

Connecticut Children's Behavioral Health Plan

**Prepared pursuant to Public Act 13-178
And Submitted to Connecticut General Assembly**

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Executive Summary

Overview

There are approximately 783,000 children under age 18 currently in Connecticut, constituting 23% of the state's population. Epidemiological studies using large representative samples suggest that as many as 20% of that population, or approximately 156,000 of Connecticut's children, may have behavioral health symptoms that would benefit from treatment, yet many of these children are not able to access services.¹ Families experience a number of barriers to treatment including a highly fragmented system in which access varies according to such factors as insurance status, involvement in child welfare or juvenile justice, race and ethnicity, language, and geographic location. In addition, the array of services lacks sufficient inclusion of supports for all children and families that promote nurturing relationships and environments that foster social, emotional, and behavioral wellness. A comprehensive plan is required to guide the efforts of multiple stakeholders in developing a children's behavioral health system that builds on existing strengths and addresses the many challenges that exist.

The Connecticut Department of Children and Families (DCF) is submitting this Connecticut Children's Behavioral Health Plan in fulfillment of the requirements of Public Act 13-178, one part of the Connecticut General Assembly's response to the tragedy in Newtown in December 2012.² The legislation called for the development of a "comprehensive implementation plan, across agency and policy areas, for meeting the mental, emotional and behavioral health needs of all children in the state, and preventing or reducing the long-term negative impact of mental, emotional and behavioral health issues on children." This Plan provides Connecticut with a unique and timely opportunity to align policy and systems to support youth and families and to promote healthy development for all our children.

Public Act 13-178 directed DCF to include in the implementation plan the following strategies to prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children:

- A. Employing prevention-focused techniques, with an emphasis on early identification and intervention;
- B. Ensuring access to developmentally-appropriate services;
- C. Offering comprehensive care within a continuum of services;
- D. Engaging communities, families and youths in the planning, delivery and evaluation of mental, emotional and behavioral health care services;
- E. Being sensitive to diversity by reflecting awareness of race, culture, religion, language and ability;

- F. Establishing results-based accountability measures to track progress towards the goals and objectives;
- G. Applying data-informed quality assurance strategies to address mental, emotional and behavioral health issues in children;
- H. Improving the integration of school and community-based behavioral health services;
- I. Enhancing early interventions, consumer input and public information and accountability by: (i) in collaboration with the Department of Public Health, increasing family and youth engagement in medical homes; (ii) in collaboration with the Department of Social Services, increasing awareness of the 2-1-1 Infoline program; and (iii) in collaboration with each program that addresses the mental, emotional or behavioral health of children within the state, insofar as they receive public funds from the state, increasing the collection of data on the results of each program, including information on issues related to response times for treatment, provider availability and access to treatment options.

Plan development was guided by values and principles underlying recent efforts in Connecticut to create a "system of care" for youth and families facing behavioral health challenges and the Institute of Medicine framework for implementing the full array of services and supports that comprise a comprehensive system. A system of care is defined as:

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.³

The Institute of Medicine (IOM) framework aligns services and resources along a continuum or array that includes universal services for all children to promote optimal social and emotional development; selective services (e.g., early identification, early intervention) for children at high risk for developing a behavioral health condition; and indicated services for treating those with serious and complex disorders. The array of services and supports is used to inform the planning and implementation of a system that will meet the needs of all youth and their families.

The theory of change driving this Plan is that a children's behavioral health system based on the system of care core values and principles will result in improved health outcomes. Four core values drive the development of a system:

- **Family-driven and youth guided**, with the strengths and needs of the child and family determining the types and mix of services and supports provided;
- **Community-based**, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level;
- **Culturally and linguistically appropriate**, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.
- **Trauma informed**, with the recognition that unmitigated exposure to adverse childhood experiences including violence, physical or sexual abuse, and other traumatic events can cause serious and chronic health and behavioral health problems and is associated with increased involvement with the criminal justice and child welfare systems.

In addition, the Plan reflects the understanding that an effective system must be reorganized to include data-informed implementation, pooled funding across all payers (public and private), and

mechanisms for care coordination, with families and youth as full participants in the governance of that system.

How the Plan Was Developed

DCF contracted with the Child Health and Development Institute of Connecticut (CHDI) to facilitate an extensive input gathering process that served as the cornerstone for the preparation of the Plan. Family members, youth, Family System Managers from FAVOR, family advocates from the African Caribbean American Parents of Children with Disabilities (AFCAMP), and consultants from Yale University took lead roles in input-gathering activities, in partnership with CHDI staff. A Steering Team and a 36-member Advisory Committee oversaw the process. The core elements of the input-gathering process were:

- 26 Network of Care Community Conversations attended by 339 family members and 94 youth;
- Open forums held in six locations and attended by 232 individuals;
- Facilitated discussions on 12 specific topic areas, attended by 220 individuals;
- Website input forms submitted by over 175 individuals and groups;
- A review of background documents and data pertaining to the children's behavioral health system in Connecticut.

The process yielded the identification of seven thematic areas that will result in significant improvements to the children's behavioral health service system in Connecticut:

- A. System Organization, Financing and Accountability
- B. Health Promotion, Prevention and Early Identification
- C. Access to a Comprehensive Array of Services and Supports
- D. Pediatric Primary Care and Behavioral Health Care Integration
- E. Disparities in Access to Culturally Appropriate Care
- F. Family and Youth Engagement
- G. Workforce

The Plan presents a set of goals and strategies for each of the areas, which are summarized below. Readers are encouraged to reference the full report for more detailed information that includes background information and summarizes the findings that inform each of the goals and strategies.

Implementation Plan: Goals and Strategies by Thematic Area

A. System Organization, Financing and Accountability

Implementing an enhanced children's behavioral health system of care will require a significant restructuring with respect to public financing, organizational structure, integration of commercial payers, and data reporting infrastructure.

Goal A.1. Redesign the publicly financed system of behavioral health care for children to direct the allocation of existing and new resources.

A core finding from all input sources is that the children's behavioral health services are fragmented, inefficient and difficult to access for children and families. Those issues would be substantially improved by integration of public funding that brings together multiple payers and streamlines eligibility, enrollment, service arrays, documentation, and reimbursement mechanisms. Strategies in this area include the following:

1. Identify existing spending on children's behavioral health services and supports across all state agencies.
2. Determine if those existing funds can be re-aligned or used more efficiently to fund the full array of services and supports.
3. Explore mechanisms for pooling funding across all state agencies.
4. Identify a full array of services and supports that will constitute the children's behavioral health system of care.
5. Conduct a cost analysis to identify cost savings associated with implementation of the system of care approach and a focus on prevention.
6. Identify and address workforce development needs in the children's behavioral health system of care.

Goal A.2. Create a Care Management Entity to streamline access to and management of services in the publicly financed system of behavioral health care for children.

Effective access to and management of the full array of preventive and treatment services within a well-designed "system of care" can improve outcomes for children and lower costs of behavioral health services.⁴ A Care Management Entity has the potential, as a model, to reduce fragmentation, integrate funding streams and service delivery, improve efficiencies and accountability, and reduce costs by disseminating information on behavioral health services, connecting families to services, and providing ongoing care coordination. This will help improve the family's experience of a culturally and linguistically appropriate system with a single point of access that helps families access information and navigate care. Efforts to improve access to information should be coordinated with the efforts underway as a result of Public Act 14-115. Strategies in this area include the following:

1. Design and implement a Care Management Entity to create an effective care coordination system based on proven Wraparound and child and family teaming models, with attention to integration across initiatives and training.
2. Develop a family support clearinghouse to increase access to information about available behavioral health services and improve supports for behavioral health system navigation.

Goal A.3. Develop a plan to address the major areas of concern regarding how commercial insurers meet children's behavioral health needs.

Given that insurance companies and self-insured employers currently cover approximately 56% of children and youth, their participation in the children's behavioral health system of care is critical. Concerns about behavioral health services for children and families with commercial insurance arose in the majority of meetings held to gather input into Plan development. Those concerns can be categorized in the following five areas: coverage for selected services; adequacy of coverage/services for selected conditions; medical necessity criteria and utilization management and review procedures; adequacy of provider networks; and perceived cost shifting to individuals and the State.

Based on the redesign of the publicly financed system, the incorporation of a Care Management Entity, and the demonstration of outcomes and cost savings, the commercial insurance sector will be incentivized to participate in the children's behavioral health system of care. Strategies include the following:

1. Conduct a detailed, data-driven analysis of each of the five issues identified in the information gathering process and recommend solutions.
2. Apply findings from the process described above to self-funded/employee-sponsored plans.

Goal A.4. Develop an agency- and program-wide integrated behavioral health data collection, management, analysis, and reporting infrastructure across an integrated public behavioral health system of care.

A core element of PA 13-178 is an emphasis on data and incorporation of results-based accountability. Implementation of the behavioral health system of care requires full attention to the development of data infrastructure for the purposes of monitoring and improving access to services, service quality, outcomes and costs. At the practice level, the collection, analysis, and reporting of data is already an element of evidence-based treatments; yet many other behavioral health services do not currently benefit from systematic data collection, analysis, reporting, standardized training and practice development and quality improvement activities. Specific strategies in this area include the following:

1. Convene a statewide Data-Driven Accountability (DDA) committee to design a process to oversee all efforts focused on data-driven accountability for access, quality, and outcomes.
2. Utilize reliable standards to guide the new data collection, management, and reporting system.
3. Assess and improve current data collection systems to serve in an integrated system across all agencies involved in providing children's behavioral health services.
4. Increase State capacity to analyze data and report the results.

B. Health Promotion, Prevention and Early Identification

Prevention of mental, emotional and behavioral health concerns for children is one of the key goals of the plan called for by PA 13-178. The law requires the inclusion of strategies that employ prevention-focused techniques, with an emphasis on early identification and intervention and access to developmentally appropriate services, which are addressed in this section.

Goal B.1. Implement evidence-based promotion and universal prevention models across all age groups and settings to meet the statewide need.

The behavioral health system should increasingly focus on promotion and universal prevention strategies to reduce or eliminate child and family risk factors, and enhance protective factors, to prevent the development of mental, emotional or behavioral disorders for children and youth of all ages. Connecticut has a wealth of expertise and programmatic efforts to train early care, education and school personnel on the promotion of social and emotional competence and how to address behavioral health concerns in school settings. However, they reach different audiences and have not been taken to scale to reach children of all (See also Strategy C.3.3. regarding professional development for school personnel in behavioral health).

The key strategy in this area is:

1. Enhance the ability of caregivers, providers and school personnel to promote healthy social and emotional development for children of all ages and develop plans to coordinate existing evidence-based efforts to take them to scale to meet the statewide need.

Goal B.2. All children will receive age appropriate periodic standardized screening for developmental and behavioral concerns as part of a comprehensive system for screening, assessment, and referral for services.

Screening and early identification are important steps toward avoiding more severe behavioral health challenges over time and deeper involvement in the behavioral health system, this is true for young

children and adolescents alike. In addition to the children's behavioral health system; parents and other child-serving systems play a critical role in this effort. Key strategies in this area include the following:

1. Expand the use of validated screening tools to assist parents and other caregivers and health, education and home visiting providers to promote social and emotional development, identify behavioral health needs and concerns, document results, and communicate findings with other relevant caregivers and providers in a child's life allowing for improved coordination of care.
2. Link all children who screen positive for developmental and behavioral concerns to further assessment and intervention using existing statewide systems to identify appropriate resources when needed.

Goal B.3. Ensure that all providers and caregivers who work with young children and youth demonstrate competency in promoting social and emotional development in the context of families, recognizing risk factors and early signs of social-emotional problems and in connecting all children to appropriate services and supports.

Providers who work with children need to have specific and developmentally appropriate competencies to assist in behavioral health promotion and prevention, and to recognize and respond to early warning signs or concerns. As those who work with young children need very specific training and have the opportunity to make the biggest difference in setting children on the right developmental trajectory, the Plan suggests beginning with this group of providers. Training for providers working with older children is covered as part of the implementation of specific interventions and through training of school personnel (Goal C.3). The following strategy is recommended:

1. Expand statewide trainings on infant mental health competencies and increase the number of providers across all relevant systems who receive Endorsement in Infant Mental Health.

Goal B.4. Develop, implement, and monitor effective programs that promote wellness and prevent suicide and suicidal ideation.

Focus on promotion and universal prevention strategies including continued support for statewide suicide prevention activities, to reduce risk factors and promote protective factors.

C. Access to a Comprehensive Array of Services and Supports

Goal C.1. Build and adequately resource an array of behavioral health care services that has the capacity to meet child and family needs, is accessible to all, and is equally distributed across all areas of the state.

The current array of services is insufficient for meeting child and family behavioral health needs, as manifested in lack of knowledge about the service array, long waitlists for some services and high emergency department utilization. In addition, the proposed expansion of screening to identify behavioral health needs will likely increase the number of youth in need of care, and must be accompanied by an expansion of services to meet those needs. There are currently wide variations in access to and utilization of the array of services among families as the result of such factors as: past and current child welfare and juvenile justice system involvement; insurance coverage; race, ethnicity and language; and geographic location. De-linking those factors from a family's ability to access a full array of services and supports will go a long way towards meeting the behavioral health needs of all children and families. The use of evidence-based, evidence-informed practices together with innovative and customized services, is highly recommended.

The Plan recommends service expansion in the following areas:

- **Early childhood interventions** with emphasis on an array of evidence-based interventions from low to high intensity, delivered in a variety of settings;
- **Non-traditional/non-clinical services** that include community-based, faith-based, after-school, grassroots, and other supports for youth who are exhibiting, or identified as at risk for, mental health symptoms;
- **Care coordination** utilizing high-fidelity Wraparound and child and family teaming approaches;
- **Behavioral health treatment** options including: outpatient care; intensive treatment models; child and adolescent psychiatry; substance use services; and services and supports for children with autism. Crisis response services and school-based behavioral health services are also recommended for expansion, which are described in more detail below.

Specific strategies in this area include the following:

1. Establish an ongoing needs assessment protocol, across local, regional, and statewide levels.
2. Finance the expansion of the services and supports within the array that have demonstrated gaps.

Goal C.2. Expand crisis-oriented behavioral health services to address high utilization rates in emergency departments.

High utilization of EDs can be addressed through expansion of crisis-oriented services, as well as other elements of the service array. Emergency Mobile Psychiatric Services (EMPS) is a proven service that helps divert youth from entering the ED by responding to families and schools, and helps reduce ED volume by diverting youth who are in the ED from inpatient admission, and providing linkages for families to community-based care. Connections between EMPS and a statewide network of crisis stabilization beds will also help address the current crisis in ED settings. Strategies in this area include:

1. Expand EMPS by adding clinicians across the statewide provider network to meet the existing demand for services including the expected MOA's between EMPS and local school districts.
2. Enhance partnerships between EMPS clinicians and EDs to facilitate effective diversions and linkages from EDs to community-based services.
3. Explore alternative options to ED's, through short-term (e.g., 23 hour) behavioral health assessment centers and expanded crisis stabilization units.

Goal C.3. Strengthen the role of schools in addressing the behavioral needs of students.

School-based behavioral health is a key area for expansion of the behavioral health service array that can positively impact all children and should result in substantial overall cost savings through early identification and early intervention. Stakeholders across the state consistently identified schools as playing a critical role in identifying and delivering behavioral health services and supports. The input-gathering process made it clear that the primary mission of schools is to educate students; however, it was widely recognized that students are best prepared to learn when they are healthy and equipped with social, emotional, and behavioral regulation skills and competencies. The State should provide support to schools to address students' behavioral health needs.

Efforts to expand school-based behavioral health services should include co-location of community-based clinicians in schools, additional school-employed behavioral health staff with adequate numbers of behavioral health clinicians, and expansion of School Based Health Centers. All efforts to expand school-based behavioral health care must be coordinated with community-based agencies so that children and families who are identified and/or treated in schools have access to the full array of services offered at

community-based clinics, and are assured continuity of care during the summer months. Schools must also closely collaborate with EMPS, as called for in PA 13-178, and with police. School-based behavioral health efforts should pay particular attention to ensuring that youth with behavioral health needs are not disproportionately excluded from the learning environment due to behaviors that may lead to arrest, expulsion, and out-of-school suspension.

Strategies in this area include the following:

1. Develop and implement a plan to expand school-based behavioral health services.
2. Create a blended funding strategy to support expansion of school-based behavioral health services.
3. Develop and implement a behavioral health professional development curriculum for school personnel.
4. Require formal collaborations between schools and the community.

Goal C.4. Integrate and coordinate suicide prevention activities across the behavioral health service array and across multiple sectors and settings.

Improving coordination and access to a full service array of suicide prevention activities to support families with children in an acute crisis.

D. Pediatric Primary Care and Behavioral Health Care Integration

Goal D.1. Strengthen connections between pediatric primary care and behavioral health services.

Pediatric primary care provides a unique opportunity to screen for and address children's behavioral health needs from a family-based perspective. Child health providers, through the medical home model of care, are an important community-based resource for delivery of health and behavioral health services, as many youth and families access a range of services through their pediatrician. Connections among pediatricians, schools, community-based behavioral health agencies, and other settings, however, need to be strengthened. Connecticut has several initiatives and models in place for improving these connections including the State Innovation Model (SIM), Medicaid's Person Centered Medical Home, Access Mental Health, and Enhanced Care Clinics. These models can be considered when determining how best to address this goal. Strategies in this area include the following:

1. Support co-location of behavioral health providers in child health sites by ensuring public and commercial reimbursement for behavioral health services provided in primary care without requiring a definitive behavioral health diagnosis.
2. Support the development of educational programs for behavioral health clinicians interested in co-locating in pediatric practices.
3. Require child health providers to obtain Continuing Medical Education (CME) credits each year in a behavioral health topic.
4. Ensure public and private insurance reimbursement for care coordination services delivered by pediatric, behavioral health, or staff from sites working on behalf of medical homes.
5. Reform state confidentiality laws to allow for sharing of behavioral health information between health and behavioral health providers.

E. Disparities in Access to Culturally Appropriate Care

Goal E.1. Develop, implement, and sustain standards of culturally and linguistically appropriate care.

Families and other stakeholders in the children's behavioral health system identified a number of concerns regarding disparities in access to culturally and linguistically appropriate services. At the broadest level, families expressed a lack of awareness of and access to culturally and linguistically competent services and supports in the existing behavioral health care system. Families requested an expansion of the workforce and the service array to include staff that are from the same community and speak the same language as the families they serve, gender-specific interventions, and enhanced access for families in the most rural areas of the state. Culturally specific marketing, stigma/discrimination reduction, and related materials are needed, along with training provided to all behavioral health clinicians on delivering services in a manner that respects the culture (e.g., family composition, religion, customs) of each family, in accordance with Culturally and Linguistically Appropriate Services (CLAS) standards.⁵ Although specific strategies are offered in this section, additional attention to disparities and cultural and linguistic competence are addressed in other sections of the report. Specific strategies in this area include the following:

1. Conduct an ongoing needs assessment at the statewide, regional, and local level to identify gaps in culturally and linguistically appropriate services.
2. Ensure that all data systems and data analysis approaches are culturally and linguistically appropriate.
3. Require that all service delivery contracts reflect principles of culturally and linguistically appropriate services.

Goal E.2. Enhance availability, access, and delivery of services and supports that are culturally and linguistically responsive to the unique needs of diverse populations.

Specific strategies in this area include the following:

1. Enhance training and supervision in cultural competency.
2. Ensure that all communication materials for service access and utilization are culturally and linguistically appropriate.
3. Provide financial resources dedicated to recruitment and retention to diversify the workforce.

F. Family and Youth Engagement

Goal F.1. Include family members of youth with behavioral health needs, youth, and family advocates in the governance and oversight of the behavioral health system.

Multiple stakeholders, including families, confirmed that a critical element in the development and implementation of a children's system of behavioral health care is the ongoing and full partnership of youth and families in the planning, delivery, and evaluation of services. At the systems-level, numerous stakeholders, including families, strongly urged that youth, family members, and family/youth advocates have "a seat at the table" in the governance and oversight of the service delivery system and that these roles be paid positions. At the service delivery level, family-advocacy as well as parent and peer support groups were highlighted as important elements of the workforce and the service array. Stakeholders highlighted the importance of opportunities for regular family and youth input and feedback into service delivery at the local and regional level. Strategies in this area include the following:

1. Increase the number of family advocates and family members who serve as paid members on statewide governance structures of the children's behavioral health system.
2. Expand the capacity of organizations providing family advocacy services at the systems and practice levels.
3. Increase the number of parents who are trained in parent leadership curricula to ensure that families develop the skills to provide meaningful and full participation in system development.
4. Provide funding to support at least annual offerings of the Community Conversations and Open Forums, and continue to sustain the infrastructure of the Plan website input mechanism to ensure ongoing feedback into system development.

G. Workforce

The topic of the workforce emerged from almost every discussion held as part of the planning process. The concept of workforce is used broadly in Connecticut with respect to children's behavioral health. It includes but is not limited to: licensed behavioral health professionals; primary care providers; direct care staff across child-serving systems; parent and family caregivers and advocates; school personnel; and emergency responders including police. It also includes youth as they engage in self-care and peer support. Concerns related to workforce included: shortages of key professionals or skills in the current workforce; lack of training capacity, including ongoing coaching, monitoring, and reinforcement in order to maintain skills; insufficient access to information for parents; and the lack of adequate knowledge among every sector of the workforce about children's behavioral health conditions and resources to address these conditions. Goals and strategies related to workforce development are reflected in 16 strategies across most of the thematic categories in the Plan. In addition, Section IV.A of the Plan calls for a workforce subcommittee of the overall governance structure for the system of care.

Implementation

In order to turn this Plan into reality, legislative action is highly recommended to fully authorize DCF and other key agencies and systems to ensure that the most urgent plan components are implemented in the short term and a detailed work plan, financing strategy and timeline are in place to implement the longer term strategies. The Plan includes a proposed timeline for implementation that focuses on the development of the infrastructure and the planning of the array of services that will comprise the System of Care.

An early task will be to design the longer-term governance structure charged with building the System of Care. The governance structure needs to have the authority to advance the ambitious agenda laid out in the plan, to develop the RBA templates to hold the initiative accountable, and a commitment to study the cost-effectiveness of service delivery types within the state. We recommend the creation of a Children's Behavioral Health Implementation Team to guarantee integrated, coordinated efforts as well as full transparency and meaningful engagement of all stakeholders, including families and youth. The Plan also recommends creation of a searchable web site with clear goals, progress benchmarks, and reporting of all actions and a Children's Behavioral Health Dashboard that will clearly report progress on a range of system and outcome measures. State level implementation will also include connection to DCF regional offices and the 26 regional System of Care Community Collaboratives, the DMHAS network of 13 Regional Action Councils and Early Childhood Community Collaboratives.

Conclusion

Children and families in Connecticut currently experience significant barriers to achieving social, emotional, and behavioral wellness and accessing quality behavioral health care. Throughout every element of the input-gathering process, it was clear that Connecticut can and should do better to meet

those needs. The process for developing the Plan yielded a comprehensive set of goals and strategies that will require a significant commitment of time and resources with the full participation of all key partners in the public and private sector and a deep commitment from state government, communities, families and youth to reach full implementation over the next five years. It is our hope that this Children's Behavioral Health Plan provides the foundation for fulfilling the vision of PA 13-178, that together we can meet the mental, emotional and behavioral health needs of all children in the state, and prevent or reduce the long-term negative impact of mental, emotional and behavioral health issues on children.

Endnotes

¹ U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, 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, 1999.

² Connecticut PA 13-178 State Mental Health Planning Initiative. See www.plan4children.org.

³ Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

⁴ Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2014). Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

⁵ U.S. Department of Health and Human Services, Office of Minority Health (2013). *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice*. Washington, DC: U.S. Government Printing Office.