
Infant Preschool Family Mental Health Initiative: Accomplishments and Lessons Learned



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IPFMHI State Leadership:

- First 5 California Children and Families Commission
- First 5 Special Needs Project Coordination and Training Team
- The ten First 5 Special Needs Project Demonstration Sites
- State Department of Mental Health
- California Institute of Mental Health
- WestEd, Sacramento

County Departments of Mental Health and their Interagency Partners:

- Alameda
- Fresno
- Humboldt
- Los Angeles
- Riverside
- Sacramento
- San Francisco
- Stanislaus

Children ages birth to five and their families

Infant Preschool Family Mental Health Initiative: Accomplishments and Lessons Learned

Executive Summary

The Infant Preschool Family Mental Health Initiative (IPFMHI) and the Special Needs Project are both First 5 California Children and Families Commission (CCFC) funded projects that promote optimal early childhood development and prepare children to be ready for school. The successful development of infant-family and early mental health services in eight pilot counties has been the focus of IPFMHI. The goal of the First 5 CCFC Special Needs Project is to advance the development of early childhood service delivery systems by identifying very young children with or at risk for having special needs and providing comprehensive services in partnership with families in Demonstration Sites in 10 counties as part of School Readiness efforts. From the beginning of the conception of the idea of the Special Needs Project, it has been the intent of the First 5 CCFC for the IPFMHI to pass on the experience and lessons learned to the Special Needs Project (SNP) Demonstration Sites. This report emphasizes the lessons learned from the experiences and accomplishments of IPFMHI and provides specific recommendations as to how demonstration sites might enhance, expand or create services to better meet the social and emotional needs of very young children in the community.

History

The IPFMHI is the latest in a series of systems change efforts in California that began with the recognition that the relationships between very young children and their caregivers are the foundation of healthy development and service delivery systems must support those relationships. Three earlier projects were funded by other sources. The first two projects were initiated by the early intervention field with funding from the Department of Developmental Services and coordinated by WestEd Center for Prevention and Early Intervention (WestEd). In 1996 the interdisciplinary Infant Mental Health Workgroup outlined recommendations for a continuum of promotion, preventive intervention and mental health treatment services. It was followed by promotion and implementation efforts of the 1998-1999 Infant Mental Health Development Project. From 1999 to 2000 the Department of Mental Health (DMH) funded the third project, the Infant Family Mental Health Initiative (IFMHI), also coordinated by WestEd. The work of IFMHI developed mental health services for children birth to three and their families in 4 pilot counties, Alameda, Fresno, Los Angeles and Sacramento, and laid the foundation of experience for the 2001-2004 Infant Preschool Family Mental Health Initiative. Now in late 2005 at the end of Phase II of IPFMHI, the knowledge and experience gained over the past 10 years is being passed on to the Special Needs Project in the form of IPFMHI consultant visits and products developed in collaboration with the Special Needs Project Technical Assistance and Training Coordinator, DMH, WestEd and the California Institute of Mental Health. The further development and promotion of infant and early mental health services in California will be a part of the First 5 CCFC Special Needs Project.

IPFMHI Accomplishments

IPFMHI successfully addressed the six goals of the Initiative. They include:

1. **Services**-expanded and enhanced services;
2. **Infrastructure**-developed and identified screening and assessment tools and processes and funding and billing mechanisms;

3. **Community Education**-provided training for community partners providing services for children birth to five;
4. **Professional Development**-provided training for mental health providers;
5. **Collaboration**- facilitated working relationships among interagency service providers toward effective service delivery systems;
6. **Evaluation**-evaluated outcomes for children and families, training and system development.

The following provides a brief summary of the IPFMHI accomplishments within each of the goal areas.

1. Services

IPFMHI expanded and enhanced the continuum of mental health services for very young children and their families in all 8 pilot counties. During the years of the Initiative from 2001 to 2004 the number of children ages birth to five served by mental health in the pilot counties increased by over 50%. Humboldt and Riverside Counties hired staff and provided services for the first time to very young children and families under IPFMHI. An ever increasing number of children and families along with childcare, preschool and early intervention service providers are benefiting from mental health consultation services developed in most of the counties after IPFMHI provided training through the University of California, San Francisco's Childcare Consultation Program. Evidence-based treatment practices such as Parent Child Interaction Therapy and Incredible Years are now available in Sacramento, Riverside and Humboldt Counties. Four case studies were collected and are available that help to explain relationship-based interventions and approaches to services. The IPFMHI Clinical Services Study, designed to evaluate the effectiveness of relationship-based services, provided descriptions of children and families in need of mental health services and experience for mental health service providers in the use of screening and assessment tools and provided statistically significant evidence of the positive outcomes for families including improved child development, decreased parenting stress and improved parent-child relationships.

2. Infrastructure

The Initiative helped to establish the use of screening and assessment tools and billing and funding mechanisms to support the delivery of infant and early mental health services in public mental health settings. As part of the Clinical Services Study county mental health providers were required to use a core set of measures for identification of risk factors, diagnosis, description of the parent-child relationship, family resources and supports, developmental functioning of the child, parenting stress and family satisfaction. Most mental health providers had very little or no experience in the use of measures prior to the CSS. The use of the measures provided experience with and encouraged the use of measures. A year after the CSS, nearly all of the agencies and programs involved in the Study had adopted one or more of the measures for routine use. The most commonly adopted measures were the Parenting Stress Index-Short Form (PSI-SF), the Diagnostic Classification for 0-3 (DC: 0-3) and the Ages and Stages Questionnaire (ASQ).

All 8 of the pilot counties developed or expanded the use of Early Periodic Screening, Diagnosis and Treatment (EPSDT) to fund direct treatment services for Medi-Cal beneficiaries. Under this Federally mandated program, children must meet "medical necessity" criteria and be given a DSM IV diagnosis for a provider to bill for services. In order to adapt billing requirements to the needs of younger children, IPFMHI developed a "cross walk" between the DSM IV and the DC: 0-3, a more descriptive diagnostic tool for very young children. Indirect services and mental health consultation services are not paid for by Medi-

Cal. Local First 5 CCFC grants are supporting some type of indirect service or mental health consultation services in all 8 counties.

3. & 4. Community Education and Professional Development

IPFMHI supported professional development opportunities in infant and early mental health needed for mental health providers learning to work with very young children and their families as well as all service providers who work directly with families who needed training in promotion and preventive intervention for over 5000 people in the 8 pilot counties. Each county developed its own plan for capacity building based on its strengths and needs. The plans shared a common framework. The framework for training includes a series of trainings or a seminar that can raise awareness, introduce concepts and treatment approaches and lay a foundation of knowledge from which to build skills. This type of training is complemented by small group case consultation that allows service providers to learn advanced concepts and treatment approaches and provides an opportunity for the service provider to discuss their work with families under the supervision of a mental health professional experienced in infant and early mental health. At the same time a service provider can gain a deeper understanding of his or her effect on a family and how the family's situation might affect him or her with individual reflective supervision from a trained supervisor.

At the systems development level, representatives from mental health in the eight counties have become an important presence in local early child hood groups and advisory committees. Their presence has promoted the importance of infant and early mental health. Infant and early mental health advisory committees and groups formed specifically with a focus on mental health services for very young children are responsible for the development of collaborations that support training and effective service delivery across agencies. Statewide meetings provided a forum for communication and exchange of experiences and strategies and have provided cross county support in building service delivery systems. Although support from IPFMHI for training ended in 2003, some type of training is available in all 8 counties. The demand for training in this rapidly growing field remains high. The Training Guidelines and Recommended Personnel Competencies developed by IPFMHI provide a reference for the knowledge and skills needed for mental health providers and other core service providers in delivering infant and early mental health services.

5. Collaboration

IPFMHI supported and facilitated collaborations with mental health providers, interagency service providers such as early intervention agencies, early care and education agencies, social services and public health, infant and early childhood interagency committees and groups, institutions of higher education and special funded projects for the purpose of developing an integrated collaborative infant and early mental health delivery system. Each county built collaborations based upon the unique strengths and resources of the county. They represent a diversity of service delivery models. From Alameda County's partnerships between Children's Hospital of Oakland, Alameda Behavioral Healthcare Services and Every Child Counts (local First 5) that strives to train all service providers in promotion and preventive intervention to Los Angeles County's ICARE network of over 38 mental health provider agencies and a growing number of interagency providers to Stanislaus County's use of parent mentors for outreach to culturally diverse populations, each model serves to enhance and promote the social and emotional development of very young children and provide access to infant and early mental health treatment services.

Collaboration as a part of service coordination was analyzed as part of the Clinical Services Study. The number of service providers involved with the family at intake ranged from 0 to

11 with an average of 4 service providers per family. Increases in the involvement with early intervention and early childhood education services from intake to discharge indicates the critical role that mental health providers have in accessing early intervention and education services for families. The greatest level of collaboration with interagency service providers was found with other mental health providers, child protective services, childcare providers and special education. Collaborations including communication and consultation are particularly important for those service providers involved in ongoing support or education for the child.

6. Evaluation

Ongoing evaluation and data collection served to document the accomplishments and provided a bank of information to determine the immediate and longer-term impact of the various activities on individuals, agencies and communities. Several Tools gathered data on the overall impact of the Initiative. They included the Participant Profile to identify the experience, attitudes, knowledge and skill of participants, the Training/Activity Evaluation Form to evaluate the training, consultation or technical assistance provided in counties and the State wide IPFMHI Impact Survey. Findings from all three evaluation sources suggest that the Initiative was successful in targeting both mental health and interagency providers for training. Training, consultation and reflective supervision continue to be needed to build professional skills and expertise in this emerging field. Information, technical assistance and resources are needed for the continued expansion of infant and early mental health services.

IPFMHI Lessons Learned

The lessons learned by IPFMHI provide ideas that can help to sharpen the focus toward the social/emotional needs of very young children and further develop the continuum of mental health services in the SNP and/or in the county. Although the First 5 California SNP Demonstration Sites are in a unique position to carry on the pioneering work of IPFMHI, the accomplishments and lessons learned have tremendous potential for other First Five programs, including School Readiness, and many other programs which serve young children and their families. The *Lessons Learned* are summarized within the following topic areas.

1. Leadership: Development of infant and early mental health services requires a committed leader with full support from administration to be actively engaged in planning, identifying needs, integrating services and building on strengths of the local community.

2. Collaboration: Building and maintaining relationships with other agencies through ongoing regularly scheduled meetings, memorandums of understanding for services, collaborative training, complementary services and a flexible attitude supports development of an integrated delivery system.

3. Professional Development: Training in the promotion of social emotional development and preventive intervention strategies is a critical element.. for all service providers who work with families. Mental health providers need training in relationship-based treatment services specific to the needs of children ages birth to five and their families. All service providers need ongoing supervision and case consultation and can benefit from reflective supervision to help them understand the impact they have on families and how the families affect their own work.

4. Outreach and Referral: Service providers involved in outreach and referral benefit from a collaborative relationship with mental health agencies receive training in promotion and preventive intervention and have a thorough knowledge of the mental health services available to families.

5. Screening and Assessment: Screening and/or assessment are a part of intervention and are an opportunity for promotion and preventive intervention. Agencies that provide screening need training to assure understanding of potential services and eligibility.

6. Billing and Funding: Early Periodic Screening Diagnosis and Treatment (EPSDT) is the most cost effective funding source for mental health treatment services for children 0-5 and their families. Collaborations with local First 5 CCFC provide funding of indirect services and mental health consultation services to childcare and preschools.

7. Service Delivery: The continuum of promotion, preventive intervention and treatment services are needed within a service delivery system. Service providers appropriate to the needs and priorities of the families are most effective when they are relationship-based, strength-based, family focused, socio-culturally competent services. Evidence-based and promising practices and mental health consultation services are needed to ensure positive outcomes for families.

8. Evaluation: Documentation and evaluation need to be incorporated into ongoing processes with results shared with all involved to celebrate successes and learn from outcomes.

Conclusions and Recommendations

Mental health services for children aged birth to five and their families have changed dramatically in the past four years. Integrated collaborative delivery of relationship-based interventions is thriving in all eight pilot counties. The experiences and accomplishments of the IPFMHI counties provide unique models for service delivery that address the diversity of strengths and resources within each county. The work of the Initiative is a significant contribution to the ongoing development of infant family and early mental health services in California. IPFMHI has been successful in developing products and resources that will benefit developing infant and early mental health programs, school readiness sites and the Special Needs Project..

The lessons learned from IPFMHI provide a platform of ideas that may be helpful to the development of mental health services in any community. The First 5 California SNP Demonstration Sites are in a unique position to take advantage of IPFMHI experience and apply it to meet their individual needs. SNP Leadership Teams can use this information to:

- Reinforce the efforts in development of the continuum of mental health services that have already been implemented;
- Reflect on ways that efforts could be enhanced in accord with the lessons learned;
- Identify potential areas of need that may require further training;
- Further explore mental health resources within the SNP and in your community that might be available for consultation or training;
- Identify one or two areas from *Lessons Learned* for the creation, expansion or enhancement of services that meet the social-emotional needs of children and families;
- Move forward to develop these areas and further the infant and early mental health movement in California!

The IPFMHI Accomplishments and Lessons Learned serves as an important resource for the Special Needs Project and other infant and early mental health development efforts for the continued building and expansion of services to promote social and emotional development the children of California.

Infant Preschool Family Mental Health Initiative: Accomplishments and Lessons Learned

Overview

The Infant Preschool Family Mental Health Initiative (IPFMHI) and the Special Needs Project (SNP) are both First 5 California Children and Families Commission (CCFC) funded projects that promote optimal early childhood development and prepare children for school. The successful development of infant-family and early mental health services in eight pilot counties has been the focus of IPFMHI. The goal of the First 5 SNP is to advance the development of early childhood service delivery systems by identifying very young children with or at risk for having special needs and providing comprehensive services in partnership with families to Demonstration Sites associated with School Readiness programs within 10 counties. From project conception, it has been the intent of First 5 for the IPFMHI to pass on the experiences and lessons learned to the SNP Demonstration Sites). This report explains the relevance of the IPFMHI to the Special Needs Project by presenting the history of infant and early mental health in California, the accomplishments of IPFMHI in building infant and early mental health service delivery systems in eight pilot counties and lessons learned and recommendations for the SNP. The IPFMHI Accomplishments are presented by the goal areas including services, infrastructure, community education and professional development, interagency collaboration and evaluation. The lessons learned are described by the following topic areas: leadership, collaboration, professional development, outreach and referral, screening and assessment, billing and funding, service delivery and evaluation. Each topic area is followed by key questions to help reflect on how infant and early mental health services are currently integrated into the project and how they might be enhanced, expanded or created to better serve the social and emotional needs of children in the community. Conclusions and recommendations describe how the SNP might use the lessons learned to develop services that address the social and emotional needs of the children and families they serve.

History

The Infant Preschool Family Mental Health Initiative in California is about successful systems change envisioned and funded by First 5 CCFC. The momentum for the Initiative came from three earlier projects funded by other sources. It began with the recognition by professionals in the early intervention community that the health and well being of a child cannot be viewed separately from his family and caregivers. From birth and even earlier a child's relationships and interactions with his mother, father, other family members and caregivers have a profound and lasting impact on his cognitive, physical and social and emotional development. In 1996 the interdisciplinary Infant Mental Health Work Group outlined recommendations for a continuum of services including promotion, preventive intervention and mental health treatment services to support and empower the relationship between very young children and their primary caregivers. The first efforts to implement the recommendations came with the Infant Mental Health Development Project (IMHDP) in 1998, funded by the Department of Developmental Services and coordinated by WestEd Center for Prevention and Early Intervention. This project sponsored a series of statewide institutes to promote infant mental health and facilitated local interagency demonstration projects emphasizing relationship-based approaches to services in

early intervention agencies. As a result of their efforts IMHDP was successful in raising awareness of infant mental health concepts and approaches to services, the need for infant mental health treatment services, the need for additional training in relationship-based approaches to service and the need for support for interagency collaboration.

In 1999, the State Department of Mental Health took the lead to build the capacity of mental health agencies to provide treatment services to infants and toddlers ages birth to three and their families in four pilot counties, Alameda, Fresno, Los Angeles and Sacramento, in the Infant Family Mental Health Initiative also coordinated by WestEd. The work of that initiative provided the foundation and framework for the CCFC funded Infant Preschool Family Mental Health Initiative that began in 2001, expanded the participating counties to eight and the ages of children served up to 5 years old. The four new counties included Humboldt, Riverside, San Francisco and Stanislaus. IPFMHI expanded mental health treatment and consultation services, piloted and established effective screening and assessment measures, established billing processes and funding sources, built capacity to provide the continuum of prevention, early intervention and treatment services by training mental health providers and their interagency partners who work with very young children and families, developed a framework of competencies needed for preventive intervention and mental health treatment, facilitated community collaboration and tracked progress and evaluated the effectiveness of the services provided. As a result of IPFMHI integrated collaborative delivery of relationship-based interventions is thriving in all 8 counties.

At the end of the first phase of the IPFMHI, five reports were produced to document and explain the work of IPFMHI. Four of the reports, *The Clinical Services Study*, *Building Capacity*, *Training Guidelines and Recommended Personnel Competencies* and *Impact and Evaluation Findings*, are available from the WestEd.org website at <http://www.wested.org/cs/cpei/print/docs/215> . The fifth publication, *"Evolving Perspectives in Infant-Family Mental Health and Reflective Supervision: A Collection of Published and Unpublished Articles,"* is also available. Please call 916/492-4011 to order a copy.

IPFMHI Phase II of the past year with participation by DMH, WestEd, CIMH and the Special Needs Project Coordination and Training Team, CIHS-SSU, developed products and resources specifically to benefit the SNPs as intended by First 5 CCFC. The products include this report, *IPFMHI Accomplishments and Lessons Learned*, and 3 manuals developed by CIMH addressing finance, screening and triage and referral, are available on the Special Needs Project Website <http://www.First5CAspecialneeds.org/> . In addition, three other reports were produced by WestEd. A detailed account of the accomplishments of the counties is found in *The IPFMHI Phase II Final Report Consolidation and Sustainability: The Status of Infant Family and Early Mental Health Services in IPFMHI Pilot Counties*. A bridge to understanding infant and early mental health as part of school readiness is available in *Social and Emotional Well-Being: The Foundation for School Readiness*. The third report entitled, *Compendium of Best Practices/ Literature Review* provides a thorough review of literature on research based practices in early intervention. All three of these reports are available on the WestEd.org website, <http://www.wested.org/cs/cpei/print/docs/215>. As these reports and the associated resources are distributed and promoted to the SNP for use in developing infant and early mental health services in the demonstration sites, the torch is being passed. The Demonstration Sites are now part of the pioneering effort to expand and enhance the continuum of mental health services for very young children.

IPFMHI Accomplishments

The Infant, Preschool, Family Mental Health Initiative (IPFMHI) was funded by the First 5 California Children and Families Commission for 2001-2004 to develop and expand infant and early mental health services for children ages birth to five and their families. Led by the State Department of Mental Health and coordinated by WestEd, Sacramento, the project was developed with and implemented by the departments of mental health and their interagency collaborators in eight pilot counties: Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco and Stanislaus. The first phase of the Initiative was highly successful in implementing all 6 goals of IPFMHI. The accomplishments of the first phase of IPFMHI are documented in 5 volumes of reports submitted to the First 5 California Children and Families Commission in July 2003. The accomplishments addressed in this report are organized by the goals of the Initiative. They include:

1. **Services**-Initiation or expansion of mental health services for children 0-5 and their families in the eight pilot counties including mental health consultation services, evidence-based practices and promising practices, case studies describing relationship-based approaches to services and the Clinical Services Study evaluating the effectiveness of the services.
2. **Infrastructure**-Development of infrastructure, screening and assessment and billing and funding sources, to support the provision of mental health services to children 0-5 and their families
3. **Community Education**-The expansion of local community awareness, understanding and knowledge of infant and preschool mental health, and of relationship-based services through interagency and interdisciplinary trainings
4. **Professional Development** -The expansion of mental health provider capacity to serve children 0-5 and their families through training, consultation and supervision of mental health clinicians and development of competencies to define the training needed to provide infant family and early mental health services
5. **Collaboration**-Expanded and strengthened interagency collaboration by identifying and developing working relationships with key agencies and groups involved with very young children
6. **Evaluation**-Successful evaluation efforts with positive outcomes shown for the children and families served as documented in the Clinical Services Study, for participants in training shown by the training evaluations and participant profiles and for all participants in the Initiative as documented in the Impact Evaluation.

The first phase of the project ended in June of 2003. The second phase of IPFMHI was funded to complete the work of the first phase, including continued delivery of services in the eight pilot counties, development of products based on the work of IPFMHI in phase I, and provision of technical assistance and support to school readiness programs. The Department of Mental Health, WestEd and the California Institute of Mental Health (CIMH) worked cooperatively to meet the goals for the second phase of the Initiative including coordination with the SNP Coordination and Training contractor, CIHS-SSU, to develop materials for use in the SNP Demonstration sites. The goals of the second phase of IPFMHI are below.

1. **Local Assistance**-Continue direct, indirect, case management and consultative services for one additional year 2003-2004. (WestEd monitored and reported county accomplishments in the report, *IPFMHI Phase II Final Report: Consolidation and Sustainability: The Status of Infant Family and Early Mental Health Services in IPFMHI Pilot Counties* <http://www.wested.org/cpei/familyresource/phasellfinalreport.pdf> .)

2. **Resource Development and Dissemination**-Develop promising practices and lessons learned from the Initiative for use in supporting School Readiness and other First 5 programs.(A collaborative work group led by Special Needs Project Training and Technical Assistance Coordinator with WestEd, DMH and CIMH contributing developed the 3 products authored by CIMH on screening, financing and triage and referral. This report, *IPFMHI Accomplishments and Lessons Learned* also addressed this goal.)
3. **Support School Readiness Programs and Other First 5 Programs and Activities**- Provide technical assistance, training and consultation to School Readiness initiative programs. (WestEd till January 2005; CIMH and DMH till December 2005.)

The following section of this report summarizes the accomplishments of the IPFMHI from 2001 to 2004 as described above by the goal areas of the first phase of the Initiative.

Services:

Number of Children and Families Served

The success of the counties' capacity building efforts in infant and early mental health are demonstrated in the increases in the number of children birth to 5 and their families served in the past 4 years. As shown in Table 1 approximately 8842 children and families were served by county mental health departments in 2003-2004. This number represents an increase of 51% from 2000-2001. Programs in all counties except Fresno showed substantial growth in the number of young children served. Fresno's capacity to provide services had significantly expanded in 1999-2000 and has remained about the same since then.

Table 1 Number of Children and Families Served Ages Birth to Five¹

County	Fiscal Year 00/01	Fiscal Year 01/02	Fiscal Year 02/03	Fiscal Year 03/04	% Increase
Alameda	589	710	699	928	57%
Fresno	617	703	685	609	---
Humboldt	0	15	32	40	167%
Los Angeles	3,552	4,285	5,175 ²	5,175 ³	46%
Riverside	0	68	247	388	470%
Sacramento	899	728	1,286	1,347	50%
San Francisco	112	103	115	176	57%
Stanislaus	81	157	196	179	120%
TOTAL	5,850	6,769	8,435	8,842	51%

¹ Data reported by the county coordinators for the fiscal years 2002-2003 (02/03) and 2003-2004 (03/04) IPFMHI Year End Reports

² Los Angeles data is a projected estimate for 02/03 from three quarters of data submitted.

³ No data was available for 03/04 so the 02/03 data repeated is a conservative estimate for 03/04.

Humboldt and Riverside programs served their first children, ages birth to five, in 2001-2002 with resources provided by IPFMHI and have grown every year since. Humboldt's Early Years program grew from serving 15 children very young children and their families in 2001-2002 to 40 children in 2003-2004. Riverside's Preschool 0-5 Program increased the number of children served from 68 in their first year to 388 in the third year. Alameda, Sacramento and San Francisco programs have increased services to very young children by more than 50%. Stanislaus County's Leaps and Bounds has grown by 100%. Los Angeles County services have also increased considerably and most likely much more than the 46% increase shown here, but because of problems with their Management Information System (MIS) exact numbers are not available.

Mental Health Consultation Services and School Readiness Activities

Consultation services offered by the counties, particularly mental health consultation to childcare and preschools, is a new and fast growing area of mental health services. In 2002-2003, IPFMHI provided training in mental health consultation to childcare for Stanislaus and Sacramento County through UC San Francisco's mental health consultation program led by Kadija Johnson, Director of the University of California San Francisco Infant Parent Program. Alameda County received training from the same source with local First 5 funding.

Infant and early mental health consultation refers to a reflective and instructive exchange of information between an experienced competent mental health provider and a person or group seeking assistance or instruction in relationship-based approaches to providing services. Consultation helps providers of services to young children to integrate the concepts and principles of infant mental health into their programs and helps them to identify children and families in need of more intensive mental health treatment services.

According to Chris Home of Riverside County, *"Mental health consultation to childcare or preschools allows clinicians to regularly meet with early childhood development staff to review and discuss classroom management that supports healthy social emotional development without first enrolling a child into treatment. This kind of light support is appreciated because it does not stigmatize the child or blame the teacher, as is often the case when signs of early issues are allowed to develop until medical necessity criteria are met."*

The 8 pilot counties provide consultation services to early childhood education agencies, early intervention agencies, public health, social services, child protective services, childcare agencies, homeless children's shelters and school readiness sites. The use and availability of consultation services has grown as it has been promoted and supported by grants from local First 5 Children and Families Commissions in various counties and strongly encouraged by IPFMHI and the State First 5 as part of school readiness programs and in preparation for work with Special Needs Demonstration Sites. Table 4 shows the mental health consultation services and school readiness activities in each county for 2003-2004.

Table 2 Mental Health Consultation Services and School Readiness Activities

County	Consultation Services	Comments
Alameda	1400 hours in 2003-2004	Lead agency in The Partnership Grant to provide mental health consultation to childcare funded by First 5 Alameda, Every Child Counts
Humboldt	18-20 hours in 2003-2004	Consultation to interagency providers, including public health and social workers funded by mental health
Fresno	336 hours in 2003-2004	On site consultation to early intervention, regional center and early childhood education programs funded by mental health
Los Angeles	In the process of development	LA Co. DMH is collaborating with Children's Hospital Los Angeles in building relationships with the 42 School Readiness sites , conducting focus groups and providing training in mental health consultation for mental health providers
Riverside	3,742 hours from March 2002 to June 2004	Consultation hours are provided primarily to CAL-SAFE, childcare programs, Rob Reiner School Readiness Center, public health clinics and Inland Regional Center and are funded by First 5 Riverside.
Sacramento	Contracted to provide 200 contacts (by phone or onsite) in 2004-2005	Consultation as part of the Quality Childcare Collaborative
San Francisco	Childcare 2002-2003: 5745 children served with 1368 receiving direct therapy. Homeless Children 2003-2004: 1000 children served and 200 received direct therapy	High Quality Childcare Mental Health Consultation Initiative funded by First 5 Homeless Children's Mental Health Consultation funded by First 5
Stanislaus	5,000 hours funded in 2003-2004 10,000 hours funded for 2004-2005	Mental health consultation to childcare funded by Local First 5 serving approximately 30 childcare/preschool sites including sites in the Modesto City School District and small private non profit programs

Alameda County Behavioral Health Care Services is the lead agency in the Partnership Grant to provide mental health consultation to childcare funded by Every Child Counts (First 5 Alameda County). The Partnership Grant provides training, services and help with developing funding (EPSTD) for treatment services. The collaborative, Early Childhood Systems Development Group, developed *Standards of Practice for Mental Health Services to Early Care*

and Education to explain, promote and guide mental health consultation to childcare in Alameda County (See Appendix C).

Sacramento County Mental Health is providing mental health consultation services as part of the Quality Childcare Collaborative (QCC). The QCC provides 4 levels of service to family daycare including resources, consultation and referral. (See Innovative Collaborations page 31 for more information.)

San Francisco County provides mental health consultation to the High Quality Childcare Mental Health Initiative and to homeless shelters both through grants from First 5 San Francisco. A Childcare Mental Health Screening Checklist was developed to help identify children in need of services.

Stanislaus County Leaps and Bounds now serves approximately 30 childcare sites including large programs in the Modesto City School District and small nonprofit programs as well. They offer consultation services to the programs and provide referrals to those families in need of more intensive mental health treatment services. Consultation services are funded by First 5 Stanislaus County. Early in the development of the consultation services Stanislaus developed and conducted a needs assessment for childcare providers. The needs assessment helped to identify childcare programs in need of consultation and specific areas of concern at particular sites. Outcome measures were developed to determine the effectiveness of the consultation from the perspectives of the family, childcare providers and mental health consultant. An Indirect Therapist Log was developed to track consultation hours provided by Leaps and Bounds.

Riverside County's Preschool 0-5 program serves the Rob Reiner School Readiness Center (which serves 9 different school districts) with onsite consultation and treatment services available to all agencies and programs at the Center as well as in the community. They also serve CAL SAFE programs, early intervention, early childhood education and childcare programs. In developing their services they consulted with CIMH to help provide a well-articulated explanation of the roles and responsibilities of the mental health consultant and the childcare or preschool staff as well as a formal agreement to be used with agencies that they consult with. The following documents were developed and are available in Appendix C:

1. Infant Mental Health Consultation Concept and Description for Preschools/Childcare Settings
2. Consultation MOU Template for Preschool/Childcare Settings

Los Angeles County Department of Mental Health in collaboration with Children's Hospital Los Angeles is in the process of developing mental health consultation services for their 42 School Readiness Sites. With a major grant from First 5 Los Angeles augmented by IPFMHI funding they are developing relationships with school readiness site administrators, conducting focus groups and developing training for mental health providers and School Readiness Sites.

Humboldt and Fresno Counties both provide in kind mental health consultation to their agency partners. In Humboldt the mental health provider met with public health and social workers for 2 hours monthly. In Fresno early intervention programs, regional centers and early childhood education programs receive 2 to 4 hours of onsite consultation weekly.

Evidence-Based Practices and Promising Practices

Evidence-based practices, sometimes called “best practices” or “exemplary models,” are those practices, treatments, therapies or programs that have been found through research to have consistently good outcomes. A growing recognition of evidence-based practices is leading funders, policy-makers, mental health professionals and families to seek out treatments that have a solid scientific base. With this in mind, several pilot counties have sought training and adopted evidence based practices to serve very young children and their families.

Incredible Years⁴ and Parent Child Interaction Therapy⁵ are the two forms of evidence-based practice that have been most often implemented in the pilot counties. Incredible Years targets children ages 2-8 years old, their parents and teachers with the use of three sets of developmentally appropriate curriculum. It is designed to promote emotional and social competence and to prevent, reduce and treat behavioral and emotional problems in young children. Parent Child Interaction Therapy, (PCIT), is aimed at children ages 2-8 with behavior problems and their parents. It consists of 12 sessions of parent-child therapy geared toward improving the quality of the relationship between the parent and child. Mental health providers in Humboldt, Riverside and Sacramento County are using both PCIT and Incredible Years. Some Los Angeles County mental health provider agencies are using PCIT.

Promising practices refers to treatment approaches that are supported by some research and experts agree on the effectiveness of the approach. Alicia Lieberman and Patricia Van Horn of the University of California, San Francisco’s Child Trauma Research Project (CTRP) at San Francisco General Hospital, a mental health provider group that participated in the IPFMHI Clinical Services Study, recently published *Don’t Hit My Mommy! A Manual for Child-parent Psychotherapy with Young Witnesses of Family Violence*⁶. The manual is designed to provide treatment guidelines to address the behavioral and mental health problems of infants, toddlers and preschoolers whose relationships have been disrupted by violence. The guidelines were developed from evidence-based approaches to therapy developed and evaluated by CTRP. San Francisco County’s Infant Parent Program and Alameda County’s Infant Mental Health Seminar are using approaches very similar to those researched at CTRP.

Watch, Wait and Wonder⁷ is a dyadic child led psychotherapeutic approach that has been empirically tested and is used with children aged birth to 9 with relational, behavioral and regulatory and developmental problems. IPFMHI sponsored trainings on this approach in Sacramento and Los Angeles Counties. Sacramento County reported use of this approach in some of its mental health provider agencies.

⁴ Incredible Years: <http://www.incredibleyears.com/>

⁵Herschel, A., Calzada, E., Eyberg, S.M., & McNeil, C.B. (2002). Parent-child interaction therapy: New directions in research. *Cognitive and Behavioral Practice*, 9, 9-16. <http://www.php.ufl.edu/~seyberg/>

⁶ Lieberman, Alicia and Van Horn, Patricia, (2005), *Don’t Hit My Mommy: A Manual for Child Parent Psychotherapy for Young Witnesses of Family Violence*. Available from Zero to Three Press. <http://www.zerotothree.org/bookstore/>

⁷Muir, E.,Lojkasek, M. & Cohen, N., (1999), Watch, Wait and Wonder, Available from the Hincks-Dellcrest Centre. http://www.hincksdellcrest.org/infant_mental_health/documents/wwwIntro.pdf

Family Stories Explain Relationship-Based Approaches to Intervention

A vivid way to describe infant family and early mental health services is through family stories. Four stories originally developed for other purposes have been collected to present a variety of approaches to relationship-based intervention and treatment. The collection includes one newspaper article, two stories of intervention presented at the Georgetown Institute System of Care Conference in June 2003 and a composite case study written for a recently published book. The mental health providers who worked with the families and/or wrote the stories were important participants in the Infant Preschool Family Mental Health Initiative as providers of care and many as consultants and trainers. The stories include examples of approaches to intervention that address the continuum of promotion, preventive intervention and mental health treatment for infants and their parents as well as interventions for preschoolers with behavior difficulties. One case specifically describes a family's experience receiving social emotional support for their child in preschool. A summary of the stories is presented in Appendix A. Web links to the complete stories follow each of the summaries below.

1. The Brain Connection is a newspaper article written by Rob Waters for the San Francisco Chronicle on November 14, 2004. This article provides an overview of infant and early mental health in the Bay Area of California. Through interviews with clinicians and other service providers at the University of California San Francisco Infant Parent Program and Children's Hospital and Research Center in Alameda County and other program staff serving families in Alameda County the writer draws on family stories to explain the rationale for and examples of relationship-based interventions. Interventions including nurse home visits, infant massage and infant parent psychotherapy are described. A brief history of infant mental health, the work of Selma Fraiberg and the UCSF Infant Parent Program is presented along with the results of the most recent research on the brain. Proposition 10, First 5 California Children and Families Commission, is credited with the increase in new services and programs developed to focus on the mental health needs of very young children and their families. For the complete story go to: <http://www.sfgate.com/cgi-bin/article.cgi?f=/chronicle/archive/2004/11/14/CMGA99BSEI1.DTL>

2. Infant Parent Program/Daycare Consultants: A System of Care in Itself is a case study prepared by staff at the UCSF Infant Parent Program and UCSF Day Care Consultants program for a presentation at the Georgetown Institute, System of Care Conference in June 2004. Judy Pekarsky, Program Director of the UCSF Infant Parent Program, tells about the program and their ways of working with very young children and their families. Miriam Silverman and Adriana Taranta make this more captivating by describing their work with Andrew and his adoptive mother, Betsey. It begins with intensive services when Andrew is two years old and continues with supports and services through preschool and transition to kindergarten. Examples of collaboration with other service providers, ongoing work with the family and work with the preschool staff as part of a mental health consultation is described. The story is unique as an example of continuity of services and addresses the social and emotional aspects of school readiness. The story includes a thank you letter to the therapist from the mother. For the complete story go to: www.wested.org/cpei/sfcasestudy.pdf

3. "Out of My Head"©: A Personal History Bag© is a detailed case history described by Emma Girard, Senior Clinical Psychologist at Riverside County Department of Mental Health's Preschool 0-5 Program. She tells the story of a particular intervention with a 4 year old boy in his 7th foster placement exhibiting extreme behavior difficulties as a result of the trauma and abuse that he experienced when he was living with his birth parents. The boy was identified and referred for evaluation at his preschool from screening concerns found in the Devereux Early

Childhood Assessment administered as part of a collaborative screening project through the Public Health Department and the Riverside Preschool 0-5 Program. After assessment and initial interventions including play therapy with the boy and his family a trusting relationship was developed with the therapist. At this point the focus of treatment became the boy's symptoms of Post Traumatic Stress Syndrome. The "Out of My Head" intervention was developed as a unique and age appropriate way for the boy to deal with his trauma. The intervention idea of a personal "History Bag" is a concrete tangible object made together by the boy, his foster mother and the therapist. Once the bag is created the child is encouraged to draw pictures of his memories. Then the child is asked to describe his memories as the caretaker writes verbatim what the child says on the picture. The child then places the picture in the History Bag. The child's actions of placing the memories, via their drawing, into the bag transforms the event they had no control of into a memory they can physically contain in their personal history bag. In this way the memory is taken "out of my head" as described by the boy in this intervention. For a complete description of the concept and application of the intervention, the outcome and further significant history of the family please go to: www.wested.org/cpei/girardcasestudy.pdf

4. Play Therapy with Preschoolers Using the Ecosystemic Model is a chapter written by Sue Ammen and Beth Limberg in the book, Handbook of Training and Practice in Infant & Preschool Mental Health edited by Karen Finello published by Jossey Bass in New York in 2005. Sue Ammen of Alliant International University in Fresno served as a consultant and trainer for the Infant Preschool Family Mental Health Initiative. Beth Limberg also provided training for the Initiative and is program director for the Building Blocks Program, an intensive mental health intervention program for children birth to five and their families within the River Oak Center for Children in Sacramento, California. They developed a composite case study to represent a mix of symptoms and concerns that is not unusual. The case study describes intervention based on the Ecosystemic model of play therapy. This model is developmentally organized, strength-based, relationship-focused and contextually grounded in the child's ecosystem. According to Ammen and Limberg:

"Ecosystemic Play Therapy (EPT) can be seen as a framework for play therapy rather than a specific modality. As such many modalities are integrated into the EPT framework depending on the needs of the client and the preference and training of the therapist. In the case example components of several distinct therapeutic approaches (including Theraplay®, Watch, Wait, & Wonder® and social learning theory) are thoughtfully integrated in the EPT assessment and intervention."

The case example describes the EPT model of assessment and intervention for 4 year old Germaine, an African American boy referred by his grandmother who is also his primary caregiver, Ms. Anderson. The social worker told her to make the call because Germaine has become aggressive with his younger brother and sister and she was worried that Ms. Anderson couldn't handle him. Germaine's mother is in prison. His father lives with them but is frequently absent. Intake and assessment, treatment planning, the treatment process and ending treatment are explained in detail with reference to the EPT framework. For more information about EPT and the case example see www.wested.org/cpei/limbergcasestudy.pdf

The Clinical Services Study

IPFMHI designed and carried out the Clinical Services Study (CSS) as a quality improvement study in public mental health settings to:

- Describe the characteristics and risk factors of children birth to five and their families in need of mental health services,
- Give mental health providers experience in using screening and assessment measures
- Evaluate the effectiveness of relationship-based mental health services for children ages birth to 5 and their families and the feasibility of providing these services in public mental health settings.

Significance

The Clinical Services Study was unique as it was carried out as an expansion of the routine delivery of mental health services to very young children and families in real time without randomized groups in eight different county public mental health delivery systems with 49 clinicians. It was of particular importance to the expansion of mental health services in the 8 pilot counties because it required the counties to develop and carry out service delivery plans and capacity building plans that included hiring or contracting with mental health providers, establishing or strengthening working relationships with other agencies and service providers who serve children and families and at the same time providing training for the mental health professionals and the collaborating service providers. For Humboldt, Riverside and several agencies in Los Angeles County the first children ages birth to five and their families served were as part of the CSS.

Method

Screening and demographic data only was collected from 295 families at intake. For another 93 families entering treatment chronologically the same screening and demographic data along with detailed assessment data was collected both at intake and later in treatment (after an average of 22 sessions). These families received relationship-based mental health treatment services from mental health agencies providing services for public mental health departments in the eight counties participating in IPFMHI. The common set of measures and tools used to screen, assess and gather data from the families included mental health diagnosis, development, the parent child relationship, parental stress and resources and supports.

Results

Analysis of the data showed no group differences between the 93 children and the 295 children indicating that the children and families in the study were similar to other children and families served by public mental health. Table 3 presents the sociodemographics of the index sample of 93 children and the reference sample of 295 children. This data provides a description of the characteristics and risk factors of children birth to five and their families in need of mental health services. Note that most of the children served were male (62%), the ethnicity of the children was primarily Hispanic (29%) and Caucasian (29) but also included a large proportion of African American (21%) and Other (21%). Most of the families served had incomes of less than \$15,000 per year. An average of about 4 risk factors were found for the families served. The most common risk factor was a parent child relationship problem identified in 65% of the families. Other common risk factors were parent with a mental health problem (44%), single parent (46%), inadequate income (40%) and domestic violence (39%).

Table 3 Sociodemographics of Clinical Services Study Index and Reference Samples*

	Index Sample (N = 93)	Reference Sample (N = 295)
Age of Child (months) Mean \pm SD	34.7 \pm 17.3	35.4 \pm 17.9
Gender of Child (% male)	62	61
Ethnicity of Child (%)		
Hispanic	29	33
Caucasian	29	31
African-American	21	18
Other (Asian, American Indian, Mixed Ethnicity)	21	18
Caregiver Education (%)		
Less than HS degree	22	28
HS degree or GED	39	47
More than HS degree	39	25
Annual Family Income < \$15,000 (%)	52	64
Total Family Risk Factors (Mean)	3.9	4.2
Most Common Family Risk Factors: (%)		
Parent-child relationship problem	65	56
Parent with mental health problem	44	44
Single parent	46	43
Inadequate income	40	42
Domestic violence	39	45
Parental substance abuse	30	48
Child separated from caregiver	33	29
Child abuse or neglect	25	36
Poor housing	24	24

*NS at $p < .01$; independent sample t -tests for age & total family risk factors; χ^2 for ethnicity and caregiver education; χ^2 w/ contingency correction for gender, family income, & specific risk variables

Analysis of outcomes from the measures showed statistically significant improvement in the well-being of the families served by agencies and providers through the study. The results of two of the pre and post treatment measures are presented in tables below. There was a statistically significant decrease from pre to post treatment in the total number of developmental risk factors ($F(1,44)=5.35$, $p = .013$, one-tailed) as measured by the Ages and Stages Questionnaire. The proportion of children with at least one developmental risk factor declined from 53% to 40% and at-risk scores in the cognitive functioning subdomain declined from 38% to 13%. These clinically significant results demonstrate the positive influence that relationship-based interventions have on overall development and particularly on cognitive functioning. A child with emotional, behavioral or relationship disturbance may appear to be child with a developmental delay since the child's development occurs necessarily in the contest of he/her nurturing relationship. A relationship-based intervention helps the child to return to an expected developmental trajectory.

Table 4 **Ages and Stages Questionnaire**

	<i>N</i>	<i>Pretest % At Risk</i>	<i>Post test % At Risk</i>	<i>Significance McNemar p (one-tailed)*</i>
Cognitive	45	38 %	13 %	.004
Fine Motor	45	29 %	24 %	NS
Gross Motor	44	11 %	7 %	NS
Language/Communication	45	31 %	24 %	NS
Personal-Social	45	18 %	13 %	NS

There was a statistically significant decrease in the level of total parenting stress ($F(1,54)=6.74$, $p = .006$) as measured by the Parenting Stress Index Short Form. Elevated parenting stress is correlated with at risk parenting behaviors, dysregulated child behaviors and difficulties in the parent-child relationship. The percent of parents reporting overall parenting stress in the clinically significant range dropped from 51% to 42%. Similarly, for all three of the subscales the proportion of parents reporting clinically high risk scores at pretest dropped at post-test. On the parental distress subscale 27% of the parents reported very high levels of stress in the parenting role at pretest compared with 13% at post-test. The proportion of parents reporting in the very high risk range for relationship stress declined from 30% at pretest down to 23% at post test. The proportion of parents experiencing clinically high levels of stress related to their child's behavior also declined from 36% at pretest to 27% at post-test. These results indicate that relationship-based interventions contribute to decreased parenting stress, improved parent child relationships and a more positive view of the child. It should be noted that very high levels of stress on the relationship scale are of particular concern for the future functioning of the child because it is associated with problems in the parent-child attachment and indicates a risk of disruption in the relationship. Thus, a clinically significant decrease in parents reporting relationship stress in this high-risk range is a notable outcome.

Table 5 **Parenting Stress Index- Short Form**

	<i>N</i>	<i>Pretest % Above High Clinical Risk Cut off</i>	<i>Post test % Above High Clinical Risk Cut off</i>	<i>Significance McNemar p (one-tailed)*</i>
Parenting Distress	56	27%	13%	.011
Parent-Child Dysfunctional Interaction	56	30%	23%	NS
Difficult Child	55	36%	27%	NS

Conclusions

The CSS identified and described the characteristics of children and families in need of mental health services in eight diverse counties. The comparability of the clinical sample (93 children) and the reference sample (295 children) provided promising implications for all families in need of infant-family and early mental health services. The positive outcomes for all of the pre and post measures showed that relationship-based interventions for very young children reduced symptoms of mental disorder, accelerated child development, improved the parent/child relationship, resources and supports and reduced parental stress. The CSS demonstrates the effectiveness and the feasibility of providing mental health services to very young children in public mental health settings. The executive summary of the complete report of the CSS is available at <http://www.wested.org/cpei/familyresource/cssexecsumm.pdf>.

Infrastructure

Screening and Assessment Measures

As part of the IPFMHI Clinical Services Study from 2001-2003 to evaluate the effectiveness of relationship-based interventions for very young children and their families, county mental health providers were required to use a core set of measures with the families they served in the study. Most mental health providers had very little or no experience with the use of measures prior to their use in the Clinical Services Study. Measures were chosen based on the experience of the mental health providers, ease of administration and use by other service providers in local communities. The use of measures in the Study served the following purposes:

- Screening-To identify and describe risk factors associated with the families served.
- Assessment-To gather information that would help to guide treatment.
- Outcomes-To provide data at two points in time during treatment to evaluate the effectiveness of the treatment
- Experience-To provide experience for the mental health providers and agencies in the use of measures

IPFMHI strongly encouraged the continued use of measures after the completion of the Clinical Services Study. The hope was that the mental health provider agencies would incorporate some or all of the measures into their assessment process and where applicable as outcome measures later in treatment. Use of measures provides a common language for discussion of diagnosis, description of the parent child relationship, family resources and supports, developmental functioning of the child, parenting stress, and if used as an outcome measure, change as a result of treatment.

More than a year after completion of the Clinical Services Study, the pilot counties were asked about the use of measures in their counties. The following provides a brief summary of the results of that inquiry and a description of the most popular measures adopted for use.

The Parenting Stress Index-Short Form has been adopted for routine use in all of the pilot counties except San Francisco where it is being considered for use. Seven of the 11 agencies in Los Angeles County that reported their experience are using the measure. This instrument is used in treatment planning and provides information about the parent child relationship, parent's experience of the child's behavior and parental stress. The measure has also been found to be

useful as an outcome measure and continues to be used as such by Riverside County and 4 agencies in Los Angeles County.

The Diagnostic Classification for 0-3 (DC: 0-3) is used “often” or “very often” in 6 counties and in 6 of the 11 Los Angeles County mental health provider agencies. A DSM IV diagnosis is required for Medi-Cal billing, however, the DC: 0-3 provides a more appropriate and detailed description of a very young child’s mental health. IPFMHI helped to develop and promote the use of a “crosswalk” which translates a DC: 0-3 diagnosis into a DSM IV diagnosis required for billing. Los Angeles, Sacramento and Stanislaus Counties have incorporated the DC: 0-3 in their initial client assessments. With funding from First 5 Sacramento, Sacramento Department of Mental Health, Cherise Northcutt, collaborated with the Sacramento County Office of Education, Chris Wright, to develop a “Schematic Decision Tree for DC: 0-3” to facilitate training in the use of the DC: 0-3 and help clinicians to use it for diagnosis. See the List of Materials and Products developed by Counties, for the publication reference.

The Ages and Stages Questionnaire (ASQ) is used in 5 counties and 8 of the 11 agencies in Los Angeles County. This popular easy to administer screen describes developmental functioning in 5 domain areas including: language communication, fine motor, gross motor, cognitive and personal-social. In Sacramento County the ASQ is used by home visitors in the CAL SAFE model Birth and Beyond program. In Alameda County the ASQ is used primarily by child care mental health consultants and Every Child Counts Healthy Steps Program (developmental specialists in pediatric offices) to inform the service plan and referrals for developmental assessment.

The Marschak Interactive Method (MIM) is used by 4 counties, Fresno, Riverside, Sacramento and Riverside. This measure assesses the parent child relationship with the use of video. Special training in the use of video and the MIM was provided by IPFMHI to support the use of this measure in these counties.

The Devereaux Early Childhood Assessment (DECA) was not a core measure in the CSS but is used by 3 counties, Alameda, Riverside and Sacramento, and by 2 agencies in Los Angeles County. Riverside County uses the DECA as the screen for their county-wide screening project funded by First5 Riverside and also uses the DECA as an outcome measure. In Alameda County mental health consultants use the DECA in conjunction with early care and education teachers to inform treatment plan/respond to child’s needs within the classroom. The DECA is designed to identify children with behavior concerns and develop intervention plans based on individual protective and concern profiles. Scoring and interpretation require a high degree of training.

The Bayley and the **Infant Toddler Development Assessment (IDA)** were options for use in the CSS to provide information on developmental functioning. Alameda and Sacramento Counties use both of these measures. Three agencies in Los Angeles County use the Bayley. Both require a high degree of training for use.

The Mental Health Screening Tool (MHST) developed by CIMH and the **MHST Supplemental (Moderate Risk Assessment)** developed Sue Ammen and Peggy Thompson for use by the CSS are screens for children and families at high and moderate risk respectively for mental health problems. The MHST is used by referral sources in Humboldt and San Francisco Counties and Children’s Hospital Los Angeles. The MHST Supplemental is used in by referral sources in Fresno and Humboldt Counties and Children’s Hospital Los Angeles.

The BABES (Behavioral Assessment of Babies Social and Emotional Style) developed by Marie Poulsen and Karen Finello is a screen completed by the parent that provides information about the parent's experience of the child's behavior and the parent-child relationship. It was used in the CSS and continues to be used by agencies in Sacramento County and Children's Hospital Los Angeles.

The Fresno Resource and Support Scale (FRSS) developed for the CSS by Sue Ammen and Peggy Thompson based on the Dunst Scales and available from IPFMHI, is a quick and simple assessment of a family's resources and supports including finances. It continues to be used by Fresno and Stanislaus Counties and by three agencies in Los Angeles.

The Achenbach Child Behavior Check List (CBCL) was not used by the CSS but is used by Humboldt and Riverside Counties and eight agencies in Los Angeles County for both assessment and outcome measures. For a time the CBCL was a mandated outcome measure for the Department of Mental Health Systems of Care programs.

The Temperament and Atypical Behavior Scale (TABS), Early Relationship Assessment, and Edinburgh Maternal Depression were not used in the CSS, however, are all used by Alameda County's Children's Hospital of Oakland.

The IPFMHI Intervention Tracking Form was used in the CSS to document the activities of each intervention session, track the attunement between the parent and child and the overall progress in treatment. Riverside County continues to use the form routinely.

The DMH/ICARE Initial Assessment is a comprehensive tool used to gather information about the background, history, and risk factors of the child and family. It was developed by the Los Angeles County Department of Mental Health and the ICARE Network and is used by 6 of the agencies in Los Angeles County.

For more detailed information on screening and assessment measures see the CIMH product, *Compendium of Early Childhood Social and Emotional Development Screening Tools*, on the Special Needs Project website <http://www.First5CAspecialneeds.org/>.

Billing and Funding of IPFMHI Programs

Billing and funding of both direct and indirect mental health services is of vital importance to the provision and sustainability of services to very young children and their families. The primary source of funds for direct mental health services for children ages birth to five and their families is Early Periodic Screening, Diagnosis and Treatment (EPSDT) a Federal mandate which is implemented in California for Medi-Cal beneficiaries with a General Fund match. Billing for services under EPSDT is available for children who are full scope Medi-Cal beneficiaries between the ages of 0 and 21 and who meet criteria for medical necessity. A case must be "opened" and DSM IV diagnosis assigned before a provider may bill for services. The bulk of direct mental health services provided to children birth to five are billed to EPSDT Medi-Cal in all eight counties.

Indirect mental health services to children and families are not billable. Screening of children and families in potential need of mental health services and mental health consultation services to other providers of services to children and families are examples of non-billable services. Grants from local First 5 California Children and Families Commissions have enabled County Mental Health Departments and other mental health provider agencies to significantly expand their services by providing screening and consultation services as well as mental health

treatment services to children and families who don't qualify for Medi-Cal. All eight counties have local First 5 grants to support new services to children and families. For additional information on financing of mental health services see the IPFMHI product, *Financing Strategies for Early Childhood Mental Health Services* on the Special Needs Project website <http://www.First5CAspecialneeds.org/> . The following describes the funding and billing sources used by the 8 pilot counties.

- **EPSDT Medi-Cal** is used by all eight counties.
- **Medi-Cal Administrative Activity (MAA)** is a payment source for indirect services such as consultation. It requires special billing codes and provides reimbursement at 25% of the cost of providing service. Alameda, Fresno, Sacramento and Stanislaus Counties access this source of funding.
- **Health Maintenance Organizations** serving Medi-Cal is indicated as a billing source for Fresno, Riverside and Stanislaus Counties.
- **Healthy Families** is a Federal insurance plan with a mental health benefit offered to families for their children 0-19 years old not eligible for Medi-Cal with family incomes below 250% of the poverty level. Fresno and Los Angeles County have had experience with this funding source.
- **Cal-WORKS** Mental Health/Substance Abuse funds are available to fund mental health services to children and families in Cal-Works programs found to be in need of additional family support. This funding source had been used by Humboldt County and to a very limited degree in Alameda, Fresno and San Francisco Counties.
- **Victim/Witness Funds (Criminal Justice System)** are available from the State District Attorney's office for mental health services to children who are victims of crime or traumatized by a crime committed toward a family member. It is a payor of last resort and has been used by Alameda and Humboldt Counties and to a lesser degree in most of the other counties.
- **Private insurance** has been accessed "often" by Alameda and Humboldt Counties, but very seldom or never by the other counties.
- **Patient fees**, usually on a sliding scale, have been a funding source for Fresno and Los Angeles Counties, but very seldom or not at all for the other counties.
- **Targeted Case Management** funds have been used by Alameda and Los Angeles Counties
- **Regional Center Funds** have been used by Alameda County to provide services to children in the Early Start program and children with developmental disabilities.
- **The California Endowment**, a private source for grants for projects that support the health of California families, has funded special projects in Fresno County
- **Local First 5 California Children and Families Commission** grants are used by all eight counties for special projects including screening, mental health consultation and treatment services. Stanislaus County's Leaps and Bounds program developed an Indirect Therapist Log to track hours spent on consultation and other activities not billable under Medi-Cal.

Community Education and Professional Development

IPFMHI addressed the shortage of professionals and paraprofessionals trained to evaluate and intervene with early social emotional and behavioral needs for children 0-5 by providing education and training for mental health professional and their community partners. Each county developed a training and technical assistance plan based on their local resources, priorities, needs and desired outcomes and the goals of the Initiative. Training was funded by IPFMHI and supported by the State Team. State-level activities included technical assistance, presentations and trainings in collaboration with other state and national agencies as well as cross-county training and resource sharing facilitated by the state Initiative team. The 2003 report, *Building Capacity*, provides detailed descriptions of each county's capacity building plans and is available on the WestEd.org website at

<http://www.wested.org/cpei/familyresource/buildingcapacity.pdf>.

A total of 100 formal training events and activities at the county level served 5425 participants from 2001 to 2003. Table 1 displays the number of training activities and total participants by county.

Table 6 Number of Training Activities And Participants

County	# of Training Activities	Total Participants
Alameda	5	68
Fresno	13	687
Humboldt	23	647
Los Angeles	12	847 (partial numbers)
Riverside	21	1590
Sacramento	16	1300
San Francisco	3	139
Stanislaus	7	147

Framework for Trainings

Table 7 presents an overview of the types of training provided in the IPFMHI Counties throughout the State. The categories of training help to describe the common framework that address the building blocks of training that were carried out by the counties with a diversity of approaches based on the specific strengths and needs of the county. The framework includes Topical Trainings, Ongoing Reflective Supervision, Case Consultation, Local Meetings and Committees and Statewide IPFMHI All County Meetings. All counties provided topical trainings, case consultation and participated in IPFMHI Statewide All County Meetings and local meetings and committees. Ongoing reflective supervision was provided in most counties by the county mental health provider or the contracting agencies.

Table 7 Categories of Training Approaches

TYPE	LEAD	PARTICIPANTS	FREQUENCY OF MEETINGS	CURRICULUM OR CONTENT
Topical Trainings	<ul style="list-style-type: none"> ▪ National and state experts ▪ County consultants ▪ Team members 	Large groups of multidisciplinary providers, administrators, parents/families	As planned; generally ranging between 1-3 days	Infant and early mental health concepts and approaches to intervention
Ongoing Reflective Supervision	<ul style="list-style-type: none"> ▪ Experienced supervisors of mental health programs and agencies ▪ Centers of Excellence 	Small groups or one on one supervision for individual mental health providers	Monthly or biweekly	Reflection on daily work
Case Consultation	<ul style="list-style-type: none"> ▪ State/county consultants and ▪ Centers of Excellence 	Small groups of multi-disciplinary providers or mental health providers	Monthly or biweekly	Instruction in application of concepts and case-based consultation
Seminars	<ul style="list-style-type: none"> ▪ Alameda County Children's Hospital of Oakland 	Mental health providers developing specialized clinical expertise- 18 participants per year	Weekly for 16-20 weeks	Intensive training, case consultation and reflective supervision
Learning Labs	<ul style="list-style-type: none"> ▪ Fresno County Mental Health Consultants 	An average of 10 multi-disciplinary providers each session	Weekly for 5 weeks	Training in key concepts, intervention and case discussions
Local Meetings and Committees	<ul style="list-style-type: none"> ▪ Mental Health and/or ▪ Other groups involved in serving children 0-5 and their families 	Representatives from a variety of agencies and groups involved in providing services to very young children	Varied	Local resources, needs and problem-solving, special projects and events, interagency and interdisciplinary meetings, promotion of infant and early mental health
Statewide IPFMHI All County Meetings	<ul style="list-style-type: none"> ▪ IPFMHI State Team Members 	Representatives from mental health and collaborating agencies from the 8 pilot counties, State Leadership from various Departments First 5 CCFC, administrators and guest from other interested counties	2-3 per program year	Topical presentations, facilitated group discussions, products developed by counties, resource sharing across counties

Topical Trainings given by national, state and local experts provided a broad range of information for interagency providers and mental health practitioners that served to:

- Introduce and promote mental health and interagency service providers to the need for infant family and early mental health services and the importance of relationship-based approaches to services and Intervention and treatment.
- Provide information and training on the key components of infant family and early mental health.
- Provide training in relationship- based approaches to services and relationship-based interventions and treatment services.

All eight counties provided topical trainings to multidisciplinary audiences. These trainings were very well received by the community as evidenced by consistently high attendance, positive training evaluations and requests for more.

Ongoing Reflective Supervision is usually individual supervision that involves a focus on relationships, qualitative improvement, support and the investment of self in the intervention and treatment process. It is most effectively provided by a supervisor experienced in infant-family and early mental health who can provide feedback in the effective application of basic concepts and interventions. Reflective supervision is particularly important for service providers new to providing relationship-based approaches to services for very young children and their families.

Alameda County's Children's Hospital of Oakland provides training in reflective supervision and also provides a support group twice a month for the reflective supervisors.

San Francisco County's Infant Parent Program provides reflective supervision as an ongoing part of their training program.

Los Angeles County's Children's Hospital of Los Angeles voluntarily provides reflective supervision to 8 clinicians at no cost to the agencies they represent as an extension of training provided to LA County Pioneer Providers under the Initiative.

Riverside County's Preschool 0-5 Program offers reflective supervision to all clinicians, however, it is the less experienced, unlicensed clinicians who take advantage of it most often.

Fresno County clinicians realized the need for reflection and case consultation among themselves and implemented twice monthly peer review as an opportunity to discuss their cases and support each other.

Case Consultation services to mental health clinicians or staff from interagency service providers in the pilot counties involved instruction in advanced mental health concepts and approaches to services from an established expert in the field. The expert serves as a mentor and instructor for small groups of mental health providers or other service providers in the application of infant and early mental health concepts and provides guidance with individual cases as part of the learning process. Case consultation is an important part of any training program as it supports learning with instruction and feedback related to the actual work with families. Separately from the case consultation with experts provided by the Initiative most county programs and agencies provide regular opportunities for service providers to discuss their cases as part of weekly group supervision and case consultation or as part of a peer review program.

Local Meetings and Committees involving mental health agencies and interagency partners serving children ages birth to five and their families serve as a venue for promotion, planning and coordination of training as well as educational presentations to inform mental health provider agencies and other service providers about infant family and early mental health

concepts and services available and developing in the community. These meetings and committees provide an ongoing forum for communication and building of relationships to facilitate service delivery. According to the results of the 2004 County reports all of the various local committee activities that were developed as part of the Initiative or participated in as part of the Initiative will be sustained. County infant and early mental health has become an important presence in local communities in all eight counties as a result of the activities under IPFMHI.

The Infant Family Mental Health Seminar developed in Alameda County by Children's Hospital of Oakland is a weekly training for mental health providers that includes intense training in the key concepts of infant family and early mental health, ongoing reflective supervision and case consultation. Following the last year of Initiative support for the training was sustained with alternate funding. The fourth year of training covered the 2004-2005 fiscal year and will continue indefinitely to provide training in infant and early mental health for mental health providers in Alameda County.

Learning Labs, developed collaboratively by Fresno Department of Mental Health and Alliant International University, provided weekly instruction on relationship-based approaches to services and infant family and early mental health concepts and case consultation to home visitors for the Fresno County interagency partners and private mental health providers. Unfortunately alternate funding for Learning Labs was not available and they were discontinued.

Statewide IPFMHI All County Meetings provided the opportunity for all eight counties to present and hear about local experiences and capacity building activities, share strategies for addressing challenges, receive information and instructions regarding statewide activities like the Clinical Services Study and learn about the State Department of Mental Health and First 5 California Children and Families Commission activities. County coordinators reported in their 2003 IPFMHI Final Reports that networking with, developing relationships with and hearing about the experiences of the other counties provided some of the most valuable learning opportunities for program development and personal gratification for leaders in the

IPFMHI provided resources for training only in the first phase of the Initiative from 2001-2003. County coordinators were asked how not having funds for training from IPFMHI for 2003-2004 impacted their ability to provide training. Alameda and San Francisco County both said there was no impact as they are able to continue to provide the same ongoing training programs but with different funding sources. Fresno, Humboldt, Riverside, Sacramento and Stanislaus Counties all echoed the sentiments of Los Angeles County who said, *"We do not have the funding streams available to provide the same type and quality of trainings provided previously to our providers through the IPFMHI. Also, many new providers would like more training in infant and early childhood mental health."* Training by IPFMHI has only begun to meet the demand and need for training.

Despite diminished or discontinued funding from State and or County Mental Health Agencies for training, other collaborators are providing training activities and conferences addressing infant, family and early mental health topics. Some type of training is available in all counties.

- **Alliant University in Fresno** developed the Infant Family Mental Health Certificate Program based on the Training Guidelines and Recommended Personnel Competencies developed by IPFMHI. It is available in Fresno and Sacramento Counties.
- **Alameda County's Children's Hospital of Oakland** will provide the Infant Family Mental Health Seminar on an ongoing basis with other funding sources to continue to increase the capacity of mental health providers in the county.

- **San Francisco County's Infant Parent Program** continues their long time well respected training program.
- **River Oak Center for Children in Sacramento County** has developed a training program that includes introductory and advanced training in infant family and early mental health that is offered to its staff and open to the community. Training is available by contract to other counties and programs outside of Sacramento.
- **Los Angeles Child Guidance**, a large mental health provider in LA County, with the support of the ICARE Network developed and conducted their own one day training institute with nationally known speakers in January 2005.
- **Local First 5 Commissions** have supported training as part of grants for special programs like Parent Child Interaction Therapy training in Riverside and mental health consultation to childcare training in Los Angeles County. They also support annual interagency conferences in Riverside and Stanislaus Counties.

The trainings described above in Fresno, Alameda, Sacramento and Los Angeles were developed as part of the Initiative or as a result of the impetus and support provided by the Initiative over the past four years.

Training Guidelines and Recommended Personnel Competencies

Training Guidelines and Recommended Personnel Competencies: Delivering Infant-Family & Early Mental Health Services is another report developed by IPFMHI that recommends a framework for training and personnel competencies necessary for the effective delivery of infant family and early mental health services. It describes two sets of guidelines for training service providers. One set is focused on developing applications of the core concepts of practice for mental health practitioners. The other set of guidelines introduces early mental health concepts and general principles of practice to core providers. (Core providers are professionals working with infants, toddlers and preschoolers and their families from the fields of child care, early childhood education, early intervention, nursing, occupational therapy, physical therapy, speech and language pathology, special education and human development.) These guidelines provide a concise resource developed by infant family and early mental health experts containing recommendations for the provision of training and personnel competencies necessary for effective delivery of infant-family and early mental health service. They reflect the framework and content of the trainings provided by the Initiative. The Training Guidelines and Recommended Personnel Competencies are available on the WestEd.org website, <http://www.wested.org/cpei/familyresource/personnelcomp.pdf>.

Summary

IPFMHI supported professional development opportunities for mental health providers learning to work with very young children and their families and service providers who needed training in promotion and preventive intervention with young children. Over 5000 people in the 8 pilot counties participated. The framework for training included a series of trainings or a seminar that raised awareness, introduced concepts and treatment approaches and established a foundation of knowledge from which to build skills. This type of training was complemented by small group case consultation that allowed service providers to learn advanced concepts and treatment approaches and provided an opportunity for the service provider to discuss their work with families under the supervision of a mental health professional experienced in infant and early mental health. At the same time reflective supervision from a trained supervisor gave the

service provider a deeper understanding of his or her effect on a family and how the family's situation might affect the service provider.

At the systems development level, representatives from mental health in the eight counties became an important presence in local early childhood groups and advisory committees. Their presence promoted the importance of infant and early mental health. Infant and early mental health advisory committees and groups formed specifically with a focus on mental health services for very young children are responsible for the development of collaborations that support training and effective service delivery across agencies. Statewide meetings provided a forum for communication and exchange of experiences and strategies and provided cross county support in building service delivery systems. Although support from IPFMHI for training ended in 2003, the demand for training has remained high. Training programs developed as a result of efforts begun through IPFMHI are available in most of the counties. The *Training Guidelines and Recommended Personnel Competencies* developed by IPFMHI provide a reference for the knowledge and skills needed for mental health providers and other core service providers in delivering infant and early mental health services.

Interagency Collaboration:

Types of Agencies

Interagency collaboration is a natural and ongoing part of the development and success of a mental health program serving very young children and their families. Below is a list of the types of agencies that collaborated with the IPFMHI Team and the key collaborating agencies in each county.

- **Mental Health Providers** including Department of Mental Health (DMH) operated agencies, DMH contracted agencies, private individual providers and private community-based provider agencies for promotion, training and service delivery.
- **Interagency Service Providers** including Early Start, regional centers, early childhood special education, childcare providers, preschools, social services, child protective services, public health and any agency that serves very young children and their families for promotion, program development, training and service coordination.
- **Infant and Early Childhood Interagency Committees and Groups** which may include the service providers listed above as well as policy groups, institutions of higher education and funding sources for the promotion and development of infant family and early mental health services, coordination, policies and training for the provision of services to children birth to 5.
- **Institutions of Higher Education** to promote the infusion of concepts and values and development of course work and certificate programs in infant family and early mental health.
- **Special Funded Projects** included those funded by local First 5, California Endowment and other grants or special projects.

Innovative Collaborations for Outreach, Screening and Referral

The Initiative encouraged and supported each county's development of infant and early mental health service delivery based on the unique strengths and resources of the county.

Collaborations developed and built by each county help to describe a diversity of service delivery models. In each model, training, consultation and ongoing communication is essential to building and maintaining relationships among and between different agencies and service providers involved with very young children and their families. Below is a sample of some of the collaborations developed by counties to ensure effective screening and referral of children 0-5 and their families. For a more complete report on the collaborative activities of the 8 pilot counties see the IPFMHI Phase II Final Report at <http://www.wested.org/cpei/familyresource/phaseIIfinalreport.pdf>.

Alameda County makes a concerted effort through the partnerships with Every Child Counts (ECC) (First 5 Alameda County), Children's Hospital Oakland (CHO) and Alameda Behavioral Health Care Services to train providers of services to young children in promotion and where appropriate preventive intervention services. Interagency providers attend annual interagency trainings and topical trainings provided by ECC. They learn about the importance of young children's social/emotional development and the basics of relationship-based approaches to services. When an agency is identified and is interested in preventive intervention or is working with families at high risk for mental health problems a team from mental health, ECC and possibly CHO meets with the agency to develop a relationship and begin planning and consultation to help the agency gain the awareness, knowledge and skills necessary to be effective in promotion or preventive intervention and the identification of children and their families in need of a referral to mental health treatment services.

ECC provides expert consultants to provide guidance and training. Alameda Behavioral Health Care Services coordinates efforts. CHO may invite the agency to get intensive training by sending a representative to the Infant Mental Health Seminar. Most recently Alameda County began meeting with the peri-natal substance abuse program. Programs that have already received training are the public health home visiting program, teen parenting programs, programs within Social Services and childcare agencies involved in the extensive mental health consultation to childcare program in Alameda County.

Fresno County receives most of its referrals from the court system. The volume of referrals generated as a result of mandatory assessment of all children removed from their homes required that mental health collaborate with Child Welfare and CASA (Court Appointed Special Advocates). Through BASYC (Baseline Assessment and Screening of Young Children), funded by the California Endowment, Fresno County Mental Health provided training for Child Welfare staff and CASA to conduct assessment and screening of very young children who have been removed from their families. The BASYC program identifies children in need of treatment services in a timely manner and prevents backlogs.

Humboldt County is a geographically large rural county. With 26% of the children 0-5 living in poverty they are at high risk for mental health issues. The county's addition of mental health treatment services for children 0-5 and their families has significantly increased the county's capacity to serve children and families, but with only one county clinician, collaboration with other service providers is essential to serving the needs of its families. Public health, social services, early intervention, special education, child care council, Head Start/Early Head Start and United Indian Health Services and county and community mental health providers meet regularly and all work together to coordinate services, share training opportunities and access additional funding through grants and share the funds that are awarded.

Los Angeles County's capacity building efforts have focused on the promotion of infant family and early mental health and the provision of training for mental health provider agencies operated by or contracting with the Los Angeles County Department of Mental Health

(LACDMH). Training supported by the Initiative from 2001-2003 included both topical trainings on infant family and early mental health approaches to treatment and mental health consultation and mentorship for mental health providers in training, pioneer providers. Mentorship and consultation was provided by six centers of excellence identified by the LA County Department of Mental Health as having considerable experience and expertise in serving infants and young children and their families and geographically accessible to various pioneer provider agencies.

The guiding force and source of core participants in training came from the infant family and early mental health advisory group made up of representatives from mental health provider agencies interested in developing services for children age birth to five and their families. It has developed into what is now called the ICARE Network (Infancy Child and Relationship Enhancement). The success of LA County's capacity building efforts are demonstrated by the growth in the number of mental health provider agencies in this group from only a few to 38 who have received training and are now providing services to children birth to five and their families.

The ICARE Network has recently been expanded to include early intervention, early childhood education and childcare providers. Collaboration with these other service providers will facilitate Los Angeles County's plans for 2004-2005 to build capacity to provide mental health consultation to school readiness sites. Initiative funds and a First5 LA County grant will be used in 2004-2005 to provide training in mental health consultation for mental health providers establish relationships with the 42 school readiness sites and conduct focus groups in preparation for involvement in school readiness sites.

Riverside County's Social/Emotional Screening Project—In collaboration with the County Department of Health and funds from First 5 Riverside countywide screening for emotional problems in children 0-5 is conducted in familiar family settings like pediatrician's offices and childcare centers. Screening using the DECA is completed while families wait for related services. Screens are submitted by Internet or fax to a central location for scoring. Results are immediately provided back to the provider who sent the screen so that the outcome can be discussed with the family at the same visit. For all screens that indicate a mental health concern follow-up calls are made to families inviting them for further assessment, treatment and planning. The ongoing collaboration between mental health and the pediatrician's offices and childcare centers opens the doors to needed services for children and families in Riverside County.

San Francisco County enhanced the screening and referral of children and families in San Francisco General Hospital by having a mental health provider from the Infant Parent Program provide consultation to the joint screening and referral meetings and to multi-disciplinary Nursery Rounds. The ongoing consultation provided by a senior psychologist at San Francisco General Hospital has educated other mental health professionals, pediatricians, public health nurses and social workers with the awareness and knowledge needed to assess the service needs of children 0-5 and their families. The success of this consultation activity was evidenced by increased referrals.

Sacramento's Quality Childcare Collaborative participants include 10 major collaborating agencies with Child Action, the local childcare resource and referral agency, as the lead in this First 5 Sacramento funded project. Some of the collaborators are Sacramento County Office of Special Education Infant Development Program (special needs), Department of Mental Health (mental health consultation), Public Health (health consultation), WestEd Program for Infant Toddler Caregivers (training for childcare providers), UC Davis (training on school readiness and leadership development) and California State University Sacramento (provides interns to

childcare and conducts ECERS). The Collaborative provides 4 levels of service including screening within each level for services in the next level:

- Level 1 Information Team: Provides information about community and agency resources, training and education for parents and providers.
- Level 2 Resource Team: More in-depth discussion of a provider's deep concern about staff development, administration or behavior/inclusion concerns about a particular child or group.
- Level 3 Consultation Team: At this level the childcare provider can access consultation services regarding children with special needs, health, mental health or administrative concerns.
- Level 4 Outside Referral: When more intensive services are needed referrals are made for specialized services including mental health treatment service.

Childcare providers, children and families benefit from the variety of services available from this collaborative.

Stanislaus County Leaps and Bounds initiated case management and mental health services to children 0-5 and their families in 2000 just a year before becoming a part of the Initiative. Programs and services have expanded substantially since then. For all three years of the Initiative Leaps and Bounds used their direct funding to pay for three part time parent mentor positions. Parent mentors have a unique role in outreach and support to families in need of or at risk for mental health treatment services. They are paraprofessionals who according to the Program Director, Janette Jameson *"are able to meet and establish positive relationships with families without the "professional" distance of mental health professionals. They are able to engage with families when clinicians are unable to. Families will engage with them about their concerns and needs. They are enthusiastic and want to do more."* Over the past three years they have:

- Promoted infant family and early mental health by increasing access to families of children with special needs.
- Provided community education regarding 0-5 children's developmental needs.
- Implemented a "Fun Friday" for parents of small children.
- Actively assisted families in receiving food, shelter, clothing and other resources and services in other systems.

The parent mentor positions are an important part of the Leaps and Bounds Team and will be sustained with First 5 Stanislaus County funding.

Service Coordination

As part of the Clinical Services Study, which evaluated the effectiveness of relationship-based treatment provided as part of the Initiative, clinicians documented the services that children and families were receiving at intake and again at discharge. They also provided an assessment of the level of collaboration they engaged in with each of the service providers the family was involved with. Table 12 summarizes the service coordination for 91 families and involvement with 29 different types of agencies or services. Highlights of the findings are below:

- The number of service providers involved with each family ranged from 0 to a high of 11 with an average of 3.9 service providers per child and family.

- At intake the largest percentage of families were receiving services from physicians (42%), followed by Child Protective Services (33%), child care providers (30%) and other mental health intervention services from the county (24%).
- Emergency Food Assistance was added as a service for the greatest percentage of children and their families increasing from 0 to 14% from intake to discharge.
- Involvement with early intervention and early childhood education all showed increases from intake to discharge including increases from 13% of the families to 21% for Regional Center services, from 13% of families to 20% for preschool, special education from 12% of families to 17% and Early Start from 2% to 6%.
- Decreases in service provider involvement from intake to discharge were shown for health service providers including a decrease in the percentage of families involved with physicians from 42% to 30% and public health nurses from 12% to 3%.
- Family involvement by Child Protective Services also showed a large decrease from 33% of families at intake to 24% at discharge.
- The greatest percentages of service providers with a moderate or high level of involvement with mental health providers were other mental health intervention services (16%), Child Protective Services (16%), child care providers (15%), special education (14%) and Head Start/Early Head Start (11%).

These findings provide evidence of the importance of service coordination as part of services delivered to families in need of mental health treatment services. With an array of 29 different services that families may be in need of or using while in treatment and an average of about 4 agencies or services per family, the importance of service coordination is clear from the outset. Those service providers most often involved with families at intake include agencies which may be the referral source such as Child Protective Services or other mental health intervention services and service providers that have information about the child and family that will help the mental health provider accurately assess the needs of the child and family such as the physician and child care providers.

The increase in involvement with early intervention and early childhood education services from intake to discharge indicates that the mental health provider has a critical role in assessing special needs and helping families to access the additional services that their child may need.

The highest levels of collaboration were identified for those service providers that spend the most time with the child such as child care providers and special education or those that have provide the most intense support, such as Child Protective Services. Ongoing communication and consultation between the mental health provider and other service providers facilitates relationship-based interventions within the context of the child's natural environment.

Impact and Evaluation Findings

Evaluation was one of the major goals of the Initiative and provided the impetus for developing tools and procedures for both ongoing and overall evaluation of activities and outcomes. Ongoing evaluation and data collection served to document accomplishments and track changes and provided a bank of information to determine the immediate and longer-term impact of the varied Initiative activities on individuals, agencies and communities. An impact evaluation was conducted at the end of the project period. The following tools were developed for this purpose:

A Participant Profile to identify the experience, attitudes, knowledge and skills of IFPMHI participants. The profiles were also used to collect information on providers and

agencies with training and experience in infant-family and early mental health concepts, practices and intervention and treatment services for children younger than 5 years of age and their families.

The Training/Activity Evaluation Form to evaluate the training, consultation or technical assistance provided in counties and at the state levels. A standard form was developed and adapted for use in various activities to assess how well the training accomplished its goals and its relevance to the participant's daily work.

The IPFMHI Impact Survey a web-based survey was developed and connected to the information obtained in the Participant Profiles. Participants who provided e-mail addresses were contacted in the last month of the Initiative and asked to complete this online survey, which provided both quantitative and qualitative data on the impact of the Initiative on individuals, agencies and communities.

Findings from all three evaluation and documentation sources suggest that:

- The Initiative was successful in targeting mental health professionals and agencies for training and technical assistance while maintaining a focus on interagency and interdisciplinary collaboration.
- Ongoing training, consultation and reflective supervision continue to be needed to build professional skills and expertise in this emerging field.
- Information and technical assistance is needed to identify new resources and strategies for effective billing and funding of services, training activities and reflective supervision for mental health and other early intervention, childhood development and family support professionals.

Detailed findings from each of the IPFMHI evaluation tools may be found in the Impact and Evaluation Findings Report on the WestEd website
<http://www.wested.org/cpei/familyresource/impacteval.pdf> .

IPFMHI Lessons Learned

Introduction

The lessons learned from the experiences and accomplishments of the IPFMH provide important information for the development of mental health service systems. The SNP was conceived with the intention that the continuum of infant and early mental health services, promotion, preventive intervention and mental health treatment services would be an integral part of the services offered to enhance and expand the services of the School Readiness sites. These are often the services needed by that targeted group of kids who have special needs but who are not identified until problems develop in school. The SNP Demonstration Sites are in a unique position to carry on the pioneering work of the IPFMHI Counties. To help in that endeavor, IPFMHI has reviewed the experiences of the Initiative and developed a set of “lessons learned” with a particular focus on mental health service delivery system development. These lessons learned by IPFMHI may provide ideas for the SNP that will help sharpen the focus of School Readiness sites toward the social/emotional needs of very young children and further develop the continuum of mental health services in the SNP and in the county. The following is the list of topic areas that describe the IPFMHI lessons learned:

1. Leadership
2. Collaboration
3. Professional Development
4. Outreach and Referral
5. Screening and Assessment
6. Billing and Funding
7. Service Delivery
8. Evaluation

Each of the *Lessons Learned* topic areas are followed by “Key Questions for the SNP” (or other programs which serve young children) to help the SNP Demonstration Sites and other programs reflect on how they might adopt the lessons learned and apply them to development of infant and early mental health services at their site.

1. Leadership

- A leader with commitment and vision is a necessity. The most successful IPFMHI counties created positions dedicated to infant and early mental health, such as infant and early mental health coordinators or program directors. An effective leader has a big picture view of the entire project and is actively engaged in planning, identifying needs and integrating services into all agencies involved with children.
- Programs that thrive have an administration that fully supports and provides resources for development of services. The administrative support needed includes: a location for services, adequate resources such as staff, materials and equipment, healthy relationships with other agencies and funding sources, plans for growth in the future and responsiveness to the needs of growing services. Counties with administrative support grew dramatically.

- Building on strengths helps to ensure success by identifying local needs, interests, expertise and local experience and training. This is an effective strategy for all areas of program and training development. The identification of local resources and interests can serve as a catalyst for collaborations that may provide new funding sources, training opportunities and service delivery options.
- Key Questions for the SNP (or other programs which serve young children)
 - ☞ *Who will provide leadership for the identification and development of the continuum of infant and early mental services?*
 - ☞ *How does the SNP support the development and delivery of infant and early mental health services?*
 - ☞ *What services are available through the SNP to provide promotion, preventive intervention and treatment? How could those services be enhanced? What local resources are available to build on?*

2. Collaboration

- Building and maintaining relationships between mental health providers and other family service providers is necessary for mutual understanding of services to effectively meet the needs of families. Ongoing regularly scheduled meetings are needed to support relationships and communication and provide an opportunity for informal consultation.
- Participation by mental health providers on interagency committees provides a natural opportunity for promotion of infant and early mental health services and training.
- Memorandums of Understanding (MOUs) for ongoing services facilitates clarification of roles and commitment to services and ensures mutual understanding and cooperation between mental health providers and other service providers.
- Collaborative interagency training promotes shared knowledge and skills related to social/emotional concepts and relationship-based approaches to services.
- Complementing instead of competing for services with other agencies facilitates collaboration and better serves the needs of families.
- Flexibility helps in building working relationships with different groups and agencies. Thoughtful exploration of the strengths and needs of collaborators will yield more productive efforts toward shared goals. Negotiation is part of success in any relationship.
- Key Questions for the SNP
 - ☞ *How are representatives from mental health involved in the SNP? Are they part of the Leadership Team? Do they attend interagency meetings?*
 - ☞ *Do you have an MOU for mental health consulting or treatment services?*
 - ☞ *Have all service providers who work with families received training so that they understand social/emotional development and the services available through the SNP to support it?*
 - ☞ *How is the SNP working with other agencies or groups to complement their services?*

3. Professional Development

- Training in promotion and preventive intervention is needed for all service providers who work with families. Everyone who works with families has an opportunity to promote the social and emotional development of children and may either engage in or be aware of preventive intervention strategies.
- Ongoing professional development opportunities are needed for mental health treatment providers. Infant-family and early mental health treatment approaches are being researched, evaluated and refined in this rapidly growing and changing field. Training and supervision in effective treatment approaches for very young children is an ongoing need for all service providers.
- Ongoing support and supervision and opportunities to discuss work with families is needed for all service providers. Sharing information about experiences with families can help to refine and adjust service delivery processes and approaches and provide support to service providers.
- Use of reflective supervision facilitates learning especially for new service providers. Reflective supervision can help service providers understand their relationship with a family and the affect the family may have on the service provider.
- Development of local resources for training ensures availability of training and is most effective for the expansion and sustainability of services.
- Mental health consultation services can provide ongoing training for development of skills in working with families and supporting relationships. Consultation is a cost effective way to support service providers in their efforts at preventive intervention.
- Opportunities to network with others involved in the same type of work with families inspire new ideas and provides mutual support. Statewide and local meetings and conferences benefit administrators as well as direct service providers.
- The Training Guidelines and Recommended Personnel Competencies developed by IPFMHI is a reference in determining education, training and experience needed for qualified core and mental health service providers.
- Key Questions for SNPs
 - ☞ *What resources are available for training in social/emotional development and relationship-based approaches to services?*
 - ☞ *What kind of training and experience do service providers already have and what additional training is needed to ensure their skills in promotion, preventive intervention and treatment?*
 - ☞ *What opportunities for support and ongoing supervision are you providing to screeners? Is your mental health partner available for consultation to the screeners and to other programs in the SNP Demonstration Site?*

4. Outreach and Referral

- The development of relationships with mental health provider agencies and ongoing opportunities for communication are needed for all agencies and service providers involved in identifying children and families in need of services.

- A thorough knowledge and understanding of the resources and services available to children and families and the eligibility and referral processes for each service provider is necessary for effective outreach and referral.
- Training and ongoing supervision in promotion and preventive intervention strategies and best practices for working with families is needed for all service providers involved in outreach and referral to work effectively with families.
- Regular consultation with mental health providers serves as a source of information and support to outreach and referral providers.
- Key questions for the SNPs:
 - ☞ *Do the service providers in the SNP involved in outreach and referral collaborate and consult with mental health providers?*
 - ☞ *Have service providers involved in outreach and referral received training in promotion and preventive intervention strategies and received ongoing supervision in best practices for working with families?*

5. Screening and Assessment

- Screening and/or assessment is intervention. It is an opportunity for promotion of the importance of social emotional development and preventive intervention as the service provider establishes a supportive relationship with the family and works with the family to determine the need for services and appropriate referrals.
- Results of screening and assessment provide information for referrals and to inform treatment. They can provide a common language for the discussion of such things as risk factors, diagnosis, child development, description of the parent child relationship, child behaviors and parenting stress.
- Assessment measures provide objective criteria for decision making and can be used as outcome measures.
- Agencies that provide screening need training to assure understanding of potential services and eligibility.
- Key questions for SNPs
 - ☞ *Have screeners been trained to provide promotion and preventive intervention services?*
 - ☞ *Are screeners familiar with all services available to families in the SNP and school readiness community?*
 - ☞ *How is the information gathered at screening and discussed by the child study team communicated to service providers for use in guiding treatment?*

6. Billing and Funding

- Early Periodic Screening Diagnosis and Treatment (EPSDT) is the most cost effective funding source for mental health treatment services for children 0-5 and their families.
- Collaborations with local First 5 CCFC provide funding of indirect services and mental health consultation services to childcare and preschools.

- Collaborations with other agencies to fund treatment programs that benefit families across agencies are effective in meeting the needs of families and are also cost effective.
- The IPFMHI Report, Financing Strategies for Early Mental Health Services, found on the SNP website is a resource for more detailed information on funding mental health services
- Key Questions for SNPs
 - *In what ways are mental health services funded for the SNP?*
 - *Is EPSDT used to fund mental health treatment services?*
 - *How is local First 5 supporting early mental health services?*

7. Service Delivery

- Effective service delivery includes the continuum of promotion, preventive intervention and treatment services.
 - Promotion includes:
 - The provision of information about social-emotional development in the context of care giving relationships to all parents, health care providers, childcare providers, etc. as part of the child find and public awareness efforts;
 - The creation of caring environments that strengthen the social and emotional development of young children;
 - Addressing social and emotional development issues in early intervention, childcare, preschool and Healthy Start environments and include activities that proactively address social and emotional developmental issues.
 - Preventive Intervention includes:
 - Screening and assessing social and emotional development as part of the early identification process;
 - Working with mental health providers when there is a concern about maternal depression, parental substance abuse and other family mental health disorders;
 - Assisting parent/caregivers to respond sensitively to the cues that the child gives;
 - Supporting families as they increase their coping skills and build resilience in their children.
 - Treatment includes:
 - Identification and referral young children who would benefit from family-centered community mental health services and supports.
 - Ongoing collaboration between mental health professionals and other service providers involved with the family
- The social and emotional needs of families can be served by an array of different service providers. Parent mentors, case managers, home visitors, social workers, mental health therapists, psychiatrists, physical therapists, occupational therapists, speech and language

therapists, childcare workers, teachers and pediatricians are among the many potential service providers. Services are most effective when delivered by the service provider appropriate to the needs and priorities of the family.

- Relationship-based approach to services focuses on the importance of parent child interaction. Listening to families to help them identify, clarify and address issues that may be affecting the developing relationship with their child is key to this approach.
- Parallel process can effectively model supportive health relationships from administration down to the parents or caregivers and children. Administration provides positive support and has a healthy relationship with staff; staff provides positive support and has a healthy relationship with parents; parents in turn provide positive support and have a health relationship with their children.
- Family focused services support the family in supporting their child and are responsive to the needs and involvement of all members of the family.
- Strength based services promote and affirm assets in the child and family and in early care and education programs.
- Socioculturally competent services acknowledge and addresses diversity among children, teachers, families and mental health providers.
- Evidence-based and promising practices have proven positive outcomes for children and families in mental health treatment services.
- Mental health consultation services are a cost effective way to support and train staff in promotion and preventive intervention services.
- Key Questions for SNPs
 - *How is the SNP providing promotion, preventive intervention and treatment services?*
 - *How is the SNP focusing on relationships between parents and children and caregivers and children?*
 - *Are mental health providers in your community using evidence-based and promising practices?*

8. Evaluation:

- Documentation and evaluation incorporated into ongoing processes helps to track progress record accomplishments, reflections and suggestions for improvement.
- Sharing results of evaluation with all staff promotes teambuilding and gives everyone an opportunity to share in success and learn from experience.
- Results of evaluation provide opportunities to refine processes, celebrate successes and learn from outcomes.
- Key Questions for SNPs
 - *What is the SNP doing locally for evaluation?*

Conclusions and Recommendations

Mental health services to children aged birth to five have changed dramatically over the past four years in the eight IPFMH pilot counties. The Initiative's approach to building capacity to provide infant family and early mental health services based on the individual strengths and resources of each county has proven to be extremely successful. All eight counties built integrated programs of service delivery that can serve as unique models for other programs and counties that are developing their own capacity to provide the continuum of promotion, preventive intervention and treatment services for children, birth to 5, and their families. County mental health consultation and School Readiness efforts demonstrate the diversity of effective approaches that support and facilitate the social and emotional development of very young children. Infrastructure appropriate to each county has been established to inform and fund treatment services through effective screening and assessment measures and reliable funding mechanisms. Training programs developed under the Initiative and other training opportunities continue to be available in each county. County mental health has become an important presence on local interagency early childhood committees and meetings. The work of the Initiative as implemented by the eight pilot counties provides evidence of the commitment to and the long-term sustainability of relationship-based mental health treatment services for very young children and their families in public mental health settings.(watch tense throughout paragraph)

The *Lessons Learned* from IPFMHI provide a platform of ideas that may be helpful to the development of mental health services in any community. With encouragement and support from First 5 and the Coordination and Training Team, SNP Demonstration Sites and other programs that serve young children are in the unique position to take advantage of IPFMHI experience and apply it their Demonstration Sites. SNP Leadership Teams can use this information to:

- Reinforce the efforts in development of the continuum of mental health services that have already been implemented
- Reflect on ways that efforts could be enhanced in accord with the *Lessons Learned*
- Identify potential areas of need that may require further training
- Further explore mental health resources within the SNP and in your community that might be available for consultation or training
- Identify one or two areas from *Lessons Learned* for the creation, expansion or enhancement of services that meet the social-emotional needs of children and families.
- Move forward to develop these areas and further the infant and early mental health movement in California!

Healthy social and emotional development of children is the foundation for school readiness and success and well-being in life. The accomplishments and lessons learned from IPFMHI serve as an important resource to the field for the continued development of effective services, programs and delivery systems that support the relationships between children and their parents and caregivers and promote healthy social and emotional development.

Appendix A: Table - Case Studies: Family Stories Explain Relationship-Based Approaches to Intervention

Case Studies: Family Stories Explain Relationship-Based Approaches to Intervention

Case Study Title, Origin and Authors	Mental Health Providers	Approaches to Intervention	Summary of Key Features
<p>The Brain Connection: Armed with new research on developing brain structure, social workers can help fix troubled baby/parent relationships <i>San Francisco Chronicle November 14, 2004 by Rob Waters</i></p>	<ul style="list-style-type: none"> • Children’s Hospital of Oakland • UCSF Infant Parent Program 	<ul style="list-style-type: none"> • Infant Parent Psychotherapy • Infant Message • Nurse Home Visits to Newborns 	<p>Several infant parent relationship interventions are woven with a brief history of infant mental health and results of research that has prompted the growth of new programs that focus on the mental health needs of very young children and their families.</p>
<p>Infant Parent Program/Daycare Consultants: A System of Care in Itself <i>Georgetown Institute, System of Care Conference, June 2004</i> <i>Judy Pekarsky, Miriam Silverman, and Adriana Taranta</i></p>	<ul style="list-style-type: none"> • UCSF Infant Parent Program • UCSF Day Care Consultants 	<ul style="list-style-type: none"> • Infant Parent Psychotherapy • Mental Health Consultation to Childcare/Preschool 	<p>A story of continuity of care for a toddler and his adoptive mother through preschool and transition to kindergarten demonstrates collaboration, access to other services, intervention and support for the child and family, support for preschool staff and support for school readiness.</p>
<p>“Out of My Head”: A Personal History Bag <i>Georgetown Institute, System of Care Conference, Poster Presentation, June 2004</i> <i>Emma Girard Ph.D.</i></p>	<ul style="list-style-type: none"> • Riverside County 0-5 Preschool Program 	<ul style="list-style-type: none"> • Intervention technique for young children with Post Traumatic Stress Syndrome 	<p>A successful intervention with a severely abused and traumatized four year old boy in his 7th foster placement ends in adoption.</p>
<p>Play Therapy with Preschoolers using the Ecosystemic Model <i>Used with author’s permission from Ammen, S.A., Limberg, B. (2005). Chapter from K. Finello (Ed.), <u>Handbook of Training & Practice in Infant & Preschool Mental Health</u>. New York: Jossey Bass</i></p>	<ul style="list-style-type: none"> • River Oak Center for Children, Building Blocks Program, Sacramento 	<ul style="list-style-type: none"> • Ecosystemic Play Therapy 	<p>Composite case study of an intervention using the Ecosystemic Model for a preschooler being raised by his grandmother demonstrates the intake/assessment, treatment planning and process and ending treatment.</p>

Appendix B: List of IPFMHI Reports and Web links

List of IPFMHI Reports and Web links

Special Needs Project website including CIMH reports on screening tools, financing strategies, and screening and referral capacity and this report, IPFMHI Accomplishments and Lessons Learned <http://www.First5CAspecialneeds.org/>

WestEd IPFMHI Reports

<http://www.wested.org/cs/cpei/print/docs/215>

1. Building Capacity to Provide Infant-Family and Early Mental Health Services: Training, Technical Assistance, Consultation and Supervision Models.

<http://www.wested.org/cpei/familyresource/buildingcapacity.pdf>

2. The Delivery of Infant-Family and Early Mental Health Services: Training Guidelines and Recommended Personnel Competencies.

<http://www.wested.org/cpei/familyresource/personnelcomp.pdf>

3. Impact & Evaluation Findings: Training Activities and Changes in Providers and Communities.

<http://www.wested.org/cpei/familyresource/impacteval.pdf>

4. The Clinical Services Study Executive Summary: Development, Implementation, and Preliminary Findings (Contact 916/492-4011 for a copy of the full report.)

<http://www.wested.org/cpei/familyresource/cssexecsumm.pdf>

5. IPFMHI Phase II Final Report: Consolidation and Sustainability: The Status of Infant Family and Early Mental Health Services in IPFMHI Pilot Counties.

<http://www.wested.org/cpei/familyresource/phaseIIfinalreport.pdf>

6. Compendium of Best Practices/Literature Review

Introduction

<http://www.wested.org/cpei/familyresource/intro.pdf>

Reference and Practice

<http://www.wested.org/cpei/familyresource/refdomainevidencebased.pdf>

Reference and Domain

<http://www.wested.org/cpei/familyresource/refdomainsocemot.pdf>

Evidence Based Practices

<http://www.wested.org/cpei/familyresource/evidencebasedpractices.pdf>

Emerging Practices

<http://www.wested.org/cpei/familyresource/emergingpractices.pdf>

Promising Practices

<http://www.wested.org/cpei/familyresource/promisingpractices.pdf>

Other Practices

<http://www.wested.org/cpei/familyresource/otherpractices.pdf>

Early Intervention/Early Childhood Websites

<http://www.wested.org/cpei/familyresource/websites.pdf>

7. "Evolving Perspectives in Infant-Family Mental Health and Reflective Supervision: A Collection of Published and Unpublished Articles," is available from WestEd. Please call 916/492-4011 to order a copy.

Appendix C: Sample Materials Developed by the Counties

1. Riverside County's Infant Preschool-Family Mental Health Initiative Consultation Model and Sample Memorandum of Understanding
2. Alameda County's Standards of Practice for Mental Health Services in Partnership with Early Care and Education in Alameda County

**Infant-Preschool-Family Mental Health Initiative
Consultation Model**
and
**Sample Interagency Agreement
(Memorandum of Understanding)**

Riverside County, Department of Mental Health
Children's Services/Preschool 0-5 Program

Introduction

This initiative is to support a formalized consultation model in which Riverside County, Department of Mental Health staff are assigned to center based childcare/ preschool centers to provide access to screening; assessment; treatment for children and family; case managed referrals; relationship based and reflective child development information. This effort is focused on early childhood social-emotional development through supportive family relationships; parent support; and joint mental health/child care / preschool staff development efforts. The model is supported by the California State Department of Mental Health's "Infant-Preschool Family Mental Health Initiative" in collaboration with the WestEd Center for Prevention and Early Intervention and funded by a California Children and Families Commission (Prop 10) grant.

This project integrates mental health or social-emotional services through what may be called "Family Counselors" (FC) "Classroom Consultants" or "Behavioral Specialists" depending on the center's preferences and sense of what their families will accept. These staff are licensed or license eligible masters level therapist with related experience of working with young children. All consultation services are provided under an experienced departmental licensed clinical supervisor.

Consultation Tracks

Although services through the project are available to children and families in each center, the method by which families access mental health services through the Family Counselor/ Classroom Consultant/Behavioral Specialist (FC) is dependent on how the facility's administrative and childcare staff want those services presented. That is, the primary working relationship is between the FC and administrative and childcare staff. Families start to work with the FC through an established team approach where facility staff makes the link to mental health services. This structure is intended to recognize: (1) the overall responsibility the childcare facility carries for the safety and welfare of the families that participate in center's programs; (2) that the primary relationship needs to continue to reside with primary service providers – in this case the facility administration and classroom teachers; and (3) that the least invasive interventions occur when understanding a child's struggle is viewed first from an environmental and relationship based perspective. The FC, at the request of facility staff, will help teachers develop generalized approaches to one child's struggles. Classroom interventions will be used when one child's behaviors represent a broad range of typical developmental challenges that the teacher recognizes episodically surfaces in the classroom independent of a specific child's behaviors. The benefits of meeting these challenges can then be generalize to other children in the classroom. When generalized classroom interventions fail to help individual children, then arrangements may be made to offer individualized help through the child's parent/caregiver.

There are two basic consultation services tracks: (1) consultation to the classroom and (2) consultation directly with families.

1. In this first service phase, the primary focus of the work is for the consultant to get to know the classroom setting (general tasks and goals of the program, and what the teacher and families want to accomplish). Once the facility staff are confident the consultant understands the setting, then the general classroom make-up can be reviewed to gauge the overall temperament of the environment. From this baseline, the consultant and facility staff can then look at ways to expand on observed successes within the classroom given current circumstances and situations. These may include a discussion of approaches from a teacher's and consultant's joint observations. Joint observations are useful to identify behavioral patterns or clusters related to room set-up, general activity levels, specific stimulation (noise, lights, activity patterns, room décor) teacher attention to child activities, general cues that are antecedents to problem behaviors, child-to-child interactions, child isolation, caregiver/child separation patterns, and scheduling classroom activities that support age-appropriate opportunities for children to develop self-regulation and social competency skills.
2. Following the work provided in the classroom with facility staff, some families may be invited to consider additional services. For some children, additional support outside of the classroom may be beneficial. If both the facility staff and consultant agree, then families may be approached and offered additional services provided by the consultant. These services may be provided on-site, in the caregiver's home, or in other natural or clinical settings depending on the family's preference and availability of resources in the childcare center.

Consultation Process

The consultation process may be initiated in a number of ways depending on the protocol the facility wants and that will fit their onsite programs. The consultant will take requests from any of the sources listed in a way that is prescribed by the facility per MOU:

- Facility Director(s)
- Program Directors(s)
- Master Teachers
- Classroom Teachers
- Classroom Aides

Because the initial requests for consultation is facility based, only staff referrals are accepted to begin the process. Parent self-referrals may be accepted, but only after consultation with those staff who would usually make initial facility requests. If a parent approaches a FC for help related to their child's experience in the facility, then the first preference is for the parent to know about and then use the center's process for a consultation request. If the parent's request is related to personal issues unrelated to their child's experience in the facility, then the consultant could encourage the parent to consider a self-referral to Preschool 0-5 Programs. Under most circumstances, however, a referral to the FC for consultation will originate with facility staff. Below is a list of potential roles the consultant may take in their work with facility staff toward a common goal of supporting families and their children in ways that promote healthy social-emotional relationships:

1. Participate with early childhood staff to observe and understand positive as well as problematic child behaviors: joint observations.

2. Team with facility staff (administrative, program or classroom) to design classroom interventions to promote emotional strengths and strong early relationships, including mutual social-skills competencies.
3. Share information about the importance of early relationship for infants, children and their families as well as implications for future interpersonal relationships related to general early childhood and brain development concepts.
4. Jointly increase staff skills (teacher's and Family Counselor's) to work with children with challenging behaviors or atypical emotional development.
5. Collaborate with staff to work effectively with families, individually or through parent support groups: parent support groups could be lead by Preschool 0-5 's Parent Partner at the childcare facility or off-site.
6. Help staff to identify when children and families need specialized mental health services.
7. Work with staff to identify and address cultural issues as these impact a child's healthy emotional development and general well being.
8. Provides access to social-emotional screening to help identify both strengths and areas of concern that a program director, classroom staff or families request help to understand and plan for.

One primary concept in consultation is called "**Parallel Process**". This idea recognizes that modeling behaviors is unavoidable, and happens not just within families but also at every level of work that involves families with young children. That is, if we want parents to recognize the powerful influence that positive interaction has when they live, learn and play with their children, then a consultant must be prepared and skilled in constructive and positive work with facility staff that builds on their inherent strength. Parallel processes then becomes a template for the work the consultant and staff engage in, and it becomes a model that is compatible for direct work with families that both the consultant and facility staff use as a common approach.

During joint observations with facility staff, a strong focus is on continually identifying what works well with specific children in various situations that the teacher has set-up for the child. Once a baseline of constructive behaviors is identified along with the antecedents of success for the child, then "**Reflective Consultation**" is used. This is a process where together the classroom teacher and FC "wonder out loud" about how other related interventions could be developed from the baseline of constructive behaviors. These plans can then be used for when a child struggles with adjusting to new activities, getting along with peers, or mastering age appropriate developmental tasks.

Building on success thorough thoughtful and purposeful consideration of what works best for individual children, their families and caregivers in natural environments is the foundation of "**Relationship Based Intervention**". Relationship based intervention is the simple acknowledgement that genuine efforts to understand (relate to) the meaning of a child's behavioral, cognitive, social-emotional states is central to working with a 0-5 population. Understanding a family's beliefs about the meaning of their child's behaviors is a primary source to comprehending, valuing, supporting and overcoming developmental struggles: helping the child and their family achieve positive outcomes.

It is not possible to accurately understand (Reflect on) a child's purposeful and positive responses or to generalize a child's strengths to broadening areas of her development without working consistently through the various relationships that are present in a child's environments (Parallel Process).

Consultation Features

Consultation may occur in any combination of the activities above. Facility staff involved may be directors, program managers, and teachers, and consultation may take place during staff meetings, in the classroom, directly with families or occasionally by phone. The availability of the Family Counselor may be part of family orientation to the facility's programs or may be identified only as needed when facility staff request a family is introduced to available consultation services.

An MOU template (attached) is modified with each facility to set up a schedule of work the consultant will follow while on-site. Work schedules include any check-in and follow-up procedures the facility requires or prefers along with the facility staff that has been identified for this process. The check-in is an opportunity to plan, provide updates from previous weeks, review a schedule of classrooms to visit, or to calendar facility staff who want to see the consultant for the current week.

If as a result of the consultation process, both the FC and facility staff agree a specific family's child would accept more individualized help than is possible in a classroom setting only, then the parents will be approached. Generally the facility staff introduce the idea of getting additional help, and then join the parents in a brief meeting with the FC who will offer additional social-emotional assessments or other related services. Additional assessments are always voluntary, and never a condition to receiving other helpful services nor should they be the basis for continued enrollment in the childcare/preschool center. Offers for a comprehensive assessment are made using the following principles to guide work with families:

1. **Family Centered:** In this view families are seen as experts on their children who make valuable contributions to developing plans and options, and who control any helping process on their child's behalf.
2. **Strength Based:** From this perspective there is a concerted effort to identify what children and their parents do well in their mutual relationships, and then to build on these competencies to support future change once options are considered. The fundamental concept is that families want the best for their children and that there are many routes to planning and achieving good outcomes.
3. **Natural Environments:** These include the family's home, within their pediatrician's office, in preschool and childcare settings. Selecting one environment depends only on what parents/caregiver believe provides the best surroundings in which to observe and work with their children.

Comprehensive Social-emotional Assessments:

Again, these services should be offered only as a team decision that comes from the work the consultant and facility staff have engaged in to accommodate a child in the classroom or other facility environments. The significant factors that should proceed approaching a family for additional help are:

1. A team decision that has the mutual support of facility staff and the consultant.

2. That services offered are voluntary and not a condition to other services including continued enrollment in the center.
3. There has been a joint identification of family strengths that both the consultant and facility staff will rely on as their primary intervention with the parents and child.
4. Whenever possible, the principles of Inclusion should guide this work so that “pull-out” services are avoided as appropriate.

In most cases, individual services will be started by integrating the results of a social-emotional screen during an intake process as a pre and post-test for those families who accept further services. The screen will identify social-emotional issues that meet a threshold for further assessment as well the strengths and protective factors the family can build on. The same screen will then be re-administered at discharge from the program or after each 6 months of services. Individual family services *may include any one or a combination of the following*:

- Screening – reviewing the results of a screen the family completes. An initial screen (provided by the consultant) may be offered to a family through the childcare and development staff with follow-up from mental health OR mental health staff may meet with family to complete a screen and then review the results with parents/caregivers.
- Assessment – meeting with family to ascertain/organize/present strength based information as a primary intervention to address issues identified from the initial screen.
- Care Plans – Family meetings in which consistent responses to childcare concerns are mutually developed and agreed to by all caregivers. Once a plan is developed in this process, then – with the family’s agreement – it is reviewed with facility staff for its fit with a classroom environment.
- One-to-One – individual sessions with family members to help with relationships and situations that impact a child’s healthy social-emotional development.
- Referrals – to other mental health/health services, Early Start, or educational services referrals may be offered to families with case management support to ensure the family receives the services most helpful to them.

Outcomes

1. For those children who receive only classroom consultation, the facility staff will be asked to complete the following on each service provided:
 - a. Participant Profile (once per year and provides basic information about staff education, training, experience and interest)
 - b. Activity Evaluation (evaluates the success of consultation activities)
 - c. A DECA screen (Devereux Early Childhood Screen: provides a teacher’s impressions about the child’s development.
2. Families who accept additional social-emotional assessment will be asked to complete the following measures:
 - a. ASQ: Ages and Stages Questionnaire

- b. DECA
- c. BABES: Behavioral Assessment of Baby's Emotional and Social Styles
- d. PSI: Parent Stresses Inventory
- e. Fresno County Resource and Support Scale
- f. MHST: Mental Health Screening Tool (with supplement)
- g. Parent Satisfaction Questionnaire

The center's staff and families will be asked to complete these various measures as a part of the State's efforts to develop effective infant mental health programs; these are voluntary, but there is a strong preference to gather information on this local effort for program improvement and expansion.

Interagency Agreement: Draft/Temporary Memorandum of Understanding,

Riverside County, Department of Mental Health (RCDMH), Children's
Services:

PRESCHOOL 0-5 PROGRAM

AND

This agreement is between Preschool 0-5 Program's Infant-Preschool Family Mental Health Initiative (IPFMHI) and _____, for the period of September 200_ to June 200_.

Purpose:

The purpose of the Agreement is to define working procedures, and interagency roles and functions between the Preschool 0-5 Programs and _____ for *on-site* mental health/social-emotional consultation services. (For additional program detail, please see "Consultation Model" attached)

It is the intent of this Agreement to:

1. Define services to be provided by each agency.
2. Document interagency common goals to provide family centered, strength-based services in natural environments wherever possible, effective, and as will be accepted by the child's family.
3. Ensures that each agency cooperatively maintain regular communication and shared leadership for the effective use of available resources for the benefit of each child and family served by this agreement.

Consultation Services:

1. A licensed or licensed eligible mental health clinician will be regularly assigned to provide 4(four) hours every two weeks of on-site consultation to participating centers: referred to as the "Preschool Consultant".
2. Services provided by this agreement and participating staff will reflect the principles of:
 - a. Family Centered Services.
 - b. Strength-based screening, assessments, interventions, and evaluations.
 - c. Relationship-based Services in which the process of working with interagency partners, families and children has primacy.
 - d. Services provided in Natural Environments following Inclusion Practices.
3. Consultation services may include the following:
 - a. Class room observations;
 - b. Helping early childhood staff observe and understand problem behaviors;

- c. Developing classroom interventions that support healthy social- emotional development, improve child/caregiver relationships and build age-appropriate social skills;
 - d. Providing a focus on the importance of early relationships for children;
 - e. Providing joint staff development for dealing with challenging behaviors and problematic emotional development;
 - f. Helping to effectively work with families;
 - g. Identifying when specialized mental health services are needed or required (may include mandated reporting obligations);
 - h. Developing responses to cultural issue and domestic violence;
 - i. Promoting strength based and family centered approaches with parent-professional partnerships.
4. Community Awareness, Forums, and Outreach
- a. The Preschool Consultant will be available to provide community awareness activities on a bi-monthly basis; such efforts can include a presentation to parents (center-based parent group, foster parents, or parents from other child care services), open-house activities in which social/emotional information can be distributed or presented or brief presentation to community groups that support child development services.
 - b. Outreach activities may include inviting other local childcare service providers to observe consultation services described in this agreement.

Provider Site Commitments:

1. Provider sites participate through:
 - a. Providing a working area for the Preschool consultant as possible that maximizes confidential meetings with parents.
 - b. Willing to support and train center-based staff about confidentiality with assistance from the Preschool Consultant.
 - c. Willing to provide regular access to program staff for consultation activities with the Preschool Consultant.
 - d. Willing to provide/offer childcare services for bi-monthly community awareness forums and outreach activities as can be arranged with available resources.
2. Principles for classroom consultation activities;
 - a. Classroom teachers have the lead role for in-class consultation activities following as much as possible "Inclusion Principles" as appropriate (In-class intervention vs. "Pull-out" services).
 - b. Regular preparation before consultation occurs is desirable and should be preceded by a mutually agreeable plan between the consultant and the center's administrative and teaching staff.
 - c. Debriefing time for each consultation to consider the following:
 - i. Evaluation of plan and outcomes
 - ii. Review of role definitions and functions of team interventions
 - iii. Planning/follow-up
 - iv. Planning with/for parent involvement
 - v. Consultation as needed or requested with Parent Liaison, Center Director, and/or Mental Health Supervisor
3. Provider Sites will aid efforts to collect program outcome data from participating families and center-based staff for the "Clinical Services Study" (CSS) by:

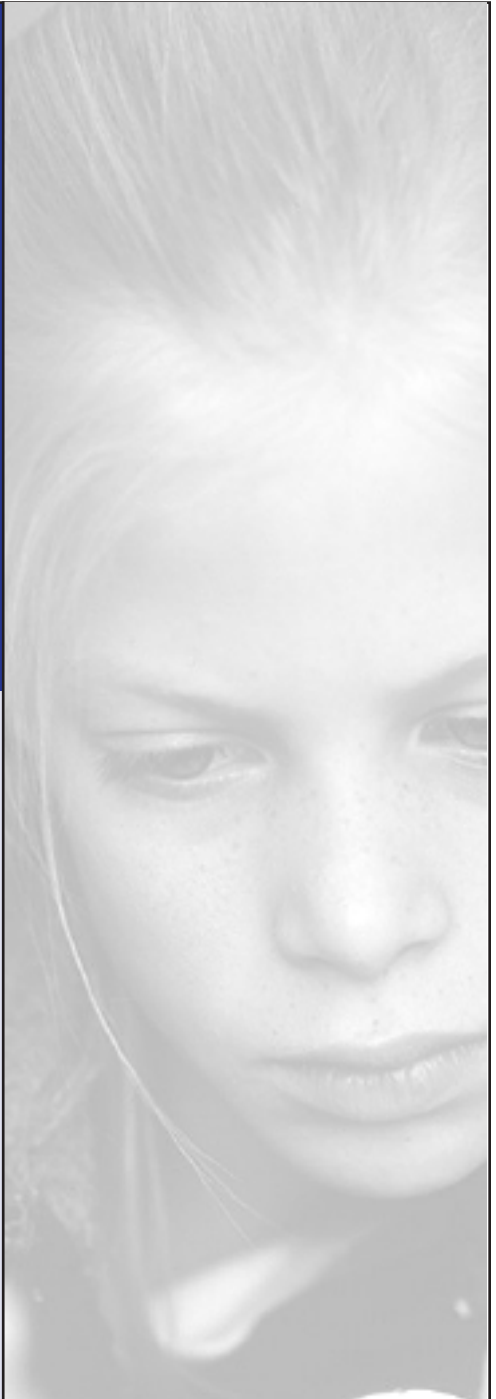


Conclusion

This document is intended to guide and inform the provision of high quality mental health services in partnership with early care and education in Alameda County. It is part of an overall effort among early care and education programs, mental health service providers, policymakers and funders to develop a continuum of prevention and early intervention services, and ultimately to enhance the social and emotional well-being of our County's youngest children.

Acknowledgements

This document was compiled with the assistance of Mingyew Leung, members of the Alameda County Early Childhood Mental Health Systems Group, members of the Safe Passages' Early Childhood Policy Committee, and members of the Alameda County Child Care Planning Council. Funding was provided by Safe Passages. Portions of this document were adapted from *Working Towards a Good Start in Life: Mental Health Approaches in Early Childhood Settings*, published in 1996 by the Miriam and Peter Haas Fund. We thank all participants for their helpful feedback and assistance.



The Early Childhood Mental Health Systems Development Group

In response to requests from the early care and education community to develop and identify resources for children's mental health services, a group of individuals began meeting on a regular basis in early 2000. The group, now known as the Early Childhood Mental Health Systems Group, is sponsored by Alameda County Behavioral Health Care Services, Alameda County First Five, and the Alameda County Child Care Planning Council. Its mission is to advocate for, develop and facilitate the implementation of a community-based, county-wide system of preventive mental health and treatment services for all young children (prenatal

to age five) and their families within the home, early care and education, and the community. The group consists of early care and education providers, various early childhood and early care and education mental health services providers and other interested individuals.

For more information, please contact Margie Gutierrez-Padilla at (510) 777-2103, or Angie Garling at (510) 208-9675, or go to www.acgov.org/childcare.

Safe Passages' Oakland Early Childhood Initiative

Safe Passages is a partnership of the City of Oakland, Alameda County, the Oakland Unified School District, and other community agencies,

working to better coordinate resources and make policies that help improve the quality of life for Oakland's youth. The Safe Passages Early Childhood Policy Committee has been meeting regularly and has made recommendations to improve identification and service delivery to young children exposed to violence. The Initiative includes four areas: 1) coordination of services, 2) identification of children exposed to violence, 3) a violence prevention curriculum for early care and education sites, and 4) mental health services, which include assessment, mental health consultations at early education sites, and infant/child-parent psychotherapy. For more information, please contact Dana Inman at (510) 238-4910 or go to: www.safepassages.org.

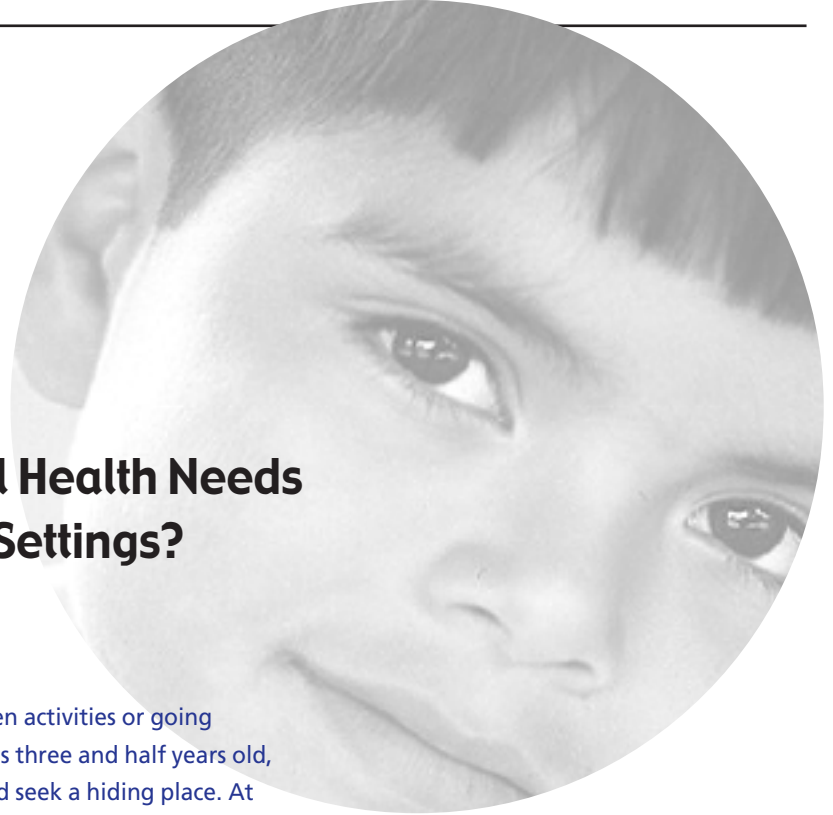
Standards of Practice

for **Mental Health Services** *in Partnership with* **Early Care and Education** *in* **Alameda County**



*Alameda County recognizes
the important contribution that a
partnership with mental health services
and early care and education makes
to the environment and to the
overall development and
education of the young child.*

Standards of Practice



What are Some of the Mental Health Needs In Early Care and Education Settings?

Jack:

When moving between activities or going outside, Jack, who was three and half years old, would run outside and seek a hiding place. At times, he got so agitated that he would hit or shove a playmate who approached him.

Julia:

Julia's parents had received several warnings from her preschool because she hit other children, and often had screaming and crying fits.

Fatima:

Fatima's mother recently died in an unexpected accident. Fatima's father was concerned about how she was coping with her mother's death, and spoke with Fatima's teacher about his concerns. The early care and education teacher, however, had not seen any behavioral changes or symptoms.

Garden Street Child Care:

The majority of the teachers at Garden Street Child Care are African-American. The director observed that these teachers felt that Elva, a Latina teacher, was aligning with Latino families and not communicating the families' needs to the remainder of the staff. Elva often translated for monolingual Spanish-speaking families and discussed child rearing practices that were culturally based. Her co-workers felt that she was showing "favoritism" towards Latino families and excluding other children. They also felt that their working relationship with her was suffering with some growing resentment and alienation. ■

* For ease of reading this document and to promote professionalism of the early care and education field, we will be using the term "teacher" to describe all individuals caring for children in a center-based program or family child care program.



SOCIOCULTURALLY COMPETENT

Mental health services acknowledge and address the diversity among children, teachers, families and mental health providers. It's imperative to pay attention to diversity at all levels. Every person's experience of the early care and education setting is unique, depending upon their cultural and social background, which spans ethnicity, culture, migration experiences, disability and socioeconomic status. Awareness and attention to such differences creates a context for shared concerns about the child, and supports effective and mutually beneficial relationships.

STRENGTH-BASED

Strength-based services promote and affirm assets in the child, in the family and in the early care and education program. This orientation enables families and caregivers to develop their resources and abilities to more effectively respond to a child and the child's environment.

BEGIN EARLY

Services should focus on the promotion of mental health through prevention and early intervention. Services should stress training for teachers with a focus on early warning signs and systems to identify vulnerabilities and problem areas, as well as consultation to establish preventative interventions in the early care and education program environment. Services should be made available until the mental health issue or concern has been effectively addressed.

DEVELOP AND SUPPORT A NETWORK OF WELL-TRAINED, COMPETENT MENTAL HEALTH SERVICE PROVIDERS

Providers should operate based on a strong foundation of existing research and training in child development theory, early care and education practices, and early childhood mental health. The mental health service organization should have adequate resources to provide ongoing training and supervision to mental health providers with varying levels of experience.

Standards of Practice

The following seven standards of practice are essential to quality early care and education mental health services

ENGAGE FAMILIES AND PROVIDERS

at all levels of the organization serving the child: Of critical importance is cooperation, interaction and collaboration among all parties involved, including full parental knowledge of, and consent for, mental health services.

No one can do the job alone, everyone faces pressures and obstacles, and solutions come if there is teamwork, mutual respect and goodwill. The full endorsement and support from top management staff, including adequate release time for teachers, is essential to the success of early care and education mental health services. Mental health can help teachers support the families' primary role in their child's development.

RELATIONSHIP-BASED

The promotion of stable, nurturing relationships is a basic prerequisite for mental health. Mental health services, whether they focus on child-specific concerns, general consultation, or programmatic concerns, are centered on and implemented through relationships. Relationships between teachers, directors, families, children and the mental health provider form the basis for the provision of mental health services. While short term interventions may be effective, frequently considerable time is needed to build the relationships that support change for children and programs.

BE FLEXIBLE AND RESPONSIVE

Creativity and innovation help develop solutions to respond to particular needs, cultures and settings. Inventive solutions among families, teachers and mental health consultants are a prerequisite for success and should be encouraged. If the solution requires a change to the established patterns and procedures, the mental health provider will work with the teacher and families to maximize the success of that innovative solution, both in the home and the classroom. The emotional wellness of children is the primary goal.

Introduction

The Alameda County Early Childhood Mental Health Systems Group created this document with support from Safe Passages to outline standards of practice for mental health services in early care and education. We recognize the important contribution that a partnership with mental health services and early care and education makes to the environment and to the overall development and education of the young child. This partnership includes collaboration with families with their full knowledge of, and consent for, mental health services. Substantial research shows that quality early care and education has long-term benefits to children's social and emotional wellness, prepares them for future school success and supports healthy families.

The scenarios above illustrate typical situations that regularly confront early care and education teachers, families and children. Collaborative solutions to such situations, along with early identification and intervention, are critical to maintaining healthy children, healthy families, healthy teachers and a healthy program. **Our hope is that this document will:**

- **Identify** how mental health providers, teachers and families can work together to enhance children's emotional wellness;
- **Illustrate** the benefits of mental health services when partnering with early care and education;
- **Provide** consistent guidelines for early care and education mental health services throughout Alameda County for use by practitioners, families, providers and policy makers.

Ultimately, our goal is to build a County-wide system of prevention and early intervention services for young children and their families, in coordination with early care and education programs and resource and referral agencies in Alameda County. Mental health services and the focus on the social and emotional development of young children can be an integral component of early care and education programs, as well as professional training institutions in Alameda County.

There is no single way to provide mental health services in a early care and education setting. At a minimum, these services are based on sound knowledge of child development and the culture of early care and education, delivered with flexibility and responsiveness. Therefore, we use the term **mental health services** throughout this document to refer to the full range of services provided within an early care and education setting, including consultation to early care and education teachers and directors as well as direct services, such as child and/or group therapy. ■



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Purpose and Benefits of Mental Health Services in Partnership with Early Care and Education

A recent report, *Preventative Mental Health Services for Young Children in Alameda County: An Action Plan to Meet the Urgent Needs of Children Caregivers and Families*, makes the case for mental health services in early care and education, describes current challenges faced by early care and education, and notes the significant diversity of teachers, families and children in Alameda County. The report's findings indicate that many caregivers of young children in Alameda County, families as well as early care and education teachers, feel inadequately prepared to successfully address children's social and emotional needs. Mental health services can enhance the ability of caregivers to meet these needs, if the mental health consultant is knowledgeable about the classroom curriculum, and has established trusting relationships with the early care and education teachers. Service providers observe, provide suggestions and feedback, and encourage caregivers to build upon their skills as nurturers and teachers of young children.

Early care and education mental health services are essential to:

- **Promote** high quality early care and education. Disruptive, challenging behavior in group care settings creates a chaotic, stressful classroom, which is not conducive to learning. In working with the teachers, the mental health provider addresses the child's needs, reduces anxiety, helps the child to develop the coping skills to manage his/her behavior, and helps the family support the child. The mental health consultant also

consults with the teachers to better manage the child in the classroom setting, and to improve and foster positive experiences for all children in the classroom.

- **Minimize** negative effects associated with children's challenging behaviors or other mental health needs, particularly when such needs have gone previously unidentified;
- **Optimize** children's social, emotional and physical health by providing early identification and intervention, such as making referrals for developmental assessments or more intensive mental health services;
- **Establish** school readiness and successful learning. Children who are worried, distressed or are experiencing social/emotional difficulties are unable to focus on learning. Once the child's needs are met through the mental health provider and teacher's interventions, the child is free to

focus on developing social skills, as well as academics. Mental health providers can offer complementary or ongoing services once a child enters school, as needed;

- **Enhance** relationships among the child and the child's teachers, peers and family members;
- **Provide** ongoing professional development and training for early care and education providers to support the social, emotional and physical health of all children and to support the families' role in the life of their child;
- **Increase** teacher capacity to address the multiple and varied needs of children in their care by combining knowledge and experience from the field of mental health with the field of early care and education;
- **Ensure** that a child's special needs or disabilities are addressed according to Americans with Disabilities Act (ADA) guidelines. ■

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What Do Mental Health Services in Partnership with Early Care and Education Look Like?



Julia:

Julia's teachers, with the support of the center's director, called in a mental health consultant. Ann, the consultant, observed Julia in her classroom. In particular, Ann noticed Julia's high level of frustration and suspected that there may be speech and language delays. Ann also talked with Julia's teacher who shared invaluable observations and insight regarding Julia's behavior and her relationships with both peers and adults. Later, the mental health consultant learned from Julia's mother that she had a history of ear infections. Ann encouraged Julia's family to follow up with the pediatrician about putting tubes in Julia's ears to address her chronic ear infections. The mental health consultant also worked with the early care and education program staff regarding the protocol they use when they feel overwhelmed by the children in their care. This included consultation with Julia's family, who felt frustrated with the early care and education program's initial response to Julia's behavior.

Jack:

Jack's teachers requested mental health consultation to address Jack's disruptive behaviors. The consultant worked with Jack's parents, his teachers and the center director to develop a shared understanding of the meaning of Jack's behaviors. Together, they concluded that his behaviors were related to his parent's recent separation, as well as an unusually high teacher turnover at the early care and education program site. Early care and education staff assigned one "buddy" teacher to Jack to provide consistency and reassurance on a daily basis. The mental health consultant, Jack's teacher and his parents continue to work together to ensure that Jack feels secure in his adult relationships, both at home and at school.

Fatima:

Fatima's teacher relayed the father's concerns to the center's mental health services provider. On one of her regular visits to the early care and education center, she assessed Fatima and saw a need for play therapy. She used this opportunity to provide training to the early care and education staff about asymptomatic behaviors that children may exhibit. In addition to play therapy, the mental health services provider offered counseling to Fatima's father.

Garden Street Child Care Center:

The director requested a mental health consultant's services to address this conflict among her staff. With the help of the consultant and the site director, staff meetings to improve the lines of communication were held. Initially, Elva felt that she could "handle" the Latino families' needs without problems. Her co-workers clarified that they felt that parental concerns should be discussed among all staff, not addressed by one teacher exclusively. A plan to have a "feedback loop" among director, staff and families was then formed. The mental health consultant continues to work with staff on this format and to promote empathy, respect, and understanding of cultural values in early care and education practices and communication styles. ■

While the previous scenarios illustrate some of the mental health services provided in early care and education settings, the following list demonstrates the wide range of services that could be provided if agreed upon by the mental health provider, early care and education program and families:

- Assessment and early identification of children's mental health needs. This includes coordinating services or planning for next steps, such as making referrals for additional or complementary services;
- Consultation with early care and education teachers and families about a child's specific developmental or behavioral concern within the context of early care and education and family dynamics;
- Consultation with teachers and families about general issues related to child development and related mental health needs;
- Consultation to early care and education settings to address program-wide issues that may affect the child's experience, the interaction of families and teachers as well as the interaction between teachers, if requested by those working with young children.
- Direct mental health services such as therapy for the child or the family, direct therapy to support the relationship between the parent and child, or therapeutic play groups, and
- Training and support of early care and education providers to enhance their ability to identify and respond to a child's behaviors and to understand child development processes. ■