



**The Mayor's  
Blue Ribbon  
Commission**  
on Children's  
Behavioral Health

**FINAL REPORT**  
Philadelphia, PA  
January 2007

# Blue Ribbon Commission Members

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**Hon. Blondell Reynolds Brown**, Philadelphia City Council

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Family Member

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Philadelphia Coalition of Community  
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Centers

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Family Member

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Family Member

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Treatment Research Institute,  
University of Pennsylvania

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Mental Health Association of  
Southeastern Pennsylvania

**Robert Berkowitz, M.D.**  
Children's Hospital of Philadelphia

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Project HOME

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Mothers In Charge

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Young Adult

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Community Developer and Family  
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Philadelphia City Council

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A. Pomerantz and Company

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Family Member

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Human Services Prevention Consultant

**Rachel Mann, Esq.**  
Disabilities Law Project

**Tony Valdes**  
Children's Crisis Treatment Center/  
The Philadelphia Alliance

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Intercultural Family Services, Inc.

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Consumer Satisfaction Team Inc.

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Family Member

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Family Member

**Cynthia Figueroa**  
Women Against Abuse

**Acel Moore**  
The Philadelphia Inquirer

**Kerry Williams**  
Youth Golf Academic Program

**Paul Fink, M.D.**  
Consultant

**Douc Quach**  
Young Adult

**Shelly Yanoff**  
Philadelphia Citizens for Children and  
Youth

**Dear Friend:**

It is an honor to present the Final Report of Philadelphia's Blue Ribbon Commission on Children's Behavioral Health. Last February, Mayor John F. Street brought together 48 committed individuals to form the Commission, challenging us to develop goals and recommendations for improving the social and emotional health of Philadelphia's children.

The Commission embarked on an inclusive and open process that encouraged involvement and input from hundreds of Philadelphians through three working committees and many public meetings held throughout the community. This report, which sets forth six goals and 22 recommendations, is the result.

The goals and recommendations are founded on the principle that children have an inherent resilience that - if nurtured, strengthened, and supported - can enable them to succeed, even under trying conditions. Further, they are built on the belief that everyone in the community, from parents to teachers to neighbors, must take responsibility for helping the city's children to be socially and emotionally healthy.

The report provides the framework for a citywide commitment to the healthy social and emotional development of all Philadelphia's children. Like the work of the Commission, the implementation process will strive for transparency, accountability and broad stakeholder representation.

On behalf of the entire Commission, we express our deepest gratitude to Mayor John F. Street for his leadership in creating and empowering the Commission, to Dr. Arthur C. Evans Jr., Director of the Department of Behavioral Health and Mental Retardation Services, and to Cheryl Ransom-Garner, former Commissioner of the Department of Human Services, for their continuing guidance and support throughout the Commission's deliberations. We are grateful to the scores of individuals representing city agencies, city schools, provider agencies, advocacy organizations, and the general community who participated in the Commission's meetings and committee activities.

Most of all, we thank the children, youth, parents, and other family members who shared their hopes, their challenges, and their advice at the Commission's meetings and public hearings.

It is our profound hope that the common agenda articulated in this report, and the work that follows, will move us closer to a time when Philadelphia can protect and promote the positive social and emotional health of all of its children.

Sincerely,



Blondell Reynolds Brown  
Councilwoman At-large  
City of Philadelphia

Co-Chair  
Blue Ribbon Commission



Kevin Dougherty  
Administrative Judge  
Family Court, Juvenile Division

Co-chair  
Blue Ribbon Commission



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# The Blue Ribbon Commission

## The Commission's Purpose and Approach

In February 2006, Mayor John F. Street convened the Blue Ribbon Commission on Children's Behavioral Health, a group of 48 knowledgeable and committed people that share an interest in the **behavioral health** needs of Philadelphia's children.

### The Mayor's Charge

The mayor charged the Commission with developing a framework and set of recommendations to improve the Philadelphia community's ability to promote social and emotional wellness in all of the city's children. The Mayor urged the Commission to focus on the needs of children, to rethink the traditional ways of responding to those needs and to be innovative and creative in finding solutions. In short, the Commission sought to answer this fundamental question: "If we did not have the systems that we have now, what would we build to promote social and emotional wellness in Philadelphia's children?"

There are numerous national, state and local reports that limit their focus to the behavioral health system's shortcomings. Studies show that behavioral health services are fragmented, inflexible, not sufficiently family- and consumer-driven and not culturally-competent.<sup>1\*</sup> While similar deficiencies must be addressed here in Philadelphia and were considered as part of the Commission's work, the Commission began by thinking more broadly. Guided by the Mayor's charge, it began with the premises that children and families have real needs, that these needs must be

**behavioral health:** A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, and can function productively and fruitfully with family, with peers, in school, and in his or her community.

foremost in the minds of those seeking to transform the state of children's behavioral health in Philadelphia, and that these needs cannot be met by focusing exclusively on the behavioral health system.

Research indicates that all human strengths and problems are best understood by viewing people within their respective social, cultural, economic, geographic and historical contexts. Children's abilities to master developmental milestones, for example, are greatly affected by the environments in which they live and learn.

The issues facing children and families in Philadelphia are complex and multifaceted. No single service system operating independently of others can provide the holistic approach that they need and deserve. To establish settings that promote competence and well-being, strategic changes are needed at multiple levels and across multiple systems. These changes must serve everyone including children with the most severe difficulties.

### The Changing Face of Philadelphia

Philadelphia was home to more than 405,000 children and youth ages 19 and younger in 2005, representing 29 percent of the city's total population.<sup>2</sup> (See map on the following page.) It is an ethnically and culturally rich city that continues to grow more diverse over time.

The past 15 years have seen a significant increase in the Hispanic population. Puerto Rican, Mexican, Dominican, Colombian, Brazilian, and Cuban immigrants have contributed to this growth. Other racial and ethnic groups show varying yet consistent rates of growth including immigrants of Indian, Korean, Chinese, Vietnamese, Filipino, Cambodian, Thai, and Pakistani descent. The African-American population grew more slowly while the percentage of non-Hispanic whites has decreased over the past two decades, now accounting for 43 percent of the total population.<sup>3</sup>

\* Sources can be found in Appendix B (page 94).

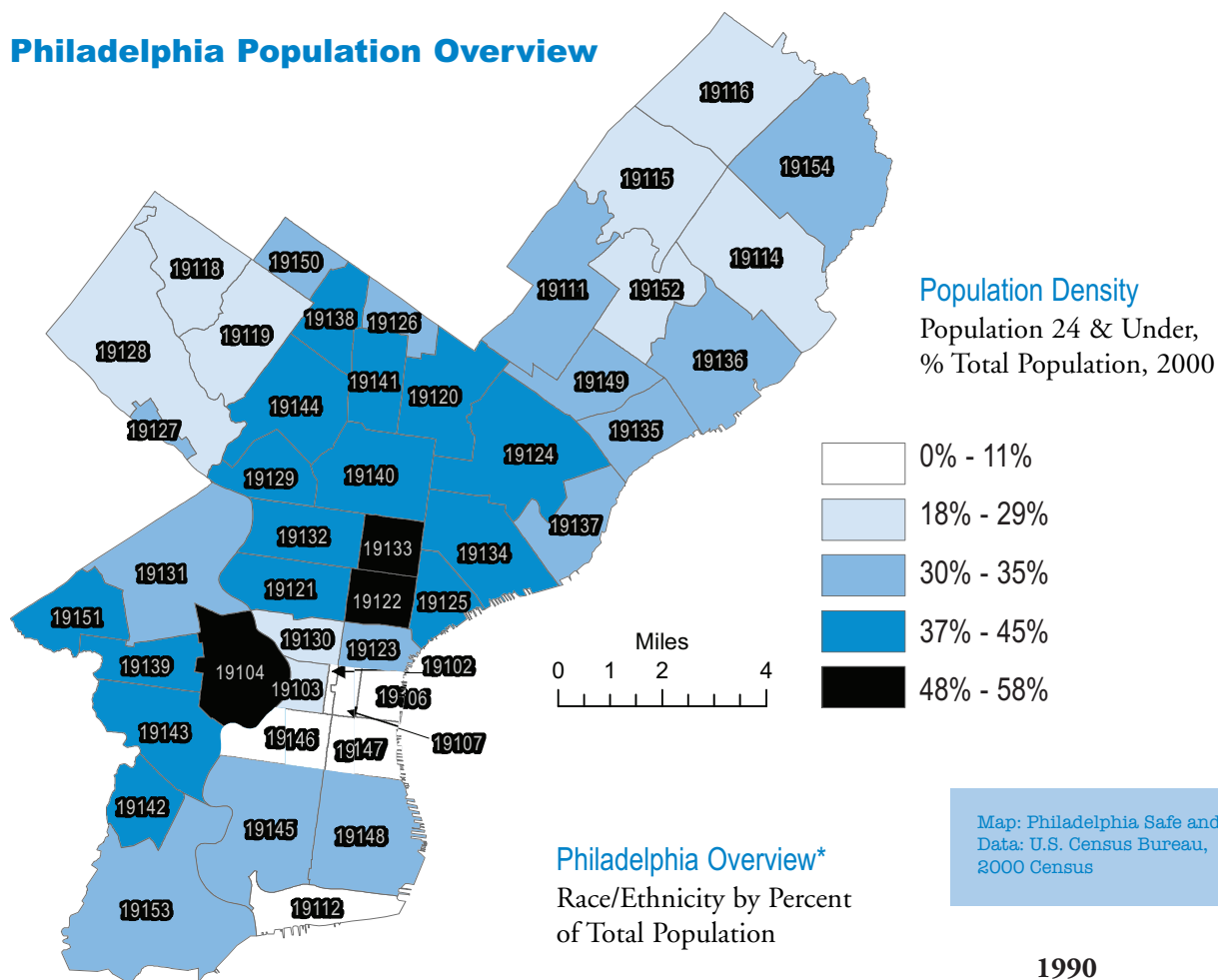


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Philadelphia also includes groups of Sub-Saharan Africans and West Indians, Ethiopians, Somalis, Sudanese, Liberians and Nigerians. Caribbean countries like Jamaica and Haiti are also represented. Russian, Greek, and Ukrainian immigrant populations have also grown. Since 1990, the city's Middle Eastern population has tripled as people of Turkish, Lebanese, Iranian, Egyptian, Iraqi, Saudi, Syrian, and Afghani descent make homes in the city.

All told, about 11 percent of Philadelphia's population is foreign born.<sup>4</sup> More than 30 languages are spoken in the city.<sup>5</sup> Many immigrants arriving in Philadelphia leave behind traumatic pasts. Nearly all leave familiar cultures behind while attempting to adapt to American cultural norms. As detailed later in the report, this can have implications for the behavioral health needs of immigrant children and youth.

## Philadelphia Population Overview



### Philadelphia Overview\*

Race/Ethnicity by Percent of Total Population

	1990	2005
African-American	39%	46%
White	52%	43%
Hispanic/Latino	6%	10%
Asian	3%	5%
Other	4%	7%

\*Race and Hispanic origin are two separate concepts in the federal statistical system. People who are Hispanic may be of any race. People in each race group may be either Hispanic or Not Hispanic. Data presented in this report show population totals by race as well as Hispanic origin, including the overlapping population in both totals. Therefore population totals may equal more than 100%.

Source: U.S. Census Bureau, 1990 Decennial Census and 2005 American Community Survey.

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## The Importance of the Commission's Mission to Philadelphia's Children and Families

The Blue Ribbon Commission's mission is vitally important to Philadelphia's future. The Commission acknowledges the challenging environment in which many of Philadelphia's children and their families live. Burdened by poverty, crime, substance use, unemployment and other difficulties, many of the City's children face enormous challenges:

- An estimated 35 percent of Philadelphia's children live in poverty.<sup>6</sup>
- Despite improvements in recent years, child abuse and neglect remain serious concerns: 1,168 children in Philadelphia suffered child abuse or physical neglect in 2005.
- Nearly one in three of Philadelphia's children are already behind in reading preparedness when they start kindergarten in the city's public schools.<sup>7</sup>
- About 4 of every 10 Philadelphia public school students entering 9th grade do not graduate in four years.<sup>8</sup>
- In 2005, an average of 12 children and youth under age 18 were victimized by major crime (i.e., murder, manslaughter, rape, robbery, aggravated assault, burglary, theft and vehicle theft) every day.
- More than 2,250 juveniles were arrested for drug-related offenses in 2005 while nearly 4,000 were arrested for major crimes.

These conditions and their consequences have a direct and significant effect on the behavioral health and well-being of Philadelphia's children. Additionally, unrecognized and untreated behavioral health problems can make children and youth more vulnerable to many of these adverse conditions and risky behaviors.

## The Role of a Child's Environment in Behavioral Health and Well-being

A child's environment and what he or she experiences have a significant impact on that child's development and behavior.<sup>9</sup> Examining the many environmental factors or variables in a child's life can provide a framework for viewing the child's development in what some behavioral health experts call an "ecological context." This context starts with individual factors, including the child's skills and values. Another variable is the child's daily, direct interactions with parents, family members, peers, and others at home, in school and in the neighborhood. More broadly, and often less directly, a child's interaction with systems – education, social welfare, juvenile justice or others – can affect his or her development. Beyond these interactions, the broad values, norms, and behaviors of the community also influence a child's development, as can the physical environment within which they live. For better or worse, all of these factors play a major part in the molding of a young person.

One of the most compelling studies to examine the effect of a child's environment on the child, the Adverse Childhood Experiences study, found that individuals experiencing more adverse childhood experiences, or "ACEs" (exposure to domestic violence, physical abuse, sexual abuse, incarcerated parent or other household member, a parent who abused substances), were more likely to engage in maladaptive and addictive behaviors over their lifetimes.<sup>10</sup>

## The Correlation Among Social and Emotional Problems and Other Adverse Conditions and Behaviors

The President's New Freedom Commission on Mental Health's Final Report noted that childhood disorders, if left unchecked, can lead to a "downward spiral" that can affect children in school, at home, and in the community as they grow into adulthood. Social and emotional difficulties in preschool children can adversely affect their school readiness and academic achievement.<sup>11</sup> More than one-half of youth with

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serious emotional disturbances drop out of high school, a much higher proportion than youth with other disabilities.<sup>12</sup> Many children with undiagnosed, untreated emotional disorders end up running afoul of the law, resulting in a high percentage of youth with psychiatric disorders and/or substance use disorders in the juvenile justice system.<sup>13</sup> Absence of intervention and treatment of behavioral disorders may also correlate with incidence of suicide. More than 9 of 10 people who commit or attempt suicide had been identified as having a psychiatric disorder.<sup>14</sup>

The links between serious childhood adversity (e.g., abuse and neglect) and depression, suicide, alcoholism, and drug abuse are well known. However, adversity and poor behavioral health can negatively affect physical health. Along with a higher likelihood of maladaptive and addictive behaviors, individuals having more adverse childhood experiences (ACEs) were more likely than their peers to develop one or more of the leading causes of death for adults including heart disease, cancer, diabetes, liver disease, or emphysema.<sup>15</sup> In short, behavioral health is integral to overall physical health.<sup>16</sup>

The impacts of social and emotional disorders on children often follow them into adulthood. For example, research found that children with depression or other behavioral disorders tended to require higher levels of specialty care and generated higher care costs as adults.<sup>17</sup> Adult's behavioral health problems can have an impact on the next generation as well. For example, children of depressed parents are three times as likely to develop anxiety disorders, become depressed and abuse illegal substances.<sup>18</sup> Research highlights the importance of preventing behavioral health problems, identifying behavioral health problems early when they do arise, and intervening in an effective and efficient manner upon identification.

Moreover, unless the community recognizes and accepts the strong link between behavioral health and overall physical health, the shame surrounding behavioral health problems will persist, opportunities

to make a positive difference on all of Philadelphia's children will be lost, and the enormous costs of failing to meet the behavioral health needs of children will continue to mount.

National research indicates that five to nine percent of children have serious emotional disturbances.<sup>19</sup> This statistic however, is part of a larger, more troubling picture. Many children are at-risk for serious emotional disturbances or other behavioral health issues because of individual, family, or community factors in their lives.

Without interventions, many vulnerable children can end up with serious behavioral health problems. Even children who appear to be on track for healthy social and emotional development can slip off that track if faced with significant stress. However, communities can address and prevent these negative results in a variety of ways. These include prevention programs, early intervention and improved access to a range of support services and treatment. Further, the Commission recognizes the importance of understanding the patterns of children's growth and development that occur from infancy through late adolescence. We must, in short, tailor intervention programs and activities to specific developmental stages.

## The Importance of Resiliency in a Child's Behavioral Health and Well-Being

The research and data on Philadelphia's children's behavioral health paint a daunting picture. It overlooks one important factor, however: a child's resiliency enables him or her to overcome adversity and succeed in the face of difficult circumstances. Resiliency is a person's capacity to thrive and adapt in an adverse environment.<sup>20</sup>

The Commission recognizes the importance of children's inherent resiliency to their social and emotional well-being. Its approach is founded on the belief that children must be valued and their strength acknowledged as an important resource in their healthy

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development. While environmental conditions can affect behavioral health, vigor and good behavioral health can enable them to succeed under trying conditions.

However, resiliency does not exist in isolation. Children require support in hostile or otherwise unhealthy environments. Youth can get off track, develop risky behaviors, and fail to reach their potential in the absence of appropriate nurturing environments and protective factors. The significance of positive environmental factors for these children cannot be overstated.

This report stresses the importance of neighborhood support in helping children grow and thrive. High expectations for youth in their communities, parental and adult involvement as role models and mentors, the availability of quality recreational activities and opportunities for positive **bonding** with adults demonstrate a community's power to support the healthy development of children.

The Commission, through its goals and recommendations, envisions a community that will work together to enhance resiliency in children and families, promote social and emotional well-being in our children, and address the needs of all children in Philadelphia so they

can develop into healthy, productive citizens. To achieve this vision, all child-serving systems must be transformed to build on the strengths of children and their families in an individualized way, across all elements of their lives (e.g., family, school, community). For those children struggling with behavioral health problems, these systems must deliver on their promise of hope and recovery to make full and healthy lives possible.

## The Commission's Core Values and Guiding Principles

The Commission identified a series of core values and guiding principles to focus its task and provide a lens for developing goals and recommendations.

### *Core Values*

The core values reflect a fundamental belief that children and their families should be viewed within a framework that emphasizes a developmental, strength-based, culturally-sensitive perspective.

- Children and families possess strengths, interests and a capacity for growth and change that can be augmented by support from the community, including their peers.
- The strengths and needs of children and families should be understood within each child and family's unique cultural context and should be met with culturally-relevant services.
- The needs of children and their families should be met within, or as close to, their community as appropriate.
- The strengths and needs of children and families should dictate the types of services and supports provided, with a recognition of the factors shaping the child's and his or her family's world.
- The needs of children and their families should be addressed through a citywide **public health** approach that promotes the essential value and worth of all children. The approach should also recognize the

**bonding:** Bonding is the emotional attachment and commitment a child makes to social relationships beyond primary caregivers in the family, peer group, school community, or culture. Positive bonding with an adult is crucial to the development of a capacity for adaptive responses to change, and to grow into a healthy and functional adult.

**public health:** Public health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention.

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importance of developing and providing child- and family-centered services that acknowledge the **developmental framework**, which occurs between birth and 21 years of age.

- Children's needs should be identified and addressed early to enhance the likelihood of positive outcomes and to prevent the development of more serious problems.
- Families and providers within all child- and family-serving systems should understand the importance of the first years of life in developing a foundation for healthy social and emotional development. These systems also should recognize the ongoing influence of the developmental framework in understanding children's and youths' behavior.
- **Health promotion** and problem **prevention** should both be recognized as necessary to allow families to access assistance before problems reach a crisis stage.
- Children's rights should be protected across all child-serving systems.
- Children and their families should have their needs addressed free from discrimination as it relates to race, religion, national origin, sex, gender identification, sexual orientation or disability.

## *Guiding Principles*

The guiding principles articulate the standards to be incorporated upon implementation of this report's recommendations. The Commission achieved consensus around the guiding principles early in the process of their work. It is possible that as the state of knowledge regarding children's behavioral health evolves, the guiding principles may need to be updated and revised.

- Children deserve to have their needs addressed in the most **natural setting** possible.
- Families and children of all ages should participate in all aspects of service planning and delivery to the fullest extent possible.

**developmental framework:** In this report, a developmental framework acknowledges that from infancy through adulthood, individuals are experiencing biological, cognitive and social-emotional change. As they move through these stages or phases, there are achievements and milestones that children, adolescents and young adults are expected to master if they are healthy and on track.

**health promotion:** Behavioral health promotion activities are offered to individuals, groups, or large populations to enhance competence, self-esteem and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders.

**prevention:** Prevention includes the promotion of mental health, as well as the reduction in the occurrence and impact of behavioral health disorders.

**natural setting:** A setting that is not exclusively identified as a location where behavioral health services are provided, such as a primary care office, school, day care center, community center, recreation center, or home. Behavioral health services can be offered in such non-clinical settings. In this report, natural setting refers to a place that an individual is likely to spend time in the course of their usual daily activities in their community.

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- Children should have their needs addressed using practices that are **evidence-informed**.
- The strengths and needs of children and their families who have experienced childhood abuse and/or other trauma should be understood within a **trauma-informed** context.
- Children and families should receive integrated, coordinated care, regardless of the system or systems through which they receive it.
- Children should have access to an array of services that addresses their physical, emotional, social, and educational needs.
- Children should have access to services and supports that ensure a smooth transition from child to adult services.

**evidence-informed:** The conscientious use of current best evidence in making decisions about interventions and treatment, taking into account the target population, the local context, and other critical variables.

**trauma-informed:** A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that serious adverse events play in the lives of people seeking mental health and addiction services. A “trauma-informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients.

- The needs of children and their families should be satisfied by high-quality services regardless of service type or approach. Treatment should emphasize attaining measurable, positive outcomes.

## Public Systems Serving Philadelphia’s Children

A significant number of this report’s recommendations call for reforms and for better collaboration among systems serving children. Efforts should strive to create better connections for children and youth between systems. The primary systems serving children and families in Philadelphia are:

### *Department of Behavioral Health and Mental Retardation Services*

Philadelphia’s Department of Behavioral Health and Mental Retardation Services oversees the city’s mental health, drug and alcohol treatment and mental retardation services through the Office of Mental Health, the Coordinating Office for Drug and Alcohol Abuse Programs, Community Behavioral Health, and Office of Mental Retardation. This system currently serves approximately 110,000 Philadelphians annually including 35,000 children.

### *Philadelphia Courts – Family and Juvenile Courts*

The Family Division (Family Court) is a division of the Court of Common Pleas. It includes two major divisions, Juvenile and Domestic Relations. Juvenile Court hears the following cases involving juveniles: (1) delinquency cases involving offenders under 18 charged with misdemeanor or felony offenses, (2) dependency cases involving abused or neglected children, or children and youth demonstrating challenging behavior, (3) criminal cases involving an adult offender and a juvenile victim, and (4) termination of parental rights and adoption cases. In 2005, there were 9,363 new delinquency case dispositions.

### *Office of Supportive Housing (formerly the Office of Emergency Shelter and Services)*

The Office of Supportive Housing assists and prepares adults and families for self-sufficiency and independent

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living. The office offers a network of shelters and boarding homes. It also refers families, couples and single individuals to available housing resources. In 2005, 3,275 children were without homes and spent at least one night in a city shelter during the year. Forty-four percent of these children were under the age of 6.<sup>21</sup>

## ***Department of Human Services***

The Department of Human Services protects children from abuse, neglect, and delinquency and ensures their safety and permanency in nurturing home environments. In 2005, it handled 1,168 substantiated cases of child abuse or serious physical neglect and served 8,525 children and youth in dependent or delinquent placements. The Department operates the Youth Study Center, Philadelphia's detention center for youth awaiting a court hearing and/or transfer to a long-term placement, and Court and Community Services. It also works to strengthen and preserve families by enhancing community-based prevention services.

## ***Philadelphia Prison System***

The Philadelphia Prison System's correctional program incarcerates individuals accused or convicted of illegal acts. It provides those incarcerated with access to social service programs, supervision and training. The system helps prepare them to be functional, productive members of society upon their release. It detains or incarcerates more than 7,000 people at any time, nearly all of them adults.

## ***Department of Public Health***

The Philadelphia Department of Public Health promotes the availability of, accessibility to, and quality of preventive and personal health services for the city of Philadelphia. The department provides and monitors public health services including communicable disease prevention and treatment, food safety and air quality control. In addition, the department operates eight neighborhood district health centers that provide primary medical care to all city residents regardless of

their ability to pay.

## ***Department of Recreation***

The Philadelphia Department of Recreation manages and operates City recreation facilities including 100 public parks and squares. These encourage and enhance the development of the physical, cultural, artistic and life skills of the residents of the city. The department strives to provide a positive alternative to drugs, violence, and crime and to instill the values of individual pride and community giving.

## ***School District of Philadelphia***

The School District of Philadelphia, the seventh largest school district in the country, serves approximately 220,000 students from preschool through high school. The district operates 273 public schools and supports 55 charter schools. It has a diverse student body including 66 percent African-American, 15 percent Latino, 14 percent white, five percent Asian and less than one percent Native American. Nearly 73 percent of Philadelphia public school students were enrolled in the free- or reduced-lunch program in the 2005-06 school year. More than 27,000 students in Philadelphia public schools receive special education services. (Over and above the School District, there are numerous non-public schools in Philadelphia, particularly those operated by the Archdiocese of Philadelphia, which has 74 elementary school, 11 high schools, and five schools of special education.)

## ***Early Intervention***

The city provides Early Intervention services for infants and young children experiencing at least a 25 percent developmental delay in one or more areas of development. There are two tiers to the Early Intervention system based on age: ChildLink coordinates services for infants to 3-year-olds. ChildLink received calls regarding 3,232 infants and toddlers in 2004. Elwyn SEEDS (Special Education for Early Developmental Success) coordinates early intervention services for 3- through 5-year-olds. It provides Early Intervention services to approximately 5,000 3- through 5-year-olds annually.

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## The Commission Process

The Blue Ribbon Commission's process began with a two-day conference in February 2006. The conference, *Improving Systems, Improving Lives*, brought together local and national experts to share their experiences "and knowledge of other children's behavioral health transformation initiatives across the country. A broad stakeholder group participated in the first day of the conference while the second day offered an opportunity for Commission members to discuss Philadelphia-specific issues with national experts.

From February to July 2006, the Commission met monthly. These meetings were open to the public and attended by advocates, city officials, family members and service providers. The Commission established three committees to support their work that met biweekly over the course of five months. The Commission also held public meetings in various locations throughout the city to receive the direct input of youth, parents and other community members.

## Public Meetings and Input

The Commission held 10 public meetings to hear first-hand from the community about their concerns and desires for children's behavioral health in Philadelphia. The Commission provided public notice, conducted extensive outreach into the community, and varied the times of the meetings to maximize community participation.

February 28, 2006 City Hall  
March 1, 2006 City Hall  
May 1, 2006 Kingsessing Recreation Center  
May 2, 2006 Edward O'Malley Recreation Center  
May 3, 2006 Julia de Burgos Middle School  
May 4, 2006 MLK Recreation Center  
May 8, 2006 Kendrick Recreation Center  
May 9, 2006 Dorothy Emmanuel  
Recreation Center  
May 10, 2006 Cora Services, Inc.  
May 11, 2006 Lawncrest Recreation Center

For additional input, the Commission also heard from consumers, parents and other community stakeholders at the Commission's regular meetings and accepted letters and written testimony from the public.

Several primary themes surfaced from this public input, all of which were addressed in this final report. These included:

- Treating children and families with dignity and respect,
- Giving children and youth a voice in their treatment,
- Addressing the problem of **stigma** associated with behavioral health problems and services,
- Addressing community violence,
- Ensuring that children and families have knowledge of, and access to, resources,
- Providing parent education and increasing parent involvement in programs for their children,
- Delivering services in both school and community settings,
- Providing culturally relevant interventions,
- Promoting collaboration,
- Expanding staff training and improving staff quality,
- Providing non-clinical supports and services, and
- Developing alternative and non-traditional treatment approaches.



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## The Blue Ribbon Commission's Committees

Three committees supported the Blue Ribbon Commission: the “All Children Committee,” the “Vulnerable Children Committee,” and the “Children with High Needs Committee.” Together, these committees included approximately 200 community stakeholders from a range of backgrounds, interests and experiences. Each committee had two co-chairs including a Commission member and a non-Commission member. Each committee drafted and presented a report that focused on the needs of children and contained recommendations and strategies for meeting those needs. These individual committee reports formed the foundation for the final Commission report.

### *All Children Committee*

This committee examined the needs of all children in the city focusing on those currently functioning well and at low risk for developing behavioral health problems. These children may have some **risk factors** or may be missing certain **protective factors**, but the balance of protective factors to risk factors is favorable overall. The mission of the All Children Committee was to propose recommendations to support the emotional and social well-being of *all* children, youth, and their families in the city through the promotion of healthy development, broad prevention activities and community commitment to support children’s health. This community context includes activities that promote continued wellness and ongoing **resilience**.

In its deliberations, the All Children Committee recognized that there are many families - though faced with significant financial limitations and other adverse circumstances that provide optimal care and nurturing for their children. It understood that many families have the strength, personal resources and skills to successfully care for their children. These families can teach us how we might best serve them and help them meet their children’s needs when necessary. The Committee’s conclusions do not seek to place families in a dependent position, but to partner with them and

use their suggestions, insight and recommendations to develop and implement strategies that can benefit all children.

### *Vulnerable Children Committee*

The Vulnerable Children Committee addressed the needs of children at greater risk for developing behavioral health problems because of environmental, family and/or biological factors. Such children may have increased risk of developing behavioral health problems or may have fewer protective factors that might help shield them from such problems. They have a need for prevention services and sometimes early intervention and support to reduce the chances that they will develop serious behavioral health problems.

**risk and protective factors:** Risk and protective factors are characteristics or conditions that, if present, increase or diminish, respectively, the likelihood that people will develop behavioral health problems or disorders.

**stigma:** Stigma refers to negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses and/or substance abuse disorders. Responding to stigma, people with behavioral health problems may internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

**resilience:** Resilience is the qualities that enable individuals or communities to rebound from adversity, trauma, tragedy, or other stresses - and to go on with life with a sense of mastery, competence, and hope.

The Vulnerable Children Committee’s mission was to propose recommendations for early identification and intervention efforts that could prevent the development and onset of behavioral health problems and promote positive behavioral health.

# The Blue Ribbon Commission

The Committee based its work on the knowledge that children may be vulnerable to behavioral health problems as a result of a number of developmental, physical, familial, environmental and/or societal factors, circumstances or conditions. Therefore, the Committee divided into subcommittees based on these different types or “clusters” of vulnerability. The vulnerabilities identified by the Committee included:

- Children exposed to neglect, physical abuse, and/or sexual abuse,
- Children exposed to other violence at home or in the community including bullying,
- Children with parents, caregivers, and/or siblings who have behavioral health problems,
- Children who have developmental delays or learning disabilities,
- Children with chronic physical illness, and
- Children facing challenges relating to their racial, ethnic, or cultural backgrounds, sexual orientation, or gender identities.

The subcommittees identified needs and developed recommendations and strategies relating to each of the clusters listed above.

## *Children with High Needs Committee*

The Children with High Needs Committee devoted its work to the needs of children having behavioral health problems that meet diagnostic criteria. These children have a clearly identified need for behavioral health treatment and supports. Their risks may outweigh protective factors. Many such youth can possess resiliency that supports recovery.

The mission of the Children with High Needs Committee was to develop recommendations to ensure that children and their families received the best possible treatment and supports to improve their condition and

foster positive life experiences with their families and communities.

## **Outcomes of the Commission’s Work**

The Commission aims to break new ground by transforming how Philadelphia addresses the behavioral health needs of all of its children. The product of the Commission’s work is this final report presenting the Commission’s goals and recommendations for ensuring strength and emotional wellness among Philadelphia’s children. This is only the first step toward the transformation of systems to support the resiliency of children.

The Commission’s final report will be used as the framework for developing an initial implementation plan in early 2007. The plan will set forth the action steps necessary to put the recommendations into practice, the outcomes used to measure progress toward achievement of those recommendations, the stakeholders and partnerships needed to carry out these activities, the agencies or organizations primarily responsible for seeing that these activities are carried out, and the timeline for completion.

Implementation will begin in spring 2007. During the implementation phase, key stakeholders and other partners will begin to take action on those Commission recommendations that can be executed in the short-term and will institute in-depth planning for the Commission’s longer-term recommendations. In the spring of 2008, monitoring and evaluation of the implementation process will track progress and identify modifications when necessary.

During the implementation phase, the Commission’s recommendations will be put into action. The Commission’s report focuses primarily on the needs of children and on how those needs would be addressed. The implementation will focus on the concrete steps needed to build on the effective practices and programs already in place, to reform those practices and programs that have not been successful, and to fill any remaining gaps in service.

# The Blue Ribbon Commission

## ***Phase I - Blue Ribbon Commission***

FEBRUARY 2006 - JULY 2006

- Hold Commission and Committee meetings and public hearings.

AUGUST 2006 - JANUARY 2007

- Draft report and hold editing sessions.
  - Endorsement and release of Commission Final Report.

## ***Phase II - Implementation Plan***

JANUARY 2007 - SPRING 2007

- Develop action steps for initial implementation.
  - Identify outcomes for recommendations.
  - Identify strategies that can be implemented immediately and begin putting into place.

## ***Phase III - Initial Implementation***

SPRING 2007 - SPRING 2008

- Strengthen and fully integrate partnerships in support of implementation process.
- Implement short term strategic priorities with support and collaboration from all stakeholders.
- Begin collaborative planning for implementation of long term strategies.

## ***Phase IV - Ongoing Evaluations and Stakeholder Feedback***

SPRING 2008 - FUTURE

- Provide periodic implementation updates.
  - Monitor process and modify as needed.
- Evaluate outcomes and the impact of system enhancements for children and families.
  - Adjust implementation as necessary.



# **The State of Children's Behavioral Health in Philadelphia**

# Children's Behavioral Health

The vignette presented here, drawn from the real-life experiences of many children in Philadelphia, provides a case study in the challenges to healthy development affecting many children. This case study, presented from the perspective of a young mother, is used to personalize and underscore the needs of children and their families that must be addressed if the state of our children's behavioral health is to be advanced. The same story is revisited later in this report to envision how the story would unfold in a more responsive community, in which the Commission's recommendations have been implemented.

## **A Vignette: Mary and Eddie Jr.**

Mary was waiting in the Crisis Response Center with her 6-year-old son Eddie Jr. sitting by her side, holding her hand, looking scared. When the school told her earlier that day that she had to take Eddie Jr. to the Crisis Response Center, she thought, "Well it's another crisis. It's nothing new." But this crisis upset her more than some of the others. At least while they were waiting to be seen, Eddie Jr. wasn't running around "acting like a maniac" like he had been in school that morning.

Mary's mother, ill in bed with the flu, had called Mary at work, and told her that she had to pick Eddie Jr. up from school because he had taken scissors to class and threatened another boy. When the teacher told him that she might have to call the police, Eddie Jr. ran out of the classroom, went up to the second floor, said he wanted to die and that he was going to throw himself out of a window.

Mary left her job (her boss wasn't pleased) and went to the school. Eddie Jr. was in the principal's office being held by the security guard. The principal told her that there was a zero tolerance for this type of behavior, especially "after Columbine and all that." Mary wasn't sure what Columbine meant, and she tried to tell the principal that another boy had been bullying Eddie Jr., stealing his dessert from the lunches that she packed for him. The principal told her that Eddie Jr.'s behavior was out of control, and she had to take him to the Crisis Response Center, which was some kind of emergency room.

# Children's Behavioral Health

While waiting in the Center, she began to think again, as she had done many times in the past, "Where had it all gone wrong?" Well, she knew some of the answers. Her father was an alcoholic, had beaten her mother, had done things to Mary that she tried hard not to remember, and then left when Mary was 10. Her mother said she still loved Mary's dad, though, and took to her bed crying most of the time. So when Mary was 16, and Eddie Sr. came along, Mary went off with him because, at first, he seemed to care for her. He seemed happy when he learned she was pregnant, and he especially liked the idea of having a son named after him. But three months before Eddie Jr. was born, Eddie Sr. disappeared. Mary, her mother, and Eddie Jr. tried to manage on their own. Mary quit school, went to work at a fast food restaurant, and then delivered Eddie Jr., a healthy 8-pound baby.

But almost from the beginning, he was a difficult child. He was cranky, hard to feed and cried a lot. Then, when he began to walk, he was all over the place. Mary couldn't afford day care, and when Eddie Jr. started kindergarten, the teachers complained that he wouldn't listen, got into fights, and didn't have any friends. Mary was afraid to let her son play outside because of the violence in their neighborhood. Mary went back and forth to the kindergarten and then to his first grade school to talk about Eddie Jr. whenever she could, but she was worn out by all of it. She didn't go out on any dates, didn't trust men, and felt tired most of the time. Beyond that, her mother kept telling her that she should never have gotten pregnant; yet her mother usually gave Eddie Jr. everything he wanted and never tried to discipline him.

When Mary took Eddie Jr. to the pediatric clinic for one of his visits, the doctor told her that he might have something called Attention Deficit Hyperactivity Disorder, and he needed an evaluation at a mental health clinic. She had to wait a few weeks for the first appointment. At the appointment, the intake worker asked her some questions; she filled out forms, and was told to come back in two months for an appointment with the doctor. But then "all hell started to break loose" at school, requiring many phone calls. Eddie Jr. wreaked havoc in first grade.

When the crisis doctor called her and Eddie Jr. into the room, Mary told him about her son's behavior and what had happened at school that day, and how she just didn't know what to do. The doctor listened, and then said that Eddie Jr. needed to be in a psychiatric hospital because he was out of control and might be suicidal. Mary began to cry. She had never been separated from her son; Eddie Jr. started to cry when Mary cried. She didn't want him to go to the hospital, and she asked the doctor, "Isn't there anything else we can do?"

# Children's Behavioral Health

## Overview of Eddie Jr.'s Story

The problems Eddie Jr. and his mother faced related to the community in which they lived, the school Eddie Jr. attended, his family environment and biology. A discussion of how these areas affected Eddie Jr.'s behavioral and emotional well-being follows, along with some context regarding how they affect *all* children in Philadelphia.

## Community

One of the most pervasive themes in Eddie Jr.'s story, and that of many other children, is community violence. Eddie Jr.'s mother was afraid to let him play outside because of violence in their neighborhood. Eddie Jr. was the victim of constant bullying at school. In these ways, Eddie Jr. was indirectly and directly affected by community violence. While it is difficult to measure children's exposure to violence,<sup>22</sup> most research suggests that children are twice as likely as adults to be the victims of serious violent crime; 23 percent of adolescents report being a victim of assault and more than 50 percent of urban children have witnessed at least one act of community violence.<sup>23</sup> More than one-third of children report getting into a fight at school in a given year with many more being the perpetrator or victim of bullying.<sup>24</sup>

According to *Report Card 2006: The Well-Being of Children and Youth in Philadelphia*, violence by and against children and youth in Philadelphia continues to be a major challenge in Philadelphia.<sup>25</sup> The best measure of violence available may be police records, although they clearly understate violence occurring in the City. In 2005, there were 4,433 juvenile victims of major crime offenses,<sup>26</sup> an average of 12 major crimes against juveniles every day of the year. While arrests of juveniles for major crimes have declined since 2000, the number of arrests of juveniles for violent crimes (or "crimes against the person") has remained fairly constant. In 2005, 1,954 juveniles were arrested for violent offenses. However, the number of reported school assaults has doubled from 1999 to 2005. There were 3,264 assaults in public schools during the 2004-05 school year.<sup>27</sup>

Perhaps most troubling is the recent rise in homicides among young people. Homicides of young people ages 7-24 years increased 41 percent in 2005, to 149 from 106 the year before. Of these homicides, 24 victims were between the ages of 7 and 17. Guns were used in 90 percent of youth homicides. All told, there were 920 gunshot victims ages 7-24 in Philadelphia in 2005.<sup>28</sup>

Children in Philadelphia are also victimized by child abuse. Though there has been a 41 percent decline in the annual number of substantiated child protective service (CPS) cases (i.e., the most serious incidents of child abuse or physical neglect including sexual abuse or exploitation) over the last decade, there were still 1,168 substantiated CPS cases in the City in 2005.<sup>29</sup> In addition to the many children and youth victimized by violence, a substantial but unconfirmed number are witnesses to violence or otherwise exposed to it.

Many studies have shown that these types of violence have a dramatic negative effect on children's health and their ability to do well at home, school and in their communities.<sup>30</sup> Children who experience direct or indirect violence are more likely than other children to fail in school, develop the symptoms of post-traumatic stress disorder, become depressed or anxious, use drugs, and become violent or delinquent themselves. For Eddie Jr., it was likely that his constant fighting and problems in school were directly related to the violent environment in which he lived and learned.

A second community-related theme is the lack of resources available to him and his family. For example, Mary could not find affordable child care for Eddie Jr. More than half of poor women are raising children under the age of 6, but child care, especially in poor neighborhoods and during untraditional hours, is very hard to find.<sup>31</sup> Despite the dramatic advantages associated with quality center-based early childhood care for poor families,<sup>32, 33</sup> only 22 percent of working women with young children use center-based child care. Many of these women do not use center-based care because they cannot find any in their neighborhood, cannot afford it, or have concerns



# Children's Behavioral Health

regarding its quality.<sup>34</sup> While some of the remaining working mothers may find affordable, quality family-based care, many others are forced to become dependent on welfare or to leave their children in less than ideal situations during work hours.

There are indications that affordable child care and early childhood education are not available to all the children who need it in Philadelphia. In the spring of 2006, there were waiting lists for subsidized child care in four of the five city child care regions. Waiting lists ranged from two to more than four months. There were also waiting lists for the school district's Head Start programs. The school district estimated that only about half of the eligible children were receiving Head Start services.<sup>35</sup>

While not directly stated in the vignette, the lack of other resources for Eddie Jr. were implicit. For example, there is no mention of recreational activities available in Eddie Jr.'s neighborhood. A number of studies have shown that participation in recreational sports or other organized group activities can decrease depression and problem behaviors and improve self-esteem and social competence in children.<sup>36, 37</sup> A related concern is the lack of positive, adult role models for Eddie Jr. having a positive adult mentor can increase children's psychological well-being and the prospects that they will finish school and become employed.<sup>38, 39</sup>

## School

Schools face enormous challenges when educating children arriving with varying levels of preparation for school, from environments often burdened with crime, poverty and drug cultures and from families struggling with their own psychosocial stresses. Although Eddie Jr.'s emotional and behavioral problems were recognized by the school when he attended kindergarten, no one implemented any intervention. Despite a growing body of research suggesting that **early intervention** for behavioral health problems can result in improved outcomes for children, problems that are evident early are often not addressed, and even less often referred to specialists.<sup>40</sup>

Given the increased demands on teachers, especially in urban environments, it is unfair to expect them to know how to respond to children with significant emotional and behavioral health needs without extensive education and support. Numerous instances in this vignette highlight the need for greater teacher and staff training relative to recognizing behavioral health issues. For example, the teacher's response to Eddie Jr.'s behavior perhaps exacerbated the situation and may have contributed to Eddie Jr.'s running out of the room and threatening suicide. Teachers and other school personnel need higher levels of training to respond to the daily challenges of classroom management.<sup>41</sup>

One of the ways that schools have attempted to manage violence has been with a zero-tolerance policy, to which the principal in this vignette refers. While these policies have become increasingly popular, there is no evidence that they alone result in any positive outcome for children or schools.<sup>42</sup> While dangerous behaviors will not be condoned, there must also be efforts to identify and address behavioral health or other issues underlying such behavior.

## Family

Eddie Jr.'s mother, Mary, had shown remarkable resilience and strength in maintaining a job, keeping a home and taking care of her son. Family environment can promote risk factors as well as protective factors. Eddie Jr.'s mother had a terrible childhood filled with violence, abuse, and trauma that remained unaddressed. Mary's mother is likely depressed, which makes it even more likely that Mary will be depressed. In turn, Mary's depression increases the chance that Eddie Jr. will experience emotional and behavioral problems.<sup>43</sup>

**early intervention:** Services that prevent escalating behavioral health risk symptoms through the identification of early stage problems in individuals or groups of any age who do not yet require treatment. This definition encompasses but is not limited to the Early Intervention programs for children 0-5.

# Children's Behavioral Health

Mary's early experiences also led her to leave home early and become pregnant as a teenager. Teenage pregnancy often puts both mother and child at risk for a number of poor outcomes, such as the mother dropping out of school (as Mary does), putting her and her child at a severe economic disadvantage. Teenage mothers and their children are also more likely to develop poor mental health. Teenage mothers are often less familiar with appropriate parenting techniques, which can also lead to poor child development.<sup>44, 45</sup>

Eddie Jr. is growing up without a father. While many children of single parents thrive, a growing body of research suggests that children in two-parent households experience greater academic success and emotional and behavioral health.<sup>46</sup>

Finally, between Mary and her mother, Eddie Jr. is subject to inconsistent discipline. Inconsistent discipline has been linked to children's conduct problems, depression, anxiety and eating disorders.<sup>47</sup>

## Biology

Eddie Jr. has distinct advantages over some of his peers in that he was born healthy and has an involved mother and grandmother who are both concerned for his welfare. However, Eddie Jr.'s mother's likely depression and father's alcoholism make it likely that he is at genetic risk for depression and alcohol abuse himself. His early problems (crankiness, constant crying and feeding difficulties) suggest possible biological factors that put Eddie Jr. at risk for developing emotional and behavioral problems.<sup>48</sup> What is increasingly apparent, however, is that genetic risk alone does not make it inevitable that later problems will develop. The interactions between genetic risk and environmental factors determine the outcome. The balance of protective and risk factors in the environment influence what type of outcome will occur.<sup>49</sup> These important findings suggest that for children whose biology puts them at increased risk for developmental and behavioral problems, screening and assessment is particularly important.

## Health Care

Ideally, the health care system should serve as a supportive link to services that can address the many problems Eddie Jr. and his mother face. Two health care encounters regarding Eddie Jr.'s behavioral health are mentioned in the vignette. Both highlight some of the ways in which the current health care system in Philadelphia does not provide optimal care to children who have emotional and behavioral health needs.

First, Eddie Jr.'s primary care physician tells his mother that he may have **Attention Deficit Hyperactivity Disorder** (ADHD) and makes a referral to the behavioral health system. The fact that the pediatrician recognizes that Eddie Jr. has behavioral health problems is positive; children's behavioral health problems are frequently missed in primary care.<sup>50</sup> Once the problem is recognized, however, the pediatrician should have taken further steps to work with Eddie Jr. himself, and/or refer Eddie Jr. to the behavioral health system. The American Academy of Pediatrics has stated that, especially for common conditions like ADHD, where the first-line treatment is clear, primary care physicians must take a greater role in managing care; a third of children receiving mental health care do so in the primary care system.<sup>51</sup> A study in Philadelphia found, however, that there is a lack of consensus about who should oversee care for children with ADHD.

### **Attention Deficit Hyperactivity Disorder (ADHD):**

Attention Deficit Hyperactivity Disorder (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. Some hyperactive-impulsive symptoms that cause impairment must have been present before age 7 years. Some impairment must be present in at least two settings (e.g. at home, and at school or work). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning.

# Children's Behavioral Health

There is insufficient training for primary care physicians and distrust and blame among professionals in different systems caring for the same child.<sup>52</sup>

The encounter with the behavioral health system proved to be frustrating for Eddie Jr. and his mother. Although they were seen within a few weeks, the first appointment was a lengthy intake appointment that provided no immediate intervention. Unfortunately, behavioral health systems are often plagued with long waiting lists for appointments. In Philadelphia, while estimates vary, there is evidence that there are wait times for intake into children's **behavioral health services** and for an appointment with a therapist. In the vignette, the follow-up visit with a clinician is scheduled for two months later, a delay that in some circumstances is experienced in Philadelphia. The intake experience speaks to the need to dramatically rethink the way we provide immediate care to children in need. The lengthy wait for the next visit is indicative of at least two factors: (1) the need for improvements in the intake process, and (2) the national workforce crisis in children's mental health in which we have neither the appropriate number of professionals given the need, nor the right training for existing professionals to provide appropriate care.<sup>53</sup>

Eddie Jr.'s experience culminates in his being sent to a psychiatric emergency service and possible admission to a psychiatric inpatient hospital. The fact that this is the first option considered by the emergency service psychiatrist depicts the lack of treatment options available to children with mental health needs. While hospitalization can be a helpful level of intervention for some children with the most serious forms of serious emotional disturbances,<sup>54</sup> most children with mental health problems – even severely impaired suicidal youth – show much greater improvement from community-based interventions.<sup>55</sup> Taking children out of their homes and communities should be a last resort, and the behavioral health system must put more of its resources into developing and providing community-based interventions.

**behavioral health services:** Behavioral health services refer to services and programs organized to meet the needs of people with mental health problems, drug or alcohol problems, or developmental disabilities that interfere with their ability to cope with the normal stresses of life and to work productively.



# **Blue Ribbon Commission Goals and Recommendations**

# Goals and Recommendations

The Blue Ribbon Commission identified six goals that serve as the foundation for transforming how Philadelphia's communities meet the behavioral health needs of their children and youth. Each of these goals and their underlying recommendations is interwoven with the others. For example, themes like recognizing and enhancing resiliency in children and their families, the importance of cultural sensitivity and the need for stronger collaboration and integration across systems occur throughout the goals and recommendations.

Each goal addresses the needs that arose during the Commission's meetings, its three committees' deliberations and the members of the public who presented their views throughout the process. Each goal focuses on the needs of all children including those on an appropriate developmental trajectory, those vulnerable because of their circumstances, and those with pressing behavioral health needs.

Ultimately, the Blue Ribbon Commission wants to see the city move beyond the traditional continuum of care. It endorses a comprehensive array of quality, needs-driven services and supports for children and families, spanning from non-clinical interventions to a range of treatment services. This would be a seamless array that runs across service systems. This array would draw on the framework of resiliency that recognizes the strengths and needs of children and families. It would serve children and their families with a dignity and respect that is sensitive to their cultural identities and backgrounds. It would serve children in the least restrictive setting within the community whenever possible. The services and supports would be effective and provided by skilled and knowledgeable professionals.

## **Goal 1: Children's Social and Emotional Well-Being Is the Responsibility of the Entire Community**

### **Recommendation 1.1**

Advance a framework of resiliency based on the strengths of children and their families throughout the community.

### **Recommendation 1.2**

Support parents and caregivers in their emotional attachment and bonding to children and youth.

### **Recommendation 1.3**

Create community strategies to build public awareness and knowledge of factors that promote social and emotional health and safety.

### **Recommendation 1.4**

Develop strategies to strengthen communities and address environmental factors affecting social and emotional health and safety.

### **Recommendation 1.5**

Ensure that all agencies and organizations commit to promoting the behavioral health of the children they serve.

## **Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect**

### **Recommendation 2.1**

Create opportunities in child-serving systems for children and families to have a voice in decision-making regarding planning, service delivery and treatment.

### **Recommendation 2.2**

Deliver services and supports in a way that respects and is responsive to children's racial, ethnic, and cultural backgrounds, sexual orientation, and gender identities.

### **Recommendation 2.3**

Create mechanisms for a youth and family peer component to be integrated into all behavioral health care services for children and youth, and place peer support in communities with children and families.

# Goals and Recommendations

## **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

### **Recommendation 3.1**

Improve and expand broad-based prevention and health promotion activities to keep all children on the right track.

### **Recommendation 3.2**

Identify and intervene early with children who are vulnerable to behavioral health problems.

### **Recommendation 3.3**

Identify, promptly refer, and secure services for children and youth experiencing behavioral health problems including those in early care and education, school settings, and the child welfare and juvenile justice systems.

## **Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them**

### **Recommendation 4.1**

Provide children and families with information about all available services.

### **Recommendation 4.2**

Develop better access points to services and supports for children and their families.

### **Recommendation 4.3**

Ensure availability of a full array of quality, culturally-competent and community-based services for children and their families.

### **Recommendation 4.4**

Make every effort to move children from distant and residential settings to community- and home-based settings.

## **Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff**

### **Recommendation 5.1**

Create and employ accountability and quality assurance measures to ensure effective services.

### **Recommendation 5.2**

Expand the number of professionals and paraprofessionals serving children and families at all levels of care by developing strategies for recruiting, retaining and rewarding a skilled and culturally-competent workforce.

### **Recommendation 5.3**

Upgrade the skills of those working with children by expanding and improving training and education for behavioral health and other staff.

### **Recommendation 5.4**

Boost the effectiveness of services by incorporating culturally-sensitive, developmentally-appropriate and trauma-informed practices.

## **Goal 6: True Collaboration Is Achieved at the Service Level and the System Level**

### **Recommendation 6.1**

Improve coordination and integration across individual, service provider and system levels.

### **Recommendation 6.2**

Develop specific reforms to improve collaboration in schools and between schools and the behavioral health system

### **Recommendation 6.3**

Increase the integration of behavioral health and physical health services.

# Goals and Recommendations

## 1

### Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

**H**ealthy social and emotional development of children promotes academic achievement and overall health and well-being. It affects all aspects of children’s lives: how they learn, play, work, and relate to others. Conversely, conditions in all domains of children’s lives – their physical health, schools, families, communities – have a strong impact on their behavioral health as they develop from infancy to adulthood.

Recognizing these strong connections, the Blue Ribbon Commission believes that a united effort is needed to help all of Philadelphia’s children attain social and emotional well-being. The magnitude of this responsibility demands commitment from all aspects of the community: parents and caretakers, schools, the youth themselves, social service systems serving children and their families, community-based organizations, faith-based institutions, formal and informal neighborhood groups, law enforcement legislators, the business community and citizens across the city. In short, the behavioral health and well-being of Philadelphia’s children requires the full commitment of the entire community.

The five recommendations furthering the goal of instilling responsibility for children’s well-being throughout the entire community are based on the understanding that children do not exist in a vacuum. The first recommendation, which emphasizes the importance of building on children and families’ resiliency, supports the others. Since responsibility begins with the family, both the first and second recommendations urge efforts to support resiliency at home by fostering healthy attachments with their parents and caregivers. The community, in turn, supports the family; this is addressed in the third and fourth recommendations, embracing the belief that all those in the community interacting with children should have their well-being in mind. The last recommendation addresses an even broader context: the social welfare system, the legal system, and all other organizations and agencies coming in contact with children.

#### Recommendation 1.1

Advance a framework of resiliency based on the strengths of children and their families throughout the community.

#### Recommendation 1.2

Support parents and caregivers in their emotional attachment and bonding to children and youth.

#### Recommendation 1.3

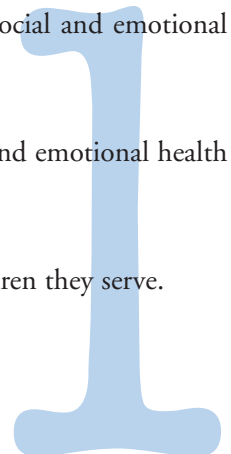
Create community strategies to build public awareness and knowledge of factors that promote social and emotional health and safety.

#### Recommendation 1.4

Develop strategies to strengthen communities and address environmental factors affecting social and emotional health and safety.

#### Recommendation 1.5

Ensure that all agencies and organizations commit to promoting the behavioral health of the children they serve.





# Goals and Recommendations

## Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

1

**Recommendation 1.1:** Advance a framework of resiliency, based on the strengths of children and their families throughout the community.

To be successful, a community-wide effort must be founded on a framework of resiliency. Resiliency is the ability to adapt to change, adjust to stress, and recover from misfortune. Like a healthy immune system that wards off disease, resiliency shields children from social and emotional problems that can often arise from life events.<sup>56</sup>

A resiliency framework is based on the conviction that children and families possess strengths, interests and the capacity for growth and change that can be reinforced by positive behaviors and healthy relationships. Resilience is strengthened by supportive, loving family relationships and positive relationships with peers and adults from outside the family. It is fortified by safe and caring local communities.

The Blue Ribbon Commission proposes that Philadelphia build its transformation agenda for children’s social and emotional health upon a framework of resiliency. Under this framework, decisions made about children will be guided as much by children’s assets and competencies as by their needs or deficits.

**Recommendation 1.2:** Support parents and caregivers in their emotional attachment and bonding to children and youth.

Children need supportive and loving relationships with parents, caregivers and other adults to stay on a positive developmental track. Failure to have such relationships

increases the risk for social and emotional problems. The most important relationships in children’s lives are with their parents or primary caregivers.

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“Instead of a behavioral health system, we need to be the behavioral health community... and we are the community.”

### Family Advocate

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The Blue Ribbon Commission recognizes the importance of children having healthy **attachments** to parents, caregivers, and other steady, reliable, loving people in their lives who understand their development and needs. Parents and caregivers that listen to and talk with their children and respond to them in positive, supportive, and loving ways are critical to forming healthy attachments.

**attachment:** Attachment is an emotional tie that a child forms with a primary caregiver, such as mother and baby, bonding them together and enduring over time. One may be attached to more than one caregiver; there is usually a gradient in the strength of such multiple attachments.

# Goals and Recommendations

## 1

### Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

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“I think a lot of the parents aren't involved enough in their children's lives, and you don't know where to go, so you go out on the street. You just got to take care of yourself. So I think having more positive people in their lives will have such a better effect.”

Youth

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The Commission proposes several strategies to strengthen parents’ attachments with their children.

#### *1.2.1 Parenting education, awareness and support programs that promote healthy, safe and secure attachments with children.*

Parenting and family caregiver programs can help strengthen family bonds and attachments. Such programs, including parenting education and respite care, should be expanded and made available at natural access points such as health clinics, community centers, schools, the workplace and early care and education sites.

Parent education should address:

- The importance of family attachment and connectedness, both inside the immediate family (e.g., parent and child interaction and communication, marital or partner relationships and connections) and beyond it (e.g., social connections to extended family and communities, including places of worship and clubs).
- Children’s health, nutrition and wellness, and healthy child development including developmental milestones and expectations, and other issues affecting the social and emotional development of children.

In making these parenting services and supports available, there should be a special focus on the needs of parents or caregivers whose parenting skills are compromised by their own behavioral health problems.

In addition, special attention should be paid to the importance of children’s relationships with fathers, male caregivers, or other male adult role models. Consultation with and involvement of men’s groups and father’s organizations should occur to pursue

**family-focused:** An approach that incorporates the family as the primary support system for the child and includes their full participation as a full partner in all stages of the decision-making and treatment planning process.

# Goals and Recommendations

## Goal 1: Children's Social and Emotional Well-Being Is the Responsibility of the Entire Community

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strategies for parent and caregiver information, forums and programs geared toward men.

**1.2.2 Family-focused delivery of services for children and their parents.** Children and parents need services that are **family-focused**. This means that the services concentrate on the strengths and the needs of the family rather than those of the child alone. A family-focused model aims to strengthen both children and their families by helping them to function in a healthy and self-reliant manner. It is neither practical nor sustainable to treat the child in isolation. The child's behavioral health issues affect the entire family's interactions and well-being. Thus, effective interventions and treatment must recognize and address this interaction.

This family focus should occur at every level: assessment, treatment planning, program operations management and policy development. For example, in the course of service delivery, child-serving systems should offer opportunities for adults to enjoy time with their children and promote family attachment. Opportunities for family activities can be built on existing programs including in-school parent and student activities and after school programs. In addition, service providers for children and families should recognize the struggles and time constraints facing parents and caregivers by providing services that respect the parenting challenges. Services and supports should be flexible in terms of availability and delivery so that parents can take advantage of them.

### **1.2.3 Attention to children who have lost or been separated from parents or other primary caregivers.**

The ACE study identifies three adverse childhood experiences that are linked to a higher likelihood of maladaptive and addictive behavior: an incarcerated parent, a parent on drugs and alcohol, or a missing parent.<sup>58</sup> Physical separation jeopardizes the ability of a child to form and sustain attachments with parents or other family caregivers. When appropriate, all systems involved in such situations must identify and remove the obstacles to pursuing parent-child attachment. This challenge will require major cultural shifts regarding family treatment in Philadelphia.

Further, transportation and other assistance could be provided to help families remain in contact with incarcerated parents or youth in residential placement. Youth in any type of out-of-home care (e.g., foster care, delinquent incarcerations, hospitals) should help determine how they can maintain attachments with parents and other family members.

Additionally, every effort should be made to reduce the use of out-of-state residential treatment facilities; these make it extremely difficult for youth in placement to remain connected to their families. (This issue is discussed further in *Recommendation 4.4: Make every effort to move children from distant and residential settings to community- and home-based settings.*)

Also, staff at agencies and organizations in child-serving systems should receive core training and supervision on how to recognize and address the impact that

# Goals and Recommendations

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### Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

attachment loss may have on children. This training must be ongoing and evolve over time to address the multiple challenges facing both children and their parents or caregivers.

Where attachment is not possible (e.g. due to the death of a parent or a child being removed from dangerous family situations), supports should exist for children to develop and maintain attachments with other steady and predictable people in their lives. Mentoring programs can help develop such attachments. There are a variety of mentoring opportunities already in place that can be built upon. These include mentoring models based in schools, corporate mentoring models, Police Athletic Leagues, community mentoring models (e.g., Boy and Girl Scouts, Boys and Girls Clubs, and Big Brothers/Sisters), and models enlisting college students. In addition, mentoring and peer support with other youth who share the common experience of being abused, neglected, removed from their homes, or separated from a parent should also be expanded.

#### Recommendation 1.3: Support communities in creating strategies to build public awareness and knowledge of factors that promote social and emotional health and safety.

Public awareness campaigns can intensify community awareness of the need to protect children from conditions that can increase the risk of behavioral health problems (e.g., child abuse or neglect, exposure to violence, substance abuse, family disruptions, long term medical issues, and physical or developmental disabilities).

Community strategies to build public awareness and knowledge of social and emotional health should be undertaken on multiple levels and could include:

- Citywide media and neighborhood-level grassroots activities that heighten public awareness of the impact of conditions that place children at risk for behavioral health problems.
- Activities to educate children, parents, and child-serving professionals about children’s needs for safe and supportive environments that are free from trauma, physical and emotional neglect, abuse and risk of physical danger. Education activities can focus on prevention of sexual abuse, physical abuse, emotional abuse, neglect and other traumatic events.
- Dissemination of information about positive activities that communities can support to improve the emotional well-being of children and youth.
- Efforts to identify and partner with community organizations and community leaders (e.g., recreation centers/community resource centers, block captains, faith-based organizations, local elected officials, small-business owners, day-care centers, organized clubs, libraries, community health centers, large corporations active in their respective communities, local media and shelters) to address issues that place youth at risk for behavioral health problems. Cultivate community leaders by developing community advisory boards that address issues placing youth at risk. This effort should include strategies for improving trusting relationships between young people and the Philadelphia Police Department.

## Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

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“We need to have public awareness, where everybody gets involved and the community becomes aware that this is something that we all need to be involved in, not just the schools, not just your organization, not just the churches, but the block captains and the political people.”

Community Provider

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- Engagement of the business community and private sector to promote healthy communities and pro-social and emotional health messages.

- Partnerships with the faith-based community to promote social and emotional well-being among children and youth.

### Recommendation 1.4: Develop strategies to address environmental factors affecting social and emotional health and safety.

Children should live in safe, stable and supportive communities that can reinforce their individual and family resilience. Living in such a community is an important protective factor for children.

The impact of the relentless violence against or witnessed by children in Philadelphia is a major challenge facing the city. A safe community starts with efforts to eliminate neighborhood crime and violence. While it is critical to recognize the importance of a safe community, this important goal is beyond the Commission’s purview. The Commission set out to establish a foundation for building a safer, more stable and supportive community. This would include:

- Greater availability of, and improved access to, mentoring and other activities to help children form healthy relationships with caring adults (see also the strategies related to *Recommendation 1.2* on pages 27-30).

- Greater availability of, and access to, affordable early child care, before-school, after-school, and youth-development programming to provide safe, supervised activities for children and young adults. School-age activities should include opportunities for children to build healthy relationships with peers such as safe and structured play in schools (e.g., physical education) and in communities (e.g., recreation centers, community centers and YMCAs). These programs are important because children respond to structure, and the programs can provide safe and supervised activities during the peak periods of crime and victimization for children.

- Education for children, parents and child-serving professionals about how to provide children with safe and supportive environments. This education should focus on prevention of sexual abuse, physical abuse, emotional abuse, neglect, and other traumatic events. It should also help youth learn and practice alternatives to the use of aggression and bullying.

# Goals and Recommendations

## 1

### Goal 1: Children’s Social and Emotional Well-Being Is the Responsibility of the Entire Community

#### Recommendation 1.5: Ensure that all agencies and organizations commit to promoting the behavioral health of the children they serve.

To achieve consensus on community responsibility for children’s social and emotional well-being, social service departments and other agencies and organizations serving children must recognize their roles in promoting children’s behavioral health. While the Department of Behavioral Health and Mental Retardation Services has the primary responsibility for children’s behavioral health, other service systems and agencies also play important parts. They include: Family Court, Office of Supportive Housing (formerly the Office of Emergency Shelter and Services), Department of Human Services, Philadelphia Prison System, Department of Public Health, Department of Recreation, and the Philadelphia School District.

The behavioral health system has traditionally focused on delivering intervention and treatment services in clinics, hospitals and similar settings to children already experiencing behavioral health problems. This approach, however, is not enough to ensure the behavioral well-being of all children. The natural settings of family, school, community, primary care provider, and recreation center all offer chances to support children and their families in a positive and meaningful way, to cultivate and build on their innate resiliency that may protect them when trauma, stress and other behavioral challenges arrive. In partnership with the behavioral health system, these settings can promote resiliency and wellness, prevent social and emotional disorders, and

supplement behavioral health interventions and treatments where they are needed.

This commitment to collaboration is appropriate and necessary because of the links between behavioral health and other indicators of child well-being that are the primary responsibility of those agencies. These include the link between behavioral health and physical health (the domain of the Department of Public Health) and the link between behavioral health and academic success (the domain of the School District). Consistent with this call for commitment from all agencies and organizations serving children, this report recommends steps to be taken by many agencies and organizations from the various service systems to promote behavioral health among children and their families.

One of the key underlying objectives of the collaboration should be to make sure that all staff in every system can help children and their families navigate through the systems to easily identify and access the service or support they need. The staff in every system should take full ownership of the responsibility for assisting people to identify what they need and guiding them to the entry point for that service or support.

# Goals and Recommendations

## Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

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A clear message emerged from the Blue Ribbon Commission's proceedings, particularly its 10 public hearings: the community wants to ensure that every child and family served by the behavioral health, child welfare and other child-serving systems is treated with dignity and respect. The community also called for children and their families to be empowered to participate in the decision-making about their services, supports and treatments.

Guided by this message, the Commission endorses a goal of value, dignity, respect and empowerment for children and their families. An important element of these qualities is a framework of resiliency, which is based on the strengths of the child and family. (Resiliency is discussed extensively as part of Goal 1.)

Further, Philadelphia boasts diverse ethnic and cultural groups. Attitudes toward behavioral health problems vary among these groups. Pride, stigma, shame, and the expression of emotional distress may be viewed differently in different cultures. Consideration of cultural differences, respect for differences, and celebration of one's ethnic identity and cultural heritage are important factors while meeting the behavioral health needs of children and youth in various settings.

The Commission also recognizes that dignity, respect, and empowerment demand that the needs of children and their families be addressed absent discrimination as it relates to race, religion, national origin, gender identification, sexual orientation or any disability.

### Recommendation 2.1

Create opportunities in child-serving systems for children and families to have a voice in decision-making regarding planning, service delivery and treatment.

### Recommendation 2.2

Deliver services and supports in a way that respects and is responsive to children's racial, ethnic, and cultural backgrounds, sexual orientation, and gender identities.

### Recommendation 2.3

Create mechanisms for a youth and family peer component to be integrated into all behavior health care services for children and youth and place peer support in communities with children and families.



# Goals and Recommendations

## 2

### Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

#### Recommendation 2.1: Create opportunities in child-serving systems for children and families to have a voice in decision-making regarding planning, service delivery and treatment.

The effectiveness of service delivery can be reinforced by the involvement of the child and family in designing, planning and implementing decisions. Gaining more interest is the “family-driven, youth-guided” approach. “Family-driven” means the family has a primary decision-making role in their child’s care and in policy decisions about care for children in their community. “Youth-guided” means that youth are empowered and educated to have a role in their own care and in the policy decisions about care for youth in their community.<sup>58</sup>

The child and family perspective is important to understanding the child’s condition, the strengths of the child and family, and other important factors that affect service planning. Families’ participation can improve the relationship between the family and the professionals providing services and supports. When the child and family participate in decision making, they feel valued and respected.

**2.1.1 Child-serving systems that include child and family input instill true dialogue and choice into the process.** Child and family input should be infused in all aspects of services for children including design, assessment, planning, service delivery, treatment and transition from one type of service to another. Children and families should receive sufficient information to understand the services and treatment being offered and why. Older children should have the opportunity

to participate in the decision-making process for the extent appropriate to their age and development. Other children should be represented by a parent, caregiver, or another concerned, responsible adult.

This input and involvement can take many forms, both in the care of an individual child and his or her family, and in more systemic decision making. For example, on the individual level, professionals in child-serving systems should:

- Consult the child and family to identify where the child feels safe, so that services and supports can be provided in that type of setting or environment.
- Identify child’s existing attachments with caregivers and use these attachments to promote resilience in the child.
- Where appropriate, include the child or an identified advocate (e.g., parent, caregiver, teacher, clergy or religious representative) in interagency and other planning meetings to ensure that the child is engaged in the decision-making process.

This involvement is especially important leading up to and during key transition points in a child’s life or course of treatment. For example, for youth in residential treatment programs, a process should be in place that examines what additional services a youth needs to prepare for discharge. This process should start well in advance of the youth’s discharge date. The youth and family should participate both in this discharge planning process and in the selection of options for reintegration back into the community. The goal of



## Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

this process should be to partner with families to structure expectations and select and deliver services that will help ease the transition such as intensive community-based services immediately after discharge.

Of course, it is important that there be sufficient service alternatives and flexibility in funding and use of services so that the child and family have a true choice in their service planning.

The strengths, resources, and knowledge of children and their families should be used to help inform policy decisions about how the behavioral health and other child-serving systems operate. They also should be used to improve services and training for service providers. The perspectives of children and their families can be gathered using focus groups, advisory groups, surveys and other methods. In addition, where appropriate, family members could participate in training, receiving training and delivering it.

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“We fail to realize that the parents and caregivers are the experts on the child . . . They are not given that due respect and, therefore, the system breaks down.”

Family Advocate

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**Recommendation 2.2: Deliver services and supports in a way that respects and is responsive to children’s racial, ethnic, and cultural backgrounds, sexual orientation, and gender identities.**

Children need to feel positive about their racial, ethnic, and cultural backgrounds, sexual orientation, and gender identities. One of the Guiding Principles adopted by the Blue Ribbon Commission states that “children and their families should receive services that are free from discrimination as it relates to race, religion, national origin, sex, gender identification, sexual orientation, or physical or other disability, and services should be sensitive and responsive to cultural differences and special needs.”

**2.2.1 Establishment of cultural competence as a core element of all child-supporting systems as a way to ensure that the diversity of families and communities is respected.** Delivery of services in a culturally-competent and culturally-sensitive manner is essential for respect, dignity and empowerment. There are numerous steps that can be taken to instill **cultural competence** into systems and programs serving children, such as:

**cultural competence:** Cultural competence is the acceptance and respect for differences among individuals or groups, continuing self-assessment regarding one’s own or another culture, attention to the dynamics of individual and group differences, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations.

# Goals and Recommendations

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## Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

- Developing and implementing cultural competency standards and benchmarks that can be used to measure agencies' effectiveness in serving children and their families in culturally-appropriate ways.
- Supporting and using behavioral health research conducted by and for racial, ethnic, cultural, sexual and gender minorities to ensure a broad range of perspectives and more culturally-relevant practices.
- Where appropriate, hiring staff that share racial, ethnic, cultural, sexual, and gender identities and backgrounds of the children they serve.
- Ensuring that staff possess linguistic competencies appropriate to the populations they serve, and that interpreters are available when needed.
- Offering culturally-affirming activities for children and their families in a variety of settings.
- Encouraging communication about racial, ethnic, cultural, sexual and gender issues among staff, children and families.
- Creating partnerships with culturally-relevant community organizations and institutions to ensure that cultural sensitivity moves from providers to the families and from families to providers.
- Compiling a cultural-competence resource manual for service providers.

*2.2.2 Educational and training programs for providers in child-serving systems, including the behavioral health system, to build cultural competence to address the needs of racial, ethnic, cultural, sexual, and gender minorities.* Provide a set of training courses to ensure that service providers can work effectively with specific populations. Training should be conducted by people with expertise in cultural competence and relevant substantive areas. It should target provider staff at all levels. It could include:

- Training to increase cultural awareness that includes a standard set of training objectives including personal belief inventories.
- Establishing a training schedule for new workers and updates for seasoned staff. A system of monitoring, evaluating and reporting on the cultural awareness and competency training that is delivered to providers should be created.

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*“We need to have people there who are culturally sensitive, culturally competent, bi-cultural and bi-lingual, if not tri-lingual, because we have a lot of different nationalities in the city.”*

*Philadelphia Social Worker*

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# Goals and Recommendations

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## Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

### *2.2.3 Delivery of behavioral health services in languages that children and their families understand.*

Philadelphia is a city of many languages. The need for access to services in the consumer's language was an issue raised repeatedly in the Commission meetings, committee meetings and public hearings. This will require developing greater direct provider capacity in different languages, creating standards for testing provider language proficiency, hiring more interpreters and using technologies such as video conferencing to make access to interpreters easier and less costly.

### *2.2.4 Attention to lesbian, gay, bisexual, transgender and questioning (LGBTQ) issues and anti-discrimination policies within all systems' initiatives, contracts and projects.*

In serving LGBTQ young people or children of LGBTQ parents, services and supports across all child-serving systems should be tailored to their specific goals, strengths, and needs. Provide these in LGBTQ-welcoming environments that involve community organizations, advocacy groups, and other groups that specialize in providing LGBTQ-focused community support services.

Services should be delivered in a culturally-competent manner to reflect LGBTQ diversity. They should include a comprehensive, wrap-around approach to providing services to LGBTQ consumers. Such services should offer LGBTQ-affirming activities for children and their families, create partnerships with culturally relevant community organizations and institutions and use research conducted by and for LGBTQ minorities to guide services for LGBTQ children and their families.

Several steps can be taken to fulfill this strategy. First, provider processes should be sensitive to LGBTQ consumers' needs and circumstances. For example, providers could:

- Structure service intake processes to ensure privacy and confidentiality.
- Use client forms that reflect gender- and sexual-inclusive language.
- Post non-discriminatory signs in places where services are delivered.
- Create grievance procedures addressing LGBTQ issues and concerns.
- Encourage communication about LGBTQ issues among staff, children and families.
- Track quality assurance relating to LGBTQ issues and elicit LGBTQ issues from consumers.
- Make available a culturally-appropriate hotline to provide information, referral, and peer counseling, as some local organizations have already done.

Second, all child-serving systems should have access to information about resources and support groups for LGBTQ issues. Develop a resource manual for service providers. Third, take steps to ensure that service providers are sensitive to issues such as homophobia and transphobia.

# Goals and Recommendations

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## Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect

Finally, develop staff training programs in cultural competence and accountability to address cultural awareness. Develop training through partnerships between providers and LGBTQ organizations. Establish benchmarks for achievement of provider training standards to ensure training quality.

**Recommendation 2.3: Create mechanisms for a youth and family peer component to be integrated into all behavioral health care services for children and youth and place peer support in communities with children and families.**

Peer support must play a role in any systems reform. Peer interventions are critical for advancing a resiliency and recovery oriented system of care. For example, one peer intervention model includes a peer specialist who is an individual that has experienced behavioral health problems and behavioral health services and has been trained to help his/her peers. Peer specialists assist peers in identifying and achieving life goals, promoting the ability to make informed decisions, and gaining information and support from the community to achieve their goals.

There will likely be a need for different types of youth and family peer models. A peer model allows for support and understanding in ways that can be age and culturally appropriate and that allows youth the opportunity to actively participate in youth-centered wellness and recovery programs.

A key component for peer support is the shared experience with behavioral health services. Some peer functions for youth may be served by age peers whereas others will require adult mentors. Youth and family peer support helps foster resiliency in youth and families.

■ Peer support and peer experienced support (adults who are peers by experience) promote constructive environments where youth and their families no longer passively receive treatment and services. Peer support can also play a vital role in the area of prevention as well as in treatment.

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“[Parents] need a person who has the time and the relationship who can walk them through the process of accessing mental health service for themselves or for their child.”

Concerned Citizen

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■ Youth and family peer support will strengthen the voice and perspective of youth and families in planning, designing, and participating in interventions.

# Goals and Recommendations

## **Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated With Dignity and Respect**

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- Consult with organizations on incorporating youth into a peer support model. There are numerous organizations working to promote youth voices in decisions affecting youth living with disabilities and which allow youth the opportunity to participate in youth-centered behavioral health programs.
- Begin to shift the paradigm from solely placing adults in control and allow peer support models to help youth develop relationships with caring adults, strengthen connections to the community, and create policies and programs that make sense for youth.

# Goals and Recommendations

## 3

### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

There is considerable evidence supporting the importance and effectiveness of strategies that promote positive mental and emotional health, prevent behavioral disorders before they develop, and intervene early to avert more serious “disorders. The Blue Ribbon Commission endorses a series of recommendations to support the goal of prevention, early identification and early intervention of behavioral health problems.

#### Recommendation 3.1

Improve and expand broad-based prevention and health promotion activities to keep all children on the right track.

#### Recommendation 3.2

Identify and intervene early with children who are vulnerable to behavioral health problems.

#### Recommendation 3.3

Identify and promptly refer youth experiencing behavioral health problems including those in early care and education, school settings, and the child welfare and juvenile justice systems.

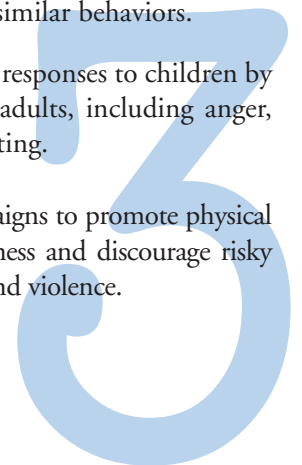
#### Recommendation 3.1: Improve and expand broad-based prevention activities to keep all children on the right track.

Prevention activities promote social and emotional health and prevent or delay the onset of behavioral health problems. These activities help children and their families engage in healthy behaviors. They bolster protective factors and reduce risk factors that affect a child’s behavioral health. Effective prevention services build on the strengths of children, families and communities.

The necessary steps in making prevention programs readily available includes legislative and policy changes at the state and federal levels to adopt prevention as a priority under various funding streams and to provide flexibility to Philadelphia and other local governments to make investments in prevention.

Prevention strategies can consist of:

- Activities in schools and the community targeted at children and their families to keep children on a normal developmental trajectory and prevent risky behaviors such as unsafe sex and substance use that can contribute to behavioral health problems.
- Activities in schools and the community to promote healthy social and emotional development and prevent bullying, dating violence, and similar behaviors.
- Programs to reduce negative responses to children by parents, caregivers, and other adults, including anger, shaming, humiliation, and beating.
- Community awareness campaigns to promote physical and behavioral health and wellness and discourage risky behaviors like substance abuse and violence.



# Goals and Recommendations

## 3

### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

**3.1.1 Broad access to a range of high-quality prevention activities.** Affordable early care, after-school and youth development programs can be effective in promoting social and emotional health, discouraging risky behavior and reducing the risk of conditions that can lead to behavioral health problems. Greater access to these types of programs is needed to provide safe, supervised activities and care while parents are at work and to deliver prevention and healthy development activities to children and youth.

Several steps are proposed to further this strategy:

- The array of services and supports for infants and young children up to age 5 and their families should be expanded. This should include expansion of the home visiting model in which a trained nurse, social worker, teacher or community health worker makes periodic home visits to provide parent education in child development and in positive parenting skills. It should also include expansion of Head Start programs, community-based early childhood education, and other programs with staff that are culturally and linguistically competent.

- The array of opportunities for school-age children to have safe and structured play to help them build bonds with their families and with other children should be expanded. This should include increased opportunities for physical education activities in schools and in the community.

- To guide expansion of early care and school-age programming, conduct analysis to determine geographic distribution in early care and after-school programming across the city. A plan should be developed for providing more affordable, community-based early care and after-school programs based on this analysis. The plan should ensure that high-quality services are provided year-round and at the times needed, including evenings and weekends.

- There should be additional opportunities for children with mental retardation or other disabilities to obtain early care and education, after-school or other services in settings where they are not segregated from the rest of the children, since they are often excluded from such settings now.

- School-age child and youth involvement in school- and community-based activities should be expanded by teaching outreach and engagement strategies to child-serving agencies, training about factors that inhibit children's use of these programs, and developing quality assurance measures to increase participation. In addition, informational hotlines should be provided to help parents identify low- and no-cost, safe, high-quality early care, after-school, and youth development programs, including recreational opportunities.

- The availability of effective mentoring services for children and youth of all ages should be expanded through a campaign to recruit, train, and retain more mentors across the city. The experience of having a mentor can be a powerful turning point for at-risk

# Goals and Recommendations

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### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

youth including those who may be prone to delinquent behavior, who may be shy or withdrawn, may lack self esteem, or may have learning difficulties. Mentors can provide additional positive role models. This is especially true when mentors are able to maintain a relationship with the same child for several years.

■ As part of the after-school and youth development program network, services should be developed that provide adolescents and young adults with education and training experiences to develop skills they will need to make the transition to adulthood. These services should focus on the important transition points for young people who may require services and supports after they turn age 18. These services can include opportunities for mentoring and training including mentoring programs that partner with private corporations to provide support for jobs, apprenticeships and career readiness training. In addition, financial and personal resources that can help provide basic economic supports (e.g., for food, transportation, clothing and other needs) must be established and built upon to assist these young people as they navigate their way toward adulthood.

**3.1.2 Community involvement to support children and their families and address issues that put children and youth at risk.** As was made clear in the discussion surrounding *Goal 1: Children's Social and Emotional Well-Being Will Be the Responsibility of the Entire Community*, children's families and communities have a significant impact on their social and emotional well-being. Safe and stable communities that support

children and their families are needed to promote children's behavioral health and prevent risky behaviors and emotional disorders.

Goal 1 suggests several steps to strengthen communities' involvement in children's well-being. These steps include: a public awareness campaign; community awareness activities to educate children, parents and child-serving professionals; partnerships with community organizations and community leaders to address issues that place youth at risk for behavioral health problems; and engagement of faith-based organizations, the business community, and the private sector. These strategies are also important for improving and expanding prevention and health promotion to keep all children on the right track.

Additional activities identified by the Commission include:

■ Placing highly-trained professional and community lay people in sites where children frequent including child care programs, after-school programs, recreation centers and shelters.

■ Continuing the Philadelphia Police Department's work to change its image in communities and to increase trust and visibility among children and youth.

■ Training and supporting first responders to reassure children and youth victims of trauma and violence, and to provide supports to assist and counsel siblings and other family members when a child has been abused or neglected.



## Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise

**3.1.3 Effective programs to help children develop skills to prevent or delay the onset of the use of alcohol, tobacco and other drugs.** Effective community-based programs have been developed that can prevent adolescents from using alcohol, tobacco and other drugs (ATOD). The Commission recognizes the contributions of these substance abuse prevention programs. In Philadelphia, effective prevention efforts for children of all ages must be expanded. These efforts should be carried out in schools and the community and should engage both children and their parents.

Substance abuse prevention programs should incorporate the National Institute on Drug Abuse (NIDA) guidelines as well as recent Institute of Medicine (IOM) and Substance Abuse and Mental Health Services Administration (SAMHSA) guidance.<sup>59</sup> For example, the guidelines suggest that programs should:

- Address all forms of substance use, including underage use of legal drugs (e.g., tobacco and alcohol), use of illegal drugs (e.g., marijuana, cocaine and methamphetamines), and inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.
- Address the relationship among risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support) at the appropriate development level based on the age of the child.
- Intervene as early as preschool to address risk factors for drug abuse such as aggressive behavior, poor social skills and academic difficulties.

- For elementary school activities, focus on improving academic and social learning to address risk factors for substance abuse such as early aggression and academic failure. Education should focus on skills such as self-control, emotional awareness, communication, social problem solving and academic support.

- For middle or junior high school students, focus on increased academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, reinforcement of anti-drug attitudes, and strengthening of personal commitments against drug abuse.

- Develop programs that target children at key transition points such as those entering new school levels (e.g., elementary to middle). Since these types of efforts do not single out at-risk populations, this approach can reduce associated stigma.

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*“I think there’s a lack of, I want to say, positive environments where [youth] can come in, express themselves positively...I think that more positive locations, physical locations that have resources and programs would do a lot better in terms of the setting in Philadelphia, which is mostly neighborhoods.”*

Youth

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# Goals and Recommendations

## 3

### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

■ Integrate family, school and community program components for more effective intervention. In particular, efforts should be made to reach youth who have dropped out of school.

■ Schools in all systems should implement or expand alcohol, tobacco and other drug education and resistance skills development at all grade levels, as per PA Act 211.

- Staff, coaches, supervisors, and other personnel at recreation and community centers, youth organizations, sports associations, day care centers, and other sites serving children and youth should be educated on how to include ATOD education as a regular part of their activities.

- Family-based prevention programs offered in formal or informal service settings should be designed to enhance family bonding and relationships because they are the most effective prevention tool. Programs should also include parenting skills aimed at keeping kids drug-free, practice in developing and enforcing family policies on substance use, and ATOD education and information.

The prevalence and the early onset of substance use by many girls warrant more substance abuse prevention efforts for them. These activities should be aimed at making girls, parents, schools and the community more aware of the unique vulnerabilities that lead to substance abuse by girls and the physical and mental

consequences of substance abuse. They should be based on proven prevention efforts that are successful in reducing substance use and abuse among girls.

Beyond these individual education and prevention approaches, broader environmental interventions are needed to build a strong societal commitment to reduce substance use and underage drinking. For example, the Institute of Medicine recommends changes in alcohol advertising to ensure that they are not targeted at young people, commitments by the entertainment and media communities to refrain from glamorizing ATOD use, and development of community mobilization campaigns to support strong enforcement of the law and other local efforts to reduce ATOD use.

#### **Recommendation 3.2: Identify and intervene early with children who are likely to develop behavioral health problems.**

One of the Blue Ribbon Commission's Guiding Principles is that children's needs should be identified early and addressed by interventions to improve the likelihood of healthy development and other positive outcomes. The Commission recognized that early identification and intervention has a higher likelihood of success and is more cost-effective than later, more intensive corrective measures. The Commission concluded that particular attention should be paid to the key developmental stages and transition points especially, but not limited to, the first five years of children's lives.

## Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise

There is a vital need for early identification and intervention with youth who are at greater risk of behavioral health problems by virtue of developmental, physical, familial, environmental, and societal circumstances, including:

- Abuse or neglect,
- Exposure to violence at home or in the community,
- Behavioral health problems of parents or other family members,
- Developmental delays or learning disabilities,
- Challenges relating to their racial, ethnic or cultural background, sexual orientation, or gender identity,
- Chronic illnesses or physical disabilities, or
- Separation from a parent.

These children must be identified early and linked to the effective, age-appropriate, non-stigmatizing and culturally-sensitive interventions they need.

**3.2.1 Adoption of standardized, validated, and easy-to-use screening tools across settings where children are served.** Vulnerable children and their needs could be more easily identified through use of user-friendly questionnaires about children's adverse childhood experiences and associated problems that would be helpful for everyone serving the child and family. A simple, uniform tool that is used with children across settings could identify which children may need preventive or low intensity interventions and which may need higher intensity services. The tools should be developed so that they are appropriate for children and

youth at all stages of development. For example, appropriate screening tools should be adopted for, and made available to, children age 5 and under.

**3.2.2 Identification of, and early intervention with, abused or neglected children who are at risk of developing behavioral health problems.** It is important that professionals in the child welfare system are equipped to identify children who are at greatest risk of behavioral health problems and refer them to the appropriate intervention services. This includes school personnel and child welfare system staff; providers of home-based services; providers of abuse, neglect and delinquency prevention services; and juvenile court staff. Among the actions that can be taken to make this happen:

- Provide appropriate training for all child-serving staff in the child welfare system to help them identify children who have the highest risk.
- Develop resource and referral information that can be easily available to child welfare system staff so they can link at-risk children to the appropriate services.
- Ensure that mechanisms are in place in the courts and the child welfare and juvenile justice systems to identify children's needs. These mechanisms could include developing and promoting prevention and intervention services as an alternative to placement as well as treatment diversion alternatives.

# Goals and Recommendations

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### Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise

In addition to those children who have already been identified as abused or neglected, there are many other children who have not been formally identified, but who are at high risk of abuse and neglect. These children should have easy access to non-stigmatizing, family-friendly, age-appropriate services in their neighborhoods including resources and information that can reduce the risk of abuse and/or neglect. These services could include:

- Community-based wellness centers that offer a wide range of resources in each area of the city.
- Early care and education, mentoring, and youth development programs.

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“So there's no parental control..just be free, do whatever you want. You just have to be more active in your kid's life and give them something to do besides go out and hang on corners and do drugs.”

#### Youth

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- A range of respite child care services for parents and families outside the Department of Human Services system.

- Hands-on parenting skills training programs, including education on avoiding corporal punishment, which can be a precursor to abuse.

- Parenting programs and parent education programs should be trauma informed so as to better recognize the potential for a history of trauma in adults, intervene in a sensitive manner, and address the needs of traumatized parents. Every effort should be made to enhance the emotional health of parents which naturally has an impact on how they parent.

*3.2.3 Identification of and intervention with children exposed to violence who are at risk of developing behavioral health problems.* Professionals working with children should have a better understanding of the effect of violence on children including its impact on behavioral health.

More training is needed for medical personnel, school staff, child care staff and other community workers to help them recognize specific signs of violence and identify children at risk of developing emotional or behavioral issues due to violent experiences. There should be routine in-service training to educate community personnel working with children about specific signs of victimization in children and families in *all* settings. More specifically, training of school and day-care staff should be improved to assist them in identifying child behaviors indicative of violent experiences.

Professionals should be available and equipped to conduct assessments of children to evaluate the impact

## **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

of exposure to violence. For example, appropriate school personnel should routinely assess children and their families known to have experienced violence to determine their need for behavioral health interventions.

In addition, primary care physicians and other health care professionals serving children should survey parents to identify potentially violent situations resulting from stressors such as drug and alcohol issues, finances, or occupational issues, and encourage self disclosure of abusive or violent situations.

***3.2.4 Identification of, and intervention with, children who are at risk of developing behavioral health problems because their primary caregiver has substance abuse or other behavioral health problems.*** Children who have primary caregivers with behavioral health problems, such as substance abuse or depression, are vulnerable to behavioral health problems themselves. These vulnerable children should be identified regardless of the primary child-serving agency serving them so that they can be referred to the services and support they need.

For example:

- The knowledge and skills of adult mental health and drug and alcohol treatment staff should be increased so they can better identify unmet needs of the children of the adults they serve. In addition, drug and alcohol treatment protocols should address the effects of parental substance abuse on children and should include assessment of this issue as part of drug and alcohol case treatment.

- Judges and other court personnel should be properly trained to identify children of parents with mental illness or substance abuse problems coming before the court for any reason and refer them for assistance.

- Drug and alcohol treatment protocols in the child welfare system should be expanded to include greater awareness of the effects of parental substance abuse on children.

- Screening for maternal depression is critical and should be widely available across systems that serve families.

- Efforts of schools and community-based substance abuse treatment providers, faith communities, fellowship groups (e.g., Alcoholics Anonymous, Narcotics Anonymous) should provide information regarding children affected by parent's substance abuse.

***3.2.5 Identification of, and intervention with, children with academic difficulties who may be at risk of developing behavioral health problems.*** Some children have a higher risk of developing emotional or behavioral problems due to developmental delays, learning disabilities, or other learning deficits. There should be additional support to help school staff and parents to more easily recognize warning signs for these problems. For example, a list of school-related behavioral health indicators (such as tardiness, academic difficulty, multiple absences, acting out or bullying, being subjected to bullying, and social isolation) could

# Goals and Recommendations

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### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

be developed to guide assessments and referrals. School-wide programs that promote conflict resolution and create a culture throughout the school of no bullying should be pursued. In this way, the entire school can be targeted for solutions, not just individual students.

Truancy can be a sign of behavioral health problems. The school district and the Department of Human Services should implement truancy protocols and responses in a consistent manner that emphasizes early identification, intervention and more communication with parents.

In addition, the Commission recommends that the implementation of the zero tolerance policy in Philadelphia public schools should be examined and refined if necessary. Instances of disruptive or threatening behavior in schools should be followed up with assessments to identify any underlying behavioral health problems so that the necessary interventions can be provided to the child and his/her family.

***3.2.6 Identification of, and intervention with, children who may be at risk of developing behavioral health problems because they are experiencing separation from a caregiver.*** Children experiencing separation from a parent or caregiver (due to parental death, incarceration, divorce, domestic violence, or removal from home by the child welfare system) may need help in maintaining an attachment with their caregiver. Any obstacles to attachment that exist in any of the systems serving children and families must be removed, except in those cases in which interactions

and relationships between the parent and child would not be beneficial to the child. Where attachment is not possible (e.g., due to the death of a parent or because interaction with a parent would be harmful to the child), supports should be in place for children so they can develop and maintain attachments with other steady, predictable persons in their lives. This should include building strong connections with siblings, paternal and maternal grandparents, and other extended family members.

***3.2.7 Identification of, and intervention with, children who may be at risk of behavioral health problems due to challenges relating to their racial, ethnic or cultural background, sexual orientation, or gender identity.*** Some children in Philadelphia face racism or challenges resulting from their racial, ethnic or cultural background, sexual orientation, or gender identity. Attacks on a child's identity can make him or her more vulnerable to develop emotional or behavioral problems. Staff across child-serving systems should recognize this risk and should have resources to link children with the culturally-appropriate support they

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“We need some parenting classes, and we need some classes to show us how to break the ice with these kids.”

Concerned Citizen

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## Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise

may need. (See *Goal 2*, related to *Value, Dignity, and Respect for Children and Their Families*, for a further discussion of cultural competency.)

**3.2.8 Identification of, and intervention with, children who may be at risk of behavioral health problems due to chronic health issues or physical disabilities.** Children with long-term health issues or physical disabilities are at higher risk of developing emotional or behavioral problems. Education and training should be provided to medical professionals to expand their abilities to recognize, assess and respond to behavioral health problems among their patients. (See *Goal 5, Recommendation 5.4*, relating to *Integration of Behavioral and Physical Health Services*.)

**3.2.9 Identification of, and intervention with, children using alcohol, tobacco and other drugs (ATOD).** Identification and intervention efforts are needed for children who use alcohol, tobacco or other drugs regardless of the duration or severity of their use. More timely identification can be accomplished through training and education for primary care professionals, child welfare staff, probation officers, adult human service providers, teachers, and others who come in contact with youth, so that they can identify these children and refer them for help.

Timely and successful intervention can be achieved by:

- Ensuring that children and their families are aware of and have access to appropriate substance abuse intervention services, and that such interventions are delivered in an effective way.

- Expanding and making improvements to services based in schools, so that there is an effectively functioning and fully staffed mechanism for identifying and addressing substance abuse problems facing youth in every Philadelphia school.

- Creating sufficient ATOD intervention activities in the community to reach the many teenagers who have dropped out of school.

**3.2.10 Identification of, and intervention with, children who are homeless.** Homelessness is a particularly disturbing experience that can have a significant and adverse emotional, social and mental health impact on children. The needs of these children, trapped in situations where their physical and mental health needs are often barely acknowledged, must be addressed through greater collaboration between the Office of Supportive Housing, private shelters, and the behavioral health system. This should include increased screenings and assessments of children in the shelter system and placement of behavioral health professionals in shelters.

# Goals and Recommendations

## 3

### **Goal 3: Prevention, Early Identification, and Early Intervention Activities Help Children and Their Families to Prevent Behavioral Health Problems, or Reduce Their Impact Once They Arise**

**Recommendation 3.3: Identify, promptly refer, and secure services for children and youth experiencing behavioral health problems including those in early care and education, school settings, and the child welfare and juvenile justice systems.**

There are numerous children and youth in Philadelphia with high behavioral health needs who go undiagnosed or, if diagnosed, may not be referred promptly for treatment. Many are in special education, in early care and education, or in the child welfare and juvenile justice systems. It is imperative that these young people are identified and promptly referred for behavioral health treatment. Similarly, appropriate behavioral health diagnostic and screening tools should be adopted for and made available to children age 5 and under.

These systems must be engaged to ensure that the youth and families they serve have access to counseling and innovative treatments that take into account the real challenges the youth face. In particular, any identification and referral process should be developed in a way that prevents youth from bouncing from one system to another, leaving them with the feeling that they are “throw-away kids.”

Some actions to improve the identification and screening of young people are underway in other systems. For example, every youth entering the city’s Youth Study Center undergoes a health screening by a registered nurse within an hour of their arrival. Those youth who stay in the Center for more than a day or two also receive a screening designed to identify youth who may

have special mental health needs. These types of screening activities should be expanded and replicated across other systems. Similarly, drug and alcohol screening should be available for juvenile offenders, with treatment as a diversion from residential placement where needed.

In addition, behavioral health screening, assessment and intake processes should be continually reexamined to ensure that they are as streamlined and efficient as possible, so that there are no delays in identification and referral to treatment of children with high levels of need.



# Goals and Recommendations

## Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

4

**C**hildren and families seeking services should be able to find out what services are available and where to get them. They should also be able to receive those services when and where they need them.

The Blue Ribbon Commission and its committees identified the issue of access to services as a critical goal for Philadelphia. In its discussions, the Commission identified three issues that address access.

- Barriers to easily identifying and obtaining services (e.g., stigma, lack of information, restrictive points of entry, inconvenient transportation, language barriers, time constraints on when and where services are offered, and an ability to pay).
- Gaps in the full array of needed services so that the service a child needs is readily available.
- Sufficient resources to meet the needs of children across the city so that all children in need are treated promptly.

The Commission also emphasized that access alone is not sufficient unless services are of quality to make a positive difference in the children's lives. (Service quality is addressed in *Goal 6*.)

### Recommendation 4.1

Provide children and families with information about all available services.

### Recommendation 4.2

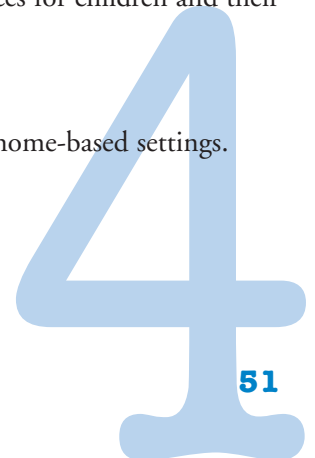
Develop better access points to services and supports for children and their families.

### Recommendation 4.3

Ensure availability of a full array of quality, culturally-competent and community-based services for children and their families.

### Recommendation 4.4

Make every effort to move children from distant and residential settings to community- and home-based settings.



# Goals and Recommendations

## 4

### Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

#### Recommendation 4.1: Provide children and families with information about all available services.

Families cannot get help if they do not know what is available and how to get it. Children and families need prompt and easy access to information on available resources that meet their needs. This is true for children who appear to be on the appropriate developmental trajectory, those who may be vulnerable to behavioral health problems, and those who need treatment because of existing behavioral health problems.

The Commission, in response to strong appeals from consumers, families and other community voices heard throughout the process, identified access to information about services and supports for children and their families as a key step toward transforming attitudes toward children's behavioral health.

Information about existing services through all child-serving systems must be made available to the community. This can be achieved through broad dissemination of information on available services, such as:

- Develop a comprehensive and easily understandable inventory of all programs, agencies, and services for children and families. Make the list available to the community through a “211” helpline, a website, and trained staff at city agencies and schools. Include other community-based organizations that serve children and families. Provide information in multiple languages.
- Designate community-based centers where families can learn about resources, supports, and services while also taking part in other activities.

- Prepare professionals who interact with children and families to share information on community services and how to access them. These professionals should include primary care providers (e.g., doctors, nurses, and nurse practitioners), teachers, recreational staff, religious leaders, and police officers. Enlist neighborhood-level community leaders to provide information about available resources.

- Implement community-specific education and outreach programs about available resources. Deliver the information in culturally and linguistically appropriate ways at community events, back-to-school nights, block parties and other community functions.

#### Recommendation 4.2: Develop more convenient and timely access points to services and supports for children and their families.

Even when families know that services are available, there can still be obstacles to getting help. Services may not be available at convenient times or in convenient places. The waiting time for new intakes, evaluation, and initiation of treatment in outpatient settings has been reported as a problem. Perceived stigma in the community about receiving mental health treatment may make children and families reluctant to use services. This can result in children and families avoiding needed treatment, thereby exacerbating their problems.

In addition, there may be other cultural disconnections relating to behavioral health services in some communities. Culture and language differences can make it difficult for service providers and families to communicate with each other about behavioral health problems.

## Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

**4.2.1 Convenient and natural points of entry for service.** Ensuring that there are convenient points of entry for services, with services provided in places where children already spend time, will make it more likely that children and their families will get the help they need. This will be particularly the case if these points of entry are natural and non-stigmatizing (e.g., child care centers, public health centers) and are not identified by those in the community as being purely related to mental health treatment.

■ Expand comprehensive behavioral health supports and services in schools. Schools are excellent venues to promote behavioral health, intervene with children who are in vulnerable situations and address the needs of students with emotional and behavioral difficulties. While a wide variety of behavioral health programs exist in Philadelphia public schools, capacity is not adequate to meet the need. All schools should be equipped to treat children and families on the premises. In addition, it is not clear what behavioral health services and supports are available within private, parochial, and charter schools. A range of interventions that promote social and emotional well-being should be made available across different types of schools. A review is needed of existing services in all schools, both public and private. The review would assess whether sufficient services exist, how well they are working, and how they can better coordinate with other services.

■ Incorporate behavioral health interventions along with supports like recreation, arts, culture, and sports activities into community-based settings to promote friendship, self-awareness, hope and optimism for children and families. These settings include primary care facilities, health centers, early care and education centers, child care centers, family centers, and recreational centers. By reaching children in these community settings, the behavioral health needs of children and their families can be addressed in the context of the family and the community, with less stigma and in the least restrictive setting possible. Service providers should receive incentives to serve children and families in these settings.

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“One of the things that struck my attention is the lack of the parents knowing how to access the mental health services as well as the teachers not knowing that they could refer this information to parents in order for them to receive these services for their child as well as the families.”

Community Provider

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# Goals and Recommendations

## 4

### Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

- Create more natural points of entry for children who need urgent support so they can receive it immediately. Crisis situations should be addressed immediately and as close as possible to where children and family are at the time of the crisis. One possible approach is to expand the availability of mobile teams of experienced individuals (e.g., professionals, family/peer specialists, and paraprofessionals) that can provide a holistic assessment of children’s needs and make connections to immediately available emergency support.

- Building on existing community-based programs where possible, establish a citywide system of child and family centers that promote family wellness and connect the current child-serving systems so children and their families will have a one-stop shop for services and referrals. These centers would focus on prevention, providing recreational activities, medical and dental services, behavioral health services, child care, and other services, depending on the needs of that community.

- Promote healthy social and emotional development using behavioral health experts in community settings (e.g., child care settings, primary care settings), thereby avoiding stigma.

- Re-institute the use of dedicated professional clinicians in community mental health centers to serve “walk-in” clients during day and evening hours so that services are available immediately in the community.

- Expand services delivered in the home, including those provided through nurse home visiting models.

- Evaluate the extent to which neighborhood-based programs are dispersed throughout the city and are in areas of identified need, to guide decisions about where resources should be located.

- In neighborhood-based programs, overcome cultural and language barriers by including providers who speak the language used in communities where English is not the primary language. Interpreter services should also be available if necessary. Use developmentally- and culturally- appropriate screening and evaluation tools. Ensure that providers and staff are culturally-competent. (See *Goal 5* for further discussion of culturally-competent services.)

- Provide flexible services that are respectful of the challenges parents face. For example, behavioral health programs and other services should be available on evenings and weekends.

- Develop a system of contingency funds (beyond Intensive Case Management, or ICM, programs) that will help procure resources that may not fit within a medical necessity model but represent an important need in a child’s life.

**4.2.2 Remove barriers to immediate intervention and treatment.** One of the barriers to effective service delivery, particularly for children with high needs, is a delay in formal evaluation and diagnosis. Children and families need seamless and immediate access to services and supports without having to wait for a formal evaluation and diagnosis.

## Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

To overcome this obstacle, the Commission recommends that all children and families have timely access to a brief assessment in order to begin services and supports immediately. This should occur before a comprehensive evaluation is completed. Immediate access could be provided by onsite assessment at schools and public health centers followed by referral if needed.

To provide immediate intervention services for children and families who do not have a diagnosis or who lack a complete bio-psychosocial evaluation, other approaches that ensure that the children are receiving appropriate support and monitoring should be explored.

**Recommendation 4.3: Ensure availability of a full array of quality, culturally-competent and community-based services for children and their families.** The Blue Ribbon Commission was guided by the principle that the behavioral health needs of children, youth and families should drive services. The familiar traditional continuum of care, a linear system of care with the least intensive services being the least restrictive, may not truly meet the needs of children and their families.

The traditional continuum of care with existing services is well developed in certain areas but lacking in others. As a result, there are needs not adequately addressed and gaps in the continuum of care. For example, the continuum does not have adequate capacity to serve children at all the key developmental stages or transitions in their lives (e.g., infants and young children in critical periods of development, children

going from preschool to compulsory education, youth returning to their families after juvenile placement, youth aging out of foster care or older adolescents transitioning to adulthood).

In addition, this array of care should be structured to encourage continuity of care, emphasizing ongoing service and supports rather than merely treatment in response to acute episodes of need.

**4.3.1 Closing gaps in services at developmental transition points.** Children need assessments and services that address behavioral health issues that may arise during transition points in their development, such as the period from birth to age 5 and the period when children age-out of the children's system into the adult system.

The Commission recognizes the importance of filling the service gaps for children from birth to 5 years as this represents a crucial stage in their development. During the course of the Commission's work, parents and others emphasized how difficult it is to find providers with sufficient experience working with young children. Strategies should be employed to increase expertise in conducting early childhood comprehensive developmental assessments and in providing developmentally appropriate interventions to young children and their families.

The Commission recommends development of a broadly available array of services and supports designed for infants, young children and their parents.

# Goals and Recommendations

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### Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

Examples of such an array of services include:

- Expanded home visiting models.
- Enhanced screening for social, emotional, developmental and physical problems.
- Community-based early childhood programming with culturally and linguistically competent staff.

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“Many parents feel that they’re being railroaded through the systems because, oftentimes, when they have outpatient appointments for therapy, it’s during the times that they’re working; they can’t take off, and they need the behavioral health system to be more sensitive in terms of their work hours.”

Family Advocate

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- Increased consultation and access to behavioral health expertise at day care and preschool settings.
  - Parent peer support, for parents with infants and young children.

- Youth peer support models for teenagers to help them transition from adolescence to adulthood.

The Commission calls for action for older youth as well. There are currently gaps in service for older adolescents as they transition to early adulthood. Youth between the age of 16 and 24 years need a range of flexible services to become productive, capable adults. This is particularly true of youth aging out of the foster care or other child-serving systems or returning from residential behavioral health treatment or juvenile justice settings. Existing adult serving programs are presently not designed to address the needs of these individuals. To help young people make this transition, the following steps should be taken:

- Start transition-to-adult planning early in adolescence. (These resources may come from a number of child serving systems and are not limited to those within the behavioral health system.)
- Develop a network of community-based programs to promote independent living skills among youth leaving the child welfare system by connecting youth with work readiness and vocational training, college-prep education, and/or parenting skills training.
- Deliver coordinated support to youth in the behavioral health system ages 16 to 24 years through the collaboration of professionals from various systems.

**4.3.2 Closing gaps in services for substance use and abuse and co-occurring disorders.** Children and youth need access to an array of services that help them

## Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

address their substance use and abuse problems and co-existing mental health disorders. The Commission emphasizes the importance of substance abuse prevention, early intervention and treatment. Services should cover needs associated with early experimentation through substances abuse and dependence and should take into account the following points:

- Service delivery across this array must embrace a developmental framework, recognizing that adolescent treatment needs are significantly different from those of adults.
- Ethnicity, culture, gender and sexual orientation need to be taken into account when developing interventions.
- Substance abuse prevention, intervention and treatment programs should be delivered by qualified providers in sites such as schools and Department of Recreation facilities (particularly in those designated as Teen Centers or Youth Access Centers).
- Systematic screening to identify substance use problems should occur in all settings where youth are at high risk including mental health treatment settings, juvenile justice, and child welfare settings (e.g., foster care, group homes).

Services addressing substance use and abuse should be better integrated with other behavioral health services, particularly for youth with co-occurring disorders. Typically, the mental health service system and the drug

and alcohol treatment system have been segregated with separate physical locations for services, separate funding of services, separate training of providers and often too little combined expertise in addressing the needs of youth who have substance use problems as well as mental health problems. Thus, children and adolescents who have co-occurring mental illnesses and substance use disorders are inadequately served. The Commission supports the development of services that are more fully integrated to address youth who are dually diagnosed with mental health and substance abuse problems.

**4.3.3 Closing Gaps Related to Levels of Service or Care.** Children and families need to be able to transition from more intensive to less intensive services as they make progress toward recovery. The Commission identified a variety of gaps in services for children who are moving from intensive inpatient or residential services back into the community. A concerted effort should be made to ensure that there are adequate school- and community-based therapeutic options (including after-care planning) available to children and youth transitioning from inpatient programs or residential programs. These services should be developmentally-appropriate and of sufficient duration to help ease transition. The following recommendations identify strategies to fill critical gaps in levels of care at the school and community levels:

# Goals and Recommendations

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### Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

In schools:

- Expand effective services in schools that help children develop their social, emotional and educational skills, either as stand-alone prevention and intervention programs or to supplement treatment. This should include greater availability of programs that will provide children opportunities to develop pro-social skills in the school setting and educational tutors that can be available to children in school.
- Develop and expand alternative behavioral health programs in schools that provide a community-based intensive day treatment alternative to partial hospital programs and that contain a quality education component. In particular, expansion of day programs should include services that can accommodate children with physical or cognitive disabilities, meet the needs of children who require either short-term or long-term day treatment, and increase the capacity for young children (including pre-K) and adolescents.

In the community:

- Expand effective services in community-based settings to support the development of social and emotional regulation skills, either as stand-alone prevention and intervention programs or to supplement treatment.
- Design community-based respite care for families to accommodate children with multiple needs.
- Ensure that services such as group therapy, peer support groups, art and recreation therapy, and mobile crisis teams are available to those who need them.

#### *4.3.4 Closing gaps in dependent and delinquent settings*

Children and youth in both dependent and delinquent settings often have behavioral health treatment needs that are not met. There are barriers to treatment for children in dependent settings such as group homes or foster care. Factors that can create barriers include disruption in treatment due to changes in placement where previous treatment history does not follow the child or adolescent, issues regarding consent to behavioral health treatment, recognition of the need for treatment, insurance coverage for behavioral health treatment and accessibility to treatment services in the setting.

Consent to behavioral health treatment remains an obstacle, as children may be in placement such as foster care, yet find themselves with no readily available legal guardian to consent to behavioral health treatment in a non-crisis, ongoing situation. Children may be in foster care and parents retain parental rights, including the legal right to consent for a minor's mental health treatment. However it is not always possible to locate parents of youth in child welfare placement, parents may not wish to consent to treatment, or parents may be incarcerated. Foster care parents may want their foster child to get treatment but legally, unless the child or youth is involuntary committed, neither the foster care parent or the DHS social worker can sign for the child unless DHS has become the legal guardian.

For youth involved in the juvenile justice system and in delinquent settings, receiving behavioral health



## Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

treatment is also an issue. A recent study reports only about 20% of depressed incarcerated youth and about 10% of adolescents with other disorders received treatment.<sup>60</sup> Similarly less than half of incarcerated youth who needed treatment for substance use disorders received it.<sup>61</sup> Specialty behavioral health services for delinquent youth need to take into account both treatment and security needs.

- Expand access to treatment services for both dependent and delinquent youth. Access issues may require legal solutions for the ongoing concerns about who can sign for consent for treatment. (See also Recommendation 3.2 *Identify and intervene early with children and youth who are likely to develop behavioral health problems.*)

- Develop mechanisms to ensure that information regarding receipt of behavioral health treatment follows the child or youth during transitions to placement.

- Continue to develop specialized behavioral health treatment services that are delivered in the settings where children and youth reside.

**4.3.5 Closing Gaps Related to Other Specialized Care.** The Commission identified specific gaps in specialized care. The primary gaps identified by the Commission (aside from specialized care for children during the key transition points and for youth with co-occurring substance abuse and mental health disorders) are in services for children in inpatient resi-

dential settings, children who have experienced trauma, and children who have both mental retardation and mental health needs. To address these gaps, the Commission makes the following recommendations:

- Make available more specialized intervention options for different disorders challenging children and youth in inpatient or residential settings to ensure that there is adequate capacity to provide treatment. Such specialized treatment options include addressing co-occurring behavioral health and substance abuse problems, combined behavioral health and mental retardation challenges, combined behavioral health and chronic physical illness, autism or pervasive developmental disorders, and victims and perpetrators of physical or sexual abuse. Efforts should be made to keep these programs within the city limits of Philadelphia, to reduce stress and anxiety to promote the attachment of youth and their families, and facilitate integration into the community.

- Provide trauma-focused treatment and other trauma-informed services for children and youth who have experienced trauma by creating more trauma treatment programs targeting children across the developmental spectrum. These programs should employ evidence-informed and promising practices. Create a multi-disciplinary city trauma team to respond to major crises or events that occur in the community that could be traumatizing to groups of children and families.

# Goals and Recommendations

## 4

### Goal 4: Children and Families Are Able to Obtain Quality Services When and Where They Need Them

■ Increase child care, respite care, and other programs for children who have mental retardation and behavioral health needs. Ensure that there are adequate supports available to handle the unique needs of this population.

#### Recommendation 4.4: Make every effort to move children from distant and residential settings to community- and home-based settings.

Service options should include adequate capacity to permit children to be served as close to their home and community as possible. Inappropriate and disproportionate use of residential treatment, particularly residential services outside the Philadelphia area, can hinder attachments between children and their families, increase child and family stress, and increase costs.

Sufficient home- and community-based treatment and support services should be available so that as many youth as possible can move from out-of-state facilities to local facilities and from residential facilities to community service settings.

For those in residential placement, partnerships between residential treatment facilities and community- and home-based providers can help expedite movement home. For example, effective pre-discharge planning and continuity of after-care services that can begin prior to actual discharge and continue well after the child's return home may help shorten residential lengths of

stay and reduce the likelihood of the child's return to residential treatment. This approach can reduce the use of residential settings in favor of community settings in the long run.

Efforts should be made to develop promising approaches and practices that keep youth out of residential treatment facilities, such as mobile response and stabilization services, wrap-around supports (including family supports and respite), intensive case management, and multi-dimensional treatment foster care.

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**“A lot of people need help but just can't get to us. That's a big problem in the Philadelphia area. Sometimes people don't know how to get to us, but they need our services.”**

**Community Provider**

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# Goals and Recommendations

## Goal 5: Supports and Services\* for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

5

**C**hildren and their families have a right to expect high-quality, effective service that responds to their needs. Thus, the Commission identified service quality as an essential element of children’s behavioral health reform. It further identified several areas of action to improve the quality of behavioral health services and supports for children. Those areas include: culturally-sensitive services; developmental appropriateness; reliable trauma-informed and evidence-informed data; the need for more skilled behavioral health professionals and paraprofessionals; the need to expand and improve training for professionals, paraprofessionals, and all others serving children; and the need for greater quality assurance and accountability in the delivery of behavioral health services.

### Recommendation 5.1

Create and employ accountability and quality assurance measures to ensure effective services.

### Recommendation 5.2

Expand the number of professionals and paraprofessionals serving children and families at all levels of care by developing strategies for recruiting, retaining and rewarding a skilled and culturally-competent workforce.

### Recommendation 5.3

Upgrade the skills of those working with children by expanding and improving training and education for behavioral health and other staff.

### Recommendation 5.4

Boost the effectiveness of services by incorporating culturally-sensitive, developmentally-appropriate, and trauma-informed practices.

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#### Recommendation 5.1: Create and employ accountability and quality assurance measures to ensure effective services.

Child-serving systems and agencies should function effectively and should be able to successfully support

children and families when they need help. Systems transformation must include reforms to ensure effectiveness through the use of “evidence-informed practices” (i.e., practices that have been proven to work) and through greater accountability.

\* Supports and services encompass health promotion, prevention services, early interventions, and treatment services.

# Goals and Recommendations

## 5

### Goal 5: Supports and Services\* for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

**5.1.1 Promising or evidence-informed practices to improve service delivery.** Systems transformation requires that service delivery and program management in child-serving systems, including the behavioral health system, be founded on promising practices or evidence-informed practices. Programs should follow practices that are shown to be effective, and providers should receive training on how to put those practices in place. Provider fidelity to the evidence-informed or best practices is essential to their success. In order to institute evidence-informed practices, the following activities should be implemented:

- A review should be conducted on promising and evidence-informed practices to serve the range of children and address their full range of needs. This review should serve as the basis for development of new models of service, improvements to existing models, and the manner in which services are delivered under these models.
- Provider contracting should contain requirements that providers institute promising or evidence-informed practices. Contract performance monitoring should measure how well providers are applying those interventions.
- Promising and evidence-informed services, training manuals and other technical assistance should be made available to providers to support their implementation.

**5.1.2 An accountability model to track the effectiveness of the behavioral health system and other child-serving systems.** There should be greater accountability for systems that serve children and their families. These systems can deliver high-quality services regardless of service type or approach. Each should emphasize attaining measurable improvements and positive outcomes.

The city should create an accountability model with the input of a broad base of stakeholders (such as behavioral health professionals, parents and older youth, and health and human services staff). This will ensure that government and health providers provide services that are aligned with the community's priorities and establish assessment methodologies and outcomes to monitor the effectiveness of the behavioral health system and other systems serving children.

As part of this model, the city should develop an array of measurable outcomes and benchmarks to track system and provider performance measures, including customer satisfaction and clinical and functional outcomes. Performance measures should track effectiveness and customer satisfaction using criteria such as cultural and linguistic competence, wellness and strengths-based orientation, developmental appropriateness, use of evidence-informed practice, cost-effectiveness, and outcomes of treatment or services.

## Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

**5.1.3 Multi-faceted performance information and training tools.** The accountability model can generate tools on many levels. For example:

- Tools should be developed and disseminated for providers to help them use the accountability model to assess their own performance and to provide technical assistance on meeting performance benchmarks.
- The accountability model should be used to guide decisions about system reforms, service improvements, service expansion, or reallocation of resources with input from a range of stakeholders, including professionals who represent both “inside” and “outside” perspectives, as well as parents and other community members.
- The accountability model should be used as the basis for public dissemination of an “annual report card” that assesses the degree to which the needs of these children are being met across systems, agencies and providers.
- Local university-based and other researchers can use the data gathered under the model to develop, conduct, and publish research on this process, for broader dissemination of effective strategies.

**Recommendation 5.2:** Expand the number of professionals and paraprofessionals serving children and families at all levels of care by developing strategies for recruiting, retaining and rewarding a skilled and culturally-competent workforce.

Children need service and support from skilled staff and providers across all systems. The Blue Ribbon Commission recognizes that access and quality are closely linked. There must be a sufficient capacity of skilled staff to sustain a quality system. A lack of qualified staff contributes to wait lists and delays in service.

Strategies for increasing the quality workforce capacity are necessary. The skilled workforce need is greatest for children and adolescent psychiatrists and other behavioral health professionals who can serve children within:

- Age and developmental stages (e.g., ages 5 and under, teens)
- Problem areas (e.g. substance use, co-occurring disorders, trauma)
- Settings (e.g., schools, child care)
- Special populations (e.g. lesbian, gay, bisexual, transgender and questioning youth; children and youth with mental retardation)

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“Everyone who works with any individual in the family needs to be able to work with the family as a whole. I think that’s a real gap in the training.”

Community Provider

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# Goals and Recommendations

## 5

### Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

A recruitment, training, and incentive program should be implemented to ensure that there are adequate staff resources available to meet children's needs, in all levels of care. However, special attention should be directed at the areas of need suggested above.

The program should include actions such as:

- The development of a credentialing and career ladder model for behavioral health professionals to create pathways for advancement as they gain more education and expertise.
- Identification of shortages and development of incentives to attract more skilled people into those areas.
- Incentives to recruit people that speak languages other than English.

**Recommendation 5.3: Upgrade the skills of those working with children by expanding and improving training and education for behavioral health and other staff.**

Quality service delivery cannot be attained without a highly-skilled and well-trained staff. An array of training and education is needed to upgrade the quality of services and supports. Efforts to expand and improve training and education should include the following strategies.

**5.3.1 Provide training and education for behavioral health staff.** Training opportunities for behavioral health professionals and community-based agencies should be expanded and improved. Training should be provided through a training institute or other training model that infuses knowledge, best practices, natural supports and evidence-informed creative models into the system for families and community-based agencies. This training institute or other training model should contain opportunities for specialized training through credentialing and career ladders, community training programs, mentoring, and other opportunities. Wherever possible, the training model should include the use of parents as trainers, so professionals can understand the perspective of parents. In these training models, special focus should be placed on retaining and “growing” professional staff throughout the system.

The array of training opportunities could include expanded training for providers and staff – both professionals and paraprofessionals – to:

- Effectively treat youth with substance abuse problems, regardless of the presence of other behavioral health problems.
- Evaluate and treat young children (under 5 years) in different settings, including child care.
- Effectively treat children and youth during key transition points in their lives.
- Evaluate and effectively treat children and youth with mental illness and mental retardation.

## Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

**5.3.2 Education and training for primary care physicians, pediatricians, and other health and human services professionals.** Education and training should be more widely available for primary care physicians and other medical professionals to help them increase their abilities to recognize, assess, and respond to behavioral health problems, including substance abuse, among children. Cross-training topics that fulfill continuing education credits should be offered regularly.

Similarly, training on best practices should be more widely available to assist health and human service providers – in day care and school programs, in child welfare and juvenile justice settings, etc. – in meeting the needs of children at risk of or suffering from emotional disorders or other behavioral problems. Materials and supportive training and technical assistance for health and human service providers should be expanded to strengthen providers’ capacity to deliver effective and non-stigmatizing, culturally-sensitive services to these children in community settings.

**5.3.3 Education and training for professionals in other fields.** Training for professionals in other fields (e.g., social workers, foster care and other child welfare staff, law enforcement, staff from Family Court, teachers, first responders, licensing and inspection staff) should be provided to help them more readily recognize potential behavioral health problems, including substance abuse, among children and build on children’s and families’ strengths and resiliency to address potential problems. This should include:

- Specific drug and alcohol issues-related training to police and firefighters, through the Department of Behavioral Health and other agencies, for application in response to assistance calls.
- Staff development training and mentoring for teachers in working with children and families with behavioral health needs as well as navigating systems and available resources. Parent and peer mentors could be included in the delivery of this training.
- Training for juvenile justice and law enforcement staff to promote communication and partnering with parents.
- Training for after-school and youth development providers on the ways of providing services for adolescents that are competent, caring, and culturally sensitive. Training should enhance these providers capacity to serve as role models.

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“Begin training more people  
how to work with our children  
so that they will trust us and  
so they will open up to us.”

City Administrator

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# Goals and Recommendations

## 5

### Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

**5.3.4 Higher education partnerships to support effective education and training.** To strengthen both workforce capacity and quality, higher education partnerships should be more extensively used to support and improve education and training in degree programs at local universities for behavioral health professionals and other professionals serving children. These formal higher education linkages in many disciplines and areas of training can ensure that the courses being offered cover the content necessary (e.g., trauma, child development) and include training on providing culturally-sensitive care and services.

**Recommendation 5.4: Boost the effectiveness of services by incorporating culturally sensitive, developmentally-appropriate, and trauma-informed practices.**

Cultural competence and cultural sensitivity are an important focus of *Goal 2*, relating to children and families being *Valued and Treated with Dignity and Respect*. Within that goal, the Commission proposes several actions to instill cultural sensitivity into services for children. The Commission also recommends that steps be taken to ensure that services are geared to addressing the needs of children exposed to trauma and are appropriate for the age and development level of the children being served.

**5.4.1 Timely, specialized trauma-informed services for children who have experienced a traumatic event and their families.** With the recent rise in homicides and other violence in Philadelphia, there is a heightened need to address children and families who have experienced trauma. This is a two-fold need. First,

professionals coming in contact with children in all systems are equipped to recognize and respond to the impact of trauma on children exposed to it. Second, children should have prompt access to trauma-focused treatment once they are identified as needing behavioral health services.

A plan should be developed to ensure that services for children identified as having behavioral health problems should be trauma-informed and that all service systems that significantly touch the lives of children (e.g., child welfare, juvenile justice, education, health care) should be trauma-informed. This could include, for example:

- Target training about trauma to child protective service workers, supervisors and administrators. Training should address the effects of trauma on children and the family system, the identification of those in need of trauma treatment, how and where to access such specialized services, how to prevent further traumatization of children, and how to best support caregivers of children with a history of trauma.

- Behavioral screenings and assessments for children entering other child-serving systems who have experienced trauma. (The Philadelphia Department of Human Services currently assesses children entering the child welfare system who have experienced trauma.)

- Placement of trained trauma-informed peer specialists, mobile support services, and staff in targeted community health centers.



## Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff

- Placement of an onsite clinician with trauma specialization in those behavioral health service delivery settings where there is a high concentration of traumatized children (e.g., inpatient, partial, residential, drug and alcohol programs). Some such activities are already underway.

To expand the availability of treatment services for children experiencing trauma:

- Create more trauma treatment programs targeting children across the developmental spectrum and requiring that such programs employ evidence-informed and promising practices. This should include a multi-disciplinary city trauma team to respond to major crises or events that occur in the community that could be potentially traumatizing to groups of children and families.

- Provide additional support, education, training, and credentialing of trauma specialists working with children and their families to ensure accountability.

**5.4.2 Developmentally-appropriate services and supports.** Supports and services for children and youth must be developmentally informed and tailored to the child's specific stage of growth and development.

Developmental stages are accompanied by expectations for mastery of the youth in multiple domains: at home, at school, and with peers. For example, one expects children at various developmental stages to be able to express their thoughts and feelings with words rather

than actions, to know the difference between real and imagined, to be able to attend to self-care, to develop friendships outside of the home, to strive for more independence and so on. Each developmental stage is accompanied by expectations that certain milestones or developmental challenges will be met.

Children's developmental needs change over time and supports and services should reflect the child's stage and push for mastery. During transitions such as pre-school to school age, middle school to high school, and transition to adulthood there are opportunities for social and emotional growth that can be fostered by family and community.

For children and youth who are at risk for developing behavioral health problems or for those who have already experienced the onset of a behavioral health problem, these transitions can be more challenging. Developmentally appropriate services and supports must be available for those in need during transition points. (See 4.3.1 *Closing gaps in services at developmental transition points* for further discussion of the need for services at key transition points.)

The importance of delivering services that are appropriate for the age and developmental level of children and youth should be recognized across systems that serve children. The extent to which practices are developmentally-informed should serve as a key criterion in evaluating and designing services. Education and training programs for professionals should include this developmental perspective.

# Goals and Recommendations

## 5

### **Goal 5: Supports and Services for Children and Families Are Effective and Provided by Skilled and Knowledgeable Providers and Staff**

In addition, assessments of child-serving systems, particularly the behavioral health system, would ensure that services and supports are available during key transition points in children's lives (e.g., children going from pre-school to kindergarten, children changing homes, neighborhoods or schools, youth returning from juvenile placement and youth aging out of foster care). It would also ensure that those services and supports are appropriate for the ages and development levels of the children they serve. Education and training programs for professionals should include this developmental perspective.

# Goals and Recommendations

## Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

6

**C**hildren need access to an array of services that address their physical, emotional, social, and educational needs. Their needs must drive the services such that services are seamless, complementary and coordinated.

When children are served by multiple systems there is a greater need for communication between systems, such as follow-up on receipt of services and the effectiveness of those services, to ensure children's needs are being met. For example, a school-age child with behavioral health issues who is also a victim of neglect is served by the child welfare, behavioral health, and public school systems concurrently. Many children also transition from one service system to another or from one service within a system to another. For example, children receiving behavioral health services may move from inpatient or other intensive services to community-based services. Without proper collaboration, these situations can result in duplication of services, inconsistent or even contradictory responses to a child's needs, gaps in services and disruptions in service delivery.

The Blue Ribbon Commission was charged with going beyond a review of the current behavioral health system to examine ways to promote behavioral health across all systems serving children and families. It recognizes that greater collaboration within and across all child-serving systems, including behavioral health, physical health, schools, child welfare, child care, early care and education and homeless services, is essential to achieving seamless, complementary, and coordinated service systems. Collaboration may require changes to policies and practices at multiple levels including staff cross-training, service co-location, respect for the objectives and challenges of those in other service-systems, or organizations and cross-system communication and data sharing.

As noted above, one of the underlying objectives of collaboration must be to make sure all staff in every system can help children and their families navigate their way to the service or support they need. Staff in every system must be responsible for helping people to identify the service or support they need and guiding them to the entry point for that service or support.

This goal calls for improving collaboration at all levels of service delivery: the individual, service provider and system levels. It also is supported by recommendations that focus on two important aspects of collaboration: collaboration in our schools and collaboration between the physical and behavioral health systems. In addition, the Commission noted that the implementation phase of its behavioral health reform process should also pursue specific ways in which children in the juvenile justice system, child welfare system, drug and alcohol treatment, and other systems can receive high quality behavioral health services.

# Goals and Recommendations

## 6

### Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

#### Recommendation 6.1

Improve coordination and integration across individual, service provider, and system levels.

#### Recommendation 6.2

Develop specific reforms to improve collaboration in schools, and between schools and the behavioral health system.

#### Recommendation 6.3

Increase the integration of behavioral health and physical health services.

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#### Recommendation 6.1: Improve coordination and integration across the individual, service provider and system levels.

Children and families need services delivered in a coordinated manner, regardless of how many systems or agencies are involved. Programs in schools, foster care, homeless shelters, juvenile justice, mental health, and drug and alcohol, however, typically have different procedures for screening, assessment, and service delivery. The Commission believes that there must be true partnership requiring greater coordination at the individual child, provider and systems levels.

**6.1.1 Foster collaboration at the individual child level.** Greater collaboration is needed at the service level to coordinate services and care for individual children across systems when necessary. In the area of child evaluations, for example, consumers and parents raised concerns about different child-serving systems requiring multiple evaluations for the same child with little information sharing among them. The evaluation procedures of one system identifying the behavioral

health needs of a child may not always make it easier to access services from other systems.

The Commission recognizes differences across settings and systems in definitions, evaluation procedures and intervention that may not allow for a single evaluation system. Nevertheless, the Commission recommends some steps that can improve partnership at the evaluation stage:

- Develop a system of electronic records that, with the necessary privacy safeguards, can be shared across systems where appropriate. The city is already developing an integrated data information system called DSS CARES (Division of Social Services - Cross Agency Response for Effective Services) that will serve as the platform for such a system. DSS CARES includes information from the city social service agencies such as the Department of Human Services, the Office of Supportive Housing, and the Department of Behavioral Health. To ease development of a broader system, School District and court data should be integrated into DSS CARES.

## Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

- Develop procedures to ensure that critical evaluation components conducted in one setting can be shared with other settings.
- Develop procedures to allow evaluations of children and their families to be accepted across systems until that system completes its own evaluation.

There is also a need for greater collaboration in delivering services to children. Strategies to address collaboration at the *individual* child or youth service level include:

- Implementation of a team management approach to a child's care or family's care including the appointment of a team leader. Team leaders would serve as the central contacts between the team and the family, ensuring comprehensive, coordinated, and consistent communication with children and families. Whenever possible, team members should be a diverse group of individuals representing the racial, ethnic, and cultural diversity of the children and families they serve.
- Fully develop and use the DSS CARES integrated data system and other information tools (including systems containing School District and Court data) to share information at the individual child and family level across systems so that all team members have access to the same information and can communicate easily among themselves, with the necessary consents.

**6.1.2 Foster collaboration at the service provider level.** Strategies to address collaboration at the *service provider* level include:

- Improve communications and information-sharing across provider agencies.
- Create an interactive and searchable database that describes what providers are available in all the child-serving systems and the types of services they provide.
- Provide incentives for providers from different systems to collaborate (e.g., behavioral health programs based in schools, behavioral health programs in the juvenile justice system, behavioral health supports in homeless shelters).

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“We’re either not able to work together or we’re working at cross purposes because of the billing structure...Due to the funding crunch, our requirements for billing are so high that we can’t afford to do anything we can’t bill for. And a lot of necessary work goes undone because of that.”

Community Provider

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# Goals and Recommendations

## 6

### Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

- Develop funding mechanisms to support the collaborative process and reduce paperwork.
- Establish periodic forums, led or facilitated by area experts, where providers from across systems can attend and focus on a particular issue. Participation in these forums could count toward continuing education requirements or incentives for job promotion.

**6.1.3 Foster collaboration at the system level.** System-level collaboration becomes important in two major areas: (1) collaboration and integration of services for children and families served by more than one system at a time, and (2) collaboration of services when children and families move from one level of care to another.

To address issues in each of these two situations, the Commission recommends that a cross-agency committee of stakeholders be created and charged with developing and fostering collaboration efforts at large system levels and removing bureaucratic obstacles to collaboration.

Among the *system level* strategies that could be pursued by this group of stakeholders:

- Fully develop and use the DSS CARES integrated data and information system, which is now in place. DSS CARES helps case workers and managers in multiple social service systems communicate and share information about common clients (see 6.1.1 *Foster collaboration at the individual child level*). On the systems level, it provides information to agency heads and other policy makers to help them implement cross-agency reforms, monitor reform efforts, and measure outcomes.

- Develop universal policies and procedures and implement uniform intake forms and processes for multiple programs and systems serving children and families.

- Develop protocols for those children involved in multiple systems of care to allow one authorization for an array of services, rather than having duplicate authorizations for services that often are contradictory to what is needed.

- Explore greater opportunities for blended, flexible funding, so that funding can support effective cross-system services and service delivery that lead to greater efficiency and better outcomes.

Improved collaboration at key transition points in services must occur to ease movement of a child from one system of care to another and to ensure that there is no disruption of service. At these transition points, responsibility for delivering services is transferred from one service system to another. For example, the Early Intervention service system is divided into two tiers: the ChildLink system for infants and toddlers up to age 3 and the Elwyn Special Education for Early Developmental Success system from ages 3 to 5. Beyond age 5, children transition into either the K-12 system or the Special Education system.

In addition, transition from middle school to high school, particularly grades 9 and 10, must receive greater attention as this period represents a period of high-risk for behavioral health and other problems.

### Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

Similarly, a transitional challenge exists for adolescents between 18 and 24 years who have been receiving services in one or more child-serving systems. Youth who age out of child systems are often not prepared for the independence of adulthood. Providers and case managers in the child serving systems do not serve individuals over age 18, making transition planning critical. The range of adult services is often unfamiliar to those in the child system and may not meet the needs of young adults. The Department of Human Services does not have oversight, with some exceptions, over individuals after age 18, the juvenile justice system switches to an adult criminal system, and, depending on the specific educational needs (e.g., learning disorders, mental retardation), the public school system may or may not play a continuing role.

In each of these cases, coordination and continuity of services is essential to avoid disruption in the kinds of services provided or the quality of service delivery. Cross-system partnership at these key transition points can be improved by pursuing strategies such as:<sup>62</sup>

- Providing cross-system training for early intervention, behavioral health and primary care staff.
- Developing interdisciplinary treatment teams at key transition points. For example, transition teams made up of professionals from various systems should be developed to coordinate transition for youth aging out of foster care, child behavioral health, or juvenile justice systems.

The need to close gaps in services at key developmental transition points is also discussed as part of *Goal 3: Children and Families Will be Able to Locate and Obtain Quality Services When and Where They Need Them*.

#### Recommendation 6.2: Develop specific reforms to improve collaboration within schools and between schools and the behavioral health system.

Because of the important role schools play in children's lives and the amount of time children spend in school, there are considerable opportunities to provide prevention and intervention services there. The Commission endorsed the development of specific strategies to improve partnerships within schools and between schools and the behavioral health system.

Strategies for improving collaboration within schools and between schools and the behavioral health system include:

- Institute greater collaboration within schools, including more partnerships between school counselors, social workers, and consultation and education specialists to secure services for children who need them.
- Foster greater parental involvement in their children's education and more parent-teacher communication. Institute policies encouraging parent-teacher communication regarding children's progress and challenges, establish parent-peer liaisons to support parents' positive relationships with schools, and work with teachers and school staff to improve communication regarding positive and negative information about children.

# Goals and Recommendations

## 6

### Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

■ Ensure that adequate administrative support exists for school behavioral health staff to promote efficiently-met behavioral health needs in schools.

Strategies for improving collaboration between schools and the behavioral health system include:

- Expanding the level of behavioral health services provided in schools, including the number of mental health counselors and alcohol and drug counselors.
- Partnering with representatives from the local police districts so that schools are better informed regarding community incidents that may increase youth vulnerability to behavioral health problems.

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“When I say it takes a village to raise a child, I wonder if you understand how many different ways I have to send my child to be a part of this village. If I could send his left arm to the mental health system, if I could send his right foot to the hospital, if I could send his head and his head only to school, maybe these systems would work, but I can’t do that.”

Parent

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Finally, there are opportunities to advance collaboration between schools and other child service agencies including improving communication among probation officers, teachers, and other school personnel about the progress and problems of youth on probation.

#### Recommendation 6.3: Increase the integration of behavioral health and physical health services.

Children need physical and behavioral health services delivered in an integrated manner to promote overall well-being. Behavioral and physical health are tightly interwoven. Good physical health can strengthen emotional well-being and foster mental and emotional development across a person’s entire life.

The physical health care delivery system encompasses screenings and treatment with implications for children’s behavioral health throughout their development. In infancy, for example, screening for fetal alcohol syndrome and developmental delay is most likely to occur in the primary health care setting. The early intervention programs that use visiting nurses have had success in monitoring infants and children, keeping them on a normal developmental track and supporting their parents. For children and families coping with an ongoing medical condition or developmental disability, it is the logical place to access support, resources, and services.

Similarly, caregivers with identified mental health or substance abuse problems can receive referrals for themselves and their children from primary care providers. Visits to OB-GYN physicians and general



## Goal 6: True Collaboration Is Achieved at the Service Level and the System Level

# 6

practitioners offer opportunities for prevention of and intervention for behavioral health problems. For example, screening for perinatal depression and psychosis, and detecting and intervening in risk-taking behaviors (e.g., drug use, unprotected sex) that have behavioral health consequences can take place.

Settings where children go for routine health care are ideal for providing practical parenting resources, screening and early identification of behavioral health problems, preventive services and treatment for behavioral health and substance abuse problems. Since these settings are not specific to mental health treatment, stigma is reduced.

Finally, for children who are taking medication for behavioral health problems, primary care providers should monitor outcomes, side effects and interactions that may occur.

In practice, however, integration of behavioral and physical health care is limited. A citywide plan for coordinating and integrating medical and behavioral health services should be developed and implemented. This plan should encompass a range of elements, such as:

- Integrating behavioral health services in neighborhood health centers.
- Creating mobile health care service units that go directly into neighborhoods to reach children and families with physical health care and behavioral health services.

- Creating other opportunities for co-location of behavioral health and physical health care services.
- Increasing training of physical health providers in behavioral health including training that heightens awareness of risk factors and early signs of disorders.
- Creating funding and reimbursement arrangements that foster integration of behavioral health and physical health care services.



**Mary and Eddie Jr.:  
A New Philadelphia Story**

# A New Philadelphia Story

A revised version of the vignette of Mary and Eddie Jr. from pages 16-17 is presented here. The Commission's vision for how the community would respond to the collective task of promoting social and emotional well-being for children, once the recommendations of this report have been implemented, is indicated by including the recommendations most relevant to each section of the revised vignette.

## **A Vignette: Mary and Eddie Jr.**

Mary was exposed to domestic violence as a child. The cruelty, initiated by her father, included inappropriate sexual interaction, drinking, and led to their subsequent separation. Her mother later found information about community resources and support for victims of domestic violence that avoided stigmatizing Mary. Mary's mother learned how to get help from her local community center. Mary's teachers knew about different programs that would help Mary deal with the difficult things that happened to her and her family. Mary's mother's primary care provider recognized that she was showing some signs of depression after her husband left and discussed various options with her; Mary's mother decided to begin attending a women's support group.

### Relevant Report Recommendations:

Recommendation 3.2: Identify and intervene early with children who are vulnerable to behavioral health problems

Recommendation 4.1: Provide children and families with information about all available services

Recommendation 4.2: Develop better access points to services and supports for children and their families

Recommendation 5.3: Upgrade the skills of those working with children by expanding and improving training and education for behavioral health staff and other staff

\*\*\*\*\*

When Mary discovered she was pregnant, she didn't think that she had to quit school. Mary felt comfortable confiding in certain teachers and counselors who possessed relevant training. Through her school or her primary care provider, she and her Mom learned about special programs for pregnant teens, allowing Mary to take parenting classes. Although it was not easy, she stayed in school

# A New Philadelphia Story

and was very proud to get her diploma. After Eddie Jr.'s birth, a visiting nurse came to see her and the baby every week. Mary learned how to figure out what the baby wanted, that it was not her fault if he was cranky, and how best to help him develop. The nurse kept visiting as Eddie Jr. aged and became more mobile. She pointed out Eddie Jr.'s good points (he talked well, was very coordinated, and liked to try new things) and areas where he needed help (listening, following directions). Mary learned about some early childhood programs in her community that could help Eddie Jr. prepare for kindergarten. She also suggested that it might be confusing for Eddie Jr. when Mom said "no" to certain behaviors, and Grandmom took him out for ice cream after he misbehaved. She suggested some parenting groups that Mom and Grandmom could attend together so they could both help Eddie Jr. stay on track.

Relevant Report Recommendations:

Recommendation 1.2: Support parents and caregivers in their emotional attachment and bonding to children and youth

Recommendation 3.2: Identify and intervene early with children who are vulnerable to behavioral health problems

Recommendation 5.3: Upgrade the skills of those working with children by expanding and improving training and education for behavioral health staff and other staff

\*\*\*\*\*

Mary remembered her mentor when she had a difficult time in high school and wondered if Eddie Jr. could get someone like an older brother. During kindergarten Eddie Jr. complained that other students picked on him and took his dessert. He told his mom he just had to fight back at times. He thought the teacher didn't like him. Eddie Jr. often forgot to give Mom important papers from school so

Mom got into the habit of checking his backpack. She found a pair of scissors in there. When Mary asked him why he was bringing scissors to school, he said, "Just in case I need to scare away the bad kids."

Mary already had a teacher meeting coming up. She and the teacher decided Eddie Jr. needed more help. The teacher talked about a program in the school for students to prevent bullying. There was also a program Eddie Jr. could join. Mary and the school staff would work on a plan to get Eddie Jr. more help in school. Mary also took Eddie Jr. to the pediatrician who told her he thought Eddie Jr. probably needed treatment for Attention Deficit Hyperactivity Disorder (ADHD). He could be seen at the pediatric clinic or further evaluated by a behavioral specialist at school.

Mary thought about something the teacher said to her. Although Eddie Jr. often got into trouble, the teacher told Mary, "I see you really care about Eddie Jr.; you juggle working and coming to school meetings and other appointments. You and Eddie Jr. have a close relationship even though he is a handful. I noticed you spoke up at the meeting and taught us something about Eddie Jr. I just wanted to say, you're a good Mom."

Relevant Report Recommendations:

Goal 2: Every Child and Family Served by the Behavioral Health System, or Other Service Systems, Is Valued and Treated with Dignity and Respect.

Recommendation 1.1: Advance a framework of resiliency based on the strengths of children and their families throughout the community

Recommendation 6.2: Develop specific reforms to improve collaboration in schools and between schools and the behavioral health system

Recommendation 6.3: Increase the integration of behavioral health and physical health services

# A New Philadelphia Story

## Looking Forward: A Blueprint for Building Healthy Communities for Philadelphia's Children

This Blue Ribbon Commission report should serve as a roadmap for transforming the way Philadelphia guarantees the social and emotional health of its children. By following this roadmap, the Commission envisions a Philadelphia in which:

- All of its citizens - government leaders, teachers, government agency employees, community organizations, parents, neighbors and businesspeople – take responsibility for and play a role in making sure the city's children are socially and emotionally healthy.
- More time and resources are spent to prevent behavioral health problems rather than responding to crises after they have arisen.
- All children and their families with behavioral health concerns can get help, when and where they need it.
- All children and their families with behavioral health concerns are treated with dignity and respect.
- All children and their families with behavioral health concerns will receive services that work and that are delivered by highly-skilled and caring professionals.
- Greater collaboration by all those serving children and their families produces seamless and coordinated services that ensure that no child falls through the gaps.

This report, though the product of months of work by scores of Philadelphians committed to children, marks a beginning, not a conclusion. It sets the stage for implementation of children's behavioral health reform that examines existing programs and services, effective policies and practices, funding availability, and other factors that affect how to make the goals envisioned in this report a reality. Phase II will produce an implementation plan that sets forth the specific and

concrete action steps – in policy and in practice – for transforming how our city ensures the social and emotional health of every child in Philadelphia.

### *Phase II - Implementation Plan*

**JANUARY 2007 - SPRING 2007**

- Develop action steps for implementation.
- Identify outcomes for recommendations.
- Identify strategies that can be implemented immediately and begin putting into place.

### *Phase III - Initial Implementation*

**SPRING 2007 - SPRING 2008**

- Strengthen and fully integrate partnerships in support of implementation process.
- Implement short term strategic priorities with support and collaboration from all stakeholders.
- Begin collaborative planning for implementation of long term strategies.

### *Phase IV - Ongoing Evaluations*

*and Stakeholder Feedback*

**SPRING 2008 - FUTURE**

- Provide periodic implementation updates.
- Monitor process and modify as needed.
- Evaluate outcomes and the impact of system enhancements for children and families.
- Adjust implementation as necessary.







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## Appendix B: Definitions

### Attachment

Attachment is an emotional tie that a child forms with a primary caregiver, such as mother and baby, bonding them together and enduring over time. One may be attached to more than one caregiver; there is usually a gradient in the strength of such multiple attachments.

*Source: Weiner, J.M., and Dulcan, M.K. (2004).*

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### Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder (ADHD) is a persistent pattern of inattention and /or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development. Some hyperactive-impulsive symptoms that cause impairment must have been present before age 7 years. Some impairment must be present in at least two settings (e.g. at home, and at school or work). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning. *Source: American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders, fourth edition, text revision, DSM-IV-TR. Washington, D.C.: American Psychiatric Association.*

### Behavioral Health

A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, and can function productively and fruitfully with family, with peers, in school, and in his or her community.

### Behavioral Health Services

Behavioral health services refer to services and programs organized to meet the needs of people with mental health problems, drug or alcohol problems, or developmental disabilities that interfere with their ability to cope with the normal stresses of life and to work productively.

### Bonding

Bonding is the emotional attachment and commitment a child makes to social relationships beyond primary caregivers in the family, peer group, school community, or culture. Positive bonding with an adult is crucial to the development of a capacity for adaptive responses to change, and to grow into a healthy and functional adult. *Source: The Commission Chairs of the Annenberg Foundation Trust at Sunnylands' Adolescent Mental Health Initiative. (2005). Treating and preventing adolescent mental health disorders. Oxford University Press.*

### Cultural Competence

Cultural competence is the acceptance and respect for differences among individuals or groups, continuing self-assessment regarding one's own or another culture, attention to the dynamics of individual and group differences, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of diverse populations. *Source: Cross, T.L., Nasron, B.J., Dennis, K.W., Isaacs, M.R. (1989). Toward a culturally competent system of care. Washington, DC: Georgetown University Child Development Center.*

### Developmental Framework

In this report, a developmental framework acknowledges that from infancy through adulthood, individuals are experiencing biological, cognitive and social-emotional change. At they move through these stages or phases, there are achievements and milestones that children, adolescents and young adults are expected to master if they are healthy and on track.

### Early Intervention

Services that prevent escalating behavioral health risk symptoms through the identification of early stage problems in individuals or groups of any age who do not yet require treatment. This definition encompasses but is not limited to the Early Intervention programs for children 0-5.

# Appendix B: Definitions

## Evidenced-Informed Practice

The conscientious use of current best evidence in making decisions about interventions and treatment, taking into account the target population, the local context, and other critical variables. *Source: Sackett, D.L., Rosenberg, W.M., Gray, J.A., Haynes, R.B., Richardson, W.S. (1996). Evidence-based medicine: What it is and what it isn't. British Medical Journal, 312: 71-72; Lavis, J.N., Posada, F.B., Haines, A., Osei, E. (2004). Use of research to inform public policymaking. Lancet, 364: 1621-1625; McLennan, J.D., Wathen, N., MacMillan, H.L., Lavis, J.N. (2006). Research-practice gaps in child mental health. Journal of the American Academy of Child and Adolescent Psychiatry, 45(6): 658-665.*

## Family-Focused

An approach that incorporates the family as the primary support system for the child and includes their full participation as a full partner in all stages of the decision-making and treatment planning process.

## Health Promotion

Behavioral health promotion activities are offered to individuals, groups, or large populations to enhance competence, self-esteem, and a sense of well-being rather than to intervene to prevent psychological or social problems or mental disorders. *Source: Institute of Medicine. (1994). Reducing risks for mental disorders: Frontiers for preventive intervention research. National Academies Press.*

## Natural Setting

A setting that is not exclusively identified as a location where behavioral health services are provided, such as a primary care office, school, day care center, community center, recreation center, or home. Behavioral health services can be offered in such non-clinical settings. In this report, natural setting refers to a place that an individual is likely to spend time in the course of their usual daily activities in their community.

## Prevention

Prevention includes the promotion of mental health, as well as the reduction in the occurrence and impact of behavioral health disorders.

## Public Health

Public health is the science of protecting and improving the health of communities through education, promotion of healthy lifestyles, and research for disease and injury prevention. *Source: What is Public Health? (www.whatispublichealth.org)*

## Resilience

Resilience is the qualities that enable individuals or communities to rebound from adversity, trauma, tragedy, or other stresses - and to go on with life with a sense of mastery, competence, and hope.

## Risk and Protective Factors

Risk and protective factors are characteristics or conditions that, if present, increase or diminish, respectively, the likelihood that people will develop behavioral health problems or disorders. *Source: U.S. Department of Health and Human Services (2001). Mental health: Culture, race, and ethnicity - A supplement to 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.*

## Stigma

Stigma refers to negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses and/or substance abuse disorders. Responding to stigma, people with behavioral health problems may internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

## Appendix B: Definitions

### Trauma-Informed

A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that serious adverse events play in the lives of people seeking mental health and addiction services. A “trauma-informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, closely knit collaborative relationships with other public sector service systems serving these clients. *Source: Harris, M., and Falot, R. (2001). Using trauma theory to design service systems. New Directions for Mental Health Services, 89, Jossey Bass.*



# Appendix C: Acknowledgements

## The Kick-Off Conference to the Mayor's Blue Ribbon Commission on Children's Behavioral Health

### Improving Systems, Improving Lives:

Special thanks and appreciation are extended to the following organizations for their support in making the kick-off conference, *Improving Systems, Improving Lives*, possible.

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - Center for Substance Abuse Treatment (CSAT)
  - JBS International, Inc.
  - State Systems Technical Assistance Project (SSTAP)
- Robert Wood Johnson Foundation

The Blue Ribbon Commission would also like to thank the following presenters for lending their expertise and guidance to the *Improving Systems, Improving Lives* Conference:

Doreen Cavanaugh, Ph.D., *Georgetown University*  
Colette Croze, MSW, *Croze Consulting*  
Richard H. Dougherty, Ph.D., *DMA Health Strategies*  
Arthur C. Evans, Jr., Ph.D., *Department of Behavioral Health and Mental Retardation Services*  
Larke Huang, Ph.D., *American Institutes for Research*  
Peter Jensen, MD, *Columbia University*  
Ken Martinez, Psy.D., *American Institutes for Research*  
Miguel Melendez, *Valley Youth House*  
Kathleen Meyers, Ph.D., *Philadelphia Safe and Sound*  
John O'Brien, MA, *Technical Assistance Collaborative*  
Sheila Pires, MPA, *Center for Health Care Strategies*  
Adrienne Stinson, *Valley Youth House*

## The Mayor's Blue Ribbon Commission on Children's Behavioral Health Committees

The work of the Blue Commission on Children's Behavioral Health could not have been accomplished without the contributions of its three committees. The broad community stakeholder involvement in the committee process brought diverse knowledge, creativity, and ingenuity to the Commission's report. The BRC would like to particularly acknowledge the leadership of each committee's Co-chairs, Lead Staff and Facilitator. All Commission members who participated in the committees are indicated by a "\*".

### **All Children Committee**

Patricia Coulter\* (Co-chair), *Urban League of Philadelphia*

Amy Maisterra (Co-chair), *School District of Philadelphia*

Denise T. Patterson (Lead Staff), *Department of Behavioral Health and Mental Retardation Services*  
Richard Gladstone (Facilitator), *Consultant*

### **Vulnerable Children Committee**

Denise Ray\* (Co-chair), *Family Court*

Regan Kelly (Co-chair), *Northeast Treatment Services*

Kelley Berke (Lead Staff), *Department of Behavioral Health and Mental Retardation Services*

Richard Baron (Facilitator), *University of Pennsylvania, Collaborative on Community Integration*

### **Children with High Need Committee**

Tony Valdes\* (Co-chair), *Children's Crisis Treatment Center*

Mary Anne Delaney, M.D. (Co-chair), *Drexel University*

Renee Finley (Lead Staff), *Department of Behavioral Health and Mental Retardation Services*

Richard Gladstone (Facilitator), *Consultant*

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Amy Maisterra (Co-Chair), *School District of Philadelphia*

Denise T. Patterson (Lead Staff), *Department of Behavioral Health and Mental Retardation Services*

Richard Gladstone (Facilitator), *Consultant*

# Appendix C: Acknowledgements

## **Members**

Julia Alexander, Ph.D., *Department Human Services*  
Kwame Asante, *Children's Crisis Treatment Center*  
Eric Ashton, MPH, J.D., *Mental Health Association of Southeastern Pennsylvania*  
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Mita Chatterjee, *Pennsylvania Health Law Project*  
Ingrid Chung, *Hall Mercer*  
Annemarie Clarke, Ph.D.\*, *Special People in the Northeast, Inc.*

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David Dan, *Mentor, Inc.*  
Martha Davis, MSS, *Institute for Safe Families*  
Andy Devos, *Department of Behavioral Health and Mental Retardation Services*  
Mary Doherty, *Cora Services*  
Stephanie Drabble, LCSW, *Kencrest DVG/WAIMH*  
Vivian Drayton, *Supportive Child/Adult Network (SCAN), Inc.*  
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Dwane Dykes\*, *Mental Health Association of Southeastern Pennsylvania*  
David Fales, *Northwestern Human Services*  
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Doris D. Fowler, MA, *Department of Human Services*  
Julie Friedman, *Mental Health Association of Southeastern Pennsylvania*  
Claudia B. Garcia-Leeds, MA, ABD, *Congreso*  
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Abayomi Ige, M.D., *Dr. Warren E. Smith Health Centers*  
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Dorena Kearney\*, *COLOURS*  
Roland Lamb, MA, *Department of Behavioral Health and Mental Retardation Services*  
Chad Dion Lassiter, MSW, *Children's Hospital of Philadelphia*  
Janet Lonsdale, *Mental Health Association of Southeastern Pennsylvania*  
Rosalind Lopez\*, *ASPIRA, Inc.*  
Toni Mack, *COLOURS*  
Nandipha Majeke, *Consortium, Inc.*  
Maddy Malis, *Federation Early Learning Centers*  
Edie Mannion, *Mental Health Association of Southeastern Pennsylvania*  
Katherine Maus, *Department of Public Health*  
Pamela Mayo, *Department of Human Services*  
Crawford Mechem, *Department of Public Health*  
Jacki McKinney, *Family Member*  
Robin Miller, *Kencrest Children and Family Services*

Michael Moore, *Philadelphia Health Management Corporation*  
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Theresa Powell, *Consortium, Inc.*  
Ann Reid, *Hall Mercer*  
Michelle Afanado Sanchez, *Mental Health Association of Southeastern Pennsylvania*  
Sister Mary Scullion\*, *Project HOME*  
Charles Seth, LSW/ACSW, *Bethanna*  
Roomana Sheikh, M.D., *Community Council*  
Sara Sheneman, *CATCH*  
Eva Silver, M.ED, LPC, *Shalom*  
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Brenda Taylor, *School District of Philadelphia*  
Jennifer Thorpe, *Community Education Alliance of West Philadelphia*  
Vern Trent, *School District of Philadelphia*  
Barbara Trout, M.D., *Silver Springs School*  
Marlene F. Watson, Ph.D., *Drexel University*  
Chuck Williams, Ph.D., *Department of Behavioral Health and Mental Retardation Services*  
Kerry Williams\*, *Youth Golf & Academics Program*  
Donna Young, MSW/LCSW, *PATH, Inc.*  
Lori Young-West, *PATH, Inc.*

### Children with High Need Committee

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Mary Anne Delaney, M.D. (Co-Chair), *Drexel University*  
Renee Finley (Lead Staff), *Department of Behavioral Health and Mental Retardation Services*  
Richard Gladstone (Facilitator), *Consultant*

### Members

Angelo Adson, *The Bridge*  
Barbara Altenburger, *Mental Health Association of Southeastern Pennsylvania*  
Margie Austin\*, *Family Member*  
Robert Bartlett, *Silver Springs School*

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Dionne Beaman, *Philadelphia Developmental Disabilities Corporation*  
Selena Board, *Dr. Warren E. Smith Health Centers*  
Wesley Brown, *Department of Human Services*  
David Buckley, *The Mentor Network*  
Judy Burns, *Intercultural Family Services*  
Bryan Cohen, *Interac, Inc./Philadelphia Coalition*  
Maureen Davey, *PATH, Inc.*  
Tommie Davis, *Dr. Warren E. Smith Health Centers*  
Michael DeStafano, *Belmont Center*  
Joyce Dukes, *School District of Philadelphia*  
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Angel Flores, J.D., *District Attorney's Office*  
Judy Frank, *Department of Human Services*  
Cynthia Garrett, *Elwyn, Inc.*  
Karen Garrison, *Family Member*  
Bert Harris, Ph.D., *Department of Human Services*  
Ivan Haskell, Ph.D., *Children's Outreach Services*  
Brian Haynes, *Albert Einstein Medical Center*  
Renee Henderson, *Department of Behavioral Health and Mental Retardation Services*  
Anne Holland, Ph.D., *Children's Crisis Treatment Center*  
Norman Johnson, Ph.D., *Children's Service, Inc.*  
Rosemary Karabinos, *Elwyn, Inc.*  
Martin Konov, *COMHAR*  
Joseph Kumi, M.D., *Temple University*  
Jeanne Lehrer, Ph.D., *Northeast Treatment Services*  
Dottie Lynch, *PATH, Inc.*  
Rachel Mann, J.D.\*, *Disabilities Law Project*  
John McGee, *Department of Human Services*  
Jackie Newton, *Consortium, Inc.*  
Paul O'Rourke, *Consortium, Inc.*  
Catherine Panzarella, *Mental Health Association of Southeastern Pennsylvania*  
Loren Preheim, *Presbyterian Children's Village*  
Susan Proulx, Psy.D., *Elwyn, Inc.*  
James Randolph, *Department of Human Services*  
Joe Rogers\*, *Mental Health Association of Southeastern Pennsylvania*  
Lordes Rosado, *Juvenile Law Center*  
Anita Rosenfeld, *Resources for Human Development*

Jean Ruttenberg, *Center for Autistic Children*  
Alisa Simon, *Philadelphia Citizens for Children and Youth*  
Geneva Williams\*, *Family Member*  
Kehinde Solanke, LSW, *Department of Behavioral Health and Mental Retardation Services*  
Sabrina Tate, *Northwestern Human Services*  
Fari Thompson, *John F. Kennedy Center for Mental Health and Mental Retardation*  
David Tomlinson, LCSW, *Northeast Community Center for Mental Health and Mental Retardation*  
Sabra Townsend, *Department of Public Health*  
Francesca Vassalluzzo, *Mental Health Association of Southeastern Pennsylvania*

## State and City Leadership

Acknowledgement of the cross-systems contributions and collaboration that were critical to the development of this report is extended to the organizations below. A special thanks is given to Dr. Calvin Johnson, Pennsylvania Secretary of Health, and Estelle Richman, Pennsylvania Secretary of Public Welfare for their state participation in and support of the process.

### State Leadership

- State Department of Public Welfare
- State Department of Health
- Office of Mental Health and Substance Abuse Services

### City Leadership

- Philadelphia School District
- Philadelphia Family and Juvenile Courts
- Managing Directors Office
- Division of Social Services
- Department of Human Services
- Department of Behavioral Health and Mental Retardation Services
- Office of Supportive Housing
- Department of Public Health
- Prisons Department
- Recreation Department
- Office of Adult Services
- Mayor's Office of Community Services

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### Other Contributors

Project management, writing and editing assistance were provided by Philadelphia Safe and Sound, the University of Pennsylvania's Center for Health, Achievement, Neighborhood, Growth, and Ethnic Studies (CHANGES), the Center for Mental Health Policy and Services, the Department of Behavioral Health and Mental Retardation Services, and the Department of Human Services.

Ijeoma Acahara-Abrahams, Psy.D., *Department of Behavioral Health and Mental Retardation Services*  
Cathy Bolton, Ph.D., *Department of Behavioral Health and Mental Retardation Services*  
Jennifer Dorwart, *Department of Behavioral Health and Mental Retardation Services*  
David Dupree, Ph.D., *University of Pennsylvania, Center for Health, Achievement, Neighborhood Growth, and Ethnic Studies (CHANGES)*  
Gail Edelsohn, M.D., M.S.P.H., *Department of Behavioral Health and Mental Retardation Services*  
Emily Fargione, *Philadelphia Safe and Sound*  
Deborah Ferrell, *Department of Behavioral Health and Mental Retardation Services*  
Marc Forman, M.D., *Department of Behavioral Health and Mental Retardation Services*  
Susan Giampetroni, *Philadelphia Safe and Sound*  
Richard Gladstone, *Consultant*  
Raymond Gunn, Ph.D., *University of Pennsylvania,, Center for Health, Achievement, Neighborhood Growth, and Ethnic Studies (CHANGES)*  
Joseph Kuna, Ph.D., *Department of Human Services*  
Marvin Levine, *Department of Behavioral Health and Mental Retardation Services*  
Charlie Lyons, *Consultant*  
David Mandell, Sc.D., *University of Pennsylvania, Center for Mental Health Policy and Services*  
Nina Park, *Department of Behavioral Health and Mental Retardation Services*  
Douglas Sudia, *Philadelphia Safe and Sound*  
Lucia Williams, *Department of Behavioral Health and Mental Retardation Services*

Finally, the work of the Blue Ribbon Commission and the completion of this report would not have been possible without the hard work and dedication of many staff of Dr. Arthur C. Evans, Director of the Department of Behavioral Health and Mental Retardation Services and Cheryl Ransom Garner, Commissioner of the Department of Human Services.

Gloria Barrow	Pamela McClenton
Nicole Beaufort	Anthony McLaughlin
Brenda Bennett	Nyia Morrison
Kelley Berke	Margie Navarro
Chandra Brown	Marilyn Nicolette
Khadijah Brown	Charlene Nixon
Joanne Butler	Darrell Paige
Rod Chandler	Denise Patterson
Andrew Devos	Dorothy Payne
Laura Deriggi	Trena Pugh
Deborah Dorsey	Sonovia Riley-Law
Connie Falcone	Venetta Robinson
Renee Finley	Tracey Scott
Sean Gallagher	Muriel Silva
Shakiera Gillette	Amy Smith
Lazette Gray	Dee Smith
Ervia Guttierrez	Tanya Smith
Carol Handy	Kehinde Solanke
Mary Harper	Delores Thompkins
Jemma Howard	Renee Vessles
Gail Hunter	Jamie Hulsman Williams
Eric Jones	Earnest White
Chad June	LeVan White
Howard Kelly	Peg Wilsbach
Jon Korczkowski	Natalie Williams
Jessica Kushner	Pat Wilson
Jenniema Kusi-Appouh	Dennis Woods
Nancy Lucas	Josephine Wright
Michael Lewis	Anne Zembroski
Murtis Lyghts-June	

Every effort was made to provide complete and accurate credit for all agencies and individuals. We apologize for any errors or omissions.



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