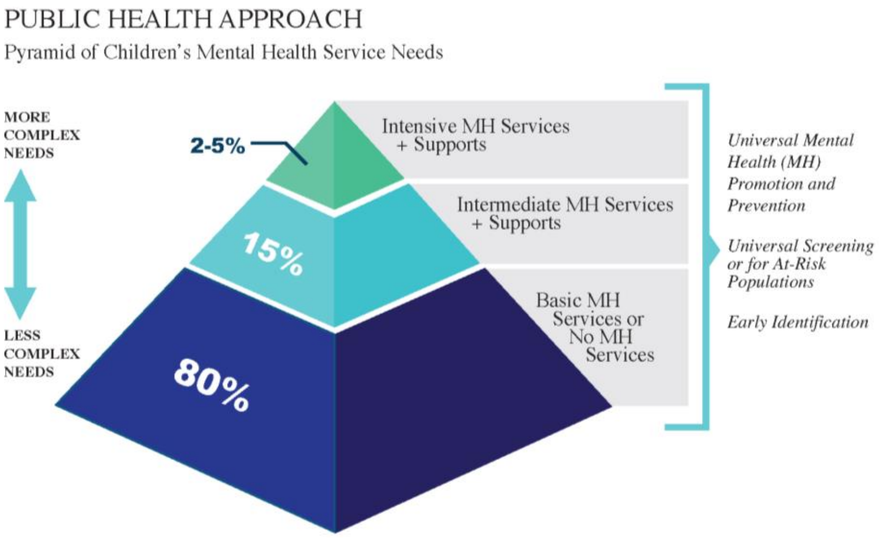
The Public Health Approach

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.

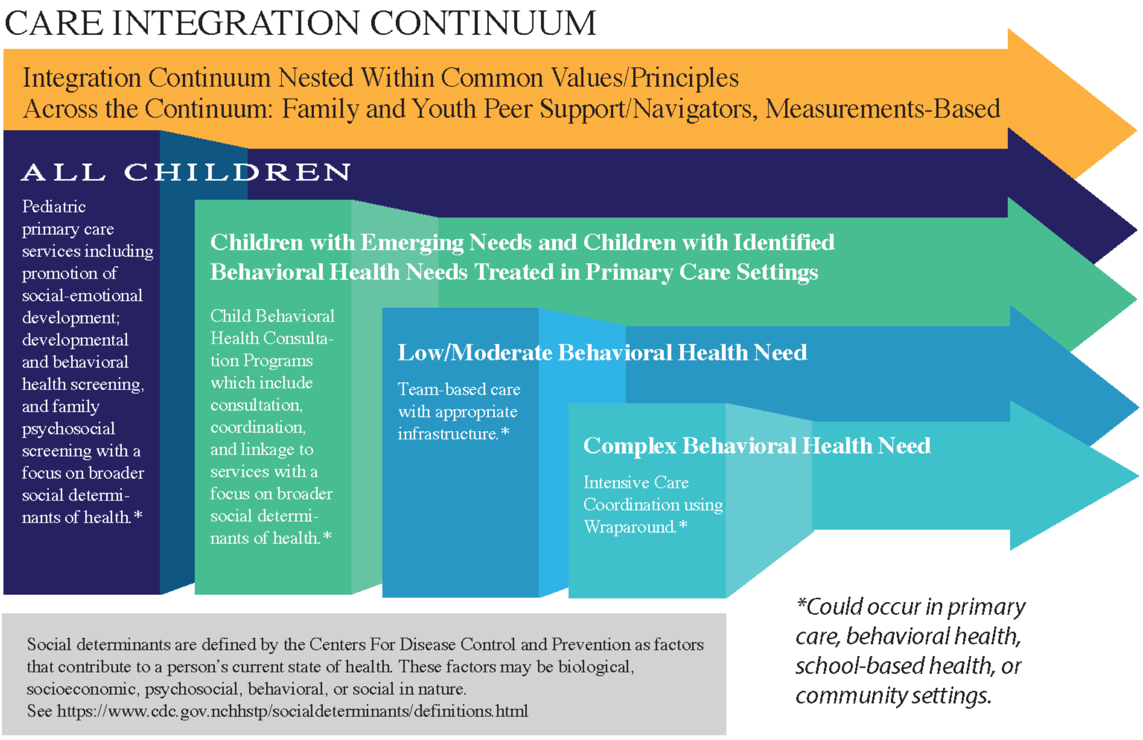
The care integration framework addresses the role PCPs in providing mental health services and the importance of improving collaboration between primary care and mental health providers. The American Academy of Child & Adolescent Psychiatry (2010) outlined goals for this approach, such as promoting optimal 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



Social determinants are defined by the Centers For Disease Control and Prevention as factors that contribute to a person's current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.
See https://www.cdc.gov.nchhstp/socialdeterminants/definitions.html

*Could occur in primary care, behavioral health, school-based health, or community settings.

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.

References

Acri, M., Hooley, C. D., Richardson, N., and Moaba, L. B. (2017). Peer models in mental health for caregivers and families. *Community Mental Health*, *53*, 241-249.

American Academy of Child & Adolescent Psychiatry. (2010). A guide to building collaborative mental health care partnerships in pediatric primary care. AACAP.

American Academy of Pediatrics. (2009). The future of pediatrics: Mental health competencies for pediatric primary care. *Pediatrics, 124*(1), 410-421.

Ansell, D. I. & Insley, S.E. (2013). Youth peer-to-peer support: A review of the literature. YouthMOVE National.

Anthony, B. & Biss, C. (2016). Changing landscape: Integration of behavioral health and primary care. Presentation at Annual Meeting of Child, Adolescent, and Families Division, National Association of State Mental Health Program Directors.

ARCH National Respite Network (2012). The Technical Assistance Center for Lifespan Respite Fact Sheet Number 34.

Averill, O. H. & Rinaldi, C. (2013). Research brief: Multi-Tier System of Supports (MTSS). *Urban Special Education Leadership Collaborative.*

Barbot, B., Bick, J., Bentley, M.J., Balestracci, K.M., Woolston, J.L., Adnopoz, J.A., & Grigorenko, E.L. (2016). Changes in mental health outcomes with the intensive in-home child and adolescent psychiatric service: a multi-informant, latent consensus approach. *International Journal of Methods in Psychiatric Research, 25*, 33-43.

Batsche, Elliott, J., Graden, J., Grimes, J., Kovaleski, J., Prasse, D., et al. (2005). Response to intervention: Policy considerations and implementation. National Association of State Directors of Special Education.

Boothroyd, R. A., Kuppinger, A. D., Evans, M. E., Armstrong, M. I., & Radigan, M. (1998). Understanding respite care use by families of children receiving short-term, in-home psychiatric emergency services. *Journal of Child and Family Studies, 7*, 353-376.

Bostic, J. & Cullins, L. (2018). Early identification of mental health problems saves lives. *American Academy of Pediatrics, District of Columbia Chapter.* http://aapdc.org/early-identification-of-mental-health-problems-saves-lives/

Brauner, C. and Stephens, C. B. (2006) Estimating the Prevalence of Early Childhood Serious Emotional/Behavioal Disorders: Challenges and Recommendations. Public Health Rep. 2006 May-Jun; 121(3), 303–310. https://doi.org/10.1177/003335490612100314

Bruns, E. & Burchard, J. (2000). Impact of respite care services for families with children experiencing emotional and behavioral problems. *Children's Services: Social Policy, Research, and Practice, 3*(1), 39-61.

Bruns E. & Shepler, R. (2018). Defining and establishing quality standards for in-home behavioral health treatment. Presentation at National Association of State Mental Health Program Directors Children, Youth and Families Division 2018 Meeting, July 24, 2019, Washington, DC.

Bruns, E. J. & Suter, J. C. (2010). Summary of the wraparound evidence base. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound.* National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Bruns, E. J., Walker, J. S., & The National Wraparound Initiative Advisory Group (2008). Ten principles of the wraparound process. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. National Wraparound Initiative, Research and Training Center for Family Support and Children's Mental Health.

Carpenter, R. A., Falkenburg, J., White, T. P., & Tracy, D. K. (2013). Crisis teams: Systematic review of their effectiveness in practice. *The Psychiatrist, 37*, 232-237.

Cené, C.W., Johnson, B.H., Wells, N., Baker, B., Davis, R., & Turchi, R. (2016). A narrative review of patient and family engagement: The "foundation" of the medical "home". *Medical Care*, *54*(7), 697-705.

Center for Health Care Strategies. (2011). Care management entities: A Primer [Fact sheet]. https://www.chcs.org/media/CHIPRACMEPrimer.pdf

Center for Health Care Strategies. (2013). Family and Youth Peer Support Literature Review. https://www.chcs.org/resource/family-and-youth-peer-support-literature-review/

Center for Integrated Health Solutions, Substance Abuse and Mental Health Services Administration. (n.d.). A quick start guide to behavioral health integration for safety-net primary care providers. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/Website-Resources.pdf?daf=375ateTbd56

Center for Integrated Health Solutions, Substance Abuse and Mental Health Services Administration (2013). Integrating Behavioral Health and Primary Care for Children and Youth: Concepts and Strategies.
https://static1.squarespace.com/static/545cdfcce4b0a64725b9f65a/t/553e7ef4e4b09e24c5c935db/1430159092492/13_June_CIHS_Integrated_Care_System_for_Children_final.pdf

Center for Integrated Health Solutions, Substance Abuse and Mental Health Services Administration. (2016). Back to the Basics: What You Need to Know About Primary and Behavioral Health Care Integration (webinar). https://www.youtube.com/watch?v=Una9ZI0hEbE

Center for Integrated Health Solutions, Substance Abuse and Mental Health Services Administration. Six levels of collaboration/integration [Infographic]. https://www.thenationalcouncil.org/wp-content/uploads/2020/01/CIHS_Framework_Final_charts.pdf?daf=375ateTbd56

Center for Medicaid and CHIP and Substance Abuse and Mental Health Services Administration. (2013). Coverage of behavioral health services for children, youth, and young adults with significant mental health conditions. *Joint Informational Bulletin.*

Centers for Medicare & Medicaid Services. (2020). State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding the Use of Telehealth. COVID-19 Version. https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf

Centers for Disease Control and Prevention (2016). About Behavioral Risk Factor Surveillance System ACE Data. https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/ace-brfss.html

Centers for Disease Control and Prevention. (2021). Improving access to children's mental health care. https://www.cdc.gov/childrensmentalhealth/access.html

Child Welfare Information Gateway (2018). Respite Care Programs. https://www.childwelfare.gov/topics/preventing/prevention-programs/respite/

Chorpita, B. F., Daleiden, E.L., & Weisz, J.R., (2005). Modularity in the design and application of therapeutic intervention. *Applied Preventive Psychology, 11*(3), 141-156.

Clarke, A. M., Kuosmanen, T., & Barry, M. M. (2015). A systematic review of online youth mental health promotion and prevention interventions. *Journal of Youth and Adolescence, 44*, 90-113.

Cook, J. R. & Kilmer, R. P. (2004). Evaluating systems of care: Missing links in children's mental health research. *Journal of Community Psychology 32*, 655–674.

Dollard, N., Evans, M. E., Lubrecht, J., & Schaeffer, D. (1994). The use of flexible service dollars in rural community-based programs for children with serious emotional disturbance and their families. *Journal of Emotional and Behavioral Disorders 2*, 117-125.

English, K., Lieman, R.B., & Fields, S. (2016). Services in support of community living for youth with serious behavioral health challenges: Intensive in-home services.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine 14*, 245-258.

Fuhr, D.C., Salisbury, T. T., De Silva, M. J., Atif, N., van Ginneken, N., Rahman, A., & Patel, V. (2014). Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: A systematic review and meta-analysis. *Social Psychiatry and Psychiatric Epidemiology, 49*, 1691-1702.

Focal Point. (2001). Respite care for children with serious emotional disturbance and their families: A way to enrich family life. *A National Bulletin on Family Support and Children's Mental Health*, *15(*2), 26-30.

Gopalan, G., Lee, S. J., Harris, R., & Acri, M. & Munson, M. (2017). Utilization of peers in services for youth with emotional and behavioral challenges: A scoping review. *Journal of Adolescence, 55*, 88-115.

Gordon, R. (1987). An operational classification of disease prevention. In *Preventing Mental Disorders: A Research Perspective*, pp. 20-26. Rockville, MD, US: National Institute of Mental Health.

Gordon, S. Y., Savicki, K., & Tadehara, E. (2021, March 4). Maximizing telehealth services to reach youth and families. Presentation for Training Institutes LIVE! Institute for Innovation and Implementation, University of Maryland School of Social Work. https://www.youtube.com/watch?v=ixzq6mXPpu4&list=PLvwWJsRJoLMN35PMZ6zcTKef-c8TpPbBr&index=10

Green, L. W. (2008). Making research relevant: If it is an evidence-based practice, where's the practice-based evidence? *Family Practice, 25* (Suppl 1), i20-24.

Hoagwood, H., Burns, J., Kiser, L., Ringeisen, H., and Schoenwald, S. (2001). Evidence-Based Practice in Child and Adolescent Mental Health Services. https://doi.org/10.1176/appi.ps.52.9.1179

Hoagwood, K. E., Cavaleri, M. A., Serene Olin, S., Burns, B. J., Slaton, E., Gruttadaro, D., & Hughes, R. (2010). Family support in children's mental health: A review and synthesis. *Clinical Child and Family Psychology Review, 13*, 1-45.

Hodges, S., Ferreira, K., Israel, N., & Mazza, J. (2010). Systems of care, featherless bipeds, and the measure of all things. *Evaluation and Program Planning, 33*, 4-10.

Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, O., Sheriff, L. & Cashman, J. (2019). Advancing Comprehensive School Mental Health: Guidance From the Field. National Center for School Mental Health. University of Maryland School of Medicine

Hoover Stephan, S., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for Integrating Mental Health into Schools via a Multitiered System of Support. Child & Adolescent Psychiatric Clinics of North America. Volume 24, Issue 2, 211-231 https://doi.org/10.1016/j.chc.2014.12.002

Howell, E., & McFeeters, J. (2008). Children's mental health care: Differences by race/ethnicity in urban/rural areas. *Journal of Health Care for the Poor and Underserved, 19*, 237-247.

Institute of Medicine (1988). *Institute of Medicine (US) Committee for the Study of the Future of Public Health.* National Academies Press (US).

Interdepartmental Serious Mental Illness Coordinating Committee [ISMICC] (2017). The way forward: Federal action for a system that works for all people living with SMI and SED and their families and caregivers.

Jackson, S., Walker, J. S., & Seibel, C. (2015). Youth & young adult peer support: What research tells us about its effectiveness in mental health services. Research and Training Center for Pathways to Positive Futures, Portland State University.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *American Journal of Psychiatry, 159*, 1548-1555.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593-602.

Knitzer, J. (1982). Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services. Children's Defense Fund.

Kutash, K., Duchnowski, A. J., & Green, A. L. (2011). School-based mental health programs for students who have emotional disturbances: Academic and social-emotional outcomes. *School Mental Health, 3*, 191-208.

Kutash, K., Duchnowski, A. J., Green, A. L., & Ferron, J. M. (2011). Supporting parents who have youth with emotional disturbances through a parent-to-parent support program: A proof of concept study using random assignment. *Administrative Policy in Mental Health and Mental Health Services Research*, *38*, 412-427.

Kutash, K., Garraza, L. G., Ferron, J. M., Duchnowski, A. J., Walrath, C., & Green, A. L. (2013). The relationship between family education and support services and parent and child outcomes over time. *Journal of Emotional and Behavioral Disorders*, 21(4), 264-276.

Lieberman, R., Zubritsky, C., Martinez, K., Massey, O., Fisher, S., Kramer, T., Koch, R., & Obrochta, C. (2010). Issue brief: *Using practice-based evidence to complement evidence-based practice in children 's behavioral health*. ICF Macro, Outcomes Roundtable for Children and Families. http://cfs.cbcs.usf.edu/_docs/publications/OutcomesRoundtableBrief.pdf

Manley, E., Schober, M., Simons, D., & Zabel, M. (2018). Making the case for a comprehensive children's crisis continuum of care. National Association of State Mental Health Program Directors.

Manteuffel, B., Stephens, R. L., Brashears, F., Krivelyova, A., & Fisher, S. K. (2008). Evaluation results and systems of care: A review. In B.A. Stroul & G. M. Blau (Eds.), *The system of care handbook: Transforming mental health services for children, youth, and families* (pp. 25-69). Baltimore: Brookes.

Marsac, M. L., Kassam-Adams, N., Hildenbrand, A. K., Nicholls, E., Winston, F. K., Leff, S. S., & Fein, J. (2016). Implementing a trauma-informed approach in pediatric health care networks. *JAMA Pediatrics, 170*, 70-77.

Martinez, K. (2008). Evidence Based Practices, Practice Based Evidence, and Community Defined Evidence in Multicultural Mental Health. Presented at NAMI Annual Conference, Orlando, Florida. https://www.racialequitytools.org/resourcefiles/Evidencebasedppt.pdf

McGorry, P. D., Purcell, R., Goldstone, S., & Amminger, G.P. (2011). Age of onset and timing of treatment for mental and substance use disorders: Implications for preventive intervention strategies and models of care. *Current Opinions in Psychiatry, 24*, 301-306.

Miles, J., Espiritu, R. C., Horen, N. M., Sebian, J., & Waetzig, E. (2010). A public health approach to children's mental health: A conceptual framework. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Moffett, S., Brotnow, L., Patel, A., Adnopoz, J., & Woolston, J. (2017). Intensive home-based programs for youth with serious emotional disturbances: A comprehensive review of experimental findings. *Child and Youth Services Review, 85*(C), 319-325.

Mrazek, P.J. & Haggerty, R.J. (1994). Reducing risks for mental disorders: Frontiers for preventive intervention research. Institute of Medicine (US) Committee on Prevention of Mental Disorders. National Academies Press (US).

National Center for School Mental Health Services [NCSMH]. (2019). Advancing comprehensive school mental health systems: Guidance from the field. www.schoolmentalhealth.org/AdvancingCSMHS

National Academies of Sciences, Engineering, and Medicine. (2019). Achieving Behavioral Health Equity for Children, Families, and Communities: Proceedings of a Workshop. The National Academies Press. https://doi.org/10.17226/25347

National Institute of Mental Health [NIMH]. (2017). Integrated care. https://www.nimh.nih.gov/health/topics/integrated-care/index.shtml.

Obrochta, C., Anthony, B., Armstrong, M., Kalil, J., Hust, J., & Kernan, J. (2011). Issue brief: Family-to-family peer support: Models and evaluation. ICF Macro, Outcomes Roundtable for Children and Families. https://www.ffcmh.org/sites/default/files/Issue Brief - Family to Family Peer Support Outcomes Roundtable 2011.pdf

Olson, J. R., Benjamin, P. H., Azman, A. A., Kellogg, M. A., Pullman, M. D., Suter, J. C., & Bruns, E. J. (2021, In Press). Systematic review and meta-analysis: Effectiveness of wraparound care coordination for children and adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry.* https://jaacap.org/action/showPdf?pii=S0890-8567%2821%2900155-6

Ontario Centre of Excellence for Child and Youth Mental Health (2016). Youth peer support in a mental health context. *Evidence In-Sight*. http://www.excellenceforchildandyouth.ca/resource-hub/evidence-in-sightdatabase.

Outcomes Roundtable (2011). Issue Brief: Using Practice-Based Evidence to Complement Evidence-Based Practice in Children's Mental Health. http://cfs.cbcs.usf.edu/_docs/publications/OutcomesRoundtableBrief.pdf

Peart Boyce, S., Pires, S.A., & Stroul, B. (2015). Financing tools for systems of care: A series of practical guides, analyzing service use and costs at the individual child level. The Technical Assistance Network for Children's Behavioral Health.

Perez, A. (2018). Implementing trauma-informed systems of care. Presentation at National Association of State Mental Health Program Directors Children, Youth and Families Division 2018 Meeting, July 24, 2018, Washington, DC.

Perou, R., Bitsko R. H., Blumberg, S. J., Pastor, P., Ghandour, R. M., Gfroerer, J. C., Hedden, S.L., Crosby, A. E., Visser, S. N., Schieve, L. A., Parks, S. E., Hall, J. E., Brody, D., Simile, C. M., Thompson, W. W., Baio, J., Avenevoli, S., Kogan, M. D., & Huang, L. N. (2013). Mental health surveillance among children: United States, 2005-2011. *Morbidity and Mortality Weekly Report.* Centers for Disease Control and Prevention.

Pires, S. (2010). *Building systems of care: A primer.* 2nd Edition. National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

Pires, S., Fields, S., & Schober, M. (2018). Care integration opportunities in primary care for children, youth, and young adults with behavioral health needs: Expert convening. National Technical Assistance Network for Children's Behavioral Health, University of Maryland School of Social Work.

Pumariega, A.J., Winters, N.C., & Huffine, C. (2003). The evolution of systems of care for children's mental health: Forty years of community child and adolescent psychiatry. *Journal of Community Mental Health*, 39, 399-425.

Ringeisen, H., Stambaugh, L., Bose, J., Casanueva, C., Hedden, S., Avenevoli, S., Blau, G., Canino, G., Carter, A., Colpe, L., Copeland, W. E., Fisher, P. W., Kaufman, J., Merikangas, K., Narrow, W., Stroul, B., & West, J. (2017). Measurement of childhood serious emotional disturbance: State of the science and issues for consideration. *Journal of Emotional and Behavioral Disorders, 25*, 195-210.

Rzucidlo, S.E. & Campbell, M. (2009). Beyond the physical injuries: Child and parent coping with medical traumatic stress after pediatric trauma. *Journal of Trauma Nursing, 16*, 130-135.

Schurer Coldiron, J., Bruns, E., & Quick, H. (2017). A comprehensive review of wraparound care coordination research, 1986-2014. *Journal of Child and Family Studies, 26*, 1245-1265.

Simons, D., Hendricks, T., Lipper, J., Bergan, J., & Masselli, B. (2016). Providing youth and young adult peer support through Medicaid. Center for Health Care Strategies and YouthMOVE for the National Technical Assistance Center for Children's Mental Health. http://www.chcs.org/media/Providing-Youth-and-Young-Adult-Peer-Support-through-Medicaid.pdf

Stroul, B. (2002). Issue brief: Systems of care: A framework for system reform in children's mental health. Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. (2020). The System of Care Approach: Improving Outcomes for Children, Youth, and Young Adults with Mental Health Challenges and Their Families. Presented at Kentucky FIVE Regional Kick-Off, February, 2020.

Stroul, B. & Friedman, R. M. (1986). A system of care for children and youth with severe emotional disturbances (rev ed.). Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.

Stroul, B. A. & Friedman, R. M. (2011) Issue brief: Strategies for expanding the system of care approach. Technical Assistance Partnership for Child and Family Mental Health.

Stroul, B. A., Blau, G. M., & Friedman, R. M. (2010). Updating the System of Care concept and philosophy. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Stroul, B., Goldman, S., Pires, S., & Manteuffel, B. (2012). Expanding systems of care: Improving the lives of children, youth, and families. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Stroul, B. & Le, L. (2017). Rating tool for implementation of the system of care approach for children, youth, and young adults with behavioral health challenges and their families: Guide for self-assessment. Georgetown University Center for Child and Human development, National Technical Assistance Center for Children's Mental Health.

Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2015). Issue Brief: Return on investment in systems of care for children with behavioral health challenges. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Substance Abuse and Mental Health Services Administration. (1993). Final notice [Final definitions for: (1) Children with a serious emotional disturbance, and (2) adults with a serious mental illness]. https://www.samhsa.gov/sites/default/files/federal-register-notice-58-96-definitions.pdf

Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Substance Abuse and Mental Health Services Administration. (2017). Family, Parent, and Caregiver Peer Support in Behavioral Health. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf

Substance Abuse and Mental Health Services Administration. (2017). Research Brief. The integration of behavioral health into pediatric primary care settings. https://www.nashp.org/wp-content/uploads/2019/09/The-Integration-of-Behavioral-Health-into-Pediatric-Primary-Care-Settings.pdf

Substance Abuse and Mental Health Services Administration. (2017). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program. 2017 Report to Congress. Rockville, MD: Author. https://store.samhsa.gov/product/The-Comprehensive-Community-Mental-Health-Services-for-Children-with-Serious-Emotional-Disturbances-Program-2017-Report-to-Congress/PEP20-01-02-001

Substance Abuse and Mental Health Services Administration. (2019). Strategic Plan FY 2019 - FY 2023. https://www.samhsa.gov/sites/default/files/samhsa_strategic_plan_fy19-fy23_final-508.pdf

Substance Abuse and Mental Health Services Administration and Center for Medicaid and CHIP. (2019). Guidance to states and school systems on addressing mental health and substance use services in schools. *Joint Informational Bulletin.* Stephan, S. H., Sugai, G., Lever, N., & Connors, E. (2015). Strategies for integrating mental health into schools via a multitiered system of support. Child and Adolescent Psychiatric Clinics of North America, 24(2), 211-231.

Taylor C. & Goodman, J. (2021, April 1) Using Data for Equity: Creating and Expanding Capacity for Data-Driven Decision Making. Presentation for Training Institutes LIVE! Institute for Innovation and Implementation, University of Maryland School of Social Work. YouTube. https://www.youtube.com/watch?v=WvYrrV42tSc&list=PLvwWJsRJoLMN35PMZ6zcTKef-c8TpPbBr&index=13

University of South Florida. (2011). Implementing a multi-tiered system of support for behavior: Recommended practices for school and district leaders. https://flpbis.cbcs.usf.edu/foundations/MTSS.html

Urdapilleta, O., Kim, G., Wang, Y., Howard, J., Varghese, R., Waterman, G., Busam, S., & Palmisano, C. (2012). National evaluation of the Medicaid demonstration home and community-based alternatives to psychiatric residential treatment facilities, final evaluation report. IMPAQ International.

U.S. Department of Health and Human Services. (2013). Report to the President and Congress Medicaid Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities Demonstration. https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/institutional-care/downloads/prtf-demo-report.pdf

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2015). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Report to Congress, 2015.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2017). Cooperative Agreements for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (System of Care Expansion and Sustainability Cooperative Agreements), Funding Opportunity Announcement. No. SM-17-001. Catalogue of Domestic Assistance (CFDA) No. 93.104, Rockville, MD.

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2019). Grants for Expansion and Sustainability of the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances (System of Care Expansion and Sustainability Grants), Funding Opportunity Announcement. No. SM-19-009. Catalogue of Domestic Assistance (CFDA) No. 93.104, Rockville, MD.

Walker, J.S. & Baird, C. (2019). Wraparound for older youth and young adults: Providers' views on whether and how to adapt Wraparound. National Wraparound Initiative and Research and Training Center on Pathways to Positive Futures.

Weisz, J. R., & Chorpita, B. F. (2012). "Mod squad" for youth psychotherapy: Restructuring evidence-based treatment for clinical practice. In P. C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures* (p. 379–397). Guilford Press.

Whitmore, K. E. (2017). The concept of respite care. *Nursing Forum, 52*, 180-187.

Williams, N. J., Scott, L., & Aarons, G. A. (2018). Prevalence of serious emotional disturbance among U.S. children: A meta-analysis. *Psychiatric Services*, 69(1), 32-40.

World Health Organization [WHO]. (2004). Summary report: Prevention of mental disorders - effective interventions and policy options. World Health Organization.

Zechmeister, I., Kilian, R., McDaid, D., & the MHEEN group (2008). Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of the evidence from economic evaluations. *BMC Public Health 8*, 20.

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

Suggested Citation:

Stroul, B.A., Blau, G.M., & Larsen, J. (2021). The Evolution of the System of Care Approach. Baltimore: The Institute for Innovation and Implementation, School of Social Work, University of Maryland.

Affiliations:

Beth A. Stroul, M.Ed., President, Management & Training Innovations
Gary M. Blau, Ph.D., Executive Director, The Hackett Center for Mental Health, Meadows Mental Health Policy Institute
Justine Larson, M.D., M.P.H., DFAACAP, Medical Director, Schools and Residential Treatment, Sheppard Pratt

Acknowledgements

This document was partially supported by the Center for Mental Health Services, SAMHSA, DHHS under the Contract No. HHSP233201860076A by Write Brain LLC and by the Institute for Innovation and Implementation of the University of Maryland Baltimore School of Social Work. The contribution of Marie Rowland, PhD, and her staff at Write Brain in the initial phase of this work is gratefully acknowledged.

Disclaimer

Delivering and Financing Children's Behavioral Health Services in Connecticut

A Report to the Connecticut General Assembly

Pursuant to Public Act 99-279, Section 36

From the Connecticut Department of Social Services

Presented by Patricia Wilson-Coker, MSW, JD, Commissioner

in collaboration with the Department of Children and Families, the State Department of Education, the Department of Mental Health and Addiction Services, the Department of Mental Retardation, and the Office of Policy and Management

Prepared for the Department of Social Services by

The Child Health and Development Institute of Connecticut, Inc.

February 2000

Delivering and Financing Children’s Behavioral Health Services in Connecticut

A Report to the Connecticut General Assembly

Submitted by:
The Connecticut Department of Social Services

Prepared by:
The Child Health and Development Institute of Connecticut, Inc.

Funded by:
The Connecticut Department of Social Services
The Children’s Fund of Connecticut, Inc.

Study Team:
Carl Valentine - F. Carl Valentine & Associates
James Farnam - Holt, Wexler & Farnam, LLP
Dianne Jenkins - Consultant

Coordinated by:
Judith C. Meyers, Executive Director
Child Health and Development Institute of Connecticut
270 Farmington Avenue, Suite 325
Farmington, CT 06032
(860) 679-1519

For A Copy of the Report and Technical Appendix Contact:

David Parrella
Department of Social Services
25 Sigourney Street
Hartford, CT 06106
(860) 424-5978/(860) 424-5114 Fax
Email: pris.dawidowicz@po.state.ct.us

PREFACE

The Child Health and Development Institute of Connecticut prepared this report under an agreement with the Connecticut Department of Social Services (DSS). The Institute is a not-for-profit organization established to promote and maximize the healthy physical, behavioral, emotional, cognitive, and social development of children throughout Connecticut. The Institute creates, supports, and facilitates innovative primary and preventive strategies for children, and works to maximize the effectiveness of the institutions and systems that contribute to their well being. The Institute retained F. Carl Valentine & Associates to conduct the study that is the basis of this report.

The analyses and recommendations presented in this report and the accompanying Technical Appendix were developed with DSS and the Department of Children and Families, in consultation with members of the Children's Behavioral Health Task Force established by DSS. The Task Force membership is listed below. The group consisted of representatives of State departments with responsibilities related to children's behavioral health, behavioral health care providers, and consumer parents.

Children's Behavioral Health Task Force Members

David Parrella, Chair	Department of Social Services
Karen Andersson	Department of Children and Families
Lois Berkowitz	Anthem Blue Cross Blue Shield of Connecticut
Gary Blau	Department of Children and Families
Eva Bunnell	Family Representative / Medicaid Managed Care Council
Paul DiLeo	Department of Mental Health and Addiction Services
George Dowaliby	State Department of Education
Tracey Halstead	Connecticut Association of Nonprofits
Dawn Anderson Henschel	Family Representative / No. Central Regional Mental Health Board
Steve Larcen	Natchaug Hospital
Rolando Martinez	Hispanic Health Council
Barbara Parks Wolf	Office of Policy and Management
Sherry Perlstein	Child Guidance Center of Southern Connecticut
Andrew Wagner	Department of Mental Retardation

Delivering and Financing
Children's Behavioral Health Services in Connecticut

Table of Contents

NOTE: The Technical Appendix to this report is available as a separate document, and contains more detailed information, data, and references that are the basis for the findings and recommendations in this report.

List of Tables and Figures

Delivering and Financing Children's Behavioral Health Services in Connecticut

Executive Summary

State policymakers and practitioners are increasingly concerned about children in Connecticut who have serious emotional or behavioral problems, as are the families of these children. Providing appropriate and effective services to meet their needs is a high priority.

The State of Connecticut invests an estimated $207 million annually in behavioral health services for children, addressing many of their needs. Behavioral health services, however, are administered by more than five state agencies and a myriad of local agencies and the schools. The result is a complex and fragmented system that leaves families confused about where to turn when they recognize that their children need help.

In response to these concerns, the State Legislature requested that the Connecticut Department of Social Services (DSS) conduct a study of the State's behavioral health services for children, specifically services for those enrolled in the state-sponsored health insurance programs for low-income families (HUSKY A and B)[1]. Legislators also sought recommendations for improving the quality and integration of these services for Connecticut's children. DSS engaged the Child Health and Development Institute of Connecticut to conduct the study. A task force comprising representatives from the state agencies who fund or provide behavioral health services for children, along with major service providers, consumer parents, and managed care organizations assisted with the study.

The study was conducted in the context of national research, documented in a recent report by the U.S. Surgeon General. This report advanced a "system of care" approach in which multiple problems associated with "serious emotional disturbance" are addressed comprehensively.

The good news for Connecticut is that the foundation to implement this approach is already in place. The State has begun to build a network of systems of care under the mandate and principles established by the Legislature in 1997 (P.A. 97-272). These local systems must now be fully supported and replicated on a statewide basis.

The results of the study are presented in two parts: 1) the main report that summarizes the findings and presents the recommendations; and 2) a technical appendix to the report that provides more detailed information, data, and analyses that were the basis for the findings and recommendations.

Children Served by HUSKY

- Approximately 184,000 children are enrolled in HUSKY A and B– about 20% of all children under 21 in the state.
- Approximately 22,300 or 12% of children in HUSKY A used one or more behavioral health services in the twelve-month period studied (April 1998 – March 1999).
- 8,419 children (5%) enrolled in HUSKY A were in the custody of DCF during the year studied.

Behavioral Health Services Delivered and Their Cost

- 70% of all behavioral health dollars are spent for psychiatric hospitals and

---

[1] HUSKY A is for children enrolled in Medicaid and HUSKY B is for uninsured children in families whose income is above 185% of the federal poverty level.

residential treatment, serving 19% of all HUSKY children receiving services.

- Acute Care Psychiatric Hospitals, the most intensive and expensive level of service, serve an estimated 1,067 children in a year and cost the state $41.1 million.
- Residential Treatment and other out of home placements through DCF and the state and local education system (in various settings both in state and out of state) serve an estimated 3,000 children per year and cost $104.2 million.
- Community-based services serve about 18,200 children with a state investment of $61.3 million.

Funding Sources for Services

- Connecticut spent approximately $207 million across the five child-serving systems (DCF, SDE/LEA, DSS, DMHAS, and DMR) included in this study, for behavioral health services in FY 1999 for children enrolled in HUSKY plans.
- A majority of the public investment in behavioral health services (72%) comes from the State's General Fund. The federal government contributes 20%, primarily through Medicaid and Title IV-E foster care funds. Local funds through local education agencies account for the remainder.
- DCF administers 58% of all behavioral health services funds. State and Local Education Agencies fund 23% (through the Special Education program). DSS directly administers 14% of the total funding.
- $62 million in HUSKY/Medicaid funds flow through five state agencies, with DSS directly administering 48% of these HUSKY/Medicaid funds.

Critical System Issues

The study identified the following critical system issues:

1. There are insufficient mechanisms for effective coordination of care between levels and across systems for children and their families.
2. Community-based resources and treatment alternatives must be better developed to avoid serious bottlenecks in the treatment system.
3. Funding is allocated by program and agency, each with its own requirements and incentive structure. This fragmentation within the system must be reduced.
4. Families must have a greater role in planning services for their own children and in system planning and oversight. Currently there are not adequate supports to enable families to be sufficiently involved in these ways.
5. Current resources may not be sufficient, but a redistribution of existing resources and taking fuller advantage of federal financing mechanisms could go a long way toward supporting a more effective system of behavioral health services for children.

Some study highlights that drive these issues home include the following:

- From July-December 1999, fully 55% of the children in DCF custody enrolled in HUSKY A who were in private psychiatric hospitals were ready for discharge to a less intensive and less expensive setting (residential treatment or home). As of September 1999, almost half of these children had been there for longer than 90 days.
- The State spent $8 million for reinsurance for a 10-month period in FY 1999 to support stays longer than 15 days in psychiatric hospitals or subacute units. Projections are that reinsurance costs will be $12 million for FY 2000.

- Residential treatment facilities are at or near capacity, yet many children in residential treatment no longer need this level of care. There are not sufficient community-based services to support their return to the community.
- Placements by parole and juvenile justice authorities through DCF have increased 34% in the last three years (accounting for 432 of the 1,268 children in placements in December 1999).
- Children in DCF custody are 5% of the HUSKY population but account for 60% of behavioral health expenditures.
- There has been a 40% increase in the number of children in out-of-state placements through DCF over the past three years. (347 of the 1,268 children in placement in December 1999 were out of state).
- There is no statewide support organization for families of children with serious emotional and behavioral problems, an important component for supporting family roles in systems of care.

Recommendations

Building on existing models already in place in Connecticut, this Report presents the following recommendations in support of building a system of care to address children's behavioral health:

A. Expand and enhance local systems of care established under P.A. 97-272 as the mechanism for coordinating and delivering behavioral health services for children with severe emotional disturbance and their families.

1. Expand the eligibility criteria for system of care services to include all children meeting functional and diagnostic criteria for serious emotional disturbance and those at high risk, regardless of family income or placement status.
2. Decentralize decisions about individual care planning for eligible children to the local level, where individual care teams can access a flexible funding stream to purchase all services that are part of individual treatment plans.
3. Support local systems of care efforts to develop a richer array of community-based services for children with severe emotional disturbance and their families as an alternative to long-term residential care.
4. Actively support the development of a statewide family support network with local chapters to build capacity for family involvement.

B. Design, develop, and implement a blended funding approach to support these comprehensive, integrated, community based systems of care.

5. Fund the system of care operation and services by pooling the portion of federal and state dollars currently spent on children with serious emotional disturbances through DSS and DCF.
6. Carve out behavioral health services funding from the capitation rate for existing HUSKY A and HUSKY B plans for children who meet defined assessment criteria. Develop case rates based on an actuarial analysis of the service needs of the population of children with serious emotional disturbance and for those at high risk for becoming seriously emotionally disturbed.
7. Explore the feasibility of maximizing federal Medicaid reimbursement to expand resources for children's behavioral health services.
8. Ensure that sufficient resources remain available through the HUSKY Plans to respond to the behavioral health needs of children not eligible for, or in need of, the extensive systems of care services.

C. Establish a coordinating and administrative structure to direct and implement the expanded system of care model.

9. Establish an administrative structure to implement the expanded system of care under the joint direction of DSS and DCF. The structure would include an Administrative Services Organization (ASO) to administer the system of care funds and up to 10 regional Lead Service Agencies (LSAs) to contract with providers and provide services and administrative support required by local systems of care.
10. Form a state-level Interagency Committee for strategic planning and support for the development and implementation of the expanded system of care, with representation from DSS, DCF, SDE, DMR, DMHAS, the Department of Public Health (DPH),and OPM.
11. Establish an Advisory Committee with representation from consumer families and providers.
12. Develop measurable outcomes against which the state and local systems of care can assess the effectiveness of services.
13. Conduct training for state agency staff, providers, families, and other system participants to support the implementation of the system of care.
14. Develop a case management information system to support service delivery and management and evaluation.
15. Conduct a systematic, comprehensive, independent evaluation of this endeavor, examining the process of design, development, and implementation, and the outcomes, including impact and cost-effectiveness at multiple levels.

D. Study additional critical issues including: early intervention and prevention for young children, children in transition to adulthood, children with dual diagnoses (mental health and substance abuse, mental health and mental retardation), enhancing cultural competency, and effects on the education system.

Moving Forward

The state should continue to research the most effective mechanisms for implementing the recommendations in this report and address the issues identified for further study, working with the Children's Behavioral Health Task Force. Initial Foundation funding has already been secured for this continuing effort from the Connecticut Health Foundation and the Children's Fund of Connecticut.

The issues needing further study to support implementation of the recommendations include: development of community based service capacity; outcome accountability; contractual arrangements; governance at state and local levels; cross agency systems of care training; and financing mechanisms.

The children and families of Connecticut deserve no less than a collective best effort to build effective systems of care. With the focused attention and increased awareness of so many groups and individuals, the opportunity to take action to improve the way Connecticut delivers services for children with serious emotional and behavioral problems has never been better. The findings and recommendations of this study help point the way.

Delivering and Financing
Children's Behavioral Health Services in Connecticut

I. Introduction

The Essence of the Problem

State policymakers and practitioners are increasingly concerned about children in Connecticut who have serious emotional or behavioral problems, as are the families of these children. Providing appropriate and effective services to meet their needs is a high priority.

Approximately 22,000 Connecticut children covered by the state's health insurance program for children (HUSKY) seek some form of behavioral health services over the course of a year. An estimated 4,000 (2%) of these children suffer from emotional disturbance severe enough to seriously impair their daily functioning.

The State of Connecticut invests over $207 million annually on behavioral health services for children, addressing many of their needs. The majority of services, however, are administered by more than five state agencies and a myriad of local agencies and the schools. The result is a complex, fragmented system that leaves families confused about where to turn when they recognize that their children need help.

The public financing structure complicates the coordination of a child's care across several systems and many providers. As a result, children who need care may not receive care. Left untreated or inadequately treated, their problems become more serious over time. Eventually some children end up in psychiatric hospitals and residential treatment settings -- often far removed from their own homes, schools, and communities, and even in other states. Too often, children remain in these settings long beyond the time they need to be there, but there is nowhere else for them to go. There may not be specialized programs to treat their problems, or sufficient programs at a less intensive level of care that would provide the treatment and support to allow them to remain safely at home and in school.

Meanwhile, other children, who need hospitalization or residential care, are in detention centers, shelters, and emergency rooms awaiting an open bed. At the community level, treatment is difficult to access, and for those needing services from more than one source, hard to coordinate. There is no single point of accountability for the outcome of interventions at any level.

The backlogs in hospital, residential and community-based placements create difficulties for children and their families, and consume scarce resources that could be better used in more appropriate community-based care and increased early intervention and prevention.

Connecticut is not unique. These are problems with which all states struggle, as documented in the recent Surgeon General's Report on Mental Health. The good news for Connecticut is that the ingredients for a more systemic approach to resolve the problems are in place. The recommendations in this report build on existing resources and models as an excellent foundation from which to start.

The Basis for the Report

In response to the mounting concerns of parents, advocates, providers, and state agencies, the State Legislature requested that the Connecticut Department of Social Services (DSS) conduct a study of the behavioral health services specifically for children enrolled in the state-sponsored health insurance programs for low-income families (HUSKY A and HUSKY B). Legislators were interested in knowing about the services being used and the costs of those services. They also sought recommendations for improving the quality and integration of these services for Connecticut's children.[2]

DSS engaged the Child Health and Development Institute of Connecticut (CHDI) to conduct the study. A task force comprising representatives from the state agencies who fund or provide behavioral health services for children, along with major service providers, consumer parents, and managed care organizations assisted with the study.

This report summarizes the findings and recommendations. A Technical Appendix with more detailed information about the pattern of service use and expenditures across agencies and at different levels of service has been prepared and is available as a separate document.

The findings are derived from the following sources: state agency data sources; interviews with key providers, advocates, and state agency staff; and the deliberations of the Task Force. The focus of the study is on programs and services provided or financed by the Department of Children and Families (DCF), the Department of Social Services (DSS), the Department of Mental Health and Addiction Services (DMHAS), the Department of Mental Retardation (DMR), the State Department of Education (SDE), and local education agencies.[3]

This report documents the current commitment of resources for children with behavioral health problems, and identifies systemic issues that reduce the efficiency and effectiveness of the current services. It concludes with a set of recommendations.

If current resources could be used more effectively, building on existing models to fully support and expand their reach, many of the current difficulties could be corrected. Connecticut has the opportunity to forge a system of services that could be a model for the rest of the country. HUSKY could stand for #1 both on and off the basketball court.

As background to understanding behavioral health services for children enrolled in HUSKY, the next sections provides a national perspective on children's mental health and describes the HUSKY program in Connecticut.

A National Perspective on Children's Mental Health: The Surgeon General's Report

Connecticut is not alone in its concern for the mental health of its children. A recent report by the Surgeon General of the United States addressed the issue from a national perspective. This comprehensive document provides a thorough review of the literature and a framework for action. The report emphasizes the application of principles of child development in considering mental illness in children. It includes the following definition of children's mental health:

---

[2] Public Act 99-279, Section 36

[3] Behavioral health services provided or financed by the Court Support Services Division of the Department of Justice, the Department of Corrections, or other state agencies were beyond the mandated scope of this study.

> Mental health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social, and emotional milestones and by secure attachments, satisfying social relationships, and effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (Hoagwood et al., 1996).[4]

The Surgeon General's major conclusions about children's mental health provide an excellent capsule summary of the nature of mental health and disability in children, and the best approaches for treating behavioral health problems.

The points most relevant to this Connecticut study are summarized below.

- Childhood is a period of rapid development. It is critical to assess the mental health of children in a developmental context that takes into account family, community, and cultural expectations about age-appropriate thoughts, emotions, and behaviors.
- Approximately one in five children experiences the signs and symptoms of a disorder during the course of a year, and five percent experience "extreme functional impairment".
- Children at greatest risk include those with physical problems; intellectual disabilities (retardation); low birth weight; family history of mental and addictive disorders; multigenerational poverty; and caregiver separation or abuse and neglect.
- Primary care and the schools are major settings for the recognition of mental disorders, yet trained staff are limited, as are options for referral to specialty care.
- Families are essential partners in the delivery of mental health services to children.
- Culturally appropriate services improve access to services, but are not widely available.
- The multiple problems associated with "serious emotional disturbance" are best addressed with a "systems" approach in which multiple service sectors work in an organized, collaborative way. These systems of care lead to positive system outcomes and functional outcomes for children.

What is HUSKY?

HUSKY is Connecticut's comprehensive health insurance plan that covers children. There are approximately 195,500 children receiving publicly financed health coverage of which 184,000 are enrolled in the HUSKY Plans – about 20% of all children under 21 in the state.[5] There are three programs under the HUSKY umbrella: HUSKY A, HUSKY B, and HUSKY Plus.

- **HUSKY A** is Connecticut's Medicaid managed care program. It includes children in families with income at or below 185% of the federal poverty level ($30,895 annual income for a family of 4 in 1999). The program, begun in 1995, is administered through DSS.

---

[4] Mental Health: A Report of the Surgeon General. (U.S. Department of Health and Human Services, 1999), p. 123.

[5] There are an additional 11,500 children receiving Medicaid fee-for-service benefits, including children new to the program in the process of joining a health plan, children in hospitals who are not plan members, and children who have disenrolled to participate in the DMR Case Management Program.

The agency contracts with four managed care organizations to provide coverage. HUSKY A covers all "medically necessary" services, including physical and/or behavioral health needs. ***There are approximately 179,700 children currently enrolled***.

- **HUSKY B** is a health insurance program for children in families with incomes above 185% of the poverty level who have been without insurance for at least six months and have no other means of accessing insurance. The program is administered similarly to HUSKY A, although its benefits are different, mirroring those available under the State's Employee Health Plan. ***There are about 4,300 children currently enrolled across the state.***
- **HUSKY Plus** is a program begun in 1998 providing supplemental coverage for children enrolled in HUSKY B who have intensive physical and/or behavioral health needs. The Yale Child Study Center administers the behavioral health aspect of the program through arrangements with twelve HUSKY Centers throughout the State. Only seven children are currently enrolled largely because of the limited eligible population -- those without insurance for at least six months and in families with incomes between 185% and 300% of the poverty level. Also, many children whose disorders are serious enough to qualify them for HUSKY Plus are enrolled in HUSKY A rather than B, or are receiving services through the DCF voluntary services program

The next section of the report summarizes key findings of the study, addressing the following:

- Who are the children enrolled in HUSKY who are using behavioral health services;
- What services are they receiving;
- What are the sources of funds for these services.

II. Major Findings[6]

Who are the Children Using Behavioral Health Services?

Based on the best available health services encounter data from DSS, it appears that ***approximately 22,300 or 12% of children in HUSKY A used one or more behavioral health services in the twelve months from 4/1/98-3/31/99*** (referred to as the "reporting year" throughout this document). Males were disproportionately represented.

As one might expect given their history, children in the custody of DCF were significant users of behavioral health services. Although only 5% of children enrolled in HUSKY A were in the custody of DCF during the reporting year (8,419 children), they accounted for 60% of all behavioral health expenditures on behalf of HUSKY children.

What Behavioral Health Services Do Children in HUSKY Receive?

Children who have an emotional disturbance require a range of treatments and supports tailored to their diagnoses and personal situations. Behavioral health providers and funders have developed a variety of programs and facilities to address these needs. These programs and facilities generally fall into three categories of care described below. Figure 1 compares the percentage of children served by each category and the funding devoted to each. Over time children may receive services from more than one category.

- **Acute Care Psychiatric Hospitals** - the most intense and expensive level of service, for children who may be suicidal, dangerous to themselves or others, or whose behavior cannot be managed in a less restrictive setting.
- **Residential Treatment and Other Out-of-Home Placements** – treatment for children ages 5-21 who are unable to function in their home, school, and community. Settings include residential treatment facilities, group homes, therapeutic foster homes, and supervised apartments.
- **Community-based services** – a wide range of services for children and families with an array of needs. Services include extended day treatment, outpatient therapy, in-home services, evaluation, case management, emergency services, and family support services.

The majority of children in HUSKY received their behavioral health services in a community-based setting-- only 1,067 were hospitalized (5%), and 3,000 were in

---

[6] Much of the quantitative data concerning the HUSKY A population were drawn from encounter data for the period 4/1/98 – 3/31/99. The data were submitted by the HUSKY A MCOs, to Qualidigm, the firm under contract with DSS to perform external quality review for HUSKY. Two MCOs that submitted incomplete data were excluded from the study. Totals were developed based on projections of the data from the 4 MCOs whose submissions were complete.

Expenditures for behavioral health services under HUSKY were based on the application of the Medicaid fee for services schedule, as MCOs provided very little information about their actual costs. DSS believes these rates are sufficiently comparable to those used by the MCOs.

residential care (13%) during the reporting year. Yet, as Figure 1 illustrates, the greatest investment of dollars is for the fewest children in the most intensive level of services: ***70% of all behavioral health dollars are spent for psychiatric hospitals and residential treatment, serving only 18% of all HUSKY children receiving behavioral health services.***

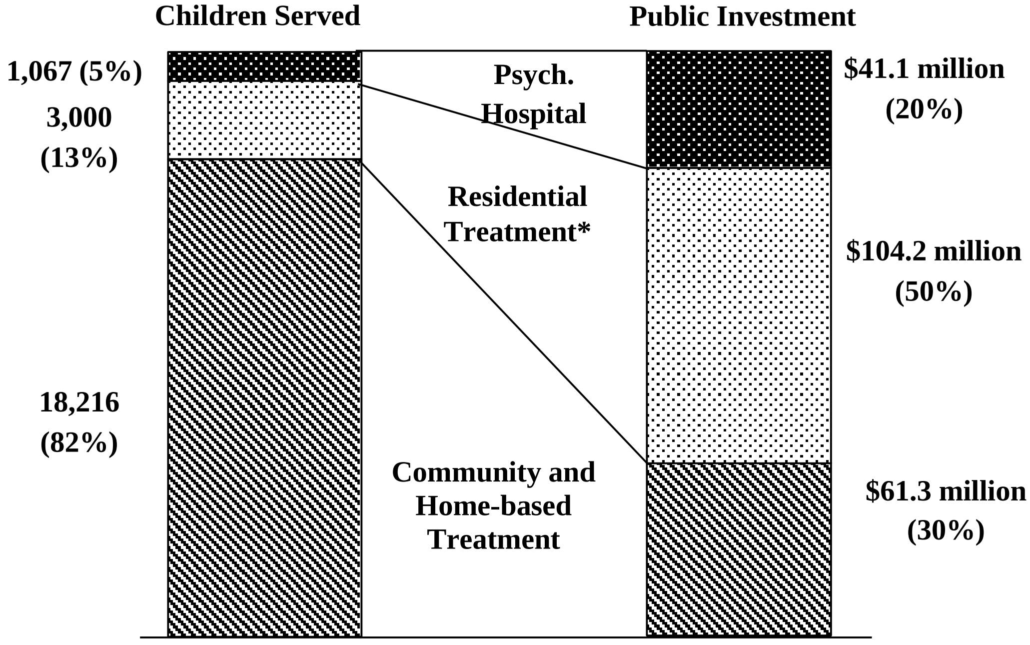


Figure 1: Children Served and Public Investment in Behavioral Health Services, by Level of Treatment' for Children Enrolled in HUSKY Plans, 1998-99

Total Served: 22,283 Total Investment: $207 million

* includes services in residential treatment facilities and other out-of-home placements by DCF and Local Education Agencies, including group homes, therapeutic foster homes, and supervised apartments.

NOTE: Numbers of children include all children accessing that level of service during the year

What are the Sources of Funding for Behavioral Health Services?

Connecticut spent approximately $207 million for behavioral health services in FY 1999 for children enrolled in HUSKY plans. This amount includes a combination of federal, state, and local dollars, administered by five state agencies and numerous local agencies. The study examined which state agencies were responsible for administering these funds, and the sources of these revenues, and learned the following:

- ***A majority of the public investment in behavioral health services (72.2%) comes from the State's General Fund as direct investment or match for federal funds.*** The federal government contributes 20.4% of the total dollars through the Federal Medicaid program (reimbursement of 50% of eligible state Medicaid expenditures), and through Title IV-E that reimburses 50% of room and board costs for children placed in residential treatment facilities through DCF. Local funds, through local school districts, account for the remaining 7.4% (See Figure 2).

- ***DCF is clearly the lead agency in this system, administering 58% of the funds spent on behavioral health services***. (See Figure 3.) Children in DCF custody account for 40% of the expenditures for hospital stays in FY 1999. DCF expenditures of $82 million account for 79% of all expenditures for residential treatment in FY 1999.

Figure 3: Total Behavioral Health Funding for HUSKY/Medicaid Children, by Agency: FY 1999

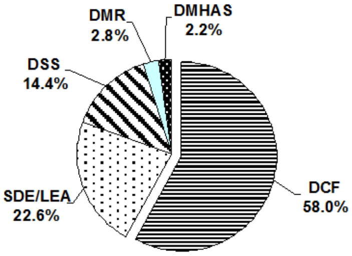
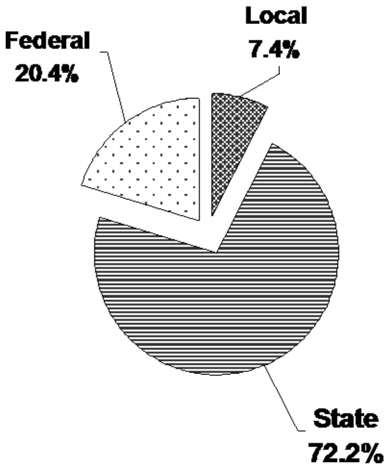


Figure 2: Federal, State, and Local Revenues Supporting Public Behavioral Health Services for HUSKY/Medicaid children – FY 1999



- ***State and local education agencies expend 23% of the funds ($46.8 million)***, spent primarily through the Special Education process. About 30% of this amount is for residential treatment. In the 1998-99 school year, 423 HUSKY eligible children with severe behavioral disabilities were placed in residential settings, at a cost of $14.5 million. 40% of these expenditures came from local school district funding, 56% from state funds, and the remaining 4% from federal funds.

- ***A combination of federal and*** s***tate Medicaid dollars totaling $62 million flows through a number of state agencies. Federal and State Medicaid dollars are the source of 30% of the dollars spent on behavioral health services for children enrolled in***

HUSKY. Table 1 shows the amount of Medicaid funds for behavioral health services that flows through each agency and the percent these funds comprises of the agency's total funding for behavioral health services. DSS administers 48% of the Medicaid funds and DCF administers another 26%. Because of its reach, the Medicaid program can serve as a unifying force for a common approach to children requiring behavioral health services.

Table 1: HUSKY/Medicaid as a Proportion of Public Funds Spent on Behavioral Health by Department, FY 1999 ($$ in millions)

Agency	Total Funds	Medicaid (Federal and State)	% Medicaid
DCF	119.79	16.36	13.7
SDE/LEA	46.77	8.0	17.1
DSS	29.72	29.72	100.0
DMR	5.75	4.94	85.9
DMHAS	4.60	2.8	60.9
Total	$206.63	$61.82	29.9%

Special Concerns for Further Study

In addition to the findings presented above, the study attempted to explore several additional issues of concern and importance, specifically:

- Early identification and prevention services for young children;
- Youth in transition from the child-focused mental health system to the adult system;
- The impact on local schools of serving increasing proportions of children with behavioral health service needs in the community;
- Children with dual diagnoses (mental health and substance abuse; mental health and mental retardation);
- Access to outpatient services;
- Enhancing the cultural competency of the service delivery system in response to the high proportion of children enrolled in HUSKY who are Black or Hispanic.

Each of these topics addresses a serious concern, and is an important component for designing a comprehensive system of mental health treatment for children. However, there were relatively little data available to fully explore these issues. More time than was available for this study is needed to generate the necessary information. (See the Technical Appendix for findings based on what information was available.) Further study of the listed areas is recommended to better inform the design and development of appropriate interventions.

III. Critical Systems Issues

Although an impressive array of resources and capabilities in Connecticut are devoted to children's behavioral health, there are significant problems in the current way services are organized, financed, and delivered. The study pointed to five major problems:

1. There are **insufficient mechanisms for effective coordination of care** between levels of intensity and across service systems for children and their families.
2. Community-based resources and treatment alternatives must be better developed to avoid the **serious bottlenecks in the treatment system.**
3. Funding is allocated by program and agency, each with its own requirements and incentive structure. This **fragmentation within the system** must be reduced.
4. Families must have a greater role in planning services for their own children and in system planning and oversight. Currently there are not adequate supports to enable families to be sufficiently involved in these ways.
5. Current resources may not be sufficient, but a redistribution of resources and taking fuller advantage of federal financing mechanisms could go a long way toward supporting a more effective system of behavioral health services for children.

These concerns were based on the following key findings of the study.

- ***From July-December 1999, 55% of the children in DCF custody who were in private acute care psychiatric hospitals were ready for discharge to a less intensive and less expensive setting (residential treatment, therapeutic foster care or home-like setting)***. Their conditions had stabilized and were less severe, but there was nowhere for them to go. They remained in the hospital but on what is termed "subacute" status, at a lower daily rate.

- ***Almost half the children in these hospitals on subacute status in September 1999 had been there for longer than 90 days.*** The experience of Nayib, a child in DCF custody, illustrates the human and financial toll of this problem. (See box on p. 10).

- ***13% of children discharged from psychiatric hospitals were readmitted within 30 days,*** as compared to a national average of 10%. This suggests problems with discharge planning and follow-up care.

- ***The State spent $8 million for reinsurance for a 10-month period in FY 1999*** to support hospital stays longer than 15 days. Projections are that reinsurance costs will be $12 million for FY 2000. The State's reinsurance program was instituted in September 1998 to prevent premature discharges that occurred under managed care when the hospitals were not being reimbursed for extended stays. Through reinsurance, the State's Medicaid program pays a portion of the cost of hospital stays over 15 days, preventing children from being discharged from hospitals prematurely. An unintended consequence has been to create a financial incentive to keep children in acute or sub-acute care longer than necessary.

- ***Residential treatment facilities are at or near capacity, yet many children in residential treatment no longer need this level of care.*** There are not sufficient community-based services to support their return to the community.

- ***Placements by parole and juvenile justice authorities through DCF have increased 34% in the last three years.*** (They accounted for 432 of 1,268 children placed by DCF's central placement team in December 1999).

- ***5% of children enrolled in HUSKY are in DCF custody, yet this population accounts for 60% of the behavioral health expenditures.*** Although this is not suprising, given the nature of the life experiences of this group, the finding highlights the need for special attention to the financing and delivery of services to this population.

- ***There has been a 40% increase in children placed out of state through DCF over the past three years.*** In December 1999 there were 347 children in DCF custody who were in out of state facilities (27 % of all children in DCF-funded residential care). There were also 107 HUSKY-eligible children children placed out of state by local school districts in FY 1999. There were also 159 children placed out of state by local school districts in FY 1999. Children in out of state placements are much more likely to have one or more of the following challenging behaviors than children in group or private residential placements in the State: sexually reactive; sexually offending; suicidal, assaultive, threatening. There are insufficient resources or incentives to care for these children within the state, the causes of which merit further exploration.

Nayib (not his real name)

Nayib is a ten-year-old African-American boy who entered the DCF system when he was five years old. He has spent most of the past year in a psychiatric hospital, awaiting an appropriate placement. During part of that time, his mother was in jail. Nayib was hospitalized in January 1999 because he was a danger to himself and others, but he had stabilized within a few weeks and was ready to be discharged. The hospital's discharge recommendation was a therapeutic foster home, but despite repeated attempts, none could be found. After a period of disagreement over discharge recommendations, DCF and the hospital are now trying to find a residential placement for Nayib. Not only has this situation been the wrong placement for Nayib, it has tied up an acute care bed that could have served other children needing that level of care. Eleven months after admission, Nayib still remained hospitalized. At $400/day and approximately 350 days in the hospital, the state had paid approximately $140,000 for an intensity of service that, after the first ten days, was not medically indicated.

- ***One in four of the 274 children awaiting placement through DCF's central placement team in December 1999 were classified as having mental retardation.*** This is another population for whom appropriate services appear to be a problem.

- ***At the community level, $61 million is spent by the five state agencies reviewed in this study. Each program has its own funding with its own set of rules governing how the money***

can be used. Funding is rarely flexible or comprehensive. A child with serious emotional problems cannot easily have his or her physical, emotional, social, and educational needs met in a coordinated way. Even a seasoned case manager experiences difficulty in coordinating community-based services for children with complex needs. For families it is an even greater challenge.

- ***DMR and DMHAS account for a relatively small portion of the funds spent on behavioral health services.*** DMR spent a total of $5 million on 64 children with behavioral health needs and in out-of-home placements (out of a total of 3,773 children and their families served through DMR in FY 1999). A review of participants in DMR's Birth–To-Three program identified 4% of the children as receiving behavioral health services (153 of 3,500 children) at a cost of about $800,000. DMHAS expended $2.1 million in FY99 to provide residential behavioral health services for young adults age 18 through 20 who could not live at home. The agency spent $1.8 million on community based mental health services and $300,000 on substance abuse services for Medicaid eligible children and youth age 18 through 20.

- ***Psychotropic drug costs accounted for 48% of HUSKY-supported non-hospital-related behavioral health costs for individuals enrolled in HUSKY A,*** in FY 1999. This includes use of pharmaceuticals by children in all settings except psychiatric hospitals.

- ***There has not been an active statewide family organization for families of children with emotional, behavioral, or cognitive problems in Connecticut for the past five years.*** Experience in other states indicates that such an organization is crucial to strengthening the capacity of families to participate actively in the care of their own children as well as in the development and implementation of systems of care and state and local policy.

- ***Children who are Black or Hispanic comprise a high proportion of children in HUSKY (62%).*** There were not sufficient data to indicate the proportion of Black and/or Hispanic children among users of behavioral health services. Further attention to documenting their service utilization and services needs will be important to help guide the development of culturally appropriate behavioral health service systems.

Conclusions

The critical issues outlined above, backed by the key findings, identify a clear need to develop more integrated systems of services, supported by an integrated approach to funding, and more supports for family involvement.

The high number of children who remain in psychiatric hospitals and residential treatment settings for increasingly long periods of time, when such care is no longer considered appropriate, is a direct result of the combined lack of care coordination and lack of alternatives in the community. Children remain in these settings because of a lack of "step-down" and other appropriate transitional services that can provide less intensive care when a child's family, the school, or the community are unable to provide adequate support and services for him or her. The current approach to funding services is not conducive to the development of these community-based resources.

This lack of available step-down services not only keeps children in these out-of-home settings for longer periods than is necessary and at high cost, it prevents other children from quickly accessing these services when they need them, leaving children backed up in emergency rooms and in the community awaiting care.

For services to be more responsive, appropriate, and effective, supporting the best possible developmental outcomes for children with behavioral health disorders, reform in the children's behavioral health system must occur. Significant restructuring is needed in the way that services are organized, financed, and delivered for children with serious and complex behavioral health problems. Though there has been a reduction of 65 hospital beds in Connecticut since 1994, the ability to use current beds only for the child requiring acute care would be a far more cost-effective solution than adding new ones. The solutions must emphasize capacity building at the community level, using community-based, family-centered, culturally-competent, systemic approaches to treatment, rather than a "bricks and mortar" approach through building more institutional settings or adding beds.

IV. The Foundations for a Solution

Building on Existing Models

The good news for Connecticut is that there are resources and know-how to do a far more effective job in taking care of children with behavioral health concerns. Most of the ingredients for success are in place.

Local Systems of Care. Notably, Connecticut has begun to build the "systems of care" recommended in the Surgeon General's report for children with the most serious and complex problems and recognized nationally as the best practice for delivering responsive behavioral health care. State legislation passed in 1997 (Public Law 97-272) adopted the national system of care approach, identifying a set of core values and guiding principles for Connecticut's services for children and adolescents with serious emotional disturbances (included in Technical Appendix). The systems approach is already being developed and tested through several initiatives that can serve as models.

DCF has sponsored local systems of care in 19 communities for children who have serious emotional problems and are at risk of, or in, an out-of-home placement for mental health treatment. DCF has developed practice standards for local systems of care and has provided training and technical assistance to the local collaboratives.

Through this initiative, DCF has begun to create an infrastructure that lays the foundation for systems change. The State spent $590,000 in FY 1999 to fund 16.5 case managers and eight family advocates to work in these local systems. Other DCF funds also paid for the expansion of essential community-based services such as respite and emergency mobile psychiatric services.

Other promising pilots include the following:

- DCF's Continuum of Care initiative (through a IV-E Waiver Demonstration) is testing a flexible funding approach in which local collaboratives manage the care of children with serious emotional disturbance within an overall budget cap.
- HUSKY Plus: This is a well-designed model of "wraparound" services (community supportive services that enhance the effectiveness of behavioral health treatments) for children with serious emotional disturbance. It is currently available to only a few children through HUSKY B. A pilot demonstration of its applicability to children in HUSKY A who are enrolled through Anthem-Blue Cross is being tested, with some promising results.

Although the number of children served by these programs remains small, they are being carefully evaluated. Initial findings suggest that cost and health-related outcome data demonstrate success. For these small pilots to be brought to scale, however, significant changes, outlined in the recommendations section of this report, must occur.

Financing the System of Care

The system of care and associated community-based service enhancements can be largely financed over time by reducing unnecessary hospitalizations and residential placements and reinvesting the savings in new services at the community level, and from increased federal Medicaid reimbursements.

There is an opportunity to increase federal reimbursement by as much as $14 million through (a) Medicaid supported case management, (b) Medicaid supported rehabilitative services in residential and community based settings, and (c) Title IV-E supported training activities.

As we look to the future, the proposed system of care approach, which relies heavily upon expanded use of case management and community-based services, could be supported in part through the use of the two Medicaid programs -- targeted case management and the rehabilitative services options – and Title IV-E training.

Targeted case management would provide about 40% federal participation for each state dollar invested in enhanced case management by DCF and its local systems of care partners.

Residential placements through DCF and local education agencies for special education are presently financed almost exclusively by state dollars, despite the availability of Medicaid as a federal reimbursement source. Use of the rehabilitative services option could provide two critical benefits: 1) free up an estimated $14 million of state investments in residential treatment services ($11.7 million by DCF and $2.3 million by SDE/local school districts) for investment in the development of infrastructure necessary for system of care development; 2) support new investments in community-based services. Use of the rehabilitative services option for community-based treatment services would provide about 33% federal participation for each state dollar invested (assuming 67% of the children served will be Medicaid/HUSKY eligible).

Federal Title IV-E funds can be used to support the extensive training needs required for the introduction and ongoing support of the local system of care.

If these funds were reinvested in expanding and improving the system of behavioral health services for children, much could be accomplished without the need for substantial new state dollars beyond some initial transitional funding.

V. Recommendations

Connecticut should implement an expanded, community-based System of Care Model for the management and delivery of behavioral health services to all children with serious emotional disorders, building on the structures established under P.A. 97-272. This system of care should also be charged with assessing and developing responses to the needs of all children requiring behavioral health services from prevention and early intervention to intensive treatment.

The following 15 recommendations would move the existing children's behavioral health system in Connecticut toward an accountable, community-based system of care that incorporates the core values and guiding principles already adopted in statute. The recommendations concern tasks required to implement this expanded system of care in three categories:

- local system and service development
- finance
- coordination and administration

The structural reform recommended would greatly reduce, if not eliminate the major system gaps and barriers described above. The recommendations also address areas for further study, important to informing this work but unable to be completed with existing data within the timeframe available.

The intended results are that children with serious mental health problems will have the opportunity to experience healthy social, emotional, physical, and cognitive development in the context of a nurturing family and community, leading to their ability to succeed in their families, schools, and communities. Better-coordinated, integrated care will help ensure that appropriate treatment plans are developed and followed. This should result in a significant reduction in length of stay in psychiatric hospitals and residential treatment placements as well as a reduction in out-of-community and out-of-state placements.

The many specific changes in practice and procedure that will be required to implement these recommendations are not addressed in this report. They will need to be developed by state agencies responsible for funding and administration of services, with the help of the further analyses recommended and guidance from key parties in the system.

Through cost savings on placements and expanded federal Medicaid reimbursement, these recommendations should not require substantial new State dollars. This approach, however, will only work if the savings achieved from reduced reliance on costly services are reinvested in building the community-based infrastructure necessary to meet the full needs of children and their families.

A. Expand and enhance local systems of care established under P.A. 97-272 as the mechanism for coordinating and delivering behavioral health services for children with severe emotional disturbance and their families.

1. Expand the eligibility criteria for system of care services to include all children meeting functional and diagnostic criteria for serious emotional disturbance and those at high risk, regardless of family income or placement status.

Currently most systems of care work primarily with children involved with DCF.

Any family or agency should be able to access treatment services for children who meet functional criteria for enrollment, without DCF intermediation, as long as the payor joins in supporting the costs of care.

2. **Decentralize decisions about individual care planning for eligible children to the local level, where individual care teams can access a flexible funding stream to purchase all services that are part of individual treatment plans.**

3. **Support local systems of care efforts to develop a richer array of community-based services for children with severe emotional disturbance and their families as an alternative to long-term residential care.**

Under the mandate of P.A. 97-272, DCF has facilitated the development of 19 systems of care covering 151 of the 169 towns in the state. These local systems handled 500 cases in FY 1999. They bring together key providers of services, parents, and other agencies working with children to plan services for individual children as well as to identify gaps in treatment that need to be addressed. Although some of the local systems are more developed than others, the vision and principles that inform their development are an appropriate starting place. These local systems of care can be the foundation for changing the overall approach to the financing and delivery of services.

The bottlenecks in the current system that are causing children like ten year old Nayib to stay in psychiatric hospitals or inappropriate residential treatment facilities unnecessarily can be mitigated by decentralizing the responsibility and funding for care planning to the local case planning and management teams. Under the proposed system, these teams would command the resources to purchase integrated, community-based services as well as hospitalization or residential treatment when necessary.

The study found a shortage of community-based placements offering a range of intensive services that could accommodate many of the children now in expensive hospitals and residential treatment. The short-term emphasis of the systems of care should properly be on improving care coordination and developing new treatment alternatives for those children needing the most intensive services. This is where the most dramatic opportunities for improvement can be seized, building on some of the promising practices and current substantial capacity identified in the study. The long-term value of the system of care lies as well in its role of provoking increased investments in early intervention and prevention activities that can improve children's outcomes and reduce the demand for more intensive services.

A goal of the system of care should be to reverse the trend of placing more children out of state and in other locations that are far from their families and communities. Such placements sever the child's valuable connections to family and community, making his or her return and reintegration more difficult. It is also very difficult for DCF or schools to monitor care at a distance. Clearly the answer lies in the development of additional quality placement resources within the state through investment of system of care funds for services.

4. **Actively support the development of a statewide family support network with local chapters to build capacity for family involvement essential to the success of a well-functioning system of care.**

Parents play a critical role in the coordination of care for their children and in the development of their Individual Treatment Plans. They also have a role to play in providing valuable feedback for the continued improvement of services and in supporting other parents coming into the system. Connecticut needs a strong statewide family organization that can be instrumental in building the capacity of parents to participate in developing plans of care for their own children as well as at the state and local systems levels. Parents can and should play important roles in design, development, oversight, and evaluation.

B. Design, develop, and implement a blended funding approach to support these comprehensive, integrated, community based systems of care.

5. **Fund the system of care operation and services by pooling the portion of federal and state dollars currently spent on children with serious emotional disturbances through DSS and DCF (e.g., HUSKY A, HUSKY B, HUSKY Plus Behavioral funds, Medicaid fee for service, state funds for reinsurance, Title IV-E funds, and DCF state funds).**

6. **Carve out behavioral health services funding from the capitation rate for existing HUSKY A and HUSKY B plans for children who meet defined assessment criteria. Develop case rates based on an actuarial analysis of the service needs of the population of children with serious emotional disturbance and for those at high risk for becoming seriously emotionally disturbed.**

7. **Explore the feasibility of maximizing federal Medicaid reimbursement to expand resources for children's behavioral health services.**

8. **Ensure that sufficient resources remain available through the HUSKY Plans and through direct contracts to service providers (e.g. child guidance clinics, school-based clinics, and other private providers) to respond to the behavioral health needs of children not eligible for, or in need of, the extensive systems of care services.**

In the proposed model, behavioral health funds would "follow the child" rather than the categorical requirements of a particular program. Care managers would have access to flexible dollars to design individualized treatment plans that best meet the needs of children. Local systems of care should receive funding on an actuarially determined case rate. The fact that the current systems of care control few if any resources has limited their effectiveness and role. The newly flexible funds would stimulate development of community-based alternative and wrap-around services.

The proposed "carve out" would dedicate a portion of the per member per month capitation rate currently paid to Managed Care Organizations under HUSKY plans to fund treatment for eligible children through the system of care mechanism. These children would continue to receive primary care services under HUSKY.

Those children not needing the extensive behavioral health care services offered through a systems of care approach would continue to receive their behavioral health services through the HUSKY plans as well.

The state should work towards inclusiveness, with the long-term goal of developing services that will draw the participation of the education system and, where appropriate for special populations, the mental retardation and mental health/substance abuse systems.

Additional federal Medicaid funds can also be accessed for this purpose. The study has identified at least $15 million in behavioral health services costs for HUSKY A participants that could be submitted for federal reimbursement. This number is based on re-categorizing expenditures for DCF residential treatment, special education residential placements, and Targeted Case Management so that they are eligible for Medicaid reimbursement. This can be done through options available in the state's Medicaid plan, including provisions for funding Targeted Case Management and the rehabilitative services option.

With reference to the need for resources for less intensive services, at least 14,000 children in HUSKY A with less serious conditions accessed behavioral health services through a wide variety of community-based providers. These services play a crucial role in preventing the development of more severe conditions and avoiding the need for expensive residential treatment. DSS, with input from the local systems of care and family support networks, should continue to monitor the policies and practices of the Managed Care Organizations to urge the full implementation of contractual provisions related to behavioral health.

C. Establish a coordinating and administrative structure to direct and implement the expanded system of care model.

9. **Establish an administrative structure to implement the expanded system of care under the joint direction of DSS and DCF. The structure would include an Administrative Services Organization (ASO) to administer the system of care funds and up to 10 regional Lead Service Agencies (LSAs) to contract with providers and provide services and administrative support required by local systems of care.**

10. **Form a state-level Interagency Committee for strategic planning and support for the development and implementation of the expanded system of care, with representation from DSS, DCF, SDE, DMR, DMHAS, DPH, and OPM.**

11. **Establish an Advisory Committee with representation from consumer families and providers.**

Based on their mandates, DSS and DCF are the lead partners in creating the expanded system of care. They should work with the existing Children's Behavioral Task Force in the coming months to develop the governance and administrative structure that will support effective development of the systems of care. An interagency memorandum between DSS and DCF should establish the roles of each agency in administrating and operating the plan. Suggested roles are as follows:

- **DSS Role:** administer pooled funding, handle all Medicaid/HUSKY plan changes, waiver amendments, federal reporting, claims processing and financial management.
- **DCF Role:** set standards, and monitor implementation; develop statewide training on the systems of care approach for providers, families, and other major stakeholders. Develop outcome measures and an evaluation plan.

DSS and DCF would jointly contract with the Administrative Services Organization described below and ensure continued administrative and financial support for an integrated funding stream.

Strategic Planning: An Interagency Committee would be responsible for maintaining the vision, coordinating planning, and work toward expanding the participation of other systems in an integrated funding approach at the state and/or local level. This Committee would be composed of those agencies listed that fund children's behavioral health services. The Committee should be expanded eventually to include representatives from other agencies that fund or provide behavioral health services (e.g., Judicial Services).

A process to involve providers and consumer parents in the work of designing the new system will help ensure its relevance to the needs of children. The Behavioral Health Subcommittee of the DCF Advisory Committee, which currently advises DCF on behavioral health issues, could be charged with advising this effort. It has representatives from providers, consumer parents, and state agencies.

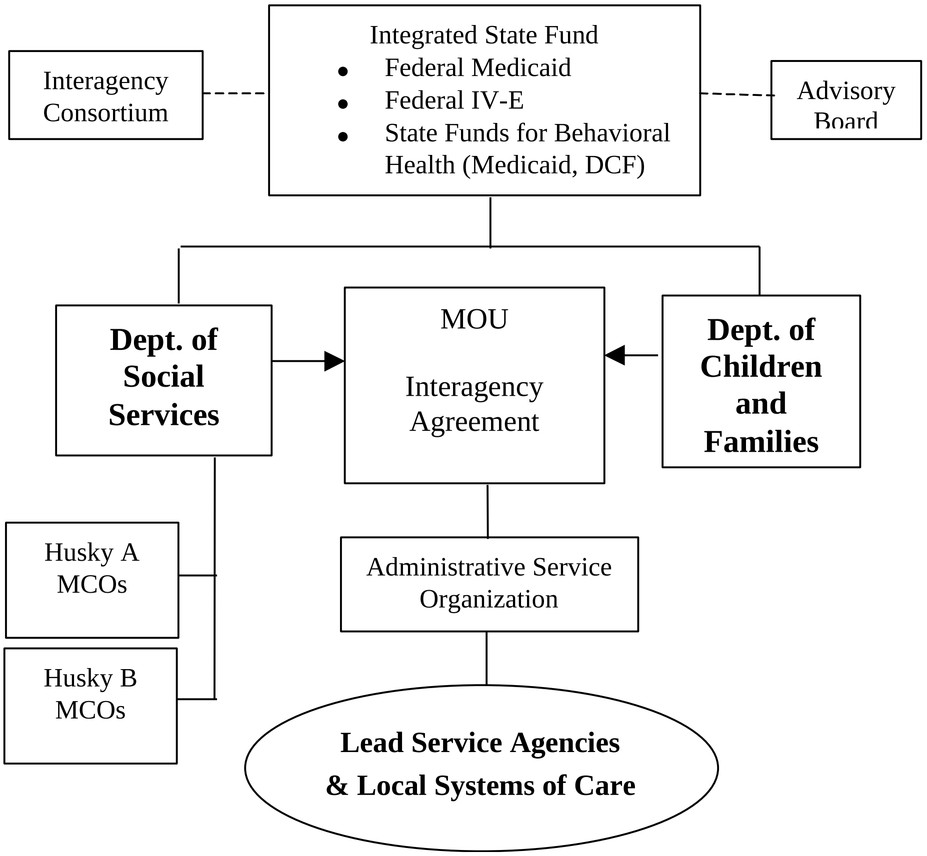
Administration: Based on the experience of other states engaged in similar efforts, the proposed administrative structure has three main components (Figure 4): a statewide Administrative Services Organization, “regionalized” Lead Service Agencies, and local systems of care.

The roles for each of these participants in the system will need further development, but in general terms may encompass the following:

The ASO would provide administrative support for the local systems of care. It would be responsible for maintaining performance and outcome data and providing financial management for reimbursements and reconciliation of funding requirements for the lead service agencies.

The Lead Service Agencies would work with local systems of care to provide a comprehensive array of community-based services and supports. They would be responsible to do the following: authorize and reimburse services delivered under approved individual treatment plans, fund all care required within a case rate, gather and organize all information required for quality management and performance oversight, provide administrative support to the system of care, and ensure that the local systems of care respond to the unique needs of their communities.

Figure 4: System of Care Governance and Administrative Model



The system of care at the local level would be built on the foundation of the 19 systems of care established since the passage of P.A. 97-272.

12. **Develop measurable outcomes against which the state and local systems of care can assess the effectiveness of services.**

A major concern expressed about the current delivery system for behavioral health services is the difficulty in assessing whether investments result in positive outcomes for children. Joining in a national trend, Connecticut should require all providers to measure and report outcomes against a set of agreed measures. This will move the system toward greater accountability. The results of a study of outcomes in children's behavioral health commissioned by DSS are due this fiscal year, and may help inform this work.

13. **Conduct training for state agency staff, providers, families, and other system participants to support the implementation of the system of care.**

Additional resources would provide needed support for staff, provider and consumer family training in the provision of services under the system of care model. A system of care approach requires that all participants work collaboratively on behalf of the child, and they need to be able to assess strengths and develop interventions that build on these.

14. **Develop a case management information system to support service delivery, program management, and evaluation.**

This study highlighted the difficulty of accessing information across systems and across time for individual children. An effective case management information system to track children and services delivered will be required to facilitate operation of and planning for the system of care.

15. **Conduct a systematic comprehensive, independent evaluation of this endeavor, examining the process of design, development, and implementation, and the outcomes, including impact and cost-effectiveness at multiple levels.**

The evaluation should look at three dimensions: child and family outcomes, process and system development outcomes, and financial outcomes.

D. Study additional critical issues that require attention.

The study uncovered a number of critical areas for which insufficient data was available in the window of time for the study, or that presented dynamics too complex to unravel through this process. The following areas are suggested for further study, and could yield substantial benefits in system improvements and improved outcomes for children.

Early Intervention and Prevention Services for Young Children: Parents, child care providers, health practitioners, teachers, and others in a position to recognize early signs of problems need to be able to access information, referrals, and services easily. As noted in earlier sections, they should have resources readily available to them. Further study should focus on delineating the existing system of services for young children and developing recommendations as to how services can be developed, funded, managed and delivered in a way that best meets the need for prevention, early intervention, and treatment services for this population.

Children in Transition to the Adult System: There are collaborative efforts underway between DMHAS and DCF to ensure that youth who are in transition to the adult system are served appropriately and that smooth transitions occur. Further study is recommended to help better inform the design and development of appropriate interventions for this special population.

Special Education: Federal and state legislation constrains schools serving children through special education from taking a broader view of the service needs of children in its care. A substantial portion of residential treatment funds is invested through the education system, yet the primary mission of that system is education rather than behavioral health. Further work is needed to understand this issue and to facilitate partnerships that serve children well, preferably through the system of care model.

Children with Dual Diagnoses

Mental Health and Mental Retardation: Children with mental retardation and behavioral problems require an intensive level of services that combines the skills of providers in both the mental retardation and mental health arenas in order to assure good outcomes. Effecting good practice and service delivery without draining resources needed for other children is a system challenge in need of further review.

Mental Health and Substance Abuse: Service providers have stated that youth with both substance abuse and mental health problems are not currently well served. The amount spent on services for them is known, but little is known about whom they are or how to assess whether services are effectively provided. Further study is needed to assess how best to serve these children and youth.

Cultural Competence: There was very little information available for this study about the demographics of the children receiving services at the various levels of intensity and there was not an opportunity to analyze the cultural competency of the existing services. In order to enhance the cultural competency of the service delivery system in response to the high proportion of children in HUSKY who are Black or Hispanic, further study will be needed.

VI. Moving Forward

DSS and DCF should work with the other state agencies and the Children's Behavioral Health Services Task Force to develop the detailed design and guidelines for implementing the recommendations put forth in this Report. The issues needing further attention include: development of community based service capacity; outcome accountability; contractual arrangements; governance at state and local levels; cross agency systems of care training; financing mechanisms; and the need for legislation.

Initial funding has already been secured to assist with this continuing effort and the further studies needed from the Connecticut Health Foundation and the Children's Fund of Connecticut.

The children and families of Connecticut deserve no less than a collective best effort to build effective systems of care. With the focused attention and increased awareness of so many groups and individuals, the opportunity to take action to improve the way Connecticut delivers services for children with serious emotional and behavioral problems has never been better. The findings and recommendations of this study help point the way.

15

Judith C. Meyers

Pathways to Reforming Children's Mental Health Service Systems

Public and Personal

This chapter weaves together reflections on two journeys, one quite public and the other more private. The public journey is the evolution of services for children with serious mental health problems in America over the past century and how the experience of one state—Connecticut—provides a more in-depth look at what has and has not occurred. The private journey is the evolution of my own thinking about children's mental health service systems, informed by my education as a clinical and community psychologist, my training in the world of public policy, my experience working in leadership positions in federal, state, and local settings over the past 20 years, and my most recent work in Connecticut. I will explore how these journeys have intertwined and what might be learned from each.

In 1983 the United States Congress appropriated $1.5 million to the National Institute of Mental Health to create the Child and Adolescent Service System Program (CASSP) to address the needs of children and adolescents with serious emotional disturbances. These needs had been recognized from the earliest years of the twentieth century. Despite a series of efforts, most of which ended in failure, they had been inadequately met. With the creation of CASSP, the concept of a "system of care" became part of the lexicon, and the tide turned (Stroul & Friedman, 1994). Over the past 20 years there has been tremendous growth in systems of care, with expanding resources, research, and services to respond to children whose emotional, behavioral, and cognitive disorders make it difficult for them to succeed in their own homes, schools, and communities.

In an article about the creation of CASSP, as part of a history of the federal government's efforts to improve services for children and adolescents with mental health problems, the authors noted that the CASSP appropriation was but a short phrase attached to the legislation for the continuation of the then 6-year-old Community Support Program for adults with chronic mental illness. The phrase was "placed by an aide in the congressional report that described Congress' intent that $1.5 million be expended on a similar program for children and adolescents with serious emotional disturbances" (Lourie, Katz-Leavy, DeCarolis, & Quinlan, 1996, p. 104). I happened to be that unnamed aide. At the time I was a Congressional Science Fellow in the House of Representatives working in the office of David Obey (D-WI), who served on the Appropriations Subcommittee responsible for funding for the Department of Health and Human Services, and who was an avid supporter of the Community Support Program.

Sixteen years later, having worked in several policy and academic settings related to children's services, I moved to Connecticut to direct the Child Health and Development Institute of Connecticut, a new not-for-profit organization created to promote long-term systems change to improve the health of children throughout the state. One of the first projects I was asked to undertake was a review of the publicly sponsored children's behavioral health services in Connecticut. What I found out was that 16 years after the advent of CASSP, Connecticut was still struggling with many of the same issues that the program was intended to remedy.

Connecticut's Journey

When I arrived in Connecticut in 1999, there was an increasing concern among state policymakers, practitioners, and parents about children with serious behavioral and emotional problems. This, however, was by no means the first time that policymakers in that state had recognized the need to attend to the difficulties in meeting the needs of children with emotional disorders. In fact, three decades of reports about children's behavioral health reveal striking consistency in articulated goals and in the descriptions of the difficulties attaining them (Geballe, 2002). In 1975 Connecticut established a consolidated state children's agency (Department of Children and Families [DCF], including child protection, children's mental health, and juvenile services), which had as one of its goals a well-functioning children's mental health system that connected all Connecticut children and youth who have mental health problems to appropriate care in a timely manner (Geballe, 2002). Connecticut had even gone so far as to frame a systems of care orientation in legislation passed in 1997 that articulated the principles and mandated a systems of care approach (Public Act 97-272), and as many as 18 communities had developed local systems of care collaboratives by 1999.

Despite these significant milestones, little had been done to reorient a system based in institutional and residential treatment and traditional modes of practice to put the principles of a system of care into practice. Unlike many other states, Connecticut had neither a history of investing in building community-based services to meet the needs of children nor a strong family advocacy and support system—two key ingredients for building and sustaining a community-based, family-centered approach to serving children and their families. By 1999 the state was investing more than $200 million in mental health services for children, but five separate state and local child-serving systems administered these services, including child welfare, mental health, mental retardation, education, and Medicaid. The resulting system, such as it existed, was complex, fragmented, and difficult for families to access and maneuver. The situation had reached the point where large amounts of state funds were being used to maintain children in psychiatric hospitals far beyond the time necessitated by their clinical conditions. This budget drain captured the attention of the highest officials, who were facing a severe budget shortfall as an economic downturn was beginning to result in declining revenues.

Shortly after I arrived, the Child Health and Development Institute of Connecticut (CHDI) was asked to conduct a study for the Department of Social Services (DSS) in fulfillment of a legislative mandate (Section 36 of Public Act 99-279). The study resulted in the report *Delivering and Financing Children's Behavioral Health Services in Connecticut* (2000), which included a review of the service utilization and expenditures for behavioral health services by the state Departments of Social Services, Children and Families, Mental Health and Addiction Services, Mental Retardation, and Education and a set of recommendations to improve the quality and integration of children's behavioral health services.

CHDI is a nonprofit organization created in 1998 by the board of the Children's Fund of Connecticut, a public charitable foundation focused on community-based primary and preventive health care initiatives. The board created the institute to serve as a mechanism for promoting long-term change in the systems that have the greatest impact on children's health in Connecticut. Connecticut's two leading medical universities—Yale and the University of Connecticut—play a leadership role in CHDI's development and work, contributing their resources to bring the best information from research and best practice experiences throughout the country to help inform, train, and support policymakers and practitioners.

CHDI was likely perceived by state leaders to be a good fit for carrying out the study for several reasons: it was perceived as neutral and objective (not affiliated with one branch of government, one particular state agency, or a particular political point of view); it was affiliated with both of the state's two major universities, and thus there was no need to pick one over the other; it was a new organization with no history or baggage, which can accumulate very quickly in a small state like Connecticut; and its new director, namely, me, had expertise in program, policy, and financing with regard to children's mental health systems. The study was conducted in partnership with DSS and the DCF (Child Health and Development Institute of Connecticut, Inc., 2000). I hired Carl Valentine, a national consultant with expertise in financing children's systems, to assist with collecting and analyzing the state data. We developed a state implementation team with representatives from DSS and DCF to assist with the study and created a Children's Behavioral Health Task Force as an advisory committee with representation from other state agencies, family advocates, and providers, to review and discuss the findings along the way.

The study's findings were derived based on the following: financial and service utilization data provided by state agencies; a review of the literature on the organization and financing of children's behavioral health services; review of case studies; deliberations of the Children's Behavioral Health Task Force; interviews with service providers, consumer families, and advocacy groups; and extensive discussions with staff of state agencies.

Delivering and Financing Children's Behavioral Health Services

Key findings of the study included the following:

- Of the 184,000 children enrolled in Connecticut's Medicaid managed care program (HUSKY A), approximately 12% used one or more behavioral health services during the 12-month period studied (April 1998–March 1999).
- The state spent approximately $207 million from five different child-serving systems (Medicaid, child welfare, education, mental health, and mental retardation) for behavioral health services during this time (the juvenile justice system, which spends additional dollars for mental health services for court-involved children, was not included in this study).
- Twenty percent of the dollars ($41.1 million) was spent on acute psychiatric hospitalizations for 1,067 children (5% of the population receiving services).
- Fifty percent of the dollars ($104.2 million) was spent for residential treatment serving another 13% of the children.
- The remaining 30% was available for home and community-based services serving the largest proportion of children.
- Bottlenecks in the system were keeping children in psychiatric hospitals and residential treatment settings long beyond the time they needed to be there. More than half of the children in the state's custody who were in private psychiatric hospitals were ready for discharge to a less intensive and less expensive setting but in many cases were hospitalized for more than 3 months because of inadequate community-based services.
- Seventy-two percent of the funds expended were state dollars, 20% were federal dollars, and 8% were local funds through the school systems.
- Children in custody of the state's child protection system through DCF accounted for a large share of the expenditures. Although only 5% of children enrolled in HUSKY A were in the custody of DCF during the reporting year, they accounted for 60% of all behavioral health expenditures on behalf of HUSKY children.

With regard to service delivery, the study reinforced what was already known by many: that the high number of children who remained in psychiatric hospitals and residential treatment settings for increasingly long periods of time when such care was no longer considered appropriate was a direct result of the combined lack of care coordination and lack of alternatives in the community. Children remained in these settings because of a lack of "step-down" and other appropriate transitional services that could provide less intensive care when a child's family, the school, or the community was unable to provide adequate support and services. This lack of available step-down services not only kept children in these out-of-home settings for longer periods than was necessary and at high cost but also prevented other children from quickly accessing these services when needed, leaving children backed up in emergency rooms and in the community awaiting care.

For services to be more responsive, appropriate, and effective, supporting the best possible developmental outcomes for children with behavioral health disorders, reform in the children's behavioral health system was needed, including significant restructuring in the way that services were organized, financed, and delivered for children with serious and complex behavioral health problems. The solutions rested on capacity building at the community level, using community-based, family-centered, culturally competent, systemic approaches to treatment rather than a "bricks and mortar" approach through building more institutional settings or adding beds.

The study recommended the following actions:

- Expand and enhance local systems of care as the mechanism for coordinating and delivering behavioral health services for children with severe emotional disturbances and their families;
- Build a richer array of community-based services;
- Develop a statewide family support network;
- Develop and implement a blended funding approach to support the comprehensive integrated community-based systems;
- Develop measurable outcomes to assess the effectiveness of services;
- Conduct training to support the implementation of the system of care;
- Improve information systems;
- Conduct a thorough evaluation.

The timing of the study was critical, resulting in the state's readiness to adopt the recommendations rather than have them shelved. The status quo was becoming increasingly unacceptable. There were the mounting costs to the state of children remaining in hospitals as the result of a reinsurance agreement whereby the state picked up a larger portion of the costs after a child had been hospitalized for more than 15 days. There was pressure from the hospitals, whose emergency rooms were overflowing with children with mental health problems for whom there were no open beds. There were predictions that it was only a matter of time before a child died unnecessarily as a result. Connecticut Community KidCare was the outcome of this planning process.

The commissioner of DCF, Kristine Ragaglia, became a strong proponent of the reform agenda. In her first several years as commissioner she had been an advocate for increasing the number of residential beds, but soon she came to recognize this was an expensive and not particularly effective way to fix the problems in the system. Her counterpart at the DSS, Patricia Wilson-Coker, had a background in child welfare and law and was also supportive from the start.

The study produced by CHDI lent credence to a direction that key state agency staff and advocates were already supporting by documenting objectively and irrefutably the problems in the system and the need for change. The proposed reforms were further supported by the General Assembly, which, in June 2000, charged the commissioners of DCF and DSS to develop the elements of a plan to reform the current system, and by a July 2000 report issued by the Governor's Blue Ribbon Commission on Mental Health.

Connecticut Community KidCare was designed over the next 8-months to a year by an implementation team of state agency staff working in concert with the Behavioral Health Advisory Group. CHDI continued to provide technical assistance and facilitation to the process but moved to a behind-the-scenes role as the state agencies took increasing ownership of the process.

The details of the plan were presented in January 2001 in a report to the General Assembly (Connecticut Department of Children and Families and Department of Social Services, 2001). The plan at that point represented a far-reaching vision, incorporating all the elements of the systems of care values and principles. As written in the first paragraph of the implementation plan submitted to the legislature in January 2001:

> The Department of Children and Families and Department of Social Services are preparing to embark on a sweeping reform of the public child behavioral health service system. The new Connecticut Community KidCare initiative is designed to eliminate the major system gaps and barriers that have plagued child behavioral health in recent years. The proposed initiative

> will allow children with behavioral health problems to grow and develop within nurturing family environments, increasing their ability to succeed in their homes, schools and communities. The new system will be family driven and family focused, giving families choice and helping families to care for children who have behavioral health challenges. The new system will emphasize the strengths of individual families and children and be culturally responsive. (p. vii)

The state agencies recognized that their vision was a tall order, but they firmly believed that it could be realized. As the report further states:

> Building this new system is an evolutionary process that will require time for planning, training and capacity building, and a gradual phase-in of fully working systems. It will also require changes in structure, organization, management, financing, practice, and philosophy, affecting those involved at every level, from families to providers to State agencies. (p. vii)

The key elements of the Community KidCare plan at that point included the following:

- A full carve-out from managed care of children's behavioral health services for all children enrolled in HUSKY;
- A comprehensive benefit package, including outpatient, day program, home-based, care coordination, nonmedical support services such as respite care and therapeutic recreation, as well as out-of-home services, including residential, therapeutic foster care, and hospitalization;
- Integrated funding streams, including Medicaid, S-CHIP, Title IV-E, and state general funds;
- Support for family involvement through funding for a family support organization, and involvement of families at all levels of policy and planning;
- A new administrative structure to include an administrative service organization (ASO), regionally based lead service agencies, and community collaboratives (formerly known as local systems of care);
- Training and staff development;
- A comprehensive evaluation of the reform.

Phase-in of KidCare was scheduled to begin in July 2002 with the selection of an ASO to administer a full carve-out followed by the selection of two lead service agencies with access to the enhanced benefit package. The intent was for KidCare to be operational statewide within 1 to 2 years after that.

In spite of a few setbacks that slowed down the rate of progress, the implementation of KidCare continued on track over the next 18 months. More than $23 million in new funding was committed to community services, including emergency mobile services, care coordination, day treatment, intensive home-based treatment services, and respite services. Twenty-seven local collaboratives were engaged in developing individual treatment teams, with the support of more care coordinators and more services from which to draw. Family organizations had been invigorated through state and foundation support with a thriving network of parent support groups, including several focused on the needs of Afro-Caribbean and Hispanic families. More than 2,000 people in state and provider agencies and family members came together in 4-day workshops to learn about how to work in a community-based, family-centered, strengths-based approach through the KidCare Institutes. There was an increasing effort to support evidence-based interventions such as multiple systemic therapy and functional family therapy.

The values and principles of a system of care approach had been deeply embedded in legislation, policy standards, and guidelines in Connecticut, as indicated by the following statement included in DCF's 2002 System of Care Status Report to the legislature:

> The federally defined System of Care Model underlies the paradigm shift in financing and service delivery in which KidCare is founded. Like the System of Care model, KidCare is based upon a philosophy in which service planning is driven by the needs and preferences of the child and family. Both KidCare and the systems of care model provided through the Community Collaboratives seek to prevent children's problems from escalating by offering an array of flexible, individualized services that will maintain children in their homes and community. KidCare and Connecticut's Community Collaboratives espouse quality, comprehensive,

> community-based service provision through partnerships, interagency agreements, and key-stakeholder associations. While KidCare is the materialization of systemic service restructuring, the system of care approach has been the solid foundation created a decade ago in which to frame the core tenets of Connecticut's reform initiative. (Connecticut Department of Children and Families, Division of Mental Health, 2002).

As a participant, witness, advocate, and possibly even one of the catalysts to the beginnings of a major transformation in Connecticut's mental health system for children, I found this a thrilling time. There was a readiness for change that had been building for years. I was one force among many that converged at that time, and I felt tremendously lucky to have been in the right place at the right time to be able to make a difference. I also had had enough experience to understand that such transformative change in public systems is not linear and never easy. As the first 6 months of this fiscal year (January–June 2003) unfolded, that reality came home to roost. Connecticut's journey in the past 3 years mirrors the nation's journey of the past 20 years.

The Nation's Journey

Building Systems of Care in Connecticut

Connecticut was not alone in its history of having years of concern for children with serious mental health problems—recognizing the need for action yet experiencing the slow pace of reform. Nationally there has been a consensus on the nature of the problem that has not changed much for decades. The awareness of a need for comprehensive coordinated services for children with emotional disturbances was articulated as far back as the 1909 White House Conference on Children, which recommended new programs to care for "mentally disturbed children," and again in 1930 when another White House Conference echoed these recommendations. It was not until 35 years later that attention was again focused on the need for improved mental health services for children. The Joint Commission on the Mental Health of Children was convened and delivered its report to Congress in 1969, stating that large numbers of emotionally, physically, and socially handicapped children did not receive necessary or appropriate services and that the mental health service system for children and youth was wholly inadequate (Joint Commission on the Mental Health of Children, 1969). The report stated: "It is an undesirable fact that there is not a single community in this country which provides an acceptable standard of services for its mentally ill children, running a spectrum from early therapeutic intervention to social restoration in the home, in the school, and in the community" (pp. 6–7). The report called for complete diagnostic, treatment, and preventive services available to all children and youth and a child advocacy program at all levels of government, including an adviser in the White House. It also recommended funding to provide incentives to states and communities to establish a range of coordinated services providing interrelated, continuous care and treatment for children in need.

As Nicholas Hobbs aptly summarized in 1975:

> Countless commissions, committees, and conferences, including White House conferences, have addressed the problem of providing services for children and have been appalled by the confusion they find. Report after report stresses the absence of any overall design for the delivery of services, the dispersion of responsibility among dozens of agencies, the fragmentation of effort, and the frequency with which children in need of assistance get lost in the system. (p. 180)

With the advent of CASSP in 1983, however, there has been remarkable progress. With CASSP as an impetus, the concept of a system of care to serve children with serious emotional disturbances was defined and continues to this day. Children's mental health services received another significant boost when the Children's and Communities Mental Health Services Improvement Act of 1992 created a new federal program to support the expansion of community-based systems of care for children with serious emotional disturbances and their families. This program, the Comprehensive Community Mental Health Services for Children and Their Families Program, began in 1993 with initial funding of $5 million. From 1993 to 2002, grants to 67 communities in 43 different states to improve and expand their systems of care have been awarded, with $107 million projected to be available in fiscal year 2004. According to the national evaluation of these programs, the approach was more effective in helping children and adolescents with serious emotional disturbances (Friesen & Winters, 2003).

The troubling news is that despite the recent progress after almost a century of attention of one kind or another, we still have a long way to go. Although the values and principles that are the foundation of a systems of care approach seem widely accepted and adopted, the full translation of these principles into practice still eludes us, and the call to attend to the problems continues to be sounded at the state and national levels. In a review of reports addressing children's mental health issued by 10 states between 1997 and 2001, a strong and consistent concern about the inadequacy of efforts to address the mental health needs of children and their families was evident. In a familiar-sounding theme, these reports were consistent in favoring the values, principles, and beliefs of a system of care framework—interagency collaboration, individualized, comprehensive, and culturally competent care, and support for a strong family role. The range of recommendations also had a familiar ring: create more flexible and less categorical funding; integrate and coordinate planning and improve accountability; improve the quality of services through increased attention to the recruitment, training, and retention of staff; make greater use of evidence-based treatments; expand provider networks; establish professional standards; and reduce stigma and increase support for children's mental health through public education (Friedman, 2002).

The Surgeon General's landmark report on mental health in 1999 observed: "The system for delivering mental health services to children and their families is complex, sometimes to the point of inscrutability—a patchwork of providers, interventions, and payers. Much of the complexity stems from the multiple pathways into treatment and the multiple funding streams for services" (U.S. Department of Health and Human Services, 2000, p. 179). The report also concludes that most children in need of mental health services do not receive them.

Even more recently, President Bush established the President's New Freedom Commission on Mental Health. The commission's goal was to recommend improvements to enable adults with serious mental illness and children with severe emotional disturbance to live, work, learn, and participate fully in their communities (New Freedom Commission on Mental Health, 2003). Once again, a national report cites fragmentation and gaps in care for children with serious mental illness and calls for replacing unnecessary institutional care with efficient, effective community services and integrating programs across levels of government and among many agencies. Once again, a report calls for services and treatments that are individual, family centered, and culturally competent rather than oriented to the requirements of bureaucracies. Once again, a report calls for creating flexible financing strategies to support the use of the most effective treatments and services. Once again, a report calls for early identification, screening, and treatment.

Challenges to Change

Connecticut's journey mirrors the nation's journey in developing systems of care, and while much progress has been made, the challenges remain, leading to continued calls for transformations in how services are organized, financed, and delivered (Glied & Cuellar, 2003). There has been an expansion in federal, state, and local funding, but our public systems continue to spend most of their resources on crisis situations. When dollars are as short as the political horizons, it is hard for elected officials to invest in the long haul. In Connecticut the first part of the reform to bite the dust were the lead service agencies. As the economy turned downward in 2000–2001, a time in which Connecticut, one of the wealthiest states in America, was hit hard by the loss of revenues from declining capital gains, those who controlled budgetary decisions in the Office of Policy and Management determined that money needed to be spent on services, not infrastructure. While it is not hard to recognize the political appeal of that decision, and perhaps even the short-run humanitarian appeal, it was also clear to those of us who had helped design the reform that if the system was going to be successful, it needed to be operated and administered as close to the communities as possible, rather than centrally out of Hartford. Connecticut does not have counties that serve as governing units; it has a state government and 169 cities and towns, with nothing in between. Pulling away the lead service agency model was a major setback for building a community-based system.

The implementation of KidCare became seriously stalled 6 months ago. One major aspect of the reform, the creation of a Behavioral Health Partnership whereby funds would be pooled, and three state agencies would partner to contract with an ASO to manage a full carve-out of the system, hit a snag. The inevitable resistance resulting from major change efforts is coming, not surprisingly and perhaps understandably, from providers who are concerned about the impact on their reimbursement rates and whether enhancements to the children's system will result in diminished resources for the adult system. Ostensibly as a result of a disagreement between several key legislators and the executive branch regarding rate setting for providers and oversight of the system, the implementation came to a halt.

There has been no KidCare training for the past 6 months, the evaluation has been put on hold, and while the community-based services continue to be developed, the system as envisioned is still a long way off. In Connecticut, as is true nationally, while there is progress in developing a broader ranges of services, the majority of children with serious mental health problems are involved with multiple systems associated with poor treatment planning and outcomes. The greatest portion of public dollars for children's services continues to be spent on the fewest children—to pay for institutional and residential placements for children with the most serious problems. The least amount is spent for prevention and early intervention.

One positive development has been a burgeoning interest in and attention to the mental heath of young children that accompanies the increased focus on young children being better prepared to succeed when they enter kindergarten. As noted in the Surgeon General's report:

> The wider human services and law enforcement communities, not just the mental health community, have made prevention a priority. Policymakers and service providers in health, education, social services, and juvenile justice have become invested in intervening early in children's lives: they have come to appreciate that mental health is inexorably linked with general health, child care, and success in the classroom and inversely related to involvement in the juvenile justice system. It is also perceived that investment in prevention may be cost-effective. (U.S. Department of Health and Human Services, 1999, p. 133)

The President's New Freedom Commission also devotes one of its six goals to early detection and intervention, and includes among its recommendations that we promote the mental health of children. It remains to be seen whether there will be a shift in resources to move the rhetoric to reality.

Reflections on Why Sustainable Change Is Difficult to Achieve: My Personal Journey

No one has the definitive answer to why lasting change is difficult to achieve, but as someone whose professional journey over the past 22 years has given me the opportunity to observe and engage in the efforts to improve children's mental health systems at the federal level and in several states, including the most recent work in Connecticut, I can offer my own reflections, routed in a paradigm of systems change that stems back to my earliest days as a clinical and community psychologist.

Although I did not have a name for it when I first chose to become a clinical and community psychologist more than 30 years ago, I came to learn that the theoretical underpinnings of much of what I believe and do have been guided by general systems theory. This theoretical orientation, first articulated by biologist Ludwig Von Bertalanffy in the 1920s, is a framework that highlights the complex relationships and interconnectedness among the biological, ecological, social, psychological, and technological dimensions of our increasingly complex lives. The key characteristics of systems thinking are as follows:

- A shift in focus from the parts to the whole—a system as a whole cannot be reduced to its parts—or, as more commonly stated, the whole is greater than the mere sum of its parts;
- Thinking in terms of connectedness, context, and relationships—the properties of the parts can be understood only within the context of the larger whole;

- Objects are embedded in a world of relationships from which they cannot be separated;
- Organisms as a network of relationships exist within societal relationships within social systems and within ecosystems. Each system is nested within other larger systems (Senge, 1994).

Systems thinking clearly underlies the values and principles of a systems of care approach, which is based on the recognition that children are part of families, families are part of communities, and that to improve outcomes for individual children, one has to understand the connectedness of the child to all aspects of community life, including groups, organizations, agencies, institutions, and neighborhoods. All are separate entities but also parts of related networks, such that intervention in one part of the system has repercussions for the whole system.

I was first introduced to general systems theory while a postdoctoral fellow at the Yale Department of Psychiatry, working on a psychiatric unit of a community hospital. The director of the unit, Dr. Irwin Greenberg, was steeped in systems theory and used it to shape the clinical service and clinical teaching. Case consultations under his direction involved seeing individuals in the context of their biological, intrapsychic, familial, community, and larger world systems, as well as along the time dimensions of past, present, and future. This theory has informed my thinking and work ever since.

During that time I was working as a clinician with individuals and families and had little opportunity to focus on community-level change. In working with adults diagnosed as chronically mentally ill, I often felt frustrated and ineffective, like Sisyphus pushing the proverbial rock. Individual, group, family, and milieu therapy along with psychotropic medications may have helped relieve symptoms or helped people adjust to their conditions, but they did little to pave the way for productive participation in the economic and social aspects of their so-called community, the place where they resided and called home. One patient would leave only to be replaced by another with similar concerns. I observed that conditions such as neighborhood efforts to prevent zoning for halfway houses, rejection of applications for Social Security Disability Income, and lack of job training and supported employment were much more powerful in keeping people out of a community than any of the therapeutic approaches we were providing to keep them in the community. At best we were helping people adjust to bad situations over which they had little control.

The combination of my roots in community psychology, with its focus on primary prevention, social change, and understanding of individual, organizational, and societal behavior, experience in clinical settings, and exposure to systems thinking led me to depart from the traditional role of a psychologist to seek preparation to engage at a broader level with the issues I saw as much more determinant in affecting the lives of people with serious mental health problems. I completed a 2-year postdoctoral fellowship at Yale's Institute for Social and Policy Studies, during which time I became affiliated with the Bush Program in Child Development and Social Policy at Yale. I learned a great deal more about economics, political science, policy analysis, epidemiology, and public health than had ever been broached in my graduate training in psychology. During that time I changed my focus from adults to children, for it became apparent to me that if one was going to have an impact on reducing the consequences of mental illness in our society, it made most sense to focus on prevention and early intervention beginning in the earlier years of life. A 1-year Congressional Science Fellowship sponsored by the American Psychological Association in conjunction with the American Association for the Advancement of Science followed.

Since then I have served in various settings and locations in the arena of children's mental health and child welfare services. I have worked in university-based programs focused on linking research and policy for children at the Bush Program in Child Development and Social Policy both at the University of Michigan and at Yale; served as the administrator of Iowa's child welfare system, where I was responsible for administration of the state's services for children, including foster care, adoption, child protection, child care, home-based services, and the state's juvenile institutions; was a senior program officer overseeing the Mental Health Initiative for Urban Children at the Annie E. Casey Foundation (King & Meyers, 1996); and worked as a consultant to several states and communities largely through my affiliation with the National Technical Assistance Center for Children's Mental Health at Georgetown University. These and other experiences have given me a broad perspective on the challenges in instituting systemic reform on behalf of children with mental health problems and their families as I have grappled with how one supports, prods, catalyzes, facilitates, promotes, and advocates for change, both from within as the administrator of a state system and from without as a consultant.

I gave up my career as a clinician because I thought I could make a greater difference by working at the systems and policy level. Within a few years time, I went from an inpatient unit of a community hospital to the halls of Congress, and since then have been many places in between. I have come to appreciate that it takes many people at all levels—policy, systems, practice, families—who share a common vision and goal to push for systemic change. No one place or position has more power than any other to make it happen. The power in one position comes mostly from being in a position to stop the movement temporarily, but the movement will eventually find its way around the resistance if the cause is right.

What Will It Take to Support and Sustain Systems Reform?

The reform of children's mental health service systems as envisioned is clearly no easy task or it would have succeeded by now. In a review of the factors necessary for maintaining children's mental health systems over the long haul, Koyanagi and Peres-Merchant (2000) stated, "Adopting the systems of care approach promoted in federal law requires a sea change in policy, clinical practice and administration. States and localities are expected to reorient, re-design and re-finance child mental health services into true 'systems' of care" (p. 11). As they noted, and I have observed repeatedly, this rarely is a linear process, and it can be easily sidetracked by changes in leadership, funding commitment, and the inevitable pockets of resistance that arise when major systems changes are being undertaken.

A systems perspective teaches us that pressing for change threatens stability, increasing the power of forces resisting change and thus maintaining the status quo, preserving the integrity of the existing system. Reforms always encounter resistance. This stability is important to us as biological organisms and as a nation that has survived as a democracy without the threat of revolution beyond the one that created us. This stability can be a detriment when it preserves a way of operating that has far surpassed its usefulness. As noted in a monograph summarizing the lessons learned from the Annie E. Casey Foundation's New Futures Initiative, as the reform agenda threatened the stability of the current system, "Vested interests in current practice, fiscal constraints, and political risks created a constant force capable of minimalizing system change" (Annie E. Casey Foundation, 1995, p. 2). Perhaps in understanding the forces of resistance to the changes inherent in moving from an institutional- and residential-based system that is focused on the individual child, excludes the family, and is not rooted in the community and schools to a systems of care approach, those who are committed to change can overcome the status quo.

In moving a children's mental health system toward a community-based, family-centered approach, pockets of resistance to change may occur in a variety of places. Providers and their agencies may see the changes as threatening their sources of funding or requiring them to change their deeply embedded theoretical orientation and methods of practice. Often these are groups that have an organized and strong presence in the legislature and executive branch. Others fear the unknown and do not want to leave the comfort of the familiar. If a practitioner is used to the comfort and safety of his or her own office as the locus of treatment, leaving that confine and venturing out into the community or homes of children and families can be daunting. Inertia is another powerful force for keeping things as they are, as exemplified by the statement "That's the way it's always been" as a common refrain to explain why things occur as they do in a bureaucracy even when they make no sense. One can usually look for which groups or individuals may lose power, influence, status, a sense of identity, or earning power to locate the strongest resistance to change, regardless of its broader benefit.

Elements of Change

My experience, both in Connecticut and nationally, further informed by the observations of others, suggests that key elements must be in place if we are to overcome resistance to change and support and sustain all the elements of a system of care. These elements include (1) leadership; (2) a broad-based commitment at all levels; (3) mechanisms to build the capacity of practitioners and support and sustain the presence of family advocates; (4) increased attention to quality improvement and accountability through solid data and evaluation; (5) adequate and sustained funding; (6) the integration of mental health principles and practices into all child-serving systems; (7) the expansion of the use of evidence-based practices that have demonstrated that clinical interventions in the right context will result in better outcomes for children and families; and (8) building public will and support. If these elements are left unattended, the next generation of policymakers and practitioners will be repeating the same tired litany 20 if not 100 years hence. I will elaborate on each of these elements.

Leadership

For a reform of state policies and services to succeed, leadership from both within government and without is necessary. Leaders are needed who can articulate the vision, manage the complex process of change, and help keep sustained commitment through the political shoals. A commitment from the top leadership, ideally in both the executive branch and the legislature, is important. Change of this magnitude requires legislative and fiscal initiatives to sustain the reform over time. At the same time, leadership of a different sort, sometimes referred to as leadership from behind, or servant-leadership, is needed (Spears & Lawrence, 2002). Such leadership can exist in a variety of settings, but these are usually people committed to the cause who are invested in the betterment of community, working collectively for social change, often behind the scenes.

A turnover in top leadership can lead to a loss of momentum, of commitment, and of memory and understanding. The history of the children's mental health movement has taught us that a reversal in political will, especially with changes in leadership, can easily lead to the demise of a major reform effort. In Connecticut, KidCare had the support of the commissioners of the two key state agencies involved. They became public spokespersons, championing it each step of the way, sometimes in the face of less than full support from legislators, providers, and others in their own administration who were concerned about the fiscal liabilities. One of those commissioners has since left, and it falls to her successor to pick up the sword and continue the fight. Since it was not her initiative to begin with, it remains to be seen how effective and committed a voice she will be, particularly as the reform has begun to meet some of the inevitable resistances.

Broad-Based Commitment for the Reform Effort

Champions of the reform are needed not only from key legislators but also from private sector leaders, across multiple state agencies, and among staff at many levels within state agencies at the state and community level to keep an effort at systems reform moving through political and funding setbacks. As I wrote in an earlier publication about sustaining reform, "Ownership by one individual, one party, one agency, or even one branch of government cannot sustain a reform agenda over time. Broadening the base of support at the earliest possible time with deliberate inclusion strategies is important" (Meyers & Davis, 1997, p. 98).

Because of the many political and bureaucratic constraints on elected and appointed officials, and because they inevitably come and go before the work of a movement such as transforming a children's mental health system is sustained, leadership from without is needed. Organizations such as the Child Health and Development Institute, which are more independent and objective, can help serve as a catalyst to the process and maintain a consistent voice about the direction that needs to be maintained over the long haul, through efforts that vested interests can too often derail.

Leadership from among parent advocates is another important source of external pressure. In my experience the most powerful voices to sustain change are those of family advocates. Family members of children receiving services are committed to their children over the long haul. They are most invested in seeing change that will benefit the lives of their children and will be the most passionate advocates if brought into the process. When Connecticut committed to its KidCare reform, the family advocacy movement was weak to nonexistent across the state. Part of the reform has been an investment both by the state and by private foundations in building and supporting a family advocacy movement. As noted earlier, there are now several such organizations serving different populations and working collaboratively under one umbrella, called FAVOR. They represent a strong and independent voice. In recent setbacks to the reform, their calls and visits to their legislators have had the most powerful influence in sustaining the commitment to and support for KidCare. While theory, research findings, and data and evaluation help shape the minds of decision makers, the voices of families sharing the experiences of their children speak to their hearts.

Building Capacity

Moving from an institutional to a culturally competent and family-centered community-based approach is a major philosophical shift that requires new attitudes, beliefs, skills, and values. If government is to fundamentally change the way its service systems operate, workers from managers to front-line staff need to understand and act on this new approach in all aspects of their work so that the new systemic thinking permeates all they do. This requires a comprehensive approach to workforce development and training that cuts across discipline and agency boundaries at both the graduate preprofessional and in-service levels, instills a focus on the system of care concept, philosophy, and treatment approach, and trains providers to apply effective prevention and treatment services within that context (Meyers, Kaufman, & Goldman, 1999).

In Connecticut, with the assistance of Cliff Davis and Sheila Pires at the Human Service Collaborative, CHDI designed a 5-day competency-based institute to begin to address the attitudes, knowledge, and skills needed to provide strengths-based training that emphasizes individuals and families as partners in community-based planning and behavioral health care of children and families in support of the implementation of Connecticut Community KidCare. The curriculum addressed the basics of a system of care approach; the strengths and needs of children with serious mental health disorders; how to develop individualized strategies of treatment and support; how to build partnerships between providers and families; and how to collaborate with other systems and communities. Using a train-the-trainer model, more than 120 trainers were prepared to train groups of 25 that included a mix of parents, community service providers, and staff from the DCF, judicial, and education systems. More than 2,000 people were trained over a 2-year period. While that was successful, we never believed it would be sufficient to change practice. The challenge has been in sustaining the commitment to training necessary to move beyond this initial exposure so that all those involved have the opportunity for ongoing supervision, learning, and support to translate what they have learned to a sustained change in practice. One way this has been accomplished is by incorporating the curriculum into the preservice training for all new staff hired at DCF, while we continue to work to establish a plan for ongoing workforce development training and to work with the graduate schools of social work to infuse this material into their curricula.

Attention to Quality Improvement and Accountability Through Data and Evaluation

One of the key roles that CHDI has played in the implementation of KidCare has been to advocate for and oversee an evaluation of the reform. We were successful at the start in making the case that it would be important to document how the initiative was being developed, what was working, what was not, and why. Such information was invaluable for several purposes: improving services, marshaling public support, informing management, and sustaining involvement in service systems. A multiyear evaluation would provide information to policymakers to help sustain their investment in the initiative by addressing their key concerns about cost-effectiveness of the system; it would provide important feedback to stakeholders about how the process was developing so that adaptations could be made. Also important to me, it would document how the process was unfolding so that in the event that the initiative was derailed, there would be clear information to explain what happened so that the initiative would not be held accountable if expected results were not achieved.

DCF contracted with CHDI to manage the evaluation, and we selected the Human Services Research Institute and its partners, the Technical Assistance Collaborative and the University of South Florida, to design and carry it out. The first year of this multiyear evaluation has focused on how the reform was implemented and began to establish baseline measures. It is addressing four questions:

1. Are the new services being implemented as planned?
2. Are services family and child centered?

3. Are families satisfied with the services they are receiving?
4. Are system capacity and responsiveness improving?

In subsequent years, the evaluators will analyze trends in the capacity of the system, the responsiveness of the system over time, and changes in children's outcomes. What we have learned in conducting the evaluation is that accessing quality data is very difficult. There is a lack of technology in state agencies, leading to poor-quality data and difficulty in sharing data across state agencies. The requirements of the new federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which went into effect in 2003, only add to the challenge.

The state of the art in evaluating the effectiveness of systems of care is still quite limited. Systems of care are complex and evolving processes. The Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999) summarized what we know from national evaluation studies with the following statement:

> Collectively, the results of the evaluations of systems of care suggest that they are effective in achieving important system improvements, such as reducing use of residential placements, and out-of-state placements, and in achieving improvement in functional behavior. There also are indications that parents are more satisfied in systems of care than in more traditional service delivery systems. The effect of systems of care on cost is not yet clear, however. Nor has it yet been demonstrated that services delivered within a system of care will result in better clinical outcomes than services delivered in more traditional systems. (p. 133)

My commitment to conducting a comprehensive evaluation in Connecticut is not only about supporting the work in one state but also about making sure that we use this opportunity to contribute to the national knowledge base and evolving learning about developing children's mental health systems of care. In examining the factors that helped support and sustain the Comprehensive Community Mental Health Services system sites after the termination of federal funding, those with the strongest prospect of continuing and growing following the termination of federal funds were noted to have made excellent use of data and evaluation of outcomes (Koyanagi & Feres-Merchant, 2000). I believe this is true not only at an individual site level but also for states and for the movement as a whole.

Sustained and Adequate Funding From a Variety of Sources

In my 20 years in this field, I have seen the federal commitment to building children's mental health systems grow from just over $1 million in 1984 to over $100 million expected this year. In my 5 years in Connecticut, $23 million new dollars were appropriated to build a community-based service system. Clearly, these are substantial increases, but just as clearly it is not enough.

When Connecticut Community KidCare was first designed, we knew it would take at least 5 years to build the community-based capacity sufficiently to reduce reliance on the more expensive out-of-home services, allowing for the redirection of resources. My biggest concern was and continues to be that the state would not invest sufficiently to build and sustain the changes. Change of this magnitude takes a long time and requires a long-term investment, sufficient to have it succeed.

As an example, the plan for Connecticut Community KidCare initially called for more than 400 care coordinators, enough to cover the estimated 4,000 children with serious and complex mental health disorders, with a caseload of 10 per coordinator. To date, funding has been sufficient to hire 60 care coordinators, who have served 400 children, with no current plans for expansion.

The problem, however, is not solely one of inadequate new resources to do the job but the constraints on existing resources, with Medicaid being the chief example. Many of us in Connecticut have been working to expand the use of Medicaid to support some of the essential services for children to remain in their home communities. Connecticut has not made full use of options within Medicaid that are available for this purpose. Achieving this within an environment where cutting budgets to address state deficits includes proposals to charge families at 50% of the poverty level for their use of Medicaid has been especially difficult.

When exploring alternative sources of funding, philanthropic foundations should not be overlooked. In Connecticut several foundations have contributed substantial resources to Connecticut Community KidCare, helping to fund the elements of the system seen as most important to keeping the reform moving against odds. The Connecticut Health Foundation and the Children's Fund of Connecticut have made significant investments in evaluation, training, promoting evidence-based practices, and supporting the development of the local collaboratives. Although the amounts contributed may be small relative to the public resources, they can help sustain the work through the patches when the public funding is held back or reallocated for political reasons.

Integrating Family-, Child-, and Youth-Centered Mental Health Services Into All Systems That Serve Children and Youth

The systems of care approach is based on the understanding that one cannot address the mental health of children, particularly those with more serious disorders, without attending to many other service systems that affect their daily lives. Many of these children come into contact with the child protection system and the juvenile justice system. Whether they do or not, the schools, the health system, social services (Temporary Assistance for Needy Families [TANF] and Medicaid), and the early care and education service system are important touch points for serving the needs of these children and their families.

It is clear to any of us who have worked in this field that the children's mental health agency cannot go it alone. Looking at the experience of sites that participated in the federal Comprehensive Community Mental Health Services Grants, it was clear that funding from multiple sources was necessary to sustain the programs once the grant money was no longer available. Mental health and Medicaid dollars were not sufficient. Resources were drawn from myriad federal, state, and local sources from many different systems (Koyanagi & Feres-Merchant, 2000). Our own initial study of the system in Connecticut corroborates this.

Connecticut is one of a small number of states that has an integrated children's agency that is responsible for child protection, children's mental health, and juvenile institutional services. Even with Connecticut's structural advantage, it has still been a significant challenge to integrate planning, funding, and service delivery across systems. One of the hallmarks of progress in the development of KidCare was the establishment of a Behavioral Health Partnership Agreement whereby three state agencies (DCF, DSS, and the Department of Mental Health and Addiction Services) agreed to work together, committing both their programs and their dollars to an integrated service system, but it has taken 2 years of deliberations to reach this point, with many starts and stops. Efforts to work with the schools and the juvenile justice system are ongoing but not easy.

Expansion of Evidence-Based Practices

To achieve better clinical outcomes, we know that there is clearly a need for more attention to the effectiveness of services delivered within systems of care that includes the relationship between changes at the system level and changes at the practice level. What happens in the interaction between the therapists and the child and family is the ultimate determinant of how well the systems reforms work. We have seen marked progress in the increase in use of community-based clinical interventions that are demonstrated to be effective with specific populations of children with mental health and substance abuse problems in real-world settings. These interventions include multisystemic therapy, functional family therapy, multidimensional family therapy, and Oregon Treatment Foster Care (Ford, Gregory, McKay, & Williams, 2003).

In Connecticut we are actively seeking to expand the use of evidence-based interventions. We have developed a unique partnership to promote the use of evidence-based practices in public systems. The Connecticut Center for Effective Practice (CCEP) is a public-private partnership that includes DCF, the Court Support Services Division of the judicial branch, the Department of Psychiatry at the University of Connecticut Health Center, the Yale Child Study Center, and CHDI, which serves as its administrative home. CCEP's purpose is to enhance Connecticut's capacity to improve the appropriate diagnosis and treatment of children with serious and complex emotional and behavioral conditions by supporting the development, evaluation, training, and dissemination of effective prevention and treatment services. The initial focus of the work has been on children and youth with behavioral health needs who are in, or at risk for placement in, the juvenile justice system, and on multisystemic therapy (MST).

CCEP partners also worked together to continue the state's effort to deliver other evidence-based services, including Functional Family Therapy, Multi-dimensional Family Therapy, and Intensive In-Home Child and Adolescent Psychiatry Service (a model developed by the Yale Child Study Center and now being delivered in 16 sites throughout Connecticut under contract with DCF).

We are learning, however, that even the most well-developed models, those with defined treatment manuals and methods of quality management through training, data collection, quality monitoring, and evaluation, are difficult to replicate. As well developed as MST is, it still relies on the capabilities and commitment of provider agencies and their staffs to adhere to the model, and for the state agencies as purchasers of the service to hold firm in setting standards and requiring accountability for performance.

Our state public systems are eager to transform their systems so that their resources are used to purchase treatments that are known to be effective. This eagerness, while a tremendous opportunity, also presents a challenge in that they are moving to implement some of these practices more quickly than there is the capacity to support. A survey of providers with whom state agencies contracted to provide intensive community-based behavioral health services to children involved in the legal system in Connecticut indicated that although programs, providers, and advocates have goals that are consistent with the findings of scientific research on treating delinquency, they typically do not have access to the materials, training, or funding required to implement evidence-based practices (Ford et al., 2003).

Likening what happens when there is divergence from an evidence-based model as prescribed to what happens when physicians reduce the dosage of psychotropic medications below clinically desirable levels, Glied and Cuellar (2003) note the reduction in the efficacy of the intervention. That has been our experience to date, but we are attempting to address this challenge through the academic-public partnership, which will enhance the collection, analysis, and dissemination of evaluation and research findings and thus put us in a position to advocate for the policies and practices that support adherence to effective clinical practices.

Promote Public Awareness and Public Will

Ultimately the success of building community systems that will support the mental health of children requires ownership from the community as a whole. When it comes to mental health, we well know this is a challenge because of the stigma associated with mental illness. To build a broad understanding that a system of care approach is different and can make a difference requires helping people understand and accept new ideas. In business parlance this is known as social marketing. Among the graduates of the Comprehensive Community Mental Health Program, those sites that understood the concept of marketing were more successful in achieving sustainability. As noted by Koyanagi and Feres-Merchant (2003):

> Sites should expect to have to "sell" the system of care to staff of other agencies, to market its potential to community leaders and describe it clearly and concisely to local and state politicians. Many policymakers, and certainly many staff in other agencies, are jaded about reform in children's services. Too many attempts have been made and too many failures have occurred for them to have faith in this new approach, unless they can be shown some concrete results. (pp. 31–32)

A Journey, Not a Destination

I have spent the better years of my career devoted to a movement to build community-based, family-driven, culturally competent systems of care for children with, or at risk of having, serious mental health problems. This chapter has been an attempt to weave my own experience and perspective with what has occurred nationally over the past century and more recently in the state of Connecticut.

There are clearly lessons learned, and I have done my best to share those. In my own development I have resonated with the tenets of systems theory and servant-leadership. Both have provided conceptual frameworks that allow me to stay the course over many years while the efforts at change confront the inevitable roadblocks and challenges. As noted by Robert Friedman (2002), who along with Beth Stroul pioneered the concept of a "system of care" in children's mental health, there is an increased recognition of the complexity and difficulty of implementing the values and practices of systems of care. He states, "Given the challenge of developing and implementing systems and services for a diverse population of children and families, many with co-occurring conditions, we need to have realistic expectations to expect gradual, incremental progress, and be prepared to be in it for the long haul" (p. 47).

Systems are slow to change. That is their beauty and their curse. It takes a commitment to a vision and values, patience, and a cadre of committed people who share in the cause. While the research is not yet conclusive, an accumulating body of evidence reinforces the work. Underlying all this is the experience of children and their families, who provide the passion and the reason to continue. Occasionally someone in Connecticut will pronounce that "KidCare is dead." I look around and remind them that there has been incredible progress, even if we are not where we hoped we would be. This is true on the national scene as well. We have come a long way. We have a long way to go.

References

Annie E. Casey Foundation. (1995). *The path of most resistance: Reflections on lessons learned from new futures.* Baltimore: Author.

Child Health and Development Institute of Connecticut, Inc. (2000). *Delivering and financing children's behavioral health services in Connecticut.* Farmington, CT: Author.

Connecticut Department of Children and Families and Department of Social Services. (2001). *Connecticut community KidCare: A plan to reform the delivery and financing of children's behavioral health services.* Hartford, CT: Author.

Connecticut Department of Children and Families, Division of Mental Health. (2002). *Annual system of care status report for community collaboratives.* Hartford, CT: Author.

Ford, J., Gregory, F., McKay, K., & Williams, J. (2003). *Close to home: A report on the behavioral heath services for children in Connecticut's juvenile justice system.* Farmington, CT: Connecticut Center for Effective Practice of the Child Health and Development Institute of Connecticut.

Friedman, R. (2002). *Child and adolescent mental health: Recommendations for improvement by state mental health commissions.* Tampa: University of South Florida, Department of Child and Family Studies, Louis de la Parte Florida Mental Health Institute.

Friesen, B., & Winters, N. (2003). The role of outcomes in systems of care. In A. Pumariega & N. Winters (Eds.), *The handbook of child and adolescent systems of care* (pp. 459–486). San Francisco: Wiley.

Geballe, S. (2002). *The state of children's mental health in Connecticut: A brief overview.* Farmington, CT: Connecticut Health Foundation.

Glied, S., & Cuellar, A. (2003). Trends and issues in child and adolescent mental health. *Health Affairs,* 22(5), 39-50.

Hobbs, N. (1975). *The futures of children: Categories, labels, and their consequences.* San Francisco: Jossey-Bass.

Joint Commission on the Mental Health of Children. (1969). *Crisis in child mental health: Challenge for the 1970s.* New York: Harper and Row.

King, B., & Meyers, J. (1996). The Annie E. Casey Foundation's mental health initiative for urban children. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 249–261). Baltimore: Brookes.

Koyanagi, C., & Feres-Merchant, D. (2000). For the long haul: Maintaining systems of care beyond the federal investment. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Lourie, I., Katz-Leavy, J., DeCarolis, G., & Quinlan, W. (1996). The role of the federal government. In B. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society* (pp. 99–114). Baltimore: Brookes.

Meyers, J., & Davis, K. (1997). State and foundation partnerships to promote mental health systems reform for children and families. In C. Nixon & D. Northrup (Eds.), *Evaluating mental health services: How do programs for children "work" in the real world?* (pp. 95–116). Thousand Oaks, CA: Sage.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Promising practices: Training strategies for serving children with serious emotional disturbance and their families in systems of care. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America.* Final Report (DHHS Publication No. SMA-03-3832). Rockville, MD: Author.

Senge, P. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning.* New York: Currency/Doubleday.

Spears, L., & Lawrence, M. (2002). *Focus on leadership: Servant leadership for the 21st century.* New York: Wiley.

Stroul, B. A., & Friedman, R. M. (1994). *A system of care for children and youth with severe emotional disturbances* (Rev. ed.). Washington, DC: Georgetown University Child Development Center, Child and Adolescent Services System Program Technical Assistance Center.

U.S. Department of Health and Human Services. (2000). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

npj | mental health research

Review

https://doi.org/10.1038/s44184-024-00102-w

Infrastructure development in children's behavioral health systems of care: essential elements and implementation strategies

Jeffrey J. Vanderploeg ✉

To improve the outcomes of children's behavioral health systems, states must invest in expanding infrastructure; however, infrastructure is a commonly used and poorly understood concept. This paper aims to provide a definition of infrastructure in the context of state-level children's behavioral system of care development and describes five essential infrastructure elements: an integrated governance and decision-making structure; structures and processes for blended and braided funding; a central point of access for information, referral, and linkage; workforce development, training, and coaching in effective practices; and data and quality improvement mechanisms. Suggested implementation activities are offered for each of the five proposed infrastructure components. The important role of public-private partnership, particularly with intermediary organizations, is described, and future directions for research and scholarship are proposed.

The need to address the behavioral health of youth has never been more critical. Globally, increased prevalence of youth behavioral health conditions has been reported recently, particularly among adolescents[1]. The prevalence of youth behavioral health conditions ranges from 13–20%, costing the U.S. healthcare system approximately 247 billion dollars annually[2]. The most common conditions among youth include ADHD, anxiety, behavior problems, and depression, and many youth, particularly youth of color, have experienced significant trauma exposure[3,4]. The COVID pandemic has contributed to higher rates of externalizing and internalizing behaviors among youth and diminished caregiver well-being[5]. Despite increased need, more than half of youth globally with behavioral health conditions do not receive any treatment[6]. Those who do receive treatment are increasingly likely to do so in hospital emergency departments, raising serious concerns about the accessibility and quality of community-based behavioral healthcare systems and services for youth[7]. Decades of underfunding has resulted in behavioral health systems across the country existing in a nearly continuous state of crisis and unable to meet increasing demand for services. Behavioral health services are typically reimbursed at rates much lower than physical health, rates that are often insufficient to attract and retain an adequate provider network or cover the true cost of providing high-quality care[8]. The pandemic strained even further the behavioral health workforce, with many studies documenting increased stress, burnout, and turnover risk, further compromising the capacity to meet the demand for services[9]. The confluence of these factors underscores a need to address long-standing challenges in expanding and sustaining systems that can ensure the delivery of comprehensive, equitable, accessible, and high-quality behavioral health care.

Systems are comprised of interconnected elements designed to produce a particular result. They are complex, dynamic, and frequently comprised of both core elements and supporting elements. Consider transportation, for example. The core elements are easily recognizable. People want to travel for business or pleasure, and modes of transportation such as planes, trains, boats, and automobiles exist to get people there. The transportation system, however, is comprised of many additional supporting components that bind the core components together. They include well-maintained highways and roads, an adequate supply of vehicles, maintenance facilities to keep the vehicles running, trained and licensed operators, gasoline and charging stations, signs, traffic lights, and posted speed limits. Ideally, the core and supporting elements of the system work together to produce the desired results. The behavioral health system is similar. The core components of that system include youth and families in need in services, comprising approximately one in six youth, publicly operated systems, and networks of providers delivering an array of behavioral health services that vary in comprehensiveness and quality[10,11].

Like the transportation system, the behavioral health system also binds its core components together through additional supporting components, referred to in this paper as infrastructure. An understanding of system infrastructure is crucially important to the field of children's behavioral health research, policy,

Child Health and Development Institute, Farmington, CT, USA. ✉e-mail: jvanderploeg@chdi.org

and practice. First, behavioral health system stakeholders continue to struggle to understand why effective interventions are not brought to scale, and why the systems in place are not producing better and more equitable access, quality, and outcomes. Many correctly point to the need for increased attention to the systems' core components including increased funding for the provider network and a more comprehensive and effective service array. Attention to these elements is necessary, although it may not be sufficient. This paper proposes that insufficient infrastructure development may be another contributing factor to the failure of many behavioral health systems to produce better outcomes. If that is the case, then all stakeholders in the children's behavioral health system must develop a better understanding of what constitutes critical system infrastructure and must develop effective strategies for developing and deploying those infrastructure elements.

This paper defines infrastructure and places it within the context of children's behavioral health system of care development. Prior research and scholarship identify implementation characteristics, including some infrastructure components, at the system, provider organization, individual practitioner, and child and family levels[12]. This paper focuses on elements of infrastructure that large public systems, such as states, are uniquely positioned to fund and deploy to the benefit of all other youth behavioral health system stakeholders. The paper then describes a set of five proposed *essential elements* (rather than a full and complete list) of children's behavioral health system infrastructure: (1) an integrated governance and decision-making structure; (2) blended and braided funding; (3) a central point of access for information, referral, and linkage; (4) workforce development, training, and coaching in effective practices; and (5) data and quality improvement mechanisms. The paper ends by describing the role of public–private partnership, particularly intermediary organizations, in developing and implementing these essential infrastructure elements.

Defining behavioral health infrastructure

In the children's behavioral health field, infrastructure is a commonly used, yet poorly defined and understood term. The "system of care" concept is an essential context for understanding system infrastructure since it has provided a guiding framework for many states to improve their children's behavioral health delivery system. A system of care is defined as "a spectrum of effective, community-based services and supports for children and youth with or at risk for behavioral 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."[13] Among the most significant contributions of the system of care concept are its aspirational set of core values and guiding principles. System of care values include being community-based, family driven, youth guided, and culturally and linguistically competent. Among its many guiding principles are access to a broad array of home- and community-based services and supports, individualized care delivered in the least restrictive environment, access to evidence-based practices, coordination across child-serving systems, and many others.

The Substance Abuse and Mental Health Service Administration's system of care expansion and sustainability grant mechanism provides funding for the expansion of services as well as infrastructure development. The system of care literature depicts and describes infrastructure as the bridge between the system of care *philosophy* (i.e., the values and guiding principles described above) and the *comprehensive array of service and supports*[14]. Within that context, infrastructure is defined as "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." Additional elements of children's behavioral health infrastructure include accountability structures for policy and oversight, care and cost management, training, technical assistance, defined access and entry points, structures and processes for promoting equity, strategic planning, and others. An accompanying rating tool has been developed to assess the implementation of the values, guiding principles, and services of the system of care, including a 12-item section on infrastructure[15]. The extant literature therefore defines infrastructure primarily by describing its functions and activities, offering several examples of infrastructure elements.

For the purposes of this paper, infrastructure is defined as *system-level structures and processes for actualizing system of care values and principles and for scaling and sustaining an effective service array*. The paper expands on the notion that infrastructure serves as an important bridge between the philosophy of care and the service array by identifying its essential components. In doing so, the aim is to provide guidance for system stakeholders (e.g., state government officials, providers, consumers, advocates, and others) in directing often-limited resources for the development of the most essential infrastructure elements. The paper ends with a call for further research and scholarship to identify effective approaches to systematically enhancing infrastructure and demonstrating that such enhancements produce value-added contributions to system functioning and outcomes.

Essential elements of Children's Behavioral Health System Infrastructure

Integrated governance and decision-making structure

The stakeholders involved in the behavioral health system are the people that put values and principles into practice and make decisions about the service array; therefore, the composition and activities of a system's decision-making entity is perhaps the most critical infrastructure element. The children's behavioral health system is supported by a wide range of stakeholders including youth, parents and caregivers, providers, state agency personnel, funders, researchers, advocates, legislators, policy makers, and others. At times, governance and decision-making structures include various combinations of one or more of these representatives rather than a more efficient and integrated approach bringing all stakeholders together. The result can be a very fragmented governance and decision-making structure that fails to move the system forward in a planned, coordinated, and unified manner. The system of care approach places youth and families squarely at the center of the collaborative decision-making structure with many states striving toward 50% or higher youth and family membership. Rather than being passive observers, or final reviewers of decisions that others have already made, youth and families must have full and authentic engagement in system governance and decision-making[16]. This often requires distinct lines of funding and support so that youth and families can fully participate in the governance and decision-making structure.

Governance and decision-making structures should be fully integrated across child-serving systems and should be public, transparent, and inclusive of all stakeholders. The executive, legislative, and judicial branches of government should be represented. Because many state agencies control one or more parts of the children's behavioral health system, executive branch participants should include all agencies involved in funding, implementing, and overseeing children's behavioral health services. In addition to a department of behavioral health or children's behavioral health the governing body should include agencies responsible for child welfare, public health, physical health, education, intellectual and developmental disability, early childhood, and other areas. A state's department of behavioral health, or occasionally a children's cabinet, may provide lead oversight and coordination. The direct participation of each of these child-serving agencies can help to establish a singular system for all youth with behavioral health needs that simultaneously has the capacity to serve the unique needs of special populations. Interagency participation and collaboration also present opportunities for blended and braided funds to support service delivery and infrastructure. Key legislators representing relevant child-focused committees (e.g., children's committee, health and human services, education, appropriations, public health, etc.) should also be present, along with judicial branch personnel who can ensure that the unique needs of justice-involved youth are addressed. Representatives from the state budget office, Medicaid, and the commercial insurance industry also serve as critical stakeholders.

To help achieve goals relating to equity and racial justice, members should be diverse in terms of race, ethnicity, sex, gender, language,

Table 1 | Integrated governance and decision-making structure

Infrastructure category	Brief description and suggested implementation activities
Integrated governance and decision-making structure	Description. A single entity for the state that includes all relevant stakeholders responsible for governance, planning, and decision-making on system design, funding, service delivery, and other implementation factors. Youth and families are engaged and supported to play a crucial decision-making role. Other partners include state agency representatives, providers, legislators, payers, researchers, policymakers, advocates, and others. Driven by data and system of care values and principles, the governance body should collectively identify a unified set of prioritized goals and objectives, with a second-level structure of workgroups aligned with those goals and objectives. Suggested Implementation Activities • If needed, enact legislation to create a governing entity that includes members representing all key stakeholder groups. If multiple committees or councils exist, legislation may be needed to create a single unified structure. Ensure membership diversity with respect to race, ethnicity, gender, language, perspective, and other factors. • Contract with an outside entity (e.g., intermediary organization) with expertise and credibility in children's behavioral health to provide professional project management and coordination. • Establish a strategic plan with prioritized, measurable short- and long-term goals and objectives and align workgroups according to those goals and objectives. • Clearly specify the role and anticipated unique contributions of each stakeholder group to achieving the stated goals and objectives. • Ensure meetings are open to public input, with meeting minutes and decisions posted transparently. • Disseminate strategic communications, marketing materials, resources, and information to educate the public about the goals of the system and how to access its services and supports

geography, socioeconomic status, background, perspective, and other factors. Together, the integrated governance and decision-making structure can identify policy, legislative, and practice solutions to improve overall system functioning. The collaborative nature of the group can help to facilitate necessary interagency partnerships as well as agreements with private organizations such as family and youth advocacy groups. An efficient second-level structure of workgroups that aligns with the highest priorities and goals of the system allows for in-depth discussion, data review, and generating recommendations in key areas. The overarching decision-making body then reviews and considers for full implementation each of the workgroup's activities, findings, and recommendations.

Many states' collaborative governance and decision-making structures have formally adopted the system of care values and guiding principles, sometimes with slight modifications to reflect local priorities or other unique circumstances. Adoption of these values and principles serves to align members around a shared vision and language for the system and align state efforts within overarching federal guidance, funding, and supports. With a fully integrated collaborative decision-making structure in place, aligned around a core set of values and principles, an early task of the group is to develop a short- and long-term strategic plan that articulates a shared and prioritized set of measurable goals, objectives, and activities. The group uses system- and program-level data (described in more detail below) to guide their discussions and decisions, monitor the impacts of their decisions on system functioning and outcomes, and identify and resolve barriers. It is also frequently the role of this overarching decision-making body to develop and disseminate strategic communications, marketing materials, resources, and information to educate the public concerning the goals of the system and how to access its services and supports. To coordinate the multiple activities of a large and diverse group of system stakeholders, it is often helpful for states to engage an intermediary organization (described in more detail below). Table 1 describes an integrated governance and decision-making structure and offers several suggested implementation activities.

Structures and processes for blended and braided funding

Funding is what makes possible the realization of a system's values and principles in the form of a comprehensive service array and adequate supporting infrastructure. The governance and decision-making structure described above, or a financing workgroup within that structure, is often charged with identifying and expanding funding to support each of these system elements and to achieve the system's stated goals and objectives. A key challenge is to address the need for Medicaid, commercial insurance, and state grant funds to robustly cover service delivery in a way that meets the true cost of providing high-quality care, which at the provider level, involves more than the cost of direct service delivery. Therefore, a first step can be determining the true cost of delivering high-quality care, how much of that cost is supported through current financing approaches, and how identified gaps will be addressed, often by blending and braiding available funding sources. All children with behavioral health needs deserve access to the best system and services available, and many providers deliver services to youth and families with Medicaid or commercial insurance coverage, as well as the uninsured. Therefore, blended and braided funding approaches should focus on improving access to high-quality services for all, driven solely by need, and without restrictions based on insurance type, system involvement, geographic location, or other factors.

Financing approaches should include establishing regular, systematic rate review and adjustment processes to account for the increasing cost over time to deliver high-quality care. Some innovative financing models employ enhanced fee-for-service and/or value-based approaches that pay for direct service delivery costs, administrative overhead, care coordination, and the health-related social needs that significantly contribute to overall health and well-being[17]. These financing approaches can also incentivize identification and reduction of disparities related to race, ethnicity, language, sex, gender, and other factors. Identifying and leveraging innovative funding opportunities across all sources to support direct service delivery and infrastructure can be among the most important tasks of the collaborative governance and decision-making body.

The development and enforcement of parity laws is another important element of a comprehensive and effective financing approach. Parity generally refers to ensuring there are comparable covered services, policies and procedures, and rates between Medicaid and commercial insurance payers, and between physical and behavioral health services. Examining and improving financing approaches allows systems to address the long-standing shortfalls that have affected children's behavioral health providers for decades, and that often force those providers to supplement reimbursement rates and grants with philanthropic support and private donations just to fill in the gaps. Medicaid and commercial fee-for-service rates typically do not support most infrastructure-related activities; rather, infrastructure funding often comes from federal, state, and philanthropic grants and contracts. Table 2 describes structures and processes for blended and braided funding and offers several suggested implementation activities.

Central point of access for information, referral, and linkage

The "no wrong door" approach associated with the system of care concept envisions that youth and families in need of behavioral health assessment and intervention have defined entry points to care, and clear and consistent information and referral protocols employed in clinical and non-clinical sectors such as schools, pediatric primary care, early care and education centers, and other settings[18]. The passage of federal legislation requiring states to develop 988 systems provides unique opportunities to build out this

Table 2 | Structures and processes for blended and braided funding

Infrastructure category	Brief description and suggested implementation activities
Structures and processes for blended and braided funding	Description. Develop a system financing strategy to cover the true cost of delivering high-quality care to all children in need regardless of insurance type, system involvement, geography, or other factors. The financing approach should promote equitable access, quality, and outcomes of services and cover the costs of system infrastructure components. This frequently requires blending and braiding funds from several sources including state general revenues, federal grants and reimbursement mechanisms, Medicaid, commercial insurance, philanthropy, and other sources. Suggested Implementation Activities • Create a financing workgroup that includes key stakeholders and reports into the broader governance and decision-making entity. • Ensure that the financing approach includes funding for direct service delivery as well as infrastructure elements such as those described in this paper. • Ensure robust coverage of the service array using all relevant funding sources including state and federal grants, Medicaid, commercial insurance, and other sources. • Work with providers to conduct a fiscal analysis designed to determine the true cost of providing equitable, accessible, high-quality care. • Establish a Medicaid rate review and adjustment process that sufficiently funds service delivery and adjusts for increased costs over time. • Consider value-based and other alternative payment approaches that incentivize key system and service delivery goals focused on equitable access, quality, and outcomes of care. • Examine parity between commercial and public rates, and between physical and behavioral health, and enforce federal and state parity laws as needed.

Table 3 | Central point of access for information, referral, and linkage

Infrastructure category	Brief description and suggested implementation activities
Central point of access for information, referral, and linkage	Description. Recent federal legislation requiring states to implement 988 creates a unique opportunity for states to extend beyond traditional suicide hotline functions and instead create a single point of access to information and referral for behavioral health assessment and intervention. States should engage and educate clinical and non-clinical referrers such as youth and families, state agencies, pediatric primary care, early care and education, schools, community centers, and others about the availability of a central access point for behavioral health information, referral, and linkage. Suggested Implementation Activities • Establish a branding and marketing campaign that messages use of 988 for addressing suicidality and other behavioral health issues. • Conduct outreach to clinical and non-clinical referral sources about the availability and functions of 988. • Provide training to call center staff to establish clear and distinct protocols that serve the unique needs of youth and their families. • Establish a crisis response system by linking 988 to mobile response and stabilization services that deliver high rates of mobile face-to-face response and assessment in home, school, and community locations. • Establish dedicated, sustained funding for 988 and associated crisis response services, including considering the wireless surcharge option allowed under federal legislation. • Monitor data to ensure that increased awareness of and referrals to 988 is matched with sufficient capacity within the service array to meet the demand for services.

component of the infrastructure. The legislation originally envisioned 988 as a replacement for the National Suicide Prevention Lifeline; however, innovative state approaches are leveraging 988 funding and implementation efforts to consolidate functions and address the long-standing need for coordinated information and referral mechanisms that are more accessible to youth and families in need of a variety of behavioral health and well-being services. In addition to meeting the needs of individuals experiencing suicidality, 988 call centers can also provide public education and information, answer questions, and connect individuals to key elements of the service array.

Many 988 call centers are establishing direct connections to elements of the crisis service continuum such as Mobile Response and Stabilization (MRSS). Upon receiving calls, texts, and chats, 988 call specialists can dispatch MRSS providers to stabilize crisis situations in the home, school, or community, who in turn provide a face-to-face assessment and help facilitate linkages to ongoing care as needed. It is critical for 988 call centers to maintain the capacity to address the unique needs of youth and their families rather than defaulting to an adult-based model; for example, by deploying face-to-face mobile response to most youth and family requests for assistance, avoiding an overreliance on referring youth to crisis receiving facilities, and making every effort to maintain youth in their homes, schools, and communities whenever that is clinically appropriate[19]. Several states are using the provisions of the 988 federal legislation to enact small monthly fees on wireless plans, creating a sustainable funding source for the 988 call centers and associated elements of the crisis behavioral health service array[20]. As with any central point of access for information, screening, and referral, systems must ensure sufficient service delivery capacity exists. Building 988 infrastructure to increase awareness and identification of behavioral health needs, without also ensuring sufficient service delivery capacity, is at best insufficient and could even be harmful to youth with behavioral health needs and their families. Table 3 describes a central point of access for information, referral, and linkage and offers several suggested implementation activities.

Workforce development, training, and coaching in effective practices

The behavioral health workforce is an area of significant need that was further weakened by the COVID-19 pandemic[21]. Even the most comprehensive service array will not be effective without a sufficient and well-trained workforce to deliver those services; however, many states are struggling to recruit and retain a sufficient workforce to deliver behavioral health services and supports. The available workforce frequently does not match the population they serve in terms of race, ethnicity, sex, gender, primary language, and other factors[22]. Some states have responded by developing comprehensive workforce development plans and making significant investments to address workforce shortages and meet the increasing demand for care. A comprehensive workforce development approach addresses short- and long-term strategies for growing and diversifying the behavioral health workforce. Interrelated

Table 4 | Workforce development, training, and coaching in effective practices

Infrastructure category	Brief description and suggested implementation activities
Workforce development, training, and coaching in effective practices	Description. States should allocate dedicated funding to enhancing the behavioral health workforce. This includes ensuring sufficient insurance reimbursement rates and grant funds, but also includes other financial support for non-reimbursable workforce recruitment and retention strategies. Members of the behavioral health workforce also require ongoing training, coaching, and supervision to ensure they are delivering the highest quality clinical care. States should give specific attention to dissemination of evidence-based treatments and support community-derived and culturally specific interventions with ongoing data collection, quality improvement, and outcomes evaluation. Suggested Implementation Activities • The overarching governance structure should consider prioritizing workforce as a system goal and creating a workgroup to examine and address these issues. • Develop a comprehensive statewide behavioral health workforce development plan focused on growing and diversifying the workforce and ensuring they possess appropriate clinical competencies to address population needs. • Consider contracting with a workforce coordinating center to collect and report data on the workforce, and to coordinate policy, system development, and practices relating to workforce enhancement as specified in the strategic plan. • In addition to ensuring Medicaid and commercial insurance rates are sufficient for attracting and retaining a high-performing workforce, dedicate additional funds to pipeline development, recruitment, and retention activities. • Examine the degree of match between the socio-demographic characteristics of the population seeking behavioral health services and the workforce delivering those services. Enact policies and practices targeted to recruiting and retaining a diverse workforce. • Incorporate or expand the number of unlicensed staff such as peer support specialists and community health workers. Offer competitive pay, clearly defined roles and responsibilities, and meaningful career development pathways. • Ensure training, coaching, and supervision in core modules that enhance clinical competencies among staff across the entire behavioral health service array. Supplement with training, coaching, and supervision in clinical competencies that are specific to individual programs and services within the array. • Build capacity within the single service array for meeting the unique needs of special populations (e.g., young children, youth with intellectual and developmental disabilities, youth who are justice-involved, others). • Incorporate robust training in evidence-based treatments and other evidence-based practices (e.g., screening, measurement-based care). • Support community-derived and culturally specific practices with data collection, analysis, reporting, outcomes evaluation, and quality improvement activities.

actions can include sustained increases to reimbursement rates, providing grant funds to support recruitment and retention, launching a workforce coordinating center to track and monitor workforce data and implementation efforts, increasing diversity of the workforce, enhancing clinical competencies, removing unnecessary administrative and licensing barriers, incorporating peer specialists and community health workers, and increasing provider organization capacity to deliver health promotion and prevention activities[23].

Workforce development includes ensuring a sufficient number and variety of providers, as well as ensuring these individuals possess the clinical competencies to address the underlying needs of the population and improve outcomes. Efforts to enhance clinical competencies must go beyond one-time training, as adult professionals require more than didactic-style trainings to develop and fully incorporate new competencies. To ensure training content is applied to direct care provision, training should be accompanied by coaching and ongoing support, opportunities to practice new skills, the addressing of underlying motivational factors, and effective supervision[24]. Rather than designing training and coaching approaches one service at a time, states should seek opportunities to train larger portions of the workforce in a core set of modules that tend to be related to high-quality care across many services. This may include, for example, trauma-informed practices, suicide assessment, and culturally and linguistically responsive service delivery, among others. Furthermore, as states seek to implement a single robust service array for all children with behavioral health needs, they must also attend to ensuring there are enough clinical and non-clinical staff who can address the unique needs of special populations, such as very young children, youth who are justice-involved, and youth with intellectual and developmental disabilities.

An important subset of training includes the dissemination of evidence-based practices (EBPs) that have been shown through rigorous research to produce positive outcomes for youth and families. The training required to effectively disseminate and sustain evidence-based treatments (EBTs) tends to be more intensive, longer-term, often employing learning collaborative or other methodologies that engage organizational senior leaders, clinicians, and family partners in one collective learning experience. As a result, distinct lines of funding (e.g., grant funds, differentially higher reimbursement rates) often are needed to support EBT implementation. Other EBPs include screening for common behavioral health conditions in schools, primary care, and other settings and systems and implementation of measurement-based care approaches[25,26]. While EBTs and EBPs are important parts of the service array, community-based and culturally specific practices and innovations are always being developed and delivered alongside EBTs and EBPs. Systems must have the capacity to support these innovative practices with data collection and outcomes evaluation to ensure they meet the system's standards for quality, and that they are leading to positive, equitable outcomes. Investing in innovations and best practices in this manner may move some of these interventions closer to meeting requirements to be considered evidence based. Table 4 describes workforce development, training, and coaching in effective practices and offers several suggested implementation activities.

Data and quality improvement mechanisms

Systems and services must be guided by consistent and reliable data collection, analysis, reporting, quality assurance (QA), quality improvement (QI), and outcome evaluation strategies. In some systems, very little data is collected. In others, much data is collected but is underutilized for improving quality and outcomes. The north star for system stakeholders is to ensure equitable access, quality, and outcomes of each behavioral health service, and for the system. Frequently, provider electronic health records are insufficient for these purposes. To address this, some states have invested in data systems and require their contracted behavioral health provider network to submit data on services delivered[27]. State and local systems need to provide sufficient resources to providers for data collection and entry, with a focus on protecting confidentiality, collecting the

Table 5 | Data and quality improvement mechanisms

Infrastructure category	Brief description and suggested implementation activities
Data and quality improvement mechanisms	Description. State systems and individual services must be guided by consistent and reliable data collection, analysis, reporting, quality assurance, quality improvement, and outcome evaluation. States should consider investing in a data system that supports these functions and promotes equitable access, quality, and outcomes of care. State systems should provide sufficient resources to providers for data collection and entry, with a focus on protecting confidentiality, collecting the minimum necessary information for QA, QI, and outcomes evaluation, and avoiding inefficiency and duplicate data entry whenever possible. All activities related to data must comply with all relevant federal and state laws and best practices relating to privacy, security, and informed consent. Suggested Implementation Activities • Support all services in the array with robust data, collecting the minimal amount of data necessary to ensure equitable access, quality, and outcomes of care for individual services and the system as a whole. • Develop internal or externally contracted capacity for data analysis, reporting, quality assurance, quality improvement, and outcomes evaluation activities. • Ensure data comply with all relevant legal and regulatory requirements to protect the security and confidentiality of protected health information and other sensitive data. • Collect socio-demographic data to enable disaggregation leading to identification and reduction of identified disparities. • Avoid the data “black hole.” Any data that are collected should be analyzed and reported back to providers and used to support QA/QI activities. • Share aggregated and de-identified data with families and the public to promote accountability and trust. • Establish the capacity to link data across services and across systems to examine system throughput and identify need for tailored interventions to improve outcomes and reduce inefficiencies for youth with high clinical complexity and multi-system involvement. • Create system-level dashboards populated with categories and indicators related to overall system functioning (e.g., prevalence, service access, workforce, quality, system-level outcomes). Ensure the ability to link system-level data with service-level data to continually inform improvements at both levels.

minimum necessary information for QA, QI, and outcomes evaluation purposes, and avoiding inefficiency and duplicate data entry whenever possible.

Each service in the array must collect sufficient data to be able to examine whether equitable access, quality, and outcomes of care are being achieved. Socio-demographic data representing multiple dimensions of diversity allow for data disaggregation that reveals disparities in need of correction. Collecting the data is not enough. Systems must invest in the capacity to analyze, report, and use those data to provide QA, QI, and technical assistance to providers to improve overall access, quality, and outcomes for all, and to address any identified disparities. Systems should have the capacity to disaggregate data at the individual provider level as well and share it transparently with system stakeholders, which promotes accountability and public trust. Youth and families often participate in more than one service over time. Ideally, systems will have the ability to link data across services and systems, examine how youth move through the system, and identify opportunities for improving efficiency and outcomes.

In addition to using data to support and improve individual services, states should track and transparently report indicators that reflect the overall functioning of the system. Some system-level data monitoring approaches focus on distinct issues such as wait lists or uptake of EBTs, but few comprehensive systems exist. System-level data categories, each of which could include multiple indicators, may include prevalence of need, access to services, workforce, service quality, and system-level outcomes (emergency department (ED) volume, inpatient admission rates, discharge delays, waitlists, costs, etc.). Frequently, system-level indicators come from more than one system, which may suggest opportunities for integrating funding, service delivery, and data. As with data and QI processes at the service level, an equity lens should be incorporated whenever possible for system-level data collection and analysis.

System-level data dashboards have the potential to link with and yield critical insights into the service array. Monitoring wait lists, for example, can reveal the need for increased investment to increase capacity in one or more services. Identifying high rates of ED utilization among youth may reveal the need for increased investment in community-based services that divert from ED utilization, such as Mobile Response and Stabilization Services[28]. Examining rates of discharge delay from inpatient hospitalization, and the factors related to those delays (e.g., clinical complexity, multi-system involvement, waitlists for the recommended next level of care) can lead to expanding intermediate levels of care, improving system throughput[29]. Monitoring the service utilization patterns of youth with high degrees of clinical complexity and need can help in the design of tailored interventions for this population to increase access, reduce unnecessary costs, and improve outcomes. Table 5 describes data and quality improvement mechanisms and offers several suggested implementation activities.

The role of public–private partnership and intermediary organizations in addressing infrastructure needs

Public systems rarely perform all necessary infrastructure functions on their own. Returning to the example of the transportation system, a state department of transportation generally does not possess the workforce or the technical expertise to develop, operate, and maintain the entire system. Rather, they partner with a network of private sector contractors to accomplish their work. Once again, the behavioral health system is similar. States may develop and operate some parts of the service delivery system (e.g., state-operated psychiatric hospitals), and some parts of the infrastructure; however, they commonly supplement their own capabilities with a network of outside organizations that possess the technical and operational expertise to develop and implement other areas of service delivery and infrastructure.

States often turn to intermediary organizations to help them address system infrastructure needs[30]. Intermediaries can be housed within university departments, where they may be referred to as Centers of Excellence, independent non-profit organizations, or private for-profit consulting groups[31]. The literature on intermediary organizations largely grew out of the discipline of EBT dissemination and implementation science; however, the role of many intermediary organizations today extends well beyond those functions. Intermediary organizations are generally not involved in direct service delivery; rather, they possess skill and expertise in consultation, technical assistance, training, data analysis, QA, QI, policy analysis and development, dissemination and implementation science, best practice model development, and other areas[32]. Thus, the functions and technical skills of an intermediary overlap significantly with the essential infrastructure elements described in this paper. In fact, the case can be made that the core function of an intermediary organization is to support infrastructure development, using the variety of approaches and technical skills described above. Several infrastructure functions may come together in one intermediary organization, which can be an efficient approach for state systems. It is more common for the full complement of infrastructure supports to be provided by several intermediary organizations, ideally in

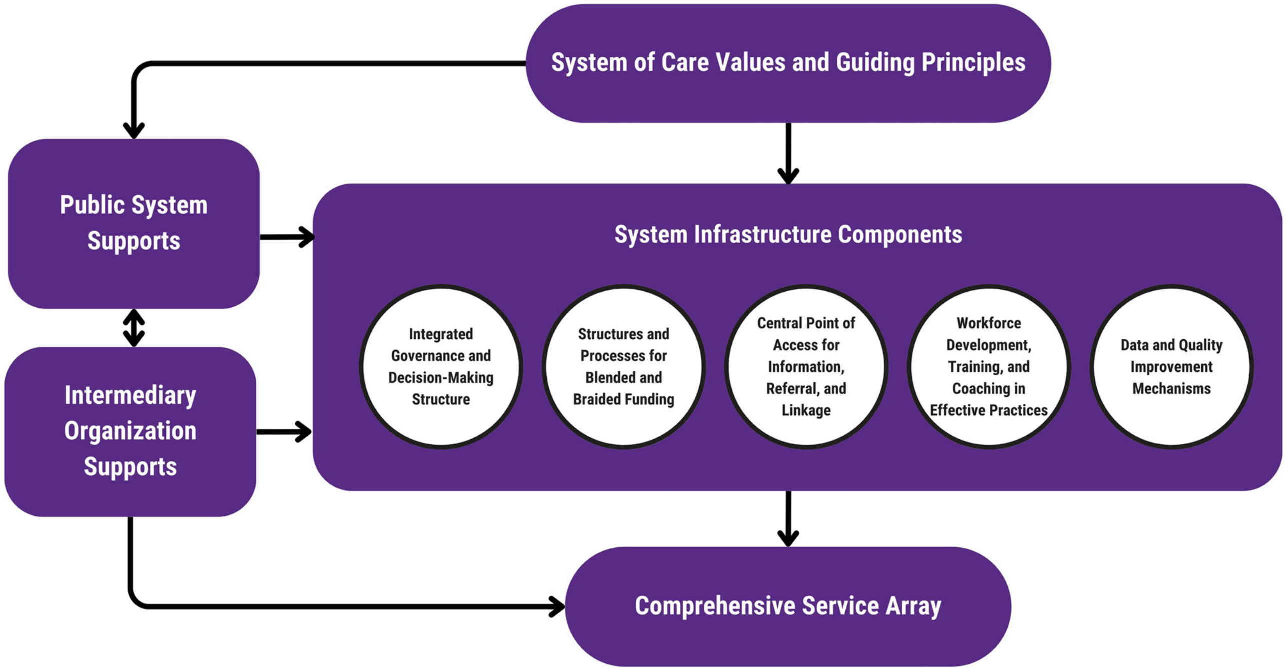


Fig. 1 | System of care infrastructure components.

coordination and collaboration with one another and with the public system. Figure 1 displays each of the five proposed system of care infrastructure components, their relationship to public systems and intermediary organizations, and their proposed function as a linkage between system of care values and the comprehensive service array.

In addition to the technical skills and capabilities described above, intermediary organizations, whether they are operated within the public or private sector, must possess additional adaptive skills to be successful in their role. First, they must be expert conveners. Intermediary organizations are generally legally and operationally independent of the public behavioral health agency or agencies (e.g., a department of mental health) and independent of the direct service provider network. This affords an intermediary organization some degree of objectivity and neutrality to convene and guide a diverse group of system stakeholders. Intermediaries may regularly convene and support the project management needs of the integrated governance and decision-making structure described above. Leadership, credibility, and the ability to establish trust and buy-in are essential adaptive skills for effective convening.

Second, intermediary organizations must have significant subject matter, consultation, and communications expertise. Effective intermediary organizations should be staffed by individuals with deep knowledge and experience across multiple dimensions of the behavioral health system including policy, finance, system change, direct service delivery, data analysis, project management, and others. The intermediary organization must itself espouse the system of care values and principles guiding the entire system. Using reliable and valid sources of data and information, the expert intermediary can translate findings into comprehensive reports with actionable recommendations that articulate measurable goals, objectives, and strategies. Intermediary organizations should be highly capable grant writers and involved in bringing additional resources into the system to support their own infrastructure development activities as well as to expand and improve the service array. Intermediary organizations should be staffed by highly effective communicators who can speak and write in ways that are understandable, relevant, persuasive, and actionable to the diverse stakeholder audiences involved. Intermediary organizations often have deep expertise in policy analysis and development and can help to ensure an enabling state policy context that contributes to optimal system functioning.

Intermediary organizations with the technical and adaptive skills described above may ultimately become long-term partners in the system, rather than short-term consultants. The information and data from convening and consultation often results in detailed plans to address various needs in the system which are then implemented over a sustained timeframe. Implementation of the recommendations of those plans, particularly those recommendations directly related to implementing essential system infrastructure, may then become the ongoing work of the intermediary organization. Table 6 includes examples of intermediary organizations across the U.S. who are significantly or solely involved in developing and implementing children's behavioral health system infrastructure.

Conclusions and future directions

Scholarship and research on systems of care propose infrastructure as one of its three primary components and as a bridge between the values and principles of the system of care and the comprehensive service array. To date, however, the existing definitions, descriptions, categorizations, and prioritizations of behavioral health system infrastructure have been insufficient for guiding system stakeholders. It is possible that lack of development and implementation of critical system infrastructure is one of the reasons children's behavioral health interventions are not sufficiently scaled and sustained, and systems do not produce better outcomes for the children and families they are designed to serve. This paper set out to define infrastructure, categorize and describe five of its most essential elements, and identify effective approaches for promoting infrastructure development, including through public–private partnership with one or more highly skilled intermediary organizations.

Funding for dissemination and implementation research has been historically limited[33]. Glasgow et al. calls for a shift in investment from research on discovery and efficacy, toward research that examines the effectiveness of interventions in practical settings, and the most effective dissemination and implementation approaches for scaling and sustaining those interventions[34]. System infrastructure is a critical element in scaling and sustaining an array of effective interventions and ensuring this service array is accessible, is implemented with the highest quality, and produces better outcomes. There are several future directions for scholarship and

Table 6 | Examples of intermediary organizations

Intermediary organization	Brief description
Child Health and Development Institute (Connecticut) www.chdi.org	The Child Health and Development Institute advances effective and innovative system, practice, and policy solutions that result in equitable and optimal behavioral health and well-being for children, youth, and families in Connecticut and beyond.
Center for Evidence to Practice (Louisiana) https://laevidencetopractice.com/	The Center for Evidence to Practice was created in hopes of bridging gaps and bringing more evidence-based behavioral health practices to communities across the state of Louisiana.
The Baker Center for Children and Families (Massachusetts) https://www.bakercenter.org/	The Baker Center for Children and Families promotes the best possible mental health of children and families through the integration of research, intervention, training, and policy.
Center for Innovative Practices (Ohio) https://case.edu/socialwork/begun/consultation-and-training/center-innovative-practices-cip	The Center for Innovative Practices is a training and technical assistance center providing support to community-based agencies that seek to implement interventions that improve outcomes for youth and families.
Meadows Mental Health Policy Institute (Texas) https://mmhpi.org/	The Meadows Mental Health Policy Institute works at the intersection of policy and programs to create equitable systemic changes so all people in Texas, the nation, and the world can obtain the health care they need.
Center for Evidence-Based Partnerships (Virginia) https://www.cep-va.org/	The Center for Evidence-Based Partnerships builds partnerships with stakeholders in public and private organizations to leverage collective support and effort for initiatives designed to improve access to behavioral health services in the Commonwealth.
CoLab for Community and Behavioral Health Policy (Washington) https://uwcolab.org/	The CoLab reimagines how evidence can be integrated with community expertise to spark creative and sustainable change in behavioral health policy and systems, particularly those involving youth and families.

research on system-level behavioral health infrastructure that would help to establish a more mature understanding of system infrastructure, framed below as a series of interrelated questions that can guide future research in this area.

- Validity of proposed infrastructure elements. What infrastructure elements are currently in place in state systems? Are the proposed infrastructure elements viewed as valid among implementation scientists and practitioners and other system stakeholders? Are the five proposed infrastructure elements consistently present in high-performing systems?
- Determining and assessing stages of infrastructure development. What are the stages of development for each infrastructure element? In each area, what characterizes early, intermediate, and mature development? What are the costs associated with infrastructure development and how do public systems pay for it? What are the factors that relate to advancing development of each infrastructure element over time? Can stages of infrastructure development be validly and reliably measured in a way that is sensitive to change over time?
- The role of public private partnership in infrastructure development. In what ways have public systems collaborated with and supported intermediary organizations and other partners to develop key infrastructure elements? In what ways are intermediary organizations and other partners involved in deploying infrastructure? What are the characteristics of intermediary organizations, and the partnerships they have with public systems, that lead to optimal development and deployment of infrastructure?
- Impact of infrastructure development. Does the presence and/or quality of each key infrastructure element relate to better knowledge, awareness, and expression of system of care values and principles among key system stakeholders? Does the presence and/or quality of each key infrastructure element relate to more comprehensive and effective service arrays? Does the presence and/or quality of each key infrastructure element relate to better outcomes for youth and families?

Data Availibility

No datasets were generated or analysed during the current study.

Received: 27 February 2024; Accepted: 1 November 2024;
Published online: 14 November 2024

References

1. Benton, T. D., Boyd, R. C. & Njoroge, W. F. Addressing the global crisis of child and adolescent mental health. *JAMA Pediatr.* **175**, 1108–1110 (2021).
2. Bitsko. et al. Surveillance of children's mental health - United States, 2013-2019. *Morbidity Mortal. Wkly. Report.* **71**, 1–42 (2022).
3. Perou, R. et al. Mental health surveillance among children: United States, 2005-2011. *Morbidity and Mortality Weekly Report*. Centers for Disease Control and Prevention (2013).
4. Pumariega, A. J. et al. Trauma and US minority children and youth. *Curr. Psychiatry Rep.* **24**, 285–295 (2022).
5. Bor, W., Dean, A. J., Najman, J. & Hayatbakhsh, R. Are child and adolescent mental health problems increasing in the 21st century? a systematic review. *Aust. N.Z. J. Psychiatry* **48**, 606–616 (2014).
6. Ghafari, M., Nadi, T., Bahadivand-Chegini, S. & Doosti-Irani, A. Global prevalence of unmet need for mental health care among adolescents: a systematic review and meta-analysis. *Arch. Psychiatr. Nurs.* **36**, 1–6 (2022).
7. Hoge, M. A. et al. Emergency department use by children and youth with mental health conditions: a health equity agenda. *Community Ment. Health J.* **58**, 1225–1239 (2022).
8. Melek, S., Davenport, S. & Gray, T. J. *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Milliman, 2019). http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf
9. Crocker, K. M. et al. The impact of COVID-19 on the mental health workforce: A rapid review. *Int J. Ment. Health Nurs.* **32**, 420–445 (2023).
10. Whitney, D. G. & Peterson, M. D. US national and state-level prevalence of mental health disorders and disparities of mental health care use in children. *JAMA Pediatrics.* **173**, 389–391 (2019).
11. Reinert, M., Fritze, D., & Nguyen, T. *The State of Mental Health in America 2022*. Mental Health America, Alexandria, VA (2021).
12. Compton, W. M. et al. Charting a course for health services research at the National Institute on Drug Abuse. *J. Subst. Abus. Treat.* **29**, 167–172 (2005).
13. Stroul, B., Blau, G. & Friedman, R. *Updating the System of Care Concept and Philosophy*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health (2010).

14. Stroul, B. A., Blau, G. M. & Larsen, J. *The Evolution of the System of Care Approach*. The Institute for Innovation and Implementation, School of Social Work, University of Maryland (2021).
15. Stroul, B. & Le, L. *Rating Tool for Implementation of the System of Care Approach for Children, Youth, and Young Adults with Behavioral Health Challenges and their Families: Guide for Self-Assessment*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health (2017).
16. Ferreira, K., Hodges, S. & Slaton, E. The Promise of Family Engagement: An Action Plan for System-Level Policy and Advocacy. In *Child and Family Advocacy. Issues in Clinical Psychology* book series (ed. Culp, A.). 253-268 (Springer, 2013).
17. Hoagwood, K. E., Kelleher, K., Counts, N. Z., Brundage, S. & Peth-Pierce, R. Preventing risk and promoting young children's mental, emotional, and behavioral health in state mental health systems. *Psych. Svcs.* **72**, 311–316 (2020).
18. Evans, E. J. The no-wrong-door approach: antidote to the boundaries within the American welfare state. *Health Soc. Work.* **44**, 8–12 (2019).
19. Innovations Institute, University of Connecticut School of Social Work. *Mobile Response & Stabilization Services National Best Practices*. In Partnership with Child Health and Development Institute (2022).
20. National Alliance on Mental Illness (Retrieved February 23, 2024). 988 Crisis Response State Legislation Map. https://reimaginecrisis.org/map/
21. Morse, G. A. & Dell, N. A. The well-being and perspectives of community-based behavioral health staff during the COVID-19 pandemic. *Soc. Work Health Care,* **60**, 117–130 (2021).
22. Wyse, R. et al. Diversity by race, ethnicity, and sex within the U.S. psychiatry physician workforce. *Acad. Psychiatry* **44**, 523–530 (2020).
23. Kelly, A., Hoge, M. & Lang, J. *Strengthening the Behavioral Health Workforce for Children, Youth, and Families*. Child Health and Development Institute (2023).
24. Lyon, A. R. et al. Developing the Mental Health Workforce: Review and Application of Training Approaches from Multiple Disciplines. *Adm. Policy Ment. Health* **38**, 238–253 (2011).
25. President's New Freedom Commission on Mental Health. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Pub. No. SMA-03–3832. Rockville, MD: U.S. Department of Health and Human Services (2003).
26. Jensen-Doss, A. et al. Measurement-based care as a practice improvement tool: clinical and organizational applications in youth mental health. *Evid.-Based Pract. Child Adolesc. Ment. Health* **5**, 233–250 (2020).
27. Seibert, J. et al. Use of quality measures for Medicaid behavioral health services by state agencies: implications for health care reform. *Psych. Svcs.* **66**, 585–591 (2015).
28. Fendrich, M. et al. Impact of mobile crisis services on emergency department use among youths with behavioral health service needs. *Psych. Svcs.* **70**, 881–887 (2019).
29. Kelly, A., Childs, A. W., & Lang, J. *Intermediate Levels of Care for Children with Behavioral Health Needs*. Child Health and Development Institute (2024).
30. Franks, R. P. & Bory, C. T. Strategies for developing intermediary organizations: considerations for practice. *Families Soc.* **98**, 27–34 (2017).
31. Mettrick, J., Harburger, D. S., Kanary, P. J., Lieman, R. B. & Zabel, M. *Building Cross-System Implementation Centers: A Roadmap for State and Local Child Serving Agencies in Development Centers of Excellence (COE)*. The Institute for Innovation & Implementation, University of Maryland (2015).
32. Franks, R. P. Role of the intermediary organization in promoting and disseminating mental health best practices for children and youth: The Connecticut Center for Effective Practice. *Emot. Beh. Disord. Youth* **10**, 87–93 (2010).
33. Purtle, P., Peters, R. & Brownson, R. C. A review of policy dissemination and implementation research funded by the National Institutes of Health, 2007-2014. *Implement. Sci.* **11**, 1–8 (2015).
34. Glasgow, R. E. et al. National institutes of health approaches to dissemination and implementation science: current and future directions. *Framing Health Matters* **102**, 1274–1281 (2012).

Acknowledgements

This paper was not supported by any external funding.

Author contributions

J.V. devised the project and outline and contributed all of the writing and critical revisions.

Competing interests

The author declares no competing interests.

Additional information

Correspondence and requests for materials should be addressed to Jeffrey J. Vanderploeg.

Tow Youth Justice Institute
Making connections. Informing solutions.

System Infrastructure Workgroup May Meeting Summary

May 10th, 2025
3:00 PM – 4:30 PM
Web Based Meeting- Zoom

Attendance

Alice Forrester
Jason Lang
Jeff Vanderploeg
Robyn Hoffman
Howard Sovornsky
Jennifer Nadeau
Gary Blau
Melissa Whitson
Katelyn Galbraith
Aishwarya Sreenivasan
Tammy Venega
Andrea Goetz
Victoria Stob
Judith Meyers

TYJI Staff

Emily Bohmbach
Jackie Marks
Stacey Olea
Erika Nowakowski

Meeting Objectives:

- Introduction
- Systems of Care Presentations
- Q&A

Meeting Summary:

1. **Introduction**
    a. Co-chairs, TCB staff, and members of the group all introduced themselves, their roles, and organizations.
    b. A workgroup co-chair gave a brief overview of the presentations on Systems of Care, which include what is a system of care, what is the system of care in Connecticut, what is the history, and where we are currently.
2. **Systems of Care Presentations**
    a. The first presenter introduced themselves, and their background with Systems of Care in Connecticut. The presenter addressed that they would touch upon improving child youth and family mental health through systems of care.
        i. The presenter gave a brief background on the national crisis of children's behavioral health and then proceeded to provide an overview of Systems of Care across the country.
        ii. The presenter provided a definition of what systems of care is, which they described to be "*A Spectrum of effective, community based- services and supports for children and youth with or at-risk for mental health or other challenges in their families. The System is designed to help families function better at home, in school, in the community, and throughout life.*"

        iii. The presenter then provided an overview of Connecticut being a national leader, through widespread dissemination of evidence-based practices, crisis services, engagement with families, and DCF's BH Data System, the Provider Information exchange (PIE).
        iv. The Presenter then touched upon continuing to transform the System of Care, through expanded School-Based and School Linked Services, fully scale systems of care, expanding the workforce, and through data for measurement based & outcome driven care.
    b. The second presenter gave an overview of their background working with Systems of Care in CT, and provided an overview of their presentation which was focused on highlighting key achievements in children's mental health reform in Connecticut.
        i. The presenter provided an overview of the milestones in children's mental health reform in Connecticut, which started in 1975 through the state establishing a consolidated children's agency, DCF.
        ii. The presenter then provided an overview of key findings of delivering and financing Children's Behavioral Health Services in CT – the data is reflective of the year 2000. Additionally, the presenter touched upon the recommendations that came out of the 2000 Report, which include:
            1. Expand and enhance local systems of care
            2. Build a richer array of community-based services
            3. Develop a statewide family support network
            4. Develop and implement a blended funding approach
            5. Develop measurable outcomes
            6. Conduct trainings
            7. Improve Information systems
            8. Conduct a thorough evaluation
        iii. The presenter then provided an update on progress in system reform from the years 2001-2010, which includes Connecticut Community Kid care, new statewide services, and community collaboratives. The presenter then touched upon Public Act 13-178, which provided key principles that support an effective system of mental health care.
        iv. Lastly, the presenter gave an overview of progress in systems reform from the years 2014-2024 in Connecticut, highlighting Trauma Informed Systems of Care (TF-CBT), EBT's quality improvement systems, school mental health trainings, new programs such as UCC's and integrated behavioral health and primary care.
    c. The last presenter identified that they will be discussing the Systems of Care movement in CT, where we stand today, and what is left to do.

      - i. The presenter went over the question of *when you think about systems of care, what do you think of* and identified that they think about this in three primary categories, which includes, values and principles of the system, the comprehensive services array, and infrastructure.
        1. The presenter identified that you will see values and principles within services and in the legislation mentioned throughout the call throughout the last twenty years.
        2. The presenter then touched upon the second focus; the services array. The presenter noted that CT has great services and touched upon the few things that could be done to improve outcomes, such as integrating behavioral health service delivery by addressing health and social determinants of health. The presenter identified that another area that stands out in the services array is ongoing behavioral health emergency department visits. Additionally, the presenter touched upon the future directions of the service array, which includes school mental health, pediatric, primary care, and behavioral health integration. Additionally, the presenter touched upon innovation.
        3. Lastly, the presenter touched upon infrastructure, and provided a definition of infrastructure to the group, *"System level structures and process processes for actualizing the system of care value and principles and scaling and sustaining an effective service rate."*
        4. The presenter then touched upon what we mean by infrastructure, which includes integrated governance and decision- making, structures and processes for blending and braiding funding, central point of access for information referral linkage, workforce development training and effective practices, and data and quality improvement.

3. **Q&A**
   - a. The floor was opened to the workgroup for questions for the presenters.
     - i. Workgroup members provided questions to the workgroup such as how do we accurately measure Connecticut's System of Care – *if we wanted to take a high-level view and assessment, how would we do that?*
       1. A presenter responded that there are systems of care fidelity measurements so that people can utilize it – the presenter additionally highlighted that PRPDQ 9 could be utilized to evaluate. The presenter noted that the key to this is there is a systematic way of capturing the data.
          - a. More discussion was had between workgroup members and presenters.

   ii. An additional workgroup member posed a question to the presenters around school behavioral health services going further, and asked what the presenters see in the sense of enhancements and improvements in that system?
      1. Discussion was had amongst multiple members and presenters within the workgroup.
   iii. An additional comment was provided to the workgroup, stating that *"1 in 5 children have Mental Health and 1 in 6 have developmental disabilities how do we ensure individuals with IDD and other disabilities are included in the work of supporting children and families with children with behavioral health needs. Especially since evidence-based support does not include this population."*
      1. Discussion was had amongst workgroup members and presenters.
   iv. A question was put in the chat that inquired if there are any other states/jurisdictions that have successfully decreased the 1 in 5 statistics of youth with diagnosable BH concern? If so, what was their approach?
      1. A presenter identified that there has been a consistent prevalence rate for years, and that it is due to many factors, and that you cannot look at just one.
   v. Lastly, a workgroup member commented on early childhood, and that there has not been much progress as people are unable to find and locate services.

Next meeting: July 15th, 2025, 3:00-4:30 PM ZOOM