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Young Minds Matter: Supporting Children's Mental Health Through Policy Change



**COLORADO
CHILDREN'S
CAMPAIGN**
Every Chance for Every Child



Children's Hospital Colorado

This paper was researched and written by the following:



Cody Belzley, Bill Jaeger, Sarah Barnes, Colorado Children's Campaign

The Colorado Children's Campaign is a nonprofit, nonpartisan advocacy organization committed since 1985 to realizing every chance for every child in Colorado. We advocate for the development and implementation of data-driven public policies that improve child well-being in health, education and early childhood.



Steven Poole, MD, Colorado Children's Healthcare Access Program

The Colorado Children's Healthcare Access Program (CCHAP) is devoted to advancing health equity and improving outcomes by promoting comprehensive, cost-effective, coordinated, quality health care for all children in Colorado. CCHAP works with more than 250 pediatric and family practices across the state of Colorado and partners with other organizations to reduce health disparities and improve outcomes for children in three ways. We inform and coach, we innovate, and we advocate. We are continuously refining our support services, as well as developing new initiatives such as: behavioral health integration; care coordination training; assistance for medical homes to prepare for health care reform; "intensive preventive care" for children in low income families; and advocacy for children's health equity.



Children's Hospital Colorado

Ayelet Talmi, Ph.D., IMH-E® (IV-C), Children's Hospital Colorado

As a private, not-for-profit pediatric healthcare network, Children's Hospital Colorado is 100% dedicated to caring for kids at all ages and stages of growth. We have more than 2,000 pediatric specialists and more than 5,000 full-time employees helping to carry out our mission. In addition to providing the best possible care for kids who need it, we also work hard to keep kids out of the hospital. Through medical research and advocacy efforts, we are working towards a world where kids are safer and healthier and will one day have less need for a hospital.

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Context for Action

Mental health is a cornerstone of child well-being. The link between a child's mental health and his or her school readiness, academic success and long term health and life outcomes is powerful.

Mental health exists on a continuum. Children of all ages experience mental health issues ranging from normal stresses to serious trauma. The impact of these experiences can be particularly influential on young children. In the absence of appropriate supports, relationships and intervention, challenging experiences in the earliest years can disrupt a child's healthy development and have detrimental effects on the future mental and physical health of young children.

Supporting the mental health of children requires a focus not only on the needs of individual children but on their caregivers and the larger environment in which children grow up. There is much we can, and should, do to promote the mental wellness and social-emotional development of children through public policy. Public policy also plays a critical role in ensuring access to services for children with serious behavioral health conditions who need treatment in addition to family support.

Data trends confirm major strides in supporting the healthy development of young children and youth made in Colorado in recent years. While we celebrate these successes, data also point to significant barriers to behavioral health care that constitute a call to action:

- Minority communities are more likely to have unmet mental health needs and are overrepresented among vulnerable populations that experience higher rates of mental illness. Our growing and changing child population requires us to consider new strategies that take into account economic and cultural factors that influence if, how, where and when families access and use mental health services.
- At the national level, less than half of the social-emotional, developmental or mental health problems experienced by children are detected before they enter school (Centers for Disease Control and Prevention, 2015). Without early identification and intervention, children will continue to struggle in school from the start.

Key Questions

This brief focuses on the following key questions as part of an increasingly robust conversation about childhood mental health in Colorado: Where are the policy gaps in supporting the healthy development of all children and families? How can redefining our approach to the mental health of children in our state help close some of these gaps?

Guiding Principles

A useful first step in systems-level policy change is framing what quality mental health care services and supports for children should look like. The following principles contribute to this frame for action:

- Recognize the need for whole family care. Effective strategies offer approaches, financing models and supports that view the child as embedded in an environment comprised of relationships with caregivers in their homes, child care settings, schools and communities.
- Emphasize health promotion, prevention, early identification and intervention. Effective strategies focus on health promotion, prevention, early identification and intervention in the settings where young children are seen by professionals able to screen, intervene and refer children for early mental health care.
- Employ evidence-based approaches to mitigate the effects of adverse experiences and environments that impact the well-being of children, including toxic stress. Effective interventions reduce the impact of stressful life experiences by mitigating that stress; enhance protective factors that guard against exposure to adverse childhood experiences and environments; support children in developing coping mechanisms to deal with stress in a healthy way; and of greatest importance, foster strong, responsive caregiving relationships.

- Capitalize on opportunities to strengthen and maximize the impact of community resources, specifically those in child care and school settings. Effective strategies offer additional training and professional development specific to child mental health to early care professionals in child care, preschool or school setting and connect schools with integrated mental health care services in primary care settings.
- Establish appropriate metrics for the care of children that take into account long-term benefits of prevention and early intervention. Effective strategies recognize the expansive time horizon for impact and assessing return on investment and evaluate outcomes with a long view.

Obstacles and Opportunities

The next step in considering system level policy change involves exploring obstacles and opportunities in the current policy environment, detailed in the full report and highlighted here:

Access and Delivery Models

- Stigma makes it more difficult for families to access mental health services.
- An individual-focused, disease treatment approach to health care delivery does not work for children.
- Existing infrastructure is inadequate to support robust screening and diagnosis.
- Coordination of care across primary care providers and mental health providers is not adequately supported.
- Additional resources are needed to help children in crisis or with severe mental health needs.

Financing

- Fee-for-service health care financing models pay health care providers for rendering specific services for diagnosed conditions. This system does not work well for providing preventive services to children who may have not yet have a diagnosable condition.

Workforce and System Capacity

- Workforce and system capacity is currently inadequate to provide needed services.
- Practice change and workforce development are difficult, requiring incentives or supports.
- Mental health professionals working in primary care settings need specific training and education to be successful in these medical settings.

Policy Recommendations

(1) Advance integration of mental health services and supports in health care and educational settings through delivery system changes, payment reform and practice transformation. Actionable steps:

- Capitalize on immediate integration opportunities in Colorado, including Colorado's Race to the Top Early Learning Challenge Fund and State Innovation Model federal grants, the Regional Care Collaborative Organization (RCCO) rebidding process, and *Colorado Project LAUNCH*.
- Consider the integration of mental health services for children in the design of the next phase of the Accountable Care Collaborative.
- Explore the carve-out of mental health funding in Colorado's Medicaid state plan and the resulting challenges faced by primary care providers around providing mental health services in primary health care settings.
- Embed healthy development components into child care licensing and quality rating systems implemented by CDHS, including Colorado Shines, to ensure that developmental screening and referral processes are used appropriately and consistently in early care and learning settings.
- Ensure components of children's social-emotional development are addressed by the school readiness assessment and school readiness planning process conducted in kindergarten, as overseen by the Colorado Department of Education and the State Board of Education.



(2) Develop and fund robust infrastructure to support a statewide screening, referral and care coordination model. Actionable steps:

- Develop standards regarding tools for use to screen young children, mothers and families. Fund appropriate implementation of these standards.
- Encourage and support screening for and early identification of psychosocial risk factors and ACEs; support interventions to assist families with socioeconomic issues that can contribute to adverse experiences and create barriers to mental health care.
- Develop a comprehensive screening system that includes: 1) whether the child and his or her caregiver(s) were screened; 2) the results of screenings; 3) whether an evaluation was completed; 4) whether the child and/or his or her caregiver(s) entered into services; and 5) whether services for the child and family were sustained.
- Support a data sharing infrastructure within the bounds of data privacy requirements that allows providers to communicate and coordinate care in a bi-directional manner and ensures feedback between primary care and mental health providers.
- Make reimbursement available to providers for care coordination services across systems that serve children; include care coordination as a defined component of a comprehensive screening, referral and care coordination model.

(3) Invest in workforce capacity development to (1) increase the number of qualified mental health professionals and (2) expand professional development and training opportunities that enhance the skills of professionals in the field. Actionable steps:

- Elevate expectations and add incentives that emphasize mental health in various early childhood settings, such as professional development and training opportunities for health care, child care and K-12 education staff.
- Support early childhood professionals working in child care and preschool settings with pre-service training, ongoing professional development and consultation to support children's mental health and social-emotional development.
- Ensure early childhood providers have adequate training and resources to identify, access and work effectively with early childhood mental health specialists.
- Promote programs that provide basic training to health care, child care and K-12 education staff regarding children's mental health and social-emotional development.
- Make efforts to increase the number of child psychiatrists or expand their capacity to provide consultation to medical and mental health professionals through telehealth systems.
- Support specialized training and invest in differentiated reimbursement for services provided by professionals that have attained the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (IMH Endorsement) as administered by the Colorado Association for Infant Mental Health.
- Increase the number of mental health professionals, including Early Childhood Mental Health Specialists, trained to provide early childhood prevention and health promotion interventions and services.
- Support Early Childhood Councils as hubs of support for families and ensure that early childhood mental health remains an explicit component of their work.
- Leverage Colorado's new credentialing system to support a workforce suited to address the mental health needs of young children.

(4) Develop a comprehensive statewide navigation system to connect caregivers, families and children to referral and mental health resources, including supports for crisis situations. Actionable steps:

- Develop an adequate referral network of providers for early childhood mental health issues and systems.
- Support telehealth / telemedicine as a way to enhance service delivery in rural and remote communities that cannot sustain local services.
- Support a network of resources to support families in crisis or experiencing stressful life experiences.
- Support mechanisms that help families, providers and community partners navigate existing early childhood mental health and social/emotional services, supports and resources such as the Colorado Social Emotional and Mental Health Navigation Guide.
- Support care coordination and referral efforts among the various settings where a family may seek help for a child with severe mental health needs, including emergency rooms, schools and primary care providers.

(5) Support innovative practices, programs and approaches, scaling those that are making a demonstrable difference and find ways to embed them into the core work of public agencies serving children. Actionable steps:

- Increase support for home visitation and community support programs that provide well child care support, home visitation, and information to parents of young children.
- Support continued reauthorization of the Maternal, Infant, Early Childhood Home Visiting Program (MIECHV), which provides funding for home visiting programs that target first-time and vulnerable parents.
- Explore opportunities to use Medicaid and other current funding resources to address unmet needs in childhood mental health and accomplish a broader reach with additional state or federal investments.
- Develop data collection systems to track information on child care and preschool expulsion rates to inform policy change that supports children with challenging behaviors in early learning settings.
- Invest in and expand early childhood mental health consultation models.
- Support Head Start and Early Head Start programs that integrate behavioral healthcare services into early learning settings.



Introduction

Mental health is a cornerstone of child well-being. According to the World Health Organization, “Children and adolescents with good mental health are able to achieve and maintain optimal psychological and social functioning and well-being. They have a sense of identity and self-worth, strong family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth. Moreover, the good mental health of children and adolescents is crucial for their active social and economic participation.”¹ Programs, services and policies that promote and support sound mental health for children hold profound potential to positively impact their development and life trajectory. The link between a child’s mental health and his or her school readiness, academic success and long term health and life outcomes is powerful.

Most commonly we think of childhood mental health challenges as impacting school age children and adolescents, especially if we associate these challenges with mental illness. However, mental health is a much broader set of attributes than mental illness and exists on a continuum. Children of all ages experience mental health issues ranging from normal stresses to serious trauma. The impact of these experiences can be particularly influential on young children in both the short and long term. In the absence of appropriate supports, relationships and intervention, challenging experiences in the earliest years can disrupt a child’s healthy development and have detrimental effects on the future mental and physical health of young children.²

Supporting the mental health of children requires a focus on individual children as well as their caregivers, including those professionals working in child care and K-12 education settings, as well as attention to the larger environment in which children grow up. There is much we can, and should, do to promote the mental wellness and social-emotional development of children by using public policy to help impact positive change. Public policy also plays a critical role in ensuring access to services for children with serious mental illness or behavioral health conditions who need access to treatment in addition to family support.

This brief examines the state of children’s mental health in Colorado and considers the implications for public policy. While the scope of the brief is prenatal to age 18, we emphasize opportunities in the early years (prenatal to age 8) for two reasons. First, we believe in the value of prevention, early recognition of mental health concerns (or high risk for later challenges) and early intervention. Research shows that investing in children early is a proven approach that delivers better long-term outcomes at a lower cost than more reactive strategies. Second, we believe that the policy environment in Colorado is ripe for positive change for our youngest children.

Our objective is to identify and summarize actionable opportunities for policy change that support children’s healthy development, with a particular focus on young children. These policies should also provide for a more efficient and effective delivery of mental health services to children and families.



Key Terms

Definitions of terms that are used throughout this brief:

- **Mental health**—a state in which children are able to achieve and maintain optimal psychological and social functioning and well-being. Mental health is marked by a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximize growth.³
- **Mental illness**—a medical condition that disrupts a person’s thinking, feeling, mood, ability to relate to others and impacts daily functioning.⁴
- **Adverse Childhood Experience (ACE)**—exposure to traumatic stressors during the first 18 years of life, including emotional, physical or sexual abuse, emotional or physical neglect, household violence, substance abuse or mental illness, parental separation or divorce, or an incarcerated household member.⁵
- **Toxic stress**—a response that can occur when a child experiences strong, frequent and/or prolonged adversity—including ACEs—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment well into the adult years.⁶
- **Trauma**—feelings of fear, horror, helplessness, loss of trust in others, decreased sense of personal safety, guilt and shame as a result of traumatic events that either occur at a particular time and place or repeatedly over long periods of time.⁷
- **Substance Use Disorders**—conditions that occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the Diagnostic and Statistical Manual of Mental disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use and pharmacological criteria.⁸
- **Social determinants of health**—the complex, integrated and overlapping social structures and economic systems that produce most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power and resources throughout local communities, nations and the world.⁹
- **Early childhood**—the period from prenatal to 8 years of age that is critical for cognitive, social-emotional and physical development.¹⁰
- **Colorado Early Learning and Development Guidelines**—a common framework for understanding the continuum of development of children from birth through age 8.¹¹
- **Screening**—the use of standardized tools to identify risk factors that make the development of a psychological or behavioral problem more likely. For example, screenings can occur for children’s mental health and social-emotional development, pregnancy-related depression, parental depression and substance use disorders.¹²
- **Integrated behavioral health services**—the care a patient experiences as a result of a team of primary care and mental health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care. This care may address mental health and substance use disorders, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms and ineffective patterns of health care use.¹³ In the pediatric context, integrated behavioral health services are largely focused on health promotion, prevention, early identification and intervention.

Where does Colorado stand?

Demographics

More than 1.2 million children call Colorado home and that number is rapidly growing. Between 2000 and 2014, the number of children in Colorado grew by more than 12 percent, the eighth-fastest increase in the country. During this same time period, the number of children in the United States as a whole grew by less than 2 percent.¹⁴ The growth in Colorado's child population results from an increase in the number of people migrating to the state, as well as an increase in the birth rate in Colorado prior to 2008.^{15,16}

As Colorado's child population is growing, it is also changing. Children of color are making up an increasingly large share of Colorado's child population, largely driven by an increase in the number of Hispanic/Latino children. In 2000, about a quarter of the children in Colorado were Hispanic/Latino, compared to nearly a third by 2014. The percentage of children who were non-Hispanic white declined from 66 percent in 2000 to 57 percent in 2014.¹⁷

A growing number of Colorado's children are also living in poverty. In 2000, one out of every 10 children in Colorado lived in poverty. By 2013, that number had grown to one out of every six. Although Colorado's child poverty rate remains below the national average, the number of children living in poverty has grown in Colorado at a rate faster than almost anywhere else in the nation since 2000.¹⁸ The segment of the childhood population most likely to be living in poverty, unfortunately, is Colorado's youngest. In 2013, 19 percent of children under the age of six were living in poverty. Although this percentage has declined for the second year in a row, the poverty rate for young children is still nearly twice what it was in 2000.¹⁹

According to a 2001 report from the U.S. Department of Health and Human Services, "minority communities have a higher proportion of individuals with unmet mental health needs." They are also overrepresented among vulnerable populations that experience higher rates of mental illness. "Studies have consistently shown that people in the lowest strata of income, education, and occupation (known as socioeconomic status, or SES) are about two to three times more likely than those in the highest strata to have a mental disorder.... They also are more likely to have higher levels of psychological distress...."²⁰ Our growing and changing child population requires us to consider new strategies that take into account economic and cultural factors that influence if, how, where and when families access and use mental health services.



“Racism and discrimination by societal institutions have resulted in minorities’ lower socioeconomic status and poorer living conditions in which poverty, crime, and violence are persistent stressors that can affect mental health.”²¹

- U.S. Department of Health and Human Services

Health Care

Colorado has made tremendous progress in reducing the number and percentage of uninsured children despite the rise in poverty. According to the most recent estimates available, 8 percent of Colorado kids are uninsured, down from a high of 14 percent in 2008.²² This progress deserves to be celebrated. We know that kids with insurance—public or private—are more likely to access needed health care services than their uninsured peers. Our enthusiasm is tempered by the fact that we continue to see significant disparities in health care coverage along racial, ethnic and income lines. Children in poverty and children of color remain more likely to be uninsured than their more affluent, white counterparts. This disparity is concerning given that children in poverty are more likely to suffer the consequences of opportunity gaps, leading to stressful and unstable environments that can lead to toxic stress and exposure to trauma. Without health insurance, it is difficult for families to access mental health services at all levels, from screening to identification of problems to treatment.

Once kids have coverage, are they able to access care and use services, including services for mental health, effectively? And are those services timely, high quality and appropriate for children? **The 2011 Colorado Child Health Survey indicates that 26.5 percent of Colorado’s parents have concerns about the emotions, concentration, or behavior of their children (about 47 percent of these parents describe their concerns as moderate or severe). Yet, only 37 percent of these parents accessed mental health care of any kind.**²³

Children of any age can experience mental illness, and symptoms often start in early childhood. The fact that so few parents with concerns about their child’s mental health accessed care may have serious consequences. In 2013, 31 percent of Colorado high school students reported having used alcohol in the past 30 days, and 16.6 percent of high school students reported binge drinking (consuming five or more drinks in a couple of hours) in the past 30 days.²⁴ In 2013, 26 percent of middle school students and 24 percent of high school students in Colorado reported that they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing their usual activities.²⁵ Approximately 19 percent of middle school students and 15 percent of high school students in Colorado reported in 2013 that they had seriously considered attempting suicide.²⁶ Suicide is the second leading cause of death for youth ages 10 to 24 in Colorado and Colorado is consistently in the top 10 states with the highest rates of suicide.²⁷ In addition, almost 70 percent of youth in the juvenile justice system have a mental health disorder.²⁸ These statistics suggest that more needs to be done to meet the mental health care needs of children in our state.



Early Childhood

Colorado has a long history of supporting young children and has recently redoubled its efforts to ensure all children in our state get off to a strong start. In early childhood policy and programming, mental health has stood with early learning, physical health and family support as necessary components of a whole child's development. The Colorado Early Childhood Framework focuses on outcomes in early learning; family support and parent education; social, emotional, and mental health; and physical health.²⁹ This framework has shaped early childhood systems building in Colorado in recent years. These efforts, in turn, contributed to the establishment of the state Office of Early Childhood; expanded access to quality early learning through the Colorado Preschool Program and the Colorado Child Care Assistance Program; increased state investments in voluntary home visitation program, the successful expansion of Medicaid and the Children's Health Insurance Program (CHIP, known as Child Health Plan *Plus*, or CHP+, in Colorado); and numerous other policy victories for young children.



In the area of developmental screening, Colorado children have been well-supported in several ways. Colorado Medicaid provides financial incentives for primary care providers to conduct developmental screening. Colorado ABCD (Assuring Better Child Development) and CCHAP (Colorado Children's Healthcare Access Program) facilitate screening processes in primary care settings. The state has demonstrated a commitment to expanding developmental, pregnancy-related depression, social-emotional, and other psychosocial screening efforts and to ensuring that these efforts are coordinated and administered according to best practice guidelines. For example, Colorado Medicaid provides incentives for primary care providers to screen post-partum mothers for pregnancy-related mood disorders and teens for depression and risk of suicide.

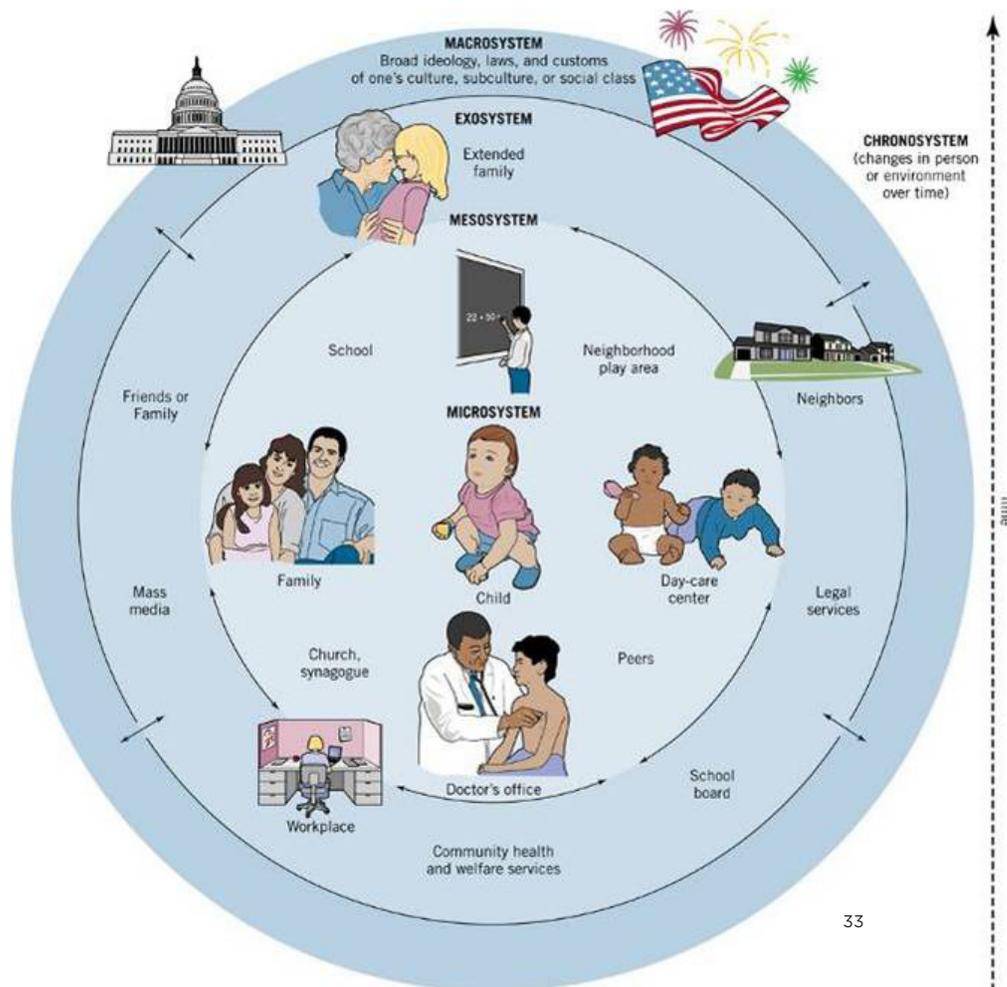
Despite these important strides in supporting young children and youth, there is much to do. Seventeen percent of children in the United States experience social-emotional, developmental or mental health problems, but fewer than half of these problems are detected prior to entering school.³⁰ Without early identification and intervention, children will continue to struggle in school from the start.

This Colorado context leads us to ask: Where are the gaps in supporting the healthy development of all children and families? How can redefining our approach to the mental health of children in our state help close some of these gaps?

Guiding Principles to Inform Policy Change

The first step in systems-level policy change requires re-conceptualizing what quality mental health care services and supports for children should look like. We offer the following principles to guide future policy changes related to supporting the mental health of young children.

Recognize the need for whole family care. Children function within the context of their caregiving environments, including their homes, child care settings, schools and communities. Uri Bronfenbrenner, a developmental psychologist, articulated an ecological systems theory that shows the ways in which a child's environment affects his or her development. Children, particularly young children, are deeply impacted by their relationships with primary caregivers. If primary caregivers, including child care providers and teachers, are not healthy themselves, it is unlikely that the child and caregiver together will establish and maintain a sturdy enough relationship for the child to feel safe, secure and stable. For example, substance use disorders experienced by primary caregivers increase the risk that children will experience abuse or neglect, as well as develop substance use disorders themselves.³¹ Moreover, when expectant mothers struggle with mental health issues such as mood disorders, depression and anxiety, or are exposed to adverse experiences or environments during pregnancy, the resulting stress can negatively affect fetal development. Hormones associated with stress and depression during pregnancy can interfere with fetal brain and immune system development.³² Effective strategies must recognize and meet the needs of the whole family, including prenatal mental health care services for expectant mothers and accessible substance use disorder treatment. They must offer approaches, financing models and supports that view the child as embedded in an environment comprised of relationships with caregivers.



Emphasize health promotion, prevention, early identification and intervention. Preventing the onset of a mental health problem offers a greater return on investment with respect to lifelong health and well-being than intervening after an acute issue is identified. Prevention can only be achieved by supporting parents, caregivers and teachers to create healthy, nurturing environments for children. When prevention is not possible, or when a child suffers from a severe mental health disorder, it is best to identify difficulties early and provide care as soon as possible in settings where children and families are already being served. The National Institute of Mental Health reports that “half of all lifetime cases of mental illness begin by age 14 and, despite effective treatments, there are long delays—sometimes decades—between first onset of symptoms and when people seek and receive treatment.”³⁴ These delays can be costly and, in some cases, deadly. An effective strategy for children must be focused on health promotion, prevention, early identification and intervention in the settings where young children are seen by professionals able to screen, intervene and refer children for early mental health care. The settings include child care, primary care providers and schools. Care coordination and communication across these settings are key components of high quality mental health care for children.

Employ evidence-based approaches to mitigate the effects of adverse experiences and environments that impact the well-being of children, including toxic stress. Children may experience trauma as a result of a significant negative life event, including a natural disaster such as a flood or fire, the death of a family member, or the absence of a parent due to divorce or military deployment. Children may be exposed to psychosocial risk factors such as relationship instability, food insecurity, parental work stress or job instability, parental incarceration or child interaction with law enforcement or the judicial system. Young children who experience intense, frequent and/or prolonged adversity, such as chronic neglect, physical, sexual or emotional abuse, caregiver substance abuse or mental illness, exposure to violence and/or the accumulated impacts of economic hardship are at risk for toxic stress. Children who experience pernicious and persistent levels of elevated stress without adequate adult support may suffer disruption in the development of brain architecture and other organs that increases the risk of stress-related disease and cognitive impairment.³⁵ While families living in poverty are more likely to endure adverse experiences and environments, all children, regardless of family income, may experience a traumatic event or endure an adverse environment at a particular point in time or over a prolonged period. According to the National Survey of Children’s Health, nearly half of all children in the United States have been exposed to at least one traumatic social or family experience.

In 1995, the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego began conducting the Adverse Childhood Experiences (ACE) Study by asking 17,000 participants receiving a physical examination to provide information about their childhood experiences. The study found that the higher the ACE Score (based on the number of ACEs reported) of a participant, the greater the risk for a variety of long term health problems.³⁶ For example, individuals who experience more than four ACEs are almost twice as likely to develop heart disease.³⁷ Individuals who experience six or more ACEs are almost three times as likely to develop lung cancer.³⁸ In Colorado, 20 percent of children under the age of 18 have been exposed to two or more ACEs.³⁹

The negative effects of trauma, psychosocial risk factors and toxic stress on children can be mitigated with adequate adult support. An effective mental health strategy for children should focus on:

- Interventions that reduce the impact of stressful life experiences by mitigating that stress.
- Enhancing protective factors that guard against exposure to adverse childhood experiences and environments.
- Supporting children in developing coping mechanisms to deal with stress in a healthy way.
- Fostering strong, responsive caregiving relationships.

“The foundation for sound mental health is built early in life, as early experiences—which include children’s relationships with parents, caregivers, relatives, teachers, and peers—shape the architecture of the developing brain. Disruptions in this developmental process can impair a child’s capacities for learning and relating to others, with lifelong implications. For society, many costly problems, ranging from the failure to complete high school to incarceration to homelessness, could be dramatically reduced if attention were paid to improving children’s environments of relationships and experiences early in life.”⁴⁰

- Center on the Developing Child at Harvard University

Capitalize on opportunities to strengthen and maximize the impact of community resources, specifically those in child care and school settings.

For many children, the adult who spends the most waking hours with them may not be a parent or primary caregiver, but rather an early care professional or a teacher in a child care, pre-school or school setting. These adults are often the first to recognize the mental health challenges and environmental adversities children face. Some resources available in Colorado today support the professional development of educators to address mental health needs of children, provide positive behavioral supports, and provide mental health care in child care and school settings. These resources include, but are not limited to, child care health consultants, early childhood mental health specialists, mental health consultants, school nurses and school-based health centers. Effective strategies for children build on those assets, offering additional training and professional development specific to child mental health, and strengthening infrastructure to connect schools with integrated mental health care and substance use disorder services in primary care settings.

Establish appropriate metrics for the care of children that take into account long-term benefits of prevention and early intervention.

We must take the long and broad view when measuring and evaluating the effectiveness of strategies to support healthy development of children. The return on investment of this work will be measured in years, even decades, and across various systems of care and services. We cannot solely hope to reduce the incidence of mental illness diagnosis. We must focus on ensuring that children and families maintain optimal developmental trajectories and, when necessary, improve rates of successful identification. Services must be delivered in a coordinated, efficient and family-centered way. Long-term investment and evaluation does not typically fit well in the context of ever-changing political environments and annual budget cycles. However, to make meaningful impact in this area, policymakers need to recognize the expansive time horizon for impact and assessing return on investment, be persistent in their longitudinal, future-oriented investments, and evaluate outcomes with a long view.



Obstacles and Opportunities for Policy Change

Targeted attention to three areas holds significant promise for improving outcomes: (1) *access and delivery models*, (2) *financing approaches* and (3) *workforce and system capacity*. In this section we identify key obstacles and opportunities in these three areas related to addressing mental health for children.

Access and Delivery Models:

Stigma makes it more difficult for families to access mental health services. Despite efforts over many decades to promote positive conversation around mental health care topics, stigma remains a real and significant barrier to accessing needed services. Typically defined as a mark of disgrace or reproach, stigma in this context refers to “a perceived negative attribute that causes one to devalue or think less of the whole person.”⁴¹ While stigma is a barrier for people of all backgrounds, a 2001 report from the U.S. Department of Health and Human Services found that “attitudes toward mental illness held by minorities are as unfavorable, or even more unfavorable, than attitudes held by whites.”⁴² Further, the report concluded that culture and social influences among minority groups play important roles in mental illness and the use of services. No single policy or program can end the stigma associated with mental illness, however, policies and programs can mitigate the impact of stigma.

One approach is to ensure that social-emotional development and mental health is a key part of conversations parents have with other adults who support the development of the child. Family and friends, doctors, child care providers and teachers should consider these topics as important as physical health, development and early learning. To this end, Colorado has recently adopted Early Learning and Development Guidelines that emphasize the social and emotional developmental needs of children birth through age 8 as well as strategies that support children’s growth in these areas.⁴³ This is one example of a strategy, promoted in coordination with early care and learning settings, as well as with family, friend and neighbor caregivers that can help reduce stigma and support effective preventive practices in a diverse settings. Another promising strategy is leveraging the expertise of early childhood mental health specialists and child care health consultants, as well as other mental health consultants, to promote preventive practices and healthy choices for physical and personal wellness by families, child care providers and other caregivers.

Another important approach to reducing stigma and increasing the likelihood that families access supports and services is the integration of mental and physical health care services in a primary care setting. Integrating mental health services into the places that families already go for other services and supports, including primary care settings staffed by pediatric and family medicine providers, is a critical strategy in reducing barriers to care. Enabling the family to access mental health services at the time and in the location of their medical visit addresses issues of access and stigma. Providers who offer integrated services can more immediately identify mental health problems, triage, and coordinate care, rather than having to convince the family to seek assistance at an external facility. This approach allows more people to receive care earlier and with fewer barriers such as transportation, prior authorization, and delayed services. Integrated services also leverage and promote trust and relationships between families and their primary health care providers.

Multiple state agencies and programs within agencies have adopted policies regarding licensing, credentialing and billing practices that do not always align. This contributes to regulatory confusion for providers and barriers to those seeking treatment or services. This maze can be a barrier to integrating mental health services into primary care settings that many health care providers will have difficulty overcoming—at least not without significant resources and support.

Finally, voluntary home visiting programs, as well as resource identification and coordination initiatives, are among our best strategies for serving families in an easy-to-access, non-stigmatizing way. Ensuring a social-emotional component in screening, referral and intervention requirements in home visiting (including those supported by the Maternal, Infant and Early Childhood Home Visiting, or MIECHV, federal funding), child welfare, and other early learning and development programs, as well as pediatric and prenatal care, emphasizes the value of this aspect of children’s health across systems.

An individual-focused, disease treatment approach to health care delivery does not work for children.

Current approaches to health care delivery are largely built on adult models that treat the individual for a standardized diagnosis. While there are certainly limitations to this approach even for adult care, it is largely inadequate for the care of children. Children, particularly young children, do not operate independently of their adult caregivers. Effective intervention must therefore involve both the parents or primary caregivers and the child. In short, the family unit becomes the patient.

Another consideration is that children often do not exhibit enough symptoms to be formally diagnosed with a mental health condition. Yet, they could still benefit tremendously from preventive services and interventions that can improve health, decrease impairment and functional difficulties, improve quality of relationships, and prevent the onset of a diagnosable condition.

Some early care and learning settings have adopted promising practices to support the mental health of young children that do not treat the child in isolation of important relationships. The early childhood mental health specialists represent a cohort of trained mental health professionals who work in community-based settings, including child care and school sites, using a consultation approach. This model supports the child in the context of their family, classrooms and peer groups, rather than treating mental health issues on strictly an individual basis. Despite its promise, only the equivalent of 17 full-time early childhood mental health specialists support all of Colorado's young children served by the 5,500 licensed child care facilities and 66 Head Start and Early Head Start centers in Colorado.^{44, 45, 46} Current requirements regarding these specialists' target population of uninsured or under-insured children when providing individualized consultation do not encourage the ideal model of integrated behavioral health services.

Reforming payment structures to support the integration of mental and physical health and promote interventions designed to address the social determinants of health within the family holds significant promise. Such restructuring will require shifts in practice culture and patient care as well as sustained workforce capacity development to ensure health care professionals have the tools and strategies to transform practice.

Infrastructure is inadequate to support robust screening and diagnosis. Screening for and identification of early signs and symptoms of mental health conditions are evidence-based practices that hold the highest likelihood of success at a lower cost. A robust and comprehensive screening, referral, follow-up and care coordination system is essential to supporting the healthy development of young children. When we screen children for developmental issues, including exposure to ACEs, social-emotional issues and mental illness, we can identify problems and intervene much earlier, heading off more costly and challenging problems later.⁴⁷ Providers can also use screening to offer anticipatory guidance to families, even when difficulties or illness are not identified. When we also screen caregivers for signs of depression and gather information about other psychosocial factors that impact family functioning, we can better support both the caregiver and the child's mental health.

And yet, we face significant challenges in implementing a robust screening, referral and follow-up care system in our state. Because most children with mental health issues are likely to be seen in a primary care setting, we must have systems that support the screening, referral and care coordination process in the context of primary care.⁴⁸ Primary care physicians (PCPs) are less likely to screen for mental health conditions and substance use disorders and refer appropriately when they lack support, both financial and training, to engage in care coordination and follow-up on referrals. One of the biggest barriers to effective screening implementation is that PCPs often do not feel comfortable identifying mental health issues without knowing that referral resources are available when the family needs a higher level of care than is available in the primary care setting. Additionally, comprehensive and coordinated care systems for children require a feedback loop that provides PCPs with information about treatment eligibility and uptake. Without such feedback, PCPs often do not know whether their referrals translated into access to necessary mental health services.



For this system to be successful from a pediatric mental health perspective, health care payment models must promote integrating mental health care and medical care within the same settings and adequately fund primary care providers to provide enhanced preventive counseling and early screening and identification. Perhaps most importantly, we must fund appropriate early childhood referral resources that lead to early intervention services and supports. Adequately meeting the screening needs of children requires engaging both public and private insurance payers in developing solutions. Providing mental health screenings at all well-child visits for children on Medicaid under Medicaid's Early and Periodic Screening, Detection, and Treatment Program (EPSDT), and properly funding them, will help to target some of our most vulnerable children.

An added challenge arises because many employer-based health plans are becoming self-funded plans, which are exempt from state insurance regulations. This exemption encompasses the statute that mandates developmental screening as a part of the well-child check-up. Bringing these self-funded plans into alignment with developmental screening expectations for private and public insurance options will help promote coverage for this vital early intervention. In addition, even though the Health Insurance Mandated Autism Treatment (HIMAT) law requires certain private insurance companies to cover services for children with autism, Medicaid and CHIP are exempt from this requirement and thus these families cannot access evidence-based autism treatments that are often unaffordable without adequate coverage, without applying for a Children with Autism (CWA) waiver.

Another challenge related to screening stems from the lack of a single reporting location, a consistent screening protocol, and a unified data collection and tracking system for developmental, social-emotional, autism-spectrum, family psychosocial and pregnancy-related depression screenings. In many cases, screening occurs in various locations, but data are not always captured and/or shared with primary care providers. Developing standards regarding which tools or parts of tools should be used to screen young children, mothers and families and appropriately funding their implementation are first steps in addressing these issues. In addition, a comprehensive screening data policy is needed to capture 1) whether the child and his or her caregiver(s) were screened, 2) the results of the screenings, 3) whether an evaluation was completed, 4) whether the child and/or her caregiver(s) entered into services, and 5) whether the child and family services were sustained.



These essential elements promote adequate care coordination for families and children. Within the bounds of data confidentiality requirements, much can be done to maximize communication and coordination between primary care providers and providers of mental health or developmental services to improve health outcomes, especially for pediatric populations. One example of a successful solution to these barriers is a HIPAA- and FERPA-compliant, bi-directional release form used by Early Intervention (EI) Colorado. If signed by a parent or guardian, this form allows EI Colorado to share information with primary care providers about eligibility status and interventions in order to coordinate care. In addition to being able to exchange information, settings serving young children need to have streamlined and effective mechanisms for integrating the information about a child and family in a place where it can be readily accessed by providers involved in the care of the child.

Coordination of care across primary care providers and mental health providers is not adequately supported. Screening alone is not sufficient to connect individuals struggling with mental health issues to care. The efficacy of screening is very limited without attention to building a comprehensive system in which screening is conducted. We need a comprehensive system that provides: (1) care and monitoring for children with mental health care needs that do not meet the criteria for specialty care or community-based services, (2) access to specialized care as a result of referrals, (3) structures for enhancing communication between mental health providers and the primary care providers making referrals to them, and (4) structures that allow providers to coordinate the care a client receives. Available data suggest that after screenings indicate a need for further evaluation, nationwide, only half of families are referred for in-depth evaluation and less than 11 percent of children for whom an initial screening raises a concern actually receive mental health services.⁴⁹ Promoting screening in the context of a larger referral and care coordination system is much more important than simply incentivizing screening.

Successful developmental and mental health screening requires oversight. One strategy is to create a monitoring system that collects data regarding screening and referral processes to ensure primary care providers who screen have access to results and families that are referred actually receive care.

Additional resources are needed to help children in crisis or with severe mental health needs. If we want providers to continue screening and providing referrals to mental health services, we need adequate crisis resources specifically for children and adolescents, as well as resources for children and adolescents who have severe mental health needs, especially in rural and frontier parts of the state where access to pediatric mental health providers is more limited. Until pediatric crisis resources are further developed, providers in these regions need a solution that is not limited to sending families to the emergency room, which is often seen as the only option.

The Colorado Crisis and Support Line (844-493-8255), a state-wide mental health crisis line operated by the Colorado Department of Human Services and Rocky Mountain Crisis Partners (formerly Metro Crisis Partners), is a new and promising tool that can provide effective assistance for older children and teens as well as parents and caregivers experiencing a crisis or struggling with a mental health problem or stressful experience such as relationship instability, loss of work or financial difficulty. Clinicians and peer specialists who receive calls on the Support Line help assess safety, practice conversations, provide support and solutions, and provide referrals to resources. Expanded outreach is needed to ensure public awareness and increase use of the Support Line. In addition, we must focus on building the capacity of the Support Line to assist families with young children by ensuring that Support Line consultants have the skill set required to support families experiencing early childhood crises rather than sending them to the emergency room.

Additionally, for children with severe mental health needs, the various settings where a child and his or her family may seek help, including emergency rooms, schools and primary care providers, must communicate with one another in order to coordinate care for the child and connect the family to needed resources.

Children who experience mental health crises or who have severe behavioral health needs and their families frequently face great difficulties accessing appropriate services in Colorado. This brief acknowledges the significant needs of these children and families; however, an in-depth discussion of the associated issues falls outside its limited scope.

Financing:

Payment reform: treatment and prevention. Fee-for-service health care financing models pay health care providers for rendering specific services for diagnosed conditions. This system may make sense if a child is in crisis or has an identified issue, but does not work well for providing preventive services to children who may have not yet have a diagnosable condition. Many prevention-oriented and health promotion interventions and services are, to date, often ineligible for reimbursement under the existing payment structure, thereby limiting access to care that could keep children from developing later difficulties and meeting criteria for diagnosable conditions.

Supporting children's mental health requires reforms to health care payment systems, across public and private coverage. The changes needed include making adequate and appropriate billing codes open to pediatric psychologists who can use them when consulting on the psychosocial impact of health conditions, during routine well-child visits, and without having a mental health diagnosis as a necessity for billing. Further needed changes: same-day billing, allowed codes for primary caregivers, adequately funding maternal depression and family psychosocial screening, and incorporating evidence-based tools that address social-emotional screening.

Addressing the socioeconomic issues that contribute to stress and adversity, exacerbate mental health problems, and create barriers to following through with treatment is an important preventive (or early) intervention. Yet attention to socioeconomic causal factors focuses on the whole family and is not currently reimbursed in either medical or mental health care.

A reformed payment model must make sense for the care of children and must include the following essential components:

- Pediatric appropriate metrics for quality care, particularly those appropriate for the care of young children from birth to age three.
- Adequate payment for provision of high quality pediatric care inclusive of preventive care (e.g., anticipatory guidance, immunizations, screening), health promotion, support for caregivers, care coordination/family navigation, and early identification and intervention.
- Payment for the provision of services to families, not just individuals (meaning that reimbursement or capitation covers multiple patients being served in the same encounter, especially dyadic units like parent and child).
- Recognition that realizing cost savings from preventive health care in pediatric populations takes years of documenting outcomes often across systems including health, education and criminal justice.

With adolescents and children, the improved outcomes from prevention-focused efforts come later in their lives, years to decades in the future. As a result, the associated cost savings accrue over the long-term. Using adult-specific models of outcomes for cost savings requires too short of a time horizon. Given that adolescents and children have not yet developed costly chronic conditions, using the mitigation of costs associated with these conditions as an indicator of systemic financial benefit results in an inherent adult bias.

In the long run, preventive mental health care saves money in multiple systems – criminal justice, child welfare, school funding for mental problems/learning difficulties, and health care. Mental health providers integrated into primary care settings are able to facilitate early identification and referral of young children in need of developmental evaluations and interventions. Unfortunately, many states feel “prevention” is being addressed solely in early intervention funding, when this is really only one part of the larger picture. Moreover, this funding can be difficult for mental health providers in primary care to access. In Colorado, approximately 3 percent of the birth through three population is being served through Early Intervention.⁵⁰ Ample evidence supports the long-term return on investment of early childhood interventions and supports, but we need an incentive and financing structure that also takes the long view.

Financing structures discourage integration of mental health supports in primary care settings. To provide integrated mental health screening and support services in the context of primary care, publicly and privately funded health plans and mental health organizations need to identify ways to pay for integrated mental health support. One example of progressive financing policy is two-generation Medicaid billing: screening for maternal depression under the child’s Medicaid identification number in pediatric primary care is reimbursable in Colorado. Another example, the Aspen Center for Women at Arapahoe House, offers a residential treatment program and outpatient services for pregnant women with substance use disorders. Medicaid covers these services for one year post-partum.

Currently, there is a lack of understanding among providers in Colorado regarding billing practices for mental health services, which leads to inconsistencies in how providers deliver and bill for these services. Greater clarity would enable providers to effectively navigate billing procedures and provide optimal integrated behavioral health services to patients.

The lack of funding for care coordination for families or parents of children also limits this essential element of providing families the services they need. Providers should be able to plan for and treat children and their families holistically to address overall needs, regardless of the primary reimbursement system. In the absence of reimbursement, practices and clinics rely on grants and other short-term funding sources to facilitate care coordination. Pediatric and primary care practices need additional practice management support to conduct care coordination in a financially sustainable manner.

Due to complexities regarding the carve-out of mental health funding in Colorado’s Medicaid state plan, primary care providers find it challenging to provide mental health services in a primary health care environment. The answer is policies that support true integration in pediatric practices and that pay providers to offer integrated behavioral health services, address psychosocial risk areas, assist parents and patients in accessing the mental health services to which they are referred, and track referrals to ensure follow-through and patient improvement.

As noted previously, our system's current diagnosis-driven model of treatment leads to challenges for providers when it comes to reimbursement for child mental health services. Children often do not exhibit symptoms that will lead to a diagnosis yet a diagnosis is often required in order to begin providing services. When a child also has an intellectual or developmental disability the complexities around reimbursement increase, as mental health and disability service providers attempt to navigate the financial and regulatory landscape of these two systems to provide children with needed services.

Additionally, significant challenges to integration exist as a result of the current financing and management structures of various systems that provide health services in Colorado. Behavioral health care services in Medicaid are currently managed and financed separately through Behavioral Health Organizations (BHOs) in five BHO regions throughout Colorado. The Accountable Care Collaborative (ACC) initiative in Colorado's Medicaid program contracts with Regional Care Collaborative Organizations (RCCOs) to administer the ACC in seven RCCO regions across the state, which do not currently share geographic boundaries with the BHO regions. The Office of Behavioral Health at the Colorado Department of Human Services (CDHS) also offers substance use disorder treatment services through Managed Service Organizations (MSOs) in seven regions across the state that do not align with the BHO or RCCO regions. The Department of Healthcare Policy and Financing (HCPF) is in the process of updating the ACC model as part of the rebidding process for the RCCOs and has indicated that it will work to align the BHO and RCCO regions in an effort to streamline the behavioral and medical health care services received by Medicaid clients who are enrolled in the ACC. In short, aligning efforts and strategies to support the integration of services is a necessary step for better supporting young children's behavioral health needs.

Workforce and System Capacity:

System capacity is inadequate to provide needed services. The implementation of health care reform has enabled hundreds of thousands of people to secure health coverage for the first time. Many in Colorado have turned their attention to whether the number of health care providers in the state is adequate to meet the needs of our population. After studying this question, the Colorado Health Institute found a wide variation in primary care workforce capacity across Colorado.⁵¹ The challenge is amplified for specialty care.

Many providers report difficulty identifying mental health professionals trained in either early childhood mental health care or integrated behavioral health services in their communities. Issues that affect children are different than adults and require specialized training. Behavioral health professionals that work in pediatric or family medicine settings need training on how to work with children/adolescents and the parents or caregivers of a young child. Primary care providers need support in effective models of integration.

Access to child psychiatrists continues to be a struggle statewide. Child psychiatrists participate in the care of children with severe mental health issues, especially psychopharmacologic interventions and medication management. Some rural counties in Colorado do not have a single psychiatrist, let alone a child psychiatrist. Concentrated attention and investments in the development of these practitioners is a necessary step in supporting young children's mental health. Programs that provide telephone and video-based consultation for primary care medical providers with child psychologists and counselors can be expanded to make these services more readily available in all parts of the state.

Colorado is also experiencing significant workforce shortages to meet the needs of individuals suffering from substance use disorders. Colorado ranks in the top 5 states for the number of individuals who need treatment for substance use disorders, but do not access it.⁵²

Accessing services is about more than just workforce shortages. For example, Early Intervention (EI) is a multi-step, multi-system process in most counties; those evaluating for service eligibility need training and professional development regarding early childhood social-emotional issues and trauma to make the appropriate referrals. Additionally, for vulnerable populations, barriers to access, such as transportation and language, can make getting through these complex processes nearly impossible. This is true even if children are appropriately identified and referred to EI.

Practice change and workforce development are difficult. The ideal support to primary care physicians is provided through on-site, integrated mental health clinicians. These clinicians engage in direct patient care, support providers in providing comprehensive care, and function as liaisons to community entities, facilitating warm handoffs to community mental health and other social support services when the mental health needs are beyond the scope of primary care. Considerable coaching is required to transform a primary care medical home into an integrated setting able to provide full mental and physical health care. Colorado pursued the State Innovation Model (SIM) grant opportunity to support practice transformation coaching and was recently awarded federal funding to support expansion of statewide efforts.

Primary care physicians can also benefit when non-clinicians, such as health educators, peer counselors, family navigators, substance use therapists and community health workers, are included in primary care settings as part of a team who provides care to patients. Non-clinicians can assist with care coordination, health education and patient engagement, and can increase the efficiency and efficacy of primary care practices, removing some of the burden from licensed providers. Medicaid rules make it difficult to provide payments to non-clinicians in primary care settings. But it is possible to structure a primary care practice to allow reimbursement for services of non-clinicians, for example, if non-clinicians are working under the direction of a licensed Medicaid provider.⁵³

The challenges of changing common practices and ensuring the preparation of the workforce to help address the mental health issues of young children extend to early care and learning settings as well. Early childhood educators need support and training to recognize and promote the social-emotional developmental needs of young children. Expanding access to effective models is one approach. Models such as Pyramid Plus or Expanding Quality for Infants and Toddlers currently only reach a fraction of the 5,400 licensed child care providers in Colorado. Increasing access to trainings and support is also essential for non-licensed family, friend and neighbor child care providers. Providers caring for young children in Colorado need access to professional development opportunities and the resources they require to provide high quality care. Supporting and maintaining practice change also requires effective consultation resources. The early childhood mental health specialists consultation model reflects one approach to helping providers build capacity to support young children's social-emotional development and prevent mental health difficulties. Head Start and Early Head Start programs provide one example of integrating behavioral health care into early learning settings. Head Start and Early Head Start programs in Colorado conduct developmental screenings and evaluations for participating children and refer children to mental health services when necessary. These programs also track the number of referred children who receive mental health services. During 2013-2014, 62 percent of children referred by a Head Start or Early Head Start program in Colorado received services.⁵⁴

Integrated mental health professionals working in primary care settings need specific training and education to be successful in medical settings. A competent, high-quality workforce will ensure that the services provided in the context of primary care appropriately meet the needs of a population whose only access to health and mental health services may be through their primary care physician. In other words, taking outpatient mental health clinicians and inserting them into primary care settings is not sufficient or effective. Mental health clinicians need training and supervision to successfully integrate into primary care and be effective in their practice.

Current state policies regarding credentialing of mental health professionals and licensing medical providers should be examined to identify and remove barriers to integrated care and the use of competent early childhood mental health providers in other settings. Colorado currently offers a competency-based infant mental health endorsement that is tiered to reflect increasing levels of skill and specialized experiences attained by a wide range of professionals serving very young children and their caregivers. But professionals have few incentives to secure the endorsement beyond the desire to attain and demonstrate a higher and more specific level of skill. Differentiated reimbursement and other incentives that reflect the expertise of these professionals can further enhance and incentivize high quality services for young children and have been implemented in other states such as Michigan.⁵⁵ Embedding social-emotional development training in pre and post-degree curricula for practicing professionals in early care, K-12, and primary care settings will emphasize the importance of this domain for all professionals who work with children.

The infant mental health endorsement, one integrated strategy supporting children's social-emotional development, can be leveraged by differential reimbursement for credentialed providers or identification of preferred mental health and other care providers with these credentials. Professional development for primary care physicians on integrating mental health screening and referral would help address provider apprehension and also equip providers with specific strategies for supporting young children.

Recommendations

This section identifies five recommendations and associated action steps for policy change to strengthen mental health services for children in Colorado.

Advance integration of mental health services and supports in health care and educational settings through delivery system changes, payment reform and practice transformation. One of the most urgent needs is a social-cultural context where mental health is viewed as a critical and central part of healthy child development and well-being. We can take an important step in this direction by integrating mental health services and supports into the settings to which children and families are already connected, including primary care practices, child care settings, schools, communities and homes. An effective pediatric strategy for children focuses on health promotion, prevention, early recognition and intervention in the settings where young children are seen by professionals who are able to screen, intervene and refer children for early mental health care. Better infrastructure to connect child care settings and schools with mental health care services also makes a positive difference. Care coordination and communication across the sectors in which children are served are key to providing high quality care for children.

Actions to advance this recommendation:

- Capitalize on immediate integration opportunities in Colorado. These include:
 - Colorado's Race to the Top Early Learning Challenge Fund grant, a \$45 million, four-year early learning challenge fund grant that is focused on building the early childhood systems infrastructure in the state;
 - Colorado's SIM federal grant to implement the State Health Improvement Plan (SHIP), which aims to ensure that 80 percent of Coloradans have access to integrated primary care and behavioral health services in coordinated community systems with value-based payment structures by 2019;
 - The RCCO rebidding process, which included a robust listening process to gather stakeholder input and feedback on how RCCOs can more effectively meet the needs of Medicaid clients; and
 - *Colorado Project LAUNCH*, a collaborative initiative between the CDHS Office of Early Childhood, the Colorado Department of Public Health and Environment (CDPHE), JFK Partners/University of Colorado School of Medicine and the Early Childhood Partnership of Adams County that will increase the quality and availability of evidence-based programs for children and families, improve collaboration among child-serving organizations, and integrate physical and behavioral health services and supports. Efforts are also underway to expand *LAUNCH* to other communities across the state.
- Consider the integration of mental health services for children when designing the next phase of the ACC.
- Engage in dialogue regarding the carve-out of mental health funding in Colorado's Medicaid state plan and the resulting challenges faced by primary care providers around providing mental health services in primary health care settings.
- Embed healthy development components into child care licensing and quality rating systems implemented by CDHS, including Colorado Shines, to ensure that approaches such as developmental screening and referral processes are utilized appropriately and consistently in early care and learning settings.
- Ensure components of children's social-emotional development are addressed by the school readiness assessment and school readiness planning process conducted in kindergarten, as overseen by the Colorado Department of Education and the State Board of Education.

Develop and fund robust infrastructure to support a statewide screening, referral and care coordination model.

While we are confident that screening is happening in medical and community-based settings at a fairly high and growing rate, we have a lower level of confidence in the quality and consistency of that screening. Furthermore, available data suggest that, nationwide, when screenings indicate a need for further evaluation, only half of families are referred for in-depth evaluation and less than 11 percent of children actually receive mental health services.⁵⁶ More data are needed to enable policymakers to determine how many families access and use screening, evaluation and intervention services, as well as what information about the evaluation process gets back to the primary care setting and the family. Today, Colorado is lacking a centralized reporting and tracking system, a consistent and universal process, and consistent data collected on developmental, social-emotional, family psychosocial and autism screening.

Actions to advance this recommendation:

- Develop standards, consistent with the Bright Futures/American Academy of Pediatrics Preventive Pediatric Health Care Screening Schedule, regarding tools for use to screen young children, mothers and families. Fund appropriate implementation of these standards to avoid inconsistency of screening practices and information and ensure that both public and private insurance providers support this process.
- Encourage and support screening for and early identification of psychosocial risk factors and ACEs and support interventions to assist families with socioeconomic issues that can contribute to adverse environments and experiences and create barriers to mental health care.
- Develop a comprehensive screening system that includes at least five points of data: 1) whether the child and his or her caregiver(s) were screened; 2) the results of screenings; 3) whether an evaluation was completed; 4) whether the child and/or his or her caregiver(s) entered into services; and 5) whether services for the child and family were sustained.
- Support a data sharing infrastructure within the bounds of data privacy requirements that allows providers to communicate and coordinate care in a bi-directional manner and ensures feedback between primary care and mental health providers. The EI Colorado referral form, which when signed by the parent or guardian serves as a release, complies with medical and educational privacy requirements and is an effective model.
- Make reimbursement available to providers for care coordination services across systems that serve children and include care coordination (ensuring families actually receive needed services) as a defined component of a comprehensive screening, referral and care coordination model.



Invest in workforce capacity development to (1) increase the number of qualified mental health professionals and (2) expand professional development and training opportunities that enhance the skills of professionals in the field. Currently there is a shortage of professionals with mental health training in both health care and early childhood settings. Many health providers report difficulty identifying mental health professionals trained in either early childhood mental health care or integrated behavioral health services in their communities. Furthermore, mental health clinicians need training and supervision to successfully integrate into primary care and be effective in their practice; these training opportunities currently are limited. There is also a shortage of high quality, licensed child care for all working families in Colorado who seek it. Early childhood educators and child care providers need additional opportunities for training to help understand and address the mental health needs of young children.

Actions to advance this recommendation:

- Elevate expectations and add incentives in various early childhood settings that emphasize mental health, including professional development and training opportunities for health care, child care and K-12 education staff. Key leverage points are licensing activities at CDHS and the Colorado Department of Education (CDE), as well as professional development activities of health professions.
- Support early childhood professionals working in child care and preschool settings with pre-service training, ongoing professional development and consultation to support children’s mental health and social-emotional development. An emphasis on how to appropriately screen and refer children should be embedded in this support.
- Ensure early childhood providers have adequate training and resources to identify, access and work effectively with early childhood mental health specialists.
- Promote programs that provide basic training to health care, child care and K-12 education staff regarding children’s mental health and social-emotional development.
- Make efforts to increase the numbers of child psychiatrists or expand their capacity to provide consultation and back-up for medical and mental health professionals through telehealth systems.
- Support specialized training and invest in differentiated reimbursement for services provided by professionals that have attained the Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (IMH Endorsement) as administered by the Colorado Association for Infant Mental Health.
- Increase the number of mental health professionals, including Early Childhood Mental Health Specialists, trained to provide early childhood prevention and health promotion interventions and services.
- Support Early Childhood Councils as hubs of support for families and ensure that early childhood mental health remains an explicit component of their work.
- Leverage Colorado’s new credentialing system to support a workforce suited to address the mental health needs of young children.



Develop a comprehensive statewide navigation system to connect caregivers, families and children to referral and mental health resources, including supports for crisis situations. Access to health care services varies widely across the state. Some regions in Colorado lack basic health care infrastructure, and access to mental health services in these regions is even more difficult. Even in well-resourced communities, navigating complex health care systems can be challenging. As a result, families may end up seeking care in the most costly and least effective settings, such as emergency rooms. If we want providers to screen and provide referrals to mental health, we need a better network of referral and mental health resources, including crisis resources, and more effective ways to connect to existing resources, in order to maximize delivery of cost-effective, quality care.

Actions to advance this recommendation:

- Develop an adequate network of providers to refer to for early childhood mental health issues and systems to ensure care ensues following a referral.
- Support telehealth/telemedicine as a way to enhance service delivery in rural and remote communities that cannot afford to sustain local services.
- Support a network of resources to support families in crisis or experiencing stressful life experiences, such as the Colorado Crisis and Support Line, Mile High United Way 2-1-1, Help Me Grow, the ParentSmart Healthline at Children’s Hospital Colorado, and family navigators.
- Support mechanisms to help families, providers and community partners navigate existing early childhood mental health and social/emotional services, supports and resources such as the Colorado Social Emotional and Mental Health Navigation Guide.⁵⁷
- Support care coordination and referral efforts among the various settings where a family may seek help for a child with severe mental health needs, including emergency rooms, schools and primary care providers.

Support innovative practices, programs and approaches, scaling those that are making a demonstrable difference and find ways to embed them into the core work of public agencies serving children. Colorado is home to many innovative, promising and proven practices. However, much of the current work in this area is grant-funded and not fully integrated into the essential work or budgets of state agencies or local practice. Policy advocates must consider how to transition from “initiative” oriented work to “core” work, and how to sustain core work with ongoing state funding through various agency budgets and reforms to current financing practices.



Actions to advance this recommendation:

- Increase support for home visitation and community support programs that provide well child care support, home visitation, and information to parents of children from birth to age three and Home Instruction for Parents of Preschool Youngsters (HIPPIY), which provides school readiness support and services at home to parents of children ages three, four, and five.
- Support continued reauthorization of the Maternal, Infant, Early Childhood Home Visiting Program (MIECHV), which provides funding for home visiting programs that target first-time and vulnerable parents, beyond 2017 so these programs can expand their reach and serve a higher number of children and families.
- Explore opportunities to use Medicaid resources and other current funding resources to address unmet needs in childhood mental health and accomplish a broader reach with additional state or federal investments.
- Develop data collection systems to track information on child care and preschool expulsion rates to inform policy change that supports children with challenging behaviors in early learning settings.
- Invest in and expand early childhood mental health consultation models in the following ways:
 - Fund flexible programming so that all children in need of services (rather than just those who are uninsured or under-insured) receive services in community-based settings including health settings.
 - Develop the infrastructure, including financing, to support the early childhood mental health consultation model, including integrated early childhood behavioral health services in primary care and the work of Early Childhood Mental Health Specialists associated with the Community Mental Health Center system consultants.
 - Explore funding mechanisms for the prevention and promotion activities delivered by consultation models.
- Support Head Start and Early Head Start programs that integrate behavioral healthcare services into early learning settings.

Conclusion

To raise successful kids, we need to start with a widely-shared and comprehensive definition of health that includes mental health and a commitment to addressing mental health in a comprehensive manner. We need to focus on prevention, early recognition and intervention, and family-centered services. Public policy can play a significant role in creating a healthier future for our children. This brief has outlined five recommendations with actionable steps that policymakers can take over the next three to five years to create systems and structures that support the healthy development of our children. The Colorado Children's Campaign, Children's Hospital Colorado and the Colorado Children's Healthcare Access Program look forward to working with elected and appointed officials, mental health care and medical professionals, child care providers, educators and other child advocates to advance this agenda and create a healthier future for Colorado.



Additional Resources

To learn more about early childhood mental health and programs and services in Colorado, please visit the following sites.

- Early Childhood Mental Health Specialists (ECMHS): <http://media.wix.com/ugd/97dde5d52d11f9678ec6a19e19e4548e96a7f4.pdf>
- Colorado Office of Early Childhood: <http://www.coloradoofficeofearlychildhood.com/#!early-childhood-mental-health-services/c1uht>
- Early Childhood Mental Health Consultation model
<http://www.colorado.gov/cs/Satellite/CDHS-BehavioralHealth/CBON/1251581866179>
- JFK Partners: <http://www.ucdenver.edu/academics/colleges/medicalschooll/programs/JFKPartners/projects/Pages/Social-Emotional.aspx>
- Colorado Early Learning and Development Guidelines: <http://www.cde.state.co.us/sites/default/files/Early%20Learning%20Guidelines.pdf>
- Harris Program: <http://www.ucdenver.edu/academics/colleges/medicalschooll/departments/psychiatry/PsychEducation/Psychology/PsychologyFellow/Harris/Pages/Overview%20original.aspx>
- Fussy Baby Network Colorado: <http://www.fussybabynetworkcolorado.org/>
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT): <https://www.colorado.gov/pacific/hcpf/early-and-periodic-screening-diagnostic-and-treatment-epsdt>
- Center for Early Childhood Mental Health Consultation: <http://ecmhc.org/>
- Pyramid Model: <http://www.pyramidmodel.org/>
- Building Bridges for Children’s Mental Health Project in Colorado: <http://www.cde.state.co.us/cdesped/buildingbridges#sthash.ZsUvXVOX.dpuf>

Other CDE resources:

- <http://www.cde.state.co.us/cdesped/MentalHealth>
- <http://www.cde.state.co.us/cdesped/Behavior>
- <http://www.cde.state.co.us/early/social-emotionalmentalhealth>
- <http://www.cde.state.co.us/early/pbs>
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1580 Lincoln Street, Suite 420 • Denver, CO 80203
Phone: 303.839.1580 • Fax: 303.839.1354

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