PUTTING THE PIECES TOGETHER
A Toolkit on Developing Early Childhood Systems of Care
Acknowledgements

As editors of this publication, we want to express our sincere appreciation to all of the early childhood system of care communities for sharing their knowledge and experience throughout the pages of this toolkit. It is because of their efforts and insights that this publication came to fruition. We also want to thank those who reviewed draft copies of the toolkit and provided additional ideas and resources, including a number of Technical Assistance Providers from the Technical Assistance Partnership (TAP), System of Care program partners, and colleagues at the National Technical Assistance Center for Children’s Mental Health (NTAC). A special note of gratitude is due to Sandy Keenan, Early Childhood & Education Content Specialist at TAP and Marisa Irvine, Policy Associate at NTAC, for their support and contributions as this project moved to completion. Finally, we are grateful to Dr. Gary Blau and the SAMHSA/CMHS Branch for fostering an environment of innovation and opportunity around early childhood mental health.

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ABOUT THIS TOOLKIT

Thank you for focusing your system-building efforts on the mental health of young children and their families! As you know, intervening early to promote positive mental health, prevent mental health challenges, and address mental health problems leads to the best possible outcomes. Hopefully, this Toolkit will provide valuable assistance in helping you to succeed in this important endeavor.

Although this Toolkit was developed for and in close collaboration with communities funded through the Comprehensive Community Mental Health Services for Children and Their Families Program (i.e., early childhood system of care communities), the content is applicable to a much broader audience. While not official grant implementation guidance, it is an impressive repository of information for any community striving for systems change around infant and early childhood mental health.

This Toolkit is designed with several goals in mind:

• to serve as a ‘navigational guide’ to key resources, so that readers can easily find information and materials organized by topic area;
• to highlight common challenges faced by early childhood system of care communities and methods for addressing those challenges (see Early Childhood Systems of Care: Lessons from the Field);
• to provide detailed summaries of successful strategies implemented by local early childhood system of care communities, to spark creativity and help readers avoid “reinventing the wheel;”
• to share tips and lessons learned from early childhood system of care communities based on their local system-building efforts; and
• to link readers to national technical assistance providers with expertise in a variety of content areas that support systems development.

Each Toolkit chapter includes the following components:

• An Introduction that describes and sets the context for the topic area
• Questions to Consider, which poses a series of questions and issues for communities to consider as they work to address the topic area strategically and effectively
• Lessons from the Field, which provides recommendations and learnings from early childhood system of care communities
• **Strategy Examples**, which describe notable efforts by early childhood system of care communities in the given topic area

• **Resource Materials**, which reflect a compilation of recommended resources from early childhood system of care grantee communities and national technical assistance providers

• **Key Contact and Websites**, which identify leading websites and national technical assistance providers relevant to the topic area

In addition to the core Toolkit chapters on individual system-building elements, there is an overview section—Building Early Childhood Systems of Care—that provides an organizing framework for overall system development. It is recommended that Readers start with this section, and then navigate to individual topic areas as needed, as the planning and implementation for system-building efforts move forward.

Finally, it is important to note that the Toolkit is not a static resource. In fact, it is specifically designed to evolve over time as new information becomes available. Current and future early childhood system of care communities are encouraged to continue contributing to the Toolkit and to share their successes and lessons learned so that others may benefit from their innovation and experiences (see Appendix for guidance on submitting new Toolkit content).

So with that…enjoy exploring the Toolkit, be inspired and good luck!

**MEET THE EARLY CHILDHOOD SYSTEM OF CARE COMMUNITIES AND EARLY CHILDHOOD TECHNICAL ASSISTANCE TEAM**

**The Early Childhood System of Care Communities**

Since the SAMHSA awarded the first early childhood system of care cooperative agreement to the state of Vermont in the fall of 1997, the number of early childhood grantees has ballooned. As of 2011, seventeen communities with a sole focus on young children were current or former system of care grantees. These communities include (grouped by cohort):

- **FY1998**
  - Vermont

- **FY2003**
  - Denver, Colorado

- **FY2006**
  - Allegheny County, PA
  - Los Angeles County, CA (1)
  - Multnomah County, OR
  - Rhode Island
  - Sarasota, FL
  - Southeastern Connecticut

- **FY2009**
  - Alamance County, NC
  - Delaware
  - Fort Worth, TX
  - Kentucky

- **FY2010**
  - Alameda County, CA
  - Guam
  - Boston, MA

- **FY2011**
  - Tennessee
  - Los Angeles County, CA (2)
Networking Among Early Childhood System of Care Communities

To help facilitate peer networking and cross-community learning, the Early Childhood Technical Assistance Team (see below), in collaboration with the grantee communities, has assembled a number of resources. These include:

1. A roster of the early childhood system of care communities.
2. Individual community profiles that describe how grantee communities’ have designed their local system of care initiative.
3. A map that shows placement of early childhood system of care communities across the U.S. states and territories.

These items, along with other resources, are available at:
http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

In addition, the Technical Assistance Partnership hosts an Early Childhood Listserv for the grantee communities. The Listserv is one of the primary vehicles for sharing and soliciting information and resources among the early childhood grantee communities. To sign up, navigate to the Early Childhood Community of Practice tab on the Technical Assistance Partnership’s website (www.tapartnership.org/COP/earlyChildhood/default.php) and visit the “Get Connected” section.

The Early Childhood Technical Assistance Team

With a cooperative agreement award, grantees gain access to a host of individuals and organizations with expertise in various areas of grant implementation (e.g., family and youth involvement, evaluation, social marketing, etc.). Early childhood system of care communities also gain access to a team with content expertise in various facets of early childhood—ranging from policy and systems development to clinical and practice-based issues. Technical Assistance Providers are available to provide individual or group consultation—typically via phone, email or webinar formats, although on-site technical assistance is also available as needs arise and scheduling allows.

The Early Childhood Technical Assistance Team is comprised of:
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Technical Assistance Partnership
INTRODUCTION

As anyone who has ever been involved in developing early childhood systems of care (EC SOC) will tell you, it is a complex and slow-moving process. A strong, sustainable early childhood system of care is best achieved when integrating mental health services and supports into existing systems that serve infants, young children and their families. As such, it requires partnering with multiple stakeholders and uniting them to action around a common vision of early childhood mental health services and supports that are child-centered, family-focused, community based, culturally competent and comprehensive (i.e., focus on promotion, prevention and intervention). While the end goal is the same across grantees, the pathways through which states and communities achieve this vision are based on local context (e.g., who are your champions? what funding streams are available? what collaborative efforts already exist? what services and supports already exist?). Thus, proven yet flexible guidance and strategies are needed.

To help states and communities navigate this journey, this section highlights key national resources as well as overarching recommendations and lessons learned from current and previous EC SOC grantees regarding systems development. It also offers an organizing framework that illustrates the critical system elements that need to be in place for a strong, sustainable early childhood system of care. These elements are further discussed throughout individual chapters in this Toolkit. At the end of this section, readers will find an updated version of Early Childhood Systems of Care: Lessons from the Field, which highlights challenges inherent in building early childhood systems of care and offers guidance from seasoned grantees on how to address these challenges. As with the original 2006 version, this document is a valuable resource for 1) strategic planning around common hurdles; and 2) communicating to audiences unfamiliar with the unique issues associated with building systems of care for this population.

A SYSTEMS FRAMEWORK FOR EARLY CHILDHOOD MENTAL HEALTH

The following diagram provides an organizing framework for early childhood systems development (visit http://gucchd.georgetown.edu/67639.html to download a full-scale version). It illustrates the interdependence and complexity of an early childhood system of care, the need for multiple stakeholders and partners, and the building blocks that provide a foundation for services and supports. It also suggests that early childhood system of care communities should look closely for opportunities to build upon existing collaborative efforts with providers in environments where young children and families are already served (e.g., primary care offices, early care and education settings). Early childhood mental
health agencies and service providers are often unfamiliar partners who may not have worked closely together previously, yet each offer specific skills, expertise, and access to services and environments that, when combined, can lead to a strong, responsive, and sustainable system.

In addition, the diagram also seeks to convey that a system for early childhood mental health should...

- Concurrently attend to promotion of positive mental health (including fostering resiliency factors), prevention of mental health challenges, and intervention for mental health problems.
- Focus on services and supports for young children as well as their caregivers (e.g., family members, child care providers, etc.), given the interconnectedness of young children’s mental health and their relationships with those who care for them.
- Build upon and expand system of care values and principles to include an emphasis on developing services and supports that are grounded in developmental knowledge, multidisciplinary, and infused into natural settings and existing services for young children, their families and caregivers.

Hopefully, communities will find this organizing framework helpful in facilitating system planning and implementation efforts. This Toolkit is in close alignment with the diagram, and Readers can navigate to specific chapters addressing the elements identified above.
QUESTIONS TO CONSIDER

The following list of questions is designed to help your community as it embarks on its system-building efforts. This list is available in a printer-friendly format so that it may be used separately as a meeting handout. Prompt questions related to specific system elements are outlined later in this Toolkit, organized by subject matter.

Vision, Values, and Guidelines

• Has your community developed a common vision and set of values and/or guidelines for early childhood mental health? To what extent do these reflect 1) system of care values and principles? 2) a holistic view of early childhood mental health that includes promotion, prevention and intervention? 3) a dual focus on young children and their caregivers?
• Who was (or will be) involved in the “visioning” process? Do these individuals reflect your community’s key system-building partners and constituents?

Strategic Planning

• Are there formal or informal planning processes in your community related to early childhood mental health? What is the focus of the initiative(s), which agencies and partners are participating, and which is the “lead agency” for the initiative(s), if appropriate?
• To what extent are you part of these planning processes? If you are not involved at the desired level, how might you gain access to these efforts, either directly or indirectly?

Supportive Policies and Procedures

• What, if any, key legislative or policy initiatives existed prior to your state’s early childhood mental health planning?
• What policy or procedural changes are needed to help facilitate systems development in your community (e.g., developing a crosswalk from DC:0-3R to ICD-9CM? pursuing legislation on serving children with multiple risk indicators? pursuing changes in Medicaid reimbursement?)

LESSONS FROM THE FIELD

In March 2006, Kaufmann, Horen and Perry issued Early Childhood Systems of Care: Lessons from the Field to illuminate the unique challenges inherent in developing early childhood systems of care. Much has happened since the original Lessons from the Field document was issued, leading to an updating of the original document in June 2011. The latest edition revisits the system-building challenges faced by early childhood system of care grantees and offers guidance on how to address these issues based on lessons learned from the grantee community.

The full, updated version is available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

RESOURCE MATERIALS

• A Systems Framework for Early Childhood Mental Health (diagram). Available at: http://gucchd.georgetown.edu/67639.html


**KEY CONTACTS AND WEBSITES**

**Websites**

- Georgetown University Center for Child and Human Development: [http://gucchd.georgetown.edu](http://gucchd.georgetown.edu)

- Technical Assistance Partnership: [www.tapartnership.org](http://www.tapartnership.org)

**Technical Assistance Provider**

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

A strong governance structure is a critical element of a successful system of care and should be given careful attention as communities design their local initiatives. One size does not fit all, and communities need to think strategically about what their governance structure should look like (one board? regional boards?) and who should participate based on the goals of their grant. Assembling a diverse mix of individuals for a governing body is essential. Board membership should reflect the demographic composition of a community’s service population, and should include representation from various systems, organizations and entities that can influence key areas that communities hope to impact with their systems change efforts (e.g., child and family services, workforce development, braiding funds, etc).

Still, assembling a governance board is only one step in the process. It is critical that a community’s governing body become vested in the system of care effort, such that members are willing to do their part to help shepherd systems change during the grant period and beyond. This requires taking time to make sure that everyone understands “systems of care” and the community’s vision for local implementation, and that each member can see how partnering on this effort makes sense for them and, if applicable, the organizations that they represent.

It is also important for communities to have clear communication and clarity about the roles, responsibilities and decision-making processes inherent in their governance structures. In defining roles, communities should be mindful that members are more likely to become and remain vested if they feel their roles are meaningful to them as well as to the overall effort. Still, grantees must explore how to balance the need to integrate the governing body into initiative operations, while maintaining an appropriate amount of control as the accountable party.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. What entities exist with whom you might partner? To what extent do these partners reflect the demographics and needs of your community?
2. Will you have one governance board or does your grant design warrant multiple regional/local governance structures as well?
3. What role will each partner have? Make sure it is clear and it is mutually beneficial.
4. What role will your governance board have (or did they have) in writing the grant?
5. What role will your governance board have in developing the initiative’s mission/vision, logic model, strategic plan, etc.?
6. How familiar are your governance board members with system of care values and principles? With system of care grant requirements?
LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Be sure your governance board reflects a strategic and diverse mix of members. Make sure community leaders with the authority to enact change are actively involved (e.g., elected officials, agency executives). Engage parents/caregivers of children accessing mental health services, as well as all levels of agency/organizational staffing—from supervisors/managers to front-line workers.

• Make sure your governance board reflects your community both in ethnicity, race, gender, and area of focus (e.g., mental health providers, health care providers, faith leaders, educators).

• Examine governance structures used by other types of agencies or organizations to help determine what will best meet your needs. One community brought in speakers to talk about different types of governance structures (e.g., for-profit organization, public/private partnership, etc.)

• Make sure the roles and responsibilities of the governance board are clear and mutually agreed upon. Revisit them regularly, along with the initiative’s mission and vision, to keep members engaged and focused.

• Give the governance board the authority to make key decisions and to “own” the effort, but be mindful that you cannot give away all the decision-making power, as the grantee is ultimately accountable for grant funds and performance.

• If possible, engage those whom you anticipate will be on your governance board in writing the grant proposal, so that they are well-versed in the goals and requirements associated with a system of care cooperative agreement. This helps to ensure that everyone is on the same page from Day One and to secure “buy-in” from the beginning.

• At the onset, take time to familiarize all members of your governance board with the grant elements and your community’s current vision for implementation. A system of care cooperative agreement is complex and it is essential that all members of the governing body have a thorough understanding if they are to provide effective leadership.

• Work with the governance board to build consensus and come to a common understanding of each goal set for the initiative.

• A comprehensive and effective communication plan is critical.

• Consider developing a “commitment form” to formalize board members’ commitment to the effort and acknowledgement of the roles and responsibilities associated with membership.

• Be strategic and respectful of time and resources when identifying tasks for governance board members, particularly if board members volunteer their time.

• To strengthen your governance board and promote sustainability, consider engaging the board in a strategic planning or similar process. One community uses a process called the “Network Development Rubric,” which provides a contextual framework for developing effective networks and measuring progress towards this goal. This process examines five dimensions including network management (i.e., purpose, structure, roles and responsibilities), knowledge development and dissemination, sustainable service systems, policy expertise and advocacy, and data-driven decision making. Each of these dimensions require network members to spell out achieved (or intended) action steps, as well as rate progress in each area (e.g., has not happened yet, occurs to a great extent).
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. **Engaging an Existing Collaborative as a Governance Board:** Hand in Hand—Tarrant County, TX

B. **Identifying Change Agents for Governance Board Membership:** Project ABC—Los Angeles County, CA

C. **Two-Tiered Governance Structure:** Alamance Alliance for Children and Families—Alamance County, NC

RESOURCE MATERIALS

**National Resources**

- Various resources on governance compiled by the Technical Assistance Partnership for Child and Family Mental Health, including publications and archived webinars. Available at: www.tapartnership.org/SOC/SOCimplementingStructuring.php?id=topic3#topicContent

**Community Resources**

- Organizational chart with governance structure embedded (Wraparound Oregon: Early Childhood/ Multnomah County, OR). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- Network Development Rubric—a sample planning tool for governance board/network development (Kentucky SEED/KY). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

KEY CONTACTS AND WEBSITES

**Websites**

- TA Partnership: www.tapartnership.org
- Project LAUNCH: http://projectlaunch.promoteprevent.org/systems-change/governance

**Technical Assistance Provider**

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ENGAGING AN EXISTING COLLABORATIVE AS A GOVERNANCE BOARD

Hand in Hand—Tarrant County, TX

Strategy/Initiative Summary
Mental Health Connection (MHC) provides the governance structure for our community’s System of Care. MHC is a collaboration of public and private agencies and individuals working with consumers and their caregivers to create and implement innovative strategies for improving the infrastructure for a quality, accessible, safe, and culturally competent system of care.

Getting Started
Why did your community pursue this effort?
In 1999, a man with mental health issues and a history of attempts to access services entered a church, shot, and killed youth and adults attending a worship service. This tragedy provided a sense of urgency among our behavioral health care providers to create “No Wrong Door to the Right Mental Health Resources.”

What were the initial steps in getting this effort off the ground?
The Mayor of the City of Fort Worth asked the mental health provider community to develop strategies to fill the gaps in the delivery system so that when an individual reached out for help, (s)he would get connected to the appropriate resource. The executive leadership of the local children’s hospital, the mental health authority, and several community-based organizations made the commitment to an action-oriented, outcome-focused effort to meet the challenge issued by the mayor. Other service providers and family members were invited to identify the issues. Task forces were organized; a dues structure based on annual budgets of the agencies was created to support the collaborative work. A part-time administrative assistant was hired with the pooled monies to coordinate meetings, record minutes, and handle communications. In the third year, a full time staff person was hired to coordinate strategic planning and implementation efforts. Bylaws were developed and committees were organized.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
Initially, Cook Children’s Medical Center, MHMR of Tarrant County, Lena Pope Home, Catholic Charities, and the City of Fort Worth provided leadership. Immediately Fort Worth Independent School District, ACH Child and Family Services, The Women’s Center, The Parenting Center, Safe Haven, Tarrant County Juvenile Services, JPS Health System, Millwood Hospital, The Art Station, AIDS Outreach, Child Study Center, Santa Fe Youth Services, Tarrant County Challenge, United Way of Tarrant County, NAMI of Tarrant County, Mental Health Association, First Methodist Church of Fort Worth, Child Study Center, Alliance for Children, University of Texas at Arlington, Samaritan House and numerous family members, consumers, caregivers, and private practitioners joined the collaboration as dues-paying members. Today, more than 70 agencies participate in MHC activities on a regular basis. Financial support is not a requirement for participation.

Implementation
How did you move from planning to implementation?
Specific goals are developed as part of all our planning so implementation is immediate, outcome-focused and measurable. Annually, the MHC board adopts a resolution establishing committees with stated goals.
At the end of the year, each committee reports on their outcomes and recommends goals to support priorities for the next year. Volunteers are recruited strategically to ensure that the goals can be attained.

**Barriers/Obstacles**

*What challenges, issues, complications or obstacles have emerged along the way?*

The major challenge has been managing change. Our work is intended to transform our system. Planning and being innovative has been relatively easy. Accomplishments have been abundant. Personal and organizational change is the greatest challenge.

*What potential pitfalls can be identified that others can avoid?*

Take time to build consensus and come to a common understanding of each goal you set. A comprehensive and effective communication plan is critical. Be strategic when determining the work load. Because our structure is dependent on a volunteer work force, respecting time and resources of all individuals is imperative. Listen to your group and its members. Celebrate successes. Document your work.

**Funding/Sustainability**

*How is this effort funded?*

Through dues paid annually by each member agency. Recommended dues are based on annual budgets. Individuals may join for $30.

*What elements are (or will be) in place to sustain this effort after the grant period ends?*

The commitment of the member agencies that the work is still valuable. Incredible in-kind donations are made to the collaborative work including staff time on committees, support staff time, meeting spaces, supplies, printing, etc.

**Lessons Learned**

*What tips can you share that might help others interested in pursuing a similar effort?*

Make sure key community leadership is actively involved (i.e., elected officials, agency executives, etc.) Include all levels of staffing from agencies (supervisors/managers, front-line workers). Include consumers of mental health services and their caregivers. Make sure your coalition reflects your community both in ethnicity, race, gender, and area of focus (mental health providers, health care providers, faith leaders, educators, etc.).

**Resources**

[www.mentalhealthconnection.org](http://www.mentalhealthconnection.org)

**Primary Contact**

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IDENTIFYING CHANGE AGENTS FOR
GOVERNANCE BOARD MEMBERSHIP
Project ABC—Los Angeles County, CA

Strategy/Initiative Summary
A key goal of Project ABC is to create the system changes needed to better serve very young children and their families in an integrated seamless fashion. We realized many years ago that “preaching to the choir” does not create such change. Clinicians and line staff may understand what is needed to best serve young children and their families but do not have the authority to create systemic changes that contribute to long term efficacy. In addition, Los Angeles has complex agency lines of responsibility and spending authorities more comparable to large states (or small countries) than small communities. We created our Project ABC Governance Board by brainstorming about key community and state leadership that would be necessary for system changes and then inviting those leaders to participate in our Governance Board alongside families and project leadership. Our collaborative partners on the Board include high level organizational leadership from the LA County Department of Mental Health, Children and Family Services, Health Services, and Drug and Alcohol Programs; the California Department of Mental Health; Los Angeles Unified School District (Superintendent of Early Childhood Programs); First 5 Los Angeles; LA City Child Care Program Office; LA Commission on Children and Families; LA Kinship Council; Zero to Three Western Office; Juvenile Courts; Regional Centers (Part C direction within California); NAMI Urban Los Angeles (Executive Director) and the LA Mental Health Commission. The intent is to have a group of leaders with the authority to create changes in the existing infrastructures in Los Angeles and California on behalf of young children and families. Such authority includes budgetary recommendations and oversight within their organization; policy changes; training oversight, etc. We have all partnered to learn about barriers to service delivery, funding constraints, family concerns, workforce gaps, and many other pertinent issues through clinical case vignette presentations at the Board meetings, discussions about critical community and state issues, and leadership retreats. Although change is always slow, we believe that some important seeds have been planted at Board meetings and that there is a greater willingness to cross agency boundaries to provide better services to young children and their families.

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**TWO-TIERED GOVERNANCE STRUCTURE**

Alamance Alliance for Children and Families—Alamance County, NC

**Strategy/Initiative Summary**

The governance structure of the Alliance is two tiers. At the CEO level governance is provided by our Children’s Executive Oversight Committee, which is made up of the CEO of all the local child serving agencies and organizations. Direct oversight is provided by the state mandated, Local Interagency Coordinating Council, which has responsibility for the 0-5 population and “child find.”

**Getting Started**

The Children’s Executive Oversight Committee agreed to pursue the grant to fill an unmet need in our community. A number of CEOC organizations actually blended funds to pay to have the grant written. It was agreed that the LICC would be the governance board for the Alliance as it would give the committee a more tangible mission.

**Key Partners**

These partners include, but are not limited to the Partnership for Children, Public Health Dept., Community Mental Health (LME), Child Welfare, Alamance-Burlington School System, Head Start, Children’s Developmental Services Agency, Family Support Network and others. As noted above we blended funds to hire a grant writer; the schools and CDSA agreed to be the portals of entry for identified children; agencies have participated in cross training, shared coaching and supervision.

**Implementation**

We moved from planning to implementation by utilizing a strategic plan and by leaning heavily on the past relationships built by individuals and by developing new and trusting relationships with new partners. Each LICC member is an active member of one of the Alliance subcommittees (Training, Family Involvement, Social Marketing, etc.)

**Barriers/Obstacles**

It has been difficult for the LICC to understand the complexity of the SAMHSA SOC grants and all its requirements. The LICC is voluntary and only meets 1.5 hours per month and although members sit on committees the LICC has not taken major responsibility in directing grant functions.

**Funding/Sustainability**

In choosing the LICC, we are sustaining the work by embedding with a legislatively mandated 0-5 community child-serving council. The members are from organizations that are already funded with missions that support and/or overlap with the work of the Alliance.

**Lessons Learned**

It would have been valuable to have active members of the LICC be involved with the grant from the time of the proposal to increase understanding of the grant and general buy-in. Making sure the
infrastructure of the Alliance is completely built within the existing LICC systems prior to the end of the grant will be important to ensure the long term work of the Alliance.

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
**INTRODUCTION**

The ultimate goal of a system of care cooperative agreement is to lay the foundation for a strong, sustainable system. This is a significant task to achieve in six years, requiring that all grantees think about sustainability from Day One. As one early childhood system of care project director remarked, “If sustainability is the last thing you do, it is the LAST thing you do!” To work towards sustainability, one must think strategically about ways to work with partners to enhance what already exists and to address gaps in the system. This collaboration requires a shared commitment to system of care values and a willingness among partners to take ownership of system changes after the grant has ended and over the long term.

Keeping a “sustainability” perspective as strategic planning and grant implementation moves forward is a key to success. This includes an emphasis on system capacity-building, leveraging existing resources, and pooling or braiding funding wherever possible. Having and communicating a clear vision and mission throughout the life of the grant can also help keep things on track and safeguard against developing a “program” with sole-source funding, all resources under one roof, and little chance for long-term sustainability.

Early childhood grantees have found success in channeling grant funds towards system capacity-building efforts, such as workforce development (pre-service and in-service strategies) and cross-agency/organization adoption of the system of care approach to providing services and supports. Other promising strategies for early childhood systems of care include finding ways to embed infant and early childhood mental health services and supports into existing efforts and initiatives—particularly those with a strong likelihood of long-term stability. These and other strategies, resources and recommendations to support sustainability are discussed below. Creative and diversified financing, which is a critical element of sustainability, is addressed in greater detail in the Maximized and Flexible Funding section of this toolkit.

**QUESTIONS TO CONSIDER**

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Have you developed a sustainability plan? To what extent is it aligned with your logic model?
2. Who was (or will be) part of the plan’s development and ongoing implementation?
3. Have you updated or do you intend to update the plan on a yearly basis?
4. Who is in charge of implementing the plan?

**LESSONS FROM THE FIELD**

This list of tips represents lessons learned across early childhood system of care communities.

- Set up your service delivery system utilizing existing systems/portals whenever possible to support long-term sustainability.

- Think about sustainability at the same time you are developing a logic model and action plan.
• Thoughtful planning and implementing with fidelity is sustainability. Focus on utilizing not only fiscal opportunities, but program, planning, personnel and evaluation opportunities that can be integrated with or used to complement system of care efforts.

• Give your program away to the community. Keeping the majority of the dollars in your organization and enhancing service delivery won’t get you to sustainability. There has to be investments in the community to develop capacity, infrastructure and mechanisms so partners can work cooperatively towards some common goals.

• Below is an extract of lessons learned from research on sustaining systems of care by Stroul and Manteuffel (2008; see pages 233-238):
  – Establish a strong link between local systems of care and state agencies
  – Engage top policymakers and system administrators
  – Incorporate the system of care approach into written plans and policies
  – Understand and create partnerships with other child-serving systems
  – Involve and strengthen family advocates and family organizations
  – Use outcome data and personal stories to advocate sustaining systems of care
  – Conceptualize grants as part of a large state strategy for system of care development
  – “Refinance” system of care grants from the outset with multiple funding streams
  – Collaborate with the state Medicaid agency
  – Cultivate leaders and champions to “carry the mantle” over time
  – Incorporate key elements of systems of care into contracts with providers
  – Implement mechanisms to pay providers for interagency coordination and individualized service planning processes
  – Use effective social marketing approaches to disseminate information and garner support for systems of care
  – Use the first year of Federal grants for implementation and sustainability planning
  – Use multiple strategies for sustainability
  – Provide extensive training on systems of care and service delivery
  – Adapt to changing circumstances
  – Learn from the experience of graduated system of care communities

STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. Embedding Infant-Family and Early Childhood Mental Health Activities into Existing Local/State/Federal Efforts: Project ABC—Los Angeles County, CA

B. System Capacity-Building through Workforce Development—see Prepared Workforce section of this toolkit.

C. Sustainability Examples from Other System of Care Communities (not specific to EC)—see www.tapartnership.org/SOC/SOCsustainabilityPlanning.php?id=topic2
RESOURCES

National Resources

• From Initial Implementation to Sustainability: Getting from Here to There. A presentation by Karen Blasé, Frank Porter Graham Child Development Institute, University of North Carolina, for Project LAUNCH on August 5, 2010. Available at: http://projectlaunch.promoteprevent.org/webfm_send/1630

• SAMHSA’s Sustainability Planning Toolkit. Available at: www.tapartnership.org/SOC/SOCsustainabilityPlanning.php?id=topic1


Community Resources
• Kentucky SEED logic model and accompanying strategic/sustainability plan. (Kentucky SEED/Kentucky). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

• Sustainability Flowchart—developed by a former system of care project director and the System of Care Alumni Network; describes the five stages of moving toward sustainability. Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

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**EMBEDDING INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH ACTIVITIES INTO EXISTING LOCAL/STATE/FEDERAL EFFORTS**

*Project ABC—Los Angeles County, CA*

**Strategy/Initiative Summary**

Project ABC links with multiple departments within the University of Southern California and at UCLA (including the School of Public Health), within Children’s Hospital Los Angeles, Oakland Children’s Hospital (particularly in collaborations on training efforts within California), the University Center for Excellence in Developmental Disabilities at UC Davis and the UC-Davis MIND Institute. Two of the PABC leaders (Drs. Karen Finello and Marie Poulsen) developed and co-teach a graduate course in USC’s School of Public Health for Masters level students every other year. The course “Foundations of Early Childhood Mental Health” has included attention to early childhood mental health issues, system of care issues, and public health policies relevant to young children and their families and draws graduate students from programs in occupational therapy in addition to public health. We also set up a collaborative project with an Advanced Design course in the USC Roski School of Fine Arts. The students in the course developed ideas and strategies for outreach campaigns around crying babies and maternal depression, including web pages, clothing designs, stigma reduction, bulletin board displays, and public transportation advertising ideas. A number of LEND (Leadership in Education and Neurodevelopment) trainees at the USC-UCEDD have become involved with various aspects of outreach, research, and services related to Project ABC through special projects in the LEND program. (The LEND Program at USC UCEDD is one of 31 federally-funded projects that provides long-term, graduate level interdisciplinary training as well as interdisciplinary services and care. The purpose of the LEND training program is to improve the health of infants, children, and adolescents with disabilities. They accomplish this by preparing trainees from diverse professional disciplines to assume leadership roles in their respective fields and by insuring high levels of interdisciplinary clinical competence.)

We have also linked with efforts at First 5 LA (including participation on special First 5 Task Forces and at First 5 Commission Meetings to provide public testimony on their efforts), with other California county First 5 commissions, and with First 5 California. Project ABC staff have contracted with the California Department of Developmental Services (through WestEd) and local Regional Centers in Los Angeles County to provide training to Early Start Regional Center Service Coordinators, Part C vendors, and other service providers. Leaders from Project ABC have been involved with several projects at WestEd Sacramento to develop quality training standards and trainings throughout California. These have been funded by First 5 California and First 5 Yolo County. Our close and long time relationships with WestEd have contributed to many current and planned collaborations focused on infant-family and early childhood mental health and development.

Several of our PABC leaders also sit on the Los Angeles County Perinatal Mental Health Task Force. The Task Force is working hard to provide large-scale screening services on maternal depression and link depressed women to treatment resources. In addition, the Task Force is developing professional training sessions and pre-service internships for graduate students to enhance workforce knowledge around maternal depression. PABC leadership has been instrumental in infusing a more dyadic approach to this work and adding training elements focused on the impact of maternal depression on infants and young children.
Another critical linkage is the role that Project ABC plays in the California Early Childhood Mental Health Systems Change Workgroup and the National Infant and Early Childhood Mental Health Systems Development Summit. Dr. Poulsen is a county delegate to State meetings representing the importance of quality integrated system of care for infants and young children and their families, and a State delegate representing Part C for the Department of Developmental Services to the national summit. Both initiatives are focused on systems change and will have an expanding influence.

Most recently, Project ABC provided leadership for a national Think Tank on Evidence Based Practices for Early Childhood Mental Health. Co-sponsorship of the all day event in February 2011 was provided by WestEd and First 5 California. We anticipate an Issue Brief and a series of focused White Papers as a result of the day long discussions among national EBP implementation leaders, EBP developers, funders, clinical agencies, organizational directors at local, state, and federal levels, researchers, parents, and trainers. Significant movement toward more effective policy around EBP adoption has already begun in Los Angeles and California as a result of the Think Tank.

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SECTION 3

STRATEGIC PARTNERSHIPS

NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

A critical ingredient in building strong, sustainable systems of care—for any age population—is collaboration with key stakeholders. Forging strategic partnerships helps to ensure that needed services and supports are identified and, further, that those services and supports are delivered in a coordinated manner (e.g., services are not duplicated, core values are shared). Strong, diverse partnerships are particularly important when serving young children, as the emphasis in early childhood systems building is embedding mental health services and supports into the various settings where young children and their families are served (e.g., child care, primary care).

To build these important partnerships, early childhood communities must first identify their key stakeholders—a process that will likely yield different outcomes for each community based on the local character, culture and context. However, one group of core stakeholders that is common to all systems of care is families. Given the centrality of family involvement to systems development, this Toolkit includes an entire section on engaging and empowering families of young children.

It is also essential to forge partnerships with and among the agencies, systems and organizations working with and for young children and their families. Common agency/system partners include, but are not limited to, mental health, public health, child care, education, child welfare, social services, family courts, and primary care. Collaborating with faith-based organizations, cultural organizations, foundations, and other local organizations can also greatly enhance system building efforts.

Building these essential relationships and achieving the true “buy in” that is necessary to sustain the effort takes time and a well thought out approach. Partners must have a vested interest in “systems change” and embrace their roles in this process. This section seeks to help communities achieve this complex, but critical, element of systems development.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Has your community done an environmental scan? Was this environmental scan used to inform the process of identifying key stakeholders?
2. Did you have a diverse array of individuals, including family members, helping to identify key stakeholders?
3. Were the identified stakeholders involved in writing the grant or shaping the grant implementation plan? If no, are there opportunities for key stakeholders to influence modifications as implementation moves forward?
4. How are state and community partnerships cultivated and maintained?
5. What are the interagency issues that you are struggling with currently, if any? Might it be useful to have an “outside” party help facilitate some collaboration and/or strategic planning?
6. To what extent have you found ‘common ground’ (i.e., common values and goals) among the partners with whom you are working? If this is still an area for improvement, could the system of care values be a unifying framework?

7. In what ways have you engaged non-agency partners, such as faith-based organizations or cultural groups?

8. Has your state developed strong informal interagency partnerships?

9. Has your community developed formal interagency agreements or Memoranda of Understandings (MOU’s) between early childhood agencies, mental health, and other agencies that guide the planning or delivery of services? Have you done the same for community organizations with whom you are partnering?

Also, A Public Health Approach to Children’s Mental Health: A Conceptual Framework (Miles, Espiritu, Horen, Sebian, Waetzig, 2010) suggests the following questions for leaders to ask themselves and others when undertaking a new collaborative initiative:

• Can I articulate my personal vision for this work?
• What resources do I/we have to lead this effort?
• What do I need to get things going and keep them moving?
• Who are my peers/who are allies that have either expressed interest in a public health approach, or seem to think in similar ways?
• Who might be a key ally that might need a little educating and encouragement, but is critical to have on board (as a participant or as a co-leader)?
• What is the ally’s perspective of mental health and how does it apply to their domain?
• Do they have a vision for a public health approach to mental health for the population of interest?

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Partnering is all about building relationships. Some will form quickly as you identify like-minded individuals with your similar passion around young children and their families. Others may be resistant. In the beginning, focus your efforts on those who are eager to partner and then work gradually, but persistently, to bring other key players on board. (See Social Marketing section for tips on persuasive messaging.)

• Seek out champions from various disciplines and support them in their efforts to advance systems change.

• Seek out individuals that have worked on systems change over time—historical perspective and “stick-to-itiveness” are important.

• If possible, write the grant application collaboratively as a community to achieve buy-in from the beginning.

• Address common partnering pitfalls, such as turf issues and struggles over what direction to go in, by finding common ground at the onset. System of care values can be embraced by many, if not all, and are a great place to start. Keeping the focus on children and families instead of agency differences can help you move through difficult times and lead to successful collaboration.

• Take time at the onset to learn about variations in language and culture across stakeholders, at both the individual and systems level. This includes clear communication and clarification about definition of terms between agencies. Often, different agencies define the same term in different ways.

• Take time to foster relationships with line staff, not just top agency/organization leadership. Good reviews trickle up.

• If you have potential referral sources that are reluctant to collaborate, consider initiating a brief trial period or pilot. This can be an effective way to build trust, but you need to be ready when that first referral comes in or it can really damage your credibility.

• Remember that SOC grant money is intended to help build the capacity of the system. Give the money away—but make sure you have a strategic plan for doing so.

• Be wary of tying up funding in personnel and service delivery. Look for capacity-building opportunities, such as pre-service and in-service trainings and/or train-the-trainer models.

• Share decision-making power with your partners so they can help guide system development, but retain budget control as you are ultimately accountable.

• Take time in developing contracts with service partners—this is your primary vehicle for control. You don’t want the contract to be so prescriptive that you stifle innovation, but it needs to clearly outline expectations so partners are accountable. Consider developing the scope of work collaboratively so it is endorsed by both parties at the onset, and spell out the philosophy (i.e., mission, vision, values) that needs to be guiding the provision of contracted services. Be very specific in outlining goals, activities/tasks and implementation timelines that must be achieved, but leave some room for creativity wherever possible.

• Clarify roles and expectations for all partners—formal and informal—and establish clear channels of communication at the outset.

• Be persistent and intentional in developing partnerships. Know whom you need to engage and for what purpose, and don’t get discouraged if it takes a long while to get them on board (which it probably will!). Build a thick skin and be patient.

• Involve stakeholders in meetings that are focused and have a clear purpose. Continually seek input and work towards consensus. Use data to help identify issues and move discussions forward.

• Foster relationships by attending and participating in meetings hosted and/or attended by community partners. Get to know your community partners and understand their goals, and look for strategic opportunities to support their efforts while furthering the development of your local system of care.

• Get out of your comfort zone and be open to new ideas and learn others’ points of view. Get out into your community all the time.

• Be transparent—let people know your struggles as well as your successes, and ask for support when needed.

• See yourself as a part of the early childhood system—you have something unique to bring to the table. Remember that “mental health” should not be seen as separate “issue”, but rather a vital component of the overall system.
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. Partnering with Child Welfare: Project ABC—Los Angeles, CA

B. Partnering with the Early Intervention System (Part C): Project BLOOM—Denver, CO

C. Community Partnerships/Community Network Team Development Process: Starting Early Together—Allegheny County, PA

D. Multi-Agency, Multi-Disciplinary & Multi-Stakeholder Collaboration: Wraparound Oregon: Early Childhood—Multnomah County, OR

E. Developing a Strategic Plan as an Organizing Framework for System-Level Partnerships: Project BLOOM—Denver, CO

RESOURCE MATERIALS

National Resources


• The Community Toolbox. A website focused on promoting community health and development by connecting people, ideas and resources. It includes mini Toolkits that will help you get a quick start in doing key activities with community partners. Available at: http://ctb.ku.edu/en/dothework/index.aspx

Community Resources

• Colorado’s Early Childhood Mental Health Strategic Plan. (Project BLOOM/Denver, CO). This plan was developed to facilitate better integration, definition, and coordination of Colorado’s early childhood mental health systems, services and supports. Available at: www.coaimh.org/UserFiles/File/Blue_Ribbon_Strategic_Plan_Early_Childhood.pdf

• Early Recognition and Response Plan (Sarasota Partnership/Sarasota, FL). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html. This plan reflects the integration of developmental screening practices throughout health, education and family support programs serving the local system of care service area.

• Sample Intergovernmental Agreements and MOUs (Wraparound Oregon: Early Childhood/Multnomah County, OR). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html. These sample agreements are used to outline the roles and responsibilities of community partners regarding development of the local early childhood system of care.
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PARTNERING WITH CHILD WELFARE
Project ABC—Los Angeles, CA

Strategy/Initiative Summary
Children under age 5 make up a large proportion of the child welfare population in Los Angeles County. Few of them receive mental health services (or referrals for services). Project ABC (PABC) has made a strong effort to build the collaboration between mental health and child welfare in order to insure that needed services are provided to the very young and vulnerable children who are served by child welfare. The Department of Children and Family Services (DCFS) is a partner on the system of care grant and leaders from DCFS are part of our Operations Team, actively attending PABC weekly meetings and contributing to the program philosophy and development. We have developed close working relationships with the Regional Administrator and Assistant Regional Administrator for the large child welfare office in the portion of LA County served by PABC. Both have attended national meetings with other project leadership, leadership retreats, brainstorming meetings, clinical subcommittee meetings, and meetings with clinical mental health staff from the project. We have held brainstorming meetings with DCFS line staff regarding their training needs related to Birth to 5 year olds and then developed a series of specialized and focused trainings, in collaboration with the DCFS regional office leadership, the DCFS Training Bureau, and the USC Center on Child Welfare (one of four local university training consortium offices responsible for DCFS trainings in the region served by our program). PABC held information sessions at the DCFS offices to answer questions about our services with line DCFS staff and to hear their concerns. We provided them with pamphlets describing the program and posters about Project ABC for the DCFS building elevators and offices that remind them of our program philosophy, “Relationships Matter.” We also provided DCFS staff with magnetic calendars listing the PABC website address to serve as ongoing reminders about referrals of young children to mental health. Finally, we established connections with the Juvenile Court judges through meetings and invitational trainings. PABC has delivered boxes of our “What is Infant Mental Health?” brochure to the courts in multiple languages. The judges distribute these brochures to families of children under 5 who enter their courtrooms.

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PARTNERING WITH THE EARLY INTERVENTION SYSTEM (PART C)

Strategy/Initiative Summary
The Project BLOOM initiative in Denver, Colorado worked closely with its Early Intervention System/Part C (locally named Early Childhood Connections) to embed early childhood social and emotional development into the system. This partnership flourished into a strong, working collaboration due to several conditions and strategic steps. First, the state’s Department of Human Services-Developmental Disabilities was the lead agency for Part C, and was welcoming of mental health initiatives such as Project BLOOM. Second, a group of mental health advocates who were part of the Interagency Coordinating Council (ICC) had recently formed a committee to develop a white paper on how to address mental health issues through Part C. (Of note, the Principal Investigator for Project BLOOM—the state children’s mental health director—was part of this committee.) This process not only yielded a detailed white paper, but helped its developers truly understand that Part C process and where mental health fits in, which was critical for meaningful collaboration. This white paper provided a blueprint for infusing mental health into Part C and was a centerpiece for discussion during a joint meeting convened by the ICC committee for mental health specialists and Part C coordinators across the state. Outcomes stemming from this meeting and from strategic efforts by Project BLOOM on the state and local levels throughout the grant period included:

• Jointly authoring a technical assistance paper on social-emotional development
• Inclusion of social emotional intervention as an approved early intervention service
• Enhanced service coordination, including a state-approved and combined Wraparound and IFSP form
• Using DC:0-3R diagnoses as established conditions
• Renaming “social work” interventions to “social and emotional” interventions
• Requiring Early Childhood Specialists, who provide mental health services throughout the state, to work with the Early Intervention System
• Integrating mental health into EI system procedures and processes, including the referral process, as illustrated by the following flowchart: www.eicolorado.org/index.cfm?fuseaction=Referral.referral&CFID=14601081&CFTOKEN=55497475 (Note: this flowchart is for infants and toddlers, but another version for children ages 3 to 5 is also available from this link.)

Lessons Learned
• Social and emotional functioning is one of the delays for which a child can be qualified for Part C enrollment, but most Child Find teams are not trained to identify these issues.
• The system has a hard time defining a developmental delay in the social and emotional area. However, using the DC:0-3R diagnostic tool helps a lot because it gives a name and a way to measure social and emotional delays.
• Having a champion on the Interagency Coordinating Council is important.
• Building relationships with University Centers of Excellence in your state is a good strategy.
• Have a clear vision of what you want to happen with the collaboration.
• Build relationships at both the state and local level. Project BLOOM’s principal investigator was the state children’s mental health director and could reach out to other state partners effectively.
• It is critical to really understand the Part C process, so you can see where you might insert mental health.
• There are great similarities between the Wraparound Process and Part C’s Individualized Family Service Plan (IFSP)—consider folding them into one plan (making sure that a strong family component is part of the final product).

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COMMUNITY PARTNERSHIPS/COMMUNITY NETWORK TEAM DEVELOPMENT PROCESS
Starting Early Together—Allegheny County, PA

Strategy/Initiative Summary
Community Network Teams were developed as an avenue to enhance community engagement and to obtain community input regarding the implementation of Starting Early Together. The boards involvement includes, but is not limited to selecting trainings for staff and family members; recruiting and hiring staff; developing outreach strategies; and creating neighborhood specific and program-wide social marketing plans. Additionally, Community Network Teams are crucial to engaging the families, earning and building trust, and strengthening the communities’ capacity to meet the needs of children and families dealing with mental health issues.

Getting Started
A Request for Qualification was developed and distributed throughout the county’s neighborhoods to apply to become a community partner for the Starting Early Together service areas. A requirement of the RFQ was the identification and development of a Community Network Team. The RFQ laid out the purpose and composition of the CNTs. After communities were selected, technical assistance was provided to help in the development and organization of the Network Teams.

Key Partners
Members of the advisory boards consisted of parents/family members; mental health representatives, staff from early intervention, family support centers, headstart, child care providers, and physical health centers; community leaders, and Starting Early Together contracted providers.

Implementation
Four communities were selected based on a combination of their written proposals and interviews. Each community application team was directed to begin by recruiting more members to have a broader representation of community members on their boards. Each community team was given an a composition grid to increase awareness of demographic diversities and various skill sets to consider when recruiting individuals to complete their teams which became their advisory boards. Once the teams were complete, they participated in a two-month orientation that comprised series of seven trainings and technical assistance sessions. Boards were given a process that outlined their phases of development with benchmarks. Boards were given technical assistance throughout the course of the grant to support their development.

Barriers/Obstacles
Turnover in the advisory board leadership was a challenge in one community. Many neighborhoods in our communities served were vulnerable and many of their basic needs were not met (i.e. Safety, employment, thriving schools, etc.) It was hard for advisory board members to focus on mental health needs of young children at times, when they felt other community issues were more pressing.
Funding/Sustainability
The advisory boards will combine with other community groups to continue their work.

Lessons Learned
• Recognize and applaud board contributions.
• Document board achievements because sometimes it is easy to dismiss and forget contributions. Reminding them may help energize the board because they can easily see their accomplishments and movement toward achieving goals.
• Regularly assess member satisfaction about meetings and discuss results with group.

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Early Childhood—Multnomah County, OR

Strategy/Initiative Summary
Wraparound Oregon: Early Childhood in Portland, Oregon is an outgrowth of a vibrant Wraparound Initiative started in 2003 by a local coalition of 12 community leaders, including a Chief Family Law Judge, who was a major champion. The PI and PD were original members of that group. This effort to build a system of care in our community formally started in 1989 with a Robert Woods Johnson Foundation grant to begin developing a system of care. Sometimes, it can take many years to build a successful system of care and grant sites are encouraged to be patient, persistent and open to new opportunities.

Our early childhood system of care was funded in 2005. One of the factors which makes this site somewhat unique is this is a mental health program sponsored by an educational service district and the Project Director has an extensive work history with public child welfare. We never viewed this to be a project to reside within the mental health arena; rather we always viewed our work towards building sustainability to be inclusive of as many partnerships as possible. As a result, most of the funding was contracted out to many organizations as a way to increase the amount of active support and “buy-in”.

With no single agency “owning” the effort, the local coalition took ownership of Wraparound Oregon: Early Childhood. The group developed guidelines, MOU’s, and Interagency Agreements, and built a community governance structure. Agency directors and middle managers and family members were all involved from the beginning, as was the philanthropy community. This combination was a key to success.

The project was designed so 70-75% of our families would have child welfare involvement. Additionally, since we are housed in education, the Early Intervention/Early Childhood Special Education program for the county, which is part of our agency, was concerned that we include the Autism Spectrum Disorder (ASD) diagnosis as an Axis I diagnosis and acceptable as an admission criteria. Within the mental health community, ASD is not considered as a primary concern the way it is in the education community. Our multi-agency, multi-disciplinary Intake Committee agreed with the ASD admission criteria as long as there was an underlying mental health concern. With the agreement of child welfare and education about which children would be enrolled, we were able to establish strong partnerships.

Partnering with the Early Childhood Community
Even though the early childhood community was somewhat resistive to a mental health/wraparound program coming into their arena, we were able to slowly develop trust and partnerships. Originally we planned for about a four year process and, in the end, that’s about how long it took. We positioned our project as a support for early childhood efforts and consistently and intentionally talked about the strengths of a system of care and especially the values and principles. The values and principles cross all agency boundaries.

System Partners
At the system levels, the collaborative governance council became increasingly active and focused. Membership includes the directors of the major child serving systems, including representative...
superintendents of local school districts, family members, philanthropy, health plans, judiciary, and cultural organizations. A lot of resources, time, effort, energy and advocacy came from this grant site towards supporting the governance structure. Our Training Academy and support for the family organization were two pieces of support. We funded portions of the statewide planning efforts in 2007 when the Governor convened the Statewide Wraparound effort. Specifically, we paid for the financial consultants, portions of the evaluation work, and some of the organizational work for the various statewide meetings which took place in the summer of 2007.

Family Partners
In terms of the family organization, not only did we fund a regional director, we have been very active collaborators with the family organization and provide mentoring, technical support, financial support for such things as the Family Game Night (we bought all the toys and games), and co-sponsored family fun nights, potlucks, etc. As a result, even though there have been some difficult times, we have helped to develop a strong family presence at the policy and planning meetings locally and statewide. The system leaders readily acknowledge that family voice is present at all levels and is here to stay. More and more funding opportunities are now available for hiring family partners for both individual families and as program developers.

Cultural Partners
We worked closely with El Programo Hispano, a Catholic Charities organization serving the Portland, OR metro area. It was a relationship that we fostered because of the large numbers of Latino families residing within our service area. It began with a simple phone call from Wraparound Oregon’s project director to the organization’s director. In the beginning, conversations did not include any mention of mental health—the goal was simply to get the relationship started and establish trust. Over time, the relationship did grow, and Wraparound Oregon channeled funds to El Programo Hispano to help with translations, conducting presentations, and providing guidance on how to work with diverse communities.

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DEVELOPING A STRATEGIC PLAN AS AN ORGANIZING FRAMEWORK FOR SYSTEM-LEVEL PARTNERSHIPS
Project BLOOM—Denver, CO

Strategy/Initiative Summary
In 2008, Colorado’s Blue Ribbon Policy Council for Early Childhood Mental Health (BRPC) issued a statewide strategic plan. The BRPC was comprised of four Colorado early childhood mental health initiatives, including the early childhood system of care community—Project BLOOM. The Plan was “intended to be a document that frames how Colorado’s public and private agencies, charitable foundations, professional development system, training opportunities, and early childhood infrastructure can best support and enhance the lives of Colorado’s youngest citizens and their families through a comprehensive early childhood mental health system (BRPC, 2008, p. 6).

The following excerpts from Colorado’s Early Childhood Mental Health Strategic Plan provide more detail on the Plan and its development process:

“The Blue Ribbon Policy Council (BRPC) developed a strategic plan for fully embracing early childhood mental health across the state. The strategic planning process began in early 2007 when a general consensus was reached that called for better integration, definition, and coordination of Colorado’s early childhood mental health systems, services and supports. Colorado’s BRPC then began an intentional strategic planning process with input from five focus groups from across the state. Key elements that drove the formal strategic planning process were:

• Enhanced recognition of the importance of preventing mental health problems at an early age
• Increased information on the status of Colorado’s young children’s social, emotional and behavioral health
• Changes in the way professionals who work with young children view their role and potential to support children’s social, emotional and behavioral health
• Recognition that traditional mental health services do not adequately meet the needs of young children and their families
• Statewide work to develop a comprehensive system for early childhood that includes mental health as an essential domain

The approach taken by the BRPC embraces system of care values and principles. Colorado also fully supports a public health approach of services and supports including promotion, prevention and intervention. The concept of family partnership, cultural competence, best practice and holistic approach are woven throughout the strategies contained in the Plan.” (Blue Ribbon Policy Council for Early Childhood Mental Health, 2008, pp. 5-6).

“The following goals reflect the areas that have been identified as priorities for ensuring a sustainable, integrated, and quality early childhood mental health system…

1. Public Engagement
   Goal: The people of Colorado have a common understanding of early childhood mental health and embrace and support the healthy social and emotional development of young children.
2. Professional and Workforce Development
   Goal: All personnel in disciplines working with young children and their families use effective promotion, prevention, and intervention strategies for mental health.

3. Funding and Finance
   Goal: Financial and human investments and policies regarding children’s mental health follow a framework for promotion, prevention, and intervention; are embedded within Colorado’s early childhood system; and demonstrate accountability.

4. Program Availability
   Goal: Colorado families and caregivers are able to easily obtain appropriate and affordable mental health resources and supports for their children and themselves at the promotion, prevention and intervention levels.

5. System of Care

The full Strategic Plan is available at:
http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Blue+Ribbon+Strategic+Plan+for+Early+Childhood+Mental+Health.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251694209631&ssbinary=true

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Family-driven care, in which families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation, is a cornerstone of any system of care. Thus, engaging and supporting families to ensure their full participation in both service delivery and system development is critical. While family engagement can be a struggle for any system of care community, there are added challenges in trying to engage families with infants and young children. Some of these challenges are inherent in the demands of caring for infants or young children, who require constant attention, have unpredictable schedules, and may or may not be in a child care or preschool setting. These variables make it difficult for families to find time to get involved, and make outreach to these families challenging as there is not one central place (like the local public school) where families congregate.

Other challenges stem from the fact that early childhood systems of care (EC SOCs) are often trying to engage families that are learning for the first time that their very young children may have some mental health issues. This can be a difficult time for families, and many EC SOCs have learned that there can be resistance to system entry due to uncertainty or distress about the possible diagnosis, fear that the child will be labeled so early on in his/her life, or other issues related to mental health stigma. Thus, targeted strategies are needed to engage this group of families and provide supports and services in a manner that fits their lifestyles and their pace of “readiness” for involvement.

Another consideration for EC SOCs is that local family organizations, who are critical partners, may not have had experience in working with families of young children. As a result, additional resources and planning are needed to build this capacity and lay the foundation for strong family support. Finally, “early childhood mental health” is an unfamiliar concept to many—including families and those working with families. So, an essential step to engaging families of young children is demystifying this term for diverse audiences so that confusion and concern does not hinder referral or access to services. This section is designed to address these issues and more.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. How does your community define “families”?

2. How are you reaching out to a diverse representation of families—families of color, non-English speakers, families of various faiths, military families, teen parents, grandparents raising grandchildren, different income groups, and families already served through various service sectors? How have your tailored your outreach approaches to “fit” each of these populations and were individuals from these populations involved in helping you determine how to best tailor your approach?

3. Are families who currently have young children in the system engaged in planning or system-development activities? If not, what steps could you take to help these families get involved at the systems level?

1 See http://ffcmh.org/r2/publications2/family-driven-defined
4. Were family members involved in the planning of your initiative, and what roles have they played/will they play in the development and implementation of your community’s system building efforts?

5. To what extent are family members engaged in hiring staff for this system of care effort and evaluating staff performance?

6. How are you integrating existing family efforts (e.g., Head Start Councils, local family organizations or support groups) into your system building efforts?

7. Are there opportunities for families to learn more about early childhood topics and for skill-building in key areas like conducting trainings, using evaluation data, and public speaking? To what extent were family members involved in decisions about what topics to cover and what skills to sharpen?

8. What supports are provided to facilitate family involvement (e.g., providing transportation, child care, food; scheduling meetings/events at family-friendly times; ensuring more than one family member is in attendance at meetings and events; conducting a pre-meeting/event orientation to let families know what to expect)? Have you asked families if the supports you are providing are the supports that they need?

9. Have you had difficulty in identifying and engaging families of young children with mental health needs? If yes, how are you addressing this issue? Are there existing family organizations or organizations that frequently work with families who have young children that might be able to provide assistance in this area?

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

Engaging Families with Young Children

- Integrate a formal “family engagement process” into your EC SOC, complete with tasks, responsible parties, and timeframes. Consider all phases of engagement, from initial outreach to enrollment to service delivery to conclusion of formal services.

- Try to link new families to a family representative as soon as possible. Often, a good amount of time will pass between a family’s initial contact with the SOC and the point when they are ready to proceed with formal service delivery. Linking these new families to a family representative helps to keep them engaged, provide them with needed interim supports, and foster trust in the SOC such that they are eventually willing to initiate services.

- Be wary of any significant lags in time between contacts with a family, and be prepared to adjust your process if you notice a drop-off trend at certain stages in the process. One community found that they had to alter their enrollment process because there was a lag of 1-2 weeks between the family’s first contact with the SOC and outreach by the lead family contact, resulting in drop-off. Now, the lead family contact connects with new families within a few days and retention rates are higher.

- Remember that families are much more likely to enroll in a strengths-based system of care where they feel empowered as the expert at the table for their young child. So, implement practices and strategies that will help facilitate that empowerment (such as family mentors, below).

- Be sure to “meet the families where they are at.” Being non-judgmental in all areas of a family’s life is critical and helps to communicate respect and a sense that you are genuine in your desire to help.
• Consider having “family mentors” as part of your family engagement and support strategy. One community initiates a supportive relationship between new families and a family mentor/advocate who has walked in their shoes and understands their fears and frustrations. The family mentor assists in reducing stigma and providing education and information about systems of care. The family mentor also supports new families in learning how to “drive” their care plan within family team meetings and how to identify the formal and informal supports that they need.

• Develop materials to support the family engagement process, such as outreach items, intake forms, and service planning tools. As you do so, remember to apply strengths-based, family-friendly, and culturally and linguistically competent principles to all. One community gives newly-enrolled families a “cheat sheet” that tells them who will be calling them and when, and lists the name and contact phone number for the lead family contact. In addition, each family is given a book mark with ideas for ways to praise young children and a children’s book that is written by a local author.

• Be patient as the family engagement process takes time and can be disrupted by a child and/or family crisis. One community’s lead family contact stressed that it can take multiple attempts to get a family on board and that persistence and a flexible process (i.e., one that doesn’t limit the number of contact attempts) are key. In one instance, after months and many trips to the family home, a mom was finally ready to have her son formally assessed and to begin services. Remember that to truly be family-driven, it is necessary to let the family lead the way as to when services begin and how intense those services are at any given time.

• Remember that a few staff members cannot build a system-wide family support infrastructure alone—it is neither feasible nor sustainable. Look for ways to embed strategies in various systems and community-based organizations that link families together for peer support.

**Family Involvement in System Development**

• Be clear as to the level of involvement that you are requesting from families. Make sure they know if they are providing recommendations or if they are decision-makers.

• When conducting a team-based planning process and/or strategic planning around system development, family representation is essential and invaluable.

• Focus on building capacity around family leadership. Integrate strategies for this into your overall strategic plan, such as trainings for families focused on skill-building and empowerment.

• In conjunction with family members, identify indicators and develop a process to monitor progress towards becoming a “family-driven” system and to assess trends, issues and needs. One community’s family organization built a state-of-the-art database to capture data regarding their work with families. They use this data to inform service delivery and advocate for systems-level change as indicated.

• Devote time and resources to helping other system partners and service providers understand and value family involvement and support. Look for ways to help facilitate partnerships between family organizations and other system partners so that the family organizations can help bolster family-focused efforts system-wide.

**Messaging, Outreach and Education**

• It is important to help families better understand early childhood mental health, as it helps to mitigate stigma concerns. Work with family members/family organizations to determine the best way to share this information.
• Be sensitive when crafting messages for families around early childhood mental health—remember that the goal is to encourage them to promote positive mental health, to “have their antennae up” for potential mental health issues, and to act early when problems are detected to optimize outcomes. Work with family members/organizations when crafting messages and materials to ensure that they do not unnecessarily provoke anxiety. One community found that avoiding the term “mental health” was helpful. They also focused on the message that healthy social/emotional development is just as important as physical development for all children.

• Consider implementing a formal parenting education curriculum, if there is need and interest from the families you are serving. One community used “Parenting Wisely,” which has a version for parents of young children. Although this curriculum is not exclusively focused on mental health, it provides strategies and techniques to help parents address and cope with typical situations inherent in raising young children. Staff members from this community’s family organization conduct the training in multiple sessions—either one-on-one or in groups. The family organization’s entire staff is qualified to facilitate the training.

Partnering with Family Organizations
• Supporting a family run organization is a key element of developing a successful system of care. However, it is important that the organization not be completely reliant on system of care funding and can sustain itself after the grant period ends.

• Seek out existing, active family organizations that focus on early childhood and/or mental health issues overall and work to integrate early childhood mental health (ECMH) into their action agendas. Consider collaborating across organizations to build a coalition around ECMH.

• Remember that not all family organizations have focused on families with young children before. If your EC SOC is partnering with a family organization that has predominantly focused on families of older children/adolescents, work with them to build capacity around early childhood mental health and to equip them with tools/practices that are aligned with the needs of families with young children.

• Make sure that the family organization(s) with whom you are partnering are well-versed in system of care values and principles and that they are ready, willing and able to operationalize them in their work with families.

• Regard your local family organization as a valuable referral source and support them, as needed, with information and materials about your system of care. For example, one community’s family organization has general information packets that include system of care information, which are given or mailed to families that contact the organization and voice concerns about a child’s behavior or other social/emotional issue. Packets can also be individualized (e.g., materials about autism) if it seems appropriate.

STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. **Family Nights:** Rhode Island Positive Educational Partnership/Parent Support Network—Rhode Island

B. **Integrating Family Partners into Early Childhood Mental Health Programs:** Early Connections—Alameda County, CA
C. **Time Banking—An Informal Support for Families:** Rhode Island Positive Educational Partnership/Parent Support Network—Rhode Island

D. **Operationalizing Family Involvement:** Starting Early Together—Allegheny County, PA

E. **Family Partners:** Alamance Alliance for Children and Families—Alamance County, NC

F. **Creating a Local Family Organization:** Starting Early Together—Allegheny County, PA

G. **Engaging Families of Young Children:** Project ABC—Los Angeles County, CA

H. **Expanding an Existing Family Organization’s Scope to include Families with Young Children:** Kentucky System to Enhance Early Development—Kentucky

**RESOURCE MATERIALS**

**Definitions**
- Working Definition of “Family-Driven Care (Federation of Families for Children’s Mental Health). Available at: [www.tapartnership.org/docs/workingDefinitionFamilyDrivenCare_200801.pdf](http://www.tapartnership.org/docs/workingDefinitionFamilyDrivenCare_200801.pdf)

**National Resources**
- Harvard Family Research Project—various resources. Available at: [www.hfrp.org/family-involvement/publications-resources](http://www.hfrp.org/family-involvement/publications-resources)
Community Resources

• All About Sarasota Kids website (Sarasota Partnership/Sarasota, FL). Available at: www.allaboutsarasotakids.org
• Family Impact Study (Project BLOOM/Denver, CO). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
• Lead Family Contact Job Description (KY SEED/Kentucky). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

KEY CONTACTS AND WEBSITES

Website
Federation of Families for Children’s Mental Health: www.ffcmh.org

Technical Assistance Provider
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**FAMILY NIGHTS**

**Rhode Island Positive Educational Partnership/Parent Support Network—Rhode Island**

**Strategy/Initiative Summary**

The Rhode Island Positive Educational Partnership (RIPEP) works closely with a local family organization, the Parent Support Network (PSN), to provide a number of family support, engagement and empowerment functions. One of the successful strategies that PSN has implemented is “Family Nights.” Family Nights are held throughout the year, and are a way to bring families together to learn about a particular topic while sharing a meal and informally networking with each other.

Family Nights are not focused exclusively on early childhood mental health. On the contrary, one of the keys to the success of this effort is that staff at PSN look to the families to determine topics of interest. This approach models a “family-driven” process, fosters trust with families, ensures that topics are relevant and, consequently, boosts the number of families in attendance. Staff members simply pose the questions: “What would be helpful to you?” “What do you want to learn?” “What do you need?” As a result, workshop topics have included 1) nutritious meals on a limited budget; 2) understanding psychotropic medications; and 3) understanding challenging behaviors.

Local speakers with expertise in the selected topic area are paid a small fee to present the workshop. For example, the session on psychotropic medications (titled, “Moods, Meds, and More”) engaged speakers from a local university’s psychiatry department. PSN also collects evaluations after each workshop to help guide future planning.

Another important element to Family Nights, other than providing dinner for the families, is free, on-site child care. PSN initially offered families stipends to cover at-home babysitting costs, but found that most families wanted to bring their children with them. So, they began offering on-site child care. To facilitate planning, prepare age-appropriate activities, and ensure the right number and qualifications of caregivers, PSN developed a form that parents who need child care had to fill out. The form captured information about the name and age of the child, as well as any special considerations or instructions, such as allergies or physical/behavioral health issues. PSN also developed a ratio policy, to clarify the number of caregivers needed based on the number and issue complexity of the children in care. PSN engages RIPEP’s youth coordinator and other youth/young adults, as appropriate, to provide child care in conjunction with other caregivers.

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INTEGRATING FAMILY PARTNERS INTO EARLY CHILDHOOD MENTAL HEALTH PROGRAMS
Early Connections—Alameda County, CA

Strategy/Initiative Summary
Family Partner Integration—Early Childhood Mental Health Community-Based Providers. Early Connections System of Care has integrated 6 Family Partners in five early childhood mental health programs throughout Alameda County. Each community-based early childhood mental health agency recruited and hired one FTE Family Partner. Family Partners are supervised by the agency’s clinical supervisor or senior clinician. Family Partners work with the clinicians in providing collateral services, advocacy, service planning, and resource navigation services.

Getting Started
Why did your community pursue this effort?
• Alameda County Behavioral Health Care Services (ACBHCS) has a history of Family Partnership. ACBHCS has a contract with United Advocates for Children and Families and has employed Family Partners in ACBHCS mental health programs for the past ten years. Early Connections recognizes that a guiding principle for SAMHSA system of care is family voice and choice—family driven care. Given the successful history that ACBHCS has with Family Partnership, and the “goodness of fit” with the SAMHSA system of care principles, it seemed like a viable, effective strategy. Family Partners can bill Medi-Cal for their services thus maximizing the chances for sustainability.
• Additionally, Early Connections’ partner agency, F5 Alameda County, has Family Navigators as part of their SART (Screening, Assessment, Referral & Treatment). The goal is to create a “warm hand” off between Family Navigators in the prevention end of the service continuum, and Family Partners in the treatment end of the continuum of care for young children.

What were the initial steps in getting this effort off the ground?
Technical assistance from United Advocates for Children and Families and the SAMHSA TA Partnership to develop a plan to integrate Family Partners in early childhood mental health programs, including:
• Understanding why Family Partners are important in the planning and implementation of mental health services.
• What it means to be a Family Partner—a person with “lived experience”.
• Roles of Family Partners
• The “cultural shift” that the early childhood mental health agencies would experience when integrating Family Partners in their programs.
• Training needs of both Family Partners and early childhood mental health agencies
• Readiness of early childhood mental health agencies and interest in pursuing integration of Family Partners
• How Family Partners are perceived and understood across cultural and linguistic communities.
• Development of a tool kit for the recruitment and hiring of Family Partners
• Technical assistance to the early childhood mental health agencies once they had hired Family Partners.
INTEGRATING FAMILY PARTNERS INTO EARLY CHILDHOOD MENTAL HEALTH PROGRAMS (CONTINUED)

- Development of training for Family Partners
- Development of training for early childhood mental health providers
- Augmentation of early childhood mental health provider contracts to include Family Partner services

**Key Partners**

*What organizations, agencies or individuals partnered with you on this effort, and in what ways?*

F5 Alameda County and United Advocates for Children and Families (UACF). UACF was the primary partner in this particular strategy and the ways they collaborated with ACBHCS are listed in the section above.

**Implementation**

*How did you move from planning to implementation?*

- Family Partner Integration has been and continues to be a detailed process that is beyond the scope of this brief Toolkit, however, I will describe the salient aspects of the strategy. The movement from planning to implementation occurred in a staggered fashion as the early childhood mental health agencies all recruited and hired the Family Partners over a period of 6-8 months and there were many details to work out along the way. Details included macro system level issues such as contracts, billing, individual agency cultures to micro system level issues, such as how clinicians would respond to working with a Family Partner, how to write a job description for a Family Partner, how to introduce families to Family Partners.

- A key component of the sustainability of Family Partnership is to provide a group that supports the Family Partners as a cohort, which already exists in Alameda County through the United Advocates for Children and Families partnership. We also plan to provide a consultation group for the clinical supervisors of the Family Partners to assist them in the overall integration of Family Partnership, plus provide support for day-to-day situations.

- Family Partners have all been at their respective agencies for several months now, and the local evaluation for Early Connections will capture the exciting and sometimes daunting process of Family Partner Integration.

**Barriers/Obstacles**

*What challenges, issues, complications or obstacles have emerged along the way?*

- There was a variance in the readiness of early childhood mental health agencies to integrate Family Partners and some of the agencies needed more technical assistance than others.

- There is a need for continued technical assistance to the early childhood mental health agencies. Until very recently we did not have a Lead Family Coordinator so I as Project Director have sought technical assistance from United Advocates for Children and Families. It would have been more effective and less stressful to have a dedicated staff position available to guide the Family Partner Integration process.

**What potential pitfalls can be identified that others can avoid?**

A possible future pitfall may be that the Family Partners are employed by the mental health agency v. a family run organization. It would have been wise to do more research on this aspect prior to beginning the Family Partner Integration process.
INTEGRATING FAMILY PARTNERS INTO EARLY CHILDHOOD MENTAL HEALTH PROGRAMS (CONTINUED)

Funding/Sustainability
How is this effort funded?
Family Partners are funded by SAMHSA and Medi-Cal (EPSDT). Family Partners are billing Medi-Cal for their services.

Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
• Have a Lead Family Contact on staff before beginning the process if possible.
• Consider having the family run organization hire the Family Partners and then outstation at the early childhood mental health agencies.

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**Strategy/Initiative Summary**

The Rhode Island Positive Educational Partnership (RIPEP) works closely with a local family organization, the Parent Support Network (PSN), to provide a number of family support, engagement and empowerment functions. An innovative strategy that PSN began implementing in 2007 to address families’ needs for informal supports is the Rhode Island TimeBank Initiative. The philosophy behind the time banking approach is that reciprocity helps empower people and builds health communities. It also validates that everyone has assets to share.

The following excerpt from PSN’s website briefly describes this effort:

“The Rhode Island TimeBank Initiative is working with partners across the state to build community networks of support across the state with individuals, children, youth, families and communities where everyone can work together to create wealth of mutual exchanges, promote positive youth development, and rebuild community for our future generations.

A Time Bank is a community of people who support each other. When you provide one hour to do something for an individual or group, you earn a Time Dollar. Then you can take that Time Dollar to receive an hour of a neighbor’s time or engage in a group activity offered by a neighbor.”

(www.psnri.org/html%20docs/support/natural.html)

When it began, the vision was that PSN would incubate this effort for several years and then it would spin off into a separate non-profit organization. The Time Bank Initiative is now poised to become its own 501(c)3. Individuals who live in Rhode Island and are interested in joining the effort simply register online to become a member at [http://community.timebanks.org](http://community.timebanks.org).

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**OPERATIONALIZING FAMILY INVOLVEMENT**

Starting Early Together—Allegheny County, PA

**Strategy/Initiative Summary**

Family involvement has been the cornerstone to the operational framework of Starting Early Together at all levels. Families direct the individualized child and family planning process for their child, but they have been involved in every stage the planning, implementation, and quality assurance of the System of Care. Families are involved in policy development, care coordination, evaluation, strategic planning, service provision, social marketing, and individual and system advocacy. In order to support their involvement, SET created and provided a number of tools to support their participation, including glossaries, acronym lists, voice and choice trainings, decision making and conflict resolution strategies, review guideline checklists, and provider descriptions. SET also provided opportunities for pre-meetings prior to system level meetings, so that families could get information relevant to the expected topic and ask questions that they might not want to ask in the larger group, or that might assist them in their participation. We also provide ongoing technical assistance as a project moves forward so that families can get additional information as the need arises.

**Getting Started**

*Why did your community pursue this effort?*

Families know best their own strengths and needs and those of the community in which they live. Their expertise, participation, and input are essential to improving access, quality, and coordination of the services they receive, and the systems that provide those services.

*What were the initial steps in getting this effort off the ground?*

The initial steps are always to ensure that families have the resources and information they believe they need to orient them to the project/meeting/activity and the expected outcomes of the project/meeting/activity so that they feel prepared to be meaningful participants. This means creating materials and trainings that develop and build their knowledge and expertise so that they feel confident and well-informed. It is also essential to have supports in place to support individual needs, such as transportation, child care, food, reading accommodations, cultural/language adaptations, etc.

**Key Partners**

*What organizations, agencies or individuals partnered with you on this effort, and in what ways?*

Our key family organization, Allegheny Family Network, has been instrumental in helping us to provide support individual needs, as well as to assist us in the review of documents to ensure family-friendliness. All of our partners have played a role in supporting family involvement and it has been a requirement for any of our contracted agencies to demonstrate how they have included family members in their own operational structure, as well as how they promote family voice and choice.

**Barriers/Obstacles**

*What challenges, issues, complications or obstacles have emerged along the way?*

- Universally convenient times for families to attend meetings.
- Transportation for families with multiple children
- Length of time families are able to commit
OPERATIONALIZING FAMILY INVOLVEMENT (CONTINUED)

What potential pitfalls can be identified that others can avoid?
Ensure that materials are readable—limit professional/clinical language, have a sense of reading levels and adapt accordingly, don’t overwhelm with jargon and acronyms—even with the right tools, these can be confusing if they are used too much.

Funding/Sustainability
What elements are (or will be) in place to sustain this effort after the grant period ends?
The initial implementation of these strategies was funded through the system of care grant and the Office of Behavioral Health in the Allegheny County Dept. of Human Services. The opportunities for training that continues to contribute to empowerment, and participation in all levels of service provision and policy development with be sustained through the Allegheny Family Network, our key family organization, and the Office of Behavioral Health.

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Family Partners

Alamance Alliance for Children and Families—Alamance County, NC

Strategic/Initiative Summary
NC Families United, the statewide family organization, provides Family Partners for the Alamance Alliance for Children and Families SOC grant. A Family Partner is a parent or caregiver who currently has or had a child in any of the systems and are able to share their own experiences with families. Family Partners are trained, then hired to provide peer support (one on one support) to families of young children, to help the families navigate the system and/or provide care coordination. The Family Partners help to engage families who are difficult to engage or who, for many reasons, may be resistant to receiving services.

Key Partners
The key partners are NC Families United, Child Welfare, private mental health providers, schools and Dr. John Price—(contracted to do assessments on children referred to the Alamance Alliance).

Getting Started
The Lead Family Partner completes the enrollment process. In the beginning an enrollment was done 2-4 weeks after an assessment was completed. We found we were losing the “hard to engage” families by waiting so long. We have shortened the time to enrollment to increase family participation.

Implementation
Family engagement is done on both a child/family level and on a community level. When an assessment is completed and it is determined the child is eligible for service, the person doing the assessment calls the Lead Family Partner while the family is present. The Lead Family Partner makes an appointment to visit the family’s house, meet the family and do the enrollment. This meeting usually happens within days. The Lead Family Partner connects the family to a Family Partner, if the family is interested. Many times the Family Partner is the only contact the family has until services start. The Family Partners give a resource notebook to the families when they meet them. This notebook serves multiple purposes and helps the family to understand what to expect in the coming weeks, how to organize all the paperwork they receive, who will be contacting them and why and to help with documentation.

Family voice is encouraged at all levels of the SOC process at Alamance Alliance Family Partners actively encourage and support the families they serve to participate in the SOC implementing committees. The Family Partners prepare them for the meetings, attend the meetings with them, and those families are compensated for their time and expertise. Alamance Alliance Family Partners are in the process of hosting Family Cafés to expand family support and participation. Alamance Alliance believes that a Family Driven system needs the voices and participation of families who are currently receiving services.

Barriers/Obstacles
Families are hesitant to place a label on their young child. Some families are not ready to receive services or only agree to receive services out of fear of retribution. Trying to engage families who are not ready yet can be difficult. Transportation is also a barrier. Many families have difficulty getting to
appointments or attending meetings because they do not have a car. Alamance County does not have public transportation. Childcare is also a barrier to engaging families in committee meetings. As much as we want and welcome families involved at all levels, not all families want to be involved beyond getting services for their child. Some, no matter what is done; do not want to sit on a committee. Because of this fact, our numbers have not reached our goal of 15-20 families served actively participating on decision making committees. Currently there are six Alliance families actively participating.

**Funding/Sustainability**

Family Partners are currently funded by the SOC grant. Sustainability will happen by expanding the partnerships we currently have, both on a local level and a state level. Our goal is to be funded in multiple ways. The team is exploring Medicaid billing through the 1915 (b) (c) Waiver, which would mean Family Partners would have to partner with agencies that are called CABHA’s (Critical Access Behavioral Health Agency’s). To provide Peer Support (in the adult world) an agency must be a CABHA. Alamance Alliance is also collecting data that can be used with LME’s (Local Management Entity’s—Community Mental Health) and with authorizing agencies to document the benefits to families of having a Family Partner. The goal is to have Family Partners employed as Peer Supports, Care Coordinators and as Facilitators of Child and Family Teams.

**Lessons Learned**

One of the first lessons we learned was the need to have families who are currently receiving services at the table. Through conversations with families we learned they had no idea who was calling them from the university or why. In this day and age of technology, we learned that caller ID can hurt the evaluators efforts to make contact with the families. Once we realized the families had no idea who was calling or why, the Lead Family Partner started taking a handout for the family explaining who would be calling, when to expect the call, and why they would be calling.

**Primary Contact**

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CREATING A LOCAL FAMILY ORGANIZATION
Starting Early Together—Allegheny County, PA

Strategy/Initiative Summary
Initiated through the Starting Early Together early childhood system of care grant, Allegheny County, PA began developing a family organization based on system of care values that is family run, family driven and independent of county management and administration. This new family organization, called the Allegheny Family Network (AFN), supports all Allegheny County family members raising children and adolescents with mental health issues.

Getting Started
Why did your community pursue this effort?
AFN fills a gap in Allegheny County services that was identified by parents of children with mental health issues. Parents have consistently recognized that lack of information regarding the challenges their children face and the systems they need to navigate, impedes their ability to meet their children’s needs. They identified a family centered organization as the vehicle that would best help them be more confident and competent parents for their children with special needs.

What were the initial steps in getting this effort off the ground?
In October 2002, a process was developed to establish a fifteen (15) member planning team comprised of family members representing the ethnic and socioeconomic diversity of Allegheny County. The members of the team were chosen through an application process that assured the team represented the diversity of needs in Allegheny County. The team met from January to May 2003. In order to assess family member needs and Allegheny County’s strengths and weaknesses in meeting their needs, the Family Member Planning Team reviewed data and information from a variety of sources. These sources included:

- Family Survey responded to by 300+ families
- Discussions with existing support groups
- Five public forums
- Review of family organizations across the country
- Review of existing Allegheny County family organizations
- Discussions with provider groups

Other start up activities included:

- Formation of a Board of Directors
- Obtain a 501(c)(3) status (the application has been submitted to the IRS).
- Develop a planning process to secure funding for infrastructure and service delivery.
- Hire staff
- Build relationships with local, state and national organizations and providers, especially those involved with System of Care, to create partnerships and ensure that AFN’s services complement already existing services.
- Development of a comprehensive web-based information and referral system will be operating countywide.
- Development of a plan for organization sustainability and funds for continued operations
Key Partners

What organizations, agencies or individuals partnered with you on this effort, and in what ways?
The Question Inc was a collaborative partner that helped with recruitment of families to be on a diverse family planning committee. Many family members from all seven System of Care community programs participated by sharing information in their communities, as well as participating in any meeting related to the development of the org.

Implementation

How did you move from planning to implementation?
After the family needs assessment was done and presented to the Deputy Director of Behavioral Health and Director of the Department of Human Services, it was found that indeed there was a documented need. From there, a family organization planning team consisting of a diverse group of families worked with SOCI staff and consultants around the development of the organization.

Barriers/Obstacles

What challenges, issues, complications or obstacles have emerged along the way?
- Staff time
- Funding
- Development timeline

What potential pitfalls can be identified that others can avoid?
Reinventing the wheel—connect and talk with other family organizations to seek information around start up.

Funding/Sustainability

How is this effort funded?
Initially the family organization was solely funded through the office of behavioral health in the Allegheny Dept. of Human Services; currently it receives funding from our current SOC grant and other offices through our Department of Human Services.

What elements are (or will be) in place to sustain this effort after the grant period ends?
In Allegheny County we are committed to family support, we are willing to work in partnership with our family organization to ensure that family support will continue after the grant. AFN has hired a grant writer to assist them with other funding mechanisms for sustainability.

Lessons Learned

What tips can you share that might help others interested in pursuing a similar effort?
- Try not to rely on just one way to fund and sustain the organization
- Ensure that there is some flexibility with development of the organization in any given timeline
- When partnering, be sure to clearly educate on all of the SOC principles and philosophies.

Primary Contact

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Project ABC (PABC) believes that families of very young children need a different approach to encourage participation and involvement since they are typically new to systems and services and may be reluctant to become involved. Project ABC favors a “developmental approach” to family involvement that encourages including Project ABC families in systems change activities in ways that encourage comfort and meaningful participation. Through this process, we hope to avoid situations where families sit on boards but do not participate or whose input is not used. Families are initially encouraged to provide input in family-only sessions, and then, based on their comfort levels, to sit on Project ABC committees and boards.

A high proportion of Project ABC families are referred by Child Protective Services; many are grappling with substance abuse, domestic violence or mental health problems. Understandably, these families often approach mental health services for themselves and their children with suspicion and trepidation. Our clinical engagement strategies include timely response to referrals, a positive, strength-based approach, immediate crisis intervention and practical assistance when needed, and open exploration of any psychological or practical barriers to services.

A few of our strategies to increase family advocate participation in the community include supporting families in becoming advocates and creating leadership opportunities to influence policy to support families through parent training by the Family Advocates, development of parent testimony (again supported by the Family Advocates), and digital stories. PABC is taking leadership in advocating for the utilization of developmentally appropriate diagnostic tools, such as the DC: 0-3R, in identifying and advocating for family-friendly state policies and financing mechanisms that are developmentally appropriate, relationship-based, and supportive.

Central to family involvement is supporting families in advocating for the needs of themselves and their children. Project ABC has been using a developmental model to provide support for families at all levels of involvement including building awareness, increasing participation, and teaching proactive advocacy. Strategies include group family trainings and advocacy, along with individual support and guidance on advocacy opportunities through the Key Family contacts and through Project ABC staff. The level of support in this area is individualized and based on each family’s strengths, challenges, readiness to assume a leadership role, and other factors. Coaching and support in this area may focus on effective communication skills, conflict resolution, personal storytelling, and systems knowledge.

Principles for family involvement include: 1) Families require culturally competent services and supports reflecting their race, ethnicity, gender orientation, language, socio-economic background, and family structure; 2) Family identified priorities and concerns should drive policy and practice; 3) Families should have access to information and training; 4) Families should share power in making decisions and responsibility for outcomes. Key Family Contacts act as support and peer coaches for families receiving services; participate on all Project ABC committees to ensure that decisions reflect family input including program design, clinical policies, program materials, evaluation tools, etc.; act as liaisons with local community leaders and outreach organizations; serve as family advocates; and coordinate family activities.
Project ABC also provides Family Activities throughout the year. The design of the family activities was informed by parent preference, with the information gathered in a survey administered by the home visitors and clinicians and through the Family Committee that consists of the key family contacts and parents from Project ABC. The Family Committee develops the activity calendar and provides input into all family activities. These activities are enrichment events for families and their children, such as group outings (including a holiday party in December with gifts for all children living in the household and pictures with Santa; a summer picnic at a local park with a picnic lunch and activities for the children), and “Family Talk Time,” which is an opportunity for parents to talk about whatever they would like. Our Family Advocates have also led workshops to increase caregiver advocacy skills including “Making Your Voice Heard,” a training on advocacy and how to write letters to elected officials; “Understanding IEPs, IFSPs and IPPs”; and workshops designed to increase letters to elected officials; “Understanding IEPs, IFSPs and IPPs”; and workshops designed to increase parent/child attachment such as the Infant Massage Workshop. Additional workshops include: Nutrition, Practicing Self-Care and a presentation on the Department of Public Social Services (DPSS). These activities are designed to provide families with an opportunity to develop a peer support network, engage in developmentally appropriate activities in a supportive environment, and spend recreational time with their children.

The focus for parent leadership in our final year of funding is moving families from involvement in Project ABC to involvement in their larger community. To this end, the CHLA Key Family Contact, who is also the Family Support Faculty in the Leadership Education in Neurodevelopmental and related Disabilities (LEND), has developed a leadership project for two LEND trainees (family support and occupational therapy). They will identify opportunities for family voice in other community agencies and organizations, as well as identify barriers and strategies to overcome those barriers.

In addition, our Key Family Contacts have been working closely with the Los Angeles County Department of Child and Family Services to involve Project ABC parents in the DCFS “Parents in Partnership” (PIP) program. PIP is a program to train parent mentors who can educate and provide support to parents with open cases at DCFS. Similar to other areas, we have found unique barriers to parent involvement in the PIP program. Some of the barriers include the requirements that parents speak English and the family’s case has been closed for at least a year. Many of the Project ABC families are mono-lingual Spanish speakers. Also many of the families are just too “new” in their involvement with child welfare. Additionally, the age of their children may preclude participation in this program. We have presented the PIP program to the family committee and they have expressed interest. This has encouraged us to seek solutions in partnership with DCFS to allow for the identification and training of parent mentors who have had child welfare involvement when their children were very small.

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EXPANDING AN EXISTING FAMILY ORGANIZATION’S SCOPE TO INCLUDE FAMILIES WITH YOUNG CHILDREN
Kentucky System to Enhance Early Development—Kentucky

Strategy/Initiative Summary
The KY Partnership for Families and Children (KPFC) has been present in all state-level planning and implementation meetings and regularly provides input on infrastructure development and service delivery. Furthermore, KY SEED contracts with KPFC to employee two lead family contacts, nine family interviewers, and is in the process of hiring three part-time Regional Early Childhood Family Contacts that will work with various regions in the state. KPFC is a long-time partnering agency that is expanding their existing training and resources to encompass children ages birth to 5 and their families. KPFC has expanded their services to include early childhood-specific content in their Leadership Academy and Family Peer Support Core Competency Training, newly developed early childhood family conferences, and newsletters. In an effort to decrease duplication of services and to expand existing ones, KPFC partners with an existing Early Childhood Family Network to include mental health issues.

Getting Started
Why did your community pursue this effort?
Historically, KPFC focused on building a statewide family support network for families of school-age children with emotional and behavioral needs. KY SEED is partnering with KPFC to expand their population of focus to include children age birth to 5 and their families. Traditionally, young parents, and fathers, particularly single fathers, were not being engaged and now, KY SEED/KPFC is focused on concentrated outreach efforts to those sub-populations.

What were the initial steps in getting this effort off the ground?
KPFC’s Board of Directors made the decision to expand the mission and vision to include the population of children ages birth to 5 and their families. The existing infrastructure for KPFC infused the early childhood perspective, resources, and services to empower the child and family voice for young families. The implementation drivers (Attachment A) delineated by Dr. Dean Fixsen and his colleagues drove the process to determine how the early childhood expansion could be implemented.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
The State Interagency Council (SIAC) that governs KY SEED, KY Department for Behavioral Health, Developmental and Intellectual Disabilities, KY Department of Public Health, KPFC, KY Department of Education, and Family Resource and Youth Service Centers partnered with KY SEED in this effort. These agencies assisted with writing the funded application, participated in the implementation planning process, and actively participate on the State Implementation Team (SIT) that meets every other month to provide guidance on expanding the family network. These individuals were chosen due to their experience in early childhood, system of care, and/or family advocacy.
Implementation

How did you move from planning to implementation?
Staff was hired based on the qualities and characteristics identified by using the implementation drivers and developed a work plan that reflects specific strategies on Goal #2 of KY SEED (Attachment B). Building upon the work of Kentucky’s earlier system of care efforts, family members have been involved with KY SEED since the initial planning. Family leaders expanded their role by being:

• Involved in the development, dissemination, technical assistance, and scoring of the applications for KYSEED funding submitted by Regional Interagency Councils (RIACs)
• Active members in theory of change/logic model development
• Involved as trainers and participants in all KY SEED training and presentation opportunities
• Involved in budget development and oversight
• Hired as interviewers for the national evaluation
• Represented on all KY SEED governing bodies, committees, and work groups, and
• Members of the KYSEED State Implementation Team.

Barriers/Obstacles

What challenges, issues, complications or obstacles have emerged along the way?

1. Obtaining access to caregivers to provide resources. As more family members are added to the RIACs that are responsible for serving children with severe emotional disabilities and their families, more questions arise regarding confidentiality. Working through those barriers will be crucial for KPFC to provide guidance to families in advocating for their child within the various child-serving systems.

2. Strategizing how to embed early childhood into an already established infrastructure. More education/awareness/outreach strategies on how to craft developmentally-appropriate services for younger children is currently being developed.

3. Families with younger children are unable to become more active with KPFC due to their primary role as their child’s primary caregiver.

What potential pitfalls can be identified that others can avoid?
Child-serving agencies may not automatically “buy in” to understanding the social, emotional, and behavioral needs of young children. There are barriers to empowering child-serving agencies to develop more early childhood information when traditionally the focus as has been on school-age children.

Funding/Sustainability

How is this effort funded?
Cooperative agreement funds as well as other federal, state, and private funds support these efforts.

What elements are (or will be) in place to sustain this effort after the grant period ends?
At this time, the hope is that additional funding streams will be identified to maintain the efforts of enhancing the participation of children ages birth to 5 and their families. Blended funding may also be an option.
Lessons Learned

What tips can you share that might help others interested in pursuing a similar effort?
1. The ultimate message of why early intervention is important should be made clear in the beginning. The message of “pay now or pay later” brings more non-traditional partners to the table.

2. Families with young children seem more receptive to intervention/services due to being new to a service delivery system. Building resiliency for the various barriers they will face (turn-over in staff, retelling their story) will be important as they develop their advocacy and leadership skills.

3. Family and partner organizations exist and create partnerships. Instead of creating numerous new early childhood committees, expanding the existing committees is sometimes a better option.

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SECTION 5

CULTURAL AND LINGUISTIC COMPETENCE

NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Cultural and linguistic competence is one of the core values of systems of care. The increasing diversity of the populations served by systems of care makes it essential to give great emphasis to this value and to underscore the need for strategies to ensure access to high-quality, acceptable services for racially, ethnically and culturally diverse populations (Stroul, Blau, & Friedman, 2010). It also calls for an increased focus on reducing disparities in access, utilization, and outcomes of care across diverse populations. Multiple factors have caused these disparities over time and will require a variety of strategies to achieve resolution.

A culturally and linguistically competent early childhood system of care acknowledges and incorporates key elements to support the positive growth and development of a diverse array of young children and their families. These include:
1. “Value, accept, and respect diversity.
2. Have the capacity, commitment, and systems in place for cultural self-assessment.
3. Be conscious of the dynamics inherent when cultures interact.
4. Have continuous expansion of institutionalized cultural knowledge.
5. Have developed service delivery models, modes, and adaptations to accommodate diversity.”
   (Hepburn, May 2004)

When a community does not offer competent services and supports for diverse families and children, families may be less likely to participate and access needed services. Different perceptions regarding the following may lead to rejection of and/or attrition from services:

- Parenting roles and functions
- Expectations of young children and beliefs about appropriate developmental goals
- Views about needing and accepting help and assistance from non-family members
- Fears about being judged unfavorably
- Barriers imposed by language
   (Hepburn, May 2004)

In working towards a culturally and linguistically competent system of care, it is critical to learn about the culture of specific families and communities using an open approach to gathering information and seeking understanding. For those focused on early childhood mental health, it is particularly important to understand the significant role that culture plays in shaping child-rearing practices and expectations of appropriate behavior.

“All aspects of early child-rearing are influenced and informed by culture, including sleep and eating habits, expectations about autonomy versus dependence, discipline, trust, early literacy and language acquisition, and health and mental health practices. The programs that serve

young children must examine how well they are reaching out to and serving diverse populations and how accessible, relevant, sensitive, and individualized their services are. There is also a need for staff to reflect on how they can communicate about effective parenting practices without implying that there is only one correct way to parent young children. Ongoing training of staff in cultural and linguistic competence and evaluation of program effectiveness will inform and enhance utilization of services.” (Stroul & Blau, 2008, The System of Care Handbook, p. 496)

As the system development process moves forward, early childhood communities should strive to infuse culturally and linguistically competent services and supports throughout. In addition, system developers must work collaboratively with their community partners to identify and implement culturally informed strategies to reduce disparities and increase service access and utilization among young children and their families.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Have you explicitly spelled out the role of the Cultural and Linguistic Competence Coordinator, including expectations regarding how he/she will support and partner with other members of the staff? Are other members of the staff aware of the CLC Coordinator’s role and how he/she can support them in their roles within the system of care (and vice versa)?

2. In what areas does your CLC Coordinator need/want professional development training? Have you identified opportunities that are available to help the CLC Coordinator strengthen his/her skills around cultural and linguistic competence?

3. How will you promote understanding of CLC across your staff? Across your system? What partners might you engage in this work?

4. How will you assess progress towards a culturally and linguistically competent system? Who will be involved in selecting progress indicators, determining how they will be measured, analyzing data, and acting upon findings?

5. Do you have a plan or initiative to address cultural and linguistic competence in your state/community?

6. Is cultural competence being addressed at multiple levels including policy, system planning, and service delivery?

7. What are the major racial, ethnic, and cultural groups in your state/community?

8. Are the major racial, ethnic, and cultural groups included in the planning and implementation of the CLC activities?

9. What key partners must be involved and how can community participation be ensured (family, youth, and providers)?

10. Is training available to providers and families on cultural and linguistic competence?

11. Do you incorporate what parents and families have learned from their own cultural heritage, countries of origin, and ancestry about families, parenting, and child development into early intervention strategies?
LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

- Ensure a unified and comprehensive philosophy and understanding of cultural and linguistic competence across all partners and aspects of service delivery. This includes a common language and definition of CLC as well as how to apply it.

- Consensus building among agency and community leadership is critical. Accordingly, CLC “champions” must include respected and trusted community and agency leaders.

- Consultation and technical assistance on CLC from experts in the field as well as continuing education of initiative leaders is essential.

- It is a good idea to have those who will be working within your system of care—particularly those that have direct interaction with families—to become familiar with different cultural perspectives on parenting practices and expectations. Consider having members of different cultural groups from your community help guide this discussion and provide expertise in this area.

- Look at demographic data to make sure you have an accurate understanding of the diversity of the community you are serving. Revisit the data over time to be sure you always have a current picture.

- Engage cultural partners to help determine how best to increase CLC in your community—be wary of having pre-conceived notions on how to infuse CLC. Work with your partners to figure out what you can do to help and what strategies will be most effective.

- A comprehensive approach to the integration of cultural competence at all levels of development and operations requires a full-time position. Work with your local budget director and, if necessary, Federal Project Officer, to find creative ways to fund a 1.0 FTE CLC Coordinator.

- It important that CLC is championed by many within your system, not just the CLC Coordinator.

- Engage the CLC Coordinator in all aspects of systems development from the beginning—from evaluation to governance to social marketing and beyond. Their perspective is invaluable and the more they are involved, the more likely the “CLC perspective” will be absorbed by others at these various tables.

- In striving for cultural competency, it is vital to incorporate community voice. By welcoming and encouraging the input of community members and families served, the task of achieving cultural competency is more easily achieved.

- In order to achieve cultural competency, it must be woven into policies and procedures. How to strive for and achieve cultural competency must be clearly articulated and embraced as “business as usual.”

- To be value driven—in any aspect, including CLC—it is important to specifically define what those values are in practice and measure their effect.

- When forging new relationships with different cultural partners, always begin by assessing “where people are” and asking them what they need. One community worked closely with Latina mothers to help them become strong advocates for their children, based on their desire to do so. The local system of care worked collaboratively with members of the Latino community to design a leadership training. In addition, the community formed the Latino Leaders Academy, which grew to 45 members strong and garnered financial support at the county level for child care and transportation during meetings.
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. **Moving Toward Culturally and Linguistically Competent Services Through a Multi-Agency Multicultural Training Program:** *Hand in Hand—Fort Worth, TX*

B. **Operationalizing Cultural and Linguistic Competence:** *Starting Early Together—Allegheny County, PA*

C. **“The Observed and the Observed”—Raising Awareness of Cultural Diversity and Mental Health Through Art:** *Sarasota Partnership for Children’s Mental Health—Sarasota, FL*

RESOURCE MATERIALS

- Definitions
  - Definition of “cultural competence”: “A set of behaviors, attitudes and policies that come together in a system, agency, or among professionals and enables them to work effectively in cross-cultural situations... Cultural competence is the acceptance and attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations.” (Cross, et. al., 1989)³
  - Definition of “linguistic competence”: “[T]he capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities.” (Goode & Jones, 2004)⁴


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• National Child Traumatic Stress Network (NCTSN) website—has a number of CLC resources, including a section focused on cultural considerations regarding different types of therapeutic interventions. www.nctsn.org

Community Resources
Interpreter Policy: Many Languages, One Voice! A policy guide to working with interpreters. (Wraparound Oregon: Early Childhood/Multnomah County, OR). Available at: http://gucchdtacenter.georgetowndata/early_childhood_SOC.html
KEY CONTACTS AND WEBSITES

Websites
• National Center for Cultural Competence: www11.georgetown.edu/research/gucchd/nccc
• CLC Community of Practice Homepage: www.tapartnership.org/COP/CLC/default.php
  – CLC Community of Practice Listserv (Scroll down to the “Get Connected” section)
  – CLC Coordinator Directory (Scroll down to the “Get Connected” section)
• Office of Minority Health: www.minorityhealth.hhs.gov

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Moving Toward Culturally and Linguistically Competent Services Through a Multi-Agency Multicultural Training Program

Hand in Hand—Fort Worth, TX

Strategy/Initiative Summary
The Mental Health Connection (MHC) has and continues to implement various strategies at different levels of the System of Care to move the county’s mental health providers toward more culturally and linguistically competent services. At the heart of those efforts is the creation of a seven person multi-agency training team which provides an intensive four day multi-cultural training to practitioners and supervisors who are members of the Mental Health Connection and whose leadership has also participated in the training. After a two-day executive retreat and a four day practitioners’ retreat was held in 2008 using the California Brief Multicultural Competence Scale (CBMCS) Multicultural Training Program curriculum, over 15 practitioners submitted applications to be a part of this team. After review of applications and interviews by a selection committee made up of community leaders and CBMCS consultants, seven people from six different agencies were selected to receive additional training and supervision with Dr. Gloria Morrow, consultant and master CBMCS trainer. Since that time, this training team has provided the intensive four-day CBMCS Multicultural Workshops for over 200 practitioners from the 18 agencies whose executives attended the 2008 retreat. Consequently, this training project has been the conduit for the beginning CLC policy and practice change at the organizational level with the goal of system change within view.

Getting Started
Why did your community pursue this effort?
In December of 2007, under the direction of the MHC, six “Learning Communities” began meeting to review existing research and identify mental health and substance abuse evidence-based programs and practices that would address the needs of Tarrant County. Representatives from various areas of the system of care met monthly with each Learning Community focusing on a different mental health-related topic. At the end of six months, each group issued an executive summary of its findings with recommendations for evidence-based practices to be piloted in Tarrant County. “At-Risk and Prevention” was the focus of one of the learning communities. In reviewing literature specific to this topic, the research was clear that effective prevention efforts are systemic and all components are interrelated; therefore, the effectiveness of any one component is related to the availability and effectiveness of all other components. Consequently, this Learning Community delved into research on effective “systems of care.” In reviewing evaluations of System of Care communities, a number of common barriers emerged. Chief among them was a constant weakness in cultural competence at many levels of those evaluated systems. As a result, the group turned its focus to reviewing articles that addressed culturally competent practices at both the practitioner and systemic levels. The findings held true regardless of the target population, risk/protective factors or evidence-based program or practice—cultural competence is critical for positive outcomes. These particular findings were the keystone for moving forward with a System of Care initiative to address cultural competence:

• To bring about coherent, systemic and sustained change related to cultural competence, all three of the following levels must be addressed: 1) authority or policymaking level, 2) organization/agency level, 3) individual clinician or provider level.
Embedding cultural competence into organizations’ structures and a SOC quality-improvement framework helps ensure that such an initiative is lasting and ongoing as opposed to an isolated or time-limited activity that is geared to only one part of a system.

What were the initial steps in getting this effort off the ground?
In order to develop the necessary commitment and sustained energy needed for system change and transformation around cultural and linguistic equity, a recommendation was made for the development of the action committee called ACCESS: Advancing Cultural Confidence and Equity in Standards and Services. This group was originally comprised primarily of Learning Community participants, which included mental health consumers and family members, front line practitioners, probation officers, college students, school district administrators, therapists, and agency executives, all from partner agencies of the Mental Health Connection. This group provided the impetus for the next stages of implementation.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
Partnerships in this effort included “Champion” from the Learning Community and project, the ACCESS Group, executives from the 15 different MHC partner agencies, including: Tarrant County Juvenile Department and Fort Worth ISD, System of Care Project staff (Hand in Hand) and Dr. Gloria Morrow, consultant. All played key roles in moving the effort forward. Monthly meetings of the ACCESS Group were held for planning and implementing the initial retreats. A smaller “steering committee” included initiative leader, Mental Health Connection Director, Juvenile Services, parent, and school district representative. This committee identified and vetted the cultural competence training (CBMCS), and consultant, Dr. Gloria Morrow. In addition, all those mentioned here helped to build consensus and organized the initial retreat, served as selection committee for training team, and met with technical assistance and consultants to follow through on implementation.

Implementation
How did you move from planning to implementation?
The Leadership of the ACCESS Committee reviewed and studied research around community change that included topics such as “creating a climate for change”, “increasing community capacity” as well as descriptions of other communities’ efforts of SOC change around Cultural and Linguistic Competence. Technical Assistance and consultants were utilized to help develop awareness. This research led the group to decide that the next steps needed to include developing a “common language” and “increasing a sense of urgency”. After some consensus building with the agency executives, a two day overnight retreat was planned for Executives and a 4 day overnight retreat was planned for practitioners. Research was done on possible CLC trainings that had evidence backing the results: The California Brief Multicultural Competence Scale (CBMCS) Multicultural Training.

Barriers/Obstacles
What challenges, issues, complications or obstacles have emerged along the way?
- Assuring that CLC training efforts are impactful is time consuming. Having staff out of the office for extended periods creates a hardship for many agencies.
• Agencies/individuals are at different stages of readiness which presents challenges in keeping all agencies engaged in the process of change since different agencies and individuals have different needs.
• A paid devoted staff member is necessary to provide the needed time and energy to accomplish the goals.
• There is much emotionality when discussing cultural issues and consequently “managing distress” is critical. Leadership must understand this concept and learn how to manage it instead of “moving away” from the CLC initiatives.

What potential pitfalls can be identified that others can avoid?
Agency leadership and support in the CLC efforts are key. The vocal support of key leaders is extremely important in increasing agency consensus.

Funding/Sustainability
How is this effort funded?
Initial training and supervision of CBMCS was funded by the SOC Grant. Other efforts were funded through local foundation grants. However, efforts are primarily volunteer driven.

What elements are (or will be) in place to sustain this effort after the grant period ends?
It is anticipated that by the end of the grant period, the MHC Training Team will have provided the CBMCS Workshop for over 300 practitioners. Sustainability plans include expanding the training team members and continuing to offer the workshop after the grant ends. Needed funds will be sought from local foundations that have been apprised of our efforts since the beginning and have been included in census building dialogues and planning. A Cultural and Linguistic Competence Committee is a standing committee in the MHC board structure. The long term goal of this effort is to have Cultural Competence standards of care interwoven within MHC Governance policies as well as those of all partner agencies.

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OPERATIONALIZING CULTURAL AND LINGUISTIC COMPETENCE

Starting Early Together—Allegheny County, PA

Strategy/Initiative Summary
All aspects of the Starting Early Together initiative, from its initial design through evaluation and continuous quality improvement, include strategies to acknowledge and support the values, customs and traditions of individuals and families. Some examples are:

• Recruiting members of the Planning Committee, Community Evaluation Team, and representatives to the Child Services Committee from representative members of the communities to be served.

• Actively recruiting and employing multiethnic and multiracial staff who live in or have broad knowledge of the community they will serve and ensuring that contracts with community-based and other providers specify the expectation.

• Community hiring process using interview teams comprised of family members and community representatives.

• Location of program offices in the heart of communities served by the system of care.

• Reviewing language of all program materials/communications to ensure that it is respectful and culturally competent.

• Training staff and volunteers in system of care principles and policies, including cultural and linguistic competence.

• Linking to service providers who speak the young adults’ native or providing translation services for participants with limited English proficiency.

• Continually assessing cultural competence through the program’s evaluation (of outreach, service delivery, facilities, hours, and access).

Getting Started
• Identification of the strengths and needs of communities to be served

• Assembly of a planning committee that is reflective of the communities to be served.

Key Partners
Parents/family members; mental health representatives, staff from early intervention, family support centers, Headstart/Early Headstart, child care providers, and physical health centers; community leaders, and Starting Early Together contracted providers.

Implementation
• Development of supportive policies and procedures that provide a comprehensive perspective on culture and guide the development of strategies and initiatives to meet the needs of those to be served.

• Development of MOUs and letters of agreement.

• Cultivating and nurturing relationships with families and community organizations who can continually inform and provide feedback relative to cultural competence of services, providers and staff.
**Barriers/Obstacles**

*What challenges, issues, complications or obstacles have emerged along the way?*

Ensuring that the community interviewers are informed of employment laws/regulations that govern interview processes.

*What potential pitfalls can be identified that others can avoid?*

- A comprehensive approach to the integration of cultural competence at all levels of development and operations requires a full-time position.
- Ensure a unified and comprehensive philosophy and understanding for the definition and application of cultural competence with all partners and aspects of service delivery.

**Funding/Sustainability**

Because culture isn’t one-dimensional, competency requires continued training, discussion and practice. Cultural competence is a journey that begins with awareness and education, and continues through the intentional application of that knowledge in working with individuals and families in the system.

**Primary Contact**

Nneka Hawthorne, Cultural Competence Specialist  
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Strategy/Initiative Summary

The Observer and the Observed project brought together sixteen local artists and four families impacted by mental health and/or behavioral challenges to create four unique artistic perceptions of each family (total 16 pieces). This project emerged from the Cultural and Linguistic Competence Work Group as a strategy to increase awareness and decrease stigma related to children’s mental health challenges, and to invite communication and reflection around key issues of cultural diversity and family dynamics. Art was used to demonstrate how we all have unique viewpoints, which makes for a very diverse world.

The Observer and the Observed documentary film mixes footage of the families’ and artists’ interactions with interviews and glimpses into the creative process, and shows the way people learn and change—or don’t—when asked to step outside their comfort zones. The film premiered at the Sarasota Film Festival to sold-out audiences with overwhelmingly positive responses. In the discussions following the screening, audience members shared their own family experiences with mental health difficulties, expressing gratitude to the families who shared their stories so that others might rethink their assumptions about children, families, and mental illness.

Getting Started

Sarasota County has a rich foundation in the both the arts and in human services. We felt that Art would have a big impact on the community and that it would visually convey the essence of cultural competence. The initial steps were to find artists and a space to host the exhibit and invite enrolled families to share their stories through this project.

Key Partners

We partnered with Art Center Sarasota to recruit artists, the Ringling Art School for student artists, and with a videographer to document the entire project as it progressed. The Cultural and Linguistic Competency Work Group, comprised of community partners and volunteers, provided oversight of the project (and a significant amount of the project work). Families were invited to participate in the project and were selected based on their time commitment and interest in sharing their family’s experiences in this creative way.

Implementation

Families and artists were matched after an interactive gathering at the Art Center. Over the next ten months, artists became acquainted with their families through activities of the families’ choosing. The artwork created was revealed to families at an Art Reception in July, followed by a three-month exhibit at the Art Center Sarasota. A full-length documentary film was created to share the experiences of participating children, families and artists with a broader audience.
Barriers/Obstacles

The Observer and the Observed project was designed as a creative expression of the “Observer” concept—how every person perceives the world in a unique way. Art is used to illustrate how perceptions are based on the lens of personal experience, values and assumptions. The creativity of the artists brought “the observer” to life; there were no pre-set rules for the production of the art. Although there was benefit in the organic evolution of the project from the artist’s and families’ interactions and creativity, the participants could have benefitted by more structure in regards to arranging contacts and events. Some families were especially hard to reach to schedule visits.

Funding/Sustainability

The Cultural and Linguistic Competency Work Group applied for Sarasota Partnership (SAMHSA) funding through a Request for Proposals initiative offered to Work Groups. The Observer and The Observer Project is continuing in the form of A World Café which hopefully will be sustained after the grant ends.

Lessons Learned

The Observer and the Observed artwork was exhibited for three months, attracting a large number of Sarasota residents, tourists and school children. The multitude of visitor’s comments suggested a deep understanding of the message, suggesting that the artwork conveyed relatively complex subjects in concrete and clear ways. The project has been recognized for the collaboration between arts and human services organizations.

Resources

www.Observermovie.com

Primary Contact

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Sarasota Partnership for Children’s Mental Health
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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Prior to 2009, all system of care grantees were required to hire a youth coordinator, reflecting SAMHSA’s strong commitment to “youth guided” as a core system of care value. This position was responsible for helping to foster a youth guided system of care, i.e., one that engages youth as equal partners in creating systems change in policies and procedures at the individual, community, state and national levels (see www.tapartnership.org). While this role made perfect sense for systems of care serving youth and young adults, early childhood system of care communities struggled with the question, “what does this mean for us?”

Early childhood communities funded prior to FY2010 found some creative ways to utilize this position (e.g., working with teen parents of young children), but it was an ongoing challenge to operationalize this role in a meaningful and developmentally appropriate manner. Certainly, young children could not be expected to participate in policy discussions nor should they be guiding decisions regarding services and supports—those were functions best suited to the parents/caregivers. It became clear that adjustments to this youth coordinator requirement were needed to better reflect the unique circumstances surrounding EC SOC communities.

Thus, in 2009, SAMHSA issued revised guidance (see resources section), which gave communities exclusively serving children younger than age 9 the option to hire a youth coordinator OR to channel funds for that position towards bolstering family involvement efforts. These revisions took effect for newly funded communities in FY2010.

While the revised guidance has been a welcome change for EC SOC communities, grantees now must deliberate on which option outlined by SAMHSA makes the most sense for the children and families served by their local system of care. This section is designed to help EC SOC communities weigh those options and to provide guidance on strategies that might be implemented for either scenario.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

When discussing the role of the Youth Coordinator (YC) in your community, consider:

1. What fits within the scope of work your community has set out to accomplish? Refer back to your strategic plan, logic model, etc.
2. What skills does your YC have (or will you ask for in a job description)? What professional development might be needed around early childhood issues?
3. How can you engage “youth voice” in an early childhood system of care without trying to interpret behavior?

1 The title for this position has evolved over time. For this publication, the term youth coordinator is meant to encompass youth engagement specialist, youth empowerment specialist, youth involvement coordinator, or any other titles reflecting the duties of the youth professional in a system of care.
When thinking about strategies for YCs to implement, consider:

1. What are the strengths and needs of your community/program around early childhood?
2. What are developmentally appropriate strategies?
3. Involvement at various levels: program, community and system
4. The potential to impact young children indirectly—through parents, siblings & other family members, or advocating for changes in services or systems that serve young children (this might include mentoring others to become advocates)
5. The partners that you might need to engage to make these strategies succeed
6. How will you know if each strategy is working well? What will you look for and how will you measure it?

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Support the youth coordinator by providing training specific to working in an early childhood system of care. In addition to general information about system of care values, focus on topics such as early childhood development, early childhood mental health, and key programs/systems/organizations that support young children and their families in your community (e.g., Head Start, Early Intervention system).
• Take time to figure out how best to capitalize on the skills and strengths of the youth coordinator. Once those areas of expertise and interest have been identified, work closely with the youth coordinator to hone those talents.
• Work with the youth coordinator and other members of your system of care team to determine how best to channel the youth coordinator’s efforts and to what audiences. It can be challenging to determine who the youth coordinator’s direct service population is in an early childhood system of care.
• Given young children’s dependency on their caregivers, consider ways that the youth coordinator can help the children indirectly through activities that support and empower the families. Close collaboration between the youth coordinator and the family support lead is particularly important in early childhood systems of care. Several communities work with teen parents—a strategy that helps to support youth/young adults and their young children.
• Make sure that any activities directly involving young children are developmentally appropriate. The team’s clinical director can be helpful in providing guidance about what types of activities are appropriate for infants, toddlers and preschoolers. One community’s youth coordinator organizes child care during system of care meetings/events, and works closely with a child development specialist to ensure the activities offered during that time are fun and age-appropriate.
• When thinking about how to encourage “youth involvement” in an early childhood system of care, older children can be a great resource for communities with an early childhood focus. One community held focus groups with older youth experiencing social/emotional issues to discuss what they wish had been available to them at an earlier age.
• Social marketing pairs very well with youth activities so be sure that the youth coordinator engages the social marketer when developing and implementing various efforts.
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. Collaboration with Public Schools: Wraparound Oregon: Early Childhood—Multnomah County, OR

B. Working with Teen Parents: Building Blocks—Southeastern Connecticut

C. Opting for a Co-Lead Family Contact Position: Kentucky SEED—Kentucky

D. Family Events Series: RI Positive Educational Partnership—Rhode Island

E. Early Childhood Focused Youth Engagement System: Delaware’s B.E.S.T.—Delaware

RESOURCE MATERIALS

National Resources
• FAQ document issued by SAMHSA with revised guidance on the youth coordinator position. Available at: www.samhsa.gov/Grants/2010/SM-10-005faq.pdf


KEY CONTACTS AND WEBSITES

Websites
• TA Partnership’s Youth Involvement: www.tapartnership.org/content/youthInvolvement/default.php
• Youth MOVE (Motivating Others through Voices of Experience): http://youthmovenational.org

Technical Assistance Provider
James Sawyer
Youth Involvement Content Specialist
Federation of Families for Children’s Mental Health/TA Partnership
Phone: (240) 403-1901
Email: JSawyer@ffcmh.org
COLLABORATION WITH PUBLIC SCHOOLS
WRAPAROUND OREGON
Early Childhood—Multnomah County, OR

Strategy/Initiative Summary
In Multnomah County, Oregon, their Youth Engagement Specialist (YES) worked with a local non-profit, Resolutions Northwest, to develop a curriculum for 6th-8th grade student council members on modeling positive peer behavior. The rationale for targeting this activity to older students was that the impact would spread to younger students and siblings. The culmination of the 8 week course was a media event, complete with the local radio station, TV, a judge and mental health counselors. Success was evident when the student council joined the faculty on the playground to model and support positive peer behaviors. The incidents of bullying declined and the school now funds the program on its own and is in the third year.

Following the success of this effort, the YES worked to implement a new curriculum for first grade students. A 16 week course, which is now in its third year, includes having the YES spend 40 minutes a week in each of several first grade classrooms between two schools. Teachers and administrators are quite enthusiastic about the program and give up instructional time for this effort. A counselor joins the YES in the classroom for readings, exercises, discussions and positive play activities. Parents are involved by giving permission and having lots of materials sent home to support the positive mental health messages. Wraparound Oregon: Early Childhood purchased the curriculum and the YES has expanded her work to three school districts, where she works with 500 first grade students each week. The school districts have all agreed to purchase this service on their own and the plan is for the YES to continue her work with the schools after the grant is complete.

Lessons Learned
• Building relationships with school nurses proved to be an excellent tool to forge partnerships with schools.
• In early childhood, it is important to support a health promotion and prevention framework.
• Our work is in alignment with the goals of the school and is a support for the teachers, which built the buy-in we needed.

Resources
Feature article describing the YES and her implementation of the curriculum: www.mesd.k12.or.us/pa/Interaction3-2-11.pdf

Primary Contact
Micah Thomas, Youth Engagement Specialist
Oregon Family Support Network/Wraparound Oregon: Early Childhood
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WORKING WITH TEEN PARENTS
Building Blocks—Southeastern Connecticut

Strategy/Initiative Summary
In Southeastern Connecticut, Building Blocks subcontracts with the local chapter of the Federation of Families for Children’s Mental Health—Families United—to conduct a variety of family and youth support activities. One that is uniquely targeted to youth is the Young Adult Parent/Caregiver Support Network for 16-25 year olds with children. This Support Network is facilitated by a Young Adult Peer Mentor, who is also a caregiver. Although there are other parent support groups in the state, this one is designed specifically to meet the needs of this age group. Each participant has the option to be connected to a Peer Mentor for more individualized support. The goal for the group is to empower participants to advocate for themselves/their families, advocate for others/peers, and advocate on a leadership level to provide the family/youth voice to decision making tables within and related to the local system of care.

Primary Contact
Danielle Chiaraluce, Executive Director
Families United
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OPTING FOR A CO-LEAD FAMILY CONTACT POSITION
Kentucky SEED—Kentucky

Strategy/Initiative Summary
During Year One, an implementation planning process based on the implementation framework (Attachment A) delineated by Dr. Dean Fixsen and his colleagues, drove the process to determine how the Youth Coordinator (YC) position would function with an early childhood system of care. The drivers and the Technical Assistance Partnership, determined an Early Childhood Empowerment Specialist (ECES) would meet the needs for this statewide early childhood initiative.

During Year Two, the State Administrative Team (SAT) and staff discovered the ECES and Lead Family Contact role were almost identical in the day-to-day activities and responsibilities.

When the ECES resigned, the SAT and staff conducted several meetings and determined a Co-Lead Family Contact position would best meet the goals and objectives for KY SEED. This additional position ensures sufficient support to Regional Family Contacts as they build local network and additional support to the regions that are implementing KY SEED. The Co-Lead Family Contact position was created (Attachment B) and was hired in Year Three.
Getting Started

*Why did your community pursue this effort?*

Although the YC position was optional, the implementation planning process and previous experience with two system of care communities in Kentucky demonstrated the position vital to the success of KY SEED.

*What were the initial steps in getting this effort off the ground?*

Initial steps included many conversations with the State Administrative Team who have years of experience with previous system of care efforts, 5-6 meetings to complete the implementation planning process from which the job description was crafted, and technical assistance from the Federation of Families. Additionally, the SAT aligned the position with the KY SEED Logic Model to determine how it would fit within the overall goals and objectives for KY SEED.

Key Partners

*What organizations, agencies or individuals partnered with you on this effort, and in what ways?*

The following individuals were committed to determine how the ECES position would meet the needs for KY SEED. They were involved with the initial steps, implementation, and evaluation of the position.

1. Laura Beard, KY SEED Lead Family Contact
2. Carol Cecil, Director, KY Partnership for Families and Children
3. Mary Beth Jackson, Division of Child Care, Department of Public Health
4. Kari Collins, Division of Behavioral Health, State Administrative Team
5. Beth Jordan, Division of Behavioral Health, Co-Principle Investigator
6. Vestena Robbins, Division of Behavioral Health, Co-Principal Investigator
7. Michelle Sames, Former Early Childhood Empowerment Specialist
8. James Sawyer, Federation of Families
9. Joy Varney, Assistant Director, KY Partnership for Families and Children

Implementation

*How did you move from planning to implementation?*

After using Year One for planning, the ECES implemented the strategic work plan which outlines the goals, objectives, strategies, and timelines for the ECES. The plan guided the work of the ECES as developed from the logic model (Attachment C), implementation blueprint, and staff/partner input.

Barriers/Obstacles

*What challenges, issues, complications or obstacles have emerged along the way?*

After the first year of implementation, the SAT, Kentucky Partnership for Families and Children (KPF), and staff discovered the ECES and Lead Family Contact day-to-day activities overlapped. The ECES found it more difficult to meet the outlined responsibilities at a local and regional level. The logistics, demographics, and score of a local and regional ECES are less complex than of a state ECES.

*What potential pitfalls can be identified that others can avoid?*

The qualities and characteristics for the ECES position should emphasize flexibility. Considering the uniqueness of the position, the SAT and KPF developed the position as it was being implemented. This type of creativity can be attractive to self-starters and risk-takers but can be stressful and confusing for others.
OPTING FOR A CO-LEAD FAMILY CONTACT POSITION (CONTINUED)

Be careful not to reinvent the wheel. As SAT and KPFC developed the position, they ensured partnering agencies did not have a similar position that was called by another title.

**Funding/Sustainability**
*How is this effort funded?*

The SAT and KPFC developed the ECES position over Year One with SAMHSA funds, implemented it for 6 months in Year Two, and discontinued it in Year Three.

*What elements are (or will be) in place to sustain this effort after the grant period ends?*

The SAT and KPFC discontinued the position for KY SEED and will not need seek additional funds for sustainability. However, a Lead Family Contact position was hired in lieu of the ECES. At this time, the hope is that additional funding streams will be identified to maintain the efforts of enhancing the participation of children ages birth to 5 and their families. Blended funding may also be an option.

**Lessons Learned**
*What tips can you share that might help others interested in pursuing a similar effort?*

Be sure to plan before implementing. Although the position was not sustained, when the decision was made to discontinue and create a Co-Lead Family Contact position, the team was confident with the decision.

When thinking about how to encourage youth involvement, older children are a benefit for the 0-5 population of focus. KY SEED held focus groups for older youth to discuss what their needs were at that age and to provide feedback to the adults providing their care.

Providers and families of children 0-5 must be empowered and engaged to maintain an effective system of care. When they are trained and think more confidently in their abilities, they help children communicate their needs and prevent further barriers.

**Resources**

www.kypartnership.net

**Primary Contacts**

Tamara Stewart, Project Director
KY SEED
Phone: (859) 622-7281
Email: Tamara.stewart@eku.edu

Cecil, Director
KY Partnership for Families and Children
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FAMILY EVENTS SERIES
RI Positive Educational Partnership—Rhode Island

Strategy/Initiative Summary
In Rhode Island, the Youth Coordinator and the Family Support & Involvement Coordinator implemented an ongoing series of family events that included simultaneous activities for parents and their young children. For the parents there were topics of interest that were presented by area experts dealing with various social/emotional, developmental, and mental health issues. The children, approximately 5-12 years, were divided into age groups, and participated in developmentally appropriate activities, also focused on social/emotional issues. These activities were planned and facilitated by the RIPEP teen youth group, under the direction of the Youth Coordinator, and a child development consultant.

Primary Contact
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State Youth Involvement Coordinator
Parent Support Network of Rhode Island
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EARLY CHILDHOOD FOCUSED YOUTH ENGAGEMENT SYSTEM
Delaware’s B.E.S.T.—Delaware

Strategy/Initiative Summary
Early childhood youth engagement—for children birth to 5—is a requirement of Delaware’s System of Care transformation. However, engaging this special population was not well-defined and required adaptation of existing materials and programs.

Getting Started
• Had to define what birth to 5 youth engagement meant for Delaware.
• Early on, established partnerships in the early childhood community and nurtured these relations.
• Made a conscious effort to include it in every aspect of our work—It’s broader than a position. It’s part of everyone’s responsibility.

Process
• Connected with other communities to explore best practices.
• Our Early Childhood Youth Engagement Specialist had previous experience working in early care and education programs, knew early childhood community partners, and had a vision of how to engage this special age group (i.e. developed customized curriculum and When I Grow Up dress-up activity).
• Established a working partnership with the Lead Family Contact—you must engage parents and caregivers when working with a birth to 5 population.
EARLY CHILDHOOD FOCUSED YOUTH ENGAGEMENT SYSTEM (CONTINUED)

• Perseverance—Realize that early youth engagement is an “unknown” idea for many people. Be patient. Be willing to educate and re-educate. Don’t give up!

**Barriers/Obstacles**

• Getting providers to trust as they are instinctively protective of the young children they serve. Work to build trust.
• Do what you say you are going to do—follow-up is crucial.

**Sustainability/Funding Considerations**

• Continue to reinforce what happens in early childhood matters for a lifetime by creating opportunity for young children to showcase their social and emotional developmental needs.
• Find local champions and nurture the relationships—Delaware’s Governor, Lt. Governor, First Lady, Children’s Department Cabinet Secretary and other administration staff support early childhood mental health initiatives and demonstrate it through participation in Awareness Day activities.

**Future Steps**

Continue to educate and expand engagement with the early childhood community.

**Key Tips/Strategies for Success**

• Know your audience—educate yourself on cultural and other needs
• Know where you need to focus your attention—stay on course
• Get commitments from key partners—it can’t be done alone (i.e. champions, advocates, elected officials, stakeholders, etc.)

**Primary Contacts**

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Lead Family Contact
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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

To achieve the best possible outcomes for young children and their families, it is important that communities offer—and ensure access to—a comprehensive array of strong services and supports. Such an array should encompass promotion of positive mental health, prevention of mental health challenges, and intervention for mental health problems, while reflecting system of care principles and values (e.g., culturally and linguistically competent, individualized, family-driven, community-based, etc.). Early childhood system of care grants provide key “seed money” to help communities put comprehensive, high-quality services and supports in place. By working with local service providers and organizations to integrate and enhance existing services and supports, as well as channeling grants dollars towards system capacity-building activities that address gaps, grantees are poised to facilitate significant systems change.

As early childhood systems of care communities prepare to move forward with systems development, it is important to remember that grantees serving this age population can enroll children at imminent risk for mental health challenges, as well as those who are diagnosed with mental health issues. This unique opportunity for early childhood grantees to focus on prevention is exciting and aligned with best practice, yet it also presents the challenge of funding prevention services in a sustainable way. Another key consideration is the widespread integration of social and emotional screenings to ensure that children with or at risk for mental health challenges are identified as soon as possible. As with all services and supports for young children, screening processes must be infused into natural settings “where the children are” (e.g., primary care, child care, etc.). Finally, early childhood system of care communities must broaden the scope of services and supports to encompass those caring for young children as well (e.g., family members, child care providers, primary care providers, faith-based leaders, etc.)

Communities with an early childhood focus should also keep in mind that families with young children may just be starting their journey in the formal service delivery system. Thus, there may be some unique sensitivity issues to which early childhood grantees must be attuned. As one EC SOC provider stated, “there is an element of uncertainty of the child’s future that is a bit larger in early childhood than with older children where patterns of behavior have been established or clear diagnoses have been made and remain constant.” Some communities have sought to address these issues by incorporating a family partner to support and advocate for families entering the system of care, offering a less intense service delivery option than traditional Wraparound, and developing a communications strategy that emphasizes the benefits of intervening early for optimal outcomes and focuses on “social and emotional health” as opposed to “mental health” terminology. Overall, there are many factors for EC SOCs to consider as they plan for and implement services and supports for young children and their families. This section provides valuable insight on this topic and offers field-tested strategies for communities to consider for local systems development.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Have you identified a population(s) of focus for services and supports (e.g., all children under age 5 in a certain county? military families with young children?). To what extent is your community prepared to provide services and supports for that meet the needs of this particular population(s)?
2. To what extent does your state/community have a comprehensive array of services and supports for young children and their families? What are the major services and supports for children and for families? Are they available statewide/community-wide?

3. Are you coordinating efforts across agencies?

4. Have you identified who is qualified in the community to make infant/early childhood mental health diagnoses? Are they trained on the DC:0-3R diagnostic tool?

5. Does your state/community have a crosswalk in place between the DC:0-3R and the ICD-9CM?

6. How do families/children access early childhood mental health services? Are there multiple points of entry for early childhood mental health services?

7. Does your system of care provide facilitated referrals for families to help them better link with needed services and supports?

8. Have you spoken to families about their feelings towards infant/early childhood mental health diagnoses? If diagnosis raises concerns about stigma, labeling, etc., how will your community address these issues?

9. What family supports such as respite, parent-to-parent support, and family resource centers are available? How are families informed about these?

10. To what extent is your family lead and/or a family advocate engaged in your service enrollment, planning, and implementation processes?

11. What services and supports are available to other caregivers (e.g., mental health consultation, mentoring, training, reflective supervision, crisis support)?

12. Is your state/community funding pilot or demonstration projects? Are they being evaluated?

13. Are you tracking the use of and outcomes associated with clinical services provided through the system of care?

14. What is your state/community’s current service capacity in the areas of: a) promotion, such as the use of mental health screening in physician’s offices, library corners with social emotional health information; b) preventive services such as prenatal screening for high-risk mothers, home-visiting, mental health consultation; and c) intervention services such as play therapy, dyadic treatment, mental health consultation?

15. Have you identified and trained on evidence-based and/or promising practices that are appropriate for your community and service population?

16. To what extent does your EC SOC offer levels of intensity for your intervention services to match the needs and preferences of the families you are serving?

17. What other early childhood initiatives are taking place in your community that focus on promotion, prevention and/or intervention, and how might you link with these efforts?
LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• An accurate assessment of the level of need/capacity around infant/early childhood mental health clinical providers is very important. You do not want to create demand that you cannot meet.

• Provide or obtain training for mental health consultants in early childhood classroom consultation (i.e., programmatic consultation), as it is different from child-specific mental health consultation.

• Be sure to collect data to track outcomes associated with the services and supports you put into place—and report out on it regularly.

• Inventory what other communities are doing and modify, as needed, to meet your community’s needs.

• Moving from service planning to implementation requires mobilizing partners around training, social marketing, and evaluation. All elements are critical for success and communities should factor these in to their strategic planning process.

• Families of young children, who care completely new to the formal service delivery system, may be reluctant to engage in “high-intensity” services. Offering less intense methods for addressing families’ needs can facilitate entry into the system of care.

• Using “mental health” terminology can create a barrier to system entry. Many communities have found that placing the emphasis on services and supports that “promote social and emotional health” is a good strategy.

• For some families with young children, engagement with natural supports can be difficult. Parents may not be comfortable engaging other family members, neighbors or friends in a “teaming” process, unless those individuals already know of the child’s difficulties. EC SOC communities may need to identify other ways to provide natural supports, such as creating linkages between families with young children currently or formerly in the system through support groups, family events, or more formalized system of care processes.

• Trying to fit young children into a service delivery model designed to support children with significant mental health disorders across multiple service systems is inefficient and almost impossible to sustain. Infusing mental health consultation and supports within existing early childhood systems (such as early care and education, health, and home visiting) is more effective, both in terms of cost-effectiveness and positive results. Providing positive behavioral supports and functional behavioral assessment, monitoring responses to intervention for children, and offering skill-building training and coaching for parents and caregivers are all effective strategies to promote social-emotional health in a variety of settings.

• Develop informal supports—e.g., transportation and child care resources—early on and throughout the process.
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. Implementing Early Childhood Mental Health Consultation: Delaware’s B.E.S.T. for Young Children and Their Families—Delaware

B. Early Recognition and Response (ER&R) Task Force—Enhancing Screening Practices: Sarasota Partnership for Children’s Mental Health—Sarasota, FL

C. Implementing Comprehensive Infant-Family and Early Childhood Services: Project ABC—Los Angeles County, CA

D. Implementing Parent Child Interaction Therapy (PCIT) and Various Adaptations of this Evidence-Based Practice: Delaware’s B.E.S.T. for Young Children and Their Families—Delaware

E. Implementing a Tiered Service Delivery Process: Sarasota Partnership for Children’s Mental Health—Sarasota, FL

F. Screening, Assessment, Referral & Treatment (SART) Linkage Line and Clarifying Assessments: Early Connections—Alameda County, CA

G. Operationalizing the Role of the Clinical Director: Starting Early Together—Allegheny County, PA

H. Implementing a Crosswalk From DC:0-3R to ICD:9-CM: The Florida Center for Child and Family Development—Sarasota, FL

I. Merging School-Wide Positive Behavioral Interventions and Supports with the “Teaching Pyramid”: Rhode Island Positive Educational Partnership—Rhode Island

RESOURCE MATERIALS

Screening and Assessment

National Resources


Community Resources

Service Coordination
National Resources


Community Resources
• *Linking and Aligning Care Coordination*—several materials to support widespread care coordination, including a care coordination plan and a customizable toolkit for local use (Project BLOOM/Denver, CO). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

Clinical Director
National Resources
• Clinical Director hiring guidance developed by the Technical Assistance Partnership for Child and Family Mental Health. Available at: www.tapartnership.org/docs/TipSheetClinicalDirector.pdf

• FAQ document regarding the role of the Clinical Director developed by the Technical Assistance Partnership for Child and Family Mental Health. Available at: www.tapartnership.org/content/mentalHealth/faq/01clinicalDirector.php

Community Resources
• Guidance regarding crafting the position of Clinical Director and interviewing for the position (Starting Early Together/Allegheny County, PA). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

Evidence-Based/Promising Practices
National Resources
• Matrix of Promising and Evidence-Based Practices (EBPs) being used across early childhood system of care communities compiled by the Georgetown University National Technical Assistance Center for Children’s Mental Health. Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html


**KEY CONTACTS AND WEBSITES**

**Websites**

• Georgetown University Center for Child and Human Development: [http://gucchd.georgetown.edu](http://gucchd.georgetown.edu)

• Project LAUNCH: [http://projectlaunch.promoteprevent.org](http://projectlaunch.promoteprevent.org)

• The Center for Evidence-Based Practices: [www.evidencebasedpractices.org](http://www.evidencebasedpractices.org)

• Center for Effective Mental Health Consultation: [www.ecmhc.org](http://www.ecmhc.org)

• National Child Traumatic Stress Network: [www.nctsn.org](http://www.nctsn.org)

• Center on the Social Emotional Foundations of Early Learning (CSEFEL): [http://csefel.vanderbilt.edu](http://csefel.vanderbilt.edu)

• The Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI): [www.challengingbehavior.org](http://www.challengingbehavior.org)

**Technical Assistance Providers**

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IMPLEMENTING EARLY CHILDHOOD MENTAL HEALTH CONSULTATION
Delaware’s B.E.S.T. for Young Children and Their Families—Delaware

Strategy/Initiative Summary
Please provide a few sentences describing the strategy/effort: Early Childhood Mental Health Consultation (ECMHC) is an effective service for supporting young children’s social-emotional development in early care and education settings. ECMHC was developed in Delaware to provide child-specific mental health consultation, classroom consultation and Teacher-Child Interaction Training (TCIT) at no cost to early childcare education and daycare programs (including home-based care setting) to enhance the ability of staff to work successfully with children with social-emotional disturbance and/or challenging behaviors. ECMHC helps early care and education staff by:

- Providing a problem-solving and capacity-building intervention to reduce incidents of disruptive behaviors;

- Building a collaborative relationship between mental health professionals, early childhood providers and parents of children in care;

- Coaching early education teachers/staff in building positive relationships with children;

- Training staff on how to enhance social/emotional skills in children; and

- Reducing teacher/staff and parent stress.

Getting Started
Why did your community pursue this effort?
According to a study (Gilliam, 2005) Delaware ranked 4th in the nation in the rate at which children are expelled from public preschool programs for bad behavior. The Delaware Early Childhood Council and the state’s Early Success Plan (to prepare preschool aged children to enter primary school ready to learn) made improving the quality of early childcare and education a priority. One specific goal was to increase the social-emotional wellness of children in care.

What were the initial steps in getting this effort off the ground?
Identification of need was in place for this service. The DPBHS application for funding ($300,000/yr) for this service resulted in funding allocation from the State’s Child Care Development Fund (CCDF), from the larger state child care development block grant. DPBHS identified and contracted with five (5) licensed mental health professionals with experience in early childhood area, provided training (Pyramid Model/USF, Tampa Florida) and technical assistance/supports. It is these clinicians who now provide the early childhood mental health consultation service across Delaware, with priority service going to programs that have children thru the purchase of care (state assistance) program which is also Child Care and Development Block Grant-funded. ECMHC works in collaboration with Delaware’s B.E.S.T.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
The Division of Social Services in the State Department of Health and Social Services received the application for funding and awarded the $300,000/yr for ECMHC as a result. Other partners include the many early child care providers who, among others, developed the State’s Early Success Plan and the many state agencies and community partners on the Delaware Early Childhood Council.
**IMPLEMENTING EARLY CHILDHOOD MENTAL HEALTH CONSULTATION (CONTINUED)**

**Implementation**

*How did you move from planning to implementation?*
Quickly. Upon receipt of funding commitment, DPBHS developed and released a Request for Proposals for licensed behavioral health professionals with experience in early childhood setting. From among the respondents, the five best qualified individuals were selected. Contract negotiation went quickly and within 2-3 months they were working in Delaware. In addition to the child-specific mental health consultation and classroom consultation to early child care teachers/centers/providers, the ECMHC offers training for parents at the centers, as well as for ECE staff on an array of topics (e.g. young children and trauma, PRIDE skills, positive behavior management, young child development (what is normal, what is not), etc. These trainings are free to participants and have proven to be highly valued by early childcare provider staff who must meet annual continuing education/training requirements to maintain licensure to provide child care. (bonus—we know they are getting GOOD training on subjects they SHOULD know more about to be effective in working with young children in care).

**Barriers/Obstacles**

*What challenges, issues, complications or obstacles have emerged along the way?*
Training in classroom- and program-wide behavior management was identified as a need, resulting in an application to TACSEI (Technical Assistance Center on Social Emotional Intervention for Young Children) for week-long training. The application was accepted, resulting in training within 6 months of service start date. Data collection/maintenance and reporting continue to be challenges, but are works in progress. Consultation with the State of Maryland (Al Zachik, M.D. et al.) was extremely helpful as they had a state level ECMHC system in place on which our service is modeled and were very generous with sharing their experience and information relating to this service in their state.

*What potential pitfalls can be identified that others can avoid?*
Assessment of the level of need/capacity that is accurate is very important. Our division worked with our early childhood community in our state, reflected on past studies and surveys to develop the application for funding to support five clinicians (actually 4.5 as one is part time) because this level of staffing was thought to be adequate, at least initially, to meet the level of demand. This assessment has been largely bourne out. In year two of the service, we find we are able to meet demands/requests for this service from centers across the state. To date, nearly 200 child-specific mental health consultations have been conducted (which result in development of an action plan for staff that includes new strategies, methods for working with children with challenging or troubling behaviors that result in reduction of those behaviors and increase in more pro-social behaviors, reduction in teacher (and often parent) stress. Among those nearly 200 consultations, just a handful (fewer than five children) were expelled from the care setting. The balance of the care was sustained/maintained as a result of the consultation service.

**Funding/Sustainability**

*How is this effort funded?*
Funds are allocated to the DPBHS from the State of Delaware’s Child Care and Development Block Grant (Child Care Development Fund). $300,000/yr
What elements are (or will be) in place to sustain this effort after the grant period ends?
The block grant is (to date) an ongoing allocation, based on formula. CCDBG is up for reauthorization
by congress in the current year and will expire without reauthorization (on 9/30/11). Should
reauthorization not occur, funding will be sought to continue the service, using data of effectiveness of
the service. This is really a work force development issue and there is plenty of data to show that the cost
to the state and society of NOT addressing the social and emotional wellness of preschool children is
quite large, while the cost of early intervention to address the issue is quite small—a sound investment
with good cost/benefit.

Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
Hire licensed clinicians for this clinical work. Provide or obtain training in early childhood classroom
consultation (as it is different from child-specific mental health consultation). And DATA—collect it,
maintain it, report out!

Resources
• The Georgetown University Center for Child and Human Development (e.g. publications such as
  “What Works? A study of Effective Early Childhood Mental Health Consultation Programs)
• The Technical Assistance Center on Social Emotional Intervention for Young Children (TACSEI)
  (website: www.challengingbehavior.org)
• Also: re: young children and trauma—the National Child Traumatic Stress Network (www.nctsn.org)

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EARLY RECOGNITION AND RESPONSE (ER&R) TASK FORCE—
ENHANCING SCREENING PRACTICES
Sarasota Partnership for Children’s Mental Health—Sarasota, FL

Strategy/Initiative Summary
The Early Recognition and Response (ER&R) Task Force efforts employ comprehensive, community-based strategies designed to:

• Support increased use of standardized developmental screening tools, particularly the community-chosen Ages and Stages Questionnaire-3 (ASQ-3), through training, coaching and resources of high quality developmental screening practices among early care and education, medical/health care, early intervention/special education, home visiting and child welfare programs/services;

• Improve integration of developmental screening efforts across community partners in collaboration with families by establishing an ASQ centralized online data system;

• Define effective early recognition and response practices; create toolkits to address the needs of young children and their families within the contexts of existing community services prior to formal referral for comprehensive developmental evaluation and eligibility determination for services.

Getting Started
Why did your community pursue this effort?
The Sarasota Partnership for Children’s Mental Health (SPCMH) convened the ER & R Task Force comprised of leaders in Sarasota’s Early Childhood systems to (a) improve access to high quality developmental screening for all children; (b) monitor child health, mental health and development of Sarasota County children; and (c) reduce the time between screening, referral, evaluation and intervention services for children with or at-risk for social, emotional and behavioral problems.

What were the initial steps in getting this effort off the ground?
• Completed an assessment of developmental screening practices in early childhood systems through a web-based survey of 12 major child-serving programs and providers in Sarasota County, Florida.

• Complete a follow-up structured interview to bridge the responses collected in the initial survey
  – Update current developmental screening practices
  – Determine what is missing or not working in the community
  – Make recommendations for systems changes with available resources

• Use social marketing/website to engage families in awareness of developmental screening, child development milestones and early learning; navigation through the systems & access

• Establish a data framework for the ASQ centralized online system
  – Advance purchase licenses/key codes for community partners
  – Establish an on-going ASQ training plan for interested/committed programs, providers, families and local pediatricians

• Determine framework for data collection and results of screening efforts
Key Partners

What organizations, agencies or individuals partnered with you on this effort, and in what ways?

- Early Learning Coalition
- Children First (Head Start/Early Head Start)
- Sarasota County Health Department
- All Children’s Hospital
- Gulf Central Early Steps (Birth-to-3 Program)
- Sarasota County School District, Pre-K Exceptional Student Education, Child Find
- The Florida Center for Child & Family Development (Mental Health Consultation)
- Healthy Start Coalition
- Healthy Families of Sarasota
- Sarasota Family YMCA, Safe Children Coalition (Child Welfare)
- USF/College of Education
- Family Network on Disabilities
- Technical Assistance Training Systems (TATS)—Florida Gulf Coast University

Implementation

How did you move from planning to implementation?

- Meetings with ER & R Task Force every 2 weeks with agreed-upon, targeted objectives to be met within the time frame and reported back to the group for feedback and further discussion
- Commitment from engaged community partners to build the framework
- Planning for sustained efforts beyond the initial work

Barriers/Obstacles

What challenges, issues, complications or obstacles have emerged along the way?

- Goals for the developmental screening are ambitious within the time frame allotted
- Communication, coordination and collaboration among professionals with busy schedules

What potential pitfalls can be identified that others can avoid?

Prioritize and set up short-term goals that can be done and reported back as a measure of success

Funding/Sustainability

How is this effort funded?

Sarasota Partnership for Children’s Mental Health, SAMHSA 6-year grant; in-kind participation by community partners; partnership with Early Learning Coalition and Florida Agency for Workforce Innovation, Office of Early Learning for the establishment of centralized data system
What elements are (or will be) in place to sustain this effort after the grant period ends?

- On-going communication, coordination and collaboration
- Training and professional development
- Family support, access and navigation through the systems (Just Ask…website)
- Framework for screening data collection & results via shared data system

Lessons Learned

What tips can you share that might help others interested in pursuing a similar effort?

Benchmark what other communities are doing and shape it to your own

Resources


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IMPLEMENTING COMPREHENSIVE INFANT-FAMILY AND EARLY CHILDHOOD SERVICES
Project ABC—Los Angeles County, CA

Strategy/Initiative Summary
Project ABC’s two lead service agencies, Children’s Institute, Inc. (CII) and Children’s Hospital Los Angeles (CHLA), have been providing services to at risk young children and their families for many years and have cultivated longstanding collaborative relationships with a broad array of service providers and other community supports within LA County. These resources enable us to address the mental health, developmental, educational and medical needs of children as well as the basic needs of families for food, safety and shelter. Within both organizations, there is also a wealth of resources that families can readily access in addition to traditional mental health services. For examples, CII provides Early Head Start, center and community-based early childhood care and education, parenting classes and a variety of family support services and CHLA offers a wide range of primary and specialty health care services, including emergency room services and child abuse examinations through our Medical Hub funded in part by the Los Angeles County Department of Child and Family Service; family support services; child and adolescent assessment services; feeding clinic services; community education; and parenting services. The University of Southern California-University Center for Excellence in Developmental Disabilities (USC-UCEDD) at CHLA also offers thorough diagnostic and developmental evaluations for infants, toddlers and preschoolers; school-based therapeutic services; home based parent guidance and education; well-researched dyadic therapies, including the McDonough Interaction Guidance Model, Parent Child Interaction Therapy, Child Parent Psychotherapy, and the Floortime Model; and a variety of adjunctive early childhood evaluations and services including occupational therapy, speech and language service, and nutrition services. Both CHLA and CII provide a wide range of additional evidence-based practices focused on early childhood mental health. Vendored Part C home-based developmental services, parent education, and family support are also offered to families of children under the age of 3 through contracts between the USC-UCEDD and several local Regional Centers (the leads in California for Part C services).

The USC UCEDD at Children’s Hospital also has a long history of collaboration in the development of training modules, and in the provision of consultation, technical assistance and support to early intervention programs, early childhood programs, Early Head Starts and Head Starts, and childcare programs. During the past two years, Children’s Institute has also expanded their early childhood consultation services to a large group of Head Start agencies in LA County.

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IMPLEMENTING PARENT CHILD INTERACTION THERAPY (PCIT) AND VARIOUS ADAPTATIONS OF THIS EVIDENCE-BASED PRACTICE
Delaware’s B.E.S.T. for Young Children and Their Families—Delaware

Strategy/Initiative Summary

Parent Child Interaction Therapy (PCIT): PCIT is an evidence-based mental health treatment for young children (ages 2-7) with behavioral difficulties and their families. The treatment was developed by Dr. Sheila Eyberg at the University of Florida. It is a short-term, assessment-driven intervention where parents and children are required to develop and master a set of skills. PCIT focuses on improving the quality of the parent-child relationship and changing parent-child interaction patterns through a live coaching format. The treatment is designed to reduce defiant and aggressive behavior in young children and to ultimately prevent future negative outcomes associated with antisocial behaviors.

Home-Based PCIT: Home-Based PCIT is an adaptation of traditional PCIT that includes more intensive services provided in the home. This allows therapists to reach a population that may be less likely to come to an office-based outpatient setting. In addition, delivering PCIT in the home may increase the likelihood that progress made in treatment will continue after therapy. This is because PCIT includes a strong coaching component, parents in Home-Based PCIT practice more in a “real world” setting. In our community, Home-Based PCIT is delivered as a part of a more comprehensive intensive clinical services management/wraparound model.

Child-Adult Relationship Enhancement (CARE): CARE was created for general use by parents and non-clinical adults (e.g., daycare providers, case managers, hospital/day treatment staff) who work with children. CARE was developed by staff at The Trauma Treatment Training Center at Cincinnati Children’s Hospital and is based on core concepts of Parent-Child Interaction Therapy (PCIT). The skills taught in CARE have been shown to help adults and children form a more positive relationship, and assist adults/caregivers in managing a variety of challenging behaviors. The overall goal of CARE is to create a solid foundation of behavior management skills by enhancing child-adult relationships, promoting positive child behaviors, and increasing compliance. CARE is a general behavior management workshop and does not take the place of clinical treatments (e.g., PCIT, TF-CBT) if those are warranted.

Teacher-Child Interaction Training (TCIT): TCIT is a research-based training program designed to promote positive teacher-child relationships and provide pre-school teachers with effective tools for behavior management. TCIT is based on core theoretical and clinical principles of Parent-Child Interaction Therapy (PCIT), an evidence-based treatment for children with behavioral difficulties and their families. TCIT is a time-limited training approach lasting approximately 8 weeks and consists of two phases, Child Directed Interaction (CDI) and Teacher Directed Interaction (TDI). Through a live feedback format, teachers are taught skills designed to enhance a more positive classroom environment and to manage a range of behavioral difficulties.
Getting Started

Why did your community pursue this effort?

Adopting PCIT and its adaptations grew out of alarming evidence that children ages 0-5 in Delaware were being expelled from publicly funded preschools at a high rate (Gilliam, 2005). This realization, coupled with Delaware’s lack of mental health services for young children ages 0-5 with emotional and behavioral disorders, prompted Delaware to apply for a CMH grant to pursue evidence-based practices and implementation of structures and supports for this population, specifically to create, provide and sustain evidence-based treatment using a system of care approach to serve such children and their families, including families as partners in all phases of the grant activities.

What were the initial steps in getting this effort off the ground?

The state’s Division of Prevention and Behavioral Health Services (DPBHS) partnered with a variety of agencies serving this population (see Key Partners) to brainstorm strategies to bridge the service gap. This collaborative effort led to the decision to apply for the SAMHSA grant. After receiving the grant, PCIT was identified as a primary intervention given its strong evidence base and focus on reducing behavioral challenges in a 0-5 population.

Key Partners

What organizations, agencies or individuals partnered with you on this effort, and in what ways?

A variety of state and community partners collaborated to assess the need and to evaluate intervention strategies. This included representatives of Delaware’s early childhood community such as the Delaware’s Children’s Department, Department of Education, Department of Health and Social Services/Division of Social Services, and Nemours. The following identifies a sample of individuals and their roles regarding implementation:

• Nancy Widdoes, Principal Investigator and Mary Moor, Project Director
• Dr. Ryan Beveridge, a faculty member at the University of Delaware with experience in PCIT. Dr. Beveridge facilitated the use of graduate students and the training clinic which served as an initial site for PCIT implementation.
• Dr. Cheryl McNeil, a professor of Psychology at West Virginia University. She is an expert clinician, researcher, and trainer of PCIT as well as the co-author of both PCIT books. Dr. McNeil conducted the initial PCIT trainings in Delaware and served as presenter at numerous division conferences and workshops.
• Dr. Tim Fowles, a faculty member at the University of Delaware, is lead evaluator on the project and worked to develop, maintain, and oversee the data collection of all aspect of the grant.
• Dr. Joshua Masse, a clinical psychologist and PCIT trainer. He was hired by the grant to train community clinicians in PCIT and has worked to develop and implement TCIT, and train CARE.
• Early Childhood Mental Health Consultants, along with community day cares and pre-schools, partnered with DPBHS to assist in the piloting and implementation of TCIT.
• Community mental health agencies and private mental health practitioners partnered with DPBHS to provide PCIT to the children and families they serve. Two agencies located on separate ends of the state provide home-based PCIT to the two largest counties in Delaware.
Implementation
How did you move from planning to implementation?
Moving from planning to implementation required mobilizing partners around training, social marketing, and evaluation. Dr. Cheryl McNeil, a Master Trainer in PCIT, conducted initial trainings for outpatient providers and University of Delaware collaborators. These efforts continued and eventually were assumed by Dr. Joshua Masse, who was hired as a full-time on-site trainer.

Along with training, awareness and social marketing efforts were underway. For example, DPBHS sponsored large-scale conferences at the University of Delaware for clinicians, pediatricians, teachers, and day-care professionals to highlight services available, increase awareness, and build a referral base. In addition, rosters were developed and updated with clinicians trained, and brochures were developed to allow for further marketing efforts. Events around Mental Health Awareness Day focused on the birth-to-five population and further increased awareness.

Finally, Drs. Ryan Beveridge and Tim Fowles at the University of Delaware worked with University resources to build evaluation systems to capture community-based PCIT data. Graduate students in the psychology department helped to build systems and connect clinicians to data collection efforts. Field experience classes at the University provided undergraduates to enter data and to serve as clinical assistants to facilitate the adoption of PCIT.

Barriers/Obstacles
What challenges, issues, complications or obstacles have emerged along the way?
One challenge has been agency-related difficulties in terms of space and physical resources to implement outpatient PCIT. Specifically, some agencies lacked an observation room and/or video equipment necessary for the consultation process. The grant staff worked closely with each agency in helping them move toward making the appropriate changes to ensure fidelity with the model. Also, some clinicians do not have a great deal of experience with evidence-based treatment with on-going treatment assessment and session data entry. Grant staff has made efforts to facilitate and increase comfort with this model.

What potential pitfalls can be identified that others can avoid?
Agency preparation has been identified as a key component to implementation with fidelity. As such, we have established an application process to help identify potential obstacles to appropriate implementation. Grant staff then work with an agency in helping to reduce these obstacles. We have also found that administration and supervisor buy-in is essential in helping with sustainability following trainings. Although we attained support on every level, ongoing collaborating has been more effective in maintaining treatment fidelity and overall organization of the implementation.

Funding/Sustainability
How is this effort funded?
This effort is funded through primarily through a CMHI grant from the Substance Abuse and Mental Health Services Agency (SAMHSA). This grant has provided staff and resources to build capacity and create systems for training, evaluation, and services. Since its inception, key partners have collaborated to build the system, which increases the likelihood of sustainability. The State of Delaware’s DPBHS has
PCIT and Various Adaptations of This Evidence-Based Practice (Continued)

a record of supporting evidence-based practices like PCIT, and adopting efforts such as the clinical services management (see Home-Based PCIT). In addition, partnerships with the University of Delaware, community providers, and the PCIT community are in place to ensure that training and evaluation can continue.

Lessons Learned

What tips can you share that might help others interested in pursuing a similar effort?

We have discovered administrative collaboration and identifying and attempting to manage obstacles prior to training and implementation to be a key component and predictor for successful dissemination. In addition, ongoing partnerships with established community agencies, university support, and recruiting professionals with specific training related to various aspects of the grant has been invaluable in our efforts.

Resources

www.pcit.org

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**IMPLEMENTING A TIERED SERVICE DELIVERY PROCESS**

**Sarasota Partnership for Children’s Mental Health—Sarasota, FL**

**Strategy/Initiative Summary**

In response to family needs and participation in SOC, the Sarasota Partnership adapted the basic Wraparound model to support families with young children experiencing difficulties in social-emotional development, relationships, and/or behavior. A tiered level system was established to be more responsive to child and family needs, while respecting the family’s level of readiness for a more robust wraparound approach.

**Getting Started**

The Partnership first established the SOC service delivery model based on traditional wraparound practices and principles in 2007 (Year 2). Consultants working with our service delivery teams provided excellent training on the principles and values of “wraparound”, offered great teaming strategies, talked about “creative brain storming”, how to gather the strengths and needs of the child/family, and how to develop a plan of care. Families began to enroll in our system of care for mental health evaluation and therapy services and family support delivered through a wraparound family service planning process. Children and families were referred to the Partnership from a number of other child-serving organizations, or directly from parent calls. “Enrollment” at that time required that the child had a mental health diagnosis, and families were assigned both a Wraparound Care Coordinator and Parent Mentor. The feedback we received from families indicated that many families of young children are early in their “journey” with their child’s difficult behavior, are uncomfortable with the “labeling” of their child with a diagnosis, have few if any formal supports in place yet, and were overwhelmed by the intensity of the family service planning team concept and practice. Additionally, there is an element of uncertainty of the child’s future that is a bit broader for younger children than with older children, where patterns of behavior have been established or clear diagnoses have been made and remain constant. For many families, engagement with natural supports was difficult. Many parents were not comfortable engaging family members, neighbors or friends into the team process unless they already knew of the child’s difficulties—concerned about the stigma of having a child with behavioral or mental health difficulties. Consequently, many families opted out of the wraparound process, sometimes proceeding to more traditional therapy arrangements (without the wraparound team process). Some families opted out from the very first phone call, when terms such as “mental health diagnosis” were used to discuss the program eligibility.

**Key Partners**

The Care Review Work Group established a Service Delivery Task Force to evaluate enrollment patterns, best practices and feedback from families in order to create a modified service delivery model to best meet the needs of families with young children. The Task Force was comprised of Wraparound Facilitators; Parent Mentors, and a number of family and community members. Discussion specifically related to the undeniable differences between serving young children vs. older children and the undeniable differences in the perspectives of the parents in each age range. One focus was specifically on the teaming aspect of wraparound. While the entire group saw huge benefits to the teaming, the reality is that many of the children who were referred to the Partnership had early social-emotional developmental or behavioral challenges that had disrupted relationships and school success, but who had...
not yet been connected to developmental or mental health services or parent support. For these families, the full wraparound process and team approach was likened to “using a fire hose to blow out a candle.” Revisions to the model allowed the Partnership to meet families “where they are” and facilitate the building of formal and natural supports to help their child be successful. The tiered level system served as guidelines (rather than distinct categories) to support families based on their strengths, needs and values. Process mapping (a common Continuous Quality Improvement strategy) was used to improve the quality and timeliness of the enrollment process and communication between service providers.

**Implementation**

Two levels of child/family enrollment were established.

**Level 1** of enrollment is considered the *service coordination phase* of the wraparound process. These children were often referred because of “big behaviors” but who had no previous mental health or developmental assessments or interventions. For some families, the threat of expulsion from preschool due to behaviors was their first indication that their child’s needs were not being met. For these families, initial care coordination efforts included an assessment of the child’s health, development and learning, as well as family relationships and functioning. The ability to enroll children at “imminent risk of mental health diagnosis” allowed for the freedom to initiate services and support for families whose children did not have psychiatric diagnosis, or for families who did not want their child to have a mental health evaluation. Monthly “teaming” or planning sessions are still required at this level; however, in the beginning some of this teaming involved very few people until additional natural and professional supports could be established. All families are offered and referred for support through our local Family Support Network at the initial visit with the Care Coordinator.

**Level 2** of enrollment is considered the *intense care management phase* of the wraparound process. These children all have a mental health diagnosis that impacts their learning, relationships or development, and have been involved in multiple service systems. In this phase, larger teams convene for monthly planning sessions and creative brainstorming to facilitate positive child and family results. All families are offered and referred for support through our local Family Support Network at the initial visit with the care coordinator.

Families may move from one level to another as needs change. Most often, children with emerging or newly recognized challenges may begin at Level I but move to Level 2 once services and supports are engaged.

**Barriers/Obstacles**

The leveling “system” was an evolving process, which created confusion for the Care Coordinators and Parent Mentors. The flow chart for enrollment helped improve the communication about the referral and enrollment process and requirements for paperwork and activities. The use of a shared data system across partner agencies (Tapestry) provided the tools to manage caseloads and improve supervisory data collection to monitor performance expectations for service providers.
Funding/Sustainability
The wraparound process has been embraced in theory and in practice throughout many of our community’s service systems that support children, adults and families. The practice of “teaming” at the more intensive level is being used more frequently in situations where children or families are experiencing complex challenges requiring multiple providers and systems to address needs.

Lessons Learned
Over the past six years, we learned that trying to fit young children into a service delivery model designed to support children with significant mental health disorders across multiple service systems is inefficient and almost impossible to sustain. We found that infusing mental health consultation and supports within existing early childhood systems (such as early care and education, health, and home visiting) is more effective, both in terms of cost-effectiveness and positive results. Providing positive behavioral supports, functional behavioral assessment and monitoring responses to intervention for children, and skill-building training and coaching for parents and caregivers are all effective strategies to promote social-emotional health in a variety of settings.

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Strategy/Initiative Summary
Clarifying Assessment services for children birth to five. Clarifying Assessments can be accessed through the SART (Screening, Assessment, Referral & Treatment) Linkage Line. When the referral pathway for the child is not clear, or the child has complex developmental and behavioral issues, the Linkage Line will refer children for a Clarifying Assessment to provide a closer look by experienced specialists.

Getting Started
Why did your community pursue this effort?
First 5 Alameda County led a planning process beginning in 2007 for a Children’s SART (Screening, Assessment, Referral & Treatment) System. SART is currently in the first pilot phase of implementation (which began in October 2009) and has gathered preliminary data for the first 19 months of implementation. SART has a Linkage Line (early childhood consultation and referral phone line) that receives referrals from five primary portals of entry: (1) Subsidized child care programs that screen children 0-5 for developmental and behavioral concerns; (2) Pediatric providers that screen children 0-5 for developmental concerns; (3) providers working with children 0-5 in the child welfare system and who have developmental or behavioral concerns; and (4) regional center personnel and (5) school district personnel who have determined that a child 0-5 is ineligible for their services and/or in need of additional supports.

During the SART planning process, community stakeholders identified the need for additional assessment services in the county, particularly for children who did not have a clear path either into the developmental system (IDEA Part B & Part C services) or the mental health system.

Clarifying Assessments were developed as an “enhanced screening” for children who presented with complicated social, emotional and developmental concerns where the appropriate referral pathway was not clear. The Clarifying Assessment project also includes an opportunity to assess Linkage Line decision pathways, provide opportunities to explore and communicate assessment practices and to pilot shorter term treatment protocols. Since treatment dollars are also tied to the Clarifying Assessment for children who qualify and require further mental health treatment, the Clarifying Assessment project also included funding for children who were not covered by Medicaid. This fund later became known as the “No Wrong Door” fund.

What were the initial steps in getting this effort off the ground?
During the SART planning phase a finance committee was established with the intent of identifying financing strategies and funding streams to support implementation of components of the SART strategic plan. This committee included a representative from Alameda County Behavioral Health Care Services (ACBHCS). Eventually EPSDT funds were identified as a potential funding stream to fund Clarifying Assessments (at the time called “Enhanced Screening”). However, recognizing that EPSDT could only be used for children with Medicaid coverage, other steps were taken to establish a fund for to pay for services for children not covered by Medicaid. Numerous discussions and meetings took place over the next 1-2 years to develop the funding mechanisms, determine funding availability and amounts, develop shared understanding regarding the scope and purpose of the project, and develop the implementation plan.
First 5 Alameda County and ACBHCS then collaborated on a Request for Proposals to recruit two early childhood mental health agencies that could provide a closer look at young children who presented with complex developmental and mental health concerns and who would participate in the data collection efforts. The RFP was carefully written to include an emphasis on expertise in the assessment of both developmental and mental health concerns and piloting short-term treatment protocols. At the same time, a “Learning Community” was created through the Children’s SART effort. The learning community includes 0 to 5 mental health providers to explore and understand best practices in assessing mental health treatment. Clarifying Assessment agencies are a part of this community and can share lessons learned with the larger 0 to 5 community.

**Key Partners**
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
First 5 Alameda County (SART), Alameda County Health Care Services Agency, and Alameda County Behavioral Health Care Services (ACBHCS) partnered on the development of the Clarifying Assessment Project. Health Care Services Agency agreed to establish and administer the No Wrong Door Fund; First 5 Alameda County agreed to allocate and help seek funds for No Wrong Door (which included a contribution from the Public Health Department); and ACBHCS agreed to administer the contracts for the provision of services. Further, SART provided the expertise of young children’s development and mental health, and the overall infrastructure of SART. ACBHCS provided the contractual relationships with community-based early childhood mental health providers, as well as expertise in the treatment of young children and their families.

**Implementation**
*How did you move from planning to implementation?*
Once the RFP was developed, which took several long meetings that required a great deal of patience and collaboration, the RFP was released and applications were received. Two community-based early childhood mental health agencies were selected to participate in Clarifying Assessments, and Alameda County Behavioral Health Care Services augmented their existing contracts.

**Barriers/Obstacles**
*What challenges, issues, complications or obstacles have emerged along the way?*
ACBHCS felt they needed to understand what the salient differences would be between a Clarifying Assessment and an assessment that a community-based provider would typically do. Once this was better understood, we moved forward.

Next, augmentation of the community-based mental health contracts took a very long time given the bureaucracy of a county mental health system. Because other components of SART began implementation in October of 2009, there was a need to develop an interim “Clarifying Assessment” process until the contracts were finalized and the contractors were ready to receive referrals. The first referrals to the contracted agencies were made in late October of 2010.

There was also miscommunication about the definition of indigent children, which would be funded through the No Wrong Door funds. To date, there are very few indigent children as defined by ACBHCS.
so F 5 has suggested that the criteria for No Wrong Door funding be modified to include children with other health insurance. AC Behavioral Health Care Services is taking this into consideration at this time.

What potential pitfalls can be identified that others can avoid?
Laying the groundwork by defining with greater clarity what each agency meant by Clarifying Assessment, and the definition of indigent children and, related, ensuring that there are shared assumptions among the partnering agencies and their staff. It would have also been a good idea to do some research on the number of indigent children ages 0-5 in Alameda County.

Funding/Sustainability
How is this effort funded?
Clarifying Assessments are funded by No Wrong Door dollars (which includes contributions from First 5 Alameda County, a federal discretionary grant made to the Children’s SART, and the Public Health Department) and Medi-Cal EPSDT (Early Periodic Screening, Diagnosis and Treatment) from Alameda County Behavioral Health Care Services. No Wrong Door funding is allocated for indigent children who are not covered by Medicaid; but currently it can only be used for children who have no insurance.

What elements are (or will be) in place to sustain this effort after the grant period ends?
The No Wrong Door funding is available through at least October, 2012, and EPSDT funding will remain available indefinitely, however, given the match re-structure for EPSDT in California this may require re-evaluation. The Clarifying Assessment contracts with the community-based mental health providers are two year contracts.

Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
• Clear communication and clarification about definition of terms between agencies.
• Research on the numbers of indigent children in Alameda County.
• Clear, specific planning and implementation timeline and work plan that delineates roles and responsibilities.
• Increased understanding of how developmental issues in young children are assessed, documented and treated within the context of EPSDT mental health dollars.

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Operationalizing the Role of the Clinical Director
Starting Early Together—Allegheny County, PA

Strategy/Initiative Summary
Starting Early Together in Allegheny County, PA developed internal guidance to help define the role of the Clinical Director in their community, and to facilitate the hiring and operationalizing of this position. This guidance is provided below.

Clinical Director Requirements: Someone who values and practices System of Care principles, enjoys working on a multidisciplinary team, has a strong child/family focus and enjoys the challenges of providing services to a diverse community. This position works in partnership with the System of Care Initiative (SOCI) Central office and four communities and will be involved in the development, implementation and maintenance of clinical best practice, service development and excellence in professional conduct. LCSW, Licensed Psychologist or Psychiatrist preferred. Knowledge of the early childhood system and expertise in Infant and Early Childhood Mental Health required. Responsibilities of this position include:

• Clinical Consultation
  – Mental health treatment needs and strategies to ensure best practices are being used
  – Diagnosis and medication to recommend 2nd opinion
  – Review service plan to ensure clinical needs are addressed
  – Support to the child and family team as requested
  – Clinical advice concerning screening and assessment tools to promote identification of children in need of service

• Process Consultation
  – Provides recommendations about screening and evaluation process that results in comprehensive and accurate identification of needs and corresponding clinical follow up.
  – Provides expertise and advice concerning children at imminent risk and strategies to promote early identification and
  – Participate in discussions to identify opportunities for clinical partnerships that will be sustainable.
  – Promote use of DC: 0-3 as a supplemental diagnostic tool across the clinical community
  – Recommendations/support around “diagnosable” language and serving children at risk.

• Training, Social Marketing and Outreach
  – Provides training for system of care staff, clinicians, partners and families and/or reviews/comments on training outline for clinical practices including:
    – Assessment tools—administration and scoring
    – Evidence based practices
    – Diagnostic-related issues
    – Best Practices in treatment strategies
  – Provides review and/or creates educational materials related to emotional wellness and emotional and behavioral challenges.
  – Provides clinical review of information in social marketing materials for accuracy
  – Acts as a liaison/takes on a leadership role in creating partnerships with clinics
Questions for Consideration in Hiring and Establishing the Role of the Clinical Director

- What are the educational and professional standards that you want your Clinical Director to meet?
- How will you assess Clinical Director candidates’ philosophical base and commitment to system of care values during the hiring process?
- Where can you advertise this position to gather a strong pool of applicants?
- How will you develop the interview questions? Who will be part of that process?
- Will this position be full time or part time? Contracted or “on staff”?
- What will the collaboration process between the Clinical Director and other licensed providers (i.e., those doing diagnosis and treatment) look like?
- What will the Clinical Director’s role look like in key areas such as service provision, identification and utilization of evidence-based practices, staff/family/provider training, system capacity-building, partnership development, promotion/prevention/outreach activities, and clinical file reviews?

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IMPLEMENTING A CROSSWALK FROM DC:0-3R TO ICD:9-CM
The Florida Center for Child and Family Development—Sarasota, FL

Strategy/Initiative Summary
The Florida Center for Child and Family Development, a partner of the Sarasota Partnership for Children’s Mental Health, developed a crosswalk between the DC:0-3R and the ICD:9-CM to facilitate billing when using the DC:0-3R assessment tool for young children. The process used to develop and implement the crosswalk, as well as the crosswalk itself, are available at: www.thefloridacenter.org/pdfs/Fl_Crosswalk_June_2010.pdf

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MERGING SCHOOL-WIDE POSITIVE BEHAVIORAL INTERVENTIONS AND SUPPORTS WITH THE "TEACHING PYRAMID"
Rhode Island Positive Educational Partnership—Rhode Island

Strategy/Initiative Summary
The RI Positive Education Partnership has developed a comprehensive approach for infants, young children and their families by providing formal training and technical assistance to early childhood programs in Rhode Island. We have merged the structure of School Wide Positive Behavioral Interventions and Supports (SWPBIS) with the Center for Social Emotional Foundations for Early Learning’s (CSEFEL) “Teaching Pyramid” practices. We call this Program Wide Positive Behavioral Interventions and Supports. The early childhood program staff forms a representative leadership team that develops a culturally appropriate, family driven system to support the social emotional health of all children in their centers. Building positive relationships and maintaining high quality environments forms the foundation of their system. Teaching and re-teaching specific essential social emotional skills, acknowledging children and adults when they demonstrate those skills, having a process for understanding the meaning of challenging behavior, developing an individual behavior support plan with families and connecting to community mental health supports when needed completes a continuum of promotion, prevention and intervention for all the programs.

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
**INTRODUCTION**

In recent years, thanks in part to federal efforts (e.g., SOC, Project LAUNCH\(^1\), Early Childhood Comprehensive Systems Initiative\(^2\)) and research on high preschool expulsion rates stemming from challenging child behavior (Gilliam, 2005\(^3\)), there has been heightened awareness of the need to attend to infants’ and young children’s social and emotional development and to secure help for those showing early “warning signs” of a possible mental health challenge. Unfortunately, there are many gaps in the workforce that hinder attempts to create a responsive and comprehensive early childhood mental health service delivery system.

First, there is a lack of early childhood providers who are trained in the promotion of social and emotional development and the early identification of mental health issues, as well as a shortage of mental health clinicians who are trained to work with the birth to five population (Ounce of Prevention Fund, 2000, p.64). Further, many pediatricians and other primary care providers, who offer critical access points to early identification and treatment of mental health issues, report that they do not feel they are sufficiently trained or skilled in evaluating the mental health of an infant or young child. Some also state that they are uncertain where to refer infants and young children if a mental health problem is suspected; a problem that is particularly acute when the issue isn’t a lack of awareness, but an actual dearth in supply of qualified infant and early childhood mental health professionals.

Thus, it is clear that EC SOC grantees must make workforce development a top priority if they are to create high-quality and sustainable systems of care. Efforts should focus not only on developing an adequate supply of mental health clinicians with expertise in infant and early childhood mental health (including administration of the DC: 0-3R), but also on pre-service and in-service training and professional development opportunities for other system partners who work and interact with young children and their families on a regular basis. Achieving these goals often requires complementary efforts to create incentives for participation in trainings and application of new knowledge, such as continuing education credits, linking to child care accreditation or quality rating structures, and/or implementing policy changes that facilitate utilization of new practices (e.g., getting approval from your state Medicaid agency for a crosswalk between the DC:0-3R and the ICD-9-CM).

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\(^1\) Project LAUNCH is a SAMHSA-funded grant program designed to help communities expand the use of evidence-based practices, improve collaboration among child-serving organizations, and integrate physical and mental health and substance abuse prevention strategies for children, ages birth to 8, and their families.

\(^2\) The Early Childhood Comprehensive Systems (ECCS) Initiative is funded by the Maternal and Child Health Bureau and is designed to support states and communities in their efforts to build and integrate early childhood service systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education, and family support.


QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. What is your community’s current provider capacity around infant/early childhood mental health? How will you address shortages (e.g., through pre-service and in-service training and preparation for early childhood and mental health professions; through certification or credentialing processes?)

2. Does your community’s cadre of service providers include nontraditional as well as credentialed professionals?

3. What is your community’s need for infant/early childhood mental health clinicians who speak a language other than English?

4. To what extent are clinicians in your community trained on the DC:0-3R? If there is a need for additional training, what entity might assume this function during and after the grant period?

5. Does your community have a crosswalk between the DC:0-3R and the ICD-9CM to facilitate billing using this assessment tool designed for young children? If so, are clinicians familiar with the crosswalk and how to use it effectively?

6. Has your community established core competencies for infant/early childhood mental health professionals to guide pre-service and in-service training? If so, what entity(s) exist to provide training on these competencies?

7. To what extent are non-clinical providers trained on infant/early childhood mental health (e.g., primary care providers, early childhood providers)?

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Prior to conducting provider trainings, get buy-in from the providers’ administrators and/or supervisors as this is essential in helping with sustainability following trainings.

• Partner with higher education to build system capacity through integration of pre-service training on infant/early childhood mental health across disciplines (e.g., mental health professions, medical professions, early care and education professions, etc.)

STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health: Project ABC—Los Angeles County, CA

B. Workforce Development Logic Model: Building Blocks—Southeastern Connecticut

C. The “Learning Collaborative” Approach: The Alamance Alliance for Children and Families—Alamance County, NC
RESOURCE MATERIALS

National Resources


• What to Expect and When to Seek Help: Bright Futures Developmental Tools for Families and Providers: www.brightfutures.org/tools


Community Resources
• Evidence-Based Competencies for Promoting Social and Emotional Development and Addressing Challenging Behavior in Early Care and Education Settings (Project BLOOM/Denver, CO). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

KEY CONTACTS AND WEBSITES

Websites
• SAMHSA—Workforce Development Portal: www.samhsa.gov/children/earlychildhood_workplace.asp
• Project LAUNCH: http://projectlaunch.promoteprevent.org/implementation/workforce-development
• Center for Effective Mental Health Consultation—various training modules related to early childhood mental health for mental health consultants, child care providers and administrators: www.ecmhc.org

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CALIFORNIA TRAINING GUIDELINES AND PERSONNEL COMPETENCIES FOR INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH

Project ABC—Los Angeles County, CA

Strategy/Initiative Summary
A core component of Project ABC is interdisciplinary professional development in the area of infant-family and early childhood mental health. We provide educational opportunities for the workforce in Los Angeles that increase community awareness and expertise around infant-family and early childhood mental health issues, while also developing a cohesive training model around skills in the area of birth to five mental health. This not only builds the capacity in the Los Angeles workforce in providing infant-family and early childhood mental health services, but allows individual service providers to build their personal expertise and professional portfolios.

Project ABC leaders, in collaboration with state infant-family and early child mental health training program directors, provided state direction for the revision of the California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health (2003, Revised 2009). The California Training Guidelines were originally developed to address repeated field requests for clarification of the competencies and training needed for personnel development and to address the shortage of qualified, well-trained practitioners available to provide infant-family and early childhood mental health services throughout California. The Revised Guidelines delineate the body of knowledge and required hours for each domain that providers need to have in order to provide quality service. The body of knowledge provides the foundation for the clinical experience and reflective supervision that is required for endorsement. A group under the leadership of the WestEd Center for Prevention and Early Intervention also worked to update the California personnel guidelines for Part C Early Interventionists and other Early Childhood specialists, incorporating the mental health components of the IFECMH Training Guidelines. (For more detailed information, visit the California Center for Infant-family and Early Childhood Mental Health website at www.ecmhrtraining-ca.org)

The California Training Guidelines provide direction for all Project ABC trainings. The Training Subcommittee refers to the Guidelines to identify training topic areas. Domains are identified for each workshop that reflect the requirements outlined in the Guidelines. We schedule trainings that touch upon each of the eight domains outlined, in order to provide a well-rounded body of knowledge for attendees. To ensure top-notch trainers, project staff carefully selects speakers based on personal knowledge of their speaking skills and/or conference with trusted organizations across the state. Our training program provides attendees with the latest information in infant/preschool/family mental health. Certificates are provided at each training event that designate the domain covered and the number of hours of training. Information about the Training Guidelines, endorsement process and use of certificates is also provided at the events. During the training events, participants also have opportunities to network and share knowledge of services, resources and family support available within the community. Over 2000 providers have received training leading to a coherent body of essential infant-family and early childhood mental health knowledge.
We created an extensive Access database to track all of our attendees, registrations, payments, training events and specific training domains attached to each training event. We have the capability to print reports for individual participants, providing them with summary information about their training event participation, hours of training received, date and name of trainer, and corresponding training domains. The database allows us to pull data about who is attending and which agencies are sending their staff. The Access database we developed to track IMH trainings is being implemented by WestEd in Sacramento to track trainings on a larger state-wide scale and by Children’s Hospital Oakland for their local trainings. It will also be used to assist individuals with tracking their own training progress. Our database shows that we have offered 23 different training events during years 1-5 of the cooperative agreement. Thirteen have been full days with nationally recognized speakers and 10 have been half-days with both nationally known and local speakers with significant expertise. We have had over 160 different agencies represented at the trainings, and approximately 1600 individuals have attended trainings with some returning for multiple trainings. During Year 6, we organized a large national two-day early childhood mental health conference (Strive to Thrive: Building Systems that Care for Birth to Fives) that was attended by over 400 professionals from across the country. The conference included plenary sessions, workshops, panels, research presentations, and poster sessions. CEU credits are available at all events for psychologists, social workers, MFT’s, and nurses, and our outcome evaluations indicate high levels of satisfaction with the trainings and the materials provided.

The Revised Training Guidelines are being disseminated statewide. Drs. Finello and Poulsen are working with WestEd on a project funded by California First 5 to develop the endorsement system that accompanies the IFECMH Training Guidelines in California. During this year, the California leadership team developed a dedicated website focused on the Training Guidelines, began reviewing portfolios and endorsing professionals around the state, refined the endorsement processes for multiple disciplines, and developed plans for opening up the process to all professionals in California. There is a plan to explore the infusion of infant and early childhood system of care training into the ongoing agency training curricula of the Departments of Mental Health, Child and Family Service, Health, and Education and to provide training and technical assistance nationwide.

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Strategy/Initiative Summary

In collaboration with community partners, it was discussed and agreed that creating internal capacity of families, partner organizations, agencies, pediatricians, early care providers and others through professional development would prepare staff to meet the social and emotional (mental health) needs of young children. Given that the social and emotional wellness of a child is shaped by secure relationships with his/her primary caregivers in nurturing environments, it was agreed that the acknowledgement of this concept would serve as the foundation for the development of a workforce development logic model. This thought process recognized that social and emotional wellness in a child, birth to five, is reflected through healthy attachments and the ability to confidently explore, regulate and express emotions in natural settings. Infant and early childhood mental health is healthy social and emotional development.

With this agreement it was determined that the outcome of a workforce development logic model would be that: “Families, providers and the medical community will have the knowledge, practice and experience to identify and meet the social and emotional (mental health) needs of children birth to five years.”

The following goals were identified:

1. All health care providers will screen children birth to five for social/emotional wellness.
2. Local colleges and universities will include early childhood mental health in pre service child development and early childhood curricula.
3. Families and youth will have opportunities to learn that social/emotional development is the underpinning of all other development including language and cognition.
4. Birth to Three staff (Part C) and DCF case workers will understand and use infant and early childhood mental health practices as they interact with families of young children.
5. Early Care providers will be knowledgeable in infant/early childhood mental health principles and practices and will reflect that knowledge in their classrooms.
6. Building Blocks will support the bringing of an endorsement for early childhood mental health to CT.

Through focus groups conducted by our data experts, Building Blocks learned that access to workforce development in the area of early childhood mental health was hindered by a number of factors, which guided the development of the Workforce Development Logic Model. These included: 1) lack of knowledge in the community of what was being offered, 2) minimal time and funding for professional development in early care and education settings, 3) lack of trained trainers in evidence-based practices, and 4) no training guidelines.

1. Calendar of Trainings: The Building Blocks website hosted the Workforce Development Training Calendar with postings for local, state, and national trainings. These ranged from one session topical presentations to on-line courses, webinars, and conferences. The comprehensive list was updated and maintained by the grant Training Coordinator. For sustainability the calendar is transitioning to the
CT Association for Infant Mental Health as part of their oversight of the CT Endorsement for Infant Mental Health.

2. **Southeast Early Childhood Collaborative (SEECC)** developed in response to the need from early care and education providers for professional development that was affordable and offered at a time that was least intrusive to their staffing needs. This free monthly networking and professional development program meets during after lunch nap time when staffing can be more flexible. On a yearly basis a Building Blocks staff person facilitates a planning and review session where logistical adjustments are made if needed and topics are selected for the coming year. The Building Blocks Training Sequence (see #4) is used to help guide the selections. The monthly program includes a 15 minute presentation by a community resource the group has identified needing more information about and followed by a 1.25 hour presentation on a topic of interest related to early childhood mental health. As grant staffing is reduced the collaborative continues as a division of the Southeast Mental Health System of Care (SEMHSOC).

3. **Train the Trainer programs** in DC:0-3R, Positive Behavior Supports for Young Children, and Wraparound were brought to Connecticut. BB offered to community health centers training for the Ages and Stages Questionnaires. There are now trainers available throughout the state to continue to educate workers in these areas. Information on the trainers is available on the SEMHSOC website.

4. **Other Trainings of Note:** Individual trainings were offered in a variety of areas. Cultural competency trainings and mental health interpreters training were critical in developing a workforce that included qualified translators. Collaboration with to the State Education Resource Center supported trainings in infant mental health and offerings have increased in the number each year and will be sustained beyond grant funding.

5. **Development of the Early Childhood Mental Health Training Sequence, purchase of the Michigan early childhood mental health competencies and adoption of the endorsement:** Early in the project key stakeholders in early childhood mental health from throughout the state came together to form the steering committee which has since turned into a state-wide consortium of the CT Association for Infant Mental Health. This group researched and selected the evidence-based programs (See #3) to be implemented as part of the service delivery component of the grant and then moved on to explore the adoption of early childhood mental health competencies. These stakeholders represented a wide range of programs and services from throughout CT and championed these discussions, and garnered the funding necessary to purchase the Michigan Competency Guidelines for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®. Subsequently the consortium recommended purchasing the license for Endorsement. The CT Association for Infant Mental Health, of which many of the stakeholders were members, became the holder of this endorsement. CT-AIMH has become a member of the League of States, an association of those 14 states offering the Endorsement in Infant Mental Health. At this time, three people from New London County have received endorsement and a total of nine persons are endorsed in Connecticut.

In addition, BB hosted several Reflective Supervision groups. Several workgroups have developed as offshoots to support the development of this process in CT. Building Blocks remains an active member with the sustainable leadership provided by the Association.
6. **Higher Education Forums**: Collaborating with Head Start Washington Collaboration Office along with CT State Department of Social Services to interest the higher-education community in incorporating infant mental health in their programs.

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**THE “LEARNING COLLABORATIVE” APPROACH**

**The Alamance Alliance for Children and Families—Alamance County, NC**

**Strategy/Initiative Summary**
The Alamance Alliance for Children and Families has utilized the Learning Collaborative integrated training and quality improvement process, based upon the Breakthrough Collaborative Series methodology, to spread and embed evidence-based practices, including Wraparound CFT and Trauma-Focused Cognitive Behavior Therapy. In addition to the Learning Collaborative model (described in greater detail below), The Alliance implements a number of other cross-agency workforce development activities including:

- System of Care Training Modules: SOC and Child and Family Team Overview, Child and Family Team Facilitation, Family-Driven Care, Cultural Competence, “What’s Up Breakfast”, and Community Agency Protocols
- Early Childhood Mental Health Training Series including Social Emotional Development, Brain Development, Risk and Resiliency, Effects of Trauma on SE Development, Mental Health Screening, Assessment and Referral and Evidence Based Interventions
- Targeted trainings and technical assistance

**Getting Started**

*Why did your community pursue this effort?*
The Learning Collaborative methodology utilizes practice improvement methods to enable teams of providers to make dramatic improvements in practice over a short period of time. The model emphasizes use of small changes to systematically test adaptations to create culturally appropriate modifications.

*What were the initial steps in getting this effort off the ground?*
- Engaging community partners
- Choosing the right team composition including direct service providers, supervisors, senior leader/champions for change, families, and key community partners from participating agencies/systems
- Determining faculty composition of the Community Collaborative Panel including clinicians, family members, front-line staff and supervisors
- Pre-work phase includes pre-work activities to ensure that participants maximize face to face opportunities for collaborative learning and undertake critical background work around clinical and implementation competence
Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
Multiple child serving agencies including early intervention, family organization, school system, public health, social services, private mental health providers and independent practitioners.

Implementation
How did you move from planning to implementation?
Learning Collaborative implementation occurred following the pre-work phase (see above) and includes:
• Learning sessions which occur over 10-12 months with three, two-day learning sessions emphasizing active learning with separate tracks and breakouts for participants in different roles.
• Action Periods occur between learning sessions. During action periods, participants engage in collaborative work to practice and apply new skills and problem-solve practice barriers.
• Small tests of change are central to surmounting individual and organizational barriers to progress and change.
• Metrics provide data to help teams gauge whether their efforts are resulting in progress toward goals. Teams collect and review metrics at regular intervals, establishing a transparent decisions process based upon mutually agreed-upon indicators.
• Collaborative Evaluation—LCs are evaluated through focus groups and questionnaires completed by participants as well as clinical assessments associated with the new practice. This extends monitoring and quality improvement to programmatic efforts to evaluate progress.

Barriers/Obstacles
What challenges, issues, complications or obstacles have emerged along the way?
Including family voice in a meaningful way during clinical learning collaboratives.

Funding/Sustainability
How is this effort funded?
Through the grant. Agencies provide in-kind support through staff participation.

What elements are (or will be) in place to sustain this effort after the grant period ends?
Sustainability strategies are developed as part of the LC work.

Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
Carefully consider readiness of the community prior to implementation.

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Funding early childhood systems of care is much like creating a patchwork quilt. It requires use of multiple funding mechanisms as well as expertise in knowing how to blend/braid federal, state, and local dollars, educating private donors on the wisdom of investing early, and managing the complexities of using multiple funding streams, each with their own requirements. In addition, there are many challenges with billing public (i.e., Medicaid) and private insurance for early childhood mental health services, given the “non-traditional” approaches that are best practice for infants and young children such as dyadic therapies and interventions like early childhood mental health consultation, which include a promotion and prevention focus.

Although it was the intent of Part C of IDEA, the federal early intervention program for infants and toddlers, to fund services for children birth to three at risk of developmental delays (including those with social-emotional delays), this has not been a major funding source for children experiencing delays in this area only. Further, stricter Part C eligibility criteria in some states and stagnated funding for this program have made it even more challenging to fund services with these dollars. Thus, early childhood grantee communities need to work together (with multiple stakeholders at the table) to find creative ways to finance—in a sustainable way—an early childhood system of care that encompasses promotion, prevention, and intervention services and supports for young children and their families.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Do you have an inventory or “financial map” of the major federal, state, and local funding being used for early childhood mental health services and supports, noting eligibility criteria? If not, are there partners in your community that may have already done this or will you need to spearhead the effort?
2. How are you organizing funding (e.g., blended, braided or pooled funding) and are any of the funds flexible?
3. Have you assessed how well you are accessing funding streams?
4. Are you utilizing both public and private funding? Have you engaged Medicaid?
5. Have you been able to redeploy or reinvest funds from restrictive settings (hospitals, residential treatment)?
6. Does your state have a managed care initiative and if so, are mental health services carved out? Are developmental services bundled?
7. Is EPSDT being used in your state/community? How?
8. Have you identified sustainable funding sources for the following key areas: 1) screening and assessment, 2) direct services, 3) informal supports, and 4) infrastructure (e.g., workforce development, social marketing, evaluation and database management)?
9. Has your community experienced changes to the budget impacting early childhood, mental health, or related programs?
10. Has the political will to address these early childhood issues changed recently?
LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Don’t tie up too much money in personnel and service delivery. Think about ways to leverage funding for overall system capacity-building and infrastructure that will sustain past the grant period.

• Become familiar with the activities and missions of various system and community partners so you can assess where mental health might fit in and where leveraging or pooling funding might make sense.

• Develop a pooled funding structure. One community formalized this funding mechanism, having various child-serving agencies that participate on their governance board sign a contract outlining roles and responsibilities, including funding responsibilities.

• Become well-versed in your state’s Medicaid policies and how to draw down Medicaid funding for mental health services and supports [this includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program]. For areas where Medicaid does not cover needed services (e.g., dyadic work with families), convene your system partners to determine how best to address these gaps. One community is working with their governance committee to propose changes to their state Medicaid plan that would accommodate work with families.

Strategy Examples

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. Blending Revenues Across Interagency Divisions: Project BLOOM—Denver, CO

B. Implementing a Crosswalk From DC:0-3R to ICD:9-CM: The Florida Center for Child and Family Development—Sarasota, FL

C. For additional financing strategies not specific to early childhood systems of care, see Effective Financing Strategies for Systems of Care: Examples from the Field (Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health, 2008) and Effective Financing Strategies for Systems of Care: Examples from the Field—Second Edition (Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health, 2009). Both available at: www.tapartnership.org/SOC/SOCfinancingResources.php

RESOURCE MATERIALS

National Resources

• Compilation of strategic financing resources for system of care grantees on topics including match funding, developing a financing plan, and Medicaid. Available at: www.tapartnership.org/SOC/SOCfinancingResources.php


MAXIMIZED AND FLEXIBLE FUNDING


• Zero to Three. Developing a DC:0-3R Crosswalk. (Slide presentation). Available at: http://main.zerotothree.org/site/DocServer/DC_0_-_3__PP_1.pdf?docID=5510


Community Resources


• Florida’s DC:0-3R Crosswalk. Available at: www.thefloridacenter.org/pdfs/Fl_Crosswalk_June_2010.pdf

KEY CONTACTS AND WEBSITES

Websites

• SAMHSA Financing Center of Excellence—an online resource for news, reports, and information on financing health care and mental health/substance use services: www.samhsa.gov/financing

• TA Partnership—Strategic Financing webpage: www.tapartnership.org/SOC/SOCfinancingResources.php

Technical Assistance Provider

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1The matrix outlines potential funding sources at the federal, state, local and non-governmental levels.
BLENDED REVENUES ACROSS INTERAGENCY DIVISIONS
Project BLOOM—Denver, CO

**Strategy/Initiative Summary**
Colorado BRAID (Blending Revenues Across Interagency Divisions) is a catalog of state and federal funding streams, similar to the Catalog of Federal Domestic Assistance (CFDA). However, Colorado BRAID goes beyond the CFDA to include information about how monies are distributed at the state level. This is a joint project with Project BLOOM (Division of Behavioral Health), The Behavioral Health Task Force, the Prevention Leadership Council, Early Childhood Colorado and Omni Institute. Temple Hoyne Buell and the Prevention Leadership Council have provided funding to make this information a searchable database that can be used by local and state interagency groups interested in best utilizing existing funding.

Project BLOOM staff outreached to key agency representatives to assemble the information for this database. Letters were sent in advance of the database launch to agency leadership alerting them of this effort and asking them to encourage department staff to submit requested information about funding streams to Project BLOOM for inclusion in the Colorado BRAID system. These letters were sent by the state children’s mental health director, who was also the Principal Investigator for Project BLOOM. Agency leadership was also asked to confirm existing funding streams in their agencies/departments for children, youth and families to ensure an accurate picture of available federal and state funds. To access the database, visit: [http://coloradobraid.org](http://coloradobraid.org)

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IMPLEMENTING A CROSSWALK FROM DC:0-3R TO ICD:9-CM
The Florida Center for Child and Family Development—Sarasota, FL

**Strategy/Initiative Summary**
The Florida Center for Child and Family Development, a partner of the Sarasota Partnership for Children’s Mental Health, developed a crosswalk between the DC:0-3R and the ICD:9-CM to facilitate billing when using the DC:0-3R assessment tool for young children. The process used to develop and implement the crosswalk, as well as the crosswalk itself, are available at: [www.thefloridacenter.org/pdfs/FI_Crosswalk_June_2010.pdf](http://www.thefloridacenter.org/pdfs/FI_Crosswalk_June_2010.pdf)

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NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Measuring outcomes and monitoring the extent to which your efforts are rolling out in the manner intended are critical components of systems development. Together, outcomes evaluation and process evaluation, respectively, provide valuable data for communicating with key stakeholders (e.g., families, funders, system partners) and identifying areas for quality improvement at both the service delivery and system/policy levels. Recognizing the essential need for data to inform, improve and sustain Systems of Care, the authorizing legislation for SAMHSA’s Children’s Mental Health Initiative (CMHI) requires a national evaluation. All CMHI grantees must participate in the National Evaluation, which is administered by ICF Macro and Walter R. McDonald & Associates. Together with evaluation partners at Kauffman and Associates, Inc., the National Federation of Families, and the University of Florida, these entities form the National Evaluation Team. While a standard set of measures is used for the collection of National Evaluation data by grantees, grantees determine best practice approaches for implementing evaluation in their communities. For example, some grantees choose to add measures to their data collection efforts to meet specific information needs at the local level.

The required early childhood evaluation measures have changed over time, thanks to collaboration between the National Evaluation Team and evaluators from the EC SOC communities. In response to concerns raised by the EC SOC communities about tool validity and suitability for administration by non-clinical interviewers, the National Evaluation Team solicited feedback from the early childhood evaluators regarding possible replacement measures. The early childhood evaluators worked together to identify common tools being used across the EC SOC communities for local evaluation efforts and determine which would best fill the gaps in the existing National Evaluation protocol without overburdening interviewees. In 2008, the protocol was amended to remove the Vineland Screener and to add versions of the Parenting Stress Index (PSI) and the Devereux Early Childhood Assessment (DECA).

In addition, evaluators from the EC SOC communities discussed and selected several instruments to be used in their local evaluations. A listing of tools being used locally among EC SOCs can be found in the resources section below. It is important to note that several EC SOC grantees purposely selected some common measures in order to aggregate their cross-site data and further explore key issues around early childhood mental health across these three communities (e.g., trauma).

Over the years, evaluators from the EC SOC communities have learned a great deal about how to effectively implement the National Evaluation, develop the local evaluation component, use findings to inform service planning, leverage additional research opportunities, and raise awareness of the positive impact of systems of care as well as unmet needs for young children and their families. This section is designed to share these valuable learnings and strategies, and to provide inspiring food for thought as EC SOC communities design and implement the evaluation component.
QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. Who will be conducting the interviews with families/caregivers? What training and/or qualifications might they need to effectively administer the tools in a reliable, family-friendly and culturally competent manner? Do you need to hire bilingual/bicultural interviewers?

2. Does your community need non-English versions of the measures and, if so, how will you assess administration fidelity or other issues associated with translated editions?

3. What accommodations are needed to effectively interview families with young children?

4. Have you developed a flowchart of your evaluation process? How much of a lag is anticipated between your system of care’s first contact with families and the first/baseline data collection? How might this impact your findings about the impact of services?

5. Will you provide opportunities for interviewees to give feedback on their satisfaction with the interviewer/interview process? If so, what will this look like and who will be responsible for entering and reporting on the data?

6. How will you motivate families with young children to stay enrolled over time?

7. What is your plan for maintaining accurate contact information for enrolled families over time?

8. How will data be used to inform strategic planning and continuous quality improvement efforts?

9. To whom will evaluation findings (national and local) be reported—respondents, funders, system partners?
   a. What method(s) of communication will be used—one-on-one conversations, written materials, presentations to governance boards, etc.?
   b. Who will be involved in reviewing aggregated findings to discuss possible causes for trends discovered, implications, etc.? Will families/caregivers served by the EC SOC be part of this process?

10. Does your community have a cross-system data collection mechanism?

The National Evaluation

1. How will families/caregivers be introduced to the National Evaluation?
   a. Who will discuss it with them? Be mindful of the number of people the families must interact with as they first enter the system of care.
   b. What training or preparation might the individuals introducing the evaluation need? Will you provide a script and, if so, will families be part of script development?
   c. Will there be written materials available as part of the introduction? If so, will family members help develop them and do they need to be translated into any other languages?
The Local Evaluation

1. How will you determine additional information needs for your community beyond those addressed through the National Evaluation data collection process? To what extent will you pull from a new or existing community needs assessment? What stakeholders (e.g., family members, key system partners) will be part of the tool selection process?

2. How many additional measures can you comfortably add, beyond those required by the National Evaluation, without excess burden to families/caregivers? Should some information only be collected from selected families/caregivers? Can the information be obtained from another source without adding to an interview, such as the child’s record, an MIS, information collected for state-level reporting?

3. How will you use local data to drive system development?

4. Is your community interested in partnering with other EC SOC communities that have selected some of the same measures to identify cross-site findings? (If so, the Early Childhood Technical Assistance Team is happy to help facilitate this process.)

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

• Engage key stakeholders—families, system partners, potential funding partners—in the evaluation process. This includes development of the logic model and selection of appropriate outcomes and indicators to track, the methodology to track them, and who to report to and how often. Integrating stakeholder information needs into the local evaluation helps to ensure meaningful data collection, fosters collaboration, and supports continuous quality improvement and sustainability efforts.

• Engage family members in developing materials (e.g., recruitment brochures) and processes for enrolling new families into the evaluation, and in training interview staff on how to talk to families. One site formed an official workgroup to help perform these functions.

• Once local information needs have been determined, first consider secondary data collection as an alternative to adding measures to the interview protocol. Information may exist in the child’s chart or electronic medical record, a management information system (MIS), or in a clinical assessment used for state-level reporting or other administrative monitoring purposes. One site is employing a quasi-experimental design using Medicaid data as well as data from the National Survey of Children with Special Health Care Needs.

• Be wary of adding too many measures/too much length to the interview protocol, so as not to overburden respondents. Before committing to additional measures, do a test-run of the full protocol (National Evaluation and additional measures) to determine how much time it takes your interviewers to complete the protocol, acknowledging that administering translated measures will likely take longer than average.

• Integrate information about the National Evaluation into the intake process as best you can so families are not overwhelmed from the start. For example, consider inserting a brochure/pamphlet about the evaluation into a general information packet and training the intake person to discuss the evaluation with families. One site had their service coordinators, who conduct the intake process, go through an interview process themselves so that they could experience it firsthand and be better prepared to converse with families about it.
• Consider using your national and/or local data to generate clinically-relevant reports for the clinicians working with the children and families that you serve. This is an important way to show the value of the evaluation to the service staff who are working so hard for the project. One community developed a process for generating these reports and made them available to both clinicians and their supervisors to compliment their assessments and assist in some of the clinical decision-making. Of course, in order to share highly-sensitive data in this way, it is essential that you obtain proper consent at all levels, develop secure data-sharing procedures, and gain approval from your Institutional Review Board (IRB).

• If you plan to have non-evaluation staff gather demographic information for the EDIF, be sure to provide adequate training and support. One site developed “cheat sheets” to address FAQs and guide staff through the process. These were modified as needed over time.

• In scheduling interviews with families that have young children, consider time of day and coordination with nap schedules. Also, be mindful of the potential need to provide a safe and developmentally-appropriate distraction for young children who might be in the home during the interview. One EC SOC community brings a portable DVD player on-site along with a selection of child-friendly movies and comfortable child-sized headphones. Another community brings a treasure chest full of puzzles and books to occupy young children while the parent/caregiver is being interviewed.

• It is important to gauge interviewees’ satisfaction with the interview process so changes can be made as needed. One EC SOC community developed self-addressed, postage-paid “self-mailers” printed with a short satisfaction survey that interviewers left with families at the end of each interview to provide the opportunity for anonymous feedback.

• Develop creative ways to stay in contact with families between interviews. One site created an evaluation bulletin that was disseminated regularly to enrolled families. Each bulletin featured a family story (with the family’s permission), highlighted some data, identified some key resources for families, provided a child-friendly puzzle or activity, and included a mechanism for providing feedback on the interviewer(s) working with the family.

• For SAMHSA-funded CMHI communities, the National Evaluation’s ICN website (see resource section) is a great resource. The standard reports and presentation slides generated through the National Evaluation and available through this password-protected website (e.g., Data Profile Reports, CQI reports) are easy to use and/or modify for local needs.

• The National Evaluation’s digital library is another great resource where anyone can view a variety of sample materials collected from across ALL grantee communities, not just those focused on early childhood.

• Once the grant is in full swing, program/service delivery staff can get overwhelmed and evaluation can fade as a priority. Evaluation staff should try to be a constant presence and an advocate for evaluation by attending staff meetings and sharing findings that can help energize efforts.

• Look for ways to collaborate with your peer early childhood evaluators. Three communities from the FY2006 cohort worked closely together to aggregate their data and to expand learning around early childhood issues, and have engaged other evaluators as new early childhood communities are funded.
STRATEGY EXAMPLES

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. **Building a Culture of Evaluation**: Project Kariñu—Guam

B. **Hiring Family Interviewers**: Kentucky System to Enhance Early Development—Kentucky

C. **Engaging Families in Evaluation—The Community Evaluation Team**: Starting Early Together—Allegheny County, PA

D. **Sharing Data in a Family Friendly Way—Family Reports**: Sarasota Partnership for Children’s Mental Health—Sarasota, FL

E. **Collaboration Between Evaluation and Social Marketing**: Wraparound Oregon: Early Childhood—Multnomah County, OR

F. **National Evaluation Recruitment and Retention Success**: Building Blocks—Southeastern Connecticut

RESOURCE MATERIALS

**National Resources**

- Cross-site list of measures being used for local evaluation component compiled by the Georgetown University National Technical Assistance Center for Children’s Mental Health. Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

**Community Resources**

- Sample “Family Report” (Sarasota Partnership/Sarasota, FL). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- Recruitment brochures—English and Spanish—and consent form script (Building Blocks/CT). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- Important family interviewer qualities and characteristics (KY SEED/Kentucky). Available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
• Community Evaluation Website (Sarasota Partnership/Sarasota, FL): Sarasota, Florida’s Evaluation Team website (www.coedu.usf.edu/spcmh) introduces families and other stakeholders to the members of the team, describes the national and local evaluation, and provides access to the logic model, reports, and presentations.

• Sample logic models
  – Sarasota Partnership/Sarasota, FL: www.coedu.usf.edu/spcmh/ssoc_logicmodel.html
  – KY SEED/Kentucky and Building Blocks/Connecticut: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html

KEY CONTACTS AND WEBSITES

Websites
• ICN Website (password protected): www.cmhs-icn.org
• National Evaluation Digital Library: www.cmhi-library.org

Technical Assistance Provider
Stacy Johnson
ICF Macro International, Inc.
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Strategy/Initiative Summary
Project Kariñu is working to infuse and integrate evaluation into all aspects of developing, implementing, and sustaining Guam’s early childhood system of care. This is a “strategy in progress,” whose ultimate goal is to build a “culture of evaluation” in which families, service providers, and community stakeholders: (1) value evaluation; (2) understand its importance for program development, continuous quality improvement, and sustainability; (3) are knowledgeable consumers and presenters of evaluation findings; (4) and are active participants in all aspects of the evaluation process, including data-based decision making. This strategy involves first building awareness and then engaging families, Kariñu staff, agency partners, and community stakeholders in an ongoing learning process through structured opportunities for them to personally participate in various aspects of Project Kariñu’s evaluation activities. It also requires integrating evaluation into service planning and delivery processes/activities through close partnerships (and sometimes non-traditional roles) between the evaluation team and project staff.

Getting Started
Why did your community pursue this effort?
Project Kariñu is Guam’s second system of care initiative. Through our first initiative, I Famagu’on-ta, stakeholders began to develop an understanding of the role of evaluation in systems change, as well as comfort with evaluation processes. Families saw that they could actively contribute to evaluation and program staff began to learn how to use data to make better decisions and partner with the evaluation team to produce tangible results. Through ongoing presentations of National Evaluation findings, local evaluation activities, and family stories, I Famagu’on-ta successfully leveraged a local appropriation in very tight economic times. As a result, from the beginning of Project Kariñu, there was a strong level of “buy-in” around evaluation and expectation that evaluation would be incorporated in all aspects of the initiative.

What were the initial steps in getting this effort off the ground?
The close relationship between the evaluation team and Project Kariñu management team was established upon initial funding of the initiative. The Project Director, Evaluator, and Cultural and Linguistic Competency Coordinator co-facilitated a series of community awareness presentations, the Evaluator actively participated in service planning related activities and meetings, and collaborated with the management team to plan and coordinate a large community strategic planning event. In early stakeholder orientations to Project Kariñu, the role of evaluation in systems change was introduced and evaluation findings and lessons learned from our first System of Care initiative were shared as “real world” examples of why evaluation is important and what it looks like in action. Efforts were made to ensure that qualitative data, family and youth stories, as well as quantitative data were highlighted to make evaluation findings relatable and culturally meaningful. Through a variety of forums (e.g., working group meetings, outreach activities, etc.) stakeholders received introductory level presentations on what is evaluation, why it is important, and how it can support the ongoing development and implementation of Guam’s Early Childhood System of care.
**Building a Culture of Evaluation (Continued)**

**Key Partners**

*What organizations, agencies or individuals partnered with you on this effort, and in what ways?*

Individual family members, representatives from Guam’s family organizations (i.e., Guam Identifies Families Terrific Strengths and Guam Positive Parents Together), Project Karinu management team and evaluation team, the Department of Public Health and Social Services (inclusive of child welfare, medical social services, community public health clinics, nurses), the Department of Education (inclusive of Head Start and special education Part C and Part B), and private child care providers.

**Implementation**

*How did you move from planning to implementation?*

With the formation of Project Kariñu’s logic model workgroup, a broad-based group of stakeholders (i.e., families, Project management and staff, partnering agencies, and private sector providers) participated in a more structured effort to build a “culture of evaluation.” During monthly meetings, the logic model workgroup engaged in learning together and building on what they were learning to develop, step-by-step, Project Kariñu’s logic model and to discuss how the logic model linked to strategic planning and service delivery. After completion of the logic model, this group agreed to expand its role and now serves as our Community Evaluation Advisory Team (CEAT). As CEAT members continue to learn more about evaluation, they will provide ongoing input into the Evaluation Plan, assist in planning and executing local evaluation activities, assist in interpreting and presenting evaluation findings and collectively problem solve around issues raised through our continuous quality improvement process. Additionally, the Evaluation Team began structured meetings/training sessions with the Wrap Coordinators and strategic planning service delivery workgroup to begin integrating evaluation into the referral, intake, eligibility, service planning, and service delivery processes.

**Barriers/Obstacles/Lessons Learned**

*What challenges, issues, complications or obstacles have emerged along the way?*

To effectively build a “culture of evaluation”, broad-based stakeholder participation is essential and effective collaboration between the evaluation team and stakeholders must be developed and nurtured over time. Stakeholders will enter the process with diverse levels of awareness, comfort and expertise with evaluation, so it is important to “level the playing field” by systematically building familiarity with terms and concepts and by finding creative ways to actively engage participants. Staff and the evaluation team may have very different perceptions of each other’s roles and responsibilities which will require open discussions, team building, and a willingness to step out of one’s comfort zone.

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Strategy/Initiative Summary
To engage families of young children in the longitudinal outcome study (LOS) of the National Evaluation by hiring caregivers who have had children who received a state-funded service as Family Interviewers.

Getting Started
Why did your community pursue this effort?
In adherence to the core value of being family-driven in all aspects of system of care implementation, including evaluation efforts, KY SEED chose to hire caregivers as Family Interviewers based on feedback from study participants in previous system of care communities that they feel “safer” answering very detailed and, at times, intimate questions about their child and family. “Knowing that the person sitting across from them has been where they are at makes a tremendous difference in their ability to answer questions openly and honestly without fear of judgment,” states Laura Beard, Co-Lead Family Contact.

What were the initial steps in getting this effort off the ground?
As part of the implementation plan for the National Evaluation, the Core Evaluation Team and staff from the Kentucky Partnership for Families and Children drafted a list of desired qualities and characteristics for a Family Interviewer. These qualities and characteristics guided their search for potential candidates as well as the hiring process. The National Evaluation Coordinator and Co-Lead Family Contacts provided this description of qualities and characteristics to community partners to assist in the recruitment of potential candidates.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
Potential Family Interviewers were identified based on recommendations from community partners and other family leaders within their respective region, e.g., members of the Regional Interagency Council, parent support group leaders, and community members. In addition to possessing the desired qualities and characteristics, Family Interviewers were selected based on the fact that they had risen to a leadership role in their advocacy journey to be able to promote and make families feel comfortable enrolling and participating in the LOS.

Implementation
How did you move from planning to implementation?
Once potential candidates were identified, the Co-Lead Family Contact and National Evaluation Coordinator conducted interviews to assess the presence of the desired qualities and characteristics. Selected Family Interviewers were trained in the history, policies, and procedures of conducting the LOS. Upon receipt of the initial training, Family Interviewers shadowed the Co-Lead Family Contact or the National Evaluation Coordinator, first as an observer and then as the interviewer with ongoing coaching assistance. During the third family interview, the Co-Lead Family Contact or National Evaluation Coordinator observed and assessed the Family Interviewer. If deemed ready, the Family Interviewer conducts interviews without assistance, with periodic observations to ensure fidelity to LOS...
Hiring Family Interviewers (Continued)

protocol. Monthly Family Interviewer meetings are held to identify and troubleshoot barriers and share lessons learned.

Barriers/Obstacles
What challenges, issues, complications or obstacles have emerged along the way?
Given the rural nature of the state, identifying and recruiting potential Family Interviewers in some areas and regions has been problematic. Similarly, some regions have rather low enrollment of children into services providing insufficient opportunities for Family Interviewers to maintain their interview skills. To that end, Family Interviewers have begun to work in multiple regions to increase their pool of family interviews.

What potential pitfalls can be identified that others can avoid?
Kentucky has had three system of care cooperative agreements. In the first two, Family Liaisons served as data collectors for the National Evaluation as well as service providers. While this model has pros and cons, communities should carefully monitor the impact of this data collection approach on the service provider and study participants.

Funding/Sustainability
How is this effort funded?
Family Interviewers are paid with cooperative agreement funds on a per interview basis and are reimbursed for mileage as well as their time in trainings, meetings, etc.

What elements are (or will be) in place to sustain this effort after the grant period ends?
At this time, no plans are in place to sustain the LOS after federal funding ends; however, the Family Interviewers are being afforded opportunities to participate on state and regional CQI teams, attend family leadership and advocacy trainings, etc. to prepare them to serve in other capacities within the system of care.

Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
Discuss the qualities and characteristics of Family Interviewers before you begin advertising. Also, determine the desired qualities and characteristics of those who will serve as trainers and coaches for Family Interviewers (e.g., National Evaluation Coordinator, Co-Lead Family Contact).

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ENGAGING FAMILIES IN EVALUATION—THE COMMUNITY EVALUATION TEAM
Starting Early Together—Allegheny County, PA

Strategy/Initiative Summary
The Community Evaluation Team (CET) is a group of families and professionals that meet on a regular basis to learn about program evaluation and to review and discuss data results—specifically from the three system of care grant programs that Allegheny County has implemented. Some of the main functions that the group has served over the 12 years of grant implementation have included: review of program data for continuous quality improvement resulting in operational changes; review and analysis of National Evaluation Outcomes Study data; report development of program and outcomes data; customization of data collection tools including various brief surveys and the Child and Adolescent Needs and Strengths Assessment (CANS); and review of Allegheny County’s system of care and other county program’s printed materials for family-friendly/appropriate language. To ensure that family participation in this group is meaningful, there have also been various trainings offered through the years to provide learning opportunities about data, evaluation and its role in the program and advocacy.

Getting Started
Why did your community pursue this effort?
Allegheny County felt it was very important to provide a regular stage for family and youth (with the transition-age youth program) involvement in evaluation. To maintain a data informed, but also family-driven program, family engagement and participation was absolutely necessary at the evaluation ‘table.’

What were the initial steps in getting this effort off the ground?
Initially, Vroon Vandenburg consulted with Allegheny County about the CET concept and presented the idea to a group of family members. From that point the initial group met to discuss the CET design—how often they would like to meet (which has varied over the years) and what their organizational structure should be (this has also varied from having parent co-chairs, standing membership, etc.). Staff support from the system of care grant office was an important component during the start up phase and continues to be a vital link for a thriving CET today. Some training about program evaluation basics was also vital so all participants were “speaking the same language” and could participate equally. After the initial structure was set, system of care staff created agendas based on current data issues.

Key Partners
What organizations, agencies or individuals partnered with you on this effort, and in what ways?
Partners through the 12 years of Allegheny County’s system of care grants have included families and youth enrolled in the programs, community members interested in children’s mental health, the local consumer satisfaction reporting organization (an affiliate of NAMI), Allegheny County Department of Human Services representatives, Allegheny Family Network (family organization created in 2008), and other shifting stakeholder partners membership. The main function of the partners was to provide additional perspectives on the program and outcomes data, insight into interacting systems/services and enhances networking opportunities.
Implementation

How did you move from planning to implementation?
After a regular meeting time and location was set, the group moved easily into implementation mode.

Barriers/Obstacles

What challenges, issues, complications or obstacles have emerged along the way?

• Though it was expected for membership to fluctuate for both families and professionals, it has seemed most difficult to maintain the professional partner involvement. Though we do not have overwhelming evidence, it has been suggested that professional engagement relies on the individual’s role and workload as well as ‘approval’ from their supervisor to participate. Essentially, the time to engage in this kind of group almost has to be formalized in a job description to ensure consistent and long term membership.

• Scheduling (location, time of day) can often be a barrier, but we have been able to maintain a steady location and date/time for many years now. This has allowed a strong foundation of families and participants to develop, but it may have also limited the introduction of new members. Current membership has reached a somewhat stagnant phase where it is vitally necessary, for the health of the group, to bring in new participants. However, we are in a ‘holding pattern’ for membership because we are in close-out of the final SAMHSA grant and are visioning the unit’s new function and role, so this issue cannot be addressed until late 2011.

• Additionally, with the creation of Allegheny’s family organization in 2008, many of the financial and other family engagement elements of the local system of care programs were transitioned to this outside entity. Though this family organization has opened many doors for reaching additional families throughout the county, there have been challenges with the transition of these elements. Most notably, there have been some shifts in stipend and incentive policies. While each organization should develop their own guidelines, at times they do not match the historical policies of the county’s system of care program, causing conflicts for families and program administrators.

What potential pitfalls can be identified that others can avoid?
Maintain focus on the group’s purpose, and if agendas and requests are frequently getting away from that purpose, revisit and evaluate. Don’t be afraid to continually reinvent. Refresh membership often.

Funding/Sustainability

How is this effort funded?
The costs of running the CET are minimal, and basically include allocation of staff time. Over the years, families brought in food for the meetings and sometimes the system of care office would offer coffee. The local family organization has also contributed bus tickets so family members could get to meetings, split the cost of an annual celebration meal with the system of care office for the participants, and provided childcare stipends to regular members.

What elements are (or will be) in place to sustain this effort after the grant period ends?
Staff support is a key component that will need to be sustained so the effort can continue. It is also vital to have a consistent data source to discuss. After the system of care grant ends, that source of data for planning, implementation, review and reporting will be gone. Currently, Allegheny County is exploring other avenues for data discussion with this group.
Lessons Learned
What tips can you share that might help others interested in pursuing a similar effort?
First, that it takes an investment of staff time, but pays off in the end. Data results are much more meaningful with youth and parent input. It is also rewarding to see youth and parents using data in their own advocacy efforts. It is also helpful to know that membership may change over time with shifts in population and interest in the various topics presented.

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SHARING DATA IN A FAMILY FRIENDLY WAY—FAMILY REPORTS
Sarasota Partnership for Children’s Mental Health—Sarasota, FL

Strategy/Initiative Summary
In Sarasota, FL, the local and National Evaluation data have been integral to enhancing family-driven services and advocating for family support. The evaluation team interprets the results for diverse audiences based on a shared language and vision for change. With the input of family members, Sarasota created family reports to disseminate child-specific data to families and reflect family progress over time. The evaluation team provides Family Reports to families at their 12 month follow-up interviews. These reports contain information on outcome data from the National Evaluation in conjunction with measures selected for implementation by a collaborative of early childhood systems of care, and it is updated every 6 months. These individualized reports show the family progress over time and reflect how things are going for the family. Tools included within the Family Reports are the Family Life Questionnaire, Caregiver Strain Questionnaire, Brief Infant-Toddler Social and Emotional Scale (BITSEA)/The Devereux Early Childhood Assessment (determined upon the child’s age), Vineland Screener, Child Behavioral Checklist, Behavior and Emotional Rating Scale and Parenting Stress Index. The report also contains a section where families can reflect on their own growth and progress.

In keeping with the values and principles of the system of care, the report needed to embrace a child-centered presentation that acknowledged the role of families in their child’s development. This component was featured in the section of the report that provided space for families to reflect on their own growth and progress. The report also need to be strength-based, and the title of the report, “Watch Us Grow: A Report of Our Family’s Progress” was selected to contextualize the information in a way that built on the strengths of the child and family. The report also created a mechanism to further engage families in a collaborative partnership with the system of care. The report allows caregivers to transition from informants for the evaluation to engaged participants who can access data to inform their decision-making process based on their child’s skills, interests, needs, and other relevant characteristics. In this
way, the report supports effective collaborations by creating a means for families to share their knowledge and feel valued for their understanding of their child’s growth and progress. The report also stresses the role of a data-driven approach in guiding service delivery options.

Family Interviewers present the report to the family during the follow-up interviews. Interviewers are trained on the various components of the report so they are able to answer any questions families may have. The family jointly reviews the results with evaluation staff, and caregivers have the option to use the information to support service development on behalf of their child.

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**COLLABORATION BETWEEN EVALUATION AND SOCIAL MARKETING**
**Wraparound Oregon: Early Childhood—Multnomah County, OR**

**Strategy/Initiative Summary**
For details on this strategy, see Evaluation Update—March 2010, page 3-4. Available at: www.samhsa.gov/children/evalupdate.pdf

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Strategy/Initiative Summary
Building Blocks in Southeastern Connecticut has achieved strong recruitment and retention rates for the National Evaluation throughout their funding cycle. Since their cooperative agreement was awarded in FY2006, Building Blocks has enrolled 100% of families into the Descriptive Study and 81.1% of families into the Outcome Study. Further, retention rates for families enrolled in the longitudinal outcomes study are as follows: 91.7% of our families at 6-month follow-up; 83.2% at 12-months; 77.1% at 18-months; and, 75.6% at 24-months. The success of these efforts is due, in large part, to the strategic processes and supporting materials developed by the community under the leadership of the evaluation team.

First and foremost, Building Blocks’ evaluation infrastructure is embedded within the work of the local system of care. Data required for the Descriptive Study are collected through a family case record that is completed by program staff. To help program staff understand the evaluation process and help them succeed in their roles, they are given tools and participate in trainings. The Evaluation Team also created a tickler system of due dates, which the Evaluation Assistant uses to alert program staff of upcoming data collection points for each family. Further, to assist with service planning and staff engagement in the evaluation, with the permission of the family, the Evaluation Team produces a brief summary of information collected during the baseline interviews that clinicians receive within two weeks of the interview.

Another key effort was partnering with stakeholders (parents, providers, policymakers) to develop recruitment strategies tailored to the unique needs of the community. As a result of this collaboration, the community developed an Outcome Study Brochure and a script for staff to use in introducing the study to families. Procedurally, Building Blocks collects phone numbers, email addresses, and other contact methods as well as contact information for three people who will always know where the families are (e.g., child’s grandmother). The Evaluation Assistant conducts consent and baseline interviews, and calls each family before assigning a follow-up interview to verify that the phone number is accurate and to let the family know who will be conducting the interview. Building Blocks has retained the same person in that position since data collection began, so families are familiar with her and expect to hear from her periodically.

Building Blocks employs part-time interviewers, half who are family members, who conduct follow-up interviews. In addition to being trained on data collection, interviewers are trained on building rapport with families and treating each family member with respect. Unless the family requests otherwise, Building Blocks tries to assign the same interviewer for each follow-up to increase the comfort level of the family. Upon completion of each interview, families receive a $40 gift card to a store of their choice and are handed a stamped postcard that asks them to provide anonymous feedback regarding their interview experience. The information provided is used in ongoing supervision with interviewers.

The Evaluation Team also uses a number of techniques to stay in touch with families between interviews. For example, a few weeks before an interview window opens, the Team sends out a postcard informing the family that they will be contacted soon to schedule their interview. Upon receipt of this postcard, many families call to schedule their interview. At the end of each interview, each family is asked if they
are planning to move and, if so, contact information is updated accordingly. Lastly, the Evaluation Team writes an article for the Building Blocks quarterly newsletter and then ensures that copies of the newsletter are mailed to outcome study participants so that they can stay informed of findings and engaged in the process.

Despite all these efforts, at times staff have trouble contacting families for their follow-up interviews. The Evaluation Team developed a series of steps to try and re-establish contact (phone calls, letters, visits to the home, call contacts provided, PeopleFinder). One novel technique that has been successful is setting up a Facebook page that enables the Evaluation Team to find families and contact them, in a confidential manner, to schedule their interview.

**Resources**
(All available at: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html)
- Recruitment brochures—English and Spanish
- Consent form script
- Logic model

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OUTREACH & STRATEGIC COMMUNICATION/SOCIAL MARKETING

NOTE: The following information reflects a compilation of tips and strategies from early childhood system of care communities, rather than official implementation guidance.
INTRODUCTION

Social marketing is a critical component of all aspects of system development. Clear, strategic communication is essential for building relationships with system partners and recruiting families to (and retaining them in) the system of care. A social marketing plan for an early childhood system of care should include a number of key elements. First—what is a system of care? It is important that all audiences are familiar with system of care values and principles and understand how these defining characteristics positively impacts services and supports. For those with whom grantees wish to partner, it is also important that those potential partners can find commonalities between the system of care approach and their agency’s/organization’s mission and vision. Common ground leads to meaningful collaboration.

The second core concept to address is “early childhood mental health (ECMH).” This may be an unfamiliar or misunderstood term for many members of the local community, and it is one that requires careful attention to ensure that it mitigates rather than exacerbates mental health stigma issues. In fact, some communities have found that re-framing the concept as “social and emotional health” as opposed to “mental health” leads to greater receptivity. Either way, if ECMH is defined clearly and in a strengths-based way, it can help lay a solid foundation for systems development. Zero to Three offers that ECMH is the developing capacity of a child to experience, regulate and express emotion; form close, secure relationships; and explore the environment and learn (see www.zerotothree.org). Two particular messages regarding ECMH are important to convey:

1. **ECMH is about every child.** ECMH is not just about intervention for mental health problems, but also promotion of positive mental health and prevention of mental health challenges.

2. **ECMH is everybody’s business.** While intervening early to address mental health issues has a significant and positive impact on future functioning, failure to do so has been linked to poor school readiness and juvenile justice involvement.

In addition to communicating these core concepts, the social marketer also has a pivotal role to play in partnering with others to develop outreach materials, ensure that evaluation findings are shared in an accessible way, and promote the system of care through various media formats (e.g., websites, news publications, audio-visual, etc.). Current and former early childhood system of care communities have employed many different social marketing strategies and developed a plethora of materials to inspire creativity and provide a strong foundation for future work efforts in this area.

QUESTIONS TO CONSIDER

The following list of questions is designed to help your community with grant planning and implementation. This list is available in a printer-friendly format so that it may be used separately as a meeting handout.

1. To what extent is your social marketer involved in strategic planning for overall systems development as well as specific efforts (e.g., family engagement, workforce development/trainings, evaluation, youth coordination, etc.)?

2. Do you have a social marketing plan in place? Were members from the community part of the plan development?
3. Have you developed key messages around early childhood mental health? Have these been tailored for specific audiences (e.g., families, mental health providers, child care providers, primary care providers, etc.)?

4. How are you tailoring messages to young parents? First-time parents? Expectant parents?

5. What different cultures are represented in your community? How is mental health perceived within each of these cultures? If unknown, who might you engage to shed light on this issue?

6. Are you prepared to respond to the question, “how is system of care different than what our agency/organization is doing now?”

7. Given that early childhood systems of care focus on infusing mental health services into existing systems that may not have prior experience with early childhood mental health, are you prepared to “make the case” as to why each particular system partner should integrate ECMH into their current activities?

LESSONS FROM THE FIELD

This list of tips represents lessons learned across early childhood system of care communities.

- Social marketing is critical to building early childhood systems of care, particularly because “early childhood mental health” is a concept that is unfamiliar to many. In order to bring partners on board and enroll families in the system of care, greater understanding and acceptance of ECMH is needed.

- When crafting messages about early childhood mental health, it is important to help the audience understand how mental health is relevant for infants and young children. Often, in early childhood and primary care settings, great emphasis is put on physical health and development while social and emotional development gets less attention. Raising awareness of the need to equally attend to all developmental domains is an important step in systems development.

- In some communities, the best strategy may be to avoid the term “mental health”—particularly in the early phases of relationship-building with partners (e.g., providers, local organizations and agencies, families, etc.). One community shifted the focus to “how are young children functioning in their family systems and how can our local system of care help strengthen that functioning?”

- Use all accessible committees to help brainstorm and market ideas. For example, social marketing, evaluation, steering or governance committee.

- Over-communicate the process and the product. It helps to think through the details and keeps everyone engaged and excited.

- Find your champion advocates and speakers to be your spokespersons

- Use social media to bring attention to your products.

- Partner with family organizations to place help disseminate your products.

- General social marketing product ideas:
  - Awareness wristbands
  - Public service announcements
  - Websites
  - Digital stories
  - Bookmarks
– Placemats
– Calendars
– Posters
– Packets of (non-toxic) crayons
– Coloring/activity books
– “Feelings” books/stories

**STRATEGY EXAMPLES**

Below are several strategies being used to address this topic across the early childhood system of care communities. Click on the heading for more details on a particular strategy or navigate to the end of this section.

A. **All About Sarasota Kids—A Website for Families of Young Children:** Sarasota Partnership for Children’s Mental Health—Sarasota, FL

B. **Relationships Matter—A Public Education and Awareness Campaign:** Project ABC—Los Angeles County, CA

C. **Sharing Data through Social Marketing:** Rhode Island Positive Educational Partnership—Rhode Island

D. **Digital Story-Telling: Wraparound Oregon:** Early Childhood—Multnomah County, OR

E. **Maximizing the Impact of Children’s Mental Health Awareness Day:** Delaware’s B.E.S.T.—Delaware

**RESOURCE MATERIALS**

**National Resources**

- Planning materials and resources for Children’s Mental Health Awareness Day: [www.samhsa.gov/children](http://www.samhsa.gov/children)

**Community Resources**

- Local early childhood system of care community websites (lots of sample marketing materials to view!):
  - Alamance Alliance for Children and Families—Alamance County, NC: [www.alamancesoc.org](http://www.alamancesoc.org)
  - Building Blocks—Southeastern Connecticut: [www.semhsoc.org/0-6%20index.htm](http://www.semhsoc.org/0-6%20index.htm)
  - Kentucky SEED—Kentucky: [http://childrensmentalhealthky.com](http://childrensmentalhealthky.com)
  - MY CHILD—Boston, MA:
    - [www.bphc.org/programs/cafh/mch/earlychildhoodmentalhealth/Pages/Home.aspx](http://www.bphc.org/programs/cafh/mch/earlychildhoodmentalhealth/Pages/Home.aspx)
  - Project ABC—Los Angeles County, CA: [www.projectabcla.org](http://www.projectabcla.org)
  - Rhode Island Positive Educational Partnership—Rhode Island: [www.ripep.org](http://www.ripep.org)
  - Sarasota Partnership for Children’s Mental Health—Sarasota, FL: [www.allaboutsarasotakids.org](http://www.allaboutsarasotakids.org)

**KEY CONTACTS AND WEBSITES**

**Website**
Vanguard Communications: [www.vancomm.com](http://www.vancomm.com)

**Technical Assistance Providers**
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Vanguard Communications
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Strategy/Initiative Summary
The All About Sarasota Kids website is a central place for parents to find out about upcoming events and activities, locate links to local resources, and find answers to questions about their child’s health, development, and educational needs. The website was designed to be fun and engaging reaching a broad audience but also contains valuable information for parents to “discover”, providing information for families who may not realize they need assistance. The website is divided into content sections, including:

• Early Childhood Education
• Helping Your Child Learn
• Keeping Children Healthy and Active
• Being the Best Parent
• Your Growing Child
• Your Child’s Behavior
• Before & After School Care
• Camps & Entertainment
• Your Child’s Safety

In addition, articles of interest and a listing of community events are posted and updated on a regular basis. The website was created as part of the Partnership’s efforts to increase community awareness about social-emotional development, and connect families to needed services within their community.

Getting Started
In the fall 2009, the Sarasota Partnership for Children’s Mental Health gathered a number of leaders from local not-for-profit organizations, community volunteers and family representatives to develop a community-wide, collaborative, comprehensive early childhood Website www.allaboutsarasotakids.org. This Website has been a long-term goal of many community members, emerging from a United Way Success By 6® and Early Learning Coalition’s Whole Child Project survey, which recognized the need for a more community-based, family focused approach of engaging an increasingly-diverse population of families with young children.

Key Partners
The Community Outreach Coordinator gathered a large group of community partners and volunteers to research, design and market the website. Committee members for the development of the site included Partnership staff, representatives from our local Head Start agency, Early Learning Coalition, Healthy Start Coalition, Sarasota County Libraries and Schools, United Way, Early Steps (Early Intervention—Part C), several not-for-profit organizations serving young children and families, as well as the Sarasota Family Support Network, parents and community volunteers.
Implementation
The Partnership contracted with a professional advertising and public relations firm to design and build the website based on the committee’s content and specifications. Teams comprised of committee members and content experts developed the material and linkages within each website section. Family members were included on each team and reviewed all of the sections before each page was completed, especially the special needs and behavioral health section. The website is advertised in local parent friendly publications and family events. Presentations are made to task forces and committees throughout the community helping to promote the site.

Barriers/Obstacles
We really didn’t experience any barriers or obstacles. We were fortunate to obtain strong participation and support for the project from inception.

Funding/Sustainability
The Social Marketing Work Group was awarded SAMHSA System of Care funding for the project through a Request for Proposals process. The involvement of agencies with long standing commitments to serving children in Sarasota County will enable the website to be sustained far beyond the time-limited grant funding. The website will be hosted by the Early Learning Coalition after the completion of the SOC grant.

Lessons Learned
Having strong support from leaders in the community from various sectors was essential to the success of this project. Engaging a web development PR/Advertising firm that was familiar with many not-for-profit leaders helped move the project along considerably.

Resources
A number of local, state, national and international online public awareness campaigns were researched used as foundation for www.AllAboutSarasotaKids.org. One which was particularly helpful was the www.teachmorelovemore.org website, which is sponsored by the Miami Early Childhood Initiative Foundation and the United Way Success by Six.

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**RELATIONSHIPS MATTER—A PUBLIC EDUCATION AND AWARENESS CAMPAIGN**

*Project ABC—Los Angeles County, CA*

**Strategy/Initiative Summary**

Project ABC is building public awareness of social emotional needs of infants and young children through media outreach, development and dissemination of public education materials, and training for professionals and families in the community. Our website, [www.ProjectABC-LA.org](http://www.ProjectABC-LA.org) provides a broad range of timely resources to help educate families, providers, and policymakers about the need for infant and early childhood mental health services that utilize a relationship-based approach.

The overarching social marketing goal is to use the public education plan and *Relationships Matter* campaign to increase knowledge of early childhood mental services and what is available. A secondary goal is to deliver clear and effective messages to key decision makers that influence future funding for early childhood mental health program/services.

*Project ABC’s system of care social marketing goals are:*

- To increase awareness of mental health needs and services for children birth to five among SOC communities, intermediary organizations, and policy makers.
- To build understanding and expertise in Early Childhood Mental Health services.
- To promote confidence in the SOC values and approach to enhance sustainability.
- To continue to produce public education materials for professionals and child advocacy agencies that are linguistically and culturally appropriate.

This means promoting values, principles and effectiveness data to people of influence most likely to support expansion and sustainability of the SOC.

This also means reaching out to family-serving agencies and professionals who work with families who have children in need of mental health services.

**Our Brand**

At the core of the social marketing plan is the branding of Project ABC, which represents a paradigm shift in the field of infant mental health care. Making Project ABC a recognized “brand” helps create the necessary framework for future growth. The branding process includes our newest materials and resources, such as Project ABC’s boards, posters, brochures, the early childhood mental health website, children’s social emotional activity book, project videos, and the electronic e-newsletter.

Since parents are children’s first teachers, it makes sense to educate parents about the importance of emotion regulation by not only modeling acceptable expressions of emotions when in the presence of their children but by reading to them about it. Early exposure is key, a child who can self regulate has good impulse control, is cooperative and more adept in social situations.
As a part of the Relationship Matters campaign, PROJECT ABC has created the “My Feelings Activity Book” to help very young children in identifying their feelings and learning how to put them to words. The book is for preschool aged children and can be read aloud to them by parents, caregivers, preschool teachers, clergy, social workers, therapists or by any other helping professional.

Our First Public Service Announcement—created to be a part of our public education campaign around the importance of infant and early childhood mental health. “All Babies Cry”/“Todos Los Bebes Lloran.” Watch PSA at: http://projectabcla.org/media/psa.php

About Project ABC’s Public Education Campaign
Project ABC incorporates various media messages that emphasize the central role of relationships during early childhood and the value of connections in meeting the mental health needs of children and youth. The overall message of Project ABC is that very young children with mental health needs and their families are thriving in the community. Early childhood mental health initiatives promote positive child development, prevention, recovery, and resilience for children and their families in need of therapeutic services.

Core Messages
Project ABC focuses on the importance of early childhood mental health needs. The program has had a dramatic impact on the delivery of child development and mental health services for young children birth to five in Los Angeles County. The custom materials and website that the project has created includes resources in the early childhood mental health birth to five arena that have been found to be highly successful with our audience.

Project ABC provides a broad range of timely resources to help educate families, providers, and policymakers about the need for infant and early childhood mental health services that utilize a relationship-based approach.

Campaign Core Message—“Relationships Matter”

Messages have been developed and posters designed to convey the value and significance of the Project ABC approach by emphasizing the central role of relationships during early childhood and the value of connections (i.e., a system of care) in meeting the mental health needs of children in SPA 4.

Message Placement
Website Created and Dedicated to Infant and Early Childhood Mental Health
The website is the key infrastructure to share information about Project ABC, our social marketing campaign and the system of care approach. The new site serves as a portal of information for early childhood mental health resources and for our “Relationships Matter” media campaign. We continue to add new resources to the site that focus on early childhood mental health. All the new campaign materials are posted on the site and are in pdf file format for easy download. A Website Submissions Guide Sheet was created to maintain the early childhood mental health consistency.
For evaluation purposes, the website is linked with Google Analytics for statistic tracking. We have expanded and updated existing pages, designed and created content sections for Parents and Professionals. Key sections have been translated into Spanish—with an easy to find navigation button titled, En Español.

**Additional Materials that we have developed to communicate our core message are:**

**Quarterly e-News:** Launched the “Relationships Matter” campaign and assists with building relationships with community partners and growing the Project ABC brand. Objective: Create an ongoing mailing list for e-Newsletter for: marketing, and other marketing techniques to establish an ongoing dialogue with child welfare professionals, policymakers and the early childhood MH community.

*Relationships Matter Posters in Spanish and English*

Posters have been designed and disseminated to convey the value and significance of the Project ABC approach by emphasizing the central role of relationships during early childhood and the value of connections in meeting the mental health needs of children.

*Pamphlet: What is Infant Mental Health and Why is it Important?*

A public education pamphlet was adapted for dissemination to the community by Project ABC and will be available July 1st. Infant mental health specialists focus on infant’s and toddler’s relationships with their parents or caregivers because there is evidence that early intervention can prevent later problems such as delinquency, criminality, school problems including failure and drop-outs, teen pregnancy, violence, and other risk factors. Available in both English and Spanish.

*Project Brochures*

The Project ABC brochure features all aspects of our systems of care project. The brochure is intended for professions in related fields and highlights our message, program overview, trainings and governance board intentions.

*“My Feelings Activity Book”—Children 3-6 Years Old*

Created for the launch of Mental Health Awareness Day, The My Feelings Activity Book was designed to assist the very young child in identifying their feelings and learning how to put them to words. The book was created to be read aloud to children by parents, caretakers, ECE’s, clergy, social workers, therapists, and any other helping professional. The book can be used as a fun and comfortable way to introduce the topic of feelings and mental health to very young children.

*Family Voices—The project has captured the family’s experience by creating innovative ways to document the parent voice through Project ABC Talk Radio, Digital Stories and Community Event Family Videos.* Project ABC has an Internet talk radio show on our website where staff, mental health professionals and families can converse about how young children are faring in the community and within Project ABC.

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SHARING DATA THROUGH SOCIAL MARKETING
Rhode Island Positive Educational Partnership—Rhode Island

Strategy/Initiative Summary

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DIGITAL STORY-TELLING
Wraparound Oregon: Early Childhood—Multnomah County, OR

Strategy/Initiative Summary
Wraparound Oregon: Early Childhood digital stories can be seen on National Resource Center for Permanency and Family Connections website at: www.nrcpfc.org/digital_stories/_soc

Getting Started
• The digital stories were designed to inform our community about Wraparound Values and Principles through System of Care while using families, youth and community partners own personal experiences and stories. The priority of this initiative was identified in our social marketing plan.

• Creating a concept and theme for the stories was vital to the success and usage of the digital stories.

• With the assistance of a contactor, National Resource Center for Permanency and Family Connections, we gained insight on how to create 10 powerful digital stories composed of family members, youth, a judge, an educator and a case worker.

• Finding key participants who could write, edit and produce their own personal digital story.

Process
• Creating a three-day workshop with all the participants. Eliminating any barriers that might exist—location, transportation, child care, food costs, interpreters and creating support systems.

• Increased communications to everyone involved, directly and indirectly

• Keeping the focus on the Values and Principles of Wraparound and how each story can support the sustainability of System of Care
Keeping everyone motivated and focused while creating their digital story

Making the digital stories cultural responsive by having families address their own cultural specific situation in their own native language

**Barriers**
- Keeping the digital stories somewhat general so other systems can use the video to showcase team-based planning process and the Values and Principles of Wraparound
- Having 12 participants but only room for 10 stories on a DVD. To resolve the issue, we created 2 audio stories
- Constantly coordinating 12 people’s schedules and thinking ahead of what could or would happen during a three-day workshop
- Regular communication and additional support systems for everyone involved can avoid problems

**Sustainability**
Wraparound Oregon: Early Childhood digital stories are being used in the following ways:
- Work-force development training with Portland State University
- Meyer Memorial Trust is using the digital stories to engage philanthropists and other funding sources to continue Wraparound Values and Principles through System of Care
- Nak Nu Wit, another local System of Care demonstration site, is using digital stories for their social marketing efforts
- Several Oregon Wraparound start-up sites are using the digital stories to describe the work and outcomes
- Displayed at Educational Board Meetings

**Future Steps**
Continue to share the digital stories with local and state child serving systems.

**Lessons Learned**
- Use all accessible committees to help brainstorm and market ideas. For example, social marketing, evaluation, steering or governance committee
- Over communicate the process and the product. It helps to think through the details and keeps everyone engaged and excited
- Look at the product as a long term investment with longevity
- Find your champion advocates and speakers to be your spokespersons
- Hire a knowledgeable and experienced digital story telling contractor. It takes a certain skill level and attitude to keep everyone engaged throughout a three workshop.
- Build trust and support with all the digital story tellers by celebrating their steps and accomplishments along the way
- Keep the Values and Principles of Wraparound as the key element in each story
DIGITAL STORY-TELLING (CONTINUED)

• Disseminate the digital stories out to the general public. Send out DVD’s, links, announcements to publicize the digital stories
• Make contact with media outlets to heighten their interest in a future story
• Use the digital stories to engage audiences that might not be on your radar
• Use social media to bring attention to your product
• Partner with family organizations to place the digital stories on their web sites

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MAXIMIZING THE IMPACT OF CHILDREN’S MENTAL HEALTH AWARENESS DAY
Delaware’s B.E.S.T.—Delaware

Strategy/Initiative Summary
1. Strategy: National Children’s Mental Health Awareness Day

2. Planning

What were the specific objectives of this strategy?
• Promote importance of early childhood mental health
• Increase understanding of the mental health needs of young children/families
• Provide information about accessing services
• Involve focus population

What overall strategy was employed to meet the objectives?
• Expanded Rita’s Water Ice partnerships for Get the Scoop on Mental Health campaign
• Engaged young children/families/childcare providers through social/emotional development curriculum and dress-up activity
• Ensured state leadership support

How does this effort relate to your social marketing plan and your overall program?
• Provided information to raise public awareness
• Meaningfully involved identified populations
DIGITAL STORY-TELLING (CONTINUED)

• Planned actions to support system change
• Social marketing strategies included in all aspects of Delaware’s B.E.S.T.

3. Cultural and Linguistic Competence

*How did you ensure that this effort was culturally and linguistically competent?*
• Statewide focus on reaching Delaware’s growing Hispanic population
• Identified childcare programs with diverse populations
• Produced bilingual calendar (English/Spanish)
• Created bilingual signs for children’s *When I Grow Up* activity
• Informational materials in both languages
• Promotional article in bilingual news publication

*What resources or methods did you use?*
• Hired professional translator
• Spanish speaking families assisted with reviews to ensure accuracy
• Included local cultural leaders
• Used expertise of CLC Coordinator

4. Youth, Family, and Partner Involvement

*How did you involve youth, families, and partners in the planning and execution of this strategy?*
• Early Childhood Youth Engagement Specialist’s experience in working in early care programs provided knowledge for engaging age group/program staff (provided customized curriculum/*When I Grow Up* activity)
• Encouraged programs to include families (families assisted their children with “dress-up”)
• Leveraged established relationships with families/key partners
• Engaged community partners actively throughout the Rita’s event

5. Message

*Explain why the message is appropriate to your target audience?*
Early Childhood Mental Health Matters!
• Engaged young children/families, Governor’s Office, legislators, childcare centers, mental health providers, agency partner’s serving young children, Rita’s Water Ice locations across the state to raise awareness about the importance of children’s mental health
• Educated families/community on how to access services for young children

6. Execution/Presentation

*How was your strategy implemented?*
• Governor, Lt. Governor, First Lady, Children’s Department representatives/partners and Rita’s participated in activities
• Governor read a proclamation
• Other dignitaries interacted with children at childcare programs
  – Read original poem
• Information distributed to 3000+ families at Rita’s
• Events photographed for later use
DIGITAL STORY-TELLING (CONTINUED)

How were unexpected circumstances—positive or negative—addressed, and how did they affect the overall effort?
• Media coverage minimal despite high profile participation
• Scheduling nightmare with coordinating multiple activities in one day
• Success made it all worthwhile!

7. Creativity

How was creativity used in the development of this activity?
Customized curriculum was developed; a themed poem was written, framed and left with the centers to display; National’s *When I Grow Up* activity was modified to engage providers, children and their families in a dress-up activity; the events were photographed for follow-up promotion; and a 2011 calendar was created to further communicate what children need to be successful when they grow up.

How does design enhance or detract from the message?
Enhanced by sustaining the message beyond Awareness Day.

8. Effectiveness and Evaluation

What methods of evaluation were used?
Follow-up survey sent to participating early childhood programs to measure awareness, usefulness of materials, and willingness to use the curriculum in the future. The evaluation form and results are included with this submission. Feedback was generally positive and will shape 2011 activities.

Audience reach was measured by the number of awareness day information packets distributed statewide at early care and education programs, Legislative Hall and participating Rita’s locations.

Informally tracked follow-up calls.

How well did this strategy succeed in reaching its target audience and meeting other objectives?
More than 3,000 individuals were reached on Awareness Day, with an additional 15,000 receiving the commemorative calendars.

For additional details on Delaware’s National Children’s Mental Health Awareness Day activities:
• A PowerPoint presentation by Delaware’s B.E.S.T. Available at: [http://gucchdtacentre.georgetown.edu/early_childhood_SOC.html](http://gucchdtacentre.georgetown.edu/early_childhood_SOC.html)

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A Systems Framework for Early Childhood Mental Health

Early Childhood Mental Health fosters the social and emotional well-being of all infants, toddlers, preschool-age children and their families.

Values
Strong Partnerships with Families
Individualized
Multidisciplinary
Culturally and Linguistically Competent
Infused into Natural Settings and Existing Services
Grounded in Developmental Knowledge

PROMOTION
of Positive Mental Health

INTERVENTION
for Mental Health Problems

CHILDREN & FAMILIES
Other Caregivers

PREVENTION
of Mental Health Challenges

PROMOTION
RESILIENCE

Governance
Prepared Workforce
Strategic Partnerships

Maximized & Flexible Funding
Supportive Policies & Procedures
Data Collection & Evaluation
Outreach & Strategic Communication

Developed by Georgetown University Center for Child and Human Development
INTRODUCTION

The “systems of care” model as an organized philosophy and framework was first published in *A System of Care for Children and Youth with Severe Emotional Disturbance* (Stroul & Friedman, 1986). Much of the work on mental health systems of care has focused on efforts to serve older children (i.e., school-age children and youth) with serious emotional disturbances (SED), who require services and supports from multiple agencies. More recently, attention (and federal funding1) has also been given to developing systems of care for young children, including infants and toddlers. This expanded focus has brought to light a number of challenges in applying the system of care framework to a very young population.

The purpose of this document, which is an updating of the original March 2006 publication by Kaufmann, Horen and Perry is to illuminate the unique challenges inherent in developing early childhood systems of care (EC SOC), and—new to this edition—to offer guidance on how to address these issues based on lessons learned from the early childhood system of care grantee community. Much has happened since the original *Lessons from the Field* document was issued: nine new early childhood communities were awarded grants; significant changes to cooperative agreement requirements specific to early childhood took place; and grantees acquired five additional years of knowledge and experience. This Update reflects all of these changes and it is hoped that current and future EC SOC grantees will use this information to avoid “reinventing the wheel” and to best serve the young children and families in their states and communities.

THE UPDATING PROCESS

Since the state of Vermont was awarded the first EC SOC cooperative agreement in 1997, many opportunities for peer learning and sharing have taken place including conference calls/webinars, conference sessions, and email exchanges via the Early Childhood Community of Practice (EC COP) listserv. A number of challenges have been identified through these forums over the years and solutions (or, at a minimum, creative strategies) reached through dialogue, compromise, and collective problem solving. To capture this valuable information for this Update, the early childhood technical assistance providers at Georgetown University and the Technical Assistance Partnership shared learnings from their

1 At the time of this publication, the Substance Abuse and Mental Health Services Administration (SAMHSA) had awarded cooperative agreements to 17 communities with an exclusive focus on young children.
work with state and community-level system of care efforts. In addition, to ensure a comprehensive picture of the critical challenges facing EC SOC communities and to gauge which of those challenges were most pressing, each community was surveyed. All 15 Project Directors from formerly and currently funded EC SOC communities\(^2\) worked with their staff/partners to rank (from least to most challenging) the ten issues identified in the original *Lessons from the Field* document, and highlight additional challenges not reflected in that list. EC SOC communities also shared strategies and lessons learned for addressing those challenges when possible.

Somewhat surprisingly, there was very little consistency in the rankings across communities. Further investigation revealed that this variance was attributed to several factors:

- existing state/community infrastructure that facilitated or impeded systems development;
- effective strategies or approaches to address some of the challenges; and/or
- each community’s developmental trajectory (i.e., some communities, particularly newer communities, had not tackled some of the issues yet and ranked them less challenging than issues with which they were currently struggling).

It is also worth noting that individuals within some communities ranked the issues differently, depending on their specific role/responsibility (e.g., Project Director, Family Support Specialist, Lead Evaluator, etc.). Given the variance in rankings, the challenges listed in this document are not prioritized in any way

**HOW TO USE THIS DOCUMENT**

As previously mentioned, the primary purpose of this document is to help those developing early childhood systems of care anticipate and plan for the typical hurdles associated with this important, but challenging task. More specifically, it is hoped that the information provided in this document will help states and communities to:

- Assess readiness for an EC SOC grant
- Guide a community assessment/mapping to evaluate (1) which of these issues are/will be most challenging for YOUR community; and (2) what work still needs to be done in your community to address these issues?
- Identify possible solutions to these issues from other EC communities; is it a “fit” for your community, and if not, how might it be adapted?
- Provide guidance around sustainability planning for new/existing communities
- Communicate the challenges inherent in developing EC SOCs to those less familiar with EC issues
- Facilitate ongoing information-gathering about EC SOCs as the field continues to evolve

It is important to note that this document does not present an exhaustive list of all the major challenges encountered in building early childhood systems of care. Rather, it highlights those that are unique to this population. There are a variety of issues with which all grantee communities must struggle, such as sustainability, which is discussed below. For more information on these areas of overlap, see *Systems of*\(^2\)The survey was sent in September 2010; at that time there were 15 early childhood grantee communities currently or formerly funded through SAMHSA.
Care: A Framework for System Reform in Children’s Mental Health (Stroul, 2002) and Updating the System of Care Concept and Philosophy (Stroul, Blau & Friedman, 2010).

Finally, this document offers brief synopses of major early childhood system-building challenges as well as some key strategies and/or resources. For additional exploration of these topics and accompanying strategy ideas, please refer to Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.) and Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems (Perry, Kaufmann, & Knitzer, 2007).

SIMILARITIES ACROSS SYSTEMS OF CARE

Before exploring the differences in systems development for young children, it is important to first acknowledge core commonalities across all systems of care, regardless of age. Several areas of convergence are noted below.

• **All systems of care are rooted in the same core values:**
  – child centered and family focused, with the needs of the child and the family guiding the types and mix of services provided;
  – community based, with the locus of services as well as management and decision-making responsibility resting at the community level; and
  – culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve

• **All systems of care grapple with sustainability issues.**
  Regardless of the age range, significant challenges exist in the ability to continue funding for both infrastructure and service delivery once the flow of federal dollars has ended. Successful sustainability plans for any age group require blending and braiding of local, state, and federal funds, as well as integration and coordination of services among service providers at the local level.

• **All systems of care rely on strong interagency collaboration.**
  While key state/local agencies/partners may differ for different age groups, collaboration among agencies is critical for the purpose of improving access to services and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for all children and youth with or at risk for a serious emotional disturbance and their families. As mentioned previously, collaboration is also critical in sustaining systems of care.

• **All systems of care must infuse a solid governance structure.**
  It is essential to create a strong governance structure(s) into systems of care early on. Governing bodies should be diverse, with representation from both professionals and family members, and the demographics of the group should mirror those of the community being served. Further, the governing body(s) should be well-integrated into decision-making processes impacting the development, implementation and ongoing quality enhancement efforts surrounding the system of care.

• **All systems of care promote services and supports that are individualized and provided in natural settings.**
  Consistent with the guiding principles of System of Care, all children with or at risk for serious emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan. Children should receive services within the least restrictive, most normative environment that is clinically appropriate.
• All systems of care face challenges stemming from mental health stigma.

Systems of care serving children and youth of all ages encounter inevitable challenges by virtue of their association with “mental health”. While progress has been made over the years to address the stigma associated with mental health, it still prevails, and can hinder one’s willingness to seek out or accept services and supports for mental health issues.

EARLY CHILDHOOD SYSTEMS OF CARE: WHAT MAKES US UNIQUE!

Below is a listing of key issues that capture how systems of care for young children and their families are different than systems of care for older populations and, consequently, present unique challenges to grantees working to develop strong, sustainable early childhood systems of care.

1. It’s not a MENTAL HEALTH System of Care

As one Project Director summarized, “This [issue] is the one in which all [other] challenges rest. When the system of care is built from the perspective of [integrating] mental health supports into the existing early childhood systems…many of the other issues fall into place…The stand-alone mental health system of care is difficult to build and sustain, and the readiness of families for an intensive model targeted only to mental health diagnoses has limited effectiveness for this population.”

To this point, it is important to consider that:

a. Young children are served in a variety of settings (e.g., child care centers, primary care offices, homes); unlike older children they’re not all in one place like school.

b. Young children’s mental health is inextricably linked to the mental health of their caregivers, suggesting a need for concerted effort to provide mental health services and supports to family members and other primary caregivers.

c. Mental health is not typically part of the early childhood service delivery system; early childhood mental health is often a new area for those working with young children and their families.

d. Consistent with a public health approach, early childhood mental health is inclusive of promotion of social/emotional health, prevention of mental health challenges, and intervention to address mental health concerns.

Thus, it is critical to infuse comprehensive mental health services into the various services and settings where young children and their families/caregivers are (i.e., their homes and communities). The field of early childhood mental health is at a new crossroads in understanding how best to identify and treat infants and young children with a mental health disorder and, even more importantly, how to utilize best practices to prevent many disorders from occurring. Because infants and young children’s brains develop so rapidly, and their environment and quality of caregiving relationships is so important to their healthy social and emotional development, an early childhood system of care that strategically incorporates mental health into existing systems is the best “fit” for this population. In essence, to truly optimize outcomes for children and families, early childhood mental health should be everybody’s business.
Progress/Lessons Learned/Resources in this Area:

Resources:
• A System’s Framework for Early Childhood Mental Health (diagram) (http://gucchd.georgetown.edu/67639.html)
• “Building Early Childhood Systems” in Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.).

2. Partnerships look different
In systems of care for older children and youth, the system partners that are traditionally involved include mental health, juvenile justice, substance abuse, education, and child welfare. Among these partners, there is generally widespread knowledge about serious emotional disorders and mental health diagnoses. The early childhood arena is quite different, as described below:

a. EC SOCs engage agencies/programs not traditionally partners in systems of care for older children, i.e., Maternal and Child Health, Child Care, Preschool Special Education (619), Part C of IDEA, Head Start/Early Head Start, Primary Health Care, Home Visitation. These partners are often new to systems of care and/or early childhood mental health, requiring time-intensive knowledge dissemination efforts by early childhood grantee communities to achieve meaningful collaboration.

b. Further, traditional partners, such as child welfare, are asked to participate in ways that are different than they are accustomed to for older populations. For example, EC SOCs might engage the juvenile justice system to focus prevention efforts on the younger sibling(s) of adjudicated youth or on young children of teen parents who are involved in the juvenile justice system.

c. Finally, given a young child’s dependency on his/her caregivers, EC SOCs place particular emphasis on partnering with adult service providers to address caregivers’ needs (e.g., mental health, substance abuse, domestic violence).

Progress/Lessons Learned/Resources in this Area:
Lessons Learned:
• Refrain from viewing the system of care grant as a project that resides within the mental health arena; rather, approach the work by engaging as many partners as possible. For example, one community contracted out to many local organizations as a way to increase the amount of active support and “buy-in”.

• Think about partnerships at many levels—state, community, and individual; large agencies, small organizations, and everything in between. To enhance community engagement, one community formalized “Community Network Teams” comprised of local agencies, organizations and individuals committed to strengthening the communities’ capacity to meet the needs of children and families dealing with mental health issues.

• Be mindful that as a “mental health program” you may encounter some resistance from the early childhood community. Work to slowly develop trust and strong partnerships by focusing on the opportunity a system of care provides to be a support to the early childhood community. Also emphasize the strengths of a system of care, especially the values and principles, which tend to resonate broadly.
• Put concerted effort into building a strong governance structure with representation from a broad and strategic mix of child and family serving systems, local organizations, family members, and other key stakeholders.

Resources:
• For detailed strategies, key questions to consider, and more information on this topic, see the “Partnerships” section in Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.).
• “Building Partnerships with Families” in Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems (Perry, Kaufmann, & Knitzer, 2007).
• Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Their Families (Rosman, Perry & Hepburn, 2005). http://gucchd.georgetown.edu/72374.html

3. It’s important to use a developmental perspective
While it is important to understand typical development at all ages, it is critically important in the early years of a child’s life for a variety of reasons:

a. The younger the child, the harder it is to distinguish mental health issues from other developmental areas (i.e., speech and language, motor, cognitive). These domains are interrelated and emotional problems in infants and toddlers often manifest through disturbances in eating, sleeping and regulating.

b. Behaviors that are developmentally appropriate at one age, are warning signs at another age (e.g., separation anxiety); differences in frequency and intensity rather than a particular behavior are important to identifying children in need of services (i.e., tantrums).

c. Early identification (and treatment) of behavioral or emotional challenges can significantly and positively impact the long-term trajectory of a young child’s life.

Progress/Lessons Learned/Resources in this Area:
Lessons Learned:
• To increase early detection and intervention, integrate screening and assessment efforts throughout the early childhood system of care, including settings such as child care centers and primary care offices. Early childhood mental health consultation3 is one strategy EC SOCs are using to improve early identification in early care and education settings and to promote overall social/emotional well-being.

• Ensure that assessments are conducted by a cross-disciplinary team of highly-trained professionals who have a strong knowledge base in both typical and atypical early childhood development, especially in the social/emotional domain.

• Foster strong collaboration among cross-disciplinary teams to ensure that when multiple needs are identified (e.g., sensory, motor, language, behavior), cross-disciplinary strategies/interventions are employed.

3 For a description of and resources on early childhood mental health consultation, see http://gucchd.georgetown.edu/67637.html
4. Diagnostic issues are challenging

Diagnosing an infant or young child with a mental health disorder can present logistical, emotional, and philosophical challenges. Although EC SOC communities have been granted permission by SAMHSA to use the DC: 0-3R diagnostic tool, which allows for more appropriate diagnoses of infants and toddlers than the DSM-IV that is widely used with older populations, communities must use a “crosswalk” to map DC:0-3R diagnostic codes to the DSM:IV diagnostic codes or the ICD-9-CM diagnostic codes for billing purposes. Further, communities must ensure that there is a cadre of mental health clinicians who are trained to skillfully administer the DC: 0-3R—often a gap in the existing workforce.

a. Beyond the logistics, some families/caregivers and early childhood advocates struggle with diagnosing an infant or young child because of concerns about labeling or concerns about the use of diagnostic classification systems that are not developmentally appropriate for this age group. Over the years, grantee communities have indicated that the requirement of an Axis I mental health diagnosis for entry into the system of care has dissuaded some families—many of whom are finding out for the first time that their child has a mental health issue—from accessing system of care services.

Progress/Lessons Learned/Resources in this Area:

Progress:
Significant progress has been made on this issue within the EC SOC community since this document was originally published. In 2007, representatives from the six currently-funded grantee communities formed a Diagnosis and Eligibility Workgroup to draft a report to SAMHSA highlighting the difficulties facing EC SOCs because of the existing diagnostic requirements and proposing that eligibility criteria be expanded for young children. In early 2009, the report was submitted to SAMHSA and later that year the agency amended eligibility criteria as follows, per the group’s recommendations.

For children 3 years of age or younger there must be significant behavioral or relational symptoms that meet the criteria for a DSM-IV diagnosis, a diagnosis as identified in the Diagnostic Classification of Mental Health Development Disorders of Infancy and Early Childhood-Revised (DC-0-3R), including an Axis II Relationship Disorder with a PIRGAS Score of 40 or below (which indicates a Relationship Disorder in the “Disturbed” Category), or a diagnostic impression of “imminent risk” that is identified through an intake process that includes a standardized measure (e.g., Baby’s Emotional and Social Style (BABES)) and an approval by a licensed mental health practitioner with knowledge and experience with early childhood development.

For children who are 4 or 5 years of age the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the DSM-IV and the imminent risk diagnosis can be identified through an intake process that includes a standardized measure (e.g., Strengths and Difficulties Questionnaire (SDQ)) and an approval by a licensed mental health practitioner with knowledge and experience with early childhood development.

This change is significant in that it allows mental health clinicians the flexibility in determining a diagnosis, reaches and includes those children in the “prevention” category, and lessens the stigma...
related to a mental health disorder in an infant or young child. Communities still struggle with a trained infant mental health therapist workforce, and questions have surfaced about a definitive definition and criteria of “imminent risk” as well as how to fund imminent risk enrollees beyond the grant period.

Resources:
- Florida’s Crosswalk between DC: 0-3R and ICD-9-CM, and accompanying narrative of the process used to get the crosswalk in place: www.thefloridacenter.org/pdfs/Fl_Crosswalk_June_2010.pdf

5. Engaging families of young children is particularly difficult

Family engagement can be a struggle for any system of care community, but there are added challenges for EC SOCs. Typically, families involved in the older child/youth system of care population have prior involvement with the mental health system and some have long histories with family advocacy organizations, such as the Federation of Families for Children’s Mental Health. Conversely, many families of infants and young children with mental health disorders are in uncharted waters. They are most likely hearing the words “mental health disorder” for the first time and may not be ready to enter the mental health system. This discomfort can stem from a number of factors including uncertainty or distress about the possible diagnosis, fear that the child will be labeled, and/or fear that they will be blamed for their child’s behavior. Even when families do seek system of care services for their young children, it can be difficult for them to engage with EC SOCs at the program and/or policy level (e.g., participating in advisory councils, advocating for policy changes), given the pressing and often unpredictable demands of caring for an infant or very young child. Another barrier to family involvement encountered by some EC SOC communities is perinatal depression. In general, systems-level engagement of young families usually does not begin to happen until they are out of crisis, have greater familiarity with early childhood mental health, and have the supports needed to attend meetings, conferences and other functions (e.g., transportation, child care, financial assistance). Given all of the above, EC SOCs must find creative ways to address these barriers to participation for families of young children.

Progress/Lessons Learned/Resources in this Area

Lessons Learned:
- Seek out existing, active parent advocacy groups that focus on early childhood and/or mental health issues overall and work to integrate early childhood mental health (ECMH) into their action agendas. Consider collaborating across organizations to build a coalition around ECMH.
- Integrate a formal “family engagement process” into your EC SOC. For example, begin by initiating a supportive relationship between new parents and a parent mentor/advocate who has walked in their shoes and understands their fears and frustrations. The parent mentor can assist greatly in reducing stigma and providing education and information about systems of care. Families are much more likely to enroll in a strengths-based system of care where they feel empowered as the expert at the table for their young child. With the guidance and support of the parent mentor they learn how to “drive” their care plan within their family team meetings and the formal and informal supports they want to invite to the table. Be patient as the engagement process takes time and can be disrupted by child/family crisis.
Resources:
• For detailed strategies, key questions to consider, and more information on this topic, see the “Family Engagement” section in Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.).
• “Building Partnerships with Families” in Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems (Perry, Kaufmann, & Knitzer, 2007).

6. “Youth involvement” looks different for this population
Historically, youth involvement, including the position of a “Youth Coordinator” as a key staff position within system of care communities, has been a grant requirement for all system of care communities. This makes sense when you are working with older children and youth with a serious emotional or mental health disorder. As a consumer of services, they need to be driving the system at both the individual and community level. However, EC SOCs were quick to discover that this role—as it has been traditionally defined—does not make sense for early childhood systems of care. Even though two year olds might be the recipients of services, they do not have the cognitive or emotional capacity to make decisions regarding their own care nor should their behaviors be interpreted by others in an attempt to guide policy per the young child’s direction. Significant changes have been made to the “youth involvement” requirements since this document was first issued. These changes and some examples of how EC SOCs are now operationalizing this role are detailed below. The current challenge for early childhood grantees is determining the best “fit” for youth involvement in their communities.

Progress/Lessons Learned/Resources in this Area
Progress:
Concurrent with efforts around diagnosis and eligibility, EC SOC communities and technical assistance providers spent considerable time and energy brainstorming creative solutions to the youth involvement “disconnect” and communicating developmentally appropriate recommendations to SAMHSA. Once again, the SAMHSA was responsive and amended the youth involvement/youth coordinator requirement as follows:

How do we address the requirement for a Youth Coordinator if we are an early childhood site that is focusing on young children?
The relatively new role of the Youth Coordinator is one that is evolving. Currently, Youth Coordinators are charged with facilitating youth involvement in the development of systems of care and ensuring that youth voice is part of service planning and implementation. These youth empowerment activities have enhanced services and supports in communities working with older children and youth, however, many activities that would be best practice in communities serving older children and youth are developmentally inappropriate when the population of focus is infants, toddlers and very young children.

In response to this disconnect and in accordance with developmentally appropriate practice, CMHS is giving those sites serving only children younger than age 9 an option to employ a youth

4The title of “Youth Coordinator” has evolved over the years. Some individuals in this role now are referred to as “Youth Engagement Specialists,” “Youth Empowerment Specialists,” or other similar titles.
coordinator. For communities serving children 9 years of age and older, hiring a youth coordinator is required, consistent with existing best practice guidance. The functional title for this position should be “Youth Engagement Specialist” or “Youth Empowerment Specialist.”

For communities who opt not to hire a youth coordinator, it is essential that they use their funds to build, enhance and extend the involvement of families of infants, toddlers and very young children in ways that are developmentally appropriate, and ensure that these families are actively included in all areas of program and policy development and implementation. Further, these grantees should develop transition plans that engage partners serving children who age out of the early childhood system, particularly school personnel (e.g. principals, teachers, school psychologists) and that address areas such as school-wide positive behavior supports and the transition from IFSPs to IEPs.

For communities serving only children under the age of 9 who choose to employ a youth coordinator, there is a need to assure that the activities they engage in are developmentally appropriate. For example, they should not work directly with the population of focus nor should they bring the voice of very young children to the planning and policy table (that role should be provided by the families being served). However, Youth Coordinators should be encouraged to work with community partners who do reach out to older youth and support their learning and empowerment. Further, Youth Coordinators can participate in program and policy planning (bringing their own experience to the table), collaborative activities, and community outreach activities. In close partnership with the Lead Family Contact and Clinical Director, Youth Coordinators may assist in the support provided to teen parents and older siblings (i.e., ages 9 and up).

As a result of this new guidance, the role of Youth Coordinator has been operationalized in a variety of ways across EC SOC communities. For example, some communities have retained the youth coordinator position, while others have found that channeling funds for the youth position into a Co-Lead Family Contact position is the best fit for their individual communities.

Resources:
• For detailed strategies, key questions to consider, and more information on this topic, see the “Youth Engagement” section in Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.).

7. Putting the necessary array of services and supports in place is challenging
A continuum of services and supports can be found in most communities for infants and young children with or at risk for physical disabilities or those with developmental delays. Primary care physicians and nurses are much more likely to screen and or refer for screening an infant or young child with a possible physical or developmental problem. Many communities have a developmental screening system in place that families and child care providers can access. Unfortunately, many of these systems do not screen for emotional or behavioral delay or disorders, or if they do include social/emotional screening, children often do not meet the criteria for enrollment into a system that can pay for services (Part C, Part B).
Young children and their families need a full array of individualized services and supports that are embedded “where young children and families are” and that span the continuum of promotion to prevention to intervention. Unfortunately, EC SOC communities face a number of obstacles in providing these services given the disconnect between “traditional” methods of service delivery and best practice in early childhood service delivery. These obstacles are briefly described below.

a. Early childhood services are best provided in child care settings and homes—relatively uncommon venues for mental health service delivery.

b. While agencies and organizations that serve young children are well-versed in the promotion/prevention/intervention service continuum, this holistic approach is relatively new to mental health agencies that have traditionally focused predominantly on treatment/intervention.

c. There is a relatively small number of evidence-based practices for children under 8, compared to older children and youth. For infants and toddlers, there are significantly fewer evidence-based practices.

d. Best practice services/interventions for infants and young children often involve methods that are difficult to fund given billing structures that are designed for one-on-one work between a clinician and client. Dyadic and relationship-based therapies, which are central to high quality early childhood service delivery, and indirect services, such as mental health consultation, fall outside of these parameters.

e. The Wraparound process often requires adaptation to best meet the needs of infants, young children and their families. Given the intensity of the Wraparound process, some EC SOCs have found that less intense levels of service delivery (e.g., fewer individuals on the planning team) are better options for families new to the system of care. Once a family is ready, they may segue into Wraparound, but another challenge can be the availability of professionals that are trained in using Wraparound for young children.

f. While natural supports are a critical element of systems of care, some families of young children are reluctant to divulge sensitive information about their children’s challenges to friends, neighbors or members of their faith communities.

Progress/Lessons Learned/Resources in this Area

Resources:
• CSEFEL Teaching Pyramid: An Organizing Framework for Promotion, Prevention and Intervention Strategies: [http://csefel.vanderbilt.edu](http://csefel.vanderbilt.edu)
• Scan of evidence-based and promising practices being used across the early childhood system of care communities: [http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html](http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html)
• Center for Effective Mental Health Consultation: [www.ecmhc.org](http://www.ecmhc.org)
• Project LAUNCH website: [http://projectlaunch.promoteprevent.org](http://projectlaunch.promoteprevent.org)
• Section on Infusing Mental Health Promotion, Prevention, and Intervention into Early Childhood Services and Supports in *Social and Emotional Health in Early Childhood* (Perry, Kaufmann & Knitzer, 2007)
8. Workforce issues heightened in this population

In recent years, thanks in part to federal efforts (e.g., SOC, Project LAUNCH, Early Childhood Comprehensive Systems Initiative) and research on high preschool expulsion rates stemming from challenging child behavior (Gilliam, 2005), there has been heightened awareness of the need to attend to infants’ and young children’s social and emotional development and to secure help for those showing early “warning signs” of a possible mental health challenge. Unfortunately, there are many gaps in the workforce that hinder attempts to create a responsive and comprehensive early childhood mental health service delivery system.

First, there is a lack of early childhood providers who are trained in the promotion of social and emotional development and the early identification of mental health issues, as well as a shortage of mental health clinicians who are trained to work with the birth to five population (Ounce of Prevention Fund, 2000, p.6). Further, many pediatricians and other primary care providers, who offer critical access points to early identification and treatment of mental health issues, report that they do not feel they are sufficiently trained or skilled in evaluating the mental health of an infant or young child. Some also state that they are uncertain where to refer infants and young children if a mental health problem is suspected; a problem that is particularly acute when the issue isn’t a lack of awareness, but an actual dearth in supply of qualified infant and early childhood mental health professionals.

Thus, it is clear that EC SOC grantees must make workforce development a top priority if they are to create high-quality and sustainable systems of care. Efforts should focus not only on developing an adequate supply of mental health clinicians with expertise in infant and early childhood mental health (including administration of the DC: 0-3R), but also on pre-service and in-service training and professional development opportunities for other system partners who work and interact with young children and their families on a regular basis. Achieving these goals often requires complementary efforts to create incentives for participation in trainings and application of new knowledge, such as continuing education credits, linking to child care accreditation or quality rating structures, and/or implementing policy changes that facilitate utilization of new practices (e.g., getting approval from your state Medicaid agency for a crosswalk between the DC:0-3R and the ICD-9-CM).

Progress/Lessons Learned/Resources in this Area

Resources:
• “Developing the Work Force for an Infant and Early Childhood Mental Health System of Care” in Social and Emotional Health in Early Childhood (Perry, Kaufmann & Knitzer, 2007)

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5 Project LAUNCH is a SAMSHA-funded grant program designed to help communities expand the use of evidence-based practices, improve collaboration among child-serving organizations, and integrate physical and mental health and substance abuse prevention strategies for children, ages birth to 8, and their families.
6 The Early Childhood Comprehensive Systems (ECCS) Initiative is funded by the Maternal and Child Health Bureau and is designed to support states and communities in their efforts to build and integrate early childhood service systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education, and family support.
9. Funding sources are different

Funding EC SOCs is much like creating a patchwork quilt. It requires use of multiple funding mechanisms as well as expertise in knowing how to blend/braid federal, state, and local dollars, educating private donors on the wisdom of investing early, and managing the complexities of using multiple funding streams, each with their own requirements. In addition, there are many challenges with billing public (i.e., Medicaid) and private insurance for early childhood mental health services, given the “non-traditional” approaches that are best practice for infants and young children such as dyadic therapies and interventions like early childhood mental health consultation, which include a promotion and prevention focus.

Although it was the intent of Part C of IDEA, the federal early intervention program for infants and toddlers, to fund services for children birth to three at risk of developmental delays (including those with social-emotional delays), this has not been a major funding source for children experiencing delays in this area only. Further, stricter Part C eligibility criteria in some states and stagnated funding for this program have made it even more challenging to fund services with these dollars. Thus, early childhood grantee communities need to work together (with multiple stakeholders at the table) to find creative ways to finance—in a sustainable way—an early childhood system of care that encompasses promotion, prevention, and intervention services and supports for young children and their families.

Progress/Lessons Learned/Resources in this Area

Resources:

- Matrix of Early Childhood Mental Health Services and Supports in Social and Emotional Health in Early Childhood (Perry, Kaufmann & Knitzer, 2007)

- What to Expect and When to Seek Help: Bright Futures Developmental Tools for Families and Providers: www.brightfutures.org/tools

For detailed strategies, key questions to consider, and more information on this topic, see the “Financing” section in Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care (National Technical Assistance Center for Children’s Mental Health, n.d.).
10. **Evaluation brings up more issues**

Historically, system of care funding has been targeted to school-age children and adolescents with serious mental health disorders, and measures used for evaluating outcomes have focused on these specific age populations. With the increase of early childhood sites in 2005, evaluators within sites focusing on very young children faced challenges since several of the measures lacked relevance or were developmentally inappropriate for an infant/young child population. Some sites realized early on that in addition to the National Evaluation data required by SAMHSA, local data was needed to capture specific outcomes most relevant to the early childhood community.

Gathering local data required additional time and resources but proved to be an important element in 1) knowing how well the system of care community was serving their young children and their families and 2) providing information to National Evaluation and SAMHSA on the differences in the infant/young child population so that changes might be made at both the policy and National Evaluation levels. As a result, changes have been implemented and continue to be made with National Evaluation efforts specific to the young child population.

Although the National Evaluation team has been responsive to the issues raised by the early childhood community and implemented adaptations to the protocol, challenges continue to exist within the early childhood mental health system itself. There is no collective set of identified outcomes for infants/young children and their families and few standardized tools to measure identified outcomes or key early childhood constructs. This is a work in progress for EC SOCs striving to advance the field of early childhood mental health.

**Progress/Lessons Learned/Resources in this Area**

**Progress:**
- Using aggregated data from three EC SOC communities on enrollees’ exposure to different types of trauma, early childhood evaluators were able to bolster efforts to include imminent risk as part of the eligibility criteria for enrollment into EC SOCs. Aggregated descriptive and outcome data from these three sites, as well as additional data from the entire EC SOC community, is informing enhanced service delivery for young children and their families within the federal grant program and beyond.

**Resources:**
- Matrix of local evaluation measures being used across early childhood system of care communities: [http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html](http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html)
- Audio recording of “Lessons Learned from EC Evaluators” conference call, November 2010: [http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html](http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html)
- For detailed strategies, key questions to consider, and more information on this topic, see the “Evaluation” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).
CONCLUSION

The early childhood system of care communities have advanced their learnings significantly over the years. Through sharing of information, collaboration, trial and error, and commitment to the mission of creating best practice, comprehensive early childhood mental health systems of care, infants and young children with or at risk for a mental health disorder and their families are doing better. Barriers to best practices in system of care development in early childhood mental health, especially in the areas of eligibility criteria for enrollment and youth involvement, have been identified and resolved through a mutually respectful partnership with SAMHSA.

One of the valuable lessons learned during the updating of this document was that system-building challenges manifest differently in each community. There was no real consistency in ranking of challenges, not even among the more established sites. This reiterates that just as we value individualized care for our children and families, we must value the individual character, culture and context of each community. What works for one community may not work for another and there is no “cookie cutter” way of developing systems of care or addressing the challenges inherent in this task. However, using the collective knowledge of the entire EC SOC community can mitigate these challenges by offering field-tested strategies that can be adapted locally and collaboratively generating creative solutions to remaining barriers.

While major advancements have been made in a relatively short period of time, there is much work yet to be done to ensure the best outcomes for the young children and families served by systems of care. Hopefully, this document will become a useful resource for communities traveling this tough, but rewarding road.

Attributions

This document was authored by Frances Duran, Georgetown University National Technical Assistance Center for Children’s Mental Health (NTAC), and Kathryn Shea, President/CEO, The Florida Center for Early Childhood and community partner with the Sarasota Partnership for Children’s Mental Health. It reflects an updating of the original Lessons from the Field developed by Roxane Kaufmann, Neal Horen and Deborah Perry at NTAC.

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References


If you would like to submit new content for the Toolkit, please use this template as a guide. Submissions should be sent to Frances Duran at bazazi@georgetown.edu.

Note: The purpose of these brief summaries is to give peer communities a general description of the strategy your community has implemented and to provide contact information for those interested in greater detail.

CONTACT INFORMATION
Community Name:

Primary Contact for More Information on This Strategy/Initiative: (Name, Title, Phone, Email)

STRATEGY/INITIATIVE SUMMARY
Brief Description
• Please provide a few sentences describing the strategy/effort.

Getting Started
• Why did your community pursue this effort?
• What were the initial steps in getting this effort off the ground?

Key Partners
• What organizations, agencies or individuals partnered with you on this effort, and in what ways?

Implementation
• How did you move from planning to implementation?

Barriers/Obstacles
• What challenges, issues, complications or obstacles have emerged along the way?
• What potential pitfalls can be identified that others can avoid?

Funding/Sustainability
• How is this effort funded?
• What elements are (or will be) in place to sustain this effort after the grant period ends?

Lessons Learned
• What tips can you share that might help others interested in pursuing a similar effort?

Resources
• Please include any additional resources (e.g., websites, publications) that might be useful to other early childhood communities interested in this strategy or topic.