



SAMHSA

Substance Abuse and Mental Health
Services Administration

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

2017 Report to Congress



2017 Report to Congress

U.S. Department of Health and Human Services

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The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program, Report to Congress 2017, was written by staff at Westat pursuant to a contract (contract number 283- 12-1105) under the direction of the Child, Adolescent and Family Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services.

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA) is pleased to present the 2017 Report to Congress for the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program.

This program, also known as the Children's Mental Health Initiative (CMHI), was authorized by Public Law 102-321¹ to provide funds to government entities to deliver comprehensive community-based mental health services to children, youth, and young adults² who have a serious emotional disturbance (SED), and their families.

CMHI is based on the Systems of Care (SOC)³ framework, defined as a comprehensive spectrum of mental health and other necessary support services organized into a coordinated network to meet the multiple and changing needs of children, youth, and young adults with SED and their families/caregivers. The goals of CMHI are to build upon progress made in developing comprehensive SOC by focusing on sustainable financing, cross-agency collaboration, the creation of policy and infrastructure, and the development and implementation of evidence-based and evidence-informed services and supports. This is necessary to ensure children, youth and young adults with SED and their families receive effective services within their communities and that providers work together to coordinate care in a family-friendly and culturally responsive manner.

Since the inception of CMHI in 1993, SAMHSA has funded a total of 340 grants and cooperative agreements to states, territories, counties, and federally recognized tribal entities, to support Systems of Care that serve children, youth, and young adults with SED and their families. To date, CMHI has provided demonstrably beneficial and effective services to more than 140,000 children, youth, young adults, and their families. Examples of the range of supports provided include medication management, day treatment, school based services, substance use treatment, intensive home based services, youth and family peer support, and supported education and employment. A broad range of therapeutic evidence based practices are provided including: cognitive behavioral therapy, interpersonal psychotherapy, multi-systemic therapy, evidence-based practice components, and family therapy.

The growth and evolution of the SOC approach over the past two decades fundamentally altered and improved

how the needs of children, youth, and young adults with SED, and their families are addressed nationally. The SOC approach improves mental, social, and emotional outcomes for children, youth, and young adults, enhances family outcomes such as reduced levels of caregiver strain, and expands the availability of effective evidence-based interventions. SAMHSA continues to build on the success of CMHI through expansion and sustainability grants and cooperative agreements that drive broader, more sustained implementation of the SOC approach nationally.

This report presents the most up-to-date findings from the national evaluation for the 91 expansion and sustainability grantees funded between 2013 and 2017. The report includes data collected and analyzed for the CMHI National Evaluation for the purpose of identifying services and practices that are best suited to meeting the unique needs of children, youth, and families. Grantee-level data were collected from grantee staff by the National Evaluation Team, using Office of Management and Budget (OMB) approved interviews and questionnaires. The caregiver and youth interviews and questionnaires included reliable and valid measures of symptoms of mental, emotional, and behavioral problems; functional impairment; and caregiver strain. After collecting the data, grantees entered CMHI specific child- and family-level data into the CMHI National Evaluation Portal. Grantees also reported child and family data analyzed by the National Evaluation Team to SAMHSA through the National Outcomes Measuring System (NOMS). The results demonstrate that CMHI grantees are implementing and sustaining effective evidence-based practices that result in improvements in mental health and functional status at home, in school, and in the community for the children, youth, young adults and families being served.

What is SED?

Children, youth, and young adults with SED have—or have had at any time during the past year—a diagnosable mental, social, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the DSM-5 that has resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

1 Section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321.

2 Throughout this report, the term child refers to someone younger than 11 years old, whereas the term youth refers to someone 11-17 and young adult to someone 18-25 years of age. Collaboration between child and adult serving agencies are critical when serving older youth who are transitioning to adulthood, and as a result, a limited number of young adults maintained involvement beyond age 21 to ensure clinical continuity of care.

3 Systems of Care (SOC) are comprehensive, coordinated networks of community-based services and supports organized to meet the challenges of children, youth, young adults, and their families. The goal is to improve service delivery and expand access to culturally and linguistically responsive mental health services for children, youth, young adults, and families.

II | Data Highlights

CMHI grantees serve vulnerable, high-risk populations.

- Nearly three quarters of the children, youth, and young adults served (71.3 percent) come from families near or below the federal poverty threshold.
- CMHI grantees provide SOC services to a racially and ethnically diverse group of children, youth, and young adults from birth to 25 years old, including Hispanic (23.1 percent), Black or African American (22.0 percent), and American Indian or Alaska Native (6.9 percent).
- Nearly two-thirds (63.9 percent) of children, youth, and young adults entering SOC services reported experiencing violence or trauma.



The children, youth, young adults, and families served demonstrate significant improvements in mental, social, and emotional functioning.

- Mental, social, and emotional symptoms among children, youth, and young adults significantly improved from intake to follow-up.⁴
- The children, youth, and young adults served significantly improved in overall functioning (e.g., relations with family members and peers, academic or occupational functioning, and involvement in general interests and activities) from intake to follow-up.⁵
- Caregivers reported significantly less stress after receiving CMHI services.⁶
- Child, youth, and young adult functioning in daily life activities, including school or work performance, getting along with friends and family, and coping skills, significantly improved by 62.7 percent from intake to follow-up.
- Psychological distress (unpleasant emotions such as anxiety and depression that impact functioning) significantly decreased by 17.5 percent from intake to follow-up.
- The proportion of children, youth, and young adults who attended school regularly or who were employed significantly increased from intake (81.6 percent) to follow-up (89.2 percent).

CMHI grantees provide effective evidence-based services to children, youth, and young adults with SED.

- CMHI grantees increase access to evidence-based services, increase family and youth voice and participation, and successfully replicate SOC implementation practice in new geographic areas.
- CMHI grantees are providing services that lead to positive outcomes, with all grantees implementing numerous, evidence-based practices.
- By the end of the 4-year grant period, CMHI funded grantees rated 60 percent or more of existing services as being sustained.

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4 Total mean symptom scores significantly improved ($p < 0.0001$).

5 Total mean impairment scale scores significantly improved ($p < 0.0001$).

6 Total mean caregiver strain significantly improved ($p < 0.0001$).

III | The National Evaluation of CMHI

The National Evaluation of CMHI is mandated by the authorizing legislation, Section 565 of the Public Health Service Act, for the purpose of describing, monitoring, and chronicling program effectiveness. The goal is to assess the outcomes of children, youth, young adults, and their families who are served through CMHI.⁷ Specifically, the National Evaluation of CMHI is designed to assess the impact of effective evidence-based SOC services on health and mental health, social and emotional outcomes and life functioning, as well as determine whether expansion and outcomes vary by award, and to describe the factors associated with successful outcomes.

IV | Description of Children, Youth, Young Adults and Their Families

Who are the children, youth, young adults, and families served by CMHI?⁸

Children, youth, and young adults served by CMHI grantees differed demographically from children, youth, and young adults in the general population (see Exhibits 1 – 3). In comparison to those of similar age in the national population, children, youth, and young adults who received services through CMHI SOC were more likely to be male. The proportion of American Indian/Alaska Native children, youth, and young adults served in CMHI communities funded in Fiscal Year (FY) 2013 through FY 2017 was close to 9 times the percentage of American Indian/Alaska Native children, youth, and young adults in the general population. Similarly, the percentage of African American children, youth, and young adults served was almost twice the percentage in the general population. These figures are consistent with CMHI goals to reach populations that are often underserved and have limited access to mental health services.

Exhibit 1. Child, Youth, and Young Adult Gender in CMHI Grant Population Funded Between 2013–2017 Compared to the U.S. Population

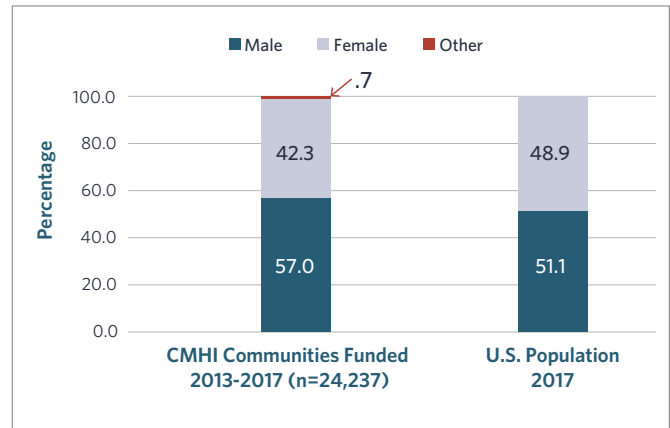
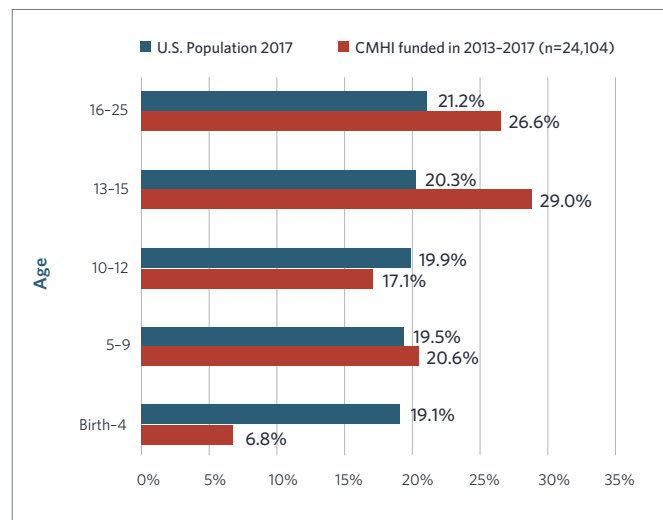


Exhibit 2. Child, Youth, and Young Adult Age in CMHI Grant Population Funded Between 2013–2017 Compared to the U.S. Population

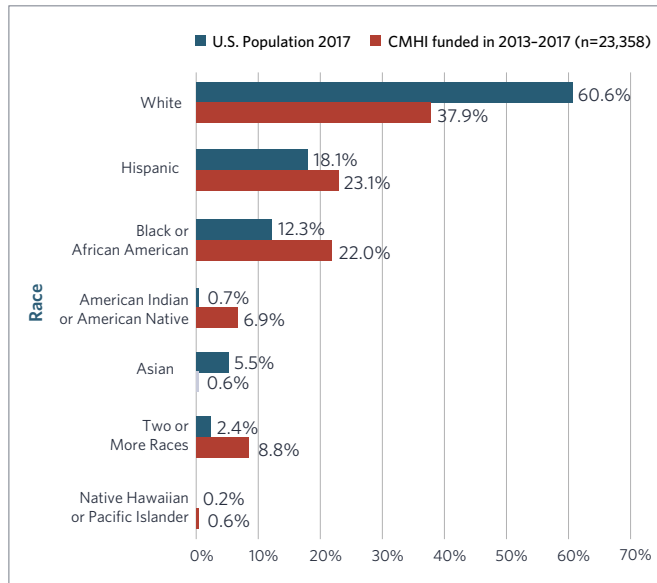


7 Details on “longitudinal studies of outcomes of services provided by such systems, other studies regarding such outcomes, the effect of activities under this subpart on the utilization of hospital and other institutional settings, the barriers to and achievements resulting from interagency collaboration in providing community based services to children with a serious emotional disturbance, and assessments by parents of the effectiveness of the systems of care” are required by law (Public Law 102-321, 42 U.S.C. § 290ff-4[c][1]).

Additionally, the law mandates that “the Secretary shall, not later than 1 year after the date on which amounts are first appropriated under subsection (c) of this section, and annually thereafter, submit to the Congress a report summarizing evaluations carried out pursuant to paragraph (1) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this section as the Secretary determines to be appropriate” (Public Law 102-321, 42 U.S.C. § 290ff-4[c][2]).

8 Exhibits show differences in n due to missing data.

Exhibit 3. Child, Youth, and Young Adult Race in CMHI Grant Population Funded Between 2013–2017 Compared to the U.S. Population



Custody Status at Intake

Approximately 93 percent of all children, youth, and young adults served in CMHI grant communities were in the legal custody of a parent or other relative at the time of intake into SOC. Almost five percent of children, youth, and young adults served were in the custody of the state compared to less than one percent of all children in the United States who are in foster care (Exhibit 4).

Exhibit 4. Custody Status at Intake for All Reporting Grants, 2013–2017

Custody Status	Percent (n=4,513)
Biological Mother Only	42.8
Two Parents (Biological or Adoptive)	36.4
Grandparent(s)	8.0
Ward of the State	4.7
Biological Father Only	3.9
Other	2.6
Aunt and/or Uncle	1.3
Siblings	0.2
Adult Friend	0.1

Poverty Level of Children, Youth, Young Adults, and Families

Children, youth, and young adults served by CMHI grantees were among the most economically disadvantaged populations in the nation. For CMHI grantees funded between 2013 and 2017, nearly three quarters (71.3 percent) of children, youth, and young adults were living near or below the federal poverty level.

Adverse Childhood Experience

For CMHI grantees funded between FY 2013 to 2017, nearly two-thirds (63.9 percent) of children, youth, and young adults entering SOC services reported experiencing adverse childhood experiences such as domestic violence and/or trauma at entry into SOC Services.

Mental Health Status

Children, youth, and young adults exhibited a variety of mental, social, and emotional symptoms at entry into services. Exhibit 5 shows the most common primary diagnoses for 2013–2017 grantees were attention-deficit/hyperactivity disorder (40.4 percent), mood disorder (39.9 percent), oppositional defiant disorder (19.4 percent), anxiety disorder (13.9 percent), and post-traumatic stress disorder/acute stress disorder (15.5 percent). Approximately 40.7 percent of children, youth, and young adults served have one diagnosis, 31.3 percent have two diagnoses, and 28.0 percent have three diagnoses.

Exhibit 5. Mental Health Diagnoses at Intake for All Reporting Grants, 2013–2017*

Primary Diagnosis	Percent (n=7,604)
Attention-deficit/Hyperactivity Disorder	40.4
Major Depression Disorder	19.4
Oppositional Defiant Disorder	19.4
Other Mood Disorders	16.5
Post-traumatic Stress Disorder/Acute Stress Disorder	15.5
Anxiety Disorder	13.9
Adjustment Disorder	10.6
Conduct Disorder	8.5
Autism Spectrum Disorder	5.3
Bipolar Disorder	5.2
Schizophrenia and Other Psychotic Disorder	2.4
Other Mental Health Diagnosis	8.2

*The percentages are duplicated.

Referral Source at Intake

Mental health agencies, clinics, and providers accounted for 35.5 percent of referrals, schools accounted for 14.4 percent, and child welfare and protective services accounted for 17.1 percent. Caregiver referrals accounted for 8.6 percent and 7.6 percent were referred by the juvenile justice system (Exhibit 6). Additional referral sources included other health care agencies, the youth or child him- or herself, and other sources that were not identified.

Exhibit 6. Referral Sources at Intake for Grants, 2013–2017

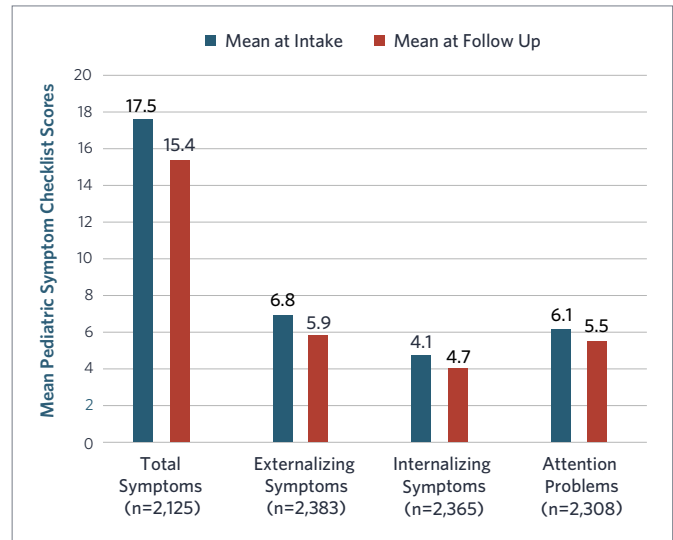
Referral Source	Percent (n=7,852)
Mental Health Agencies, Clinics, and Providers	35.5
Schools	14.4
Child Welfare and Protective Services	17.1
Caregiver	8.6
Juvenile Justice System	7.6
Other Health Care Agencies, Clinics, Providers	3.1
Youth/Child referred himself or herself	1.2
Other	12.7

V | Outcomes of Children, Youth, Young Adults, and Families Served

a. Children, Youth, and Young Adults Experienced Symptom Reduction

There was a significant, overall improvement in mental, emotional, and behavioral functioning from intake to follow-up.⁹ Exhibit 7 shows that from intake to follow-up,¹⁰ overall symptoms, externalizing symptoms such as behavior problems, internalizing symptoms such as depression and anxiety, and attention problems were all significantly reduced ($p < .0001$).

Exhibit 7. Mean Symptom Reduction Among Children, Youth, and Young Adults*

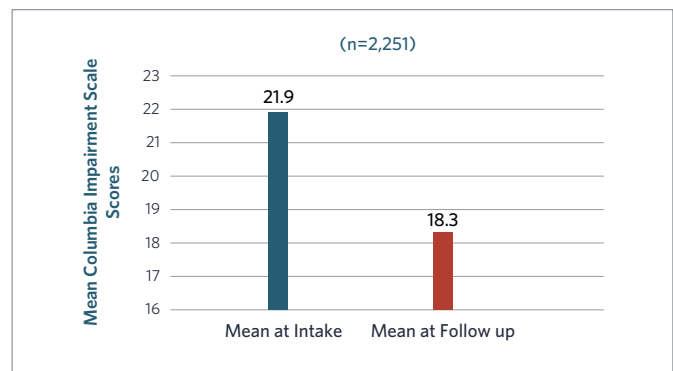


*All $p < .0001$

b. Children, Youth, and Young Adults Experienced Improved Functioning

There was significant overall functional improvement from intake to follow-up.¹¹ At entry into SOC services, children, youth, and young adults were assessed in overall functioning. Exhibit 8 shows a significant proportion of youth moved from clinical functional impairment, meaning the child or youth experiences one or more limitations from achieving or maintaining one or more developmentally appropriate social or cognitive skills, to no longer being clinically impaired.

Exhibit 8. Mean Improvement of Functional Impairment Among Children, Youth, and Young Adults*



*All $p < .0001$

9 Pediatric Symptom Checklist (Jellinek et al., 1988)

10 Follow-up refers to the most recent follow-up which could be 6, 12, or 18 months from intake and averaged 200 days.

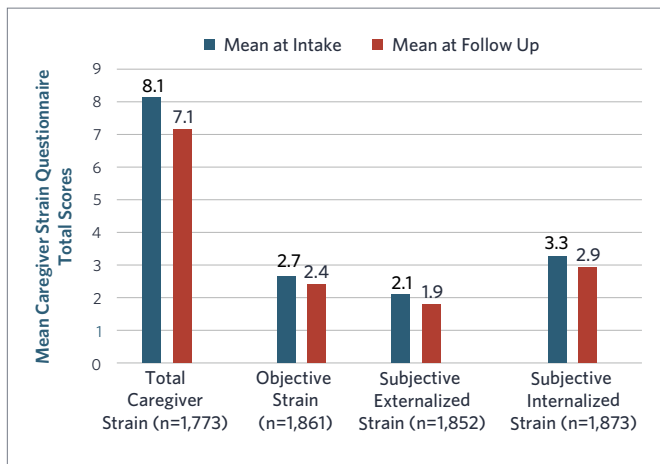
11 Columbia Impairment Scale (Bird et al., 1993)

Case Study

c. Caregivers Reported Less Strain

Caregivers reported significantly less stress from intake to follow-up. Because caring for children, youth, and young adults with mental, social, and emotional symptoms can be stressful for caregivers and families, SOC seeks to improve outcomes of caregivers, as well as children. Three dimensions of caregiver strain were assessed: subjective externalizing strain (e.g., expressing anger or resentment toward one's child), subjective internalizing strain (e.g., feeling worry or guilt), and objective strain (e.g., observable disruptions in family life such as lost work time) as part of a total global strain score. Exhibit 9 shows that according to caregivers, their level of strain was significantly reduced in all areas.

Exhibit 9. Reduced Caregiver Strain*



*All $p < .0001$



System of Care Expansion and Sustainability

The State of Delaware Department of Services for Children, Youth and their Families created the Delaware CARES System of Care in 2013. By the end of the grant in 2017, Delaware CARES successfully met its expansion and sustainability goals and accomplished the following:

- Implemented crisis stabilization for children to help reduce hospital re-admissions, which achieved effective community-based care and significant cost savings.
- Achieved sustainability of crisis stabilization efforts by awarding a contract to maintain this service model to a community service provider.
- Achieved inclusion of Family Peer Support¹² in the state's Medicaid plan as a reimbursable service.
- Expanded the family partners network to include peer-to-peer groups in all counties in the state.
- Piloted a High Fidelity Wraparound¹³ team in the state system for children and families receiving services from both the Children's Mental Health Division and the Division of Child and Family Services (including foster care).
- Implemented the High Fidelity Wraparound team approach statewide to maintain children in their home communities and support the reunification of youth and families.
- Offered training and coaching in High Fidelity Wraparound to ensure provision of High Fidelity Wraparound across the state.
- Obtained approval for a 501(c)(3) non-profit designation for Champions for Children's Mental Health, the first family-run organization in the state that is dedicated specifically to children's mental health.

12 Family Peer Support Services are an array of formal and informal services and supports provided to families raising a child up to age 21 who is experiencing social, emotional, developmental and/or behavioral challenges in their home, school, placement, and/or community.

13 The High Fidelity Wraparound process supports children, youth, and young adults with a mental health diagnosis who are involved in multiple systems. Wraparound facilitators address the unique needs of the child and their family by developing an individualized plan of care.

d. Children, Youth, and Young Adults Experienced Improved Health, Functioning, and Overall Well-Being

Children, youth, and young adults showed significant improvement in functioning at home, in school, and in the community, as well as overall improvements in health and well-being. Exhibit 10 shows the findings from intake to the follow-up interview. Significant results include:

Improvement in Everyday Functioning: Children, youth, and young adults functioning in everyday life significantly improved at follow-up (66.4 percent) compared to intake (40.8 percent), which represents a positive change of 62.7 percent ($p < 0.001$).

Improvement in Overall Health: More children, youth, and young adults were healthy overall at follow-up (87.4 percent) compared to intake (81.4 percent), which represents a significant positive percent change of 7.3 percent ($p < 0.001$).

Improvement in Social Connectedness: More children, youth, and young adults reported being more socially connected at follow-up (88.2 percent) compared to intake (75.7 percent), which represents a significant positive percent change of 16.5 percent ($p < 0.001$).

Improvement in Psychological Distress: More children, youth, and young adults reported no serious psychological distress at follow-up (89.6 percent) compared to intake (76.3 percent), which represents a positive change of 17.5 percent ($p < 0.001$).

Improvement in Illegal Substance Use: More children, youth, and young adults reported that they were not using illegal substances at follow-up (78.4 percent) compared to intake (75.0 percent), which represents a positive change of 4.6 percent ($p < 0.001$).

Improvement in Retention in Community: More children, youth, and young adults were retained in the community at follow-up (91.3 percent) compared to intake (82.7 percent), which represents a 10.4 percent improvement ($p < 0.001$).

Improvement in Education/Employment: More children, youth, and young adults were attending school regularly or were currently employed at follow-up (89.2 percent) compared to intake (81.6 percent), which represents a 9.3 percent improvement ($p < 0.001$).

Exhibit 10. Improvements in Health, Functioning, and Overall Well-Being

Outcome	n	Positive at Intake	Positive at Follow-up	Percent Change	p
Overall health	3,251	81.4%	87.4%	7.3%	<0.001
Functioning in everyday life	3,359	40.8%	66.4%	62.7%	<0.001
No serious psychological distress	1,129	76.3%	89.6%	17.5%	<0.001
Were not using illegal substances	1,106	75.0%	78.4%	4.6%	<0.001
Retained in the community	3,217	82.7%	91.3%	10.4%	<0.001
Had a stable place to live	3,803	88.0%	89.2%	1.4%	< 0.05
Attended school regularly and/or currently employed/retired	2,379	81.6%	89.2%	9.3%	<0.001
Had no involvement with the criminal justice system	3,907	95.5%	97.6%	2.2%	<0.001
Client perception of care	3,723	N/A	94.0%	N/A	N/A
Socially connected	3,207	75.7%	88.2%	16.5%	<0.001



Children, youth, and young adults with SED and their families often have complex needs that can benefit from being addressed by multiple service sectors in an organized and efficient manner. A system of care approach encourages child- and youth-serving agencies to collaborate in improving outcomes for children, youth, and young adults with SED. The first step of this collaboration is to ensure that referrals to CMHI-funded services and supports are coordinated and seamless.

“After I lost my mom, it just seemed like the whole world just stopped. No one can replace her, basically. That’s the same way I felt with my uncle, too; no one can replace him. After I lost those two, my whole world just stopped. The counselors at school noticed it more and more, so they nominated me to go to the system of care. The system of care really helped me a lot to get me through my depression and all kinds of other stuff.”

VI | Expansion, Services and Supports

The CMHI grantees strive to expand their delivery systems to provide increased access to effective evidence-based services and supports. Data from the national evaluation demonstrates that grantees expand the availability of evidence-based practices (EBPs) by using existing and innovative funding mechanisms to support service system sustainability.

Evidence-Based Practices

The CMHI grantees are promoting numerous EBPs. Stakeholder interviews were conducted with grantees funded in FY 2013 and FY 2014, and the findings reveal that among these 30 grantees, 36 different EBPs were in use, with all grantees implementing one or more EBPs.

The most commonly reported EBPs are Trauma-Informed Approaches (e.g., Trauma Focused-Cognitive Behavioral Therapy), Motivational Interviewing, Cognitive-Behavioral Therapy, Multisystemic Therapy, Supported Employment, and Strengthening Families.

Findings (Exhibit 11) reveal that over 90 percent of the respondents reported that their CMHI grant mandated the use of EBPs. Finally, results of the stakeholder interviews provide evidence for the widespread availability of EBPs among CMHI grantees. Eighty-five percent of the respondents reported that EBPs were available in most or all CMHI-funded grantees and sites funded by grantees (Exhibit 12).



Exhibit 11. Mandated Use of EBPs

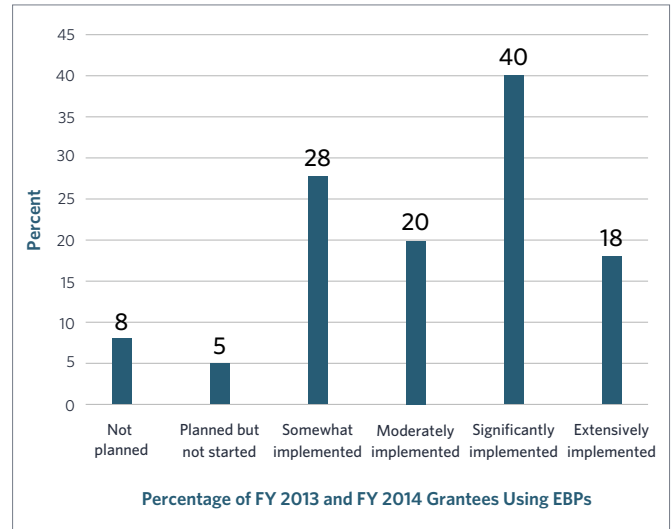
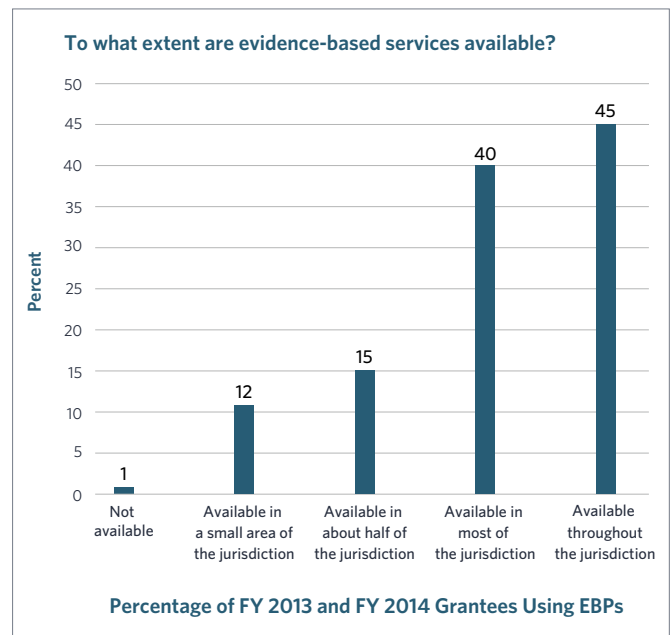


Exhibit 12. Extent of Availability of EBPs

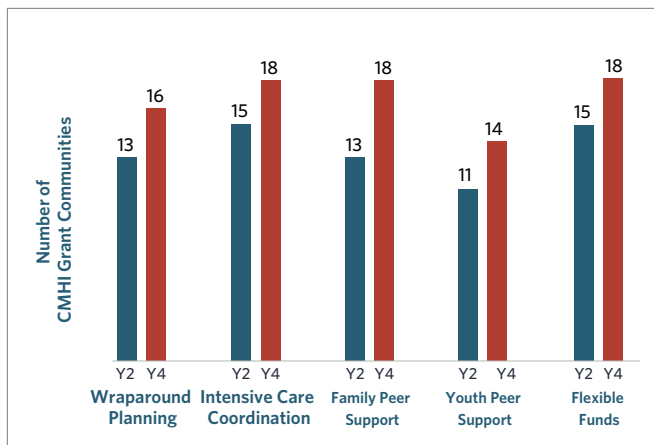


VII | Sustainability and Financing

State, County, and City Grantees

An in-depth analysis of CMHI grantees funded in FY 2013 and FY 2014 indicated that these grantees achieved sustainable funding sources for core home- and community-based services needed in their SOC by the end of their grant period. Three-quarters (76 percent) offered five key SOC services: wraparound planning, intensive care coordination, family peer supports, youth peer supports, and flexible funding. The remaining quarter of the grantees offered three or four of these services. Less than half used the CMHI grant to fund these services, and 86 percent or more of the services already had some Medicaid and/or mental health authority funding by Year 2 of the grant (Exhibit 13). By Year 4, grantees rated 60 percent or more of the existing services as being sustained, and two additional grantees planned to initiate peer support services through a pending Medicaid HCBS waiver or a Medicaid state plan amendment. State plan amendments and home- and community-based services waivers were the most frequent approaches to obtain Medicaid reimbursement. Mental health authority resources were critical for covering non-Medicaid children and for supporting the use of flexible funds to address non-reimbursable services tied to a treatment plan. Interviews found that Medicaid agencies built upon the principles of SOC for children with complex mental health problems, and suggested there were strong partnerships between mental health and Medicaid agencies for children’s mental health.

Exhibit 13. Increase in Sustainability in FY 2013 and FY 2014 CMHI Grant Communities’ Home- and Community-Based Services from Year 2 (Y2) to Year 4 (Y4)



VIII | Conclusions



The findings of this report demonstrate that CMHI grantees continue to provide effective, evidence-based services in the community that improve the clinical and functional outcomes of children, youth, and young adults with SED and their families. At the system level, providers embedded SOC values throughout their infrastructure as well as in their delivery approach—implementing EBPs, engaging and empowering youth and families, and focusing on the critical importance of cultural and linguistic competence. Moreover, CMHI grantee expansion efforts have resulted in bringing the SOC approach closer to scale nationally. The CMHI expansion and sustainability grants successfully drove more wide-scale adoption of the SOC framework by: (1) continuing to demonstrate improved outcomes for children, youth, young adults and families; (2) demonstrating service system improvements including increased access to evidence-based services and supports; and (3) identifying innovative financing strategies to sustain effective mental health services and supports.

The CMHI program continues to demonstrate statistically significant, positive outcomes for children, youth, and young adults with SED and their families as evidenced by:

- Fewer mental, emotional, and behavioral symptoms;
- Improved overall functioning (e.g., improved relations with family members and peers, and greater academic or occupational functioning);
- Improved overall health;
- Greater level of social connections;
- Reduced psychological distress;
- Improved retention in community;
- Improved school attendance and employment;
- Reduced use of illegal substances; and
- Reductions in caregiver strain.

The National System of Care CMHI program has been successful in expanding the service array by increasing:

- Family and youth involvement;
- Social marketing and engagement, particularly with hard-to-reach populations;
- Access to evidence-based services and supports; and
- Financing strategies to sustain effective, community-based services and supports.

Recommendations for Future Programming

Through expanding and sustaining CMHI-funded SOC, children, youth, and young adults with SED and their families are provided with EBPs, programs, and services that improve their mental and overall health. As CMHI continues to bring the SOC approach to scale, additional programming can advance and enhance mental health service provision.

Recommendations for future programming related to CMHI and SOC include:

- **Continue to promote SOC expansion and sustainability.** SOC demonstrate effectiveness in improving the lives of children, youth, young adults and families. Future programming should continue to support this approach, and efforts to bring SOC to scale across the nation. In particular, states can play a key role in continued expansion and sustainability given their capacity to marshal and direct resources to support SOC in local communities.
- **Continue to expand the use of EBPs, programs, and services.** CMHI grantees currently encourage EBPs through mandates, trainings, distribution of practice guidelines and manuals, and fidelity monitoring. CMHI supports a widespread and diverse cohort of service systems that can lead the development of methods to improve the rate of the successful uptake and implementation of effective EBPs.
- **Focus additional attention on co-occurring mental and substance use disorders.** Individuals with mental health disorders are more likely to experience alcohol or other substance use disorders. The co-occurrence of mental and substance use disorders magnifies the complexity of providing effective diagnosis and treatment. Future programming would best serve individuals with co-occurring disorders through integrated treatment approaches that require an increase in awareness and capacity to provide effective services and supports.
- **Continue efforts to expand SOC to other child-serving systems.** Future efforts should consider including a specialized focus on building bridges to other child-serving systems such as child welfare, juvenile justice and primary care. Specifically, given that the SOC approach is effective with these populations, developing such collaborations will integrate service delivery, improve outcomes, and ultimately help expand and sustain SOCs.

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