



**Children's Mental Health Plan
Family Engagement & Support,
Early Identification and
Evidence-Based Practices
Workgroup**

Draft Report of Workgroup Proceedings
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Division of Children and Families
Office of Planning
New York State Office of Mental Health

The ideas and recommendations expressed in this draft report reflect those of the individuals participating in the workgroup and not necessarily those of New York State agencies serving children and families. The mention of specific interventions or service models does not imply endorsement by these agencies.

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Children's Mental Health Plan
**Family Engagement & Support, Early Identification and
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I. Introduction

Joe's Story Now:

Picture a nine year old boy in a classroom. Let's call him Joe. He is smart, creative and well-behaved. He is even placed in a Talented and Gifted program because his learning has advanced beyond those of his peers. But Joe is also introverted and overly shy. His teachers don't notice that anything is wrong because he isn't acting out; he's not a trouble-maker.

Joe becomes scared of the school bus; then of school itself. He refuses to leave the house and is afraid his family won't be there when he returns. His family has no idea how to help, or where to turn for help. They hesitate to talk to his teachers because they don't want him labeled or taken out of his program.

The school is accommodating of Joe's specific needs (going to school later in the day, escaping to the safety of the nurse's office) but is not particularly helpful. There is little communication between the school and the mental health system.

His parents take him to a therapist, who says he's "sensitive". Joe lies to the therapist because he wants to appear "normal". He hides his symptoms as best he can at school so that his teachers won't see that something's wrong.

Joe struggles and suffers for 20 years, although outwardly he appears high-functioning. He graduates from college and has a successful career. Others don't question his happiness. He has good days and bad. The bad are very bad.

Joe is finally diagnosed with obsessive-compulsive disorder. He decides against taking medication and treats his anxiety and other symptoms through exercise, breathing techniques, and writing. He understands his challenges now, and embraces them. But he asks, "Where was the help I needed when I was a child?"

There are too many young people in New York State like Joe, who go undiagnosed or misdiagnosed every year. The state must make a true commitment to ensuring that

these young people do not continue to fall through the cracks by identifying young people early and by educating and involving families and others who come in contact with children and families who may be experiencing mental health issues.

II. Vision

We envision a children's mental health system that addresses the needs and enhances the strengths and competencies of young people within a service delivery system. Such a system would be focused on positive youth development and strong partnerships with families and their communities. It would place a strong emphasis on early identification and intervention; on the need to engage youth and their families in services as issues related to a child's social and emotional well-being emerge; and on a commitment to treatment approaches that are acceptable to families and supported by evidence for effectiveness. This transformed child-serving system would provide supports and services to young people and their families from the prenatal period to young adulthood.

To realize this vision, New York State must:

- Expand **early identification and early intervention** in normative settings and across child-serving systems
- Increase **family support and engagement** in all aspects of a young person's development, including the identification and treatment process
- Increase the use of **evidence-informed, evidence-based, and promising practices**

III. Background

According to the U.S. Surgeon General, there are nearly one million young people in New York State with emotional, behavioral, or substance use disorders. However, a substantially smaller number of children/youth in the state actually receive adequate mental health services. As a result, there is a clear need for a collaborative, community-based, cross-systems approach that emphasizes engaging, responsive and flexible service delivery. This approach is grounded in a shared decision-making process between young people, families, mental health providers, and others involved in the life of the young person. All child-serving partners must receive ongoing exposure, training and support for integrating evidence-based approaches to engagement and intervention, endorsed by young people and families, into the service delivery system. Further, family support and advocacy services must be made readily available to families across child-serving systems. There are numerous impasses

confronted by families, such as, the lack of information available to families related to the emotional well-being and mental health of young people and service resources; stigma associated with seeking out help; concerns regarding cultural fit of services, all of which can make accessing needed mental health services difficult. To overcome these barriers, there must be a shared vision and intensive collaboration between child-serving partners, specifically education, health (medical), child welfare, juvenile justice, housing, developmental disabilities, substance abuse, and social services.

New York State continues to try to improve the child mental health service system. Funding for children's mental health has increase substantially over the last few years. For example, in 2006, OMH was funded and additional \$62 million to initiate *Achieving the Promise*, a policy effort to bring coordination in reform, policy and funding has also raised the bar for the entire children's mental health system. However, despite these substantial investments and programmatic enhancements in children's mental health across the state, there remain serious gaps in the service system. Most notably, services to very young children in relation to emotional well-being remain very limited. This suggests a serious missed opportunity for early intervention as 85% of brain development happens before age five (some research says age three) and is in direct response to what an infant or toddler experiences.

According to James Heckman, early family environments are "major predictors" of cognitive and social-emotional abilities. He notes early interventions to engage children, both within the family and within the outside community, "promote schooling, reduce crime, promote workforce productivity and reduce teenage pregnancy." The family is the foundation for a child's success and should be supported and strengthened, while the community can provide those necessary reinforcements. Thus, addressing this gap in service delivery, strengthening services to young children, providing support services to their families and partnering with the families and providers across the state is needed to ensure children's success.

In the past, there has too often been a chasm between the mental health system and the educational system. This is despite substantial evidence that mental health issues impact quality of life, including a young person's ability to learn. One likely early indicator of mental health concerns is the manifestation of behavioral problems in preschool settings.¹ In addition, young children's social-emotional and behavioral competence is a strong predictor of academic performance in elementary school.² According to the New York State Department of Education, in 2006-07, 64% of eighth graders with no disability demonstrated reading proficiency. Among eighth graders with

¹ *Promoting the Mental Health and Healthy Development of New York's Infants, Toddlers and Preschoolers: A Call to Action*; New York City Early Childhood Mental Health Strategic Work Group; December 2004.

² *Infant and Early Childhood Mental Health: Promoting Healthy Social and Emotional Development*; Zero to Three Policy Center; May 18, 2004

an emotional disturbance that number was a mere 12%. In order to both increase educational ability and to prevent more serious mental health issues in later life, it is imperative that all child-serving systems understand brain development and provide effective early identification and intervention in partnership with educational settings and staff.

The state must also focus its efforts on increasing the capacity of other child-serving systems to understand, respond to, refer, and possibly treat mental health issues. While taking a parallel approach and increasing the number of child and adolescent psychiatrists, New York State must recognize that the shortage of qualified providers has reached crisis proportions and may never be adequate. Therefore, those who come into contact with young people and their families in normative settings must be prepared to address their mental health needs. This means an increase must occur in education and training, as well as a commitment from all child-serving systems (state and local) to communicate about and collaborate on the care of young people and their families.

The frequency of mental health problems is highest among the very poor.³ Yet, accessing mental health care has proven very complicated for those struggling with poverty. While Medicaid covers children's mental health care, it is often difficult to access services. In addition, New York State's Child Health Plus program provides limited inpatient and outpatient treatment coverage. Private insurers are required, by the passage of Timothy's Law in 2006, to cover most adult mental health issues, as well as the broad range of mental health issues related to young people. This is important because, for decades, families with private insurance were forced to pay for treatment out-of-pocket or forego it entirely when they hit their insurance "cap". The ceiling of coverage was set lower than that for physical ailments.

Over the years, parents with no insurance or with insurance limits have relinquished custody of their children in order to receive treatment. In 2001, an estimated 12,700 children nationwide entered the child welfare and juvenile justice systems explicitly to receive mental health care.⁴ These numbers do not take into account the young people who were placed for other reasons but had, indeed, a mental health problem. New York State must expand coverage for mental health services so that young people are not relegated to the child welfare and juvenile justice systems for treatment. The state must also increase its capacity to treat these young people in-state, where they can either remain in their community or, if in residential settings, be placed close to family.

³ *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*; Department of Health and Human Services; 2000; <http://www.hhs.gov/surgeongeneral/topics/cmh/childreport.htm>.

⁴ *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*; United States General Accounting Office; April 2003.

IV. Statement of Need

Family Support and Engagement

Family is the foundation on which a young person's life is built, and is the most powerful force in their young lives. Young people and their families should be involved in all aspects of service delivery. Thus, the motto "Nothing about us without us," may be used to define the collaborative nature of service delivery across the state. Treatment should be driven by the young person and his/her family. Furthermore, the family should be supported in that decision-making. Service-seeking can be a complex and too often distressing experience for families with associated confusion regarding the nature of a young person's difficulty and the appropriate service option. Collaborative approaches to goal setting, provider/ parent information sharing and intensive family involvement frequently are not part of standard practice. Currently, family support programs and child-serving systems are not integrated in a way that can be easily accessed by families or providers.

Early Identification and Intervention

Numerous federal reports estimate that between two-thirds and three-quarters of young people with significant mental health difficulties do not have sufficient or appropriate contact with the existing mental health system. A number of national and local studies point to a set of barriers that often converge to impede young people and their families receiving adequate care, particularly early on in the course of their development. For example, barriers related to the service system (e.g. fragmentation of services, insufficient resources across the diverse geographic regions of the state) can impede service use by young people and families in need. Identification and intervention must occur as early as possible, in order to be most effective and to eliminate unnecessary suffering and other negative consequences associated with undiagnosed or untreated mental health issues.

Early identification and intervention are seen as necessary steps in the prevention of more serious difficulties, as well as opportunities to enhance functioning and youth development. As a state, we must retreat from the idea that identifying a young person with mental health needs means a lifetime of labeling. We must reduce stigma and the corresponding discrimination that can shatter self-esteem, pigeonhole young people into inappropriate programs, and limit their options for future success. Instead, we need positive messages disseminated across New York State that reinforce that when issues impacting the social or emotional well-being of young people are identified early and the appropriate intervention is offered, then many early mental health difficulties can be

effectively resolved. Further, public awareness campaigns that embrace early intervention as a way to decrease both the human and financial costs of mental health issues are sorely needed.

Evidence-Based Practices

Frequently, child-serving partners do not receive extensive training or ongoing supports in the use of evidence-based practices. Further, practice settings, agency operating procedures, or supervisors often do not align to support the use of these approaches. While the child- and family-focused service delivery has become increasingly more evidence-informed and evidence-based, it is critical to recognize the importance of promising practices and support to increase the use of research-based practices that show potential within clinical settings across the state. In order to increase the number of evidence-based practices and their effective utilization, New York State must provide the tools to examine practices, assist programs and clinical sites in monitoring child and family outcomes, and routinely provide opportunities for the field to share challenges and successes in practice.

Conclusion

New York State must work across child-serving systems to identify, assess, and treat young people with mental health issues using family-driven, evidence-based practices. It is only through true collaboration and communication with parents, peers, and all involved systems that young people will cease to fall through the cracks and will receive the help that they need in a timely fashion.

The state must ensure cooperation in this endeavor by educating the public, providers, and policymakers about mental health and wellness. It is necessary to eliminate stigma and increase awareness in order for transformation to be successful and for change to be institutionalized.

The system transformation discussed here cannot happen without adequate and stable funding for services and infrastructure supports. It will also require funding for new programs and options for flexible service delivery. In order for long-term change to occur, and in order for the state to evaluate that change and its outcomes, resources must be committed over the long-term.

V. Recommendations

Family Support and Engagement

1. Increase competencies regarding family support and engagement and partner with families across all child-serving systems by increasing parent education, the use of family intervention strategies, and family support/youth peer resources.
2. Increase cultural and linguistic service system competency and respond to the shifts in community demographics and need over time.

Early Identification and Early Intervention

3. Increase awareness and decrease stigma related to mental health and the emotional well-being of young people
4. Provide opportunities for early identification and assessment to young people and families across a range of community-based settings and child-serving systems

Evidence-Informed, Evidence-Based, and Promising Practices

5. Build overall capacity and expand training in evidence-based, evidence-informed, and promising practices that are effective in real world, community settings

Family Support and Engagement

Recommendation One: *Increase competencies regarding family support and engagement and partner with families across all child-serving systems by increasing parent education, the use of family intervention strategies, and family support/youth peer resources*

Rationale

As part of an overall plan for assisting the child, the community must support family members when they experience issues that may negatively impact family life. In addition, all child-serving systems in contact with a family should respectfully assist them as they make decisions about their future. Service providers across child-serving systems rarely have the advanced training in evidence-based engagement practices necessary to help families navigate barriers to care. While the support of child-serving professionals is critical to successfully reducing barriers to services for families and engaging them as partners in care, family support services and contact with family advisors is essential for enhanced education and support. In this way, families can obtain needed information regarding child development, child social and emotional functioning, and mental health. In addition, a family support partner can respond to the expressed concerns, fears and distress of families with both expertise and the “lived experience” of obtaining services and parenting children with mental health difficulties.

Recommendation 1.1

Equip all child-serving partners with opportunities to incorporate evidence-based engagement skills into their practice via ongoing training, continuing education and supervision

Strategies

- Develop a consistent definition of “family supports” that reflects active participation of family members, uses a family-focused and strengths-based philosophy, and is funded across all systems
- Support the development of skills across the child-serving workforce in parent education and the use of family intervention strategies

Recommendation 1.2

All child-serving systems should offer family support services and opportunities to enhance parenting on-site

Strategies:

- All child-serving systems should dedicate funding streams to contract Family Support specialists to be on-site at community-based locations
- Child and Family Clinic Plus should contract with existing Family Support programs to ensure that each Clinic Plus program effectively engages children and their families. On a longer-term basis, all child and adolescent clinics should have access to family support services.
- Explore options for credentialing family parent advocates
- Develop an infrastructure for a Youth/Peer Support Movement that mirrors the Family Support Movement
- Expand Medicaid billable options in the state Medicaid plan for Family Support Services

Recommendation Two: *Increase cultural and linguistic competency and respond to the shifts in community demographics and need over time*

Rationale

New York State can engage and support families by communicating with them in ways that do not include professional jargon and are in their own home language. There are many cultural differences across all of life’s domains, including racial, ethnic, socio-economic, gender, and sexual identify. The youth culture (including age) within the

community is particularly important in this context. Even within generalized cultural standards, differences exist. Providers must have an understanding of cultural mores, values, and expectations. They must be aware of their own cultural world view and how it impacts their understanding of and interaction with families. In addition, providers must be aware of system limitations and be able to help families address system challenges and maneuver barriers.

Recommendation 2.1

Increase the diversity of and cultural awareness within agencies and organizations that provide mental health services and supports

Strategies

- Provide incentives for culturally and linguistically diverse individuals to obtain the education necessary to become a mental health provider
- Co-locate family advisors and parent advocates in community-based settings to actively target issues related to literacy, a sense of mistrust, and the need for partnership with families and communities
- As part of provider auditing process, assess that providers are actively and on an on-going basis evaluating the cultural needs of their consumers and communities
- Create and use multi-language materials
- Develop primers on cultural and mental health issues and concerns
- Adopt the National Standards for Culturally and Linguistically Appropriate Services in Health Care

Early Identification and Early Intervention

Recommendation Three: *Increase awareness and decrease stigma related to mental health and the emotional well-being of young people*

Rationale

New York State needs community-specific and statewide education efforts about mental health and wellness. These community education campaigns must be informed by public health approaches that are based on a strong appreciation for prevention and wellness. They must utilize educational approaches that foster integration between the mental and physical health of children, as well as the link between health and learning. Thus, a broad educational plan is required to educate the public regarding child development, including information regarding brain, cognitive, and social-emotional functioning.

Recommendation 3.1

Form a task force to develop and implement a statewide public awareness campaign that includes the creation of a message that is non-stigmatizing and engaging and that can be used by all child-serving systems

Strategy:

- Eliminate the use of stigmatizing language, such as terms like “special education” and “consumer”

Recommendation 3.2

Create educational requirements for all child-serving professionals, including but not limited to pediatricians, nurses, psychologists, social workers and educators, which include competencies in healthy child development and signs of early difficulties across developmental domains, including physical health, social-emotional functioning, and cognitive functioning

Strategies:

- Collaborate with institutions of higher learning on curriculum development; infuse mental health concepts (including brain development; social/emotional development; importance of first five years; ability versus disability; relation to school readiness) into education and training of all child-serving professions
- Work with the Board of Regents and the professional boards, professional organizations, and colleges/universities to provide post-secondary and in-service training on mental health, reflecting evidence-based, evidence-informed, and promising practices (this should include but not be limited to education and training pertaining to: what constitutes normal behavior; preventing/addressing risk behaviors; identification, assessment, and treatment of trauma; how to recognize triggers and warning signs of crisis situations; treating dual diagnoses; understanding the young person in context; understanding and assessing delays; understanding the importance of screening and how to effectively use screening tools; and when/where to refer for assistance)

Recommendation 3.3

Provide statewide training on evidence-based engagement approaches to all child-serving partners with appropriate adaptation made for specific geographic regions of the state (such as telepsychiatry in rural areas) and issues facing particular systems (e.g. collaborating with parents in contact with child welfare systems)

Recommendation 3.4

Develop a plan in collaboration with family support organizations and youth representatives to have family advisors, parent advocates, and youth advocates lead community education offerings and be a point of early contact for families to facilitate early identification, assessment and receipt of services.

Strategy

- Organize and facilitate dialogue forums with key community constituents, particularly parents, regarding acceptable processes for early identification, mental health promotion, and prevention efforts

Recommendation Four: *Provide opportunities for early identification and assessment to young people and families across a range of community-based settings and child-serving systems*

Rationale

Young people must be treated within the context of their families. These families live their lives in a variety of settings and not all include access to mental health treatment and supports. New York State must extend mental health service delivery to a wider range of normative settings where young people and families might more easily access those services.

Young people with mental health issues are often the same young people found in other child-serving systems. Their families are also often engaged with multiple systems. If we are to truly enhance child mental health and emotional well-being, we must tear down the silos that prevent us from doing so in a comprehensive manner. We must also co-locate services wherever possible, in order to increase access to services and collaboration across systems.

Recommendation 4.1

Expand approved locations for the early identification, assessment and delivery of mental health services into normative settings, including community-based locations such as youth after-school programs, recreation centers, and churches

Recommendation 4.2

Enhance knowledge and use of public health approaches within the mental health provider community

Strategy

- Provide technical assistance regarding formation of partnerships with other child-servicing systems, creation of linkage agreements, and effective approaches to screening

Recommendation 4.3

Ensure continuity of practice and information as young people move from system to system by increasing cross-system collaboration and information sharing

Recommendation 4.4

Enhance the State Education Department's capacity to integrate mental health support services into their schools, policies, and procedures.

Strategies

- Require the State Education Department to reimburse for non-direct services such as professional development and peer groups
- Educate and build the capacity of providers in IDEA Part C (federal law regarding infants and toddlers with disabilities) to identify, assess (as part of the evaluation), and treat social-emotional issues (as part of the Individualized Family Services Plan)
- Educate and build the capacity of providers in IDEA Part B (federal law that sets forth requirements for states and school districts to provide special education and related services to young people aged 3 to 21 with disabilities) to identify, assess (as part of the evaluation) and treat social-emotional issues (as part of the Individualized Education Program)

Recommendation 4.5**

Increase capacity for and access to mental health supports and services in all child-servicing systems to facilitate early identification and intervention

Strategies

- Ensure flexibility in financing to support service provision across settings
- Increase implementation of the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, a mandatory set of Medicaid benefits that requires states to screen children for mental and physical conditions

- Co-locate services in a range of settings or utilize a “Mobile Mental Health Team” or consultation model to reach young people remotely and to bring services to them in a variety of natural settings
- Create stronger partnerships between the mental health community and all child-serving systems and services
- Formally link family support organizations with all child-serving systems and services
- Provide continuing education to child-serving partners regarding early identification and screening approaches; identification of issues affecting a child’s social and emotional well-being; how to use a wraparound approach, etc.
- Increase the use of tools that promote mental health and wellness and that emphasize developmental screening across all child-serving systems
- Charge a cross-systems group with exploring options for funding co-location, education and training, and other recommendations outlined above, and report on findings to New York State Office of Mental Health

(**A list of system specific strategies was also identified and can be found in Appendix 1.)

Evidence-Informed, Evidence-Based, and Promising Practices

Recommendation Five: *Build overall capacity and expand training in evidence-based, evidence-informed, and promising practices that are effective in real world, community settings*

Rationale

There is a critical shortage of mental health professionals in New York State that reflects the shortage of other medical professionals. In addition to increasing the number of child and adolescent psychiatrists through pilot programs, the state must train pediatricians, primary care physicians, nurse practitioners, and community-based service providers to provide consultation and treatment of mental health issues consistent with evidence-based, evidence-informed, and promising practices. The state should also instruct and train educators, law enforcement, foster parents, and others in child-serving systems to understand, identify, and refer mental health issues. In addition, the state should increase the usefulness of assessments so that they have impact beyond identification of problems (such as matching to appropriate evidenced-based treatments).

Recommendation 5.1

Increase the use of evidence-informed, evidence-based, and promising practices across all child-serving systems

Strategies

- Encourage the production of research that is highly relevant to practice and effective in real world settings and utilize that research when necessary; offer opportunities to research promising practices that have been developed at the local level
- Provide technical assistance that integrates “real world” constraints, peer-oriented interventions, and informal support
 - Promote the use of promising interventions that serve populations of interest such as, Youth Advisory Councils and Transitional Case Management, as well as collaborative services that serve both the parent with mental health issues and their child
- Ensure fidelity in evidence-based practices and provide resources to assist; give best practice consideration to what is currently inconsistent training
- Provide ongoing continuing education on evidence-based practices to all child-serving partners
 - Address populations of interest such as, how to provide direct service to infants, toddlers, preschoolers, and their families

Recommendation 5.2

Ensure that evidence-based family engagement techniques are used across all child-serving systems

Strategies

- Integrate evidence-based engagement approaches with promising, evidence-informed and evidence-based practices
- Employ family advisors and parent advocates as systems navigators to help families request and receive evidence-based practices for their children

Recommendation 5.3

Support providers’ implementation of evidence-based practices at the state-level through technical assistance, funding and quality improvement efforts

Strategies

- Support providers across the state as they attempt to address simultaneous roll-outs of projects and competing priorities; address implementation issues by providing ongoing technical assistance around barriers and by studying successes in the field
- Fund evaluations and quality improvement (measure fidelity for models, effectiveness of interventions, and effectiveness of service provision)
- Require agencies to engage in more comprehensive self-assessments, including the use of walk-through methods that assess experience of receiving services from a young person's and families' perspective, satisfaction with the service provision, and perceptions of effectiveness
- Require ongoing clinical supervision/training of evidence-based practices at child-serving sites
- Compensate child-serving sites for elevating and maintaining practice standards

Conclusion:

New York State can realize this vision. With a transformed children's mental health system that addresses the needs and enhances the strengths and competencies of young people, focuses on positive youth development and strong partnerships with families and their communities, emphasizes early identification and intervention, and is committed to effective treatment approaches, Joe's life can change for the better.

Joe's Story in the Future if we Take Action:

Picture a nine year old boy in a classroom. Let's call him Joe. He is smart, creative and well-behaved. He is even placed in a Talented and Gifted program because his learning has advanced beyond those of his peers. But Joe is also introverted and overly shy. His teachers don't notice that anything is wrong because he isn't acting out; he's not a trouble-maker.

Joe becomes scared of the school bus; then of school itself. He refuses to leave the house and is afraid his family won't be there when he returns. His family has no idea how to help, or where to turn for help. They hesitate to talk to his teachers because they don't want him labeled or taken out of his program.

The teacher begins to notice an increase in Joe's absences and sees that he is very anxious when he does make it to school. She calls Joe's parents to see if there is a problem and if there is anyway she can help. Joe's mom shares with the teacher some of his behaviors and expresses her fear that Joe will be labeled. The teacher tries to calm the mother's fear and suggests she come in for a meeting with the school's family

advocate and school's Clinic-Plus screener. The teacher explains that the family advocate can help her decide how to help her son.

The meeting goes well and Joe's mom decides to have Joe screened for emotional wellness by the screener. Later in the week, the screener calls to explain the results of the test came back positive and to offer the mother an appointment with the local clinic for a full assessment. At the clinic, the screener meets with Joe and his family and introduces them to one of the clinic therapists. They all sit and discuss some of the problems Joe has been having and identify how each of them would like to see them resolved.

After completing a comprehensive assessment with Joe and his family, the therapist diagnosed Joe with obsessive-compulsive disorder. Together, the family and therapist decide to try a treatment of medication and Cognitive Behavioral Therapy. After just two months, Joe is much less anxious about school and leaving his family and he has even gained a number of techniques to help him manage his compulsive disorder.

After six months, Joe is doing well in school and has been kept in his Talented and Gifted program, which he likes very much. He has a very good relationship with his teacher and has a number of other adults in the school he can turn to if he needs help, like the family advocate and the school's screener. Joe is much more at ease and has even started to spend nights at his best friend's house again.

Appendix 1

System Specific Strategies for Increasing Mental Health Support and Services in Other Child-Serving Systems

Recommendation 2.4 *Increase capacity for and access to mental health supports and services in all child-serving systems to facilitate early identification and intervention*

In the primary care system

- Incorporate voluntary routine screens in primary care for maternal depression, particularly for mothers of infants and toddlers
- Screen infants during well-baby visits
- Encourage the use of *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* and *Bright Futures in Practice: Mental Health*
- Include mental health parity (including Family Support Services) in Child Health Plus
- Increase the use of the medical home model
- Provide universal access to health insurance

In early care and education

- Provide mental health support to early care and education professionals in both Pre-K and child care settings, as school districts do in K – 12

In schools

- Promote establishment of mental health services in school settings by removing barriers to shared funding and co-location
- Provide school readiness assessments; link Clinic Plus to kindergarten screening and other natural transition points

In Special Ed

- Provide early and appropriate referrals to the Committee on Preschool Special Education
- Include teachers in wraparound meetings during the summer months, to get to know the young person/family before school starts
- Ensure teachers in psychiatric hospitals and placements are qualified/certified to teach Regents courses or ensure that the placements can accommodate youth who are able to complete Regents-level work
- Increase alternatives within the classroom to support students and integrate and/or mainstream as much as possible

In after-school programs

- Ensure access to programs for young people with mental health issues
- Address staffing ratio problems so that staff can cater to young people with special needs
- Add social and life skills groups to after-school programs

- Create connections to supportive, mentoring adults and peers and to the community

In foster care

- Increase clinical and dyadic work with parents (birth and foster) and very young children
- Strengthen connections between young people in foster care and their support systems, including siblings, peers, other adults, and alumni who have aged-out
- Prepare young people for reunification and for aging-out long before either occurs, including providing life skills training and therapeutic visitation with biological parents and their children

In children's and adult mental health system

- Create standard procedures for offering opportunities for screening and early identification of children's mental health needs to parents receiving services within the adult mental health system
- Create a task force between the children's and adult mental health systems that focuses on preparing youth to transition out of the system or from system to system by promoting the development and implementation of services designed to engage youth transitioning into adulthood
- Fund and utilize peer support
- Routinely obtain feedback from families whose children are served by the mental health system to determine what supports and services they or their children might need (particularly parents of young children) and then link to services

In MR/DD

- Examine collaborative licensing
- Increase services to support children in their family home

In juvenile justice

- Educate and train staff to focus on this system as holding many opportunities for intervention
- Provide flexible funding to involve positive peer and family supports in services
- Develop a strategic plan for removing barriers to engaging families
- Develop new criteria for the relationship-based assessment of parenting for permanency decisions
- Create more reporting centers at community-based settings where prevention services and other supports are offered

In domestic violence

- Identify young people exposed to family violence for mental health needs

In substance abuse

- Train mental health providers to screen young people for substance use
- Promote and facilitate integrated service provision for dually-licensed programs