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**GOVERNOR’S BEHAVIORAL HEALTH SERVICES PLANNING COUNCIL**  
**CHILDREN’S SUBCOMMITTEE**

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**PRESENTED TO**

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Wes Cole, Chair  
*Governor’s Behavioral Health Services Planning Council*

Laura Howard, Secretary  
*Kansas Department for Aging and Disability Services*

Laura Kelly, Governor  
*State of Kansas*

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**INTRODUCTION**

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The subcommittee chose three topics this year to focus on: transitional age youth, substance abuse of parents and how it affects their ability to parent, and parent engagement models.

Transitional aged youth are defined as adolescents aged 16 to 20 years of age who struggle with mental health issues. The transition from adolescence to adulthood represents a unique developmental period, with significant changes in educational, vocational and relational roles and expectations in the face of reduced family influence and changing social networks<sup>1</sup>. Of the more than 12,000 children identified as Severely Emotionally Disturbed being served under the Community Mental Health Services project through SAMSHA, about one-third of those children are aged 16 to 20<sup>2</sup>.

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<sup>1</sup> Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *The American Psychologist*, 55(5), 469–480.

<sup>2</sup> “The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances Program”; Report to Congress 2015, SAMSHA [www.samhsa.gov](http://www.samhsa.gov)

According to the High Needs Youth in Foster Care report (2018)<sup>3</sup>, drug abuse by parents is one of six top reasons that children go into foster care. The Subcommittee was interested in ways that we could support parents struggling with substance abuse issues so that children could be maintained in their family therefore avoiding the need for out of home placement.

The Subcommittee spent the previous year studying the issues parents face in engaging in mental health services. This year we focused on models that are effective in engaging parents and the elements essential for good parent engagement practices.

## SUMMARY OF RECOMMENDATIONS

**Goal 1:** Research resources available for parents with substance use disorders, specifically drug use that is affecting the care of their children.

### Recommendations:

1. Increase funding for substance use disorder treatment for parents as well as physical and behavioral health concerns. Expansion of Medicaid would be one effective way to make progress on this recommendation.
2. Increase the availability of flexible treatment options (residential and outpatient) that allow children to stay with and participate in treatment with their parents, which also embrace a holistic and trauma-informed approach to treatment.
3. Provide resources, funding, billing mechanisms for basic health care needs such as housing, job placement, and access to medical care.
4. We support the *Kansas Strong for Children and Families* proposed strategies of interagency collaboration, coaching program and court engagement and innovations. We believe that is an effective plan for engaging parents and supporting them to be successful.

**Goal 2:** Review existing recommendations regarding transition age youth and prioritize those recommendations.

### Recommendations:

1. Provide resources to providers for implementing and sustaining evidence-based practices (EBPs) such as for the required additional training, coaching, and fidelity monitoring. This could be realized through a modified funding mechanism/rate to reimburse for these increased expenses/Evidence Based Practices (i.e. Transitional Age Youth (TAY) Program and Supported Employment)
2. Support services and interventions that are effective such as education, training, and coaching on key topics (Nutrition, Budgeting, Hygiene, Job skills/training, Vocational coaching)
3. Modify policy to allow foster children who opt-out of the system at age 18 to get access to services again when they realize they made a poor decision to opt-out.
  - Provide services/supports to families and youth in navigating and setting up guardianships (which is difficult and costly)
  - Increase recruitment and support of guardians to address the long guardianship waiting list.

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<sup>3</sup> <http://www.dcf.ks.gov/Agency/CWSTF/Pages/default.aspx>

**Goal 3:** Review and recommend parent engagement models across the continuum of care (schools, CMHCs, early childhood programs, etc.).

**Recommendations for the State:**

1. Identify parental feedback surveys already being conducted and identify the top issues from those surveys and share with partners.
2. Support, encourage, and provide resources to early childhood programs in implementing and sustaining the Kansas Family Engagement and Partnership Standards for Early Childhood.
3. Implement and support the implementation of the following policies, procedures, and practices by including in policies, procedures, and/or program requirements:
  - Use federal funds (i.e. ESEA formula grant funds, Title I State administrative funds) to support the implementation of more robust, research-based parent and family engagement practices in school districts.
  - Promote the use of recommended practices and early childhood quality rating and improvement systems that include tiers of measurable and research-informed family engagement indicators.
  - Create new staff positions, or reassigning current staff, to improve the implementation of statewide family engagement strategies and activities (see Recommendation 6 below for a specific example).
  - Provide models of how to define roles and responsibilities for all staff in implementing effective family engagement practices.
  - Provide professional development and/or peer learning opportunities to improve staff capacity to implement effective family engagement practices.
  - Provide valid assessment tools to measure family engagement, and provide training on using results to gauge progress and make needed modifications at the organizational or provider level.
4. Provide adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices.
5. Establishing or enhancing statewide technical assistance on family engagement:
  - This includes enhancing funding for training of parents across the continuum of care.
  - Technical assistance on family engagement may focus on expanding parent leadership and advocacy, enhancing existing professional development opportunities and coaching, or increasing consultation for local staff, (i.e. embed in other training and consultation initiatives).
6. Family engagement specialist: Hire or designate an existing staff member to be responsible for ensuring that family engagement plans are well managed, executed, and improved across the system.
7. Prioritize and invest funding in Evidence-Based Family Therapies:
  - Family disease
  - Family systems
  - CBT models
  - Multidimensional Family Therapy
  - Functional Family Therapy\*
  - Multi-systemic Family Therapy\*
  - Brief, strategic Family Therapy

\* EBP listed on the Family First Prevention Services Act Clearing House

## **Recommendations for Providers:**

1. Develop Family and Professional Relationships linked to Learning, Development, and Wellness:
  - Families and providers track children’s progress together, and share activities that can be done at home and in the classroom.
  - Health and developmental screenings include parental input to better ensure the accuracy of screening results.
  - Encourage families to engage with their children in their home language by providing enriching activities in the program that draw on families’ culture and traditions.
2. Provide Two-Way Communication:
  - Program policies and practices should facilitate two-way communication about children’s development—including cognitive, social-emotional, and physical development, learning, and wellness.
  - Providers should invite families to share their expertise in conversations about their children, and draw on families’ experiences to suggest how families can best support their children’s progress at home and in the program.
  - Providers should be familiar with families’ cultures and home languages and work to ensure to the greatest extent possible that all information shared with families is in their home language, and in the delivery mechanism they prefer.
  - Continuous and proactive communication will help avoid situations in which programs communicate with families only about concerns or problems.
3. Create Family Friendly Environments:
  - Staff should welcome and be responsive to families when they visit.
  - Communication with families should be in language that is easy to understand.
  - Visual and written materials should show the diversity of families, including male and female parents and caregivers, same sex parents, and non-traditional caregivers.
4. Support Family Connections:
  - Local programs should promote family networks and social support by providing facility space and opportunities for parents to get together.
5. Support Families as Decision Makers:
  - Schools and programs should ensure all interested families are prepared to participate in planning, decision-making and oversight groups such as boards, councils, committees or working groups.
  - Families, including adults with limited English proficiency or accessibility needs, should have opportunities to build upon their knowledge as leaders and advocates and engage in a dialogue with programs about the services the programs provide (i.e. leadership training, coaching or mentoring to enhance their leadership and advocacy skills).
6. Make Data about Children’s Progress Accessible and Understandable to Parents:
  - Make data easily accessible to families and support them in interpreting and using their children’s assessment and screening data to promote home and school coordination.
  - Child data should be shared and discussed with families in their preferred language.
  - Help parents understand privacy rights in relation to their child’s records, such as their rights under the Family Educational Rights and Privacy Act, IDEA, HIPAA, etc.

## 2018 - 2019 GOALS AND ACCOMPLISHMENTS

**Goal 1:** Research resources available for parents with substance use disorders, specifically drug use that is affecting the care of their children.

One of the goals of the Children’s Subcommittee this year was to study the issue of parents’ substance abuse disorders and how it affects their ability to care for their children. To inform ourselves about this topic we heard from two therapists from the Johnson County Mental Health Center’s Substance Abuse Treatment program and Sandra Dixon, Director of Behavioral Health Services at DCCCA. We also connected with the Prevention Subcommittee to hear about their work.

What we learned is that many people in substance abuse treatment have already lost custody of their children. Meth usage is the primary drug used in those families. There are many barriers that prevent them from seeking and being able to maintain in treatment. Some of those barriers are: no insurance coverage, transportation to treatment, high degree of homelessness, shortage of workers in the treatment field especially in rural areas, and the stigma attached to seeking treatment for a substance abuse issue. Many of the people seen for substance abuse issues also have a co-occurring diagnosis of anxiety or depression. According to the Kansas Strong collaborative between KU, KDADS, DCF and the foster care contractors, parents with substance abuse issues who have their children removed from custody for that reason are statistically less likely to reunite with their children.

According to the National Institute on Drug Abuse, the principles of effective treatment are:

- Addiction is a complex, but treatable disease
- No single treatment is right for everyone
- People need quick access to treatment
- Effective treatment addresses multiple needs, not just substance use
- Staying in treatment long enough is critical
- Counseling and behavioral therapies are effective

From our work, some of the elements that would aid in addressing this issue are identifying families with substance abuse treatment issues before they lose custody of their children. There are several programs around the state that allow children to attend treatment with their parents. This seems to be a positive model in supporting families staying together. It also seems helpful for programs to be “one-stop shopping” for all substance abuse, behavioral health and social service needs to be addressed in one program or location. It is difficult for families to participate and be successful in treatment if they do not first have their basic needs met such as housing. It is also essential that any program be trained on trauma-informed practices.

### Recommendations (Resources for parents with SUDs):

1. Increase funding for substance use disorder treatment for parents as well as physical and behavioral health concerns. Expansion of Medicaid would be one effective way to make progress on this recommendation.
2. Increase the availability of flexible treatment options (residential and outpatient) that allow children to stay with and participate in treatment with their parents, which also embrace a holistic and trauma-informed approach to treatment.
3. Provide resources, funding, billing mechanisms for basic health care needs such as housing, job placement, and access to medical care.
4. We support the *Kansas Strong for Children and Families* proposed strategies of interagency collaboration, coaching program and court engagement and innovations. We believe that is an effective plan for engaging parents and supporting them to be successful.

**Goal 2: Review existing recommendations regarding transition age youth and prioritize those recommendations.**

Transitional age youth are in a critical developmental stage of life. It is often the time when young people prepare to launch into independence, higher education, or full-time employment, setting the foundation for their future. Those who enter this stage without the support of a financial safety net or family connections are more likely to fall behind and experience poverty as adults. The risks are especially high for youth who age out of the foster care system without a permanent home.<sup>4</sup>

According to the United Community Services of Johnson County (UCS) which is a nonprofit agency that provides data analysis, during the past five years, transitional-age youth (TAY) have consistently experienced the highest rate of poverty in Kansas. In 2016, the poverty rate for Kansans age 18-24 was 25.9%, more than double the poverty rate of the total population (12.1%), according to estimates from the U.S. Census Bureau<sup>5</sup>.

A goal of the Children's Subcommittee this year was to learn more about the struggles that transition aged youth experience, what resources are available and determine and prioritize recommendations for services. To educate our committee we had a program panel of case managers from Family Service Guidance Center (FSGC) who oversees a Transition to Adulthood Program for transition-aged youth 16-22 years old present to our Children's Subcommittee on September 21, 2018.

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<sup>4</sup> United Community Services of Johnson County (UCS), 3/2018, Retrieved from [http://www.dcf.ks.gov/Agency/CWSTF/Documents/Reintegration%20and%20Permanency%20Placement/2018-04-25/2\\_2018-04-25\\_CWSTF\\_WGC\\_Testimony\\_USC.pdf](http://www.dcf.ks.gov/Agency/CWSTF/Documents/Reintegration%20and%20Permanency%20Placement/2018-04-25/2_2018-04-25_CWSTF_WGC_Testimony_USC.pdf)

<sup>5</sup> U.S. Census Bureau, American Community Survey, 2009-2013. Retrieved from <http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>

We learned that what is unique about this population is that many are decision wise, responsible for their care; some are dually diagnosed, some are homeless, and many need a program to educate them to transition to adulthood since they are socially awkward. When these youth in the program turn 18 years old, legally things change. Releases of information changes with the client deciding who gets access. These youth are legally responsible for making their own decisions unless parents are given consent by the youth for guardianship and sharing of information.

Most of the youth served by FSGC did not work in high school due to problems they were working through. Some try to do vocational rehabilitation, but it can be very cumbersome. Some youth believe a job is a rite of passage and struggle to be patient to get the necessary skills to hold down a job.

We also learned that there are barriers to the system for transition aged youth such as:

- Most apartment complexes will not rent to you unless you are 18 years old.
- Health access is limited, for example couch surfing is no longer considered being homeless so the youth will not be eligible for access to health benefits.
- Many jobs are grant funded and come and go.
- TAY is funded through Medicaid
- This is not really designed for Low functioning and spectrum kids
- Transition Aged Youth (TAY) is limited access due to age restrictions up to their early twenties.

Supporting transitional-age foster youth will require a thoughtful and thorough assessment of the system that serves them, followed by strategic actions to ensure that they have the best possible start to life as adults in our community.

#### **Recommendations** (prioritization of existing recommendations for transition age youth):

1. Provide resources to providers for implementing and sustaining evidence-based practices (EBPs) such as for the required additional training, coaching, and fidelity monitoring. This could be realized through a modified funding mechanism/rate to reimburse for these increased expenses/Evidence Based Practices

#### Example Evidence Based Practices:

- Transitional Age Youth (TAY) Program
  - Supported Employment
2. Support services and interventions that are effective such as education, training, and coaching
    - Nutrition
    - Budgeting
    - Hygiene
    - Job skills/training
    - Vocational coaching

3. Modify policy to allow foster children who opt-out of the system at age 18 to get access to services again when they realize they made a poor decision to opt-out.
  - Provide services/supports to families and youth in navigating and setting up guardianships (which is difficult and costly)
  - Increase recruitment and support of guardians to address the long guardianship waiting list.

**Goal 3: Review and recommend parent engagement models across the continuum of care (schools, CMHCs, early childhood programs, etc.).**

One of the goals of the Children’s Subcommittee this year was to research parent engagement across the continuum of care, and make recommendations regarding specific models or trainings for parents and staff. To inform our work on this topic we reviewed several sources of information and invited parents to come and talk to us about the importance of parent engagement. Unfortunately, due to weather and a sick child a few of the parents were unable to come and share with us. However, we did speak with Brooke Klassen, Parent Leader and Trainer with the Kansas Head Start Association and the Reno County Head Start program. She (and her child!) visited our subcommittee to talk to us about the importance of parent engagement.

Ms. Klassen reiterated from her experience and knowledge some of the research the subcommittee had reviewed during the current and previous year. In order for parent engagement efforts to be effective programs must:

- have and provide resources to meet needs and eliminate barriers (baby sitter/child care, food for parents and children, transportation, schedule around work schedules)
- Communicate with parents in a way that *meets them where they are at*. Ms. Klassen mentioned that right now this means that she and her program communicate using Facebook messenger, because that is what the majority of the parents in her program use.

Parent engagement is important because it involves the service recipients in decision making, empowers parents, and overtime involves parents as peers in providing support and services. Parent Engagement is also about informing and getting to see the strengths and the needs of the program. Ms. Klassen also reiterated the power and impact that a peer and peer support can have in conjunction with other services.

Challenges associated with having good parent engagement include:

- getting parents “there,” (eliminating barriers)
- disagreements/getting to consensus. Resources such as providing a skilled, neutral facilitator and training to parents is a good way to address this.

Below is a summary of the research on parent and family engagement that some subcommittee members were able to review. This section is followed by a summary of recommendations for the state and recommendations for providers found in doing our research.



## Parent engagement / Family Engagement Definitions

### *In schools:*

- Parent engagement in schools is:<sup>6</sup>
  - parents and school staff working together to support and improve the learning, development and health of children and adolescents.
  - a shared responsibility in which schools are committed to reaching out to engage parents in meaningful ways, and parents are committed to actively supporting their children's and adolescents' learning and development.
- The distinction between involvement and engagement is important. A definition of involve is "to enfold or envelope;" conversely, engage can be defined as "to come together and interlock." Thus, involvement implies doing to, whereas engagement implies doing with. Moreover, the term parent engagement indicates a shared and continuous responsibility for student achievement and learning that occurs across multiple settings.<sup>7</sup>
- No Child Left Behind (NCLB) - Legal definition
  - "(32) PARENTAL INVOLVEMENT.—The term 'parental involvement' means the participation of parents in regular, two-way, and meaningful communication involving student academic learning and other school activities, including ensuring:
    - "(A) that parents play an integral role in assisting their child's learning.
    - "(B) that parents are encouraged to be actively involved in their child's education at school.
    - "(C) that parents are full partners in their child's education and are included, as appropriate, in decision making and on advisory committees to assist in the education of their child.
    - "(D) the carrying out of other activities, such as those described in section 1118."

### *In Head Start/Early Head Start:*<sup>8</sup>

- Parent and family engagement in Head Start/Early Head Start (HS/EHS) is about building relationships with families that support family well-being, strong relationships between parents and their children, and ongoing learning and development for both parents and children.
- Parent and family engagement activities are grounded in positive, ongoing, and goal-oriented relationships with families.

### *Schools & Early Childhood Programs*<sup>9</sup>

- Family engagement refers to the systematic inclusion of families in activities and programs that promote children's development, learning, and wellness, including in the planning, development, and evaluation of such activities, programs, and systems.

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<sup>6</sup> Centers for Disease Control and Prevention. (2012). Parent Engagement: Strategies for Involving Parents in School Health. Atlanta: U.S. Department of Health and Human Services.

<sup>7</sup> Michigan Department of Education (2011). Collaborating for Success: Parent Engagement Toolkit.

<sup>8</sup> Head Start Resource Center. (2011). The Head Start Parent, Family, and Community Engagement Framework: Promoting Family Engagement and School Readiness, From Prenatal to Age 8.

<sup>9</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

- Engage families as essential partners when providing services that promote children’s learning and development.
- Providers are culturally and linguistically responsive to the families they serve.

### Models of Parent Engagement

*Epstein’s 6 Types:*<sup>10</sup>

- |                                  |  |
|----------------------------------|--|
| 1. Parenting:                    | Help all families establish home environments to support children as students.   |
| 2. Communicating:                | Design effective forms of school-to-home and home-to-school communications about school programs and children's progress.                                    |
| 3. Volunteering:                 | Recruit and organize parent help and support   |
| 4. Learning at Home:             | Provide information and ideas to families about how to help students at home with homework and other curriculum-related activities, decisions, and planning. |
| 5. Decision Making:              | Include parents in school decisions, developing parent leaders and representatives.  |
| 6. Collaborating with Community: | Identify and integrate resources and services from the community to strengthen school programs, family practices, and student learning and development.      |

### Three-Tiered Approach to Family Engagement in School-Based Behavioral Health<sup>11</sup>

- Tier 3: Engaging caregivers in addressing identified mental and behavioral health problems (e.g. counseling intake, conversations around care coordination)
- Tier 2: Engaging caregivers in addressing emerging mental and behavioral health problems (e.g. parent groups, parent interaction around student groups)
- Tier 1: Engaging caregivers in addressing prevention of behavioral health concerns (e.g. Family night events, substance abuse parent workshops)

### Impact of Parent Engagement:

- Engagement is essential for optimal service delivery and in achieving clinical outcomes.<sup>12</sup>
- The ability to successfully engage members of a child’s social environment is critically important for the effectiveness of any treatment. Effective interventions must include treatment engagement approaches.<sup>13</sup>

<sup>10</sup> Joyce L. Epstein, Ph.D., et. al., Partnership Center for the Social Organization of Schools

<sup>11</sup> Boston Children’s Hospital & Harvard Medical School Teaching Hospital. (2015). A Three-Tiered Approach to Family Engagement in School-Based Behavioral Health

<sup>12</sup> McKay, M. M., & Bannon, W. B. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America*, 13, 905-921.

<sup>13</sup> Saxe, G. N., Ellis, B. H. Fogler, J., & Navalta, C. P. (2012). Innovation in practice: preliminary evidence for effective family engagement in treatment for child traumatic stress-trauma systems therapy approach to preventing dropout. *Child and Adolescent Mental Health*, 17(1), 58-61.

- Engaging and retaining families in mental health prevention and intervention programs is critically important to ensure maximum public health impact.<sup>14</sup>
- Over 50 years of research links the various roles that families play in a child’s education—as supporters of learning, encouragers of grit and determination, models of lifelong learning, and advocates of proper programming and placements for their child.<sup>15</sup>
- Parent engagement in schools can promote positive education and health behaviors among children and adolescents. Research shows a strong relationship between parent engagement and educational outcomes, including school attendance<sup>16</sup> and higher grades and classroom test scores.<sup>17</sup>
- Parent engagement in schools has been identified as promising protective factors for adolescent sexual and reproductive health risk behaviors and outcomes, including ever had sex, early sexual debut, frequency of sex and pregnancy/birth.<sup>18, 19</sup>
- When parent and family engagement activities are systemic and integrated across program foundations and program impact areas, family engagement outcomes are achieved, resulting in children who are healthy and ready for school.<sup>20</sup>
- Families feel welcomed, valued, and respected by program staff.<sup>21</sup>
- Families are engaged as equal partners in their children’s learning and development.<sup>22</sup>
- When students find their school environment to be supportive and caring and their parents engaged in their school lives, they are less likely to become involved in substance abuse, violence, and other problem behaviors<sup>23, 24</sup> that are associated with HIV and STD risk.<sup>25, 26</sup>

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<sup>14</sup> Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal of Child and Family Studies*, 19, 629-645.

<sup>15</sup> SEDL. (2013). *Partners in Education: A Dual Capacity-Building Framework for Family-School Partnerships*.

<sup>16</sup> Epstein J, Sheldon S. Present and accounted for: improving student attendance through family and community involvement. *The Journal of Educational Research* 2002;95(5):308–318

<sup>17</sup> Fan X, Chen M. Parental involvement and students' academic achievement: a meta-analysis. *Educational Psychology Review* 2001;13(1):1–22

<sup>18</sup> Guilamo-Ramos V, Jaccard J, Dittus P, Bouris A, Gonzalez B, Casillas E, et al. A comparative study of interventions for delaying the initiation of sexual intercourse among Latino and Black Youth. *Perspectives on Sexual and Reproductive Health* 2011;43(4):247–254.

<sup>19</sup> Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association* 1997;278(10):823–832.

<sup>20</sup> Head Start Resource Center. (2011). *The Head Start Parent, Family, and Community Engagement Framework: Promoting Family Engagement and School Readiness, From Prenatal to Age 8*.

<sup>21</sup> Head Start Resource Center. (2011). *The Head Start Parent, Family, and Community Engagement Framework: Promoting Family Engagement and School Readiness, From Prenatal to Age 8*.

<sup>22</sup> Head Start Resource Center. (2011). *The Head Start Parent, Family, and Community Engagement Framework: Promoting Family Engagement and School Readiness, From Prenatal to Age 8*.

<sup>23</sup> Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association* 1997;278(10):823–832.

<sup>24</sup> Hawkins JD, Catalano RF, Kosterman R, Abbott R, Hill KG. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine* 1999;153:226–234.

<sup>25</sup> Van Tieu H, Koblin BA. HIV, alcohol, and noninjection drug use. *Current Opinion in HIV/AIDS* 2009;4(4):314–318.

<sup>26</sup> Maman S, Campbell J, Sweat MD, Gielen AC. The intersections of HIV and violence: directions for future research and interventions. *Social Science and Medicine* 2000;50(4):459–478.

- Studies indicate that nurturing, responsive, and sensitive parenting promotes social-emotional competence and academic success.<sup>27</sup>
- Positive relationships between families and providers reinforce learning at home and in the community.<sup>28</sup>
- In Therapy: decreased disruptive behaviors; increased caregiver self-efficacy, shorter treatments; longer-term positive outcomes.<sup>29, 30</sup>
- In Academics: increased parent self-efficacy; increased parent comfort in participating in their child’s education; improved test scores.<sup>31, 32</sup>

**Requirements:**

The Elementary and Secondary Education Act (ESEA)<sup>33</sup> amended by the Every Student Succeeds Act (ESSA) requires that states and school districts engage parents and families in ensuring positive outcomes for all students. School districts that receive Title I funds are required to have written parent and family engagement policies with expectations and objectives for implementing meaningful parent and family involvement strategies. They are required to involve parents and family members in jointly developing district plans and to provide technical assistance to schools on planning and implementing effective parent and family involvement activities to improve student academic achievement and school performance.

Specific and concrete family engagement efforts should be incorporated into:

- State Advisory Councils on Early Childhood Education and Care State plans;
- Child Care and Development Fund State plans;
- IDEA Part C and Part B policies and procedures;
- Head Start State Collaboration Office strategic plans;
- ESEA Title I district parent and family engagement policies;
- State preschool expansion plans, including Preschool Development Grant plans;
- TANF (Temporary Assistance for Family Assistance) State plans;
- Maternal and Child Health Title V State Action plans; and
- Other State plans as appropriate.

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<sup>27</sup> Thompson, R. (2008). Early attachment and later development: Familiar questions, new answers. In J. Cassidy, & P. R. Shaver (Eds.), *Handbook of attachment* (2nd ed., pp. 348-365). New York: Guilford.

<sup>28</sup> Understanding Family Engagement Outcomes: Family Connections to Peers and Community. (2014). National Center for Parent, Family and Community Engagement. Retrieved at <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/docs/rtp-family-connections.pdf>.

<sup>29</sup> Herman, K.C., Borden, L.A., Hsu, C., Schultz, T.R., Carney, M.S., Brooks, C.M., Reinke, W.M. (2011). Enhancing family engagement in interventions for mental health problems in youth. *Residential Treatment for Children & Youth*, 28(2), 102-119.

<sup>30</sup> Lowie, J. A., Lever, N. A., Ambrose, M. G., Tager, S. B., & Hill, S. (2003). Partnering with families in expanded school mental health programs. In M. D. Weist, S. W. Evans, N. A. Lever (Eds.) *Handbook of School Mental Health: Advancing Practice and Research*, pp. 135-147. Kluwer Academic/Plenum Publishers: New York, NY.

<sup>31</sup> Smith, J., Wohlstetter, P., Kuzin, C.A., & DePedro, K. (2011). Parental involvement in urban charter schools: New strategies for increasing participation. *The School Community Journal*, 21(1), 71-94.

<sup>32</sup> Alamada-Lawson, T. (2014). A pilot study of collective parent engagement and children’s academic achievement. *Children & Schools*, 36(4), 199-209.

<sup>33</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

**Barriers:**<sup>34</sup>

- Treatment Relevance / Acceptability
- Daily Stresses
- Therapeutic Alliance
- External Barrier to treatment
- Cognitions and beliefs about treatment

**Methods:**

- empathic communication
- Using strengths-based language
- providing practical resources
- addressing parent's needs
- flexible communication
- initially using a mutual connection<sup>35</sup>
- Appointment reminders<sup>36</sup>
- Parent trainings<sup>37</sup>
- Motivational interviewing
- Building therapeutic alliance
- Increased training for intake interviewers talking with parents
- Home visits
- Frequent, personal calls
- Involve families early in the treatment process<sup>38</sup>
- School-Wide Events, parent workshops, impromptu encounters ("Tier 1")
- Non face-to-face encounters, parent workshops ("Tier 2")
- Team meetings, parent meetings ("Tier 3")
- Parent-as-Consultee Support: Clinician consults with parents around self-care & skill-building, and provides emotional support.
- Provision of Needed Resources: Engaging the school community in providing resources to families.
- Relationship-Building through Empathic Communication: Clinician supports the family and their connection to the school by navigating difficult conversations with parents.

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<sup>34</sup> Boston Children's Hospital & Harvard Medical School Teaching Hospital. (2015). A Three-Tiered Approach to Family Engagement in School-Based Behavioral Health

<sup>35</sup> Boston Children's Hospital & Harvard Medical School Teaching Hospital. (2015). A Three-Tiered Approach to Family Engagement in School-Based Behavioral Health

<sup>36</sup>Bickham, N.L., Pizarro, J., Warner, B.S., Rosenthal, B., & Weist, M.D. (1998). Family involvement in expanded school mental health. *Journal of School Health*, 68(10), 425-428.

Ingoldsby, E.M. (2010). Review of interventions to improve family engagement and retention of parent and child mental health programs. *Journal of Child and Family Studies*, 19(5), 629-645.

McKay, M.M. & Bannon, W.M. (2004). Engaging families in child mental health services. *Child Adolesc Psychiatric Clin N Am*, 13, 905-921.

<sup>37</sup>Bickham et al., 1998; Ingoldsby, 2010; McKay & Bannon, 2004

<sup>38</sup>Bickham et al., 1998; Ingoldsby, 2010; McKay & Bannon, 2004

- Scaffolding: Clinician helps empower families to advocate for their child’s needs, sometimes through in-vivo coaching.
- Normalized & Strengths-Based Language: Highlighting students strengths, highlighting benefits of support, framing proposed intervention as an opportunity to maximize student’s potential, avoiding objectifying language.
- Flexibility in Communication: Alternative forms/ time of communication, e.g. emailing, after-hours
- A Mutual Connection: Having a trusted teacher or staff member do the initial introductions<sup>39</sup>
- Strategies for Clinicians:<sup>40</sup>
  - Create family philosophy of care
  - Understand their experiences
  - Help family engage SUD member
  - Outreach to connect with family
    - Invite members to evaluation and ongoing session(s)
    - Call them directly (inform client and get permission)
    - Join with family; let them know you “need” their help with patient
  - Therapist is “part” of the team (respect if family says ‘no’)
  - Outreach if need to connect with family
  - Do not label family as resistant or co-dependent!
  - Be patient, flexible, accessible
  - Provide education and support
  - Explore experiences, concerns, & questions
  - Deal with challenges facing families: emotional burden, enabling, motivation, adherence, relapse
  - Facilitate individual assessments if needed
  - Help parents focus on their children

### Recommendations for the State:

1. That the state identify surveys that are already being conducted that include parent feedback and identify the top issues from those surveys and share with partners.
2. Support, encourage, and provide resources to early childhood programs in implementing and sustaining the Kansas Family Engagement and Partnership Standards for Early Childhood.<sup>41</sup>
3. Examples of policies, procedures, and practices that States could support by including in policies, procedures, and/or program requirements:<sup>42</sup>

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<sup>39</sup> Boston Children’s Hospital & Harvard Medical School Teaching Hospital. (2015). A Three-Tiered Approach to Family Engagement in School-Based Behavioral Health

<sup>40</sup> CTN Training, National Institute on Drug Abuse (2015). Family Involvement in Substance Use Disorder and Mental Health Treatment and Research.

<sup>41</sup> <https://ksdetasn.org/resources/424>, <http://kskits.org/kansas-family-engagement-partnership-standards-early-childhood>

<sup>42</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

- Using Federal funds such as State-level ESEA formula grant funds (e.g., Title I State administrative funds) to support the implementation of more robust, research-based parent and family engagement practices in school districts.
  - Promoting the use of recommended practices and early childhood quality rating and improvement systems that include tiers of measurable and research-informed family engagement indicators.
  - Creating new staff positions, or reassigning current staff, to improve the implementation of statewide family engagement strategies and activities.
  - Providing models of how to define roles and responsibilities for all staff (including administrators, providers, and administrative support and custodial staff) in implementing effective family engagement practices.
  - Providing professional development and/or peer learning opportunities to improve staff capacity to implement effective family engagement practices.
  - Providing valid assessment tools to measure family engagement, and providing training on using results to gauge progress and make needed modifications at the organizational or provider level.
4. Providing adequate workforce compensation and reimbursement rates for time spent planning and implementing family engagement practices. Such support should be based on local needs, priorities, and goals determined at the program and school levels, in partnership with families.
  5. Establishing or enhancing statewide technical assistance on family engagement:
    - This includes enhancing funding for training of parents across the continuum of care.
    - Technical assistance on family engagement may focus on expanding parent leadership and advocacy, enhancing existing professional development opportunities and coaching, or increasing consultation for local staff, e.g., embedding family engagement in other training and consultation initiatives.
  6. Family engagement specialist:
    - a. Hire or designate an existing staff member to be responsible for ensuring that family engagement plans are well managed, executed, and improved across the system.
  7. Prioritize and invest funding in Evidence-Based Family Therapies<sup>43</sup>:
    - Family disease
    - Family systems
    - CBT models
    - Multidimensional Family Therapy
    - Functional Family Therapy\*
    - Multi-systemic Family Therapy\*
    - Brief, strategic Family Therapy

\* EBP listed on the Family First Prevention Services Act Clearing House<sup>44</sup>

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<sup>43</sup> CTN Training, National Institute on Drug Abuse (2015). Family Involvement in Substance Use Disorder and Mental Health Treatment and Research.

<sup>44</sup> Title IV-E Prevention Services CLEARINGHOUSE: <https://preventionservices.abtsites.com/>

## Recommendations for Providers:

7. Develop Family and Professional Relationships Linked to Learning, Development, and Wellness:<sup>45</sup>
  - Families and providers should track children’s progress together, and share activities that can be done at home and in the classroom.
  - Health and developmental screenings should include parental input to better ensure the accuracy of screening results.
  - Professionals can encourage families to engage with their children in their home language by providing enriching activities in the program that draw on families’ culture and traditions.
8. Provide Two-Way Communication:<sup>46</sup>
  - Program policies and practices should facilitate two-way communication about children’s development—including cognitive, social-emotional, and physical development, learning, and wellness.
  - Providers should invite families to share their expertise in conversations about their children, and draw on families’ experiences to suggest how families can best support their children’s progress at home and in the program. Providers should be able to communicate as directly as possible with all families, including families that speak languages other than English, finding interpreting services to facilitate communication between the provider and family as needed.
  - Providers should be familiar with families’ cultures and home languages and work to ensure to the greatest extent possible that all information shared with families is in their home language, and in the delivery mechanism they prefer (e.g. phone, in person, text).
  - Continuous and proactive communication will help avoid situations in which programs communicate with families only about concerns or problems.<sup>47</sup>
9. Create Family Friendly Environments:<sup>48</sup>
  - Staff should welcome and be responsive to families when they visit.
  - Communication with families should be in language that is easy to understand.
  - Visual and written materials (e.g., bulletin boards, posters, newsletters, invitations to events, among others) should show the diversity of families, including male and female parents and caregivers, same sex parents, and non-traditional caregivers.

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<sup>45</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

<sup>46</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

<sup>47</sup> Ross, T. (2016). The differential effects of parental involvement on high school completion and postsecondary attendance. Education Policy Analysis Archives, 24(30). <http://dx.doi.org/10.14507/epaa.v24.2030>.

<sup>48</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.



#### 10. Support Family Connections: <sup>49</sup>

- Local programs should promote family networks and social support by providing facility space and opportunities for parents to get together.

#### 11. Support Families as Decision Makers: <sup>50</sup>

- Schools and programs should establish policies that ensure all interested families are prepared to participate in planning, decision-making and oversight groups such as boards, councils, committees or working groups.
- Families, including adults with limited English proficiency or accessibility needs, should have opportunities to build upon their knowledge as leaders and advocates and engage in a dialogue with programs about the services the programs provide. For example, schools and programs could offer opportunities for families to receive leadership training, coaching or mentoring to enhance their leadership and advocacy skills.

#### 12. Make Data about Children’s Progress Accessible and Understandable to Parents: <sup>51</sup>

- To the extent permissible under applicable privacy laws, make all data easily accessible to families and support them, individually or in peer groups, in interpreting and using their children’s assessment and screening data to promote home and school coordination that supports children’s optimal learning and development.
- Child data should be shared and discussed with families in their preferred language.
- Programs that are subject to privacy laws should help parents understand their privacy rights in relation to their child’s records, such as their rights under the Family Educational Rights and Privacy Act (FERPA), IDEA, and State privacy laws, where applicable.

### **2019-2020 Goals**

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- Goal 1: Identify strategies of prevention that will help maintain children with their families.
- Goal 2: Identify barriers for caregivers and other support services and recommend solutions for better communication and coordination of resources (map out services, and/or resource database).
- Goal 3: Research the negative effects of online content and technology and how it impacts children’s behavioral health and make recommendations.

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<sup>49</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

<sup>50</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

<sup>51</sup> U.S. Dept of Health and Human Services & U.S. Dept of Education. (May 5, 2016). Joint Policy Statement on Family Engagement from the Early Years to the Early Grades.

**GBHSPC  
CHILDREN'S SUBCOMMITTEE  
CHARTER**

<b>GBHSPC SUBCOMMITTEE CHARTER</b>	
<b>Subcommittee Name:</b>	Governor's Behavioral Health Services Planning Council Children's Subcommittee
<b>Context:</b>	The Children's Subcommittee generates recommendations for the GBHSPC regarding the behavioral health system of Kansas as it relates to Kansas children and their families. The GBHSPC reviews not just this subcommittee's recommendations but other existing subcommittees and presents all Behavioral health recommendations to the Secretary of KDADS and the governor. It is acknowledged that although the priority focus of the GBHSPC are the SPMI and SED target populations (Federal Law 102-3210, the work of the subcommittee is to be conducted with the whole system and all Kansas citizens with behavioral health needs in mind
<b>Purpose:</b>	The Children's Subcommittee is devoted to the behavioral health needs of children and their families. The subcommittee examines and makes recommendations to improve the array of behavioral health services offered to children and their families through Kansas Community Mental Health Center (CMHC), substance use treatment providers other children service systems and collaboration between systems of care such as Psychiatric Residential Treatment Facilities (PRTF), hospitals, juvenile justice services and schools. We: <ul style="list-style-type: none"> <li>• Identify strengths and needs.</li> <li>• Make informed recommendations.</li> <li>• Use subcommittee member networks to address identified needs and influence change.</li> </ul>
<b>Vision:</b>	That all Kansas children and their families will have access to essential, high-quality behavioral health services that are strengths-based, developmentally appropriate, and culturally competent.
<b>Mission:</b>	To promote interconnected systems of care that provide an integrated continuum of person and family centered services, reflective of the Children's Subcommittees Vision and Values: <ul style="list-style-type: none"> <li>• <u>Interconnected Systems</u>: The integration of Positive Behavioral Interventions and Supports (PBIS) and School Mental Health within school systems to blend resources, training, systems, sate, and practices in order to improve outcomes for all children and youth.</li> <li>• <u>Systems of Care</u>: A spectrum of effective community based services and supports that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to enhance</li> </ul>

	<p>functioning at home, in school, in the community and throughout life.</p> <ul style="list-style-type: none"> <li>• <b><u>Integrated Services:</u></b> Integrating mental health, substance abuse and primary care services produces the best outcome and proves the most effective approach to caring for people with multiple needs.</li> <li>• <b><u>Continuum of Care:</u></b> <ul style="list-style-type: none"> <li>✓ Across the Lifespan – From birth to age 22</li> <li>✓ Across levels of Intensity – Preventative (Tier 1), target (Tier 2), Intensive (Tier 3).</li> </ul> </li> <li>• <b><u>Person &amp; Family Center Planning:</u></b> A collaborative process where care recipients participate in the development of treatment goals and services provided, to the greatest extent possible. Person and family-centered treatment planning is care planning that is strength-based and focuses on individual capacities preferences, and goals. Individuals and families are core participants in the development of the plans and goals of treatment.</li> </ul>
<p>Values:</p>	<p>The Children’s Subcommittee will use the following Values to guide their purpose:</p> <ul style="list-style-type: none"> <li>• Use data from multiple sources to ensure an accurate picture of the target population.</li> <li>• Promote person and family-centered planning.</li> <li>• Ensure all recommendations are supported by evidence.</li> <li>• Maintain collaborative and inclusive networks.</li> <li>• Listen and respect the voices of those we serve.</li> </ul>

**Governor's Behavioral Health Services Planning Council**  
**Subcommittee for Children's Mental Health**  
**Members**  
**July 20, 2018**

- ◆ Nancy Crago, LSCSW, Chair, *Director of Psychosocial Rehabilitation, Family Service and Guidance Center*
- ◆ Erick Vaughn, LMSW, Vice Chair, *Director of Strategic Initiatives, DCCCA, Inc.*
- ◆ Robert (Bobby) Eklofe, MHSA, Secretary, *Vice President of Behavioral Health Operations, KVC Hospitals, Inc.*
- ◆ Cherie Blanchat, LSCSW, Past Chair *Project Coordinator, TASN ATBS School Mental Health Initiative*
- ◆ Candace Moten, LMSW - *Family Preservation Services Program Manager, Kansas Department for Children and Families*
- ◆ Jeff Butrick, *Service Manager, Kansas Department of Corrections-Juvenile Services*
- ◆ Kevin Kufeldt, LCPC, *Program Manager, ACT Residential Treatment, Johnson County Mental Health*
- ◆ Cheryl Rathbun, *Chief Clinical Officer, Saint Francis Community Services*
- ◆ Chelle Kemper, Secretary, *Special Education Director*
- ◆ Jacob Box, *Parent Representative, Governor's Behavioral Health Services Planning Council Liaison*
- ◆ Gary Henault, KDADS Liaison, *Kansas Department for Aging and Disabilities Services, Children's Program Manager*
- ◆ Myron Melton, *Education Consultant, Special Education and Title Services Team, Kansas*
- ◆ Charlie Bartlett, KDADS Liaison, *Kansas Department for Aging and Disabilities Services, Special Projects*
- ◆ Julie Ward, LSCSW, *Topeka Public Schools, Department of School Social Work*
- ◆ Marci Ramsay, LSCSW, RPT, *Douglas County Child Development Association*
- ◆ Rich Harrison, *Behavior Consultant, Project Stay*
- ◆ Sherri Luthe, *Parent Representative*
- ◆ Vicki Vossler, *Special Education Administrator, Blue Valley Schools*