Earlier = Better
Communities Proactively Addressing Children's Mental Health

March 2014

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This brief was developed under the banner of the Keep the Promise Coalition Children's Committee. The Keep the Promise (KTP) Coalition is Connecticut's largest group of stakeholders advocating for smart policy reforms and systems change to benefit people impacted by mental health challenges. KTP is dedicated to ensuring that a comprehensive, community mental health system is created and sustained for children, adults and families in Connecticut.

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Executive Summary

The Need:

- Mental health is fundamental to overall health and wellbeing. However, one in five children and adolescents have symptoms of a mental illness and only a quarter of these children have access to appropriate mental health services--leaving approximately 125,000 Connecticut children with unmet behavioral health needs.
- Children and youth with a mental health diagnosis have the highest school dropout and unemployment rate of any disability group.
- In CT, sixty-four percent of children involved in the juvenile justice system have a mental health disorder, with a disproportionate number of children of color entering the juvenile justice system with mental health conditions.
- The best way to address this crisis is to identify and intervene early in order to prevent the development of more complex or severe problems that can negatively impact a child's healthy development.

What's Working: Key Components of iCARE (Identifying Children and Responding Early) and VKB (Valley Kids Belong) — Community-based programs of early identification and intervention for children at risk of mental health problems:

- *Partnership with Schools*—Schools are "often the stage upon which mental health problems first appear", and are naturally the site of regular contact between the children in a community and professionals who are positioned to support them.
- *Universal Screening in a Community Setting*— The screening tools used by both iCARE and VKB, as well as review of attendance and discipline data, are designed to identify at risk children and the extent of services needed.
- *Collaborations with Community Organizations*—Lack of trust is a major reason why families do not seek assessment and early intervention for their children, it is imperative that systems partner with trusted community leaders and organizations.
- *A Continuum of Preventive and Clinical Interventions as a Response to Screening Results*—One of the hallmarks of the iCARE and VKB initiatives is the focus on preventive-level interventions, and not just on clinical interventions. Outcome data from both initiatives indicate that children benefit greatly from preventive-level interventions (e.g., in-school skill building and behavioral processing, afterschool programs, family engagement).
- *Culturally Competent Services and Referral Process*—Children and parents of all cultural backgrounds must feel understood and welcome at all points along the system.

Recommendations: Taking Lessons Learned from iCARE and VKB to Scale

- Systematically implement early screening and identification of at risk children into the statewide behavioral health plan currently being developed by the Department of Children and Families (DCF) and include collaboration between state agencies and other relevant stakeholder groups.
- Create clear guidelines to establish linkages between schools and local community based mental health providers.
- Identify a continuum of preventive and clinical interventions in each community within its network of care to meet the needs of children and families. These services and supports should be culturally and linguistically competent and easily accessible to all families.
- Identify mechanisms for supporting and sustaining screening and early intervention efforts through the legislative process.

Introduction

Mental health is fundamental to overall health and wellbeing.[1] It is widely accepted that good mental health is important for all children to possess as they learn to manage life's varying challenges and obstacles. Yet, one in five children have a diagnosable mental illness[2] and approximately 50 percent of students with mental illness aged 14 and older drop out of high school.[3]

In order for children to succeed in school and in their communities, there must be widespread access to quality mental health care, when needed[4] and a commitment to prevention and mental health promotion for all, and targeted approaches for children who are at-risk of poor educational and social outcomes later in life.[5] Therefore, it is imperative that our state prioritizes early identification and intervention programs to respond to children's mental health needs and promote overall health and wellbeing.

Often, pervasive stigma and misunderstanding surrounding children's mental health issues prevent communities from appropriately addressing the emotional and behavioral wellbeing of our youth. **The goal of this issue brief is to identify the value of prevention and early identification and treatment of children's mental health problems. This brief highlights the work of two Connecticut initiatives that are contributing to the success and wellbeing of Connecticut's children.**

The Need

Youth are disproportionally affected by mental health disorders.[6] Thirteen percent of youth aged 8-15 live with mental illness severe enough to cause significant impairment in their day-to-day lives; twenty-one percent of youth aged 13-18 live with a life-impairing severe mental illness.[7]

Graphic provided by National Alliance on Mental Illness (NAMI)

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[1] Mental Health: A Report of the Surgeon General (1999)

[2] Report of US Surgeon General's Conference on Children's Mental Health (2000)

[3] U.S. Department of Education, Twenty-third annual report to Congress on the implementation of the Individuals with Disabilities Education Act, Washington, D.C., 2001.

[4] http://www.nasponline.org/resources/handouts/abcs_handout.pdf

[5] Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E. (2010). *A Public Health Approach to Children's Mental Health: A Conceptual Framework*. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

[6] National survey confirms that youth are disproportionately affected by mental health disorders. (2010 September 27). *The National Institutes of Mental Health.* Retrieved from http://www.nimh.nih.gov/news/science-news/2010/national-survey-confirms-that-youth-are-disproportionately-affected-by-mental-disorders.shtml.

[7] Merikangas, K. R. et al. Journal of the American Academy of Child & Adolescent Psychiatry. Volume 48, Issue 4 , Pages 367-379, April 2009. Retrieved from http://www.jaacap.com/article/S0890-8567(09)60044-7/abstract

Although one in five children and adolescents have symptoms of a mental illness, only a quarter of these children have access to appropriate mental health services.[8] Additionally, the average delay between onset of symptoms and intervention is 8 to 10 *years*.[9] <u>This leaves approximately 125,000 Connecticut children with unmet behavioral health needs.</u>

Graphic provided by National Alliance on Mental Illness (NAMI)

In addition, although early identification initiatives typically focus on identifying and responding to high (or clinical) levels of need, it is also essential to respond to at-risk children who may not need clinical-level care with appropriate preventive-level services and opportunities for resilience-building. When social, emotional and behavioral problems present as a "whisper" and not a "shout", it is easy to ignore them. However, many children are in a position to benefit significantly from opportunities and services that will build their resilience and protective factors at an early age, and before problems manifest at a higher level of need. For example, intervening proactively with children who have chronic low-level attendance problems – but those that do not rise to the level of mandated reporting – is an important opportunity to change the course of a child's life.

Failure to identify children and youth with mental health conditions leads to the loss of critical developmental years and can lead to involvement in high-end crisis settings and the juvenile justice system. Children and youth with a mental health diagnosis have the highest school dropout[10] and unemployment rate[11] of any disability group. Nationally, 70 percent of children involved in the juvenile justice system have a mental health disorder, with at least 20 percent experiencing symptoms so severe that their ability to function is significantly impaired.[12] In Connecticut, the rate of children with a mental health disorder involved in the state's juvenile justice system is 64 percent.[13] Additionally, it is estimated that 36 percent of court-referred juveniles in Connecticut have been exposed to

90%

of people who die by suicide have a diagnosable and treatable psychiatric disorder at the time of their death.

Graphic provided by National Alliance on Mental Illness (NAMI)

[8] U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000

[9] Kessler, R. et al. National Comorbidity Survey Replication (NCS-R), Archives of General Psychiatry, Issue June 6, 2005.

[10] U.S. Department of Education. 28th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act (IDEA). 2006. Retrieved from http://www2.ed.gov/about/reports/annual/osep/2006/parts-b-c/28th-vol-1.pdf

[11] Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, Briefing Document for the National Governors Association, Center For Best Practice (NGA) Webcast Transforming State Mental Health Systems: Promoting Independence and Recovery through Work: Employment for People with Psychiatric Disabilities, July 31, 2007.

[12] Blueprint for Change, National Center for Mental Health and Juvenile Justice, 2006

[13] CSSD presentation to Behavioral Health Services for Young Adults Task Force

trauma.[14] There are also a disproportionate number of children of color entering the juvenile justice system[15] with mental health conditions,[16] making this not only a health *access* issue, but also a health *equity* issue.

Youth suicide is also a major concern as it is the second leading cause of death among 10-14 year olds in Connecticut.[17] More youth and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease *combined*.[18] And research shows that 90 percent of people who die by suicide suffer from a diagnosable and treatable mental illness at the time of their death.[19]

These drastic outcomes can be avoided if we invest in systems that identify and intervene early on in a child's life when a mental health concern is suspected. As with nearly all health conditions, the sooner children are connected to quality services, the better the outcomes.[20]

The Approach

In July 2003, the President's New Freedom Commission on Mental Health released a report with recommendations for improving the mental health system for children and adults. One of the report's goals recommends that early mental health screening, assessment and referral to services be common practice, in order to improve the outcomes of youth with mental health needs. Specifically, the report recommends that quality screening and early intervention services occur in easily accessible and low-stigma settings.[21]

In November 2007, the nation's leading organizations dedicated to improving the mental health and wellbeing of America's children came together to educate the public about the value of early identification and intervention initiatives. Organizations that were part of this coalition include the American Academy of Child and Adolescent Psychiatry (AACAP), American School Counselors Association (ASCA), Child and Adolescent Bipolar Foundation (CABF), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), Federation of Families for Children's Mental Health (FFCMH), Mental Health America (MHA – formerly the National Mental Health Association), and the National Alliance on Mental Illness (NAMI). This coalition concluded that:

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[14] CSSD Presentation to Behavioral Health Services for Young Adults Task Force

[15] Office of Policyand Management. Biennial Report on Disproportionate Minority Contact FY 2010-11. December 2011. Retrieved from http://www.ctjja.org/resources/pdf/DMCBiennialReport123111.pdf

[16] Cross, T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who are Severely Emotionally Disturbed. Georgetown University Child Development Center / CASSP Technical Assistance Center: Washington, DC.

[17] Department of Mental Health and Addiction Services. Youth Suicide: A Public Health Problem in CT. 2009. Retrieved from http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/YouthSuicideCT.pdf

[18] National Strategy for Suicide Prevention, 2001

[19] Mental Health: A report of the Surgeon General, 1999

[20] The National Advisory Mental Health Council Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment. "Blueprint for Change: Research on Child and Adolescent Mental Health." Washington, D.C.: 2001.

[21] http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/FullReport-05.htm

- Parents play a crucial role in the identification and treatment of childhood emotional and mental disorders. Parents must drive decisions related to the identification and treatment of mental disorders to help achieve the best outcomes for their children.

- Schools are in a key position to identify mental health concerns early and to openly communicate concerns with parents.

- Treatment decisions must always be made by the parents of the child, in close consultation with a treating physician, and not with any pressure from the school system.[22]

The Connecticut early identification and intervention initiatives highlighted in this issue brief reflect and respect the above points, emphasizing the roles of families, schools and community collaboration in meeting the emotional needs of Connecticut's children.

Connecticut Health Foundation's Children's Mental Health Initiative 2009-2014

The Connecticut Health Foundation (CT Health) funded both of the initiatives described in this issue brief; Valley Kids Belong (VKB) in Derby, CT and iCARE (Identifying Children and Responding Early) in Middletown, CT. Both of these initiatives were developed in response to CT Health's children's mental health goal to reduce the number of at-risk children ages 6-14 entering intensive treatment and/or the juvenile justice system due to mental health problems.

Specifically, iCARE and VKB are initiatives that were created to fulfill one of the specific objectives of CT Health's children's mental health goal-- promoting a community-based system of early identification and intervention for children at risk of mental health problems. These initiatives provide both an example of how universal screening can be successfully implemented in a community setting as well as lessons learned that can be applied when developing policies to support universal screening.

Overview of Initiatives

Valley Kids Belong (VKB) is a collaborative, community-based project run out of the Lower Naugatuck Valley Parent Child Resource Center (PCRC). Important partners include the Derby Police Department, the Derby Public Schools, and many more community organizations. Beginning in 2010, VKB implemented a system of children's mental health early identification and intervention in five portal schools in the Lower Naugatuck Valley. VKB comprises three main operational components: screening, prevention programs, and assessments.

iCARE is a cross-sector, culturally competent system of: Early identification and assessment; Linkage to community resources; and a Continuum of preventive behavioral health interventions. Partners in this preventive, school-based mental health initiative include Middlesex Hospital, Middletown Public Schools, and the Ministerial Alliance, a faith-based group of African-American churches.

[22] *Improving the Mental Health and Well-Being of America's Children* Factsheet (November 2007)
Coalition Partners American Academy of Child and Adolescent Psychiatry (AACAP), American School Counselors Association (ASCA), Child and Adolescent Bipolar Foundation (CABF), Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD), Federation of Families for Children's Mental Health (FFCMH), Mental Health America (MHA – formerly the National Mental Health Association), National Alliance on Mental Illness (NAMI)

iCARE currently operates at two pilot sites: Bielefield and Spencer elementary schools. iCARE's mission is the early identification of elementary age children who may benefit from the provision of evidence-based, culturally competent early interventions in three settings: school, family, and community.

Lessons Learned from iCARE and VKB

(1) ***Partnering With Schools Is Essential.***

Both iCARE and VKB chose to partner closely with schools because schools are "often the stage upon which mental health problems first appear"[23], and are naturally the site of regular contact between the children in a community and professionals who are positioned to support them – either by classroom-based intervention, referral to school-based support staff, collaboration with embedded outside services (such as in the case of VKB and iCARE), or referral to outside services. Partnering with schools makes sense considering that seventy to eighty percent of children who do have access to mental health services, receive these services in the school setting.[24]

(2) ***Universal Screening Is A Fundamental First Step.***

Screening is an important part of the public health approach to early identification and intervention for behavioral health problems.[25] The screening tools used by both iCARE and VKB – the Walker Survey Instrument ("WSI") and the AML-R Behavior Rating Scale ("AML-R"), respectively, as well as review of attendance and discipline data – are designed to identify whether there is a need for services and to what extent certain services are needed. Both iCARE and VKB use screening data to triage children into levels of need. Then parents are contacted in order to approve of a more in-depth assessment of what intervention would be most effective.

It is important to realize that both initiatives profiled in this brief have implemented some form of parental consent into their screening programs. The appendices to this brief explain the specific approaches taken by each initiative to obtain parental consent.

One particular lesson learned from both initiatives is that, instead of having universal screening be conducted by community-based providers, school systems themselves are naturally better-positioned to conduct truly universal screening. Teachers and administrators regularly witness the behavioral signs and signals of the mental health needs of all children in the classroom, as well as the incidence, prevalence, and severity of attendance and discipline problems exhibited by all children enrolled at the school. The screening data discussed here is comprised only of data that the school naturally bears witness to – i.e., classroom behavior and attendance – just like basic academic performance. Screening merely brings an intentional attentiveness to the already-occurring observations by school staff of classroom behavior, attendance, and discipline events. Incorporating screening – as well as communication and consent systems for parents –

[23] Center for Children's Advocacy. *Blind Spot: The Impact of Missed Early Warning Signs on Children's Mental Health*, p 4. Andrea M. Spencer, Ph.D., 2013.
[24] Rones M and Hoagwood K. School-Based Mental Health Services: A Research Review. Clinical Child & Family Psychology Review, Vol. 3, No. 4, 2000: 223-241.
[25] Weist MD, Rubin M, Moore E, Adelsheim S, Wrobel G. Mental health screening in schools. J Sch Health. 2007; 77: 53-58.

into basic school operations is the most effective and efficient way of conducting universal screening.

(3) *Collaborations with Community Organizations Are Extremely Important.*

Because lack of trust is a major reason why families do not seek assessment and early intervention for their children, particularly in ethnic groups that have experienced bias and discrimination in the past,[26] it is imperative that early intervention and identification programs partner with trusted community leaders and organizations. Both iCARE and VKB foster community collaborations to overcome this trust barrier.

iCARE focuses on community collaborations during the development of the family action plan, where students and families connect with community and faith-based supports such as recreational or mentoring programs or mental health counseling. Community-based Interventionists, such as Ministerial Alliance members, are involved in each component of the intervention and work alongside the school-based interventionists.

VKB also leverages connections with community-based organizations in order to offer a full range of programs and services to children. Partnering with community organizations ensures that children are linked up with a wider range of services and a program depending on what best suits their needs. In addition, VKB offers community-wide parenting classes and trauma training for police officers. These additional programs aim to create systems change focused on preventing trauma, creating early identification of children's mental health needs, and bringing a greater awareness to partner organizations of the importance of a public health approach to children's mental health.

(4) *A Continuum of Preventive and Clinical Interventions Must Be Available to Respond to Screening Results.*

One of the hallmarks of the iCARE and VKB initiatives is the focus on preventive-level interventions, and not just on clinical interventions. Many children can benefit from preventive interventions to boost their resiliency and protective factors – i.e., the skills and capacities that will help them bounce back from life's inevitable challenges. These children may be ones who are struggling with their social skills, with their confidence, or with other risk factors, and who do not have a diagnosable mental health problem requiring clinical care. Evaluation data from these two programs indicates that children benefit greatly from preventive-level interventions. Accordingly, it is important that those types of interventions are available, in the form of in-school skill building and behavioral processing, afterschool programs, family programs, and more. On the more intensive end of the continuum, still other children will need clinical care, such as therapy, or potential Intensive Outpatient Services. The critically important point is to make sure that *a full continuum of services* is available to children, so that all levels of need are responded to appropriately. There is no "one size fits all" approach to screening data. Instead, screening systems must be linked with a range of options so that interventions are tailored to the specific needs of each child and family.

[26] Department of Health and Human Services. Supplement to Mental Health: A Report of the Surgeon General. Mental Health: Culture, Race and Ethnicity. 1999. Retrieved from http://www.ct.gov/dmhas/lib/dmhas/publications/mhethnicity.pdf

(5) ***Cultural and Linguistic Competence for Services and Referral Process Is Critical.***

Without cultural and linguistic competence, children will fail to be served by any early identification and intervention system. Translation of any communication into multiple languages is a necessary starting point but other steps must be taken as well. Children and parents of all cultural backgrounds must feel understood and welcome at all points along the system – at screening, parental engagement, and intervention. Efforts to ensure a culturally and linguistically diverse staff are helpful in this effort, as well as establishing an ongoing feedback loop to hear feedback from children and parents on how to improve cultural and linguistic competence throughout the system.

For example, iCARE employs community interventionists, faith-based or recognized and respected community leaders, who can address the needs of students and families through the lens of their community within a culturally responsive context. VKB employed an outreach worker who was not only bi-lingual and bi-cultural (Hispanic) but indigenous to the community. Her children attended the portal school and she worked part time in the portal school as an English as a Second Language (ESL) instructor. She was held in very high regard by parents in the community, giving the program significant credibility. All VKB brochures, release forms and communications to parents were available in Spanish as well as English.

The Success Stories: Case Studies & Outcomes

Case Study: iCARE

In one case, iCARE initially became involved with a family during the 2012-13 school year because the children were struggling with school attendance—the three children in the family had missed a concerning amount of school days. The iCARE staff met with the family and talked through the reasons why the children were missing so many days and worked to improve the home-school connection and helped the family access community resources. iCARE staff also provided information on how attendance impacts a child's ability to learn. During the school day, one of the children met with the iCARE Community Interventionist for a weekly boys' group to provide social support and mentoring. In the 2013-14 school year, the children came to school on the first day for the first time ever and have had no attendance issues through mid-October.

In another case, iCARE's work began when the Walker Screening Instrument designated a child as "at-risk" during the 2012-13 school year. This child worked with the in-school Talking and Learning Center (TLC) Interventionist during the school day, but also seemed to need more intensive mental health treatment. The iCARE Services Coordinator was able to connect the family with Mobile Crisis and put a plan in place whereby the family engaged with an in-home parenting service and began mental health counseling. This child began the 2013-14 school year with the appropriate resources in place and is off to a great start.

iCare Outcomes

Preliminary iCARE outcome data, collected between 2010-present, indicate that children who participate in iCARE have **improved overall functioning and reduced severity of behavioral problems** as measured by the Ohio Scales assessment. Both teachers and parents report high satisfaction with the initiative's efforts. Teachers have rated iCARE students as being less depressed, having fewer problematic behaviors, better attendance, improved self-worth, better interpersonal relationships, better self-direction, motivation and overall well-being.

Case Study-In the Words of One Parent: VKB

I was first introduced to Valley Kids Belong a few years ago. At the time, my son was in the first grade, having difficulty focusing in the classroom, not getting along with his peers, and struggling to form friendships. After the initial VKB Afterschool Program we were invited to attend other programs. My son and I were invited to FAST ["Families and Schools Together"]. Following FAST, I was asked to attend Triple P Positive Parenting Program. […] These programs led [my son] to become more confident and able to form positive friendships with his classmates. The staff of VKB became mentors and positive role models giving him a greater sense of security within his school. Valley Kids Belong has also been a positive influence on my life. With VKB's assistance, I was able to help my son and our household make positive changes in our lives. They gave me a sense of belonging to my community.

VKB Outcomes

To date, Valley Kids Belong has screened over 1300 children in 5 portal schools. From that group, 152 have attended the Afterschool and Summer Programs, and 52 families have participated in FAST. Additionally, at least 47 children have been served by their parents attending Triple P Groups.

There has been a marked drop in calls to the police from the 3 public portal schools, and the Derby PD reports that because of the VKB project, officers now call mental health providers first instead of arrest whenever possible.

Additionally, VKB outcome data shows that programs **cause an increase in resilience and protective factors in participating children.** Parents are reportedly more hopeful, and participating students have **increased levels of functioning, self confidence, participation, and positive peer social skills.**

Recommendations

These case examples demonstrate that universal screening can be successfully implemented with a community-based system of care. Based upon the lessons learned and the positive outcomes, we offer the following recommendations:

1. **Systematically implement early screening and identification of at risk children into the statewide behavioral health plan** currently being developed by DCF. All children in Connecticut should be routinely screened in school-based settings for at risk mental health issues and concerns, and access to services and supports needs to be assured when needs are identified.

2. **Create clear guidelines to establish linkages between schools and local provider organizations.** Children and families identified as needing additional supports should be referred for to appropriate community-based resources.

3. **Identify a continuum of preventive and clinical interventions in each community within its network of care** to meet the needs of children and families. These services and supports should be culturally and linguistically competent and easily accessible to all families.

4. **Practice ongoing interdepartmental collaboration between the State Department of Education (SDE), the Department of Children and Families (DCF) and other stakeholders** to successfully implement statewide screening for children and adolescents.

5. **Create data systems to ensure that behavioral health information is confidential and used only with parental permission to link children to needed services**. This data can be treated similarly to health screening data already collected by schools.

6. **Explore and identify financing mechanisms for supporting and sustaining universal screening and early intervention/prevention efforts** through the legislative process and in collaboration with relevant state agencies.

Conclusion

The importance of early identification and intervention services in the area of children's mental health cannot be overstated. Taking a preventive, public health approach allows for the greatest possible impact for the entire population of children in our communities, and includes the children who have more complex needs and may require higher-level supports and services and who can benefit from clinical interventions. Lessons learned in the implementation of the Connecticut Health Foundation-funded iCARE and VKB initiatives should be incorporated into future planning by policymakers in this area.

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Appendix A

iCARE *Middletown, Connecticut*

iCARE (Identifying Children and Responding Early)

The City of Middletown's Experience in Implementing a Children's Mental Health System of Early Identification and Intervention for Ages 6-14: Screening, Referral, Intervention & Assessment

I. Overview

iCARE is a cross-sector, culturally competent system of:

- Early identification and assessment,
- Linkage to community resources, and
- A continuum of preventive behavioral health interventions.

Middlesex Hospital, Middletown Public Schools, and the Ministerial Alliance, a faith-based group of African-American churches, are partners in this preventive, school-based mental health initiative. Funded through the CT Health Foundation, iCARE currently operates at two pilot sites: Bielefield and Spencer elementary schools. iCARE's mission is the early identification of elementary age children who may benefit from the provision of evidence-based, culturally competent early interventions in three settings: school, family, and community.

The iCARE initiative was developed by the Middletown community for two primary reasons: 1) behavioral issues that begin in elementary school, without adequate intervention, many times continue into the later years, and 2) children of color are less likely to get needed mental health services and more likely to become involved in the juvenile justice system later in life.

Implemented in January 2010, iCARE incorporates early identification into a model based on behavioral processing and social skills training[27], Systems of Care wraparound principles administered through a social worker[28], and connection to community supports, including faith-based. These components will be described in more detail below.

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[27] Mezzocchi, Michael A. (2000). The Student Support Center: A Prototype Program for School-Based Behavior Support and Crisis Response. Dissertation.

[28] VanDenBerg, J. E., & Grealish, M. E. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. *Journal of Child and Family Services, 5*, 7-21.

II. Methodologies

A. Screening

In early November of each school year, teachers in iCARE schools complete a behavioral screen for all students. Throughout the school year, school attendance and disciplinary conduct reports are also monitored. In addition, students may participate in the iCARE intervention through referrals by teachers, parents, Ministerial Alliance members, and other school or community representatives, including primary care providers.

1. Teacher-completed Screening

Walker Survey Instrument (WSI). The iCARE initiative uses the WSI to identify students who are experiencing mild-to-moderate school adjustment difficulties[29]. The WSI consists of 19 questions, each corresponding to a different behavior. Teachers rate the frequency that a student exhibits each of the 19 behaviors. The WSI consists of three subscales. The first two subscales measure peer-related and interpersonal social skills and the third measures adaptive behaviors that are necessary for success in classroom instructional settings. A student scoring between 0-25% on the WSI rating scale is selected to participate in the iCARE intervention.

2. Review of Attendance and Discipline Data

Attendance and discipline data is monitored by the School Climate Data Team, described in more detail below. The school nurse reviews attendance data on a monthly basis and bring concerns to the School Climate Data Team. iCARE staff systematically review conduct reports and prepare a monthly overview (e.g., student, location, type of behavior) to share with Climate Data Team members.

B. Importance of School Embedded Systems

The School Climate Data Team is the communications hub for iCARE's work. The Team includes representation from all partners and occurs within a continuum of data teams at the district, school, and grade levels. The School Climate Data Team serves as a subcommittee of the School Data Team, which reports to the District Data Team.

The School Climate Data Team meets monthly to review student data and intervention strategies. The Team focuses on the review of student data (e.g., social, behavioral, attendance, academic), the Talking and Learning Center's data (e.g., monthly logs), and adult practice relative to student performance or climate. The overarching emphasis is on intervening early with strategies that the school and iCARE can put in place and monitoring the effectiveness of the strategies.

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[29] Duerr Evaluation Resources. Walker-McConnell Scale of Social Competence and School Adjustment: www.duerrevaluation.com/wms/wms.htm Accessed November 25, 2013.

III. Determination of Need-Levels and Coordination

After a student is identified through the WSI, attendance or disciplinary data, or by a referral, iCARE gains authorization from the parent, and both the parent and the teacher complete an Ohio Scales assessment[30] for the child. In some cases this reveals a false positive screen result and the child is further evaluated by the School Climate Data Team, but most times the Ohio assessment provides a better indication of need. and the areas in which the Talking and Learning Center (Tier I Intervention), Services Coordinator, and/or Community Interventionists (Tier II Intervention) can provide connections to school and community resources and mental health services as needed (Tier III Intervention).

IV. Response/Intervention

iCARE's Tier I Intervention, the in-school behavioral processing component of the model, or the Talking and Learning Center (TLC), is a physically and emotionally safe place in the school where children participate in informal social skills training, problem-solving and calming, and scheduled check-ins. Students in the TLC are supported by a trained full-time employee. The philosophy behind the TLC was developed by Mike Mezzocchi and is based on social cognitive theory[31]. Students typically visit the TLC one to four times per week, depending on need. All students within the school benefit from the work of the TLC, whether through strategies aimed at improving school climate, participation in friendship groups, or through increased classroom instruction time.

A. Outreach to Parents

The second component of the intervention is conducted by the iCARE Services Coordinator, a Master's level social worker (MSW). Through one-on-one counseling and case management with the student and his/her family, using the Systems of Care wraparound philosophy[32], the MSW assists families with the development and implementation of a family action plan. Wraparound distinguishes itself from traditional models with its focus on connecting families, schools, and community partners in effective problem-solving relationships. When first making contact with a family, the Services Coordinator seeks to help resolve immediate issues or crises to build trust with the family (e.g., issues on housing, hunger, transportation). The Services Coordinator meets with families at least once per month.

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[30] Ogles, B., Melendez, G., Davis, D, & Lunnen, K. (2001). The Ohio Scales: Practical Outcome Assessment. *Journal of Child and Family Studies*, 10(2), 199-212.
[31] Mezzocchi, Michael A. (2000). The Student Support Center: A Prototype Program for School-Based Behavior Support and Crisis Response. Dissertation.
[32] VanDenBerg, J. E., & Grealish, M. E. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. Journal of Child and Family Services, 5, 7-21.

B. Continuum of preventive behavioral health interventions

Once a child is identified as at-risk, the School Climate Data Team coordinates services and interventions and monitors the progress of students. Interventions include traditional school services, iCARE interventions, and/or an immediate behavioral health referral.

C. Linkage to community resources

Through the development of the family action plan, the third component of the intervention is realized where students and families connect with community and faith-based supports, such as recreational or mentoring programs or mental health counseling. Community Interventionists (i.e., Ministerial Alliance members) are involved in each component of the intervention and work alongside the TLC Interventionists and Services Coordinator to assist children and families. Research has found that lack of trust is a major reason why families do not seek assessment and early intervention for their children, particularly in ethnic groups that have experienced bias and discrimination in the past.[33] The Community Interventionists are trusted community partners who can uniquely address the needs of students and families in the Middletown community.

V. Results

A. Outcomes Measures

Preliminary iCARE data, collected between 2010-present, indicate that children who participate in iCARE have **improved overall functioning** and **reduced severity of behavioral problems** as measured by the Ohio Scales assessment. Both teachers and parents report high satisfaction with the initiative's efforts. Teachers have rated iCARE students as being less depressed, having fewer problematic behaviors, better attendance, improved self-worth, better interpersonal relationships, better self-direction, motivation and overall well-being.

B. Lessons Learned and Factors of Success

- **Shared decision making at the school and community levels**.
  The Executive Committee, iCARE's governance body, has a balanced leadership structure consisting of two members from each of the three key systems involved in implementing the iCARE prevention system. The School Climate Data Team involves equal representation from all partners.

[33] Department of Health and Human Services. Supplement to Mental Health: A Report of the Surgeon General. Mental Health: Culture, Race and Ethnicity. 1999. Retrieved from http://www.ct.gov/dmhas/lib/dmhas/publications/mhethnicity.pdf

- **Facilitation of a Data Teams process provides a seamless flow of early identification through to interventions (i.e., school based and community).**

- **Culturally competent child and family engagement.** Through involvement of the Ministerial Alliance, a recognized and respected community partner, iCARE places a high priority on responding to children and families in a culturally sensitive way, especially when emphasizing the importance of mental health treatment.

- **Strong connections to community resources and behavioral health services.**
  iCARE works closely with a broad range of community providers and behavioral health services to increase linkages between these services and at-risk children and their families. Examples of services include youth development and recreational programs (e.g., Green Street After School Program, Oddfellows Playhouse, YMCA mentoring, Middletown parks and recreation) and behavioral health services (e.g., IICAPS, PPP, counseling, and therapy).

Appendix B

Valley Kids Belong (VKB) Derby, Connecticut

Valley Kids Belong: Experience in the Lower Naugatuck Valley in Implementing a Children's Mental Health System of Early Identification and Intervention for Ages 6-14: Screening, Referral, Intervention & Assessment

I. Overview

This document describes the early-identification and prevention project named Valley Kids Belong (VKB), a five-year Children's Mental Health Initiative funded by the Connecticut Health Foundation. VKB is a collaborative, community-based project run out of the Lower Naugatuck Valley Parent Child Resource Center (PCRC). Important partners include the Derby Police Department, the Derby Public Schools, and many more community organizations. *We at VKB believe that community organizations can work together to promote resilience, health, and success for children, socially, mentally, and academically.*

Beginning in 2010, VKB implemented a system of children's mental health early identification and intervention in five portal schools in the Lower Naugatuck Valley (hereinafter, Valley). VKB comprises three main operational components: screening, prevention programs, and assessments. These three components will be described in depth, below.

In addition to the screening, prevention programs, and clinical assessments, VKB also offers community-wide parenting classes – Triple P Positive Parenting Groups – open to anyone on a first-come, first-served basis, as well as a Police Trauma Training and Education Program for police officers in the Valley. These additional programs aim to create systems changes in the Valley focused on preventing trauma, strengthening the early identification of children's mental health needs, and bringing greater awareness to partner organizations of the importance of a public health approach to children's mental health.

II. Methodologies

To take a much closer look at *how* school-based screening works, here is a detailed description of the Valley Kids Belong screening system within the context of the Derby Public School (DPS) System. Please note that VKB conducts screening in two portals that are not part of DPS (the Ansonia Charger Club and the St. Mary – St. Michael Elementary in Derby), but because there are unique operational components for those portals, for the sake of clarity this brief focuses on the DPS-based screening system.

A. Screening

There are two separate screening mechanisms used simultaneously in the Valley Kids Belong Initiative: a teacher-completed screening form (the AML-R Behavior Rating Scale), completed in the classroom; and review of attendance and discipline data.

1. Teacher-completed Screening

AML-R Behavior Rating Scale. Classroom teachers complete the AML-R Behavior Rating Scale for each child in their classroom (with the exception of children who have "Opted Out", discussed, below). The AML-R is a 12-item quick screening tool. It asks teachers to identify how often they observe each child exhibiting certain behaviors in the classroom, such as difficulties interacting with peers. This scale takes about 5 minutes to complete for each child.

- *all* incoming first graders;
- any *new/transfer* students in any grades 1st-8th; and
- for *all* 6th graders entering Middle School.

2. Review of Attendance and Discipline Data

In addition to the AML-R scale, attendance data and discipline data are reviewed and analyzed by VKB staff to identify which children exhibit patterns of habitual tardiness, absences and/or discipline events. The Derby Public Schools Coordinator of Communications and Information Systems (Coordinator) has created a systematic way of running reports of which children have demonstrated patterns of habitual tardiness, absences, and/or discipline events. The Coordinator generates these reports at the end of every marking period for *all* students in grades 1st-8th. So, unlike the AML-R, which only occurs at the beginning of the year, for incoming 1st graders, 6th graders, and new students, the review of attendance and discipline happens in an ongoing, periodic way throughout the school year.

III. Importance of School Embedded Systems

A high degree of collaboration between the VKB staff and the school staff is critical to the operation of the screening and response system. After the initial screening process, the VKB staff and the Child Study Team (CST) in each portal school work together to coordinate responses to children's identified needs. In particular, this coordination is critical to marshal the full spectrum of responses that may be helpful to any given child. Responses may include school/classroom-based interventions and community-based services, and the VKB-CST collaboration allows for coordination among and between both service sectors.

IV. Determination of Need-Levels and Coordination

After screening data has been collected using the two methods (AML-R Scale and review of discipline and attendance data), the data is analyzed to group children into three levels of need:

i. Level One (*no intervention needed*),
ii. Level Two (*prevention services appropriate*),
iii. Level Three (*clinical assessment needed*).

Children get assigned to these levels based on the frequency of observed behavioral issues, attendance, and discipline problems. The more frequent the observed issues, the higher the level assigned.

One of the hallmarks of the Valley Kids Belong initiative is the focus on the Level Two designation. Typically, early identification initiatives focus only on high levels of need (Level Three children). While that is a critical issue, it is also essential to respond to Level Two children with appropriate services and opportunities for resilience-building. When problems present as a "whisper" and not a "shout", it is easy to ignore them. However, the children with Level Two designations are often in a position to benefit significantly from opportunities and services that will build their resilience and protective factors. Intervening with those children who have chronic lower-level attendance problems – but those that do not rise to the level of mandated reporting – is an important opportunity to change the course of a child's life.

V. Response/Intervention

Children in the Level Two and Level Three groups are offered services and opportunities that match their level of need. Those specific services and opportunities are discussed below. However, prior to any service or opportunities being offered, VKB and the school staff conduct significant outreach to parents to create buy-in.

A. Outreach to Parents

Effective outreach to parents and parent engagement is critical to the integrity and transparency of the screening and intervention system. Valley Kids Belong takes a graduated approach to parent engagement, which begins with "Opt-Out Letters" prior to screening, and which progresses through increasing levels of engagement depending on a children's need levels and the amount of buy-in and participation on the part of the parent.

Opt-Out Letters. First, prior to conducting any screening, the school system sends an "opt-out" letter home to all parents in DPS portal schools (the schools in which VKB conducts screening – including Irving Elementary, Bradley Elementary, and Derby Middle School, all within the DPS system). This letter goes out under the Superintendent's signature. It explains and describes the VKB screening system. It give parents the opportunity to opt-out of VKB-run screening by phone call or by returning the Opt-Out Letter to the school.

Opt-Out List. After a designated time period has passed since sending the Opt-Out Letters home, and prior to conducting any screening, an Opt-Out List of all children whose parents have opted out is created by VKB staff. This list is shared between VKB and school staff. VKB does not conduct screening on anyone on this list, nor does VKB discuss any child on this list with anyone on school staff. VKB also does not initiate further contact with any parent or child on this list. The opted-out status can be changed by a parent at any time, so if, mid-year, a parent wants their child to participate in the VKB programs, the parent can sign a permission form and be taken off of the Opt-Out List. This mid-year "opting-in" can be at the suggestion of school staff, but is not initiated by VKB staff, out of respect for the parents' initial decision to opt-out.

Outreach To Parents and Affirmative Permissions to Participate. After screening has been conducted on all children who have not opted-out, but prior to VKB working with *any* student or discussing *any* student in a VKB-CST meeting, VKB conducts outreach to the parents of Level Two and Level Three children to obtain affirmative parental consent for participation. For both Levels, it is at this point that VKB explains to parents that to go further in the VKB program, VKB staff and the parents must meet and go over the programs, the approach, and the paperwork. Parents are asked to sign Releases and Permission forms to allow open communication between VKB staff and the schools about their child's behavior, and also to allow any communication necessary between VKB staff and any outside providers.

At the point of this engagement, it is also explained to parents of Level Two children that pre- and post-measurement scales are completed for each participant, before the program begins as well as immediately after and at 6 months, 12 months, 18 months, and 24 months after completion. Parents must agree to participate in completing these scales. Additionally, as a matter of practice, prior to VKB conducting this initial outreach to parents, VKB first calls the classroom teacher to give that teacher the opportunity to conduct the first outreach call – this is up to the discretion of the teacher, based on his/her knowledge of the particular family's needs, relationship to the school, and communication style. It is also at this time that VKB staff inquire with the classroom teacher as to whether the screening results are still valid (i.e., to rule out the possibility that between screening and follow-up, any intervening change in the child's behavior may require re-screening).

B. Continuum of preventive behavioral health interventions.

Tiered System of Responsiveness and "Menu" of Choices. Conceptually, the intent of the responses to the screening data is to create a tiered system of responsiveness and a "menu" of options that parents can choose from, that best suit the needs of their child. The screening process allows for thoroughness and intentionality in responding to the social and emotional needs of children within the schools. These responses include Level Two Preventive Programs as well as Level Three Assessments.

Level Two Preventive Programs. VKB runs preventive-level programs for children in the Level Two group throughout the year. These programs focus on building resilience and protective factors in children, and the programs are fun, free, and enjoyable. The preventive-level programs increase self-esteem, confidence, social skills, communication skills, and more. Programs run by VKB include the Families and Schools Together (FAST) Program, an Afterschool Program, and a Summer Program. All of these programs take place outside of school hours. VKB also provides Triple P Positive Parenting Program (PPP) Group Classes for parents, which all parents are invited to participate in (the PPP classes are open to parents throughout the community, and not just parents of children within portal schools whose children are in Levels Two and Three. PPP classes are offered as a universal program). The VKB preventive-level programs share much in common with high-quality children's activities from other contexts; children learn fun activities like music, art, Zumba, Judo, and more. Although there are indeed social/emotional curriculum components that are specifically and directly aimed at increasing social/emotional skills, many of the other programmatic components address the importance of providing positive experiences that are appealing and enjoyable for children, and that welcome and respond to cultural and linguistic diversity. Like a very high-quality summer camp, VKB programs provide a safe, structured, and supportive environment for children to learn, experience new things, and enjoy themselves while building important life skills.

Level Three Assessments. For Level Three children, after a parent has responded to outreach and consented to participate, a MSW-level VKB clinician conducts an assessment of the child's needs. This assessment is comprised of a classroom observation, interview(s) with the child, parent, and teachers, as well as any provider as needed. Based on this assessment, the VKB clinician meets with the parents and provides a recommendation as to what type of follow-up may best benefit the child.

C. Linkage to Community Resources

Often, once a child has undergone an assessment, it is crucial to connect that child with community-based resources above and beyond the resilience-building programmatic offerings of Valley Kids Belong. In those cases, follow-up could include a referral to outside clinical services (such as therapy, Intensive Outpatient Program, or more) *or*, perhaps other community services engagement.

The goal here is to provide an appropriate, tailored response that best serves the need of the child, whether that response occurs through VKB-run programs or through the menu of community based children's mental health services offered in the area.

To that end, VKB works closely with the project fiduciary the Lower Naugatuck Valley Parent Child Resource Center (PCRC) to remain aware of clinical options for children that can be marshaled depending on the needs identified in the school population.

VI. Results

A. Outcomes Measures

To date, Valley Kids Belong has screened over 1300 children in 5 portal schools. From that group, 152 have attended our Afterschool and Summer Programs, and 52 families have participated in FAST. Additionally, at least 47 children have been served by their parents attending Triple P Groups.

There has been a marked drop in calls to the police from the 3 public portal schools, and the Derby PD reports that because of the VKB project, officers now call mental health providers first instead of arrest whenever possible.

Additionally, data on our project's outcomes measures shows that our programs cause an increase in resilience and protective factors in participating children. Parents are reportedly more hopeful, and participating students have increased levels of functioning, self confidence, participation, and positive peer social skills

B. Lessons Learned and Factors of Success

In its work over the last several years, Valley Kids Belong has learned the following about children's mental health screening.

- School-based screening is effective at identifying children who need preventive and clinical-level services.
- There are pros and cons to having school-based screening coordinated by an outside agency; although outside mental health providers bring expertise and additional work capacity, there are inefficiencies created by taking this approach, such as the need for creating an Opt-Out List as well as instituting various privacy safeguards between the two organizations.
- Preventive-level programming is effective in building resilience and protective factors in children and families.

The factors that have contributed to VKB's success include the following:

- A commitment to linguistic and cultural competence.
- A strong, engaged core leadership team comprised of school administrators, mental health professionals, police officers, agency officers, and more. Implementation of a successful inter-disciplinary initiative requires a high degree of collaboration, coordination, and buy-in from throughout the community.
- Equal partnerships with the schools. Equal partnerships and an ethic of mutual respect laid the groundwork for more lasting, effective systems changes.
- Aligning the project with the needs and pressure points within partner organizations. This helped to make the project not only effective but more sustainable. One of the experiences of community implementation has been to learn just how much the issue of children's mental health has an impact on myriad organizations throughout the

Valley. Each organization has been touched by this issue in some way. Understanding the issue from the perspective of other organizations' operational functioning and demands shaped how VKB could be the most helpful.

- Using evidence-based program models, such as FAST and PPP, as much as possible.
- Grafting our project operations onto existing structures. This has laid the groundwork for more effective sustainability planning through the five-year grant term.