Children, Youth, and Families
MHSOAC Prevention/Early Intervention Action Plan
Priorities for the First Three Years

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One of the most groundbreaking elements of the MHSA is the requirement that 20% of funds be spent on prevention and early intervention programs. The Mental Health Services Act (MHSA) emphasizes prevention and early intervention (PEI) as key strategies to transform California's mental health system and to "prevent mental illnesses from becoming severe and disabling."

The MHSA prioritizes the prevention of suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes as a consequence of untreated mental illness. MHSA-funded PEI programs are required to include

- Outreach to people such as family members, employers, and primary care health care providers who have the potential to recognize early signs of severe and potentially disabling mental illness
- Efforts to improve timely access to services for underserved populations
- Access and linkage to medically necessary care for children, adults, and seniors at the earliest possible onset of severe mental illness, and
- Reduction of stigma and discrimination associated with being diagnosed with a mental illness or seeking mental health services.

MHSA early intervention programs are to include mental health services similar to those provided under other programs that have demonstrated themselves to be

- Effective in preventing mental illnesses from becoming severe, and
- Successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.

PEI programs, like all programs funded by the MHSA, are required to "emphasize client-centered, family-focused, collaborative, and community-based services that are culturally and linguistically competent and provided in integrated service systems."

What is Prevention?

Prevention in a mental health context, according to the Institute of Medicine, is part of a spectrum of interventions that includes prevention, treatment, and maintenance. The Institute of Medicine offers the following definitions for the three components:

- Prevention—interventions to prevent the initial onset of a mental disorder
- Treatment—identification of people with mental disorders and interventions to reduce the length of time the disorder continues, stop the progression of severity, and stop the recurrence of the disorder or increase the length between episodes
- Maintenance—interventions to reduce relapse and recurrence and provide rehabilitation.

The Institute of Medicine's "treatment" component corresponds to MHSA early intervention programs, while the Institute of Medicine "prevention" component corresponds to MHSA prevention programs.

Three levels of prevention have been identified in the literature: *universal*, intended to reach all members of the community; *selective*, directed toward people with some risk, often based on their membership in a vulnerable subgroup; and *indicated*, for people identified as having the greatest risk based on specific symptoms or signs but who lack the criteria for a mental health diagnosis. It is recommended that prevention strategies include all three levels.

Prevention in mental health involves reducing risk factors or stressors, building skills, and increasing support. Prevention promotes positive cognitive, social, and emotional development and encourages a state of well-being that allows the person to function well in the face of changing and sometimes challenging circumstances.

The MHSA calls for an approach to prevention that is integrated, accessible, culturally relevant, strength-based, effective, and that provides the best value for the money.

Essential Principles

A central early task of the MHSOAC, through its Prevention Committee, was to articulate principles related to prevention and early intervention. In collaboration with diverse stakeholders, a consensus about principles influenced the original PEI funding guidelines developed by the Department of Mental Health. Essential principles, based on the MHSA, prevention literature, the Prevention Committee's August 2006 In-Service, and conversations with stakeholders included:

- Prioritize prevention efforts that have demonstrated the potential to have a positive impact on outcomes specified in the MHSA.
- Identify and respond to the self-defined needs of people to be served.
- Utilize the expertise, skills, and knowledge that derive from experience, as well as from formal training and education;
- Support the leadership of mental health clients and family members at all levels of service design, delivery, and evaluation.
- Embrace and implement culturally diverse definitions of and approaches to mental health.
- Prioritize ongoing learning and communication at all levels to increase mutual understanding and respect among diverse communities involved in mental health prevention.
- Combat stigma, using a range of direct and indirect approaches.
- Enhance positive relationships and opportunities for peer support.
- Create comprehensive, multi-faceted community-based and family-based approaches.
- Collaborate, as a priority strategy, with systems, organizations, and individuals who have not traditionally been considered part of the mental health delivery system.
- Educate a wide range of people to recognize and respond to early indications of mental health challenges.
- Intervene at key transitions in which the combination of vulnerability and openness to support creates enhanced opportunities for growth and positive change.
- Reduce risk and increase protective factors that foster resilience.

- Recognize and work to combat the negative impact for mental health of trauma and social injustice.
- Assess the impact of prevention efforts, using a variety of methods, with a focus on client-led definitions of goals and outcomes.
- Create and modify public policies to support prevention and early intervention.
- Increase over time the proportion of MHSA funding for prevention and early intervention.

First Three Year Focus

To maximize the MHSA's potential impact within prevention and early intervention, its Prevention Committee recommended that the priorities for the first three years of the funding cycle should be reducing the risk of mental disorders in children and youth, first break, and stigma and discrimination. This paper highlights a number of the areas with the highest potential to reach MHSA prevention goal for children and transition-age youth. Giving priority to prevention for our youngest residents in these areas will make a visible and lasting difference for California. This approach also allows the MHSOAC and California to set an example of leadership in children's mental health.

While people of all ages can benefit from prevention and early intervention, there are a number of reasons to prioritize significant initial-phase resources for children and youth—between birth and approximately age 24. A wide array of demonstrated successful prevention approaches have been developed and tested with diverse children, youth, and their families, as documented by the Institute of Medicine in its groundbreaking 2009 report, *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.*

Childhood is a critical period for addressing the earliest appearance of emotional and behavioral problems that frequently lead to mental disorders that persist into adulthood and worsen. Effective prevention interventions support children's healthy social and emotional development, essential prerequisites to school readiness and academic and life success. In contrast, unrecognized and untreated mental health problems in children have serious personal, family, and societal consequences.

The following facts illustrate some of the reasons to prioritize children and youth for the first phase of MHSA prevention and early intervention funding:

- According to the U.S. Surgeon General, the burden and disability in the United States from mental disorders is carried disproportionately by children/youth and people of color. They have lower utilization of services, worse quality of care, and more serious consequences from untreated mental illness.
- Half of all lifetime cases of mental health disorders start by age 14 and three-fourths start by age 24. The average age of onset of anxiety disorders, the most common category of diagnoses, is 11 years. Because the majority of adult mental illness begins in childhood, intervening early is a critically important and powerful strategy with significant potential long-term impact.
- As many as three million California children and youth can be expected to experience mental health problems in any given year, including an estimated 97% of youth in the California Youth Authority and 70% to 84% of the 80,000 California children in foster care.

- It is estimated that 50% of children in many California public schools, especially those in high-stress low-income neighborhoods, have serious psycho-social problems that place them at risk for more serious disorders. Approximately 70% of kindergarten children with developmental problems could have been identified earlier but were not.
- First break–an individual's initial episode of severe mental illness–usually occurs in the late teens or early twenties. Support, developmentally appropriate early intervention, and treatment at the first appearance of symptoms have been demonstrated to make a significant, positive difference in both immediate and long-term outcomes.
- Stigma and discrimination are serious problems for families with a child with mental health challenges, as well as for the child or youth. As a result, many families and young people are reluctant to seek services and supports. This is particularly the case for families of color: the majority in California.
- Most California children with mental health problems do not receive appropriate treatment. It is estimated that fewer than half get treatment and only one in five get treatment from someone trained to work with children.
- Early experiences have a major impact on the development of a child's brain, which undergoes 90% of its growth and forms critical neural pathways during infancy and early childhood. Early experiences can increase or decrease the development of synapses by as much as 25%; prolonged and uncontrollable stress can have a serious negative impact on brain development. Healthy development of the brain lays critical pathways for thinking, language, emotional regulation, and interpersonal relatedness through the interplay of biology and experience.
- Suicide is the third leading cause of death for youth ages 15-24 and the sixth leading cause of death for 5-15 year olds. About 19% of young people contemplate or attempt suicide each year; the rate of youth suicide has nearly tripled since 1960, while the overall suicide rate has declined. The youth suicide rate has been increasing most rapidly for African American boys.
- Children ages 15 to 21 have the highest prevalence of co-occurring substance abuse and mental disorders. Over 66% of youth with a substance-use disorder also have a mental health disorder. Drug use compounds their mental health problems, creating a downward spiral that becomes more difficult to treat, making prevention and early intervention more critical.
- Children of color are under-represented in the mental health system and over-represented in the juvenile justice system.
- People with the lowest levels of income, education and occupation are significantly more likely to have a mental disorder—conditions that frequently begin in childhood.
- Children of color are likely to face stressors including issues of identify, acculturation, intergenerational conflict; fewer available services and even fewer culturally competent services; experiences of injustice and discrimination, and trauma.
- A parent's depression is among the most consistent risk factors for children's anxiety, depression, and major behavior problems. Problems in children with a depressed parent often appear in infancy and can continue, and worsen, into adulthood. Research shows that a parent's recovery from depression has a major positive impact on children.
- Children with unaddressed mental health problems are highly likely to drop out of school, go to jail as adults, and suffer other negative outcomes. Stated positively,

children whose mental health is supported are likely to experience success in all of these areas and to make positive social contributions.

- Costs related to children with mental illness are difficult to quantify because they include expenditures in systems besides mental health, such as education, child welfare, and juvenile justice. According to the Little Hoover Commission, a month for a child in a state hospital costs $10,000; over 200 California children each month are in this category. Local juvenile detention facilities spend about $3,500 to house a child for an average stay of 27 days, while the California Youth Authority spends $3,100 per month to house a child and an additional $1,750 a month on mental health treatment; this system serves an estimated 7,200 youth each month.

Prevention and early intervention can change the course of a child's development in a positive direction and substantially improve health, educational, and social outcomes. There is significant untapped potential in homes, preschools and childcare, schools, primary healthcare, economic assistance programs, youth organizations, recreation programs, juvenile justice, supportive housing, places of worships, and other organizations to identify early signs of emotional distress and dysfunction and intervene quickly and appropriately.

Child and adolescent preventive interventions have the potential to limit the economic burden of mental illness through a reduced need for mental health and related services and the potential benefits of increased positive outcomes such as educational attainment and economic output, with net savings overall. According to the Little Hoover Commission, "Prevention offers the greatest opportunity to serve the most needs in the most cost-effective manner" and can avoid, reduce, or resolve many of the serious problems that affect children, youth, and their families. This approach offers the greatest possible benefit not only to children and their families, but also to California as a whole.

This proposal is not a template or end-point. Rather, the summary of successful prevention and early intervention approaches described is proposed as a starting point for a collaborative discussion with diverse stakeholders about principles, priorities, and promising models, within which counties can frame their programs, taking into account their knowledge about local needs, resources, and expertise.

Prevention Works

Childhood, ideally from birth, is the best time to support healthy development and life success and reduce the risk of emotional and behavioral problems and mental disorders. Most hurdles that disrupt development or create early signals of mental disturbances can be overcome or substantially reduced with appropriate response and support. Prevention research has produced evidence of outcomes, based on scientifically accepted methods, that is as high quality and sophisticated as any facet of mental health research or of prevention outcomes studies in social sciences and medicine.

Research has demonstrated success in identifying factors that put children at risk for developing a mental disorder or experiencing problems in social-emotional development, as well as protective factors that maximize the potential for positive development. Known risk factors include prenatal damage from exposure to alcohol, illegal drugs, and tobacco; low birth weight; difficult temperament or an inherited predisposition to a mental disorder; external risk factors such as poverty, deprivation, abuse and neglect; unsatisfactory relationships; parental mental health disorder; or exposure to traumatic events. Successful prevention strategies frequently target high-risk infants, young children, adolescents, and/or their caregivers, addressing the risk factors described. There is also growing evidence that programs that enhance strengths of individuals,

families, communities, and social systems contribute to decreased risk or severity of future problems.

Successful prevention models that have demonstrated positive outcomes with children and youth from diverse cultures and communities exist, but are severely underutilized in California. Various national groups have established evidence-based frameworks to assess prevention strategies and programs for children and youth that can serve as resources for California. While programs that are "proven" by the "gold standard" of random clinical trials are relatively few, there are many promising programs that can be piloted, expanded, and tested. Such an approach supports the MHSA's mandate to evaluate and revise program elements "in future years to reflect what is learned about the most effective prevention and intervention programs."

Prevention strategies for children and youth involve partnerships with parents and other family members, and with all the key groups and systems with which children and families interact. Recommended strategies highlighted in this paper include those defined by age or developmental stage of child, location of service delivery, and type of intervention.

Prevention Supports Transformation

A focus on children and youth has the potential to transform mental health delivery.

- Effective prevention requires us to move beyond "avoiding negative outcomes" to a positive, proactive approach: supporting healthy development and recognizing and encouraging the strengths and assets that families, children/youth, and communities already have. This principle is particularly obvious and essential in children and youth, whose growth and resiliency are vibrantly visible.
- Effective prevention demands a focus on families (in all their varieties) and communities, not just individuals. This principle is also especially apparent in children and youth, whose well-being is so clearly linked to those who care for them.
- Families and communities differ widely regarding how they define mental health for their children. It is impossible to bring about prevention and early intervention for children and youth without creating approaches that reflect their families' and communities' diverse values and priorities.

These principles—a positive focus on health and development, an integrated family- and community-based approach, and the essential contribution of diverse cultures— so evident in children and youth, are essential to all areas of successful implementation of the MHSA. Application of these principles to the first phase of the MHSA's Prevention and Early Intervention Program can be inspirational to the overall transformation of the mental health system.

Prevention Focus Areas

The following are starting-point recommended priority areas for prevention and early intervention, where promising approaches have been developed for children, youth, and their families:

- Reducing stigma and discrimination
- Parent education and family support
- Prevention for foster children and youth
- Early intervention at "first break"

- Interventions with parents and their infants/pre-school children
- Effective treatment for and recovery from depression and other mental disorders in parents to prevent mental health problems in their children
- Home-based services
- School-based services
- Anti-bullying programs (many based in schools)
- Partnerships with primary medical care
- Wraparound programs
- Diverting youth from the juvenile justice system
- Preventing suicide
- Youth development
- Children and youth who are homeless

Stigma Reduction

Stigma is defined by the U.S. Surgeon General's 1999 Report as including bias, distrust, stereotyping, fear, embarrassment, anger, avoidance, discrimination, and abuse. Stigma can lower self-esteem, make it less likely that people with mental and emotional issues, and their families, will seek help or treatment, limit opportunities, and increase isolation.

Parents frequently blame themselves for their children's problems, or fear/perceive that others blame them, and can be reluctant to seek help for this reason. For example, a new mother with postpartum depression is likely to feel ashamed that she hasn't bonded with her new baby and even fear that the child might be taken away. Children and adolescents who are perceived as different can be teased and bullied by peers. Many families and youth of color are particularly affected by stigma; they are likely to distrust the established mental health system, for a variety of reasons, and are less likely to seek care in such systems.

There has been relatively little research on effective anti-stigma programs for children, youth, and their families. Based on what is known in general about successful approaches, it is recommended that anti-stigma programs operate at multiple and interacting levels and focus positively on mental health. Two important messages are that children's mental health issues are real, common, often preventable, and treatable; and that mental health affects everyone.

Anti-stigma efforts must reflect and respond to cultural values and priorities: for example, that problems need to stay in the family, mental illness doesn't exist, a service provider won't understand or respect the family's experiences or perspective, treatment means admitting to being "crazy" or giving up control, or something negative will result from seeking treatment such as shame and embarrassment, deportation, or removal of the child. Other recommended approaches to stigma reduction include:

- Supportive, culturally competent anti-stigma campaign, including information about mental health issues, indicators, strategies, and available resources–targeted for particular groups, such as youth, parents or people who work with youth.
- Positive public education utilizing multi-media materials
    - Use real people, especially peers, as examples wherever possible
    - Replace negative stereotypes with facts

    - Emphasize links between behavioral and physical health
    - Explain connections between mental health and academic/economic success
    - Portray successful outcomes, social contributions, cultural and spiritual perspectives, strength, and growth that can come through the experience of mastering mental disorders
- Contact with peers with mental illness or in recovery; a speaker's bureau of peers
- Efforts to encourage increased mutual respect and supportive communication among youth in general, especially for those who are experiencing distress—for example, peer counseling programs or self-help/ mutual support programs
- Increased support overall for help-seeking behavior
- Story-telling for children that encourages mental wellness and combats misunderstanding about mental illness
- Mental health advocacy programs; inclusion of mental illness in all disability advocacy programs

Locating prevention and treatment resources in credible, respected, culturally relevant non-mental health settings, such as schools, religious organizations, primary care, recreation, family support programs, and other community organizations can combat stigma and make it more likely that these programs will be used.

Parent Education and Family Support

Family support services are potentially effective, inexpensive, and highly valued by many families. While family support programs differ in how they function, they tend to reflect a common set of principles:

- Focus on prevention and optimization
- The family as an active participant in defining its needs and planning and executing the program
- Priority to work with the entire family and community
- Strengthening adults' roles as parents, nurturers, and providers
- Commitment to nourishing cultural diversity
- Emphasis on strength-based needs analyses, programming, and evaluation
- Enhancement of a families' network and informal supports and resources
- Flexible staffing.

Although there is relatively little controlled research on these kinds of programs, a national survey indicated that 72% of parents of children with emotional or behavioral disorders considered emotional support the most helpful aspect of care. Research has documented that parent education and support improves outcomes for children, siblings, and families.

All families need support; families with children who have serious emotional or behavioral problems often have diminished support for numerous reasons: stigma, fatigue and lack of energy to reach out, and/or unavailable or uncoordinated services. It is not surprising that parents of children with a psychiatric disorder overall experience a greater sense of incompetence, more depression, fatigue, and family conflict that can be both cause and effect of inadequate support.

At the most basic level, family support in the context of children's mental health means recognizing and supporting parents' needs, expertise, and preferences. A key part of "building on strengths" is including the perspective of family members in every phase of support and service delivery. For example, parents are often the first to notice concerns or problems with their children, but often experience that their insight is minimized or ignored. Family members are not only the experts on their own needs, but also are prime contributors to defining and implementing effective solutions.

Parents often benefit from support to balance their own self-care and care for other family members with providing for and supporting their child with mental health problems. Examples of family-based services that can be beneficial especially for families coping with mental health problems include:

- Practical assistance, such as housing, income supports, transportation, or respite care
- Peer support from other parents and family members, including self-help and support groups
- Parent and family education about mental health disorders, treatment, and positive interventions, including peer-based help for navigating systems and gaining access to treatment and other resources
- Teaching parents to support children at home with specific mental health interventions
- Programs where parents act as co-therapists and partners in treatment
- Parent education and support, where parents learn new skills and practice these skills in a supportive environment with peers
- Family therapy, especially with accompanying opportunities for building skills and reducing stress
- Efforts to help parents become effective advocates for their children.

These kinds of services have demonstrated significant benefits, including increased time that the child stays in treatment, parents' increased knowledge about mental health issues, increased access to information and resources, increased sense among parents that they can have positive effects for their children, improved problem-solving skills, improved family interactions, and increased family integration.

Prevention for Foster Children and Youth

An estimated 40-85% of children entering the foster care system have significant mental health problems. Foster children with mental health problems are less likely to be reunified with their families or adopted. Foster children's emotional and behavioral problems also make them more susceptible to negative consequences such as expulsion from school or involvement with the juvenile justice system.

Less than 3% of mental health practitioners state that they work with foster children, and many of these lack specific training. Treatment levels vary by race and by gender, with younger children, girls, and children of color less likely to receive treatment. In 2000, over 70% of California foster children were of color. The need for culturally appropriate services, essential for all California mental health, is even more urgent for foster children.

Prevention efforts for foster children are critical because research shows that people who have experienced foster care are more likely to experience psychiatric impairment, personality disorders, and pervasive social dysfunction as adults. At 18, fewer than half of youth leaving the

foster care system have a high school diploma, only about 20% are able to support themselves, and 65% face homelessness.

Wraparound services and therapeutic foster care have demonstrated efficacy for foster children. Therapeutic foster care relies on foster parents as the primary interveners; it provides training, consultation, and support, and uses behavior strategies to reduce antisocial behavior. Other recommended approaches include:

- Efforts to combat the stigma of being in foster care—support for a child's or youth's resilience, focus on strengths, opportunities for positive experiences
- Screening for mental health needs for all children entering the foster care system
- Soliciting and utilizing the input of foster youth regarding placement and needed services and supports, including mental health treatment
- Early identification and intervention for children who have suffered or witnessed violence, abuse, or other extreme trauma—in a context where all foster children, by definition, have suffered trauma
- Mental health training, consultation, and support for foster parents to better identify and respond to foster children's developmental progress and emotional needs; active engagement of foster parents as partners in children's mental health interventions
- Support for foster parents to meet their own emotional needs, including peer support opportunities
- Support, treatment if needed, and involvement as partners for biological parents; 70% of foster children eventually return to their families of origin
- Training for behavioral health practitioners in best practices for engaging and treating foster children, involving foster youth and parents as partners in treatment, inspiring trust, meeting youth where they are, addressing survival as well as psychological needs, identifying and building on strengths, and collaborating effectively with child welfare and other systems in which the child and family are involved while maintaining confidentiality for the youth client.
- Cognitive behavioral therapy for foster children and youth that focuses on specific behaviors: for example, strengthening their peer relationships, social skills, self-esteem, academic skills, anger management, and impulse control and reducing anxiety or depression symptoms
- Multisystemic therapy, a home- and community-based intervention that addresses mental health needs of a youth with conduct problems by engaging all involved people and systems
- Long-term relationships between therapists and foster children—to continue as long as the child needs support and connection; the Children's Psychotherapy Project, with 10 chapters nationwide and one in Australia, recruits experienced psychotherapists to volunteer for this purpose
- Counseling and self-help/mutual support combined with other services such as housing, education, jobs, and economic supports for youth leaving the foster system
- Increased collaboration between child welfare system, foster parents, biological parents, and others involved in supporting the child.

These approaches, including treatment, can be considered preventive because of their potential to reduce the risk of long-term problems and suffering and increase the probability that foster children will have stable homes and positive health outcomes.

Early Intervention at "First Break"

An individual's initial episode of a severe mental illness can be terrifying and disorienting, for the youth involved as well as for his or her family. Cutting edge programs around the world are demonstrating that it is possible to identify and reduce or eliminate early symptoms of psychosis, significantly improving immediate and long-term outcomes. Two effective prevention approaches have been identified: intervening as early as possible in the course of a psychotic illness, or intervening even earlier, in the pre-psychotic or "prodomal" stage, to prevent the development of psychosis or minimize its symptoms and negative consequences. Both approaches are highly recommended.

Evidence increasingly shows that early intervention enhances prospects for recovery, limits the progression of the illness, and reduces negative consequences. Early intervention also helps mobilize and maintain family and social support. Unfortunately, this kind of early intervention usually does not occur. More typically there is a delay of a year or more between the initial onset of psychotic symptoms and the first effective treatment. Potential consequences of delayed treatment include loss of a job and economic independence, social withdrawal and disruption of relationships, loss of valued family and social roles, anxiety, depression, significant risk of suicide, involvement with the criminal justice system, and hospitalization.

New and ongoing research shows that it's possible to identify people who are at high risk for psychosis and intervene before they meet the full criteria for a diagnosis, despite the fact that early symptoms[1] differ from person to person and are usual fleeting and intermittent. This earliest intervention can, in many instances, prevent the development of a full psychotic disorder, or can diminish the severity if one does develop.

Another critical prevention strategy is supporting families—which in turn allows them to provide better support to a loved one who is experiencing a first break. Support at this critical time can instill hope, lighten loads, and improve the overall health of family members. Other recommended prevention and early intervention approaches for people suffering first breaks, and their families, include:

- Education and training—with leadership from clients and family members as trainers and in designing curricula
  - For the community, to combat stigma about psychosis and increase awareness of the potential for recovery—for example, the fact that up to 85% of people experiencing a first episode of psychosis who receive appropriate treatment recover completely
  - For key people such as family members, teachers, college counselors, members of the justice system, and emergency medical personnel about the warning signs of psychosis and effective, supportive responses
  - For mental health providers to enhance their diagnostic skills; utilize best practices in working with transition-age youth; address the social, emotional, and economic

[1] Examples of early signs of *possible* impending psychosis include social withdrawal, reduced ability to function, peculiar behaviors, difficulty concentrating, heightened sensory levels, loss of motivation or energy, dramatic sleep and appetite changes, suspicion of others, irrational or unusual thoughts and beliefs, or very brief psychotic episodes. A family history of schizophrenia is an additional risk factor.

impact of psychosis when offering early intervention and ongoing treatment; and increase their ability to assess for and treat co-occurring substance-use issues

- Support leadership of clients in planning and delivering all services
- Provide developmentally appropriate interventions focused specifically on transition-age youth, who often fall through the cracks between children's and adult services
- Change pathways to care; provide outreach, alternative crisis intervention, access to rapid assessment and response in community-based settings, relapse prevention, long-term supportive relationships, and follow-up
- Offer innovative approaches, such as supportive employment, housing, education and vocational training, and social programs
- With the leadership of family members, design and implement services and supports for families of youth experiencing first break, including information, education, support, therapy, groups, and advocacy
- Provide opportunities for peer support for families and youth experiencing first breaks

Interventions with Parents and their Infants/Pre-school Children

The first years of life form the basis for social-emotional development, positive sense of self, and overall mental health. Experiences during these early years have profound effects throughout life. For example, emotional wellbeing is as significant as intelligence in influencing school readiness and success.

Preventive mental health interventions on behalf of very young children focus on supporting positive relationships with their parents, since these first relationships are critical for future development. Infants are highly sensitive to their mothers' (or other primary caretakers') emotions, responding with distress to a parent's sadness, withdrawal, and inattentiveness. Infants who are unable to form safe, trusting relationships can become depressed, irritable, anxious, exhibit eating and sleeping problems, and show other signs of serious emotional distress. Young children who have experienced extreme relationship disruptions can develop a kind of post-traumatic stress disorder. These early disturbances can adversely affect the development of the brain, especially the right hemisphere. Poverty, stress, violence, lack of consistent care, exposure to trauma, loss, and homelessness can exacerbate all of these problems.

Many parents, as well as people who work with children, are not taught to recognize and respond supportively to young children's signs of distress. Since stress in babies and young children often produces stress in their caretakers, a negative cycle can begin. If parents are isolated and coping with other significant life challenges, as they often are, their emotional and physical resources to respond to their children may be limited.

Fortunately, available prevention interventions can identify these early problems in very young children and intervene while positive results are most likely. Preventive interventions before and after birth are designed to reduce the risk of such problems as postpartum depression, attachment disorders, parental conflict, and child abuse and neglect. A number of prevention interventions for infants and pre-school age children and their parents have shown impressive results, some sustained over many years: for example, reduced cognitive, health, behavioral, and economic risks and negative outcomes for children and parents.

Pregnancy and early parenting are times when many parents are most interested in learning childrearing skills and are particularly receptive to support. A number of the recommended approaches described in this proposal, including home-based programs, parent education and

support, and interventions for depressed parents, can be of great benefit for very young children and their parents.

Childcare settings have become more important settings for prevention efforts, as approximately 75% of American children under age six and 59% of children under age three are cared for outside the home. SAMHSA has recognized the critical role of child care providers in supporting children's social, emotional, and cognitive development, in close coordination with their parents and caretakers. Examples of prevention interventions in childcare include:

- Training, consultation, and support for teachers and other childcare staff to work more effectively with children with emotional and behavior problems, and to develop stronger collaboration with the children's parents
- Mental health counselors and consultants, who work directly with parents and children
- Classes, workshops, support, and respite for parents.
- Libraries of books and other materials for staff, parents and children
- Links and personalized referrals to other services, including mental health treatment.

Preliminary evaluations of programs based in childcare centers have demonstrated positive outcomes in teachers' behavior and their perceived sense of effectiveness. Studies of child and family outcomes are in process.

Treating Parents with Depression and Other Mental Disorders

The presence of a parent with depression is among the most consistent and well-replicated risk factor for children; those with a depressed parent have a 2- to 3-fold increased risk of having a major depressive disorder and are 4- to 6-times overall more likely to receive a psychiatric diagnosis. They are at increased risk for childhood anxiety, behavior disorders, emotional challenges, and school problems. Typically, about a third of children with depressed mothers have a current psychiatric disorder.

Most research has focused on maternal depression, which is unfortunately quite common: an estimated one in four women suffer from depression at some point during their lifetime, including about 10-15% of new mothers who develop postpartum depression. Sixty-eight percent of women and 55% of men who experience a mental disorder during their lifetime are parents.

Approximately 25% of postpartum depression begins during pregnancy. Depression during pregnancy can result in inadequate prenatal care, poor diet, increased risk of smoking or drinking, premature delivery, low birth weight, and higher risk of depression in the child. Depression after childbirth can lead to failure to bond with the newborn, neglect of the child, family conflict and upheaval, and suicide; depressed new mothers are less likely to play with their babies, make eye contact, or talk in an engaging voice. Risks to the child include cognitive delays as well as emotional and behavioral problems and the development of more serious mental disorders.

The consequences of maternal depression vary with a child's developmental stage. Pre-school children of depressed mothers tend to have trouble regulating their moods, cooperating, learning language, and developing problem-solving skills. School-age children often have negative self-images and school behavior problems. Having a depressed parent places children at risk as they mature, including for impaired social and occupational success and various medical problems.

Research has conclusively demonstrated that the longer mothers are depressed, the worse are the effects on their children, and that successful remission of a mother's depression has a positive effect on both mothers and children. Key factors for preventing the adverse consequences for children of having depressed parents include:

- Early detection of a parent's depression: This requires educating obstetricians, pediatricians, and other primary care practitioners about the strong association between a parent's depression and a child's mental health, combined with system supports to allow them to intervene effectively (see section on primary care).
- Treatment to support depressed parents' recovery: Children of depressed mothers who recover (reduce symptoms by at least 50%), compared to those who don't, are significantly less likely to develop depression and other psychiatric disorders. Children with a depressed mother who are themselves diagnosed with a mental disorder are more likely to recover if their mothers receive treatment and recover, whether or not the child receives treatment.
- Education for parents and families, as well as their communities, about depression, its consequences if untreated, successful treatment options, and the benefits to families that accompany treatment
- The message to parents that children and families are resilient, and that there are many things parents can do to support their children's strength, health, and happiness: It's essential to help parents understand the impact of their depression on their children without increasing their tendency to blame themselves, thereby worsening the problem.
- Encouragement, support, and skill development for parents to enhance positive communication to their children about their depression
- Mobilization and involvement of potential supports, including family, friends, community, religious organizations, self-help and advocacy groups: This strategy requires service providers to expand their capacity to act as coaches, guides, interpreters, and advocates.
- Rapid, easy, and flexible access to caregivers and services, especially in the early stages of treatment for depression—this includes one central point of contact, if multiple services and supports are involved.
- Family therapy and other supportive interventions in which family members are active partners, children have a voice, and positive interactions among family members are encouraged
- Long-term access to care and support; availability of ongoing contact for families after the crisis is over
- Efforts to support the active involvement of both parents in the lives of their children
- Support and intervention for adolescents whose parent is experiencing depression or another mental disorder: for example, mentorship programs

Home-Based Services

This category includes a broad range of services delivered in a family's home, usually designed to prevent out-of-home placement of a child, to preserve the family's integrity, and to increase family members' coping skills and resources. Such services are sometimes referred to as in-home, family preservation, family-centered, family-based, or intensive family services. They often provide evaluation, assessment, counseling, skills training, and coordination of services and community supports. Home-based services can be an effective strategy for families with children from early infancy through adolescence.

An analysis of a number of studies found that children or youth who participated in these programs were less likely to require placement outside the home (for example, foster care,

residential or inpatient treatment) and showed reduced verbal and physical aggression. These programs, which are usually provided through the child welfare, juvenile justice, and/or mental health systems, have also demonstrated significant fiscal savings. Factors that contribute to the success of home-based programs include:

- Family members are viewed as colleagues and are actively involved in defining service plans.
- Back-up services are available 24 hours a day.
- The program builds skills of family members.
- The program strengthens family relationships.
- There is effective coordination with other community services.

Often, home-based services involve visits to the home by clinicians, who provide various interventions and supports, including counseling, help with crises or transitions, education, problem-solving, advocacy, and support. An expanded definition of home-based services is to include support offered by telephone: for example, contact timed to correspond with a child's critical developmental transitions, which are likely to stress parent-child relationships.

School-based Services

Schools, in partnership with community-based mental health organizations, are among the largest providers of mental health services to children. Schools are critical sites to identify children and youth at risk for mental health problems and provide, or offer links to, services and supports. Three key reasons for the critical role of schools are

- Schools' central place in the lives of most children and families
- The fact that mental health problems often first become apparent at school
- The negative effect children's emotional problems have on their learning and school success, as well as the frequent impact of those problems on classroom peers. Youth with emotional disturbance have the highest rates of academic failure; 50% are estimated to drop out.

Key activities include screening to identify students with early indicators of mental health challenges, and training teachers and other school personnel to identify and respond to the earliest signs of children's mental health concerns and to create a school environment that fosters mental health and resilience.

UCLA's Center for Mental Health in Schools has designated five models of school-based services, all of which can contribute to prevention and early intervention:

- School-financed student support services, such as school counselors
- School-based clinics or health centers: either mental health centers or general health centers with a mental health component
- Formal links with community mental health services, including co-location of community mental health personnel and services at schools, formal linkages with nearby service providers, or contracting with community providers for needed services
- Classroom-based curricula on social and emotional functioning
- Comprehensive, multifaceted, integrated approaches to create a full continuum of services and supports.

An overall priority is to ensure that school-based prevention efforts are integrated into the overall mission, priorities, and culture of schools. Successful models are likely to weave together school, home, and community. School-based services benefit from or require effective collaboration between education and mental health; such partnerships have not historically existed in most communities.

School special education programs also deliver mental health services and supports to children with mental health disorders; however, special education has not historically placed emphasis on prevention.

School-based mental health programs face numerous challenges, including competing agendas, expanded roles for school and mental health personnel, difficulties sustaining parent and family involvement, and complexities related to evaluating outcomes. Many schools are already struggling with inadequate resources to help their often-stressed students meet mandated academic goals.

Despite these challenges, promising school-based prevention programs have demonstrated success with a broad diversity of students. There is strong and growing evidence that well-designed and well-implemented programs have positive effects on a variety of social, health, and academic outcomes, including mental health.

Various school-based programs have been developed to identify students with emotional or behavior problems that can indicate underlying mental health issues. Screening programs are most effective when they also identify students' strengths and resources. The success of screening programs depends on the availability of effective resources to address the needs of the children identified, and their families.

There has been growing interest in school-based programs that foster social-emotional learning (SEL) and enhance protective factors to increase students' assets and resiliency and reduce their risk for a variety of negative outcomes. These programs work to increase skills in self-management, communication, problem- solving, and resisting negative social influences as their primary focus. These programs have been shown to reduce interpersonal violence and other risk behaviors and increase resilience. Common factors in many successful SEL programs include:

- Multiple components that work with children, parents, and teachers and focus on changing behavior
- Programs that span multiple years
- Integration of programs into the general classroom rather than a separate, specialized approach for a few students
- Inclusion of an entire school, rather than individual classrooms; focusing on creating a positive, supportive school environment

School-based medical clinics with a mental health component are another promising approach. These comprehensive centers treat physical medical problems, and also respond to students' problems or concerns related to emotional distress, relationships, family issues, physical and sexual abuse, drug and alcohol use, exposure to violence and trauma, as well as depression, anxiety, and other symptoms of a potential mental disorder. Comprehensive school-based clinics combat stigma by offering students, and in some instances their families, an acceptable, accessible, and confidential way to ask for and get help. Data indicate that up to 50% of visits at many clinics are for non-medical issues or concerns.

Schools have also been utilized as sites for family support centers, offering comprehensive services for parents and other family members.

Anti-Bullying Programs

Most definitions of bullying specify aggressive, unwanted, repeated behavior involving an imbalance of power that is difficult to stop and that inflicts physical and/or emotional harm. Research suggests that 28% of U.S. students have experienced being bullied and that most children (70-80%) are affected at some time by bullying as victims, perpetrators, bystanders, or in more than one role. There are few known racial or ethnic differences in the incidence of being bullied, although white and black children and adolescents are more likely to disclose the experience of being bullied, and black and Latino youth who are bullied are more likely to suffer academically. LGTBQ individuals are extremely vulnerable to bullying and the results tend to be more severe, including difficulty functioning at school and increased risk for suicide.

Children who bully and those who are bullied experience significant short-term and long-term negative mental health and other consequences that frequently extend into adulthood. This shared impact includes an elevated tendency toward depression, suicidal thoughts and attempts, substance abuse, and reactive aggression. Children and adolescents who are bullied are additionally at risk for anxiety agoraphobia, panic disorder, post-traumatic stress disorder, borderline personality disorder, and eating disorders. Consequences of being bullied can include low self-esteem, school absenteeism and academic problems, psychosomatic and physical health problems, sleep issues, and physical injury. Initial research indicates that the depression and anxiety that results from cyber bullying may be more severe than traditional bullying.

Children and adolescents who bully others are more likely than peers to experience school and academic problems, and later law enforcement involvement and incidents of domestic and other violence. Children and adolescents who both bully and are bullied have the most serious risk of mental and behavioral problems, including panic disorder, agoraphobia, and suicidality. With effective screening, it is possible to identify these “bully victims” as early as first grade. Bystanders who observe bullying without intervening also experience significant mental health problems, especially depression and anxiety, as well as a tendency toward substance abuse.

Mental health problems, especially anxiety and depression, as well as the experience of physical or sexual abuse, are significant risk factors for both bullying and being bullied. Individuals with a disability, including one that results from a mental disorder, are at risk of being bullied. Risk factors for engaging in bullying, in addition to anxiety and depression, include a diagnosis of ADHD, oppositional defiant disorder, or conduct disorder.

Identifying individuals involved in bullying as early as possible and intervening effectively is extremely important. Efforts to increase screening by pediatricians and other physicians, as well by people who live and work with young people, is a priority strategy.

Research suggests that effective interventions must take into account and address both individual and environmental dimensions of bullying. Most evidence-based anti-bullying programs are located in schools. Typically they work to improve the whole school environment and build students’ social, interpersonal, communication, and emotional skills using various methods, most involving teachers and other school personnel, students, and parents. The U.S. Department of Health and Human Services, National Association of School Psychologists, and other groups have summarized principles and best practices for anti-bullying programs. Published registries list specific program models that have demonstrated their effectiveness. Evaluations of some programs demonstrate reductions of bullying and academic, disciplinary, behavioral, and social benefits, all of which tend to correlate with positive mental health outcomes. Other school-focused interventions include anti-bullying curricula, teacher consultation and coaching, and student assistance programs.

Additional recommended anti-bullying approaches include parenting and family therapy interventions and community-based interventions in non-school settings. Recently anti-bullying web sites and Internet chat rooms have been launched. Some youth-oriented call centers that focus on issues such as suicide prevention, support for runaways, and general crisis lines have reported an increase in calls related to bullying, and have provided training to staff to support the most effective responses.

Partnership with Primary Medical Care

Most children (and adults) with mental health problems who seek help see their primary physicians rather than a mental health specialist. Primary care physicians prescribe the majority of psychotropic drugs, and often counsel families facing emotional and behavioral challenges and disorders. Primary care providers are a natural and non-stigmatized point of contact for families, with the capacity to identify mental health problems and intervene early. Up to half of visits to primary care physicians are believed to be due to conditions that are caused or exacerbated by mental illness, but many of these are unrecognized and even fewer are treated.

It is critical to ensure that pediatricians, family practitioners, obstetricians/gynecologists, and other primary care providers recognize and respond appropriately to mental health risk factors in parents and children. But research shows that such training alone doesn't lead to improved outcomes for patients unless additional supports are provided. It is essential that pediatricians and other primary care providers who identify patients' mental health needs have the time and resources required to respond; currently the average primary care visit is between 11 and 15 minutes.

It is also critical to create links between primary and specialty behavioral health care to facilitate referrals and collaboration. Currently, two thirds of primary care clinicians report delays in securing appointments with a therapist for their patients, with average waits of 3-4 months.

A few examples of mental health prevention approaches that have been successfully delivered in primary care settings include:

- Comprehensive mental health, substance-use, and developmental screening for children and other family members; one strategy is to add a developmental specialist to the pediatric primary health care team
- Identification and support for children with emotional problems related to their parents' substance use, depression, or other risk factors
- Family-centered care that includes a focus on emotional, social, and developmental support and supporting parents' decision-making and strengths
- Integrating physical and behavioral health services in a primary care setting, using various strategies
- Care coordination, in which a practitioner associated with the primary practice, often a nurse or mental health professional, provides consultation, in person or by phone, to families who are struggling with a chronic mental health condition; typically, care managers offer education, support, crisis intervention, help negotiating the mental health system, community referrals, and sometimes brief, supportive counseling.
- Facilitated referrals to mental health treatment and a wide range of other community supports—a facilitated referral involves effecting a personal link to a person, not just providing a name and phone number or web site.

Other recommended approaches to enhance the effectiveness of primary care for prevention are to increase cultural awareness and competence, and increase links between primary care and mental health and community supports.

Wraparound

Wraparound services for children are considered by the MHSA to be so important that counties are mandated to provide them or to demonstrate why it is not feasible to do so. In wraparound, natural support providers, such as relatives and friends, collaborate with professionals from various organizations to develop comprehensive, flexible plans directed toward specific outcomes. Wraparound is both an approach and a set of services that are

- Community-based: services and supports cross home, school, and community
- Strength-based
- Individualized to meet children's and families' needs
- Include parents and other caretakers in every stage of the process
- Appropriate and sensitive to the unique racial, ethnic, geographical and social makeup of children and their families;
- Blend of community and family resources and supports and formal services
- Designed and implemented on an interagency basis using an interdisciplinary approach
- Flexible and unconditional, where the nature of support changes to meet changes in families and their situations
- Includes supports for families, teachers, and other caregivers
- Measures child and family outcomes to determine the effectiveness of services to ensure that appropriate populations are being served and that families' goals are being met.

Wraparound has proven particularly effective for children with severe emotional and behavioral problems. Examples of outcomes for children who have participated in wraparound include more stable and permanent living arrangements, decreased out-of-home placements, reduced inpatient hospitalization, reduced juvenile justice recidivism, fewer restrictive school settings, improved clinical outcomes and emotional functioning, improved academic success, better post-school adjustment, and reduced costs for services and supports.

Wraparound is an important complement to screening programs in schools, primary care settings, and juvenile justice diversion efforts, because it provides an effective, supportive response for children identified as at risk, and their families.

Diverting Youth from the Juvenile Justice System

Approximately 70% of youth in the juvenile justice system meet DSM criteria for one or more mental health disorders, compared to an estimated 20-22% in the general population. Approximately 60% meet criteria for three or more disorders, and 20-27% have a serious mental illness, defined as a severe condition that results in substantial functional impairment; these generally refer to specific diagnostic categories such as schizophrenia, major depression, or bipolar disorder. Female juvenile offenders consistently manifest more symptoms of mental disorders than males; an estimated 80% of girls in the juvenile justice system have at least one mental disorder, compared to 67% of boys. This difference might in part reflect their higher levels of reported experience of trauma. Almost 61% of youth in juvenile justice with a mental

health disorder also have a substance-use disorder. Youth with mental illness who become involved with criminal justice are disproportionately poor, homeless, and uninsured.

There is a growing sense of frustration that these youth don't belong in juvenile justice and that juvenile and correctional facilities do not adequately serve the significant mental health needs of youth in detention. There is increasing agreement on fundamental principles to prevent unnecessary placement of youth with mental health issues into juvenile justice and to serve those already in the system. The primary goal is to prevent youth with mental illness from entering the juvenile justice system in the first place. A secondary goal is to prevent a youth who has committed a delinquent offense from re-offending, and supporting the family to care for the child at home as quickly as possible. There is considerable evidence for the effectiveness of both kinds of approaches.

A number of innovative interventions have been developed to prevent children and youth from entering the juvenile justice system, and to minimize the negative consequences for those who become involved. Some of these approaches include:

- Prevention and resiliency programs—especially those that reach out to youth with known risk factors (for example, youth exposed to violence or who live in areas with high levels of juvenile crime) or that target youth who are beginning to engage in antisocial activities and are at high risk that they will escalate to more serious criminal activities.
- Screening youth who become involved in juvenile justice to identify those with mental health issues, including an emergency mental health screen (administered within the first hour of contact with the system) to identify any immediate mental health crisis or suicidality, and a general mental health screen to identify concerns that require additional assessment and intervention
- Diversion to effective community-based treatment and supports, to avoid or minimize the negative effects of incarceration—ideally at the earliest stage of juvenile justice involvement and throughout the juvenile justice continuum
- Juvenile mental health courts, which use a multi-disciplinary team approach to process and frequently divert cases; teams typically include a judge, district attorney, public defender or other defense counsel, mental health practitioners and/or case managers, and probation officers. Team members discuss cases, make recommendations, help arrange and coordinate treatment, monitor adherence to and progress in treatment, address relapse or non-compliance, and ensure coordination among all involved parties.
- Re-entry into the community following incarceration in the juvenile justice system—requires coordination of treatment, insurance and other payment mechanisms, probation and parole, schools, other community services, and family support.

Experts in the field emphasize that cross-system collaboration, with the active involvement of families, must form the basis for all juvenile justice mental health preventive interventions. Diversion efforts, for example, require multidisciplinary partnerships involving families, justice, mental health, schools, and all available community supports. Youth with mental health problems often need specialized and flexible education programs to avoid juvenile justice involvement and to make the transition to self-sufficiency.

Many opportunities for collaboration exist in California: for example, with the Juvenile Justice Crime Prevention Act, which supports such programs as after-school, alternative-to-confinement, gang prevention, and mental health outreach. California has also adopted a new

model for court evaluation of juvenile offenders with mental health disorders and development disabilities, including a separate disposition planning process using multi-disciplinary teams.

Suicide Prevention

Suicide, one of the most serious public health problems in the United States, is the third leading cause of death among teens. More teenagers die from suicide than from combined rates for cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease. A 1999 study found that 19.3% of high school students had seriously considered suicide, 14.5% had made concrete plans, and 8.3% had made a suicide attempt in the preceding year.

A number of approaches to suicide prevention, including for children and youth, have been developed but most have not been rigorously evaluated. Promising approaches include:

- Suicide awareness curricula and education programs
- Prevention targeted to specific issues in communities, with attention to cultural awareness and developmental appropriateness.
- Screening for depression, substance abuse, suicidal ideation, and other risk factors
- Increasing recognition of at-risk behavior among youth and key gatekeepers
- Promotion of protective factors, such as problem solving, impulse control, self-acceptance, conflict resolution, and nonviolent handling of disputes, as well as family and community support
- Reduction of peer and family conflict
- Supportive counseling and treatment for youth with early suicide risk factors and mental disorders with high suicide risk; access to effective, appropriate mental health services and encouragement to utilize these services
- Programs for school-age children to reduce early risk factors for depression, substance abuse, and aggressive behavior, and to enhance resiliency
- Student assistance programs
- Family-focused programs
- Reduction of health disparities attributable to gender, race or ethnicity, education, income, disability, sexual orientation, or other factors that can increase suicide risk
- Support for help-seeking behavior in all settings; efforts to reduce stigma associated with use of supports, mental health services, and/or suicide prevention programs
- Limiting access to lethal means of self-harm, including firearms and medication

It is critical to assess the impact of these interventions. A number of common approaches, such as some suicide awareness programs, have had unintended consequences and have failed to reduce suicide risk.

Youth Development

The first signs of mental health problems often appear in adolescence. A significant minority of preteens and teens have anxiety and mood disorders, behavior problems, and substance-use issues, while many more suffer from chronic low self-esteem, difficulties coping with their life challenges, and feelings of anger or insecurity. This suggests the need for training and high

standards for people who work with youth in early detection, positive intervention, and cross-program referrals.

A number of programs have been developed by and for youth to promote their positive development: to enhance self-esteem, increase skills and competence, strengthen relationships and social functioning, develop a sense of usefulness and contribution, increase pro-social and law-abiding behavior, and increase health, including mental health. These programs tend to have one or more of the following areas of focus:

- Caring adults with one-on-one mentoring relationships
- Promotion of safe, warm, and supportive places and environments, especially school and home
- Early identification of emotional, relationship, and behavior problems, with effective interventions and continua of care
- Strategies to increase youths' ability to cope with stress, conflict, and other challenges
- A focus on changing behavior, thinking, or both
- Enhancement of social competence and building healthy relationships
- Increase in marketable skills
- Opportunities for self-expression through arts or other avenues
- Development of leadership and advocacy skills with opportunities for community service
- Transformation of pain or traumatic experiences into growth, contribution, and positive change.

Most evaluations of youth development programs involve small samples and lack randomization. Nonetheless, the evaluations that exist show promise; for example, evaluations of after-school programs have demonstrated participants' increased academic achievement, positive body image, assertiveness, self-efficacy, and self-esteem. A comprehensive review of effective mental health promotion programs for teens found that the best results come from programs that are holistic and comprehensive, and that positive effects on one area of emotional well-being tend to carry-over to other areas.

Prevention for Homeless Youth with Mental Health Issues

An estimated 5,000 to 1.3 million youth under the age of 18 are believed to be homeless in the United States every year. Families make up approximately 40% of people in the United States who are homeless.

In addition to the inherent stress and disruption of being without stable housing, children who are homeless almost inevitably have parents who are experiencing extreme stress and are likely preoccupied with survival. The strongest predictor of mental health problems in a child who is homeless is the extent of the distress of the mother (or primary parent); an estimated 65%-90% of mothers who are homeless have suffered violent physical abuse and over 45% are estimated to have major depression.

School or child care disruptions, lack of stability of friends and other relationships, hunger and health issues, loss of possessions, lack of privacy, and stigma are examples of frequent accompaniments to homelessness that are extremely stressful for a child (or adult). Shelters

usually have no play space for children and may expose children to frightening and/or embarrassing experiences.

The first signs of emotional problems in homeless children are often behavior problems, anxiety, withdrawal, or developmental delays. More than 20% of homeless pre-schoolers suffer from emotional distress to the point of needing mental health interventions, but less than 1/3 receive any treatment or formal support. Homeless children have twice the rate of learning disabilities and three times the rate of behavior problems compared to children who have homes. Half of homeless children, compared to 18% of children with homes, suffer from anxiety, depression, or withdrawal. By the time homeless children are eight years old, one in three has a major mental disorder.

Many homeless youth have suffered physical or sexual abuse, neglect, family violence, addiction of a parent or other family member, and/or extreme strain in relationships; one study found that 46% of homeless youth had been physically abused before leaving home and 17% had suffered sexual abuse from a family member. This is in addition to the trauma they experience after becoming homeless. Former foster children are more likely to become homeless and remain homeless for a longer time.

Few homeless youth are housed in shelters and many find it impossible to attend school. Many homeless youth exchange sex for survival, for lack of other options. In addition to poor overall health, poor nutrition, and high prevalence of AIDS, many homeless youth suffer from severe anxiety, depression, conduct disorder, post-traumatic stress disorder (PTSD), learning disabilities, and substance-use disorders. Homeless youth are at high risk of suicide attempts. A study of a sample of youth who lived on the streets of San Francisco found that 2/3 met the criteria for PTSD.

Effective interventions for homeless families and youth embed mental health prevention and treatment within comprehensive, integrated, survival-focused, accessible supports, such as shelter, supportive housing, food, jobs, education, physical healthcare, mentors, and substance-use treatment. Drop-in centers can serve as critical gateways to mental health services. Addressing survival needs and establishing supportive, trusting relationships are usually precursors other kinds of help. Other recommended approaches include:

- Supporting and caring for homeless parents so they can support and care for their children
- Stable supportive housing
- Crisis intervention and problem-solving
- Specialized supportive parent education, with a focus on understanding children's development and combating the negative effects of trauma; encouraging families to accept mental health evaluations for children to determine what is a true mental health issue and what is a more transient response to the crisis of homelessness
- Child advocates and specialized programs for parents, children, and youth in homeless shelters and other services
- Training and alliances among community agencies and entities that serve, or could serve, homeless families, such as schools, hospitals, childcare centers, shelters, and food programs
- Help for schools to support children who are homeless by fostering a cooperative and accepting learning environment, welcoming and supporting parents, making school

supplies and other practical resources available to all children, providing safe places to do homework, and providing a safe place for personal belongings

- Support groups, especially that focus on counteracting the effects of trauma
- Street outreach programs, including crisis intervention and mental health/substance-use services, for youth who are homeless
- Supports for pregnant women and new parents who are homeless

Stakeholder Input

This draft proposal is a beginning of a conversation with many people who share a goal and a commitment. Together, we will create a vision that will initiate a mental health system that emphasizes innovative prevention and early intervention and that fulfills the mandate and hope of the MHSA.

References

ACLU News and Features. (2006). American Civil Liberties Union of Southern California. March 15, 2006. Available at http://www.aclu-sc.org/News/Releases/2006/101688/.

APA. (2006). Promoting awareness of children's mental health issues. APA Public Policy Office. Available at http://www.apa.org/ppo/issues/tfpacmi.html.

Adelman HS & Taylor L. (2002). Toward a comprehensive policy vision for mental health in schools. In Weist M, Evans S, & Lever N (Eds.), *Handbook of School Mental Health: Advancing Practice and Research.* Norwell, MA: Kluwer Academic Publishers.

ASA. (2011). Bullying victims often suffer academically, particularly high achieving blacks and latinos. American Sociological Association Annual Meeting, Aug. 23, 2011, Las Vegas NV. Available at http://www.asanet.org/press/bullying_victims_often_suffer_academically.cfm.

Aseltine RH & DeMartino R. (2004). An outcome evaluation of the SOS suicide prevention program. *American Journal of Public Health 94,* 446-451.

Austin L. (2004). Mental health needs of youth in foster care: challenges and strategies. *The Connection 20.* Available at http://www.casanet.org/library/foster-care/mental-health-%5Bconnection-04%5D.pdf.

Bassuk EL & Friedman SM. (2005). Facts on trauma and homeless children. National Child Traumatic Stress Network, Homelessness and Extreme Poverty Working Group. Available at http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/Facts_on_Trauma_and_Homeless_Children.pdf.

Beardslee WR. (2002). *Out of the Darkened Room: When a Parent is Depressed.* Boston: Little Brown and Company.

Beardslee WR. (1998). Prevention and the clinical encounter. *American Journal of Orthopsychiatry 68,* 521-533.

Bentelspacher, C. E., Chitran, S., & Rahman, M. A. (1994). Coping and adaptation patterns among Chinese, Indian, and Malay families caring for a mentally ill relative. *Families in Society: The Journal of Contemporary Human Services, 75,* 287–297.

Bernstein N. (2005). *Helping Those Who Need it Most: Meeting the Mental Health Care Needs of Youth in the Foster Care and Juvenile Justice Systems.* California Family Impact Seminar, Sacramento, CA.

The Better Homes Fund. (1999). Homeless children: America's new outcasts. Available at http://www.nch.asi.net.

Building Brighter Futures. (2003). Brain development. An Ounce of Prevention Fund. Available at http://www.ncsmartstart.org/parents/brain.htm.

Burk LR, et al. (2011). Stability of early identified aggressive victim status in elementary school and associations with later mental health problems and functional impairments. *Journal of Abnormal Child Psychology* 39(2), 225-238.

Burns BJ, Hoagwood K, & Mrazek PJ. (1999). Effective treatment for mental disorders in children and adolescents. Clinical Child and Family Psychology Review, 2, 199-253.

Buxton D, Potter MP, Bostic JQ. (2013). *Psychiatric Annals* 43(3), 101-105.

California Mental Health Directors. (2005). Transition Age Youth Resource Guide (First Edition). CMHDA Children's System of Care/Adult System of Care, May 11, 2005. Available at http://www.cmhda.org/tayRG.html.

Camodeca M & Goosens FA. (2004). Aggression, social cognitions, anger and sadness in bullies and victims. *Journal of Child Psychology and Psychiatry* 46(2), 186-197.

Campbell MA, Spears B, Slee P, et al. (2012). Victims' perceptions of traditional and cyberbullying, and the psychosocial correlates of their victimization. *Emotional and Behavioural Difficulties* 17(3-4), 389-401.

Cappella E, Hamre BK, Kim HY, et al. (2012). Teacher consultation and coaching within mental health practice: Classroom and child effects in urban elementary schools. *Journal of Consulting and Clinical Psychology* 80(4), 597-610.

Copeland WE, Wolke D, Angold A, & Costello EJ. (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry* 70(4), 419-426.

Cuadrado-Gordillo I. (2012). Repetition, power imbalance, and intentionality: Do these criteria conform to teenagers' perception of bullying? A role-based analysis. *Journal of Interpersonal Violence* 27(10), 1889-910.

Center for Mental Health in Schools at UCLA. (2005). Frequently-asked questions about mental health in schools. Available at http://smhp.psych.ucla.edu/pdfdocs/freqaskedmh.pdf.

Cicchetti D & Toth SL. (1998). The development of depression in children and adolescents. *American Psychologist 53(2):*221-41.

Cohen E & Kaufmann R. (2005). *Early Childhood Mental Health Consultation.* DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services Administration.

Cohn JF & Tronick EZ. (1989), Specificity of infants' response to mothers' affective behavior. *Journal of American Academic Child and Adolescent Psychiatry 28(2):*242-248.

Commonweal. (2006). Juvenile justice program. Available at http://www.commonweal.org/programs/jjp_about.html.

Copeland WE, Wolke D, Angold A, & Costello EJ. (2013). Adult psychiatric outcomes of bullying and being bullied by peers in childhood and adolescence. *JAMA Psychiatry* 70(4), 419-426.

Corrigan, P. W. & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist, 54*, 765–776.

Crowley MJ & Kazdin AE. (1998). Child psychosocial functioning and parent quality of life among clinically referred children. *Journal of Child and Family Studies 7*, 233-251.

Cuadrado-Gordillo I. (2012). Repetition, power imbalance, and intentionality: Do these criteria conform to teenagers' perception of bullying? A role-based analysis. *Journal of Interpersonal Violence* 27(10), 1889-910.

Data Trends #124. (2005). The stigmatization of mental illness in children and parents. Research training Center for family support and children's mental health, Portland State University.

Doskoch P. (2000). Can schizophrenia be prevented? *NeuroPsychiatry Reviews 1*, December 2000.

Dunst C & Trivette CM. (1994). Aims and principles of family support programs. In C. Dunst, CM Trivette, & AG Deal (Eds.), Supporting and Strengthening Families: VOL. 1 Methods, Strategies, and Practices (pp.30-48). Cambridge, MA: Brookline Books.

Durlak JA and Wells AM. (1997). Primary prevention mental health programs for children and adolescents: a meta-analytic review. *American Journal of Community Psychology* 25: 115-152.

Ericson N. (2001). Addressing the problem of juvenile bullying. OJJDP Fact Sheet. U.S. Department of Justice. Office of Juvenile Justice and Delinquency Prevention. Washington, DC.

Fight Crime: Invest in Kids California. From Promise to Practice: Mental Health Models that Work for Children and Youth. Oakland, CA: Available at http://www.calendow.org/reference/publications/pdf/mental/FCIK%20Toolkit%20-%20Prop.%2063.pdf.

Fraser MW, Nelson KE, & Rivard JC. (1997). Effectiveness of family preservation services. *Social Work Research 21:* 138-153.

Friesen BJ. (1990). National study of parents whose children have serious emotional disorders: Preliminary findings. In A. Algarin et al (Eds), Second Annual Conference Proceedings on Children's Mental Health Services and Policy: Building a Research Base (pp. 29-44). Tampa: FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Garety P & Julley S. (2000). Early intervention in psychosis. *Psychiatric Bulletin 24*, 321-323.

Garety P & Rigg A. (1998). Presentations of first and second episode psychosis in Lambeth. Submission to *Working Together in London Scheme.* London: King's Fund.

Gilman E. (1999). Mental health for young children: Experiencing the world in a positive way. *Children's Advocate:* Action Alliance for Children.

Glascoe FP. (2000). Evidence-based approach to developmental and behavioural surveillance using parents' concerns. *Child Care Health Development 26*: 137-149.

Glaser D. (2000). Child abuse and neglect and the brain – A Review. *Journal of Child Psychology and Psychiatry 41*: 97-118.

Glassheim B. (2006). *A Guide to Evidence-Based Mental Health Practices for Children, Adolescents, and Their Families*. Saginaw County Community Mental Health Authority.

Green JG, Dunn EC, Johnson RM, & Molnar BE. (2012). A multilevel investigation of the association between school context and adolescent nonphysical bullying. *Journal of School Violence* 10(2), 133-149.

Greenberg MT, Domitrovich C, Bumbarger B. (2000). *Preventing Mental Disorders in School-Age Children. A Review of the Effectiveness of Prevention Programs.* SAMHSA, U.S. Department of Health and Human Services.

Hahn A. (2005). Psychologists, mental health, and youth development. *Youth Today.*

Halfon N & Inkelas M. (2003). Optimizing the health and development of children. *Journal of the American Medical Association 290*, 3136-3138.

Harvard Mental Health Letter. (2002). Depression during pregnancy and after. Harvard Health Publications, Cambridge, MA.

Hatzenbuehler, ML. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics* 127(5), 896-903.

Healing Hands. (2000). Protecting the mental health of homeless children and youth. *Healing Hands 4*, February 2000. HCF Clinicians Network, Nashville TN. Available at http://www.nhchc.org/Network/HealingHands/2000/hh.02_00.pdf.

Hinckley EC & Ellis WF. (1985). An effective alternative to residential placement: Home-based services. *Journal of Clinical Child Psychology 14:* 209-213.

Hinshaw SP. (2005). The stigmatization of mental illness in children and parents: developmental issues, family concerns and research needs. *Journal of Child Psychology and Psychiatry 46*, 714-734.

Idsoe T, Dyregrov A, Idsoe E. (2012). Bullying and PTSD symptoms. *Journal of Abnormal Child Psychology* 40(6), 901-911.

Klomek AB, Marrocco F, Kleinman M, et al. (2007). Bullying, depression, and suicidality in adolescents. J*ournal of American Academy of Child and Adolescent Psychiatry* 46(1), 40-49.

Institute of Medicine. (2009). *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities.* Washington, DC. National Academy Press.

Institute of Medicine. (1997). *Schools and Health: Our Nation's Investment*. Washington, DC: National Academy Press.

Kamradt B. (2000). Wraparound Milwaukee: aiding youth with mental health needs. Juvenile Justice: Y*outh with Mental Health Disorders, Issues and Emerging Responses 7*, 14-23.

Kase LM. (2006). Parents report: moms and depression. Meredith Corporation, Available at http://www.parents.com/parents/story.jhtml?storyid=/templatedata/parents/story/data/5444.xml.

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

Klomek AB, Marrocco F, Kleinman M, et al. (2007). Bullying, depression, and suicidality in adolescents. *Journal of American Academy of Child and Adolescent Psychiatry* 46(1), 40-49.

Koppelman, J. (2005). Mental health and juvenile justice: Moving toward more effective systems of care. *National Health Policy Forum* (805): George Washington University, Washington, DC.

Kumpfer KL & Alvarado R. (1998). Effective family strengthening interventions. Juvenile Justice Bulletin. Washington, DC: U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention.

Kutash K, Duchnowski AJ, & Lynn N. (2006). *School-Based Mental Health: An Empirical Guide for Decision-Makers.* The Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, FL.

Lieberman JA. (2006). Practical tools for schizophrenia management: series #1. *Physician's Weekly 23*, July 24, 2006, Available at http://www.physiciansweekly.com/index.asp?issueid=368.

Little Hoover Commission. (2001). Young Hearts and Minds: Making a Commitment to Children's Mental Health: Sacramento, CA.

Maier J. (2005). Nipping madness in the bud. *Amherst Magazine*, Winter 2005, available at http://www.amherst.edu/magazine/issues/05winter/demons/maier.html.

Marsenich L. (2002). E*vidence-Based Practices in Mental Health for Foster Youth.* California Institute of Mental Health: Sacramento.

McGlashan TH. (1987). Recovery style from mental illness and long-term outcome. *Journal of Nervous and Mental Disease 175*, 681-685.

Mihalic S, Fagan A, Irwin K, Ballard D, Elliott D. (2004). *Blueprints for Violence Prevention. Office of Juvenile Justice and Delinquency Prevention*, U.S. Department of Justice, Washington, DC.

Mishna F. (2012). *Bullying: A Guide to Research, Intervention, and Prevention.* Oxford University Press. Oxford, NY.

Moran S, Smith PK, Thompson D, & Whitney I. (1993). Ethnic differences in experiences of bullying: Asian and white children. *British Journal of Educational Psychology* 63(3), 431-440.

Mrazek PJ. (1998). Preventing mental health and substance abuse problems in managed health care settings. Alexandria, VA: National Mental Health Association.

Mrzaek PJ & Haggerty RJ. (1994). Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research. Washington, DC: National Academy Press.

Nageer DR, Cohen L, Tepperman J, Biderman F, & Henkle G. (2002). First Steps: Taking Action Early to Prevent Violence. Oakland, Ca: Prevention Institute.

National Assembly on School-Based Care. (2013). School Mental Health and Education Outcomes: Messages Supported by Research. Washington, DC.

National Association of School Psychologists. (2012). *A Framework for School-Wide Bullying Prevention and Safety.* Bethesda. MD.

National Center for Education Statistics. (2011). Student Reports of Bullying and Cyber Bullying: Reports from the 2009 School Crime Supplement to the National Crime Victimization Survey. Available at http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2011336.

National Coalition for the Homeless. (2006). Homeless youth. National Coalition for the Homeless Fact Sheet #13. Washington, DC. Available at http://www.nationalhomeless.org/publications/facts/youth.pdf.

National Council on Disability. (2011). Briefing paper, "Bullying and Students with Disabilities." Available at http://www.ncd.gov/publications/2011/March92011.

National Institute of Child Health and Human Development. (2012). What Are Risk Factors for Being Bullied? Available at http://www.nichd.nih.gov/health/topics/bullying/conditioninfo/pages/risk-factors.aspx.

National Mental Health Association. (2006a). National Prevention Coalition Position Statement. Available at http://www.nmha.org/children/prevent/npcps.cfm.

National Mental Health Association. (2006b). Mental health and youth of color in the juvenile justice system. Available at http://www.nmha.org/children/justjuv/colorjj.cfm.

National Mental Health Association. (2004). Mental health treatment for youth in the juvenile justice system: a compendium of promising practices. Available at www.nmha.org/children/JJCompendiumofBestPractices.pdf.

National Scientific Council on the Developing Child (2004). Children's emotional development is built into the architecture of their brains. Available at http://www.developingchild.net/papers/emotional_development_is_built.pdf.

National Youth Violence Prevention Resource Center. (2002). Youth suicide fact sheet. Rockville, MD. Available at http://www.safeyouth.org/scripts/facts/docs/suicide.pdf.

New Jersey Task Force on Child Abuse and Neglect. (2003). Standards for Prevention Programs: Building Success through Family Support. State if New Jersey, Department of Human Services. Available at http://68.248.104.69/downloads/FinalNJDoc11-14-03.pdf.

Nicholson J, Biebel K, Hinden B, Henry A, & Stier L. (2001). Critical issues for parents with mental illness and their families. Final report prepared for the Center for Mental Health Services. Rockville, MD: Substance Abuse and Mental Health Services Administration.

NIH News. (2010). Depression high among youth victims of school cyber bullying, NIH researchers report. National Institutes of Health. U.S. Department of Health and Human Services. Available at http://www.nih.gov/news/health/sep2010/nichd-21.htm.

NIMH. (2004). Preventing child and adolescent mental disorders: research roundtable on economic burden and cost-effectiveness: February 25, 2004, Rockville, MD. Available at http://www.nimh.nih.gov/scientificmeetings/economicroundtable.cfm.

Olds DL, Eckenrode J, Henderson CR, Kitzman H, Powers J., Cole R, & Sidora K. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: Fifteen-year follow-up of a randomized trial. *Journal of the American Medical Association 278:* 637-643.

Osvaldsson, K. (2011). Bullying in context: Stories of bullying on an Internet discussion board. *Children and Society* 25(4), 317-327.

Perkins DO, Gu H, Boteva K, Lierberman JA. (2005). Relationships between duration of untreated psychosis and outcome in first episode schizophrenia: A critical review and meta-analysis. *American Journal of Psychiatry 162:* 1785-1804.

Peterson RL. Wraparpound. In Safe and responsive schools. Available at http://www.indiana.edu/~safeschl/wraparound.pdf.

Pumariega AJ, Rogers K, & Rothe E. (2005). Culturally competent systems of care for children's mental health: advances and challenges. *Community Mental Health Journal 41*, 539-555.

Research Training Center. (2005). Culturally competent children's mental health services: advances and challenges. Data Trends: #126, November 2005.

Rivers I, Noret N, Poteat VP, Ashurts N. (2009). Observing bullying at school: The mental health implications of witness status. *School Psychology Quarterly* 24(4), 211-223.

Roberts R.N., and Wasik BH. (1990). Home Visiting Programs for Families with Children Birth to Three: Results of a National Survey. *Journal of Early Intervention 14(3, Summer):* 274-284.

Rones M & Hoagwood K. (2000). School-based mental health services: a research review. *Clinical Child and Family Psychology Review 3,* 223-241.

Rosman EA, Perry DF, & Hepburn KS. The Best Beginning: partnerships between primary health care and mental health and substance abuse services for young children and their families. Georgetown University National Technical Assistance Center for Children's Mental Health.

http://gucchd.georgetown.edu/files/products_publications//TACenter/bestbeginfinal.pdf.

Scheeringa MS & Zeanah CH. (1995). Symptom expression and trauma variables in children under 48 months of age. *Infant Mental Health Journal 16(4)*, 259-270.

Schore A. (2001). The effects of early relationship trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal 22,* 201-269.

School Mental Health Project. (1997). Comprehensive approaches and mental health in schools. *Addressing Barriers to Learning 2.* Available at http://smhp.psych.ucla.edu/compapp2.htm.

Seitz V and Apfel N. (1994). Parent-Focused Intervention: Diffusion Effects on Siblings. *Child Development 65(2):* 677-683.Surgeon General's Conference on Children's Mental Health. (1999).

Shonkoff JP & Phillips DA. (2000). *From Neurons to Neighborhoods*. Washington DC: National Academy Press.

Shields A & Ciccetti D. (2010). Parental mistreatment and emotional dysregulation as risk factors for bullying and victimization in middle childhood. *Journal of Clinical and Adolescent Psychology* 30(3), 381-395.

Shufelt JL & Cocozza JJ. (2006). Youth with mental disorders in the juvenile justice system: Results from a multi-state prevalence study. *Research and Program Brief*, June 2006. National Center for Mental Health and Juvenile Justice.

Stopbullying now. (2013). Best practices in Bullying Prevention and Intervention. U.S. Department of Health and Human Services. Available at http://www.stopbullying.gov/prevention/at-school/.

Stopbullying.gov. (2013). Bullying Definition. U.S. Department of Health and Human Services. Available at http://www.stopbullying.gov/what-is-bullying/definition/index.html. .

Suri R & Altshuler LL. (2004). Postpartum depression: risk factors and treatment options. *Psychiatric Times 21.* Available at http://psychiatrictimes.com/p041064.html.

Turcotte-Benedict. F. (2012). Children with mental health disorders more often identified as bullies. American Academy of Pediatrics National Conference. New Orleans. Available at http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/Children-with-Mental-Health-Disorders-More-Often-Identified-as-Bullies.aspx?nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+tokenU.S. Dept. of Health and Human Services. (2000). Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington: DC. Available at: http://www.surgeongeneral.gov/topics/cmh/childreport.htm.

U.S. Department of Education. (2009). 28th Annual Report to Congress on the Implementation of the Americans with Disabilities Act, 2006. Washington, DC.

U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

U.S. Department of Health and Human Services. (1997). National evaluation of homeless and runaway youth. Available from the National Clearinghouse on Families and Youth. P.O. Box 13505, Silver Springs MD 20911-3505.

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

VanDenBerg JE & Grealish EM. (1997). Individualized services and supports through the wraparound process: philosophy and procedures. *Journal of Child and Family Studies 5,* 7-21.

Weissman MM, Feder A, Pilowsky DJ, Olfson M, et al. (2004). Low-income mothers coming to primary care: depression and reports of problems with their children. *Journal of Affective Disorders 78,* 93-100.

Weissman MM, Pilowsky DJ, Wickramaratne PJ, et al. (2006). Remissions in maternal depression and child psychopathology. *Journal of the American Medical Association* 295: 1389-1397.

Weisz JR, Sandler IN, Durlak JA, & Anton BS. (2005). Promoting and protection youth mental health through evidence-based prevention and treatment. *American Psychologist.*

Wimer C. (2006). Learning from small-scale experimental evaluations of after-school programs. *Out-of School Time Evaluation Snapshot.* Harvard Family Research Project. Available at http://www.gse.harvard.edu/hfrp/projects/afterschool/resources/snapshot8.html

Wolke, D et al. (2012). Bullied by peers in childhood and borderline personality symptoms at 11 years of age: A prospective study. *Journal of Child Psychology and Psychiatry* 53(8), 846-855.

Zaff JF, Calkins J, Bridges LJ, & Margie NG. (2002). Promoting positive mental and emotional health in teens: some lessons from research. *Trends: Child Research Brief.*