WISCONSIN CHILDREN'S SYSTEM OF CARE SUMMIT

Companion Guide

April 25-26, 2023

Jefferson Street Inn

Wausau, Wisconsin

Wisconsin Children's System of Care Vision

Children and families are valued, understood, and supported in their communities

Agenda Day One

Registration ..... 8:00 a.m. - 9:00 a.m.

Welcome/Opening Remarks
Monica Caldwell and Jessica Smith ..... 9:00 a.m. - 9:20 a.m.
Assistant Deputy Secretary Sarah Valencia ..... 9:20 a.m. - 9:35 a.m.

History of the Children's System of Care in Wisconsin ..... 9:35 a.m. - 10:00 a.m.
Jason Cram and Lori Martin

Where is the Wisconsin Children's System of Care now? ..... 10:00 a.m. - 10:10 a.m.
Elizabeth Waetzig

Keynote Presentation ..... 10:10 a.m. - 11:10 a.m.
Gary Blau

Break ..... 11:10 a.m. - 11:30 a.m.

Wisconsin Children's System of Care 2023 Champion Award ..... 11:30 a.m. - 11:45 a.m.
Kia Kjensrud and Phil Robinson

Inspiration through Engage, Equip, Empower ..... 11:45 a.m. - 12:30 p.m.
Jacarrie Carr and Maliya Xiong

Lunch ..... 12:30 p.m. - 1:30 p.m.

Wisconsin Children's System of Care Core Components - Philosophy, Infrastructure, Array of Services and Supports ..... 1:30 p.m. - 3:15 p.m.
Phil Robinson, Laura Gebhardt, Lauren Vargo, Evelyn Clark, Elizabeth Waetzig, Rebecca Green Blanks, Sharlen Moore, The Honorable Judge Everett Mitchell

Break ..... 3:15 p.m. - 3:35 p.m.

Wisconsin Children's System of Care Core Components - continued
Lauren Vargo, Eveyln Clark, Laura Gebhardt, Elizabeth Waetzig, Robert Kaminski, Marin Webster Denning ..... 3:35 p.m. - 4:20 p.m.

Tying it all Together - Prepare for Tomorrow ..... 4:20 p.m. - 5:00 p.m.
Monica Caldwell and Elizabeth Waetzig

End of Day One ..... 5:00 p.m.

Agenda Day Two

Registration *Find your table assignment*	8:00 a.m. - 8:30 a.m.
Welcome and Reflection	8:30 a.m. - 9:00 a.m.
Ground Truths	9:00 a.m. - 9:30 a.m.
Defining the Outcomes	9:30 a.m. - 10:00 a.m.
Break	10:00 a.m. - 10:15 a.m.
Keep, Drop, Create	10:15 a.m. - 11:15 a.m.
Drumming Circle *Bizhiki Culture & Dance Company*	11:15 a.m. - 11:45 a.m.
Lunch	11:45 a.m. - 12:45 p.m.
Work Plans	12:45 p.m. - 2:30 p.m.
Break	2:30 p.m. - 2:45 p.m.
Gallery Walk and Feedback	2:45 p.m. - 4:00 p.m.
Report, Reflect, Commitment, Evaluation	4:00 p.m. - 4:45 p.m.
Wrap Up	4:45 p.m. - 5:00 p.m.
End of Day Two	5:00 p.m.

Table of Contents

The Wisconsin Department of Health Services invites you to stay connected with the Wisconsin Children's System of Care.

This booklet and other resources are available at www.dhs.wisconsin.gov/csoc.

Land Acknowledgment

Today we gather in lands referred to as "Wausau", an Ojibwe name anglicized from "Waasa" or "far away place," These lands were rich in natural resources. To honor our First Nations relatives and this land, we have the privilege and responsibility to acknowledge the Indigenous people who have called this land home for centuries and generations, as we gather for this Children's System of Care Summit. This acknowledgment recognizes the tribal space we occupy. By doing so, we encourage all to embody the strong commitment to collaborate and partner with the sovereign tribal nations located within the territorial boundaries of what can be referred to as Wisconsin. 12 tribal nations call this land home.

- Bad River Band of Lake Superior Chippewa
- Brothertown Indian Nation
- Forest County Potawatomi
- Ho-Chunk Nation
- Lac Courte Oreilles Band of Lake Superior Chippewa
- Lac du Flambeau Band of Lake Superior Chippewa
- Menominee Indian Tribe of Wisconsin
- Oneida Nation
- Red Cliff Band of Lake Superior Chippewa
- Mole Lake (Sokaogon Chippewa Community) Band of Lake Superior Chippewa
- Saint Croix Chippewa Indians of Wisconsin
- Stockbridge-Munsee Community Band of Mohican Indians

Wellness Corner

Be Gentle on Yourself

- Breathe
- Self empathy
- Positive self-talk
- Count to ten
- Use fidgets
- Feel feet on floor
- Doodle
- Get up and walk around
- Take a break at the Wellness Corner

STATE *of* WISCONSIN

OFFICE *of the* GOVERNOR

Proclamation

WHEREAS; kids in Wisconsin with mental health and substance use challenges rely on collaboration between their families and service providers, schools, community supports, and county, state, and Tribal agencies to provide an effective system of care; and

WHEREAS; an increase in the number of young people experiencing mental health and substance use challenges in recent years has only amplified the need to strengthen the capacity of the state's system of care and to ensure that services and supports are effective, family- and youth-driven, community-based, and culturally and linguistically appropriate; and

WHEREAS; now is the time for all system of care partners to come together and commit to enhancing the provision of services and supports to kids experiencing mental health and substance use disorders; and

WHEREAS; the Wisconsin Department of Health Services (DHS), in partnership with systems of care across the state, has identified the strengths and needs of the state's system of care; and

WHEREAS; organized by DHS, the Children's System of Care Summit taking place April 25 – 26, 2023, is an opportunity for leadership from each partner group—including kids and their families—to collaborate on the next steps to build a system of care that works for all kids in the state; and

WHEREAS; this week, the state of Wisconsin joins DHS and all system of care partners in raising awareness of the importance of supporting kids across the state, especially those experiencing mental health and substance use challenges;

NOW, THEREFORE, I, Tony Evers, Governor of the State of Wisconsin,
do hereby proclaim April 23 – 29, 2023, as

CHILDREN'S SYSTEM OF CARE WEEK

throughout the State of Wisconsin and I commend this observance
to all our state's residents.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this 24th day of March 2023.

TONY EVERS
GOVERNOR

By the Gove[illegible]:

SARAH GODLEWSKI
Secretary of State

Acknowledgments

System of Care Workgroup

Bobbie Jo Disch
Wisconsin Department of Health Services

Emma McGovern
Youth Advocate - Computer Science Student

Gregg Curtis
Wisconsin Department of Health Services

Hugh Davis
Wisconsin Family Ties

Jacarrie Carr
Kicks for Kids

Jill Ellinwood
Sauk County Human Services

Kenya Bright
Wisconsin Department of Health Services

Kia Kjensrud
Wisconsin Chapter of the American Academy of Pediatrics

Laura Gebhardt
Wisconsin Department of Health Services

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White Pine Consulting

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Wisconsin Department of Health Services

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Philip Robinson
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Disability Rights Wisconsin

Samantha Feryance
Lutheran Social Services

Zachary Todd
Wisconsin Department of Health Services

Change Matrix

Elizabeth Waetzig

Evelyn Clark

Lauren Vargo

Wisconsin Department of Health Services

Jason Cram

Danielle Graham-Heine

Ann Kelley-Kuehmichel

Shana Martindale

Sally Raschick

UW-Whitewater's Center for Inclusive Transition, Education & Employment

Brenda Johansen

Heather Lee

Kristen Malach

Jessica Smith

The Wisconsin Children's System of Care Summit is a project of the Wisconsin Department of Health Services under funding provided through the Community Mental Health Services Block Grant 93.958 as part of the American Rescue Plan Act.

Presenter Bios

Monica Caldwell

Monica is a School Mental Health Consultant with the Department of Public Instruction. She has been a social worker for thirty-five years, with half of her career in child welfare/mental health positions, and the other half in schools. She is a strong advocate for youth and family-driven practices that encourage us to have greater impact through collaboration at all levels. She is excited about DPI's updated School Mental Health Framework that guides districts and their partners to provide a comprehensive continuum of supports that will enhance the well-being and resilience of children, families, and educators in the communities where we live, work and play.

Jessica Smith

Jessica Smith, MSW, CAPSW is the Director and Co-Founder of the Center for Inclusive Transition, Education and Employment (CITEE) at UW-Whitewater. She has dedicated her career as a macro practice-focused social worker to advancing the equity and inclusion for people with disabilities and mental illnesses. She has spent the past 9 years building CITEE at UW-Whitewater, including growing a statewide team of nearly 20 professionals, as well as students and interns across numerous statewide grant projects, including several long-term projects through Wisconsin's Departments of Health Services, Public Instruction, and Workforce Development and SAMHSA. Jess holds a Masters of Social Work from the University of Wisconsin - Madison and is a licensed advanced practice social worker. She also completed the MCH Leadership Education in Neurodevelopmental and other Disabilities (MCH LEND) with an autism enhancement, at the Waisman Center during graduate school.

Jason M. Cram

Jason is the Children, Youth, and Family Section Supervisor for the State of Wisconsin – Department of Health Services. Jason and his team administer contracts with tribes, counties, and agencies to deliver high-quality behavioral health services to the children, youth, and families across Wisconsin. The CYF team provides consultation, training, and technical assistance across the state on topics including systems of care, children with complex care needs, wraparound, first episode psychosis, youth crisis, primary prevention, and peer supports. Jason's passion is large-scale system evaluation, implementation, and development. Jason holds a master's degree in Public Administration. He has been in the human services field for over 30 years and has been with the State of Wisconsin for 18 years.

Lori Martin

Lori Martin is Co-Director of White Pine Consulting Service. She brings 25 years' experience supporting the development, expansion, and sustainability of wraparound systems of care in Wisconsin. In partnership with the Wisconsin Department of Health Services, Lori and her team provide statewide training to counties and tribes with Coordinated Services Team Initiatives. Lori also coordinates training and quality assurance efforts for a six-county regional Comprehensive Community Services program.

Elizabeth Waetzig, JD

Ms. Waetzig is a Founding and Managing Partner with Change Matrix, LLC, a minority- and women-owned small business that motivates, manages and measures change to support systems that improve lives. She partners with individuals, organizations and systems as they define, create, measure, and sustain change. She brings substantive experience in the areas of children's mental health, a public health approach to mental health, early childhood systems, culturally responsive and equitable evaluation, child welfare, cultural and linguistic competence, conflict engagement, change management, youth engagement and systems building.

Currently Ms. Waetzig serves as the Field Director for the National Technical Assistance and Training Center for the Mental Health of Children, Youth, and Families and serves on the Leadership team for the Early Childhood Systems Technical Assistance Coordinating Center in addition to supporting the work of other training and technical assistance centers. She also co-directs Expanding the Bench and Transforming Academia for Equity.

Ms. Waetzig is particularly focused on leadership in change, has developed a leading through change framework used across multiple initiatives and has managed the Collaboration LAB since 2009 to increase the capacity of individuals and organizations to collaborate, uniquely tailoring support to build their collaborative structure, conflict engagement interventions to repair their structure and coaching to further the growth and learning from training.

Gary M. Blau, PhD

Dr. Gary Blau is a licensed clinical psychologist who serves as the Senior Advisor for Children, Youth and Families at the federal Substance Abuse and Mental Health Services Administration (SAMHSA). He rejoins SAMHSA after spending over fifteen years as the Chief of the Child, Adolescent and Family Branch where he provided national leadership for child, adolescent, and young adult mental health, and helped created "systems of care" across the United States.

Prior to rejoining SAMHSA, Dr. Blau was the Executive Director of The Hackett Center for Mental Health, the first regional center of the Meadows Mental Health Policy Institute. After two highly successful years of growing The Hackett Center, Dr. Blau transitioned into the role of Emeritus Executive Director of The Hackett Center and Senior Fellow for Children's Mental Health for the Meadows Institute. He has also served as the Bureau Chief for Quality Management and Director of Mental Health at the Connecticut Department of Children and Families (DCF), and the Director of Clinical Services for the Child and Family Agency of Southeastern, Connecticut.

Dr. Blau is the recipient of numerous awards, including the Connecticut Governor's Service Award, the Phoebe Bennet Award for outstanding contribution to children's mental health in Connecticut, and the Making a Difference Award presented by Connecticut's Federation of Families for Children's Mental Health. He was also proud that upon the occasion of his leaving Connecticut, the Governor proclaimed December 12, 2003, as 'Dr. Gary Blau Day."

For his national work, Dr. Blau received the HHS Secretary's Award for Meritorious Service for his national leadership in children's mental health, and he was the first recipient of the Rock Star Award, presented by Youth MOVE National for "being a true champion for the youth movement and advocate for youth voice." This award has now been named the "Dr. Gary Blau Professional of the Year Award" and is given annually to a mental health professional who has distinguished themselves as a voice for youth. Dr. Blau has been acknowledged as the "father" of Youth MOVE (Youth Motivating Others through Voices of Experience), which now has over 60 chapters nationwide, and as the "founder" of the "National Building Bridges Initiative (BBI)," which is focused on improving outcomes for youth who receive residential interventions.

Dr. Blau has over 70 professional publications and is the editor of nine books. He currently holds faculty appointments as an Adjunct Clinical Professor at the Menninger Department of Psychiatry and Behavioral Sciences at the Baylor College of Medicine, and as an Adjunct Assistant Professor at the Louis A. Faillace Department of Psychiatry and Behavioral Sciences at the McGovern Medical School at University of Texas Health. He has also held a clinical faculty appointment at the Yale Child Study Center. Dr Blau also serves as Vice Chair, Board of Trustees, for the organization Social Current (which was created from a merger between the National Council on Accreditation (COA) and the Alliance for Strong Families and Communities). Dr. Blau received his B.A. degree in psychology from the University of South Florida (USF), and he was a recipient of the 2021 USF Distinguished Undergraduate Psychology Alumni Award, "In Recognition of Contributions to the Field of Psychology." He received his doctorate from Auburn University.

Philip W. Robinson, LCSW

As Co-Director of White Pine Consulting Service, Phil is excited to support the expansion of collaborative systems of care for the benefit of communities across Wisconsin. He brings a creative eye to the development of team-based interventions; Coordinated Services Teams, Comprehensive Community Services, and Medication Assisted Treatment. His mission is to enable individuals, families and communities to align their assets, heal and grow- with the recovery vision of building a "greenhouse for the mind." Phil has served in leadership roles on the Behavioral Health Policy Advisory Committee for the WI Counties Human Services Association, the Children Come First Advisory Committee, Central WI Health Partnership (CWHP), and contributes ongoing to the State of WI Mental Health Council and the WI Primary Healthcare Association. He enjoys convening groups that improve our continuum of behavioral health services. His philosophy and approach to program integration can be found in the document: Autonomy and Recovery in Community; a Framework for the Integration of Community Mental Health Services. Phil's formal training includes theology, ethics, human sciences, and art. His education comes through lived experience, his children, and their English Setter named Atticus Fetch.

Kia Kjensrud

Kia Kjensrud has been the executive director of the Wisconsin Chapter of the American Academy of Pediatrics (WIAAP) since 2007, helping more than 800 primary care pediatric clinicians across the state care for the health and well-being of all of Wisconsin's children and families. The chapter's key pillars include mental health, early childhood, adolescent health, immunizations and advocacy, including education, legislative, and coalition activities across stakeholder groups. Among WIAAP's most proud achievements are helping establish the creation of the Child Psychiatry Consultation Program (CPCP) and most recently launching the Immunize Wisconsin statewide vaccination coalition. Kia is honored to have served on the Children Come First Advisory Committee since 2014.

She is a graduate of Ripon College (in good company with Lori Martin and Phil Robinson!) and the Université de Paris-Sorbonne. She lives in Oconomowoc, WI, is the proud mom of three children, Nicholas (25), Jack (22), and Ava (18) and enjoys travel, writing poetry and cooking.

Maliya Xiong

Maliya Xiong is a second-generation Hmong American woman who grew up on the north side of Milwaukee and daughter of Hmong refugees. Growing up in a working-class, southeast asian diaspora, she was raised with a strong sense of place-based storytelling from her community. Her identity is rooted in seeing Hmong women and her elders build and rebuild kinship while navigating generational trauma, grief, loss, and displacement.

She completed her masters in Asian American Studies and Public Health at the University of California, Los Angeles. She is passionate about health equity and is committed to uplifting the narratives of communities of color, refugees and women.

She will continue to apply and deepen place-based activism through oral histories and storytelling to raise awareness of different forms of knowledge production and engage in practices to promote health equity.

Jacarrie Carr

Jacarrie is a native of Milwaukee, Wisconsin, and grew up on Milwaukee's north side. Jacarrie grew up around so much negativity, but always told himself that he would not let that stop him from being great. After high school Jacarrie decided to go off to college to the University Of Wisconsin Milwaukee. While attending UWM Jacarrie decided that he wanted to be a community advocate and provide for the underprivileged by providing resources, and workshops to help the youth survive in a world that's constantly changing. After 4 years of college Jacarrie then decided to further his education returning to school for his Master's degree, upon receiving a full ride scholarship continuing at his home town school UWM. Jacarrie graduated May 20, 2018 with his Master's Degree in Cultural Foundations of Education and Community Leadership.

Jacarrie started the Non-profit organization Jacarrie Kicks For Kids in 2013, but became an official 501(c)3 in August 2016. It all started with a little boy with a hole in his shoe. The program began with giving refurbished shoes to underprivileged youth so they can focus on their education and not worry about being bullied. Jacarrie Kicks For Kids is now evolving and is focused on its resource center for youth ages 10-18. The resource center will be an outlet for youth were they can play sports, do arts & crafts, and most importantly attend workshops that will help to increase their self esteem. Jacarrie wants to increase the self esteem of the underprivileged so that they can focus on their education, and gain the right tools to survive in a world that's constantly changing.

In the last 8 years of Jacarrie Kicks For Kids giving shoes away they have gave over 10,000 pair of new and refurbished shoes, book bags with supplies, and free haircuts to less fortunate youth at their annual event before school starts, and helped over 20,000 worldwide. Jacarrie was recently named one of the top 49 influential black males in Wisconsin for 2019, and his organization Jacarrie Kicks For Kids won Nonprofit organization of the year for 2019.
Jacarrie recently partnered his organization with St. Marcus Lutheran and he host Saturday Scholars, Summer Camp, and after school programming. This past 2 summers Jacarrie hosted Summer Scholars Camp hiring 40 high school students, and hosting over 250 students. Besides that Jacarrie works with Jordan Poole of The Golden State Warriors doing community work and giving away scholarships.

Jacarrie Partners with Jordan Poole, The NBPA, and The Milwaukee Bucks. Jacarrie has done projects with Giannis and his family, Jamaal Williams (Lions Running back), Jordan Poole, Scarface, and countless other NBA players, Rappers, and NFL players.

Laura Gebhardt

Laura Gebhardt is a mental health data and evaluation specialist for the Division of Care and Treatment Services within the Wisconsin Department of Health Services. She collaborates with state program coordinator staff to collect and analyze data from various mental health programs administered across Wisconsin.

Laura has 13 years of experience with the state, providing direct services as well as in data analysis and program evaluation capacities. In that time, she has worked for both the Department of Health Services and the Department of Corrections.

Laura earned a bachelor's degree in Zoology from the University of Wisconsin, Madison, and a master's degree in Criminal Justice from the University of Wisconsin, Platteville. Previous to state employment, she taught in various capacities in the public education system.

Lauren Vargo

Lauren Vargo is an Evaluator and Change Consultant with Change Matrix, LLC. Using Culturally Relevant & Equitable Evaluation (CREE) strategies, she has supported the WI SOC work group in gathering feedback from youth, families and tribes through "Sharing Circles". Lauren holds her Masters in Urban Planning & Design and is passionate about contributing to making systems and cities work for the people who live, work and engage in them.

Evelyn Clark

Evelyn Clark is a Mexican-Native American woman passionate about racial equity, leadership development, and peer support. She has nearly 15 years of experience serving young people and their families within systems of care. Evelyn is a change consultant and racial equity trainer at Change Matrix, a women-owned, minority-owned virtual company serving systems nationwide and in U.S. territories. She splits her time between the National Training and Technical Assistance Center for Children, Youth, and Family Mental Health (NTTAC) and the Mental health Technology Transfer Center (MHTTC). Evelyn is a Certified Peer Counselor and a justice-impacted professional. She has dedicated her career to empowering young people and their families to get involved in system reform. She is a proud recipient of the 2019 Peer Alternatives Youth and Young Adult leadership award. In addition, Evelyn is a certified healing circle facilitator through Gloetry Assembly. Her mission is to end racial and ethnic disparities within systems and to promote leadership opportunities for the BIPOC workforce.

Rebecca Green Blanks, MSW, APSW, Pn1

Rebecca is currently a Youth Social Worker/Coordinated Services Teams Coordinator at Oneida Behavioral Health with the Oneida Nation of Wisconsin. She provides advocacy, supporting and skill building with Native Youth and their families.

Rebecca started in the human services field in 2009 and has worked across various systems including legal, State and Federal community-based corrections, alcohol and drug abuse programs, foster care, community and school-based youth services, health and nutrition.

After earning a Bachelors degree in Criminal Justice/Psychology, Rebecca pursued a Master of Social Work degree as well as Precision Nutrition 1 certification. She is a proud member of the National Indian Child Welfare Association and has recently joined the Children Come First Advisory Committee.
Rebecca lives in Green Bay with her husband and two children. In their spare time they enjoy being physically active, exploring the outdoors and spending time with friends and family.

Sharlen Moore

Supporting youth in Milwaukee is a crucible and commitment for Sharlen Moore, executive director of Urban Underground. The organization, which she co-founded with her husband and partner, Reggie Moore, helps young people grapple with what they are up against in our city and gives them tools for a healthy, vibrant and empowered life. Sharlen has spent her whole life in Milwaukee, where she attended public schools and the University of Wisconsin-Milwaukee. She got her start in community organizing while working for the YMCA, where she and some friends created the Teen Achievers program. She also founded Youth Justice Milwaukee, which tries to keep kids out of the prison system and advocates for restorative justice. YJM also joined a longstanding community effort to close youth prisons, particularly Lincoln Hills School for Boys and Copper Lake School for Girls.

Honorable Reverend Everett Mitchell

The Honorable Reverend Everett Mitchell is a fierce advocate for education and equity. Judge Mitchell was elected to the Dane County Circuit Court as a juvenile court judge and presides over cases involving family re-unification, juvenile delinquency, and other civil and criminal proceedings. Judge Mitchell is the presiding judge over the Juvenile Division in Dane County. Further, Judge Mitchell also oversees Dane County's High Risk Drug Court Program. Judge Mitchell is an adjunct professor for the University of Wisconsin-Madison Law School. He teaches courses on Race, Racism and the Law as well as the Foundational Principles of the Juvenile Justice System. Judge Mitchell is committed to dismantling what he describes as the Child Welfare to Juvenile Delinquency to Adult Prison Pipeline operating not only in Wisconsin, but also around the country. In this pipeline, systems pass traumatized children from one system to the next without acknowledging or addressing their trauma. His approach is documented in the Wisconsin Public Television Series, "Not Enough Apologies: Trauma Stories." He believes passionately in the endless potential of children and communities to transform their trauma stories. As a trauma survivor himself, Judge Mitchell approaches each case with an eye bent towards making sure the court system does not contribute to the ongoing traumatic narrative that many children and families experience. He often tells the children in his court, "I am not your judge, I am your reflection."

During his tenure on the bench, Judge Mitchell has worked with colleagues to change courtroom policies to reflect trauma informed practices, such as removing restraints and handcuffs on youth during hearings. He joined several judges in petitioning the Wisconsin Supreme Court to support changing the presumption to ensure that children in Wisconsin can attend their court hearings without restraints and handcuffs. Additionally, Judge Mitchell worked with the Madison Metropolitan School District, the second largest district in the state, to create an Office of Youth Engagement that provides a bridge for youth involved in the criminal justice system to educational programming. He also initiated conversations with the District to create more inclusive policies and practices concerning youth involved in the criminal justice system, many of whom also receive special education and related services, by reducing the number of students on shortened school day schedules so their hours of instruction are increased. Judge Mitchell works tirelessly to ensure the youth under his jurisdiction are treated with respect and dignity. While this may be common sense, he has found that it is not always common practice, which is the reason why after a visit to a Youth Prison in Wisconsin and hearing from the incarcerated young men there, he advocated that black and brown children receive haircuts by a licensed barber and not a dog groomer. With every opportunity, Judge Mitchell tries to connect the community with incarcerated youth and adults. Through his support, members of the Black Law Students Association regularly visit the local detention center so law students can eat lunch with and engage youth in the detention center. Judge Mitchell is adamant that the first time people see him should not be when they appear before him in court. In contrast, he is a man woven into the fabric of his community and has visited over 30 schools in Dane County to talk with children about the juvenile justice system and empower them to think of themselves as renaissance men and women who have the capacity to be the change they want to see in the world. Judge Mitchell has also lectured or spoken at colleges and universities, national conferences, community events, corporate events, professional development workshops, and in front of many other diverse audiences.

Judge Mitchell's social justice lens is steeped in his calling and commitment to justice and equity. Since 2011, Judge Mitchell has served as Senior Pastor of Christ the Solid Rock Baptist Church in Madison, Wisconsin. He serves the congregation with passion, vision, and dedication. His resolve to pursue love, service, justice, and equity, led him to identify his congregation as a church that is open and affirming to those in the LGBTQIA community, and it is the only predominately black church to do so in Dane County. In 2015, he became the first pastor of a black Baptist church in the state of Wisconsin to marry a same sex couple inside of the church. Under his leadership, Judge Mitchell recently led the congregation into a formal alliance with a majority white congregation so that both congregations can be intentional about dismantling the racial barriers that make Sunday morning "…the most segregated hour in America."

Service is at the heart of Judge Mitchell. As the Co-Chair of the United Way of Dane County Community Engagement Committee, he created a process to provide grass roots organizations with seed funding so many could continue their work of supporting low-income families, domestic abuse victims, and children. Among the awards he has received, Judge Mitchell is most proud of being honored with the 2017 City of Madison and Dane County Reverend Dr. Martin Luther King Jr. Humanitarian Award.

Robert Kaminski

Robert Kaminski is on the Children Come First Advisory board as a lived experienced parent. He and his wife of 33 years have 5 children, 1 biological and 4 internationally adopted. The adoptions introduced him to the world of mental health awareness and care in Wisconsin.

A passionate advocate for people with mental illness challenges, Rob has served the state in many roles. He currently serves as a Lived Experience Parent Partner with the Office of Children's Mental Health, is a trainer for ACE Interface, and serves as a facilitator for the NAMI Fox Valley parent and caregivers support group. In addition, he is a Certified Parent Peer Specialist (CPPS) and also trains future CPPS candidates.

He is a plumber by trade, owning a water softening business in the Fox Valley. He likes to drive unique cars and currently owns several including a Polski Fiat and Ford Model Ts.

Marin Webster Denning

My Anishinaabe name is Nodaway Benaise and I am Sturgeon Clan. I am enrolled in the Oneida Tribe of Wisconsin, and my ancestry includes Menominee, Mille Lacs Ojibwe, Stockbridge-Munsee, French and English. My experience as an educator, lecturer and curriculum specialist in American Indian history and culture has taken me all over the world, working with people, communities and organizations. As a parent of four children, I was fortunate to serve on the board to bring about Milwaukee's Indian Community School, a flagship institution of Urban American Indian education. I have served as an advisor on the Gates Millenium Educational Foundation and I am a board member of Indian Summer Festival. When I am not in the classroom or working on a commercial project or speaking engagement – I am an adjunct lecturer at the University of Wisconsin-Milwaukee, in the school of continuing education. I have also work as a contractor and trainer with Boeing Corporation and the Office of the Director of National Intelligence.

Dylan Bizhikiins Jennings

Dylan Bizhikiins Jennings is a member of the marten clan. He graduated from the University of Wisconsin Madison with degrees in Anthropology, Archaeology, Environmental Studies, and American Indian Studies. Jennings completed his master's degree from the University of Wisconsin Madison Nelson Institute. Jennings served two consecutive terms as an elected Tribal Council Member for the Bad River Tribe. He served as the Director of Public Information for the Great Lakes Indian Fish & Wildlife Commission, which required him to be fluent in tribal/environmental news and issues. He was also a writer, photographer, and editor for the Mazina'igan newspaper.

Bizhikiins presents at many public engagements and schools throughout the Midwest on topics ranging from: traditional subsistence, sovereignty, tribal environmental perspective, cultural immersion, Ojibwemowin, Tribal Historic Preservation, food sovereignty, Ojibwe curriculum, and cultural identity. He recently served as an appointed member of the Wisconsin Governor's Task Force on Climate Change.

Currently Dylan resides in Odanah, WI with his family and is a University of Wisconsin Madison HEAL Doctoral Fellow working with Earth Partnership. Bizhikiins serves as an Associate Director of the Sigurd Olson Environmental Institute at Northland College. He also serves as a Professor at Northland College in the American Indian Studies Department and Environmental Studies Department where he teaches courses such as: Introduction to Ojibwe language & culture, American Environmental History, and Native Foodways.

Bizhikiins has been a recent recipient of the National Center for American Indian Enterprise Development "40 under 40" award and a recipient of the UW Madison Nelson Institute Rising Star Alumni award.

Wisconsin Children's System of Care Summit - Summary of Data Collection and Findings

Common Language

Wisconsin Children's System of Care Vision:
Children and families are valued, understood, and supported in their communities.

Wisconsin Children's System of Care Summit Vision:
To engage, equip, and empower Wisconsin tribes and counties in the evolution of their children's system of care.

Wisconsin Children's System of Care:
Wisconsin's system of care is a way of helping children, youth, and their families receive the right help, at the right time, in the right amount by connecting and coordinating the work of all system partners.

Components of a Children's System of Care:

Philosophy:

The system of care philosophy is the foundation of service delivery and includes the core values of:

- Family and youth-driven
- Community-based
- Culturally and linguistically responsive systems and services

The system of care guiding principles referenced in the Evolution of the System of Care Approach article are:

- Comprehensive array of services and supports
- Individualized, strength-based services and supports
- Evidence-based practice and practice-based evidence
- Trauma-informed
- Least restrictive natural environment
- Partnerships with families and youth
- Interagency collaboration
- Care coordination
- Health-mental health integration
- Developmentally appropriate services and supports
- Public health approach
- Mental health equity
- Data driven and accountability
- Rights protection and advocacy

Infrastructure:

The system of care infrastructure includes structures, policies, statutes/rules, and processes for such functions as system management, data management, quality improvement, interagency partnerships, partnerships with youth and family organizations and leaders, financing, and workforce development among others.

Common Language (continued)

Components of a Children's System of Care (continued):

An array of services and supports:

In a system of care, the intent is to create a comprehensive array of services and supports that include a range of home- and community-based treatment interventions along with inpatient and residential interventions with links to community services. Supports and services should be:

- Easily accessible and coordinated across health and mental health providers.
- High quality, evidence informed, and responsive to the culturally diverse populations served.
- An array that includes mobile crisis response and stabilization services, intensive care coordination using a wraparound approach, intensive in-home mental health treatment, respite care; parent and youth peer supports, flex funds, treatments addressing trauma, and telehealth as appropriate.

The supports and services provided to an individual young person and their family should be determined through a continuous and family-centered process that identifies the combination and intensity of supports and services that would be most beneficial.

System of Care Strategic Plan:

The document which will be developed during this summit that will guide the efforts of all partners in the children's system of care in Wisconsin. The progress of the plan will be monitored by the Children Come First Advisory Committee. The plan will be created using the Objective and Key Results methodology. The plan duration will be approximately six years.

Objectives and Key Results (OKR):

"An **Objective** is simply what is to be achieved, no more and no less. By definition, Objectives are significant, concrete, action-oriented, and (ideally) inspirational. When properly designed and deployed, they're a vaccine against fuzzy thinking and ineffective execution.

Key Results [KRs] benchmark and monitor how we get to the Objective. Effective KRs are specific, time-bound, and aggressive yet realistic. Most of all, they are measurable and verifiable. You either meet a Key Result's requirements or you don't — there is no gray area, no room for doubt.

Where an Objective can be long-lived, rolled over for a year or longer, Key Results evolve as the work progresses. Once they are all completed, the Objective is achieved."

Source for OKR definition: What Matters Website
https://www.whatmatters.com/faqs/okr-meaning-definition-example

Data Methodology and Evaluation

Data Methodology:

The Wisconsin Department of Health Services in collaboration with Change Matrix (consulting agency), developed a multimodal approach for data collection to assure voices are being heard from across the continuum of the children's system of care in Wisconsin. This data was collected through a combination of qualitative and quantitative techniques. These techniques included using an online survey; a communication tool (Thought Exchange) that allowed the participants to share their thoughts on a topic confidentially; and the facilitation of sharing circles (focus groups) to collect data through group interaction. This data collection strategy was designed to collect a host of data from a wide range of perspectives. It was also intended to be engaging, relevant, and create hands-on learning opportunities.

The use of the multimodal approach proved to be advantageous in helping identify information needed to evolve the Wisconsin Children's System of Care. The first method developed was the online survey which began by identifying demographic characteristics and the primary role of the respondent in the children's system of care. The next section of the survey is reflective of the philosophy, infrastructure, and array of services and supports. In the fall of 2022, individuals representing the spectrum of partners in the children's system of care were asked to think about and rate the children, youth, and young adults' support and services from their unique perspectives over the last 12 months. The survey included 115 questions. 496 individuals completed the entire survey and an additional 911 partially completed the survey. The partial responses were valid because the questions were not dependent on each other. The second method of data collection was the use of the communication tool Thought Exchange. Thought Exchange was used during five regional county behavioral health director's meetings across the state and during a Wraparound Statewide Meeting where attendance was comprised of tribal nation and county representatives from both Coordinated Services Teams Initiatives and Comprehensive Community Services teams. During the regional meetings, 33 people provided thoughts, and there were 452 ratings of those thoughts. During the Wraparound Statewide Meeting, over 250 people attended, 96 people shared thoughts, and over 1,700 ratings of those thoughts were captured. The last method of data collection was the sharing circles facilitated by consultants who met with a representative from the tribal nations, young adults, and parents. Through the sharing circles, strengths, gaps, and opportunities were identified. In total, there were eight sharing circles conducted.

Data Evaluation:

A work group was developed to analyze and interpret the data. This group included parents, a young adult, a tribal member, county agencies, advocacy agencies, state agencies, representatives from Change Matrix, and UW-Whitewater (project management). The work group was provided with all qualitative and quantitative data. Prior to the first meeting, they were asked to analyze the data from their unique perspectives and share this analysis. They met three times (twice in person and once virtually) and discussed ground truths, recalled relevant experiences, described what was learned from the data and experiences, and discussed how past learning may suggest a theory of success. The data identified many strengths in the Wisconsin system including agreement that eliminating disparities in access and quality of services is essential, along with using teams to support youth and families. Data also reflected areas the work group prioritized as needing the most consideration which is outlined in this summary.

Philosophy

What the data is telling us:

- In the current system, young people and their families often must endure significant negative impact on their lives before they can access effective services and supports through a coordinated and family-centered approach; this is often referred to as "fail first."
- Family and youth-driven:
    - Family and youth perspectives are not always intentionally elicited and prioritized at all stages of the assessment and planning process.
    - The wraparound principle of "unconditional care" is not universally available.
    - Underlying needs are not always considered; services are often suggested that do not address the underlying needs.
    - Statewide, there is a gap between perceptions of quality care, depending upon the role of the respondent. Quality should be largely determined by the experiences of those who are receiving services.
    - Measurable outcomes are not always tied to the goals and strategies of a plan.
- Community based:
    - Community-based options and services are not thoroughly explored before seeking out-of-home options.
    - Natural supports are not always actively sought or encouraged.
- Culturally and linguistically responsive systems and services:
    - Culturally and linguistically responsive systems and services are not always provided to diverse communities.

Summary:

The data shows that, though we have all worked diligently to set up a system of care in Wisconsin based upon wraparound, there is more work to be done. A reexamination of efforts to use our wraparound principles could be a starting point for creating better collaboration among systems and between systems and the youth and families we serve. An emphasis on community-based prevention and early intervention services rather than our current "fail first" system would have a significant positive impact on keeping young people in their communities, at home, and in school.

Infrastructure

What the data is telling us:

- There is a lack of cross partner collaboration within and across systems.
- Partnerships need to be developed between state and local systems to better meet funding, policy, and training barriers.
- There is minimal access to peer support services for youth and families.
- Structures or processes for partnerships with family-run organizations and youth organizations is minimal.
- Workforce challenges are being experienced across the system impacting service delivery.
- Families and youth cannot easily access care.
- Process and procedures differ between systems making cross system collaboration difficult.
- Current policies and funding structures can create barriers to the adoption of philosophy and development of services and supports.
- Financing for infrastructure and high-needs populations is a significant barrier.

Summary:

The data collected demonstrates the current children's system of care infrastructure in Wisconsin lacks specific, uniform procedures resulting in service disconnection that leaves families and children without supports that meet their underlying needs. While all parts of the system retain a level of uniqueness depending on their function, there is a clear need for standardized procedures to improve collaboration, strategic communication, and partnership. To effectively address and properly solve challenges, there needs to be a structured plan that includes all aspects of the system and those it serves. This includes increasing pay and pathways for peer supports; updating policies to better reflect family and child needs; transparency and communication within partnerships; and bolstering a system based in collaboration. A successful system of care requires infrastructure with policies and funding practices that embody the philosophy and development of inclusive services and supports.

Array of Services and Supports

What the data is telling us:

- Community-based services and supports identified as needing improvement in Wisconsin:
    - Parent and youth peer supports
    - Prevention and intervention services and supports
    - Intensive care coordination using a wraparound approach
    - Crisis response services, including mobile crisis for youth
    - Medication treatment and management; availability of prescriber
    - Early childhood services
    - Services for youth in transition
    - Community-based substance use treatment
- Out-of-home services and supports identified as needing improvement in Wisconsin:
    - Respite care
    - Therapeutic foster care
    - Specialized residential and treatment care
- Services and care should be better coordinated across health and mental-health providers.

Summary:

Each of the services and supports outlined above are identified nationally as important aspects of an effective system of care. The current literature describing effective systems of care includes improving the health and mental-health coordination; providing a comprehensive array of services that meet the needs of young people across the age spectrum; and enhancing out-of-home options to address specific needs while assuring these options have linkages to community-based services and supports. By addressing the identified needs and building on the identified strengths, Wisconsin will be able to achieve its Children's System of Care vision: "Children and families are valued, understood, and supported in their communities."

History of the Children's System of Care in Wisconsin

Presenters

Jason Cram
Department of Health Services

Lori Martin
White Pine Consulting

2

Pioneers

1982

Jane Knitzer publishes: "Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services"

4

1984

- Funding appropriated by congress for the Child and Adolescent Service System Program (CASSP)
- Wisconsin received federal National Institute of Mental Health (NIMH) strategic planning grant
- Dane County received five-year $2.5 million grant

5

1987

- "Kids in Crisis: A Plan for Action" published in Wisconsin
- Wisconsin Family Ties established

6

1989

- Wisconsin's Children Come First Act (Wis. Stat. § 46.56) enacted
- Authorization to create Integrated Services Projects (ISP)
- Children Come First Advisory Committee developed

7

1990

- The first Children Come First / Integrated Services Projects (ISP) established (22 established between 1990 and 1995)
- Using grant funding, Dane County developed Project FIND (Families in New Directions)

8

Mid 90s

- Children Come First Dane County established
- Wraparound Milwaukee receives a six-year $15 million federal grant
- Northwoods Alliance for Children and Families

9

1996

Governor's Blue Ribbon Commission on Mental Health Care

10

1998

The Eight Key Components of Integrated Services developed

11

Throughout the 90s

Continued expansion of Integrated Services Projects throughout Wisconsin

12

2000

Wraparound Milwaukee nationally recognized as a best practice model

13

2002

- Concept paper – Values Driven Coordinated Services Teams (CST) Initiatives Approach
- Request for proposals issued giving counties and tribes the opportunity to apply for five years of funding to develop CST Initiatives
- Training and technical assistance available to support developing CST sites

14

2003 – 2004

- 2003 Wisconsin Act 33
- Wisconsin Admin. Code ch. DHS 36: Comprehensive Community Services (CCS)
- North Central Health Care – first certified CCS program

15

2007 – 2008

- First tribal nations receive CST funding
- Child & Adolescent Needs & Strengths (CANS) chosen as a tool
- Honoring Our Children initiative

16

2010 – 2012

- Enactment of 2009 Wisconsin Act 334
- Integrated Services Projects transition to CST

17

2013 – 2014

- 2013 – 2015 biennial budget included $30 million in mental health and substance use services
- 2013 Office of Children's Mental Health created
- Enactment of 2013 Wisconsin Act 20
- 2005 – 2014 expansion of CCS

18

2015 – 2016

- First tribal nation CCS program
- Georgetown Implementation Academy

19

2017 - 2018

- Joint CCS and CST Children's System of Care Statewide Meeting
- Children's System of Care website
- Children's System of Care Self-Assessment Tool

20

2019

- Strategic planning process, resulting in the creation of the vision: "Children and families are valued, understood, and supported in their communities."
- Development of Foundations of Wisconsin Wraparound video series

21

2021 - 2023

- The Evolution of the System of Care Approach published
- System of Care Self-Assessment Tool published
- National Training and Technical Assistance Center (NTTAC) recognition
- Use of American Rescue Plan Act funds for planning and development of the Children's System of Care Summit

22

TODAY!

- CCS – 70 counties and three tribal nations
- CST – 67 counties and 10 tribal nations

23

24

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- *Wisconsin Stat. § 46.56 – Coordinated Services Teams: https://docs.legis.wisconsin.gov/statutes/statutes/46/56*
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System of Care Survey Results Overview

SYSTEM OF CARE SURVEY RESULTS OVERVIEW

Survey Timeline and Responses

- Administered in **October 2022**
- About **600 respondents** completed at least one section of the survey

Survey Overview 2

Survey Sections

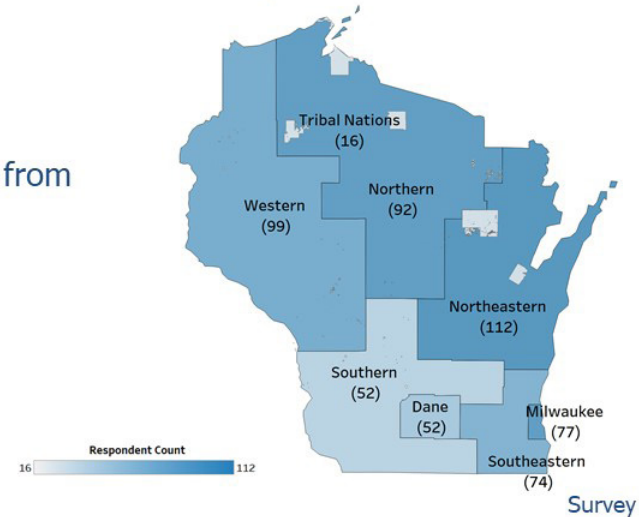
The survey contained **four sections** with a total of **112 items.**

- Service delivery guided by 10 system of care principles
- Availability of recommended infrastructure for a system of care approach
- Commitment to the system of care philosophy and approach
- Availability of recommended home/community-based treatment and support services

Survey Overview 3

Distribution of Respondents

Respondents were from across the state



Survey Overview 4

Distribution of Respondents

Average scores were **fairly consistent across the state**, with the exception of Dane County whose respondents consistently rated items lower than other regions.

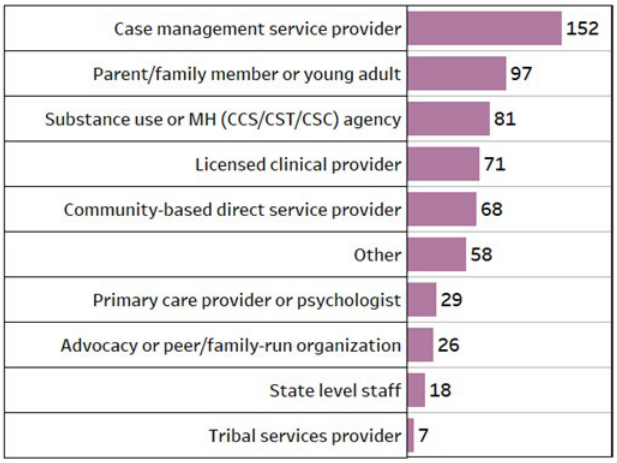
	Southern	Tribal Nations	Western	Southeastern	Milwaukee	Northeastern	Northern	Dane
Grand Total	**3.03**	**3.02**	**2.95**	**2.95**	**2.92**	**2.91**	**2.89**	**2.55**
Service Delivery Guided by 10 System of Care Principles	3.46	3.37	3.35	3.21	3.15	3.21	3.20	2.81
Commitment to the System of Care Philosophy and Approach	3.01	3.12	2.79	2.79	2.83	2.79	2.95	2.51
Availability of Recommended Infrastructure for a System of Care Approach	2.81	2.76	2.65	2.85	2.87	2.55	2.71	2.36
Availability of Recommended Home- and Community-Based Treatment and Support Services	2.40	2.63	2.45	2.54	2.56	2.48	2.42	2.19

Average Response
1.0 5.0

Survey Overview 5

Roles of Respondents

Respondents were from a variety of roles respective to the system of care



Survey Overview 6

Roles of Respondents

Service recipients and advocates (and health care professionals) often rated items **lower** than **service providers.**

Tribal service providers often rated items most favorably.

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Case management service provider	Community-based direct service provider	State level staff	Licensed clinical provider	Primary care provider or psychologist	Parent/family member or young adult	Advocacy or peer/family-run organizations
Grand Total	**3.22**	**3.22**	**3.06**	**2.93**	**2.75**	**2.74**	**2.57**	**2.54**	**2.41**
Service Delivery Guided by 10 System of Care Principles	3.59	3.63	3.40	3.31	3.08	3.02	2.78	2.78	2.52
Commitment to the System of Care Philosophy and Approach	3.52	3.10	3.02	2.74	2.77	2.62	2.66	2.39	2.29
Availability of Recommended Infrastructure for a System of Care Approach	3.22	2.94	2.84	2.70	2.73	2.46	2.40	2.29	2.34
Availability of Recommended Home- and Community-Based Treatment and Support Services	2.69	2.65	2.55	2.40	2.27	2.36	2.26	2.21	2.28

Average Response
1.0 5.0

SYSTEM OF CARE SURVEY RESULTS
SERVICES AND SUPPORTS

Services and Supports

Availability of Recommended Home- and Community-Based Treatment and Support Services Survey Section

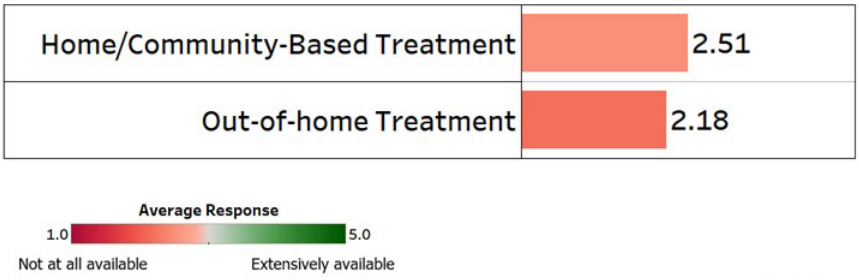
A children's system of care emphasizes the **use of evidence-supported approaches**, along with other **effective services and supports**. Therefore, it is important to get an overview of what services are available statewide.

From **your perspective and experience** over the last 12 months, rate the **extent to which the following services and supports are available**.

[List of nine out-of-home and 30 home/community-based services]

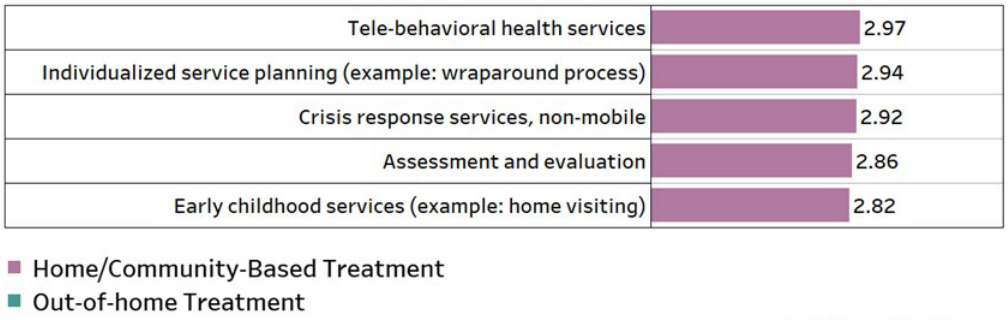
Services and Supports by Item

Out-of-home treatment services were rated as **less available** than **home/community-based** treatment services, but **both were rated negatively**.



Services and Supports by Item

The below items were rated **most favorably**, indicating **relative strengths** for services and supports. All of these services are **home/community-based**.

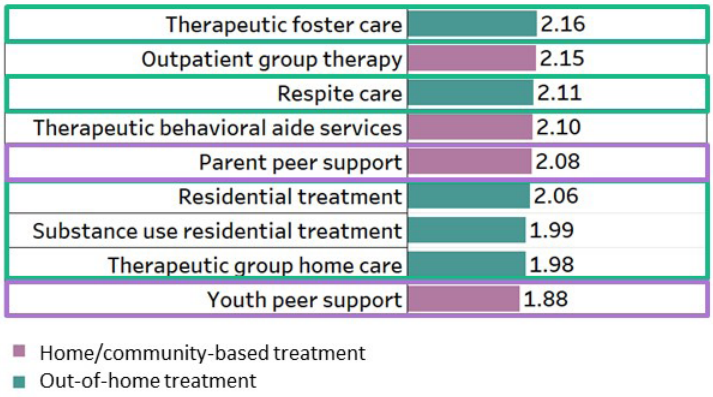


Services and Supports 11

Services and Supports by Item

The majority of the **lowest-rated** items were for **out-of-home** services.

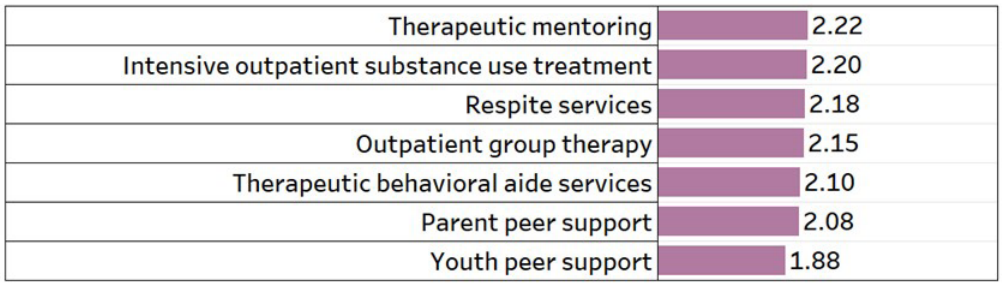
Two notable exceptions are for **peer support services**.



Services and Supports 12

Services and Supports by Item

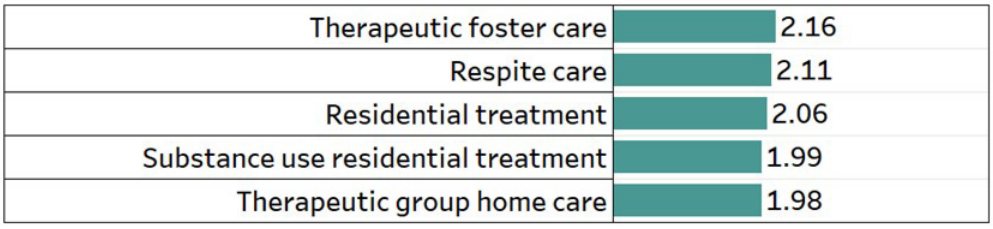
The following **home/community-based services** were rated as **least available.**



Services and Supports by Item

The following **out-of-home services** were rated as **least available.**

Three of them relate to **specialized residential care.**



Differences by Role

Several of the services with the **greatest discrepancies** in ratings between **service recipients** (and health care professionals) and **service providers** concern **crisis and intensive services.**

	SU or MH (CCS/CST/CSC) agency	Tribal services provider	Community-level child-serving system provider	Child serving agency	Licensed clinical provider	State level staff	Primary care provider or psychologist	Advocacy or peer/family-run organizations	Parent/family member or young adult	Grand Total
Grand Total	**3.31**	**2.98**	**2.97**	**2.79**	**2.61**	**2.51**	**2.34**	**2.33**	**2.26**	**2.77**
Services that are trauma focused, including evidence-supported trauma-specific treatments	3.14	2.86	2.84	2.61	2.76	2.71	2.48	2.15	2.29	**2.70**
Mobile crisis and stabilization services	3.10	2.43	2.86	2.69	2.55	2.35	2.43	2.21	2.23	**2.67**
Individualized service planning (example: wraparound process)	3.50	3.57	3.18	2.93	2.73	2.75	2.48	2.45	2.41	**2.94**
Crisis response services, non-mobile	3.55	2.71	3.03	3.02	2.91	2.53	2.48	2.67	2.35	**2.92**
There is access to service coordination for youth with less intensive needs.	3.35	3.29	2.96	2.79	2.31	2.19	1.75	2.24	2.13	**2.68**
Intensive care coordination	3.23	3.00	2.97	2.65	2.38	2.53	2.38	2.30	2.12	**2.68**

The darker the color, the farther from the overall average for that principle.

Differences by Role

These discrepancies suggest there may be:

- A **lack of awareness** of these services by service recipients
- A **difference in experiences** of the services
  - **Intensive care coordination**
  - **Access to service coordination** for youth with **less intensive** needs
  - **Crisis response services**, non-mobile
  - **Individualized service planning** (example: wraparound process)
  - **Mobile crisis** and **stabilization** services
  - **Trauma-focused** services, including evidence-supported trauma-specific treatments

Don’t Know Responses

Parents/family members or **young adults** responded **“don’t know”** to the availability of many of the **out-of-home treatment** services.

This may suggest **less need** for these services or **a lack of awareness**.

	Tribal services provider	Substance use or MH (CCS/CST/CSC) agency	Case management service provider	Community-based direct service provider	State level staff	Licensed clinical provider	Primary care provider or psychologist	Parent/ family member or young adult	Advocacy or peer/family-run organization	Grand Total
Out-of-home Treatment		10.7%	15.4%	20.7%	16.0%	18.0%	22.9%	37.6%	15.3%	**19.8%**
Home/Community-Based Treatment	1.9%	4.0%	6.4%	11.4%	9.1%	9.4%	14.0%	18.6%	12.3%	**9.9%**

Services and Supports 17

SYSTEM OF CARE SURVEY RESULTS
INFRASTRUCTURE

Infrastructure

Availability of Recommended Infrastructure Survey Section

A true system of care requires an **infrastructure to support coordination and connections** between multiple agencies and systems, **monitoring capacity**, attention to **strategic communication** across multiple levels, and support for **advisory structures** to participate in **strategic planning**. Such functions require commitment and expertise that goes beyond care coordination.

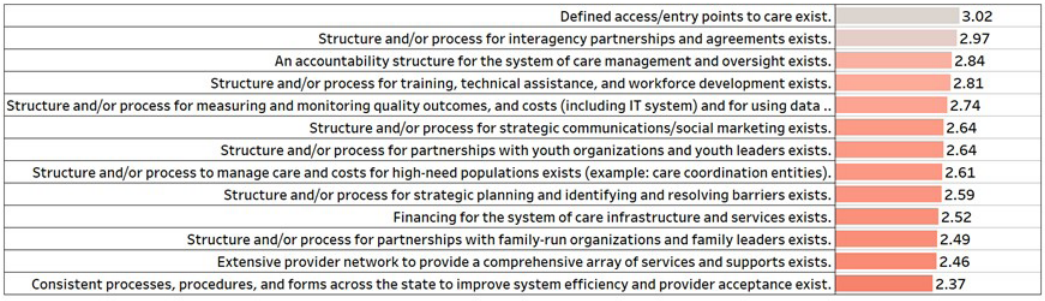
From **your perspective and experience** over the last 12 months, **rate the extent to which you agree** to the following statements.

[13 statements stating the existence of various infrastructure elements]

System of Care Infrastructure 19

Infrastructure by Item

Almost all items received a **negative** overall average response.

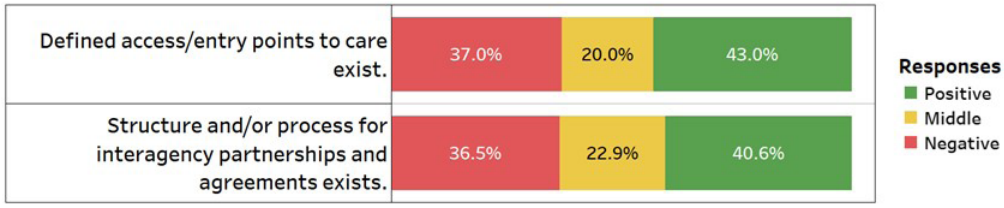


System of Care Infrastructure 20

Infrastructure by Item

The following items had **more positive responses** than negative.

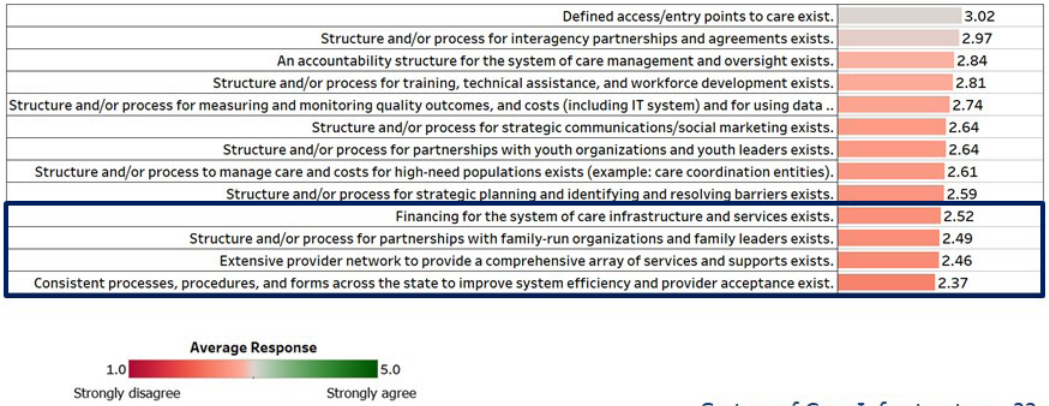
These may indicate the **relative strengths** for the Wisconsin Children's System of Care infrastructure.



System of Care Infrastructure 21

Infrastructure by Item

Highlighted below are the **lowest-rated** items.



System of Care Infrastructure 22

Infrastructure by Item

These **lowest-rated** items related to:

- **Consistency in administration** across state
- Extensive **provider network**
- **Partnerships** with **family-run** organizations
- **Financing** for infrastructure

Differences by Roles

The three **highest-ranking** items had the **most disparity** across roles.

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Community-level child-serving system provider	State level staff	Child serving agency	Licensed clinical provider	Primary care provider or psychologist	Advocacy or peer/family-run organizations	Parent/family member or young adult	Grand Total
Grand Total	**3.50**	**3.40**	**3.16**	**3.04**	**3.01**	**2.74**	**2.48**	**2.56**	**2.35**	**2.93**
Defined access/entry points to care exist.	3.83	3.62	3.18	3.06	3.06	2.89	2.82	2.80	2.32	**3.03**
Structure and/or process for interagency partnerships and agreements exists.	3.43	3.38	3.22	3.13	3.04	2.55	2.36	2.71	2.49	**2.95**
An accountability structure for the system of care management and oversig..	3.29	3.20	3.07	2.93	2.94	2.79	2.27	2.22	2.24	**2.82**

Percent of Overall Average for Item
70% 130%

Differences by Roles

The items that had the **most discrepancy** between **service providers and agencies** and **family and community/advocacy organizations** (and health care professionals) were:

- **Defined access/entry points** to care exist.
- Structure and/or process for **interagency partnerships and agreements** exists.
- An **accountability structure** for the system of care management and **oversight** exists.

Differences by Roles

In particular, **parents/family members** and **young adults** recorded relatively little agreement to:

Defined access/entry points to care exist.

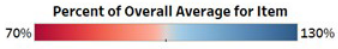
This indicates that **families and youth may not be aware of how to access services** even though service providers are general likely to agree that they exist.

Differences by Roles

Tribal service providers consistently **scored infrastructure** items relatively **higher** than other groups.

This implies that **infrastructure may be more robust** among **tribal agencies**.

Tribal services provider	SU or MH (CCS/CST/CSC) agency	Community-level child-serving system provider	State level staff	Child serving agency	Licensed clinical provider	Primary care provider or psychologist	Advocacy or peer/family-run organizations	Parent/family member or young adult
3.22	2.94	2.84	2.73	2.70	2.46	2.40	2.34	2.29



System of Care Infrastructure 27

Infrastructure

Commitment to the System of Care Philosophy and Approach Survey Section

A children's system of care doesn't just happen. It requires a **commitment from a variety of agencies and individuals**. This section addresses the breadth of **agencies working to coordinate services** for children and families and the depth of that commitment.

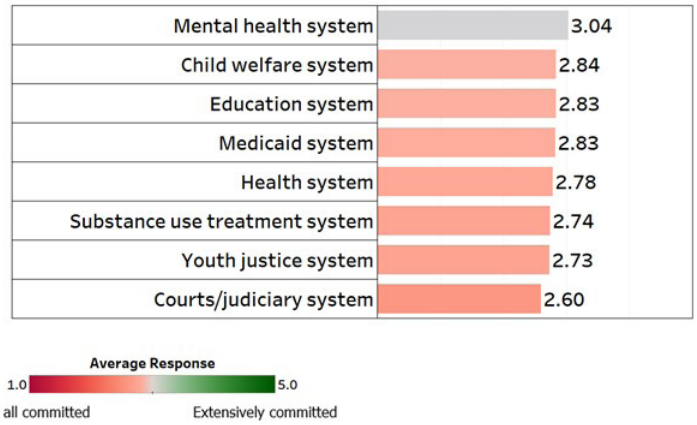
From **your perspective and experience** over the last 12 months, rate the extent to which there has been the **commitment to the system of care philosophy and approach by the following systems**.

[List of 8 child-serving systems]

System of Care Infrastructure 28

Infrastructure by Item

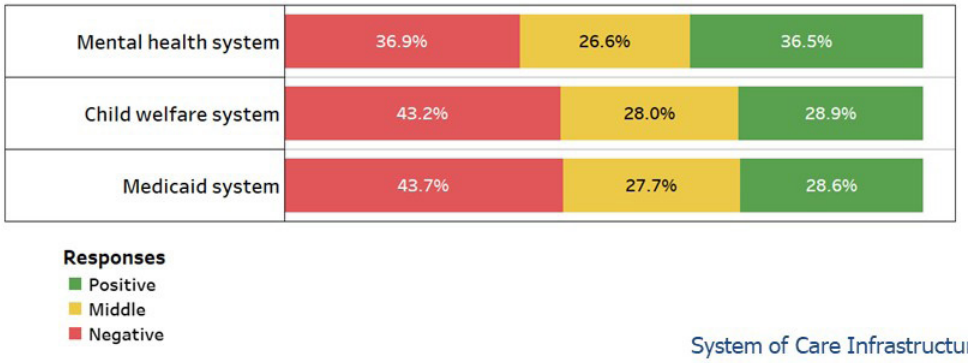
Almost all systems received a **negative** average response.



System of Care Infrastructure 29

Infrastructure by Item

The systems below had the **highest number of positive** responses. However...



System of Care Infrastructure 30

Differences by Roles

There was a **tendency for bias** towards respondents' **own field.**

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Community-level child-serving system provider	State level staff	Child serving agency	Primary care provider or psychologist	Licensed clinical provider	Parent/family member or young adult	Advocacy or peer/family-run organizations	Grand Total
Grand Total	**3.52**	**3.10**	**3.02**	**2.77**	**2.74**	**2.66**	**2.62**	**2.39**	**2.29**	**2.79**
Mental health system	3.50	3.76	3.26	3.13	2.87	2.74	2.93	2.42	2.45	**3.04**
Child welfare system	4.17	3.15	3.18	2.62	2.90	2.65	2.50	2.30	2.00	**2.82**
Medicaid system	3.25	3.00	2.96	2.86	2.73	2.74	2.71	2.60	2.44	**2.81**
Education system	3.17	3.18	2.98	2.86	2.75	2.86	2.81	2.34	2.28	**2.81**
Health system	4.17	2.75	2.91	2.86	2.67	2.86	2.79	2.50	2.60	**2.77**
Substance use treatment system	3.33	3.12	2.95	2.86	2.60	2.41	2.44	2.38	2.31	**2.74**
Youth justice system	3.17	3.02	3.04	2.54	2.82	2.44	2.47	2.19	2.06	**2.71**
Courts/judiciary system	3.25	2.73	2.87	2.38	2.53	2.41	2.20	2.33	2.12	**2.56**

Percent of Overall Average for Item
70% 130%

Infrastructure by Item

The two systems that received the **highest ratings** with the **least discrepancy** between service **recipients/supports** and **service providers/agencies** were:

	Service providers and agencies	Service recipients and supports	Grand Total
Medicaid system	2.88	2.57	**2.81**
Health system	2.84	2.52	**2.77**

Average Response
1.0 5.0
Not at all committed Extensively committed

Differences by Roles

Certain discrepancies suggest a greater need for **collaboration and communication between roles and systems.** For example:

- Service recipients and provider agencies
- Health care professionals and provider agencies
- State staff and the child welfare system

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Case management service provider	State level staff	Community-based direct service provider	Primary care provider or psychologist	Licensed clinical provider	Parent/family member or young adult	Advocacy or peer/family-run organizations	Grand Total
Grand Total	3.52	3.10	3.02	2.77	2.74	2.66	2.62	2.39	2.29	2.79
Mental health system	3.50	3.76	3.26	3.13	2.87	2.74	2.93	2.42	2.45	3.04
Child welfare system	4.17	3.15	3.18	2.62	2.90	2.65	2.50	2.30	2.00	2.82
Medicaid system	3.25	3.00	2.96	2.86	2.73	2.74	2.71	2.60	2.44	2.81
Education system	3.17	3.18	2.98	2.86	2.75	2.86	2.81	2.34	2.28	2.81
Health system	4.17	2.75	2.91	2.86	2.67	2.86	2.79	2.50	2.60	2.77
Substance use treatment system	3.33	3.12	2.95	2.86	2.60	2.41	2.44	2.38	2.31	2.74
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Courts/judiciary system	3.25	2.73	2.87	2.38	2.53	2.41	2.20	2.33	2.12	2.56

Percent of Overall Average for Item
70% 130%

Differences by Roles

Certain discrepancies suggest a greater need for **collaboration and communication between roles and systems.** For example:

- Between the justice system and other roles
- Between community-based providers and other systems

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Case management service provider	State level staff	Community-based direct service provider	Primary care provider or psychologist	Licensed clinical provider	Parent/family member or young adult	Advocacy or peer/family-run organizations	Grand Total
Grand Total	3.52	3.10	3.02	2.77	2.74	2.66	2.62	2.39	2.29	2.79
Mental health system	3.50	3.76	3.26	3.13	2.87	2.74	2.93	2.42	2.45	3.04
Child welfare system	4.17	3.15	3.18	2.62	2.90	2.65	2.50	2.30	2.00	2.82
Medicaid system	3.25	3.00	2.96	2.86	2.73	2.74	2.71	2.60	2.44	2.81
Education system	3.17	3.18	2.98	2.86	2.75	2.86	2.81	2.34	2.28	2.81
Health system	4.17	2.75	2.91	2.86	2.67	2.86	2.79	2.50	2.60	2.77
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Youth justice system	3.17	3.02	3.04	2.54	2.82	2.44	2.47	2.19	2.06	2.71
Courts/judiciary system	3.25	2.73	2.87	2.38	2.53	2.41	2.20	2.33	2.12	2.56

Percent of Overall Average for Item
70% 130%

Differences by Roles

Again, **tribal service providers** consistently **scored infrastructure** items relatively **higher** than other groups.

	Tribal services provider	SU or MH (CCS/CST/CSC) agency	Case management service provider	State level staff	Community-based direct service provider	Primary care provider or psychologist	Licensed clinical provider	Parent/family member or young adult	Advocacy or peer/family-run organizations	Grand Total
Grand Total	3.52	3.10	3.02	2.77	2.74	2.66	2.62	2.39	2.29	2.79
Mental health system	3.50	3.76	3.26	3.13	2.87	2.74	2.93	2.42	2.45	3.04
Child welfare system	4.17	3.15	3.18	2.62	2.90	2.65	2.50	2.30	2.00	2.82
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Education system	3.17	3.18	2.98	2.86	2.75	2.86	2.81	2.34	2.28	2.81
Health system	4.17	2.75	2.91	2.86	2.67	2.86	2.79	2.50	2.60	2.77
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Courts/judiciary system	3.25	2.73	2.87	2.38	2.53	2.41	2.20	2.33	2.12	2.56

Percent of Overall Average for Item
70% 130%

System of Care Infrastructure 35

SYSTEM OF CARE SURVEY RESULTS
PHILOSOPHY

Philosophy

Service Delivery Guided by 10 System of Care Principles Survey Section

The principles of the Wisconsin Children's System of Care are **listed with indicators** that **demonstrate the principles are being used.**

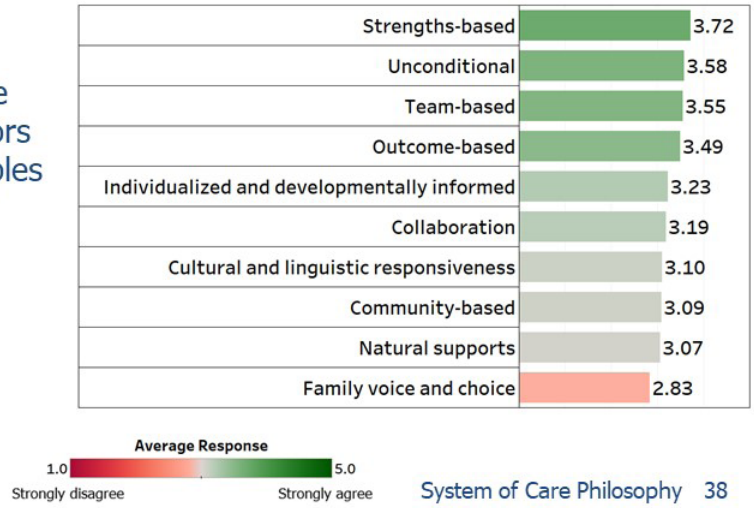
From **your perspective and experience** over the last 12 months, **rate the extent to which you agree** to the following statements.

[52 specific indicators within the 10 principles]

System of Care Philosophy 37

Philosophy by Principle

The average response ratings of the indicators for **almost all** principles were **positive.**



System of Care Philosophy 38

Philosophy by Indicator

Specific indicators that were **scored favorably** by both service **providers/agencies** and **recipients/supports** reveal:

- The **importance of equity in access** to respondents.
- General agreement that **inpatient and residential treatment** is used **only when necessary**.

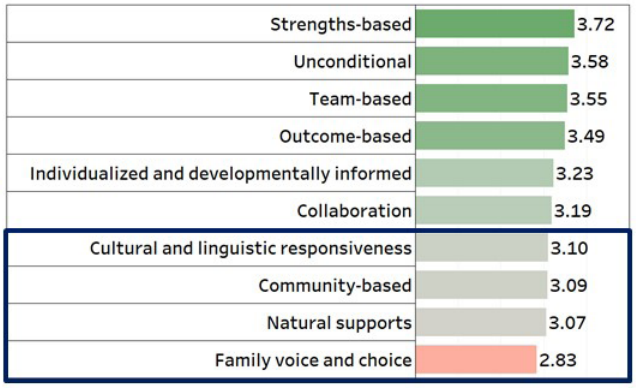
	Service providers and agencies	Service recipients and supports
Elimination of disparities in access and quality of services is essential.	4.58	4.09
Electronic health records exist.	4.20	3.79
Use of inpatient hospitalization is decreased, and it is primarily used for short-term, acute, treatment and stabilization when necessary and appropriate.	3.55	3.26
Informal and natural supports are part of the team.	3.56	3.20
Use of residential treatment is decreased, and it is primarily used for short-term lengths of stay to achieve specific treatment goals when necessary and appropriate.	3.46	3.06

Average Response
1.0 Strongly disagree — 5.0 Strongly agree

Philosophy by Principle

On average, the **lowest-rated** general principles were:

- **Family voice and choice.**
- **Natural supports.**
- **Community-based.**
- **Cultural and linguistic responsiveness.**



Average Response
1.0 Strongly disagree — 5.0 Strongly agree

Philosophy by Indicator

Among the **25% of lowest-rated** specific indicators, most relate to the principles of:

- Collaboration
- Community-based
- Cultural and linguistic responsiveness
- Family voice and choice
- Individualized and developmentally informed
- Natural supports
- Outcome-based
- Strengths-based
- Team-based
- Unconditional

System of Care Philosophy 41

Philosophy by Indicator

The **lowest-rated** indicators express a consensus that there is a need for more **community-based and peer support for families and youth.**

- A broad array of **community-based and in-home services and supports**, including family peer supports, is available.
- **Youth and young adults** have access to **peer support**.
- **Family-run organizations** exist and support family involvement at the system and service delivery levels.
- **Parents** have access to **peer support**.
- **Each family and caregiver** is offered the opportunity to access **peer support.**

System of Care Philosophy 42

Philosophy by Indicator

The other **low-rated** indicators indicate a concern about **cultural and linguistic representation and responsiveness**.

- **Providers represent the cultural and linguistic characteristics** of the population served.
- **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 are **readily available.**
- **Culture-specific services and supports** are provided.
- Specific strategies are used to **reduce racial and ethnic disparities** in access to and outcome of services.

System of Care Philosophy 43

Differences by Roles

There was a wide **discrepancy** between the average scores of **service recipients/advocates** (and health care professionals) and **mental health/substance use service providers.**

This suggests that the **intent or practices of the service providers** may **not align** with the **perception or experiences of the service recipients.**

	SU or MH (CCS/CST/CSC) agency	Tribal services provider	Case management service provider	Community-based direct service provider	State level staff	Licensed clinical provider	Primary care provider or psychologist	Parent/family member or young adult	Advocacy or peer/family-run organizations	Grand Total
Service Delivery Guided by 10 System of Care Principles	3.63	3.59	3.40	3.31	3.08	3.02	2.78	2.78	2.52	3.19

Percent of Overall Average for Item
70% 130%

System of Care Philosophy 44

Differences by Roles

	Substance use or MH (CCS/CST/CSC) agency	Tribal services provider	Community-level child-serving system provider	Child serving agency	State level staff	Licensed clinical provider	Primary care provider or psychologist	Parent/family member or young adult	Advocacy or peer/family-run organization	Grand Total
Grand Total	**3.63**	**3.59**	**3.40**	**3.31**	**3.08**	**3.02**	**2.78**	**2.78**	**2.52**	**3.19**
Strengths-based	4.32	4.15	4.06	3.93	3.71	3.80	3.09	2.98	2.76	**3.74**
Unconditional	4.19	3.75	3.86	3.91	3.36	3.41	3.04	2.84	2.83	**3.58**
Team-based	4.15	4.00	3.84	3.63	3.40	3.37	3.01	2.96	2.94	**3.56**
Outcome-based	3.79	4.00	3.44	3.69	2.94	3.67	3.54	3.13	3.19	**3.49**
Individualized and developmentally informed	3.76	3.32	3.52	3.35	3.33	2.92	2.74	2.78	2.36	**3.24**
Collaboration	3.82	3.61	3.56	3.33	3.23	3.01	2.43	2.53	2.44	**3.21**
Community-based	3.55	3.37	3.18	3.19	2.97	2.95	2.92	2.81	2.39	**3.10**
Cultural and linguistic responsiveness	3.35	3.61	3.29	3.20	2.73	2.93	2.72	2.88	2.54	**3.09**
Natural supports	3.24	3.72	3.30	3.15	2.99	2.89	2.80	2.70	2.70	**3.06**
Family voice and choice	3.24	3.57	2.93	2.92	2.84	2.72	2.50	2.60	2.20	**2.84**

Percent of Overall Average for Item

70% 130%

Differences by Roles

The principles that had the **most discrepancy** between **service providers and agencies** and **family and community/advocacy organizations** were:

- **Strengths-based.**
- **Unconditional.**
- **Collaboration.**

This indicates that, in these areas, there is the **greatest difference in experiences** of those **providing the services** and those **receiving the services**.

Differences by Roles

Collaboration indicators with the largest discrepancies included:

- **Care coordination** is provided at the service delivery level that is **tailored to the intensity of need**… [and] delivered in a **coordinated and therapeutic manner**.
- **Intensive/targeted care coordination**… is provided to **high-need** youth and families.
- **Care is coordinated** across multiple child/youth/young adult-serving **agencies and systems**.
- **Practices have been integrated** into services provided by **primary health care** and **mental health service** providers… to better respond to both… needs.

System of Care Philosophy 47

Differences by Roles

Unconditional and **strengths-based** indicators with the largest discrepancies included:

- Individual **services and supports** are… **guided by a strengths-based** planning process.
- **Challenges or setbacks** within a team are **navigated and resolved** with a team commitment by continuing forward…
- **Assessments of**… **strengths and needs** are used to **plan services and supports**.
- An abiding **commitment to the family** is **not based on circumstances, choices, words, or actions**.

System of Care Philosophy 48

Don't Know Responses

Percentages of **"don't know" responses** per role type and principle

	Substance use or MH (CCS/CST/CSC) agency	Tribal services provider	Community-level child-serving system provider	Child serving agency	State level staff	Licensed clinical provider	Primary care provider or psychologist	Parent/family member or young adult	Advocacy or peer/family-run organization	Grand Total
Outcome-based	4.1%	9.5%	10.7%	13.2%	11.1%	17.8%	17.2%	25.1%	17.9%	**14.2%**
Team-based	0.4%	14.3%	6.0%	3.9%	13.0%	7.5%	17.2%	11.3%	9.0%	**7.1%**
Community-based	3.3%	2.4%	4.4%	3.4%	2.8%	6.8%	13.3%	13.7%	9.7%	**6.7%**
Collaboration	1.0%	9.5%	4.5%	4.7%	9.3%	5.9%	9.2%	10.7%	13.5%	**6.2%**
Cultural and linguistic responsiveness	1.9%	3.6%	5.0%	2.0%	0.7%	2.3%	8.6%	14.8%	7.7%	**5.7%**
Unconditional	1.2%	14.3%	4.0%	2.2%	8.3%	6.3%	12.1%	9.8%	9.6%	**5.7%**
Family voice and choice	1.8%		4.0%	1.9%		5.2%	13.3%	6.5%	7.7%	**4.5%**
Natural supports	1.2%	10.7%	3.6%	2.2%	2.8%	3.5%	14.7%	5.7%	6.7%	**4.2%**
Individualized and developmentally informed	0.2%		1.6%	1.2%	8.6%	2.3%	11.9%	9.6%	5.9%	**3.8%**
Strengths-based		7.1%	2.0%		5.6%	2.8%	8.6%	3.1%	5.8%	**2.5%**

Don't Know Responses

Outcome-based indicators with a high percentage of "don't know" responses included:

- **Data is collected regularly** on the use of behavioral health services and supports, quality, and outcomes for **continuous quality improvement**.
- **Decisions are based on data** that are collected and interpreted.

This suggests that many participants in the system of care **are not aware** of **whether decisions are data-based**.

System of Care Philosophy 50

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

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**).

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

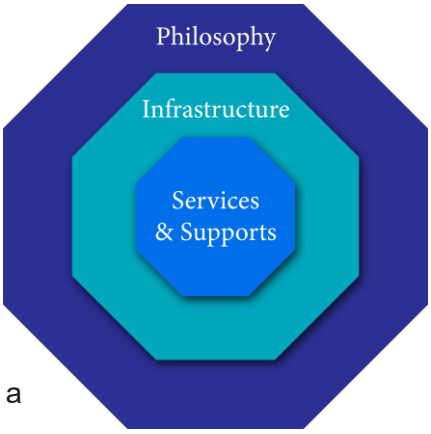
Figure 1. *Dimensions of the System of Care Framework (Adapted from Stroul et al., 2010)*

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

Philosophy

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

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



Infrastructure

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

Services and Supports

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

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

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

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

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

Outcomes of the SOC Approach

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

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

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

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

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

Updating the SOC Approach

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

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

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

Incorporating Public Health, Care Integration, and Mental Health Equity

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

The Public Health Approach

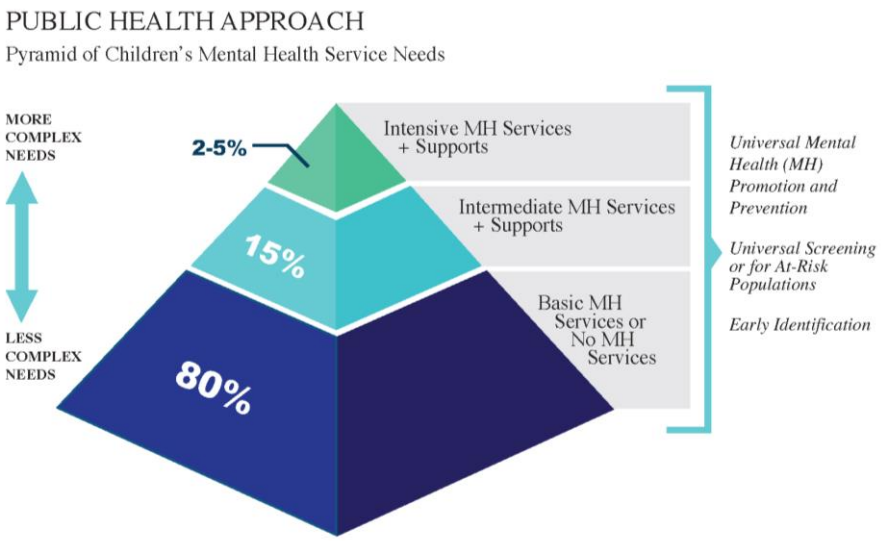
The Institute of Medicine (IOM) report *The Future of Public Health* defined public health as "what society does collectively to assure the conditions for people to be healthy" (IOM, 1988). Given the increasing demand for already overextended services and the high costs associated with

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

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

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

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



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

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

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

Health-Mental Health Care Integration Approach

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

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

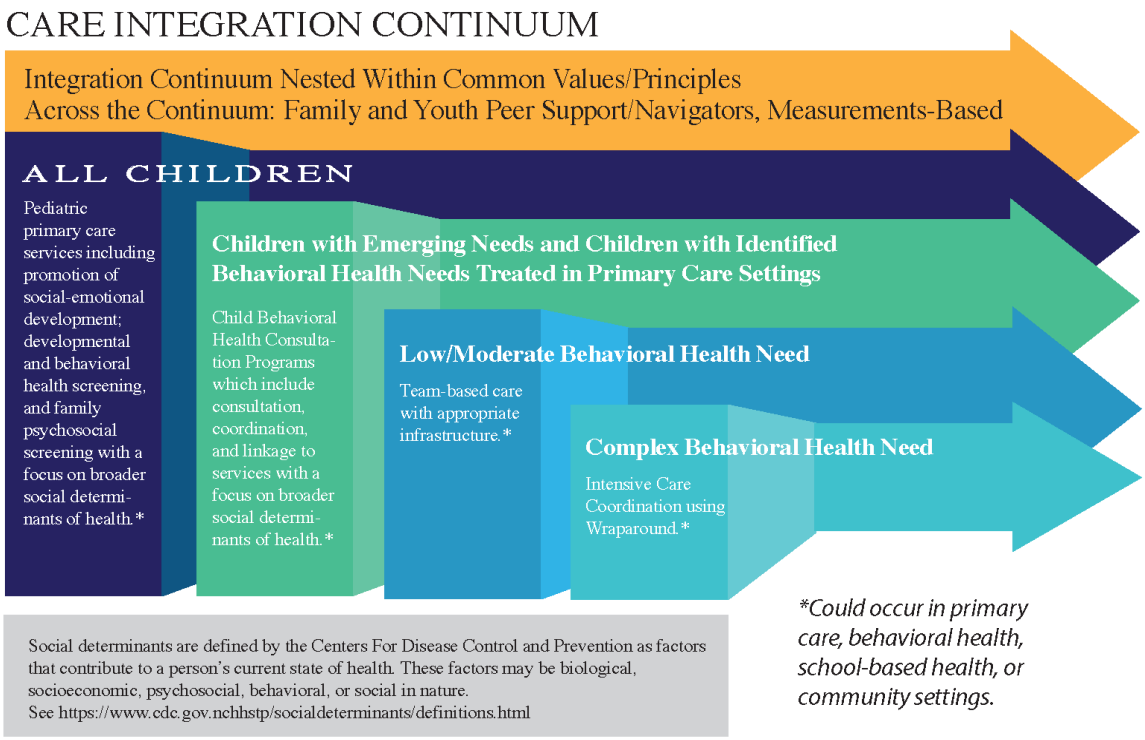
Various proposed definitions of health-mental health care integration share common characteristics (Pires et al., 2018). Integrated care has been defined as a framework that “encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative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

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

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

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

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



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

Mental Health Equity

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

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

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

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

Core Components of a Comprehensive Service Array in SOCs

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

Mobile Crisis Response and Stabilization Services (MRSS)

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

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

Intensive Care Coordination Using Wraparound

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

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

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

Intensive In-Home Mental Health Treatment Services

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

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

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

Parent and Youth Peer Support

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

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

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

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

Respite Care

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

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

Flex Funds

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

Trauma-Specific Treatments and Trauma-Informed Systems

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

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

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

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

Specific Evidence-Informed and Promising Practices

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

Telehealth Services

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

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

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

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

Revised SOC Approach

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

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

Definition

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

Philosophy

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

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

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

Infrastructure

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

Array of Services and Supports

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

Conclusion

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

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

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

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

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Appendix A: List of Expert Organizations Consulted

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

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

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Notes