Infant Family Mental Health Initiative

Final Report:
October 1, 1999 to October 31, 2000

March 2001

The Infant Family Mental Health Initiative project was funded by the California Department of Mental Health and coordinated by WestEd/CPEI through contracts with the pilot counties. Report prepared by Cindy Arstein-Kerslake, M.A., Research Consultant.
# Acknowledgements

Funding for the Infant Family Mental Health Initiative was made possible through the vision and leadership of

**Stephen W. Mayberg, Ph.D., Director**  
California Department of Mental Health

Support from the California Department of Mental Health clearly facilitated interagency and interdisciplinary collaboration and the development of early mental health services for very young children and their families.

The dedication and expertise of the following professionals significantly contributed to the success of the Initiative and this culminating report.

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Ammen, Ph.D.</td>
<td>California School of Professional Psychology, Fresno, CA</td>
</tr>
<tr>
<td>William Arroyo, M.D.</td>
<td>Los Angeles County Department of Mental Health, Los Angeles, CA</td>
</tr>
<tr>
<td>Cindy Arstein-Kerslake, M.A.</td>
<td>Research Evaluator, Sacramento, CA</td>
</tr>
<tr>
<td>Scott Berenson, LCSW</td>
<td>California Department of Mental Health, Sacramento, CA</td>
</tr>
<tr>
<td>Victor Bernstein, Ph.D.</td>
<td>University of Chicago, Chicago, IL</td>
</tr>
<tr>
<td>Lisa Bertaccini, MSW</td>
<td>Sacramento County Health and Human Services, Sacramento, CA</td>
</tr>
<tr>
<td>Deborrah Bremond, Ph.D.</td>
<td>Alameda County Children and Families Commission, Oakland, CA</td>
</tr>
<tr>
<td>Mari DeMera, MSW</td>
<td>Court Appointed Special Advocates, Fresno, CA</td>
</tr>
<tr>
<td>Karen Finello, Ph.D.</td>
<td>California School of Professional Psychology, Alhambra, CA</td>
</tr>
<tr>
<td>Lupe Fernandez, MSW</td>
<td>Fresno Department of Child and Family Services, Fresno, CA</td>
</tr>
<tr>
<td>Eileen Gonzalez, MSW</td>
<td>Babies First, Fresno, CA</td>
</tr>
<tr>
<td>Paula Gerstenblatt, MSW</td>
<td>WestEd Center for Prevention &amp;Early Intervention, Sacramento, CA</td>
</tr>
<tr>
<td>Rivka Greenberg, Ph.D.</td>
<td>Consultant, Oakland, CA</td>
</tr>
<tr>
<td>Margie Gutierrez-Padilla, LCSW</td>
<td>Alameda County Behavioral Health Care Services, Oakland, CA</td>
</tr>
<tr>
<td>Laurie Haberman, LCSW</td>
<td>Fresno County Department of Mental Health, Fresno, CA</td>
</tr>
<tr>
<td>Mary Hargrave, Ph.D.</td>
<td>River Oak Center for Children, Sacramento, CA</td>
</tr>
<tr>
<td>Mary Claire Heffron, Ph.D.</td>
<td>Children's Hospital Oakland, Oakland, CA</td>
</tr>
<tr>
<td>Mary Lu Hickman, M.D.</td>
<td>California Department of Developmental Services, Sacramento, CA</td>
</tr>
<tr>
<td>Marion Karian, R.N.</td>
<td>Exceptional Parents Unlimited, Fresno, CA</td>
</tr>
<tr>
<td>Penny Knapp, M.D.</td>
<td>California Department of Mental Health, Sacramento, CA</td>
</tr>
<tr>
<td>Mirek Lojkasek, Ph.D.</td>
<td>Hincks-Dellcrest Centre, Toronto, Ontario, Canada</td>
</tr>
<tr>
<td>Elaine Lomas, M.A.</td>
<td>Los Angeles County Department of Mental Health, Los Angeles, CA</td>
</tr>
<tr>
<td>Brad Luz, Ph.D.</td>
<td>Alameda County Behavioral Health Care Services, Oakland, CA</td>
</tr>
<tr>
<td>Susan McDonough, Ph.D.</td>
<td>University of Michigan, Ann Harbor, MI</td>
</tr>
</tbody>
</table>
Acknowledgements continued

Patrick Mangan, MSW  
Sacramento County Dept. of Health & Human Services  
Sacramento, CA

Nancy Marshall, MSW  
Birth and Beyond Program  
Sacramento, CA

Stephen Mayberg, Ph.D.  
California Department of Mental Health  
Sacramento, CA

Tobi McMannon, LCSW  
Los Angeles County Department of Mental Health  
Los Angeles, CA

Martha Moore, Ph.D.  
Fresno County Department of Mental Health  
Fresno, CA

Randy Osuna, Ph.D.  
Fresno County Department of Mental Health  
Fresno, CA

Betsy Pfommm, M.S., MPA  
Los Angeles Child Guidance  
Los Angeles, CA

Dave Nielsen, M.A.  
California Department of Mental Health  
Sacramento, CA

Marie Poulsen, Ph.D.  
University of Southern California, University Affiliated Program  
Los Angeles, CA

Linda Radford, Ph.D.  
University of Southern California, University Affiliated Program  
Los Angeles, CA

Virginia Reynolds, M.A.  
WestEd Center for Prevention & Early Intervention  
Sacramento, CA

Anne Marie Rucker, M.A.  
Birth and Beyond Program  
Sacramento, CA

Kathie Skrabo, MSW  
Sacramento County Department of Mental Health  
Sacramento, CA

Jennifer Smith, M.A.  
WestEd Center for Prevention & Early Intervention  
Sacramento, CA

Barbara Stroud, Ph.D.  
Los Angeles Child Guidance  
Long Beach, CA

Krista Swanson, Ph.D.  
Greater Long Beach Child Guidance  
Long Beach, CA

Nancy Sweet, M.A.  
Children’s Hospital Oakland  
Oakland, CA

Erika Thomason, B.A.  
WestEd Center for Prevention & Early Intervention  
Sacramento, CA

Peggy Thompson, MFT  
Fresno County Department of Mental Health  
Fresno, CA

Ruth Townsend, MSW  
Central Valley Regional Center  
Fresno, CA

Stan Taubman, DSW  
Alameda County Behavioral Health Care Services  
Oakland, CA

Donna Weston, Ph.D.  
Children’s Hospital Oakland  
Oakland, CA

Chris Wright, Ph.D.  
Consultant  
Sacramento, CA

Sheila Wolfe, M.A., OTR  
WestEd Center for Prevention & Early Intervention  
Sacramento, CA

Zohreh Zarnegar, Ph.D.  
Los Angeles County Department of Mental Health  
Los Angeles, CA
# Table of Contents

**Executive Summary** ................................................................. 1
- Background .................................................................................. 1
- Initiative Accomplishments ...................................................... 2
- Summary of Key Findings from the Impact Assessment ................ 3
- Summary of Recommendations by Goal Area ............................ 4
- Statewide and National Recognition of IFMHI ............................. 5
- Conclusion .................................................................................. 6

**Final Report** ............................................................................. 8
- Introduction and Background .................................................... 8
- IFMHI Project Development ..................................................... 8
- Project Evaluation Overview ..................................................... 9

**Infant Family Mental Health Initiative Accomplishments** ............. 10
- Purpose ..................................................................................... 11
- Methods .................................................................................... 11
- County Teams .......................................................................... 11
- Starting Points ......................................................................... 12
- Statewide Accomplishments .....................................................
  - Ongoing State Level Activities to Promote Infant Family Mental Health 13
- County Accomplishments and Ongoing Activities ..................
  - Goal 1 .................................................................................. 16
  - Goal 2 .................................................................................. 16
  - Goal 3 .................................................................................. 20
  - Goal 4 .................................................................................. 23
  - Goal 5 .................................................................................. 25

**Initiative Accomplishments Chart and Tables** ............................ 30
- Chart 1 - Goal 3: Collaboration .................................................. 31
- Table 1 - Infant Family Mental Health Initiative "County Teams" 32
- Table 2 - Starting Points: County Department of Mental Health (DMH) Experience & Resources 32
- Table 3 - Goal 1: Resource Identification .................................. 33
- Table 4 - Goal 2: Capacity Building ........................................ 35
- Table 5 - Goal 2: Capacity Building (The Numbers) ............... 37
- Table 6 - Goal 4: Model Development ...................................... 38
- Table 7 - Goal 5: Feasibility Study .......................................... 39

**Impact Assessment** .................................................................. 40
- Purpose ..................................................................................... 41
- Methods .................................................................................... 41
- Table 8 - Survey Respondents by County ................................ 41
- Table 9 - Survey Respondents' Role ........................................ 42
- Goal 1: Resource Identification ............................................... 42
- Table 10 - Local Resources ...................................................... 42
- Table 11 - Outcomes from Resource Identification and Development 43
- Discussion and Recommendations ......................................... 44
- Goal 2: Capacity Building ....................................................... 45
- Table 12 - Effectiveness of Various Types of Training............... 45
Appendix A
Infant Family Mental Health Initiative (IFMHI): Status Report Form

Appendix B
Infant Family Mental Health Initiative (IFMHI): Impact Assessment Survey Form
Infant Family Mental Health Initiative Final Report:
October 1, 1999 to October 31, 2000

Executive Summary

Infant Family Mental Health Initiative

Project Leadership and Funding:
California Department of Mental Health

Project Coordinator:
WestEd/CPEI Center for Prevention and Early Intervention

Pilot Counties:
Alameda County
Fresno County
Los Angeles County
Sacramento County
Infant Family Mental Health Initiative Final Report

for the Reporting Period:  October 1, 1999 to October 31, 2000

Executive Summary

Background

The Infant Family Mental Health Initiative (IFMHI) was funded by the California Department of Mental Health (DMH) to build capacity within the mental health system to serve infants/toddlers and their families. The project was a collaborative effort involving the Alameda, Fresno, Los Angeles and Sacramento County Departments of Mental Health, and the WestEd Sacramento Center for Prevention and Early Intervention (WestEd/CPEI) with support, resources and monitoring by the California Department of Mental Health.

Prior to the IFMHI, state level recognition and interagency collaborative development of infant-family mental health concepts and relationship-based approaches to services came from the early intervention community. Recommendations from the California Infant Mental Health Work Group (1994-1996) funded by a federal Maternal and Child Health Grant were the foundation of the Infant Mental Health Development Project (IMHDP) of 1998-1999. The IMHDP, funded by the California Department of Developmental Services and coordinated by WestEd/CPEI (formerly known as the Californian Early Intervention Network, CEITAN) provided statewide training, product and model development and technical assistance and support in selected pilot counties. The framework and funding for the IFMHI were based on the accomplishments and evaluation of the IMHDP. Recognizing the impact of the IMHDP and in response to requests for increased coordination with mental health agencies and professionals, the California DMH supported development of infant-family mental health services in coordination with selected pilot county departments of mental health.

Goals of the IFMHI:

- **Resource Identification and Development:** Identify the early childhood/infant-family mental health needs, resources and services within the pilot counties;
- **Capacity Building:** Increase the capacity of county departments of mental health to identify and serve very young children and their families;
- **Collaboration:** Facilitate interdisciplinary and interagency collaboration for services and staff training;
- **Model Development:** Provide models, resources, funding options and replicable approaches for the delivery of effective mental health services for very young children and their families;
- **Feasibility Study:** Demonstrate the feasibility and impact of providing clinical infant-family mental health services to children ages 0 to 3 and their families using team-oriented, family-centered and community-based approaches.

The Initiative provided support, resources and guidance for each of the participating pilot counties to develop and implement their own plans for training, technical assistance and enhanced service delivery to meet these goals, based on local resources, existing services and prioritized interests and needs. The Initiative assessed county accomplishments through monthly status reports provided by each county team and at bi-monthly meetings attended by representatives from the State DMH, WestEd/CPEI, and the four pilot county teams. This information is compiled and presented in the section of the report entitled Initiative Accomplishments. At the close of the first year of the project the Initiative developed and conducted the Impact Assessment Survey to evaluate the Initiative’s progress toward developing an integrated whole system of care for children from birth to three and their families. Recommendations for year two of the Initiative were developed by goal area based on the results of the Impact Assessment.
The Executive Summary of the IFMHI Final Report for October 1, 1999 to October 31, 2000 summarizes the two major sections of the Final Report:

1. The Initiative Accomplishments, which provides an analysis and summary of the activities and accomplishments of the Initiative, and
2. The Impact Assessment, which provides an evaluation of what happened as a result of the accomplishments and activities and what was learned from the experience.

Recommendations for the second year of the Initiative were based on the results of the Impact Assessment. The information from the report is intended to be used as a learning tool and to guide future efforts in the development of infant-family mental health services.

Initiative Accomplishments

With the leadership of the State Department of Mental Health and with the coordination and collaboration expertise of WestEd/CPEI, the IFMHI successfully pioneered collaborative development and implementation of mental health services for children under the age of three and their families in California. With guidance and support from the Initiative, four county teams, including county mental health system leadership, infant-family mental health experts and community partners, developed and implemented unique plans for collaborative training, service delivery, model development and a clinical research and evaluation study. The development of working relationships with local infant–family mental health experts and referral sources and the development of models for screening, assessment, intervention, training and funding ensures continuing development of infant-family mental health resources, ongoing capacity building and ongoing service delivery to infants/toddlers and their families.

The accomplishments of the Initiative:

- Identified local resources and needs and established and implemented plans for local training and resource development
- Provided training for approximately 280 mental health professionals and 950 other professional and paraprofessional service providers
- Hired, contracted or reassigned over 120 mental health professionals to provide services to infants/toddlers and their families
- Provided mental health services to over 425 children age birth to three and their families
- Established ongoing working relationships with training resources, local agencies providing services to infants and their families, and infant and early childhood advisory groups
- Explored, researched and began to develop and implement models for screening, assessment, intervention, service delivery, collaborative funding, and staff training and development
- Worked with the other county teams to develop guidelines for a clinical research and evaluation study to demonstrate the feasibility of providing mental health services to infants and their families (Feasibility Study) using team-oriented, family-centered and community-based approaches
- Developed and used screening tools, assessment tools and protocol, and intervention models in preparation for and beginning implementation of the Feasibility Study
- Successfully secured funding for continuing development and expansion of the Initiative
Significant accomplishments within each county:

- **Alameda County** Behavioral Health Care Services with Children’s Hospital of Oakland developed and implemented an Infant Family Mental Health Training Seminar and provided training and case supervision for 15 mental health clinicians. In collaboration with the Alameda County Proposition 10 Commission, 65 public health and social service providers received training in infant-family mental health concepts and relationship-based approaches to service. The interagency Early Childhood Mental Health System Development Group was established to develop a countywide system of mental health service delivery for children ages’ birth to 5 and their families. The county mental health system began providing services to very young children and their families through the Infant Family Mental Health Seminar, the Access Referral Network and the Feasibility Study.

- **Fresno County** Department of Mental Health with the California Professional School of Psychology provided ongoing intensive training for 5 mental health clinicians and developed and piloted screening and assessment tools and an intervention model in preparation for the Feasibility Study. The interagency Infant Mental Health Advisory Committee guided resource and system development. Training was provided for approximately 188 mental health professionals and 439 interdisciplinary personnel. Local infant-family mental health clinicians developed the expertise to enable them to provide promotion and awareness training and ongoing onsite training and case consultation for other health and social service providers implementing infant-family mental health concepts and relationship-based approaches to service. The number of new mental health providers hired, contracted or reassigned to provide services to infants/toddlers and their families has grown from one to 30. Collaborative service delivery is provided as part of the weekly multi-agency Infant Toddler Treatment Team meetings. Services were provided in home and community settings for over 116 families.

- **Los Angeles County** Department of Mental Health with University of Southern California/University Affiliated Project at Children’s Hospital of Los Angeles (USC/UAP) planned and implemented training and resource development for 20 provider agencies throughout the county and 70 mental health providers, who committed to developing resources and serving infants/toddlers and their families. An Infant Family Mental Health Advisory Committee was established to guide resource development and facilitate linkages and communication among providers and between providers and the county team. Promotion and awareness training was provided for over 300 interdisciplinary personnel and 50 mental health professionals. Mental health providers served approximately 264 infants/toddlers and their families since January 2000. USC/UAP developed a 12-session intervention model incorporating assessment measures and collaborated with Early Head Start in the delivery of services to 5 families through the Feasibility Study.

- **Sacramento County** Health and Human Services with River Oak Center for Children worked with the Family Support Collaborative to infuse infant-family mental health concepts and relationship-based approaches to services in the countywide child abuse prevention, Birth and Beyond Project. The Initiative provided large-scale interdisciplinary trainings for 140 Birth and Beyond staff and onsite consultation to the home visitors and multidisciplinary teams. Reflective supervision and support was provided for their administrative and leadership teams. An 8 week (3 hours per week) infant family mental health topical training was developed and provided for Birth and Beyond and River Oak mental health clinicians. A model of intervention for foster infants and toddlers was explored and implemented. The team participates in and promotes infant-family mental health at the interagency infant and early childhood Sacramento TransAgency Collaborative (STAR) meetings.
Summary of Key Findings from the Impact Assessment

The Impact Assessment was designed to evaluate the progress of the Initiative toward building an integrated collaborative whole system of care for children under three and their families. The first part of this report provides a description of the accomplishments of the Initiative. The Impact Assessment provides information about what happened as a result of the accomplishments and what was learned from the experience.

**Resource identification and development** clarified the necessity for county mental health system recognition, support and resources to sustain current efforts and ensure continuing development of mental health services for young children and their families. The process of resource identification and development promoted widespread interest by all types of service providers in the development of the continuum of infant-family mental health services. Initiative participants discovered that effective resource identification requires the development of relationships between mental health and other providers and opportunities for routine communication to ensure a clear understanding of the resources and services available to families and effective coordination of those resources.

**Capacity building** efforts promoted awareness of infant-family mental health concepts and relationship-based approaches to services for mental health and other family service providers. Small group training and consultation with a focus on the mental health provider was considered the most effective type of training followed by ongoing local training and consultation. Other professionals and paraprofessionals need access to similar types of training and consultation. A shortage of infant-family mental health specialists available to provide ongoing training and consultation was identified along with the need to develop and improve pre-service training related to infant-family mental health. Development of competencies and a certification process is needed for the continuum of infant-family mental health services.

**Collaborations** were established with a variety of training resources, service providers and advisory groups. Whole system development will require greater investment in the development of collaborations with interdisciplinary resources and referral sources, and a strong need to address, explore and develop funding resources. Collaboration inspired new and continued interest and commitment and provided expertise and resources needed for system development. Benefits to families are beginning to emerge: a decrease in redundancy of services; richness in the overall quality of service; positive outcomes for families.

**Models** for screening, assessment, intervention, prevention, collaboration, delivery systems and training were explored and developed. Most models are in the beginning stages of development and have only been implemented on a small scale. More time, experience and effort in development are needed to produce replicable models.

**The Feasibility Study** provided the greatest challenges for participants in the Initiative. This clinical research and evaluation study, intended to demonstrate the feasibility of providing mental health services to infants and their families, was in the beginning to mid stages of implementation at the time of the Impact Assessment Survey. The greatest impact of the Feasibility study was the knowledge and experience gained in the development and implementation of various aspects of the study. Experience was gained in collaborating with the IFMH specialist, screening and identification of moderate risk families, collaborating with referral sources, use of assessment tools including video-taping, development of intervention models integrating assessment as part of the intervention and conducting intervention in home and community settings. The knowledge and experience gained will provide the foundation for clinical research and evaluation to be conducted in the next year of the Initiative.

**The leadership and coordination of the Initiative** was considered most helpful in the provision of resources for training and consultation, coordination and implementation of training and promotion of infant-family mental health statewide. Respondents articulated additional needs in: support from county mental health administration, model development, coordination of the Feasibility Study, identification of funding sources and strategies, and clearer vision of project goals and roles of the participants from the onset. These needs and other suggestions by the respondents for important areas of development for the next phase of the Initiative were addressed by the Initiative with specific recommendations for action.
Summary of Recommendations by Goal Area

Recommendations for the second year of the Initiative were generated based on the results of the Impact Assessment and toward the goal of developing an integrated collaborative whole system of care for children under age 3 and their families. They were developed in response to the key findings of the Impact Assessment and specific needs articulated by Initiative participants.

Resource Identification and Development:

County mental health systems must recognize the importance of and support and provide resources for mental health services for children under three and their families within the county mental health system.

Broaden the focus of resource identification efforts toward development of a countywide interagency collaborative system of infant-family mental health.

Establish interagency infant-family mental health committees or advisory groups to promote networking and routine opportunities for communication to facilitate resource identification and coordination.

Continue to build on the unique strengths of the individual counties.

Capacity Building:

Develop a work group or task force to develop infant-family mental health competencies and certification.

Provide a full range of training, technical assistance and consultation opportunities designed to meet the information and training needs of all stakeholders from policy-makers to home visitors.

Utilize local knowledge and expertise gained in the first year to provide training, consultation and interagency resource development for others in the second year.

Collaboration:

Build on success of the first year to broaden linkages and further develop collaborative relationships and activities toward whole system development.

Build partnerships with institutions of higher education to develop and improve pre-service training in infant-family mental health concepts and relationship-based approaches to services and treatment/intervention.

Model Development:

Focus on development of models for whole system, countywide collaborative service delivery.

Continue to encourage and facilitate model development by providing resources and guidelines for the development of replicable models and opportunities for sharing information and successes.

Provide an educational forum to address the funding issues associated with serving infants and families.

Feasibility Study:

Use experience gained from the Feasibility Study in the first year of the Initiative to design a more clearly defined and expanded clinical research and evaluation study to be conducted in the second year.

Overall Initiative:

Strengthen the structure of the overall Initiative with clarity in goals, objectives, and expectations for support, schedules and communication.

Expand evaluation efforts to include outcomes for mental health and other service providers and outcomes for families.
Statewide and National Recognition of IFMHI

Statewide and national recognition of the work of the Initiative promotes the importance of infant family mental health and encourages and supports continued development.

- The leadership of the Initiative secured funding for continuing and expanded development of infant-family mental health services for the next three years in collaboration with the California Proposition 10 Commission.

- Alameda County community partners Mary Claire Heffron, Ph.D. of Children’s Hospital of Oakland and Deborrah Bremond Ph.D., of Every Child Counts Proposition 10 Commission, both were awarded national Zero to Three Mid Career Leadership Fellowships based on their work in developing models as part of the Initiative.

- Sacramento County community partner, River Oak Center for Children, was awarded a California Endowment Grant to continue work on the model of intervention for foster families.

- Los Angeles County community partner, Marie Poulsen, Ph.D. of USC/UAP was appointed to the Little Hoover Commission Children’s Mental Health Advisory Committee and serves on a number of other state committees representing the interests infant-family mental health including the Governor’s Child Development Policy Advisory Committee.

- Fresno County Department of Mental Health IFMHI coordinator, Peggy Thompson, MFT, represented the Initiative at the statewide Proposition 10 Commission Meeting to promote collaborative delivery of the continuum of mental health services for very young children and their families.

This recognition by state and national organizations of the value of the development efforts in infant-family mental health by these IFMHI participants validates the success of the Initiative and further promotes the development of infant-family mental health services.

Conclusion

The Infant Family Mental Health Initiative made great strides in expanding county mental health system's capacity to serve infants/toddlers and their families. A strong foundation of collaborations was established along with an array of models for system development and service delivery. Training increased awareness of infant-family mental health concepts and relationship-based approaches to services for mental health and other service providers and significantly expanded the expertise of mental health clinicians. The Feasibility Study provided knowledge and experience in screening, assessment, intervention and collaborative service delivery. County mental health systems expanded and enhanced service delivery to very young children and their families.

The statewide and local accomplishments in infant-family mental health development in year one of the Initiative along with the plans for expanded system development and service delivery in year two of the Initiative provide a substantial contribution to the resources, knowledge and expertise available for use in the promotion and continued development of mental health services for children from birth to age three and their families. The Initiative, equipped with significant accomplishments and ongoing efforts in development of the continuum of promotion, prevention and intervention/treatment services, is well on its way toward the goal of developing an integrated statewide collaborative system of care for very young children and their families.
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Final Report:
Introduction
And
Background

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Final Report

Introduction and Background

The Infant Family Mental Health Initiative (IFMHI) was funded by the California Department of Mental Health (DMH) to build capacity within the mental health system to serve infants/toddlers and families. The project was a collaborative effort involving the Alameda, Fresno, Los Angeles and Sacramento County Departments of Mental Health, and the WestEd/CPEI-Sacramento Center for Prevention and Early Intervention with support, resources and leadership by the California Department of Mental Health.

Prior to the IFMHI, state level recognition and interagency collaborative development of infant-family mental health concepts and relationship-based approaches to services came from the early intervention community. Recommendations from the California Infant Mental Health Work Group (1994-1996) funded by a federal Maternal and Child Health Grant were the foundation of the Infant Mental Health Development Project (IMHDP) of 1998-1999. The IMHDP, funded by the California Department of Developmental Services and coordinated by WestEd/CPEI (formerly known as the Californian Early Intervention Network, CEITAN) provided statewide training, product and model development and technical assistance and support in selected pilot counties. The framework and funding for the IFMHI were based on the accomplishments and evaluation of the IMHDP. Recognizing the impact of the IMHDP and in response to requests for increased coordination with mental health agencies and professionals, the California DMH supported development of infant-family mental health services in coordination with selected pilot county departments of mental health.

The goals of the Initiative were:

- **Resource Identification and Development:** Identify the early childhood/infant-family mental health needs, resources and services within the pilot counties;
- **Capacity Building:** Increase the capacity of county departments of mental health to identify and serve very young children and their families;
- **Collaboration:** Facilitate interdisciplinary and interagency collaboration for services and staff training;
- **Model Development:** Provide models, resources, funding options and replicable approaches for the delivery of effective mental health services for very young children and their families;
- **Feasibility Study:** Demonstrate the feasibility and impact of providing clinical infant-family mental health services to children ages 0 to 3 and their families using team-oriented, family-centered and community-based approaches.

The Initiative provided support for each of the participating pilot counties to develop and implement their own plans for training, technical assistance and enhanced service delivery to meet these goals, based on local resources, existing services and prioritized interests and needs.

**IFMHI Project Development**

The California Department of Mental Health (DMH) acknowledged the accomplishments of the 1998-1999 Infant Mental Health Development Project (IMHDP) and the importance of infant-family mental health concepts and relationship-based approaches to services. Recognizing the importance of prevention and early intervention, the State DMH moved to extend services in Children's Systems of Care to younger clients.
The goal was to build county mental health system capacity to provide mental health services to infants, age birth to three, and their families and to implement infant-family mental health concepts and relationship-based approaches to services. Funding to support this effort was drawn from onetime carry over County Children's System of Care funds from the previous year. The funds were awarded directly to four pilot counties in August 1999. The counties were chosen based on the local resources, expertise and leadership needed to succeed in this pioneering effort.

To build on the foundation of success from the IMHDP, the State DMH intended for the counties to contract with WestEd-CPEI to provide statewide development, coordination and facilitation of the new project. Directions for allocation accompanied the funding awarded to the counties.

County mental health system delivery changes began at the outset of their involvement with the Initiative. Contracting for coordination and training for services outside the county required the County Board of Supervisors approval in some counties. Each county was faced with the challenge of carrying out the project through their existing systems of contract procedures. The development of contracts between WestEd-CPEI and each of the four pilot counties required a substantial investment of time and effort. The contracting process began in September 1999 and was completed in April of 2000. During this period, WestEd/CPEI, the State DMH and the four pilot counties continued to work together to develop and implement the goals of the Infant-Family Mental Health Initiative.

Project Evaluation Overview

The diversity of activities and strategies outlined and planned by each of the four pilot counties for reaching the goals of the project required a coordinated approach for project evaluation. Evaluation was one of the major tasks of the Initiative and included developing tools and procedures for both ongoing and overall evaluation of project outcomes, including outcomes of a small feasibility study, changes in service delivery, personnel development and county capacity to provide infant-family mental health services and related staff training and supervision in a coordinated and collaborative manner. Ongoing evaluation monitored state and county level accomplishments and progress and provided routine feedback on Initiative activities. An outcome evaluation, the Impact Assessment Survey, assessed changes in county mental health systems and evaluated the IFMHI and its various components.

The Initiative assessed county accomplishments through monthly status reports provided by each county team and at bi-monthly meetings attended by representatives from the State DMH, WestEd/CPEI, and the four pilot county teams. At the close of the first year of the project the Initiative developed and conducted the Impact Assessment Survey to evaluate the Initiative’s progress toward developing an integrated whole system of care for children from birth to three and their families. Recommendations for year two of the Initiative were developed by goal area based on the results of the Impact Assessment.

This document, the IFMHI Final Report for October 1, 1999 to October 31, 2000 consists of two parts: The IFMHI Initiative Accomplishments and The IFMHI Impact Assessment. The IFMH Initiative Accomplishments provides an analysis and summary of the information gathered from the four counties and WestEd/CPEI on the activities and accomplishments of the Initiative. Immediately following this part of the report are the Initiative Accomplishments Chart and Tables, which categorizes and summarizes the accomplishments by county and specific areas of development. The Impact Assessment provides information about what happened as a result of the accomplishments and activities and what was learned from the experience. Recommendations for the second year of the Initiative are contained in the Impact Assessment and were based on the results of the Impact Assessment. The information in this report is intended to be used as a learning tool and to guide future efforts in the development of infant-family mental health services.
Initiative Accomplishments

Infant Family Mental Health Initiative Final Report: October 1, 1999 to October 31, 2000

Project Leadership and Funding:
California Department of Mental Health

Project Coordinator:
WestEd/CPEI Center for Prevention and Early Intervention

Pilot Counties:
Alameda County
Fresno County
Los Angeles County
Sacramento County
Infant Family Mental Health Initiative Accomplishments

This section of the IFMHI Final Report for October 1, 1999 to October 31, 2000 provides an analysis and summary of the activities and accomplishments of the IFMHI. Information was gathered through monthly status reports provided by each county team and at bi-monthly meetings attended by representatives from the State Department of Mental Health, WestEd/CPEI, and the four pilot county teams. Additional information was gathered from interviews with Initiative participants.

Purpose

This report documents the statewide and county accomplishments within each goal area in the first year of the Initiative. The information will be used as a resource and reference for further development of infant-family mental health services.

Methods

The IFMHI Status Report was developed for county teams to report the ongoing accomplishments, activities and challenges of the participating County Departments of Mental Health in reaching the goals of the project. The first Status Report form assessed the IFMHI progress over the first six months of the project. Subsequent project status reports provided monthly progress updates.

The Status Report form consisted of four pages. Each page addressed one of the four major goals of the Initiative. The goals were stated at the top of each page. Below the goal in the left hand column was a list of outcome components associated with the goal. The outcome components were intended to clarify the objectives of the goal area and provide focus for the descriptions of the accomplishments, ongoing activities and challenges requested in the next column. A sample of the Status Report form is in the Appendix A of this report.

The Status Report form was distributed by e-mail and fax to each of the four county mental health system project coordinators. County mental health system project coordinators were responsible for working with their team and subcontracted organizations in gathering the requested information for the various components of the project and reporting the information on the Status Report form. Only one Status Report with all relevant information from participants in the Initiative was required from each county.

Additional information was gathered from observations and meeting notes taken at bi-monthly meetings attended by representatives from the State DMH, WestEd/CPEI, and the four county teams to discuss the Feasibility Study (see Goal 5). Information about State level Initiative activities was gathered from meetings with the project leaders, interviews with the project coordinator and analysis of existing documents and reports.

County Teams

The county teams participating in the Infant Family Mental Health Initiative were from Alameda, Fresno, Los Angeles and Sacramento Counties. Each team was coordinated by the Children's System of Care in the County Department of Mental Health and included at least one local organization with infant-family mental health expertise and may have included other collaborating agencies.

- The Alameda County team included the Alameda County Behavioral Health Care Services (county mental health system), Children's Hospital Oakland (CHO), and Alameda County "Every Child Counts" Children and Families Commission (Prop. 10 Commission).
• The **Fresno County** team consisted of the Fresno County Department of Mental Health, the California School of Professional Psychology (CSPP) and the Central Valley Regional Center (CVRC). Exceptional Parents Unlimited and Early Head Start were community partners.

• The **Los Angeles County** Department of Mental Health (LAC DMH) teams with University of Southern California/University Affiliated Program Children's Hospital, Los Angeles (USC/UAP).

• **Sacramento County** Health and Human Services coordinates with River Oak Center for Children for the Sacramento County team.

In the *Initiative Accomplishments Chart and Tables* section of the report, **Table 1** on page 32 presents the member organizations participating in each county team.

**Starting Points**

Counties were selected to participate in the Initiative based on the infant-family mental health experience and resources of the county. All four of the counties participating in the Initiative have team members who were involved with the WestEd/CPEI, formerly CEITAN, coordinated the Infant Mental Health Development Project (IMHDP) of 1998-1999.

In **Alameda County**, Children's Hospital of Oakland served as a demonstration site for the Infant Mental Health Development Project and staff from the hospital provided training and technical assistance for the IMHDP throughout the state. Alameda County's mental health system was not involved with the IMHDP and limited capacity for the delivery of mental health services to infants and their families had been established prior to the Initiative. The collaborative relationship between Alameda County's mental health system and the experts in infant-family mental health at Children's Hospital of Oakland developed as a result of the Initiative.

**Fresno County** developed a multi-agency demonstration project with the IMHDP. With training and technical assistance from the IMHDP the multi-agency team initiated the ongoing development of a countywide collaborative delivery system for mental health services to infants and toddlers and their families. The California School of Professional Psychology (CSPP) had not been involved with the IMHDP. The CSPP established a working relationship with the Fresno County DMH as a result of the Initiative.

**Los Angeles County** DMH was not directly involved with the IMHDP and had not yet developed a system specifically for the delivery of mental health services to infants and toddlers and their families prior to the Initiative. However, the USC/ UAP Children's Hospital of Los Angeles served as a demonstration site for the IMHDP and provided technical assistance and training for the IMHDP throughout the State. Also a psychologist on staff at Los Angeles DMH had attended IMHDP training institutes and expressed willingness to participate. The relationship between the USC/ UAP and Los Angeles DMH was facilitated by the Initiative.

In **Sacramento County** an early intervention multi-agency team came together to develop supportive supervision skills through the IMHDP. River Oak Center for Children, a mental health provider agency for the Sacramento County mental health, provided mentoring for this intensive training. Sacramento County mental health and River Oaks Center for Children had been working together to provide and develop mental health services for infants and toddlers and their families with the Building Blocks project and the Birth and Beyond project prior to the Initiative. The Initiative provided new opportunities for Sacramento County mental health and River Oak Center for Children to collaborate together to expand and enhance the delivery of mental health services to infants and toddlers and their families in Sacramento County.

In the *Initiative Accomplishments Chart and Tables* section of the report, **Table 2** on page 32 explains the county mental health system experience and resources in infant-family mental health prior to the Initiative.
Statewide Accomplishments

The Infant Family Mental Health Initiative (IFMHI) and the four collaborative county teams worked together to develop IFMHI goals, priorities and project components as well as individual county project plans. The accomplishments and ongoing activities of the Initiative follow the goals of the project.

Goal 1: Identification of early childhood/infant mental health needs, resources and services.

- The Initiative identified and invited early childhood and infant-family mental health experts from each county to become a part of the Initiative and to participate in planning and training activities.
- The Initiative encouraged and facilitated county identification of local early childhood and infant-family mental health needs and resources.
- The Initiative aided each county in the establishment and implementation of an overall plan for training and technical assistance and resource development.

Goal 2: Capacity Building-Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.

- The Initiative consulted with each county team, helped them to identify their training needs and develop training plans.
- The Initiative contacted and coordinated with state and national leaders in infant-family mental health to provide trainings that met the identified needs of each county.
- The Initiative promoted and facilitated the development of the Feasibility Study (Goal 5), which for some counties provided their initial experience in infant-family mental health service delivery.
- The Initiative developed the opportunity for each county to provide and evaluate infant-family mental health services and outcomes to infants/toddlers and their families in each county through the Feasibility Study (Goal 5).

Goal 3: Collaboration-Facilitate interdisciplinary and interagency collaboration for services and staff training.

- The Initiative provided a model for collaboration as the State DMH, WestEd/CPEI and the four county teams productively worked together to implement the goals of the Initiative.
- The Initiative provided ongoing consultation and support in the development of strong working relationships between the county mental health systems and their local infant-family mental health experts.
- The Initiative facilitated team building among the four pilot counties and within the four county teams.
- The Initiative facilitated, supported and provided interdisciplinary and interagency trainings.
- The Initiative supported and encouraged interdisciplinary and interagency service delivery.
- The Initiative paired the identified infant-family mental health experts as mentors with county clinicians as trainees to provide practicum training and experience in infant-family mental health concepts and approaches to services through the Feasibility Study (Goal 5).

Goal 4: Model Development-Develop replicable strategies for ongoing training, service delivery, and funding of infant-family mental health services.

- The Initiative supported the counties with information, resources and training in diagnostics and assessment, various approaches to service delivery, models of intervention and funding.
• The Initiative promoted and developed the opportunity for the counties to gain experience with screening and assessment, diagnostics, various approaches to intervention and service delivery, funding mechanisms and training from which to develop replicable models through the Feasibility Study (Goal 5).

Goal 5: Feasibility Study-Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.

• The Initiative promoted and facilitated the development of statewide guidelines for a clinical research and evaluation study to demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.

• The Initiative aided each county in the development of their individual plan for implementation of the Feasibility Study.

• The Initiative and the counties collaborated to research, identify and agree upon screening and assessment tools.

• The Initiative coordinated the assembling and editing of a packet of assessment tools, the IFMHI Assessment Protocol, for use in the Feasibility Study.

Ongoing State Level Activities to Promote Infant Family Mental Health

In addition to the activities and accomplishments associated with the pilot counties, the Initiative was involved in a variety of ongoing activities to promote infant-family mental health across agencies and departments throughout the State and nationally. The Initiative:

• Continued collaboration with the Department of Developmental Services for state level interagency agreement on proposals for continued interagency funding and collaboration for service delivery and staff training.

• Infused infant-family mental health concepts and strategies in the Early Start statewide training institutes for early intervention service providers and service coordinators.

• Provided IFMHI information, consultation, and resources to regional centers and their vendors and to other state and local health, education, social service and family support agencies.

• Served as a clearing house for information on infant-family mental health resources, linkages and technical consulting for other states and other projects.

• Promoted the importance of Mental Health as a vital partner of the Early Start Interagency Coordinating Council through presentations about infant-family mental health and informed participation at meetings.

• Served as the State level interagency contact for the Departments of Social Services, Education, Child Development and Health regarding infant-family mental health policies, consultants, collaborations, linkages, materials and resources.

• Promoted and facilitated the participation of the mental health community in state and local Prop 10 efforts through the development of interagency early childhood linkages and collaboration.

• Supported statewide and local mental health providers in the provision or development services for infants and their families by presenting at regional and statewide meetings and conferences.

• Provided assistance and advice to legislators in developing proposals for future funding of infant-family mental health and early childhood programs and services.

• Promoted of infant-family mental health nationally through support for presentations by Nancy Sweet of Children's Hospital of Oakland and Marie Poulsen of USC/UAP, recognized leaders in infant-family mental health and representatives of the Initiative, at the invitation only White House Conference on Children's Mental Health.

• Met with individually with all four county teams to begin planning for year two of the Initiative.
• Organized, hosted and facilitated the year end meeting of the Initiative attended by the four county teams and their community partners with speakers from the Department of Mental Health, Department of Child Development, Department of Developmental Services and the State Proposition 10 Commission discussing future collaborations and the role of infant-family mental health in each of these agencies.

• Assembled and distributed resources from collaborating agencies, state departments and materials gathered from the December 2000 National Zero to Three Conference.

• Developed and distributed a 2001 Calendar promoting infant-family mental health with wisdom from leadership in the field.

• Facilitated two national meetings in the development of competencies for professionals working in infant-family mental health.

• Collaborated with the State Proposition 10 Commission in developing a proposal and goals for continuing development and expansion of infant-family mental health services in phase two of the Initiative.
County Accomplishments and Ongoing Activities

This section of the report provides an introduction to each goal area and a brief description of the outcome components (in italics) along with a discussion of each county's accomplishments in the goal area. The outcome components clarify the tasks and objective of the goal area. The goals are separated by key questions addressed by each goal. The questions addressed by each goal area are listed below:

- What resources and services are already available to infants and toddlers in each county? How can they be developed and coordinated to facilitate service delivery? (Goal 1: Identification of Resources)
- Who is going to provide infant-family mental health services? What skills must they have? (Goal 2: Capacity Building)
- What is the current capacity of the counties to provide infant-family mental health services? (Goal 2: Capacity Building continued: The Numbers)
- How can agencies or programs already serving young children and their families work with the county systems of mental health to develop and improve services? (Goal 3: Collaboration)
- What do counties need in order to develop infant-family mental health services? (Goal 4: Model Development)
- Is it really possible to provide effective clinical interventions with very young children and their families? (Goal 5: Feasibility Study)

The answers to these questions vary in each county depending on the existing needs, resources and services of the county. Accordingly, each county addressed these questions and the goals of the Initiative with diverse and unique accomplishments, activities and plans.

What resources and services are already available to infants and toddlers in each county?

Goal 1: Identification of the early childhood/infant-family mental health needs, resources and services

As part of building a comprehensive countywide system of early childhood infant-family mental health service delivery, the existing resources and services of the county must be identified. Results of this process help to identify priorities and areas of need that will guide establishment of a plan for training, technical assistance and resource development. Communication of the results helps to promote awareness of resources and services. Utilization of new services and resources reflects success in the development and promotion of new services and resources. This was an ongoing process that demonstrated the progress of each county in the development of their resources and service delivery system.

To reach this goal, all four of the county mental health coordinators worked closely with the local infant-family mental health specialist and primary community partners. Three of the counties, Alameda, Fresno and Los Angeles, specifically surveyed the mental health providers in their county to identify existing resources and services throughout the county. The same three counties established infant-family mental health advisory committees to guide their efforts in resource identification and development. Sacramento County identified an existing interagency collaborative project for the focus of their development efforts.

Alameda County identified and developed infant-family mental health resources in collaboration with Children's Hospital of Oakland (CHO) and the Alameda County Proposition 10 Commission. The Alameda County team established the interagency Early Childhood Mental Health System Development Group (ECMHSD). This group was formed as a result of the merging of an infant mental health work group sponsored by CHO and the Childcare Mental Health Consultation work group supported by the Proposition 10 Commission. The ECMHSD group's mission is to develop county wide coordinated mental health services for
children from birth to five and their families. Information supporting this effort was gathered from a survey of mental health providers. Eleven providers with varying capacity to serve children birth to five were identified. The ECMHSD group will also be informed about the results of a Childcare Mental Health Consultation Service program survey to identify staff and children's needs in childcare.

The Alameda County team also made progress in the identification and development of referral resources. The team provided an infant-family mental health orientation for the Access Provider Network. The Access provider Network is a referral resource that connects families needing mental health services to appropriate mental health providers.

The need for training, knowledge and information and the need to infuse infant-family mental health into existing services were identified. The Alameda County team priority was to develop and implement effective ongoing infant-family mental health training and supervision for mental health clinicians. Their greatest concern was that mental health clinicians develop knowledge, skills and experience in infant-family mental health before families were referred for services.

To meet the identified needs of the county an infant-family mental health specialist was hired to act as a liaison between the county and CHO and to serve families through the Feasibility Study. An Infant Family Mental Health (IFMH) Seminar was developed and provided weekly training and supervision for 15 mental health clinicians each serving one family. The participants were chosen with reference to their agency affiliation to maximize the diversity of agencies represented and benefiting from the training. The group was intentionally kept small to ensure the effectiveness and intensity of the training.

Promotion and awareness of resources and services was accomplished through the ECHHS group and the 15 mental health providers from the IFMH Seminar. The ECHHS group is also considering development of a resource directory.

Alameda County began serving families through referrals from the Access Provider Network, the 15 IFMH Seminar attendees and the Feasibility Study.

**Fresno County's** multi-agency collaborative has been providing infant-family mental health services since their involvement with the Infant Mental Health Development Project. Infant Family Mental Health Initiative efforts were planned, promoted and advised by the multi-agency Infant Mental Health Committee, co-chaired by a director from the Fresno Department of Mental Health and the director of the Central Valley Regional Center. The California School of Professional Psychology (CSPP) participated on the committee and played a lead role in training and model development.

Resource identification efforts were ongoing but initially included a written survey of agencies and private mental health providers. In attempting to utilize the resources identified, the Fresno County team discovered that misinformation in the survey responses due to a lack of understanding led to inappropriate referrals which clogged the system and caused extended delays in serving families. Personal contacts through telephone calls, staffings and other meetings were the best sources for identifying new and existing resources.

The priority for Fresno County was to train and support new mental health providers and other service providers in response to an overwhelming demand for services. The greatest demand was from the court system. From 30 to 40 children age birth to 3 are removed from their homes each month. All are referred for mental health services, which may include bonding studies, attachment assessments, expedited screens/recommendations and intensive treatment within a short time frame.

The demand for services required that Fresno County expedite development of county wide multi-agency collaborative training, service delivery and system development. The team actively sought and provided a menu of trainings to meet the needs of all agencies and disciplines. CSPP provided intense training and consultation for mental health clinicians combined with collaborative development of screening, assessment and intervention models. County mental health clinicians developed expertise to enable them to provide
training and consultation to other mental health providers and organizational service providers. County clinicians were stationed at two programs to provide case consultation, training and receive referrals. The County plans to station clinicians at other programs as space becomes available and agreements are in place. Long-term plans are needed for continued countywide growth in the number of trained practitioners.

Mental health clinicians provided promotion and awareness training for programs and providers. The Infant Mental Health Committee also promoted awareness of resources and services. A resource map on a web site is in the process of development.

Collaborative service delivery was established through the multi-agency Infant Toddler Treatment Team (ITTT) that meets weekly to develop treatment plans for families needing multiple services. New services were developed as 14 clinicians who work with the court system were trained to provide services to children age 0 to 3 and their families. Other new services were provided by 4 outpatient screeners and 8 contracted private providers who are now receiving referrals to serve infants/toddlers and their families.

In developing a system of collaborative service delivery Fresno County faced the challenge of service coordination. The Fresno team was in the process of developing a protocol to make decisions about what level of services should be provided to which families.

Los Angeles County Department of Mental Health (LAC DMH) had limited capacity to serve infants and their families prior to the initiative. The LAC DMH was faced with the challenge of developing infant-family mental health services in a large, highly populated geographical area. They surveyed mental health provider agencies throughout all 8 service provider areas in the county and identified at least one agency and one mental health provider within each agency to commit to becoming a "pioneer provider" of infant-family mental health services. By the end of the first year of the Initiative the number of "pioneer providers" had grown to 20 agencies and 70 mental health providers committed to developing infant-family mental health expertise.

The University of Southern California/ University Affiliated Project at Children's Hospital of Los Angeles (USC/UAP), providing infant family mental health expertise, assisted the LAC DMH in promotion, resource development, training and the Feasibility Study. During the first year of the Initiative, 5 other community resource providers experienced in infant-family mental health were identified to support LAC DMH resource development locally. Cedars Sinai Early Childhood 3 year training program was identified as training resource and accepted 14 providers, including 8 LAC DMH employees, to begin training in September 2000. In addition, three of the 20 "pioneer providers" were identified as experienced and able to mentor and provide peer support.

The Los Angeles County team visited each agency provider and identified needs for training, knowledge, and information; needs for linkages among agencies; and a severe need for infant-family mental health services within communities; the need for practical experience, clinical observation and supervision; the need for intensive training in evaluation, child development, and effective therapeutic models.

The resource development plan for the first year of the Initiative focused on twenty mental health agencies committed to: train 2 staff; serve 2-3 infant/toddlers and their families; act as the identified local provider of infant-family mental health services; train other providers in the next phase; and provide a referral/response telephone line for infant-family mental health referrals. The Initiative provided 3 two-day interagency promotion and awareness trainings and the county provided opportunities for other interagency training as part of the LAC DMH Training Bureau. Plans for the next phase of the Initiative focus on regional resource development to support local training and supervision and development of collaborative service delivery. Initial tasks are to: link providers with identified community resources; link experienced providers with inexperienced providers for mentoring and peer support; strengthen development of training opportunities through development of the early childhood training track in the LAC DMH Training Bureau.

LAC DMH communicated with the pioneer provider agencies weekly and provided articles on infant-family mental health. Monthly Infant Family Mental Health Advisory Committee meetings promoted awareness of
resources and services and facilitated linkages and communication among providers and between providers and the county team. The focus of these meetings will shift to collaboration in the second year of the Initiative.

In January 2000 pioneer providers began serving infants/toddlers and their families. Infants and their families are also being served through the Feasibility Study.

Sacramento County's prior and ongoing relationship with River Oak Center for Children and their Building Blocks program as well as their involvement with the planning of the Birth and Beyond Project provided the County with some experience in the development and delivery of mental health services to infants and toddlers and their families within the framework of existing resources. As the center of their capacity building effort, the Sacramento County team identified the Birth and Beyond Project. This Cal-SAFH model child abuse prevention project is a nine-site community-based program offering family support and home visitation services to families with pregnant mothers or infants less than 3 months old. The priority was to bring a mental health focus to the multidisciplinary teams that serve families in the Birth and Beyond Project. Needs for training in infant-family mental health concepts and relationship-based approaches to services including multidisciplinary team building and support and guidance for the home visitor were identified. Need for development of the roles of the mental health and child development specialist as part of the multidisciplinary team was also identified.

To meet the identified needs of the Birth and Beyond Project the Initiative provided interdisciplinary trainings in strength-based approaches to service and team building. Follow-up consultations and training in supportive supervision were provided for multidisciplinary team leaders. Onsite consultations to support multi-disciplinary teamwork and the work of the home visitor were provided at 8 Birth and Beyond sites. A mental health and child development work group was formed to address both system and program issues related to the two positions that are part of the Birth and Beyond multidisciplinary team. Referral language for infants and toddlers and an agency questionnaire to guide sites in their Medi-Cal requirements were developed.

River Oak Center for Children developed and implemented an 8-week series of 3-hour trainings to enhance the skills of mental health clinicians at Birth and Beyond and at the River Oak Center for Children.

A second priority for Sacramento was to address the unique needs of foster children in the Building Blocks program. The team explored a model from the Oregon Social Learning Center and developed and implemented an intervention model supporting the needs of foster children ages birth to three and their families. A California Endowment Grant awarded to the River Oak Center for Children will support further research and development of this model.

The multi-agency steering committee, the Family Support Collaborative, and the nine community-based sites promote the resources and services of the Birth and Beyond Project. The Sacramento County team represents the interests of the Initiative and infant-family mental health at the interagency infant and early childhood Sacramento TransAgency Resource (STAR) Collaborative meetings.

Families have been benefiting from the services of Birth and Beyond for over a year now. The Building Blocks program is piloting the Oregon Social Learning model for foster children and their families. Both programs are examples of new and enhanced services available to families as a result of the Initiative.

Table 3 on page 33 in the Initiative Accomplishments Chart and Tables section of the report categorizes the accomplishments of each county in this goal area by the outcome components.

Who is going to provide infant-family mental health services? What skills must they have?
**Goal 2: Capacity Building- Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.**

The primary intent of the Infant-Family Mental Health Initiative was to enable county systems of mental health to provide mental health services to children under 3 and their families. To do this mental health providers and other professionals needed training in infant-family mental health concepts and relationship-based approaches to services followed by consultation and supportive supervision as service providers begin implementation of relationship-based approaches to services. Mental health providers needed training and supervision in intervention and treatment. The Initiative supported the capacity building efforts of each county in a variety of ways including, large group interagency training, conferences, consultations, ongoing training and staff development activities and other training and capacity building efforts. Each county developed and provided training to meet the particular needs of the county.

All four counties provided large group interagency training focused primarily on promotion and awareness of infant-family mental health concepts and relationship-based approaches to service. The Initiative sponsored and coordinated promotion and awareness trainings by nationally recognized experts in infant-family mental health: Victor Bernstein and Mary Claire Heffron, Strengthening Families and Supporting Staff and Relationship Building and Staff Support; Susan McDonough, Reaching Hard to Reach Families; and Mirek Lojkasek, Watch, Wait and Wonder. These training sessions, usually two-day, most often included a half-day of interagency training and a day and a half of smaller group sessions focused on the mental health clinician.

The Initiative provided resources for participants from all four counties to attend two national conferences: the Zero to Three Conference in 1999 and the DC-03 Conference in 2000. Participants attended other conferences using their own resources.

In **Alameda County** interagency promotion and awareness training was sponsored by Alameda County’s every Child Counts Children and Families Commission (Proposition 10 Commission), who provided an introduction and orientation to infant-family mental health concepts and relationship-based approaches to services for core service providers including public health nurses and social workers with a 4-day training and monthly topical seminars. The Alameda team developed and implemented the Infant Family Mental Health Training (IFMHT) Seminar to provide ongoing training, consultation and supervision for mental health clinicians. The IFMHT Seminar provided 2 hours of training and consultation weekly for 15 mental health clinicians each serving one family. Prior to the IFMHT Seminar, 3 county mental health clinicians were involved in CHO’s DC 0-3 Orientation Seminar.

As part of Alameda County’s capacity building, the Initiative supported the hiring of an infant-family mental health specialist to provide services through the Feasibility Study and serve as a consultant to the County.

**Fresno County** has been proactively pursuing, participating in, and providing a variety of training opportunities. Since October 1999 mental health clinicians and other professionals have attended 12 different promotion and awareness trainings. The Initiative sponsored and coordinated interagency trainings with Lucia Milbourne, Chris Wright, Susan McDonough and Mirek Lojkasek. Fresno County supported attendance at other large group promotion and awareness trainings.

Fresno mental health clinicians audited CSPP’s "Play-Based Attachment" course in the fall of 1999. Beginning in February 2000 CSPP’s Sue Ammen provided weekly two-hour training and consultation for the mental health clinicians. During that time the team also worked on model development.

Fresno County mental health clinicians developed the expertise to provide consultation and training to case managers and home visitors. The mental health clinicians provided training and consultation regularly on individual cases and weekly to referral agencies including Exceptional Parents Unlimited CalSahf and Lori Ann Infant Programs, Central Valley Regional Center, Voluntary Family Maintenance C.I.T.E. Welfare Staff and E.O.C. Early Head Start. They also provided weekly consultations with the multiagency collaborative delivery
committee, the Infant Toddler Treatment Team that develops treatment plans for families needing multiple services.

Other activities provided by Fresno mental health clinicians included training for: the quarterly meeting of the 0-3 Task Force; Court Appointed Special Advocates staff from 25 counties; contracted private mental health providers; managed care staff; Court CASA staff; Child Welfare; Children's Mental Health.

**Los Angeles County** DMH, the mental health provider agencies and USC/UAP worked together to develop a capacity building plan that met the needs of the agencies as well as the individual providers. In the first year the Initiative sponsored three two-day large group interagency promotion and awareness trainings. The Los Angeles County team was successful in developing an Early Childhood Training Track for the Los Angeles County Training Bureau. In collaboration with other Los Angeles County Departments serving families the Los Angeles County Team provided and participated in five other large group interagency trainings. Regionalized ongoing training and staff development activities are planned for Phase II of the Initiative. They include: mini-seminars; training, consultation and supportive supervision; site visitation at USC/UAP by the 20 agencies.

Additional training was provided by USC/UAP. They provided a 1-day training for 9 pioneer providers from 3 agencies and an inservice training for Early Start in the Harbor Regional Center area. They also provided orientation for La Plaza Early Head Start in preparation for collaboration with them to provide services under the Feasibility Study.

Capacity building efforts included identifying the Cedar Sinai Childhood Training Program as a training resource. Fourteen mental health providers including 8 county mental health staff were admitted to the 3-year program in September 2000.

The vast size of LA County and the tremendous need for infant-family mental health services created unique challenges. While professional commitment to infant-family mental health grew, the needs for capacity building in Los Angeles County were greater than the available resources. Regional resource development is the priority for year two of the Initiative.

**Sacramento County** implemented specialized training for the multidisciplinary teams serving families in the Birth and Beyond Project. Large group promotion and awareness trainings included the one-day session, Strengthening Families and Supporting Staff, and follow-up consultations with national experts, Victor Bernstein and Mary Claire Heffron. Follow-up two-day trainings in June and September provided training in team building, supportive supervision and support for the home visitor. Onsite consultations from Victor Bernstein and Mary Claire Heffron following the October training at 8 of the Birth and Beyond sites reinforced the training and provided guidance for the home visitor in developing relationship-based approaches to services.

An 8 week 3 hour training seminar on infant-family mental health topics for mental health clinicians was developed and implemented by River Oak Center for Children. River Oak staff and mental health clinicians from Birth and Beyond attended the training.

Other capacity building activities involved training in the use of an assessment tool and distinguishing the roles of multidisciplinary team members. As a member of the infant and early childhood interagency Sacramento TransAgency Resource Collaborative the Sacramento team participated in the promotion and training sponsored by the group in use of the Infant Development Assessment tool. Use of a common assessment tool across agencies will facilitate collaborative service delivery. In addition, Sacramento County mental health and staff from Birth and Beyond formed a work group to develop the roles of the mental health specialist and the child development specialist on the multidisciplinary team.

Sacramento County progress in capacity building was hindered by a shortage of mental health clinicians. Only 4 of the 9 clinicians needed for Birth and Beyond had been hired by the end of the project year.
Oak Center for Children found it difficult to identify and hire mental health clinicians trained in infant-family mental health treatment and intervention.

**Table 4** on pages 35 and 36 in the *Initiative Accomplishments Chart and Tables* section of the report categorizes the completed trainings and other ongoing training and planned staff development activities of each of the counties by type of training.

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**What is the current capacity of the counties to provide infant-family mental health services?**

**Goal 2: Capacity Building (continued): The Numbers: Trained, Hired and Served**

Indicators of increased capacity include the number of mental health professionals and interdisciplinary personnel that training was provided for, the number of new mental health providers (hired, contracted or reassigned) to provide services to infants aged birth to 3 and their families and the number of infants aged birth to three and their families served during the project period. Each county tried to provide estimates for each of these indicators. Because of the diversity of training and services provided across counties, the numbers reported are not directly comparable. However with zero as the baseline for each indicator, conservative estimates for each indicator provide evidence of substantial growth in capacity to serve infants/toddlers and their families in each county.

**Alameda County** provided training for 31 mental health professionals and 65 interdisciplinary personnel. The county mental health system provided services for 15 children under 5 and their families. The Initiative provided screening and some consultation services for 64 children and their families through the Feasibility Study. This number includes the 10 families enrolled in the Feasibility Study for intervention services and 15 children under five and their families served by the fifteen mental health providers who received training and supervision through the Infant Family Mental Health Training Seminar. The Every Child Counts Proposition 10 Commission home visitors provided relationship-based approaches to services for 342 children and their families.

**Fresno County** provided training for 188 mental health professionals and 439 interdisciplinary personnel. They hired, contracted or reassigned a total of 30 new mental health providers to provide services for infants/toddlers and their families. This number includes 5 county mental health clinicians, 14 Youth Link clinicians, 4 outpatient screeners and 8 contract providers. Fresno County provided mental health services to 116 children under 3 and their families in the months of September and October 2000 alone.

**Los Angeles County** provided training for 50 mental health professionals and over 300 interdisciplinary personnel through the Initiative. The number of mental health providers committed to providing services for infants/toddlers and their families has grown to 70. The County provided services to 264 infants/toddlers and their families since January, 2000. The Initiative provided services to 5 families through the Feasibility Study.

**Sacramento County** provided training for 12 mental health providers and 140 interdisciplinary personnel. The number of new mental health providers able to provide services to infants/toddlers and their families is 6 including 4 Birth and Beyond clinicians and 2 Building Blocks clinicians. The County served 30 children under three and their families through Building Blocks and 4 families through the Feasibility Study. The number of families served through Birth and Beyond was not available.

In the *Initiative Accomplishments Chart and Tables* section of the report, **Table 5** on page 37 shows infant-family mental health training, hiring and utilization figures for the period from October 1, 1999 to October 31, 2000. This data helps to clarify each county’s status in the development and implementation of infant-family mental health services and provides a reference point from which to gage future progress.
How can agencies or programs already serving young children and their families work with the county Departments of Mental Health to develop and improve services?

**Goal 3: Collaboration—Facilitate interdisciplinary and interagency collaboration for services and staff training.**

Collaboration is fundamental to implementing infant-family mental health concepts and relationship based approaches to services. Strong working relationships between agencies and among staff within an agency benefits the family as well as the staff. Utilizing existing service delivery systems and local expertise and resources strengthens developing services and promotes the likelihood of future ongoing collaboration. With these advantages in mind the outcome components of this goal are to: *increase linkages and interagency multidisciplinary collaboration; establish collaborative staff development; establish collaborative service delivery; enhance teamwork skills for mental health professionals; and enhance teamwork skills of interdisciplinary service providers.*

**Alameda County** Behavioral Health Care Services (BHCS) (county mental health) worked closely with Children’s Hospital of Oakland (CHO) and the Alameda County “Every Child Counts” Children and Families Commission (Prop 10 Commission) to address the goals of the Initiative. They developed the multi-agency Early Childhood Mental Health System Development Committee to advise and work toward an overall early childhood infant-family mental health service delivery system for the birth to five population. The Child Care Health Program is part of the Early Childhood Mental Health System Group. Collaborations with the Access Referral Network support development of the entry point for referrals for services. The 15 IFMH Seminar attendees who represented various agencies promoted further collaborations and system development.

**Los Angeles County** Department of Mental Health teamed with USC/UAP Children’s Hospital of LA for infant-family mental health training and staff development and work on the Feasibility Study. The Los Angeles County Team built relationships with and among the 20 selected provider agencies and developed “agency development plans” and “individual goal setting plans” for mental health providers. The Infant–Family Mental Health Advisory Group promoted linkages and information among mental health providers at the monthly meetings.

In establishing collaborative training LAC/DMH worked with the Los Angeles County Department of Mental Health Training Bureau to develop an early childhood training track. LAC/DMH worked with the LAC Department of Health Services (DHS) to provide a half-day collaborative training on improving outcomes for children and families.

Interagency collaborations to facilitate screening and referral were established with LAC/DHS, the Department of Children and Family Services (DCFS), and the Department of Social Services to pilot the Mental Health Screening Tool (MHST) developed by the California Institute of Mental Health. Families were identified and referred to “pioneer providers” in the local community using the MHST.

Other collaborations were established with Early Head Start Program to provide services for families in the Feasibility Study and Harbor Regional Center in the development of the continuum of mental health services for infants/toddlers and their families. LAC/DMH represented infant-family mental health at the DHS Home Visitation Advisory Network and discussed the need for integration of services to families.

**Fresno County** Department of Mental Health, the California School of Professional Psychology (CSPP), and community partners including Central Valley Regional Center, Exceptional Parents Unlimited and Early Head Start worked closely together to develop and implement a collaborative delivery system in Fresno County.

CSPP worked with Fresno to provide ongoing and specialized training, guidance in the development of their service delivery system and model development for approaches to intervention.

The interagency Infant Family Mental Health Committee, co-chaired by Laurie Haberman from the Department of Mental Health and Ruth Townsend of Central Valley Regional Center, was formed prior to the
Initiative to promote local training, collaboration and services and increase awareness of how infant mental health could be infused in all levels of service delivery. Other agencies represented on the committee include Exceptional Parents Unlimited, Public Health Nursing, EOC Head Start, Clovis Early Start, Fresno's Lori Ann Infant Program, Valley Children's Hospital, Sullivan Center for Children and Court Appointed Special Advocates. This committee is a model of administrative and interdisciplinary collaboration that has guided the work of the Initiative in Fresno County.

Representatives from many of the same agencies that are part of the Infant Mental Health Committee and server more agencies are a part of the Infant Toddler Treatment Team. This interdisciplinary group provides collaborative service delivery by meeting weekly to coordinate and plan services for families requiring services from multiple agencies.

Agreements with Central Valley Regional Center, Exceptional Parents Unlimited and an EOC Head Start site enable county mental health clinicians to be stationed at these agencies to provide assessments, consultations and in-home psychotherapy as needed. Partnerships with Voluntary Family Maintenance, Child Welfare and EOC Early Head Start include plans for more clinicians to be stationed throughout the community.

Collaborative service delivery and training have expanded the mental health services of Youth Link to include services to children age birth to three. Two county mental health psychologists and one MSW are providing services half-time for court-ordered clients aged 0-3 years through Youth Link. Training has enabled 14 Youth Link therapists to provide initial intake assessments, Court reports, and treatment for those who meet medical necessity. Specialized training for 8 therapists in private practice who have contracts to provide mental health services in Fresno County will enable them to serve the birth to three population.

Fresno mental health also represents infant-family mental health as a participant on many advisory committees and councils. These committees cooperate to provide a comprehensive net of services to support infants and toddlers. They include: Babies First; Perinatal Systems Committee; Fresno County Early Childhood Coalition Planning Council; Fresno Council on Child Abuse Prevention; Mental Health Advisory Council; Birth-36 Months Task Force Committee; and Prop 10 planning committee.

Sacramento County Health and Human Services (County DMH) teamed with River Oak Center for Children, a contracted mental health provider, as their local infant-family mental health expert. They work together to provide infant-family mental health services in the Building Blocks Project and to develop and provide ongoing and specialized training to others.

The Sacramento Trans-agency Resource (STAR) Collaborative was formed to promote interagency collaboration in the interests of young children and their families. The group includes representatives from early intervention agencies including the Sacramento County Office of Education, Alta Regional Center, Alta Regional Center vendor agencies, the WarmLine Family Resource Center and Sacramento County mental health. Sacramento County mental health represents the interests of infant-family mental health on this Collaborative. The STAR Collaborative provided joint training on the Infant Development Assessment (IDA) to encourage early interventionists across agencies to use a common assessment tool.

As part of steering committee for the Family Support Collaborative, Sacramento County mental health is part of the leadership of the multi-agency group overseeing the Birth and Beyond Project.

Sacramento County mental health collaborates directly with the Birth and Beyond multi-disciplinary teams and home visitors to provide training and consultation for infusing infant-family mental health concepts and relationship-based approaches into the home visitation program.

Chart 1 on page 31 of the Initiative Accomplishments Chart and Tables section of the report provides a diagram of the collaborations that have been established as a result of the Initiative. The Infant Family Mental Health Initiative is found in the box in the center of the Chart along with the State Department of Mental Health as the supervising department and West Ed Sacramento Center for Prevention and Early
Intervention as the project coordinator. The Infant Family Mental Health Initiative collaborates with each of the four county teams to implement the goals of the Initiative and brings them together to share their information, knowledge and expertise and plans and accomplishments. The collaborative relationships formed by the individual county mental health systems are found in the four quadrants of the chart.

What do counties need in order to develop infant-family mental health services?

**Goal 4: Model Development-Develop replicable strategies for ongoing training, service delivery, and funding of infant-family mental health concepts and approaches to services**

Model development is the vehicle for documenting and sharing the experience, information, knowledge, expertise, resources and products of the pilot counties with other counties embarking on the development of mental health services for infants and toddlers and their families. It also requires that the counties establish plans that will ensure continuing collaboration and capacity development after the IFMHI project has ended. Outcome components include the development of: plans for countywide mental health service delivery for infants/families; strategies for resource sharing and funding for infant/family services; recommendations for service delivery and funding of infant/family mental health services statewide; materials and resources for dissemination; plans for ongoing training programs to be implemented after the project period; and plans for ongoing and collaborative service delivery after the project period.

The four counties developed and implemented a diverse array of models for screening and assessment, intervention, service delivery, funding and training. Most of the models are still in the process of development or refinement and were referenced earlier in the report.

**Alameda County’s** unique collaboration with the Every Child Counts Proposition 10 Commission and Children’s Hospital of Oakland focusing on the development a countywide early childhood mental health system for collaborative delivery to the birth to five-year-old population serves as a model for system development. To facilitate coordination of system development the county created the Early Childhood Mental Health Coordinator position. Seminar training models were developed and implemented in the use of DC 0-3 classification system and the Infant Mental Health Seminar (IFMH) for ongoing training and supervision of mental health clinicians. An ongoing training model for multidisciplinary providers is in the process of development. An assessment protocol for the IFMH Seminar was developed based on Selina Fraiberg’s work. A process for screening and identification of families for the Feasibility Study was developed and implemented. Videotaping and assessment was incorporated into the intervention sessions. Alameda County is funding infant-family mental health services through CalWorks, Proposition 10 and Medi-Cal/EPSDT. In addition, the team worked toward developing a specialized infant mental health service category system for Med-Cal billing codes.

**Fresno County** developed models for the Feasibility Study while at the same time developing and implementing their collaborative delivery system. As models for screening, assessment and intervention were developed for the Feasibility Study; they were tested, adapted and refined to meet the needs of service delivery in Fresno County. The Fresno County team developed and implemented a referral process, screening tools and an assessment package that includes assessment protocol and assessment tools to be administered as part of the intervention sessions. An intervention model was developed as part of the ongoing training and consultation mental health clinicians received from CSPP. The Marschack Interactive Method of videotaping is a tool of the intervention.

Fresno’s model for collaborative service delivery includes development of strategies for delivering services based on family needs and coordination and planning of services through regular interagency meetings of the Infant Toddler Treatment Team (ITTT). Funding of services is through Medi-Cal.

Training models include CSPP’s training curriculum provided for the mental health clinicians and a model for development and utilization of local expertise for consultation and training for other family service providers and referring agencies.
CSPP developed a diagram of a model for relationship-based infant family mental health intervention with moderate risk families.

**Los Angeles County** model development efforts were primarily focused on regional resource development for their service delivery system. Ongoing development links infant-family mental health providers with local community resources for training and other family service providers as referral sources.

The LA team developed and implemented screening and assessment models as they piloted the Mental Health Screening Tool developed by the California Institute of Mental Health and collaborated with Early Head Start for screening and assessment as part of the Feasibility Study. A twelve-session intervention outline incorporating assessments into the sessions was also developed and implemented as part of the Feasibility Study.

LA County accessed EPSDT, CalWorks and Proposition 10 as funding sources for infant-family mental health services.

A model for collaborative interagency training was developed as early childhood training was established as a training track in the LA County DMH Training Bureau.

The LA County team is also planning to develop a tracking system for services rendered to the birth to 3 population.

**Sacramento County’s** role in providing training in relationship-based approaches and infant-family mental health concepts and support for the multidisciplinary teams of the Birth and Beyond project serves as a model for interdisciplinary training, team-building and system development. Sacramento County’s contribution to the Birth and Beyond mental health/child development work group’s development of roles and screening and assessment tools provides models for those team positions and screening and assessment.

With support from Sacramento County, River Oak Center for Children explored and adapted the research-based Oregon Social Learning program model for foster infants and toddlers. They are also planning to expand the Building Blocks program, which currently serves infants, toddlers and their families.

The Sacramento team also developed and implemented an 8 week training seminar in infant-family mental health that serves as a training model for mental health clinicians.

Sacramento County’s use of EPSDT is well established and has already served as a model for other counties.

For the Feasibility Study the Sacramento team developed a screening tool using a combination of the BABES, part of the IDA and the identifying packet from Fresno.

**Table 6** on page 38 of the Initiative Accomplishments Chart and Tables section of the report lists the various models within the categories of screening and assessment, intervention, service delivery system, funding, training, and other types of models that the counties explored and developed.

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**Is it really possible to provide effective clinical interventions with very young children and their families?**

**Goal 5: Feasibility Study—Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.**

The Feasibility Study provided the opportunity for the four county teams to work together to research and evaluate common frameworks and effective strategies and approaches for screening, assessment and infant-family mental health service delivery. The outcome components included:
• Identification of effective measures and procedures for screening and assessment
• Identification of effective approaches and strategies for linking assessment findings to intervention and treatment services
• Descriptions of effective intervention and treatment strategies and models for ongoing service delivery
• Collection of information and data regarding outcomes for children and families as a result of infant–family mental health specific intervention and/or treatment services
• Clarification of the skills and training needed for mental health professionals and other specialists to effectively provide infant-family mental health services across the service delivery continuum
• Identification of effective training approaches and expected staff development outcomes and competencies
• Delineation of specific options, procedures, billing codes and funding resources for screening, assessment and service delivery.

With leadership from the State DMH, and coordination from WestEd/CPEI, the four county teams developed the framework and guidelines for the Feasibility Study during bi-monthly meetings. The agreed upon guidelines of the Feasibility Study directed the counties to establish partnerships in each county to include experienced infant-family mental health specialists as “mentors”, other mental health service providers as “trainees” and when possible other service providers working with the infant and family. In addition to other sources of training for the “trainees,” the “mentors” were to provide orientation, support, supervision and training for the “trainees”. The counties were to identify 10 families to participate in the study using specific inclusion/exclusion criteria. A common process for conducting the study and common screening and assessment measures would be used. Where applicable a DC 0-3 and a DSM-IV diagnosis would be assigned to each infant and/or DSM-IV diagnosis to the parents. Based on assessment findings and team/family input, service providers would develop a treatment plan and carry out an infant-family mental health relationship-based intervention for the selected families. At the end of the Feasibility Study period the families would be re-assessed. County teams would develop recommendations for screening, assessment, training, interventions and approaches to service delivery based on the experience and outcomes generated by the Feasibility Study.

Originally, evaluation of the Feasibility Study was planned to be separate from the overall evaluation and was not included as part of the Status Report Form. Later, when the collaborative development of the Feasibility Study guidelines was complete and as the county teams focused on development of plans for local implementation of the Feasibility Study, it was decided that the Feasibility Study would be added as the fifth goal of the Initiative.

Each county developed a Feasibility Study plan and procedures that match the individual county’s resources and needs as well as the guidelines of the Feasibility Study. Ongoing progress of county implementation of the Feasibility Study was monitored and reported at the bi-monthly meetings.

By the end of the sixth month of the Initiative all four counties had identified the mentors, trainees and the source of the families who would participate in the Feasibility Study. Two counties had begun screening families. By the end of the first year of the Initiative all four of the counties had screened and identified families for the Study. Two of the counties had begun assessment and intervention sessions.

Each county encountered both unique and shared challenges in planning and implementing the Feasibility Study. Plans for the Feasibility Study were altered as needed to accommodate the needs of families, coordinate schedules, staffing changes and refinement of models. Necessary preparations for implementation took much longer than planned. The needs for coordination and collection of information regarding the Feasibility Study at the state level were greater than the available resources. Upon completion of the Study a more thorough assessment of each county’s experiences and outcome data will be needed to
more fully benefit from the experiences of each county and to determine outcomes for families and clinicians.

The brief descriptions below of each county’s progress in implementing the Feasibility Study provide a snapshot of the initial plans and efforts in this goal area.

**Sacramento County** Feasibility Study implementation activities were somewhat delayed and changed by staffing changes that occurred after initial activities had begun. Preparations for implementation of the Feasibility Study plans included the need for River Oak Center for Children to hire an infant-family mental health specialist to conduct the Feasibility Study. Training on the IDA was provided to enable clinicians to conduct the assessment.

At the end of the Initiative project year River Oak Staff were in the process of screening and identifying families to be included in the study. Families were drawn from the CHEC home visitation program and the Birth and Beyond Project. River Oak used the identification packet developed by Fresno, a portion of the IDA and BABES to screen and identify families for inclusion in the Study. Three families had been screened and identified and more families were scheduled for screening. They planned to have all families identified by January 2001. Assessments and treatment would begin when Medi-Cal Access referral was complete.

**Alameda County**'s team developed collaborations with pediatricians at CHO, the ambulatory care clinic at CHO, La Clinica (county outpatient clinic), and Access Provider Network to refer families for screening. Children’s Hospital of Oakland developed a process for screening and identification of moderate risk families to be included in the Feasibility Study. At the end of the Initiative project year they had 9 families enrolled in the Study and a tenth family who had agreed to participate, but had not yet filled out the consent forms. They had completed 3 full assessments, including video-taping, instruments and summaries. They planned to have all 10 families assessed by March 15, 2001. Assessments are administered one per clinical session so as not to interfere with the clinical work. After the videotaping and assessments are complete they conduct a full review and put together a formal treatment plan in collaboration with the parents.

Prior to involvement in the Initiative CHO’s infant-family mental health services were provided primarily for infants and toddlers with developmental, health or other disabilities. Participation in the Feasibility Study facilitated development of a screening and identification process for infants and their families at risk for mental health problems or attachment difficulties. The intervention model used by CHO has been enhanced by the use of video-taping and other assessment measures that have been incorporated into the clinical sessions. Families and clinicians have benefited from the dialogue generated by the assessments and videotaping.

**The LA County Team** met with directors of Early Head Start to gain support in working with Early Head Start families for the Feasibility Study. The LA County team spent a considerable amount of time and effort building relationships and developing trust with staff and families at Early Head Start sites orienting them to the benefits of infant-family mental health as a compliment to the services offered by Early Head Start.

Early Head Start developed a two-page description of infant-family mental health to introduce families to the Feasibility Study and translated it into Spanish. Early Head Start home visitors assisted by the Early Head Start mental health specialist conducted screening of Families for participation in the Study. Screening tools included the BABES and an at risk supplemental form along with assessment of parent concerns and Early Head Start staff concerns. Results of the screening along with the interest and willingness of the families to participate in the study determined participation. USC/UAP developed a consent form and an introduction to the study. They developed a 12-session "Guided Interaction" intervention model, integrating assessments into the sessions.

Four families were identified for participation in the Study from the Plaza de la Raza Early Head Start site and one from USC/UAP. By the end of the Initiative project year USC/UAP psychology training staff had completed 2 or 3 sessions with each family. All families had completed the BABES and been videotaped once. Some families had completed the IDA and other protocol measures based on the 12-session outline.
Progress in the Study was delayed by numerous cancellations of sessions due to childhood illnesses. Another major issue concerned the time constraints of the Early Head Start Program. Most of the dyads could only be seen for 30-minute sessions making it somewhat difficult to complete the full agenda scheduled for each session.

**The Fresno County** team consisted of two mentors including a psychologist for CSPP and an MFT from the County mental health and five trainees from county mental health including 2 psychologists, 2 MSWs and 1 MFT. The team developed a referral and screening process and consent forms. The screening process included a risk factor assessment and modified scoring of the BABES to identify families for the Study. With guidance from the leadership of the Initiative they also developed an assessment protocol, incorporating all of the assessment instruments into one package with redundant questions edited out.

Fresno County had families screened, identified and waiting for treatment before any of the other counties. The Initiative leadership and the four counties were still in the process of making decisions about the assessment measures and protocol for administering them. The delays required that the identified families be referred to another program for services.

By the end of the Initiative project year the Fresno County team had refined and formalized assessment sessions, practiced using the Marschack Interactive Method of video taping and other assessment tools on ongoing clients and identified new families for the Feasibility Study. They were ready for implementation of a clinical research and evaluation study for year two of the Initiative.

**Table 7** on page 39 of the *Initiative Accomplishments Chart and Tables* section of the report summarizes each county team’s progress in developing and implementing their plan for the Feasibility Study.

The Infant Family Mental Health Initiative successfully established county level teams and provided state and local support, training and technical assistance to enhance the availability and delivery of infant-family mental health services. The four counties developed and implemented individual approaches to system development capitalizing on local resources, services and expertise. Each county gained diverse experience in models for system development, service delivery, training and collaboration. Their combined experience provides a foundation of information and resources in the development of an integrated, collaborative whole system of care for infants/toddlers and their families.
Initiative Accomplishments Chart and Tables

Infant Family Mental Health Initiative

Project Leadership and Funding:
California Department of Mental Health

Project Coordinator:
WestEd/CPEI Center for Prevention and Early Intervention

Pilot Counties:
Alameda County
Fresno County
Los Angeles County
Sacramento County

Infant Family Mental Health Initiative Final Report:

October 1, 1999 to October 31, 2000
Chart 1  **Goal 3: Collaboration** - Facilitate interdisciplinary and interagency collaboration for services and staff training.

- **Outreach:** 15 IFMHI seminar attendees represent various agencies
- **Child Care Health Program**
- **Early Childhood Mental Health System Development Committee**
- **20 Mental Health Provider Agencies**
- **Infant Family Mental Health Advisory Group**
- **Los Angeles County Department of Mental Health**, and USC/UAP Children’s Hospital L.A.
- **Los Angeles Co. Training Bureau**
- **Alameda Co. Behavioral Health Care Services** and Children’s Hospital of Oakland, Alameda County “Every Child Counts” Children and Families Commission
- **Access Provider Network**
- **Sacramento County Health and Human Services**, and River Oak Center for Children
- **Building Blocks**
- **Sacramento TransAgency Resource Collaborative (STAR)**
- **Family Support Collaborative Steering Committee**
- **Birth and Beyond** (Multi-disciplinary teams and home visitors at nine community sites)
- **Infant Family Mental Health Initiative WestEd Sacramento Center for Prevention and Early Intervention**
- **State Department of Mental Health**
- **Fresno County Dept of Mental Health**, and California School of Professional Psychology, Central Valley Regional Ctr, Exceptional Parents Unlimited, and Early Head Start

**Infant Toddler Treatment Team:**
- Maternal Child, Adolescent Health
- Public Health Nursing
- Court-Appointed Special Advocates
- Child Welfare/Juvenile Dependency Court
- Voluntary Family Maintenance/CITE
- Valley Children’s Hospital—Dept of Behavioral Peds
- “Spirit of Women”
- Lori Ann Infant Program
- Clovis Early Start
- California Children’s Svcs
- University Medical Ctr
- Fresno City College—Early Childhood Education

**Other Committees:**
- Babies First
- Perinatal Systems Committee
- Fresno Co. Early Childhood Coalition Planning Council
- Fresno Council on Child Abuse Prevention
- Mental Health Advisory Council
- Proposition 10 Planning Committee
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<thead>
<tr>
<th><strong>Table 1</strong> Infant Family Mental Health Initiative &quot;County Teams&quot;</th>
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<tbody>
<tr>
<td><strong>Type of Organization/Resource:</strong></td>
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<tr>
<td><strong>County Department of Mental Health (DMH)</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Alameda County Behavioral Health Care Services</td>
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<td>Fresno</td>
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<tr>
<td>• Fresno County Department of Mental Health</td>
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<tr>
<td>Los Angeles</td>
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<tr>
<td>• Los Angeles County Department of Mental Health Children's System of Care</td>
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<tr>
<td>Sacramento</td>
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<tr>
<td>• Sacramento County Health and Human Services</td>
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<tr>
<td><strong>Infant Family Mental Health Specialist</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Children's Hospital, Oakland</td>
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<td>Fresno</td>
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<tr>
<td>• California School of Professional Psychology</td>
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<tr>
<td>Los Angeles</td>
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<tr>
<td>• USC/UAP Children's Hospital, Los Angeles</td>
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<td>Sacramento</td>
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<tr>
<td>• River Oak Center for Children</td>
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<tr>
<td><strong>Other Collaborators</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Alameda County &quot;Every Child Counts&quot; Children and Families First Commission</td>
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<tr>
<td>Fresno</td>
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<tr>
<td>• Central Valley Regional Center</td>
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<tr>
<th><strong>Table 2</strong> Starting Points: County Department of Mental Health (DMH) Experience and Resources in Infant Family Mental Health (IFMH) Prior to Initiative</th>
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<tbody>
<tr>
<td><strong>Experience Indicator:</strong></td>
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<tr>
<td><strong>County DMH IMHDP involvement prior to Initiative</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Participation in Infant Mental Health Interest Group planning</td>
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<td>Fresno</td>
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<tr>
<td>• County-wide multi-agency demonstration project for Infant Mental Health Development Project</td>
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<tr>
<td>Los Angeles</td>
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<tr>
<td>• Initial collaborations between County DMH and IMHDP</td>
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<tr>
<td>Sacramento</td>
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<tr>
<td>• Limited- Multi-agency participation in mentoring for Supportive Supervision</td>
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<tr>
<td><strong>Infant Family Mental Health Specialist Resources</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Children's Hospital of Oakland (Demonstration site for Infant Mental Health Development Project)</td>
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<tr>
<td>Fresno</td>
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<tr>
<td>• California School of Professional Psychology (No involvement with Infant Mental Health Development Project)</td>
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<tr>
<td>Los Angeles</td>
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<tr>
<td>• USC/UAP - (Demonstration site for Infant Mental Health Development Project)</td>
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<tr>
<td>Sacramento</td>
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<tr>
<td>• River Oak Center for Children, DMH vendor (provided the mentor for Supportive Supervision)</td>
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<tr>
<td><strong>County Service Delivery to Infants age 0-3 and their families</strong></td>
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<tr>
<td>Alameda</td>
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<tr>
<td>• Little systemic capacity to serve infants and families (2 therapeutic nursery school; 3 contracted providers)</td>
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<tr>
<td>Fresno</td>
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<tr>
<td>• Ongoing development of multi-agency county-wide delivery system with an informal relationship between DDS and DMH</td>
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<tr>
<td>Los Angeles</td>
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<tr>
<td>• Little systemic capacity to serve infants and families (a few contracted providers)</td>
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<tr>
<td>Sacramento</td>
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<tr>
<td>• Building Blocks (River Oak, a private nonprofit vendor of Sacramento Co. DMH)</td>
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<tr>
<td>• Birth and Beyond (DDS) in planning stages</td>
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<tr>
<td>Outcome Components:</td>
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**Identify existing resources and services throughout the county**

- Surveyed mental health providers and identified 11 providers with varying capacity to serve children age 0-5
- Established the Early Childhood Mental Health Development Group
- Will be informed of the results of Childcare Mental Health Consultation Service Program survey
- Provided IFMH orientation for Access Provider Network to develop referral sources

| Identify priorities and areas of need | | | |

- Need for training, knowledge and information
- Infusion of IFMH services into existing services
- Priority to develop and implement training and supervision for mental health clinicians
- Surveyed mental health providers
- Personal Contact more effective than written survey in identifying resources.
- Identified contracted private providers and organizational providers willing and able to provide services
- Developing service coordination strategies (decision tree)
- Infant Mental Health Committee guided efforts
- Train and support new providers to meet increased demand for services especially for court-ordered families.
- Court is requesting Bonding Studies, Attachment Assessments and Expedited Screens/Recommendation
- Needs for training, knowledge, and information
- Needs for linkages among agencies
- Severe need for services within communities
- Need for practical experience, clinical observation and supervision
- Need for Intensive training in evaluation, child development, therapeutic models

- ‘Birth and Beyond’ Project (Nine site community-based program; Cal-SAFH model)
- Building Blocks (IFMH provider)
- Participation in Sacramento TransAgency Resource Collaborative
- DMH provides mental health focus for multidisciplinary teams
- MDT team building
- Support and guidance for home visitor
- Address unique needs of foster children
### Goal 1: Identification of early childhood/infant family mental health needs, resources, and services

<table>
<thead>
<tr>
<th>Establish plan for training, technical assistance, and resource development</th>
<th>Promote awareness of resources and services</th>
<th>Utilize new resources and services</th>
</tr>
</thead>
</table>
| • Hired IFMH specialist for Feasibility Study  
• Infant Family Mental Health Training Seminar provided weekly training and case consultation for 15 mental health providers chosen based on their agency affiliation to maximize the benefits of the training (Each MH provider serves one family)  
• Planning Phase II of Seminar | • The interagency Early Childhood Mental Health System Development Group is considering a resource directory of services for 0-5 population  
• The 15 mental health providers promote awareness to their various agencies | • Access Provider Network has begun referring families to appropriate agencies with the help of the IFMH coordinator  
• 15 families being served as cases in the IFMH training seminar |
| • Menu of trainings offered to meet needs of all agencies and disciplines  
• Provided intense training and consultation for mental health clinicians combined with collaborative development of intervention model  
• Clinicians outstationed at two programs to provide services and consultation  
• Plans for outstationing clinicians at other program sites  
• In process of developing plan to meet training needs for coming year  
• Long term plan needed for continued county wide growth in the number of trained practitioners | • Developing Resource Map for Web Site  
• Multi-agency Infant Mental Health Committee plans, promotes and advises the effort | • Multi-agency Infant Toddler Treatment Team (ITTT) meets weekly to develop treatment plans for families needing multiple services  
• 14 Youth Link Clinicians, 4 outpatient screeners and 8 contract private providers are serving referrals for IFMH |
| | • Weekly communication with agencies-including articles on IFMH  
• Monthly IFMH Advisory Committee meetings. (New focus: collaboration) | • Some referrals to pioneer providers  
• Serving 5 families through the Feasibility Study |
| | | • Hire and train mental health clinicians and child development specialists for each of nine sites  
• Provide consultation and training to Home Visitation Teams  
• Explore treatment model for Foster Children |
## Table 4

### Goal 2: Capacity Building - Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Alameda</th>
<th>Fresno</th>
<th>Los Angeles</th>
<th>Sacramento</th>
</tr>
</thead>
</table>
| **Large Group Sessions (promotion & awareness)** | Alameda County Children’s and Families Commission (Prop. 10) sponsored:  
- 4 day training for core service providers (public health nurses) on relationship-based family support services for birth to five  
  Sept. 00  
- Training connections-monthly specialty topic 2 hr. seminars on a range of topics for the birth to five population, Sept. 00 | Oct. 99-Mar. 00-Clinicians attended 4 trainings hosted by various agencies  
- Mar. 00-Clinicians and other professionals attended Ruth Ryan's CRVC Training  
- Apr. and May 00-Lucia Milbourne, Ph.D. 2 Special Topic Trainings (1 day each)  
- Apr., June, July, Aug., Sept., Oct. 00-Chris Wright, Ph.D. 6 Special Topic Trainings (6 hrs. each)  
- Jun 00-Susan McDonough (2 day)  
- June 00-Kevin O’Connor, Ph.D., and Sue Ammen, Ph.D. (2 day)  
- Sept. 00-Mirek Lojkasek (2 day)  
- Oct. 00-Allan N. Schore, Ph.D. Mental Health) (1 day)  
- Oct. 00-Ira Chasoff M.D., Ph.D. (2 day) Interagency | Oct. 99-Mar. 00:  
- DMH collaborative training ‘Putting Pieces Together’  
- DMH collaborative training with LACGC  
- LAC on Child Abuse and Neglect, Early Childhood Training track  
- June 00-Susan McDonough 16 hrs.  
  (4 hrs. interagency)  
- July 00-Victor Bernstein 16 hrs. (4 hrs. interagency)  
- Sept. 00-Mirek Lojkasek 16 hrs. (4 hrs. interagency)  
- July 00-DHS/DMH Collaborative Training 4 hrs. July 00-Connie Lillas/IDA 16 hrs.  
  June 00-Pasadena Child Development Center 4 hrs. |  
- Feb 00- Victor Bernstein Training for Home Visitation Teams (1 day)  
- June 00-Victor Bernstein and Mary Claire Heffron (2 day)  
- Sept. 00-Victor Bernstein and Mary Claire Heffron (2 day) |
| **Conferences** | Zero to Three 12/99 (3 providers)  
- DC 0-3 Conference (3 providers)  
- Rose Jenkins Conference (3 providers) | Dec. 99- Zero to Three Conference (4 county providers & 4 private providers)  
- Jan 20-21, 00- Training on specific developmental disorders (one clinician) | LAC Interagency Council on Child Abuse and Neglect Annual Conference 1999  
- May 00-DC-03 conference (2 day) | Zero to Three Conference (3 mental health)  
- Family Strategies Conference (10 mental health staff)  
- Rose Jenkins Conference (10 mental health staff) |
| **Consultations** | Part of ongoing training seminar | IFMH clinicians consult with case managers and home visitors on individual cases  
- Weekly consultations with ITTT  
- Weekly consultations with referral agencies. | Planned as part of Phase II |  
- Series of Team Leader and Home Visitor consultations with Mary Claire Heffron and/or Victor Bernstein, Spring 00 & Oct. 00 (8 sites, 2 days) |

Goal 2 continued on next page.
Table 4 (continued)

**Goal 2: Capacity Building** - Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.

<table>
<thead>
<tr>
<th>Type of Training:</th>
<th>Alameda</th>
<th>Fresno</th>
<th>Los Angeles</th>
<th>Sacramento</th>
</tr>
</thead>
</table>
| **Ongoing Training and Planned Staff Development Activities** | • DC 0-3 Orientation seminar May 00  
• Infant Family Mental Health Training Seminar Weekly 2 hr. training and consultation for 15 Mental Health Clinicians each with one case Aug. 00-Dec. 00 | • Feb. 7, 00 to Oct. 00: Weekly two-hour trainings with Sue Ammen, Ph.D., (6 clinicians)  
• County clinicians provide weekly case consultation and training to: Exceptional Parents Unlimited Cal-Sahf and Lori Ann Infant Programs; Central Valley Regional Center; Voluntary Family Maintenance C.I.T.E. Welfare Staff; E.O.C Early Head Start | • USC/UAP mini training (1 day) for 9 pioneer providers from 3 agencies  
• USC/UAP IFMH inservice for Early Start in Harbor Regional Ctr. area.  
• Plans for regionalization of development, mini seminars, USC/UAP supportive training, staff development and site visitation | • 8 week-3 hour infant mental health seminar sponsored by River Oak for agency staff and mental health clinicians from B&B. (Aug. & Sept. 00) |
| **Other** | • Hired IFMH Specialist for Feasibility Study work and consultation | • Sept. 99 – Dec. 99 Audit of CSPP “Play-Based Attachment”  
• Sept. 00-Quarterly meeting of 0-3 Task Force  
• Oct. 00-Training for CASA staff from 25 counties (5 hrs)  
• Special Training sessions for particular groups have been provided for; contracted private providers; Managed care staff; Court CASA, Child Welfare and Children’s Mental health | • Collaboration with Early Head Start to provide services under feasibility study  
• Cedar Sinai Childhood Training Program admitted 14 mental health providers to the 3 year program | • IDA Training sponsored by STAR collaborative (Sept. 00)  
• Developed the roles of the mental health specialist and child development specialist on the multi-disciplinary team |
Table 5  
**Goal 2: Capacity Building (The Numbers) —** Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.

<table>
<thead>
<tr>
<th>Outcome Indicator:</th>
<th>Alameda</th>
<th>Fresno</th>
<th>Los Angeles</th>
<th>Sacramento</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provided Training for:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Professionals</td>
<td>31</td>
<td>188</td>
<td>50</td>
<td>12</td>
<td>281</td>
</tr>
<tr>
<td>Interdisciplinary Personnel</td>
<td>65</td>
<td>439</td>
<td>300+</td>
<td>140</td>
<td>944</td>
</tr>
<tr>
<td><strong>Hired, contracted or reassigned:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New mental health providers to provide services to infants aged birth-3 and their families</td>
<td>15&lt;sup&gt;2&lt;/sup&gt;</td>
<td>31&lt;sup&gt;3&lt;/sup&gt;</td>
<td>70</td>
<td>6&lt;sup&gt;4&lt;/sup&gt;</td>
<td>122</td>
</tr>
<tr>
<td><strong>Served Infants Aged 0-3 and Their Families:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Through County DMH providers and funds</td>
<td>15</td>
<td>116&lt;sup&gt;6&lt;/sup&gt;</td>
<td>264&lt;sup&gt;7&lt;/sup&gt;</td>
<td>30</td>
<td>425</td>
</tr>
<tr>
<td>Through IFMHI resources and funds</td>
<td>64&lt;sup&gt;8&lt;/sup&gt;</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>73</td>
</tr>
<tr>
<td>Through other resources and funds (i.e., health, social services, regional center, other special grants)</td>
<td>342&lt;sup&gt;9&lt;/sup&gt;</td>
<td>3,144</td>
<td>?</td>
<td>?</td>
<td>3,486</td>
</tr>
</tbody>
</table>

1 Entry represents the largest number attending a session  
2 IFMHI Seminar attendees each have one case  
3 Includes 5 mental health clinicians, 14 Youth Link clinicians, 4 outpatient screeners and 8 contract providers  
4 Four Birth and Beyond mental health clinicians in training for IFMHI and 2 Building Blocks clinicians  
5 September '00 - October '00  
6 Number of families served in September and October 2000  
7 Total number of families served by 18 agencies from January '00 to August '00 (started with zero in January '00)  
8 Feasibility Study +15 cases  
9 Every child counts
### Table 6

**Goal 4: Model Development** — Develop replicable strategies for ongoing training, service delivery, and funding of infant family mental health services.

| Type of Model:                        | Alameda                                                                 | Fresno                                                          | Los Angeles                                                  | Sacramento                                      |
|---------------------------------------|-------------------------------------------------------------------------|                                                                |                                                             |                                               |
| **Screening/Assessment**              |                                                                         |                                                                |                                                             |                                               |
|                                       | • Seminar training model in use of DC-03 classification system          | • Referral and screening process                                | • Collaborative model with Early Head Start                  | • Combination of BABES partial IDA and identifying packet from Fresno |
|                                       | • Screening and identification process for the Feasibility Study        | • Assessment package                                           | • Piloted the Calif. Institute of Mental Health’s screening tool |                                               |
| **Intervention**                      |                                                                         | • IFMH Team and Sue Ammen are developing a model.               | • 12 session Intervention Outline incorporating assessments  | • Research-based program model for foster infants and toddlers |
|                                       |                                                                         | • Marschack Interactive Method of Videotaping                   |                                                             | • Planning for expansion of Building Blocks program.         |
| **Service Delivery System**           |                                                                         | • Developing strategies for delivering services based on family needs | • Regionalization of development by linking IFMH providers to local community resources | • Birth and Beyond IFMH Infusion |
|                                       | • County-wide Early Childhood mental health system for collaborative delivery to 0-5 year-old population | • Collaborative service delivery with referring agencies        |                                                             | • Multi-disciplinary team building                  |
|                                       | • Created Early Childhood Mental Health Coordinator position            |                                                                |                                                             | • Training and support for home visitor              |
| **Funding**                           | • CalWorks                                                             | • Medi-Cal agencies                                          | • EPSDT                                                      | • EPSDT (established)                               |
|                                       | • Proposition 10                                                       |                                                                | • CalWorks                                                  |                                               |
|                                       | • Medi-Cal/EPSDT                                                       |                                                                | • Proposition 10                                            |                                               |
| **Training**                          | • IFMH Training Seminar for Mental Health Clinicians                    | • Training curriculum for mental health clinicians             | • Training Track in Early Childhood                         | • River Oak 8 week training seminar               |
|                                       | • Planning for ongoing training model for multidisciplinary providers   | • Utilization of local expertise for consultation and training for other family service providers and referring agencies |                                                             | • Birth and Beyond mental health/child development work group addressing issues related to those team positions and screening and assessment for Medi-Cal |
| **Other**                             | • Medi-Cal billing codes for infant mental health services             | • Developed diagram of model of relationship-based Infant Family Mental Health Intervention Project with Moderate Risk Families | • Plan to develop tracking system for services rendered to Birth-to-3 population |                                               |
### Table 7

**Goal 5: Feasibility Study** - Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.

<table>
<thead>
<tr>
<th>County</th>
<th>Mentors</th>
<th>Trainees</th>
<th>Families</th>
<th>Implementation Activities</th>
</tr>
</thead>
</table>
| Sacramento | 1 Psychologist from River Oak Center for Children | 3 River Oak Staff | Drawn from CHEC and Birth and Beyond | • River Oak IFMH specialist hired; will conduct Feasibility Study  
• IDA training complete  
• Screening and identification of families in process; using ID packet from Fresno, portion of IDA and BABES  
• Three families screened and identified; more scheduled; plan to have all identified by January  
• Assessments and treatment will begin when Medi-Cal Access referral is complete |
| Alameda | 3 Mentors including 2 Ph.D.’s from CHO and 1 LCSW from CHO/Alameda Co.) | 3 Trainees including 1 MFT from Alameda contract agency and 2 LCSWs from Alameda Co. outpatient | 10-15 Drawn from Alameda Co. La Clinica outpatient and Alameda Co. Access System and possibly some from CHO | • Nine families enrolled; 10th has agreed  
• Completed 3 full assessments-video-taping, instruments, summaries; plan to have all complete by March 15, 2001  
• Assessments administered one per clinical session  
• After assessments are complete they are reviewed and a formal treatment plan is made in collaboration with the parents |
| Los Angeles | 3-5 Psychology training program faculty | 5 From 3-5 DMH agencies | Drawn from Early Head Start sites or other sources | • Early Head Start developed IFMH orientation, conducted screening and identified 4 families for inclusion (5th family recruited from UAP/USC)  
• Developed consent forms and introduction to the study  
• Integrated assessment into 12 session “Guided Interaction”  
• Each family has been seen in 2 or 3 sessions  
• All have completed the BABES and have been videotaped once |
| Fresno | 2 Mentors including 1 psychologist from CSPP and 1 MFT from Mental Health | 5 Trainees from Mental Health including 2 psychologists, 2 MSW’s and 1 MFT | 15 Drawn from Cal-SAFH for intervention;  
15 drawn from VFM-CPS for comparison (groups matched based on similar scaled responses) | • Developed screening tools; procedures and consent forms  
• Developed assessment protocol, procedures and sessions  
• IFMH Team is practicing MIM Video taping and use of assessment tools on ongoing clients  
• Identified new families for study  
• Ready for implementation |
Infant Family Mental Health Initiative Final Report: October 1, 1999 to October 31, 2000

Impact Assessment

Infant Family Mental Health Initiative

Project Leadership and Funding:
California Department of Mental Health

Project Coordinator:
WestEd/CPEI Center for Prevention and Early Intervention

Pilot Counties:
Alameda County
Fresno County
Los Angeles County
Sacramento County
Infant Family Mental Health Initiative Impact Assessment

The Impact Assessment Survey was designed to assess the Infant-Family Mental Health Initiative's (IFMHI) progress toward an integrated, collaborative, whole system of care for children from birth to three and their families. The combined accomplishments and activities of the four participating counties with reference to the five goal areas provided the foundation of information and framework for the evaluation. This part of the IFMHI Final Report provides an assessment of progress in each goal area and identifies significant outcomes. It also summarizes the participants' experience in the Initiative including the articulated challenges and needs, and results. Recommendations for each goal area address the successes of the Initiative and the identified needs and challenges.

Purpose

The Impact Assessment Survey measured outcomes from the Infant-Family Mental Health Initiative (IFMHI). It included an assessment of the changes in county mental health delivery systems as well as an evaluation of the IFMHI and its various components. It also provided an opportunity for participants to share what they've learned and provide feedback about their experience with the Initiative. Information gathered from the Impact Assessment Survey describes what happened as a result of the accomplishments of the Initiative and what was learned in the process. Results are intended to be used as a learning tool and to guide future efforts in infant-family mental health development.

Methods

The Impact Assessment consisted of a written survey, targeting each of the five goal areas of the IFMHI and the Initiative in general. A copy of the survey is included in Appendix B. The survey included both forced choice and open-ended questions for each goal area and the Initiative in general. Survey participants were limited to key partners in the Initiative in each county and at the State level. They included county coordinators, administrators, and mental health providers and the infant-family mental health specialists and primary community partners. All participants were familiar with the statewide goals and were involved in local planning and implementation of the Initiative in the county. Surveys were delivered via Federal Express to a total of 29 potential respondents in mid November 2000, shortly after the close of the first year of the Initiative.

In addition, follow-up interviews were conducted with each of the four county coordinators and the four county infant-family mental health specialists. The purpose of the interviews was to review and enhance the participants' responses to the open-ended questions and to provide an opportunity for additional comments and recommendations.

Respondents

Of the 29 surveys sent out, 22 respondents or 75% returned surveys. Respondents were well represented from each county and by roles in the Initiative. The 22 survey respondents included 4 from Alameda County, 7 from Fresno County, 4 from Los Angeles County and 7 from Sacramento County. Fresno County had the largest number of community partners involved in the Initiative and thus had a larger number of respondents. The number of respondents from Sacramento County also includes 3 respondents from the statewide coordinating agency for the Initiative. Table 8 for this section provides the number and percentage of respondents by county.

Table 8: Survey respondents by County.

<table>
<thead>
<tr>
<th>County Name</th>
<th># Resp.</th>
<th>% Resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alameda</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Fresno</td>
<td>7</td>
<td>32%</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>4</td>
<td>18%</td>
</tr>
<tr>
<td>Sacramento</td>
<td>7(^{10})</td>
<td>32%</td>
</tr>
</tbody>
</table>

\(^{10}\) Three from State IFMHI
The various types of collaborators working with the Initiative in each county are represented by their role in the Initiative. The respondents show a well-rounded representation of roles in the Initiative. All four of the county coordinators, 3 county administrators, 3 infant-family mental health specialists, 5 community partners, 3 county mental health providers, 1 other service provider and 3 state IFMHI coordinators responded to the survey. An additional survey was received from an infant-family mental health specialist too late to be included in the data tables; however the responses to open-ended questions on that survey were considered in the analysis and summary of responses to those questions.

Table 9 shows the number and percentage of respondents representing the various roles in the Initiative.

**Goal 1: Resource Identification**

Identification of early childhood/infant-family mental health needs, resources and services

**Range of Resources Identified**

The range of local resources identified, developed, and/or utilized as part of the Initiative was assessed for both mental health resources and other professional and paraprofessional resources. Respondents indicated that mental health resources and support within the existing county mental health system (91%) and mental health providers interested in developing infant-family mental health expertise (95%) followed by mental health providers with previous experience in infant-family mental health (82%) were the most prevalent types of resources identified and developed. Less focus was indicated in the development of mental health resources and support within other county and local agencies and organizations (64%).

Although the largest effort was put forth in the identification and development of county mental health resources and support, substantial effort was indicated in the identification and development of other professional and paraprofessional resources for both those health, education, developmental disabilities, and/or social service providers interested in learning more about using relationship-based approaches and infant-family mental health concepts (77%) and for the same types of providers with experience in using relationship-based approaches and infant-family mental health concepts (68%). Table 10 lists the local resources identified, developed, and or utilized as part of the Initiative.

<table>
<thead>
<tr>
<th>Table 10</th>
<th>Local resources identified, developed, and/or utilized as part of the Initiative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Resources (N=22)</td>
<td>% Resp.</td>
</tr>
<tr>
<td>• Mental health resources and support within the existing county mental health system</td>
<td>91%</td>
</tr>
<tr>
<td>• Mental health resources and support within other county/local agencies and organizations</td>
<td>64%</td>
</tr>
<tr>
<td>• Mental health providers interested in developing infant-family mental health expertise</td>
<td>95%</td>
</tr>
<tr>
<td>• Mental health providers with previous experience in infant-family mental health or related expertise</td>
<td>82%</td>
</tr>
</tbody>
</table>
Other Professional and Paraprofessional Resources (N=22)  

<table>
<thead>
<tr>
<th>Resource Type</th>
<th>% Resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health, education, developmental disabilities, and/or social service providers with experience in using relationship-based approaches and infant-family mental health concepts and approaches to services</td>
<td>68%</td>
</tr>
<tr>
<td>Health, education, developmental disabilities, and/or social service providers interested in learning more about using relationship-based approaches and infant-family mental health concepts and approaches to services</td>
<td>77%</td>
</tr>
</tbody>
</table>

Outcomes from Resource Identification

Outcomes from the process and results of resource identification and development significantly contributed to the promotion and awareness of infant-family mental health services as indicated by 68% of the respondents. The process and results of resource identification increased demand for infant-family mental health services moderately (32%) to significantly (55%). Overall, respondents felt that the county's plan for training, technical assistance and resource development was moderately (45%) to significantly (36%) successful in addressing the identified priorities and areas of need. Evidently, respondents feel they have more to do to meet the infant family mental health needs of their counties. Table 11 lists the outcomes from the process and results of resource identification.

<table>
<thead>
<tr>
<th>Table 11</th>
<th>Outcomes from the process and results of resource identification and development (N=22)</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contributed to the promotion and awareness of infant-family mental health services in your county</td>
<td>0%</td>
<td>0%</td>
<td>32%</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>• Increased the demand for infant-family mental health services in your county</td>
<td>0%</td>
<td>14%</td>
<td>32%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>• County's plan for training, technical assistance &amp; resource development successfully addressed the identified priorities and areas of need</td>
<td>0%</td>
<td>9%</td>
<td>45%</td>
<td>36%</td>
<td></td>
</tr>
</tbody>
</table>

Other Outcomes from Resource Identification and Development

Resource identification was an ongoing process that involved written surveys of resource providers as well as the development of and participation in work groups, committees and individual networking and follow-up. The responses to the open-ended questions asking about the outcomes from of resource identification and development have been summarized below in terms of: What happened as a result of resource identification efforts? and What needs and challenges were identified?

What happened as a result of resource identification efforts?

- Widespread interest in the development of the continuum of infant-family mental health services by professionals from all systems working with children and families
- Connection to resources facilitated by good communication, mailing lists and personal contact
- Increased networking and dialogue between agencies about needs and resources
- Increased interagency collaboration
- Expansion of resource identification to include private providers and other resources to meet demand for services
• Recognition that the multiple agencies serving families are valuable resources that need training and coordination to be effective as part of an infant-family mental health delivery system
• Plans to develop an extensive resource network as well as a phone tree on when and how to access the appropriate agency

What needs and challenges were identified?

• The need for person-to-person communication and understanding in the identification and coordination of resources (written surveys were not as effective)
• The difficulty in identifying the network of agencies serving infants and families
• The need to develop local relationships between referring agencies and mental health providers
• The limited number of and need for additional mental health clinicians trained and experienced in infant-family mental health
• The need for adequate training venues that provide the combination of didactic/experiential and supervision for trainees
• The shortage of resources to meet service needs
• The need to provide a treatment plan at time need is identified for a family—not put on a waiting list

Discussion and Recommendations for Resource Identification

Resource identification and development is a challenging process that to be effective requires personal communication and the development of relationships between mental health and other service providers. The process becomes more complex in the coordination of service delivery. Each of the various service providers must understand their role in the provision of service and be familiar with and knowledgeable about the other resources and services available to families. Routine opportunities for interagency information sharing, problem-solving and collaboration such as monthly infant-family mental health advisory committees and weekly interagency team meetings or conference calls are needed for effective ongoing efforts in resource identification and coordination.

Resource identification promoted awareness and widespread interest in the development of the continuum of infant-family mental health services by professionals from all systems working with children and families. During the first year of the Initiative more focus was placed on the identification and development of mental health resources. Expanded collaborative service delivery, expected in the second year, will require greater effort in the identification, development and coordination of resources from other agencies serving infants and families.

The shortage of mental health clinicians trained in infant-family mental health as well as the need for the development of effective venues of training dictate the need for continued identification and development of mental health resources.
Goal 2: Capacity Building

Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings.

Effectiveness of Various Types of Training

Training is a key component in increasing capacity. The counties, depending on their needs and priorities, utilized a variety of different types of training. Small group training/consultation with a focus on the mental health provider was considered to be the most effective type of training and highly recommended by 82% of the respondents. Local ongoing training and staff development and onsite consultations and technical assistance were considered the next most effective and were highly recommended by 68% and 59% of respondents respectively. Large group interagency training was considered moderately effective by 32% and highly recommended by 36% of respondents. National conferences and training were not offered by 27% of respondents and considered moderately effective by 32% of respondents. Table 12 shows the effectiveness ratings for each type of training.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Not offered</th>
<th>Minimally effective</th>
<th>Moderately effective</th>
<th>Very effective highly recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large group interagency training</td>
<td>5%</td>
<td>18%</td>
<td>32%</td>
<td>36%</td>
</tr>
<tr>
<td>Smaller group training/consultation with focus on the mental health provider</td>
<td>0%</td>
<td>9%</td>
<td>5%</td>
<td>82%</td>
</tr>
<tr>
<td>Onsite consultations and technical assistance</td>
<td>14%</td>
<td>9%</td>
<td>9%</td>
<td>59%</td>
</tr>
<tr>
<td>Local ongoing training and staff development</td>
<td>9%</td>
<td>9%</td>
<td>9%</td>
<td>68%</td>
</tr>
<tr>
<td>National conferences and training</td>
<td>27%</td>
<td>18%</td>
<td>32%</td>
<td>9%</td>
</tr>
<tr>
<td>Other:</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Impact of Training on Mental Health and Other Service Providers

Training was provided for both mental health providers and other professional and paraprofessional service providers. The impact of infant-family mental health training and consultation on these two groups was assessed separately. For mental health providers, respondents indicated that the most significant impact was heightened awareness of the need for qualified infant-family mental health providers (82%) followed by increased demand for training (68%). Respondents were evenly split (50/50) in their assessment of mental health provider’s moderately or significantly increasing awareness of infant-family mental health concepts and approaches to services as a result of the training and consultation. More respondents felt that the training moderately prepared mental health providers to implement infant-family mental health concepts and approaches to services (55%) and to collaborate with other early childhood and early intervention service providers (64%).

For other professional and paraprofessional service providers, increased demand for training (55%), heightened awareness of the need for qualified infant-family mental health providers (55%), and increased
awareness of infant family mental health concepts and approaches to services (50%) were indicated by respondents as significant outcomes. Although not as strong as for mental health providers, respondents indicated that the training and consultation moderately prepared other professional and paraprofessional service providers to implement infant family mental health concepts and approaches to services (41%). Overall, fewer respondents indicated that the training and consultation for other professionals and paraprofessionals either significantly (36%) or moderately (27%) prepared this group to collaborate with mental health professionals. In general, the infant-family mental health training and consultation had a greater impact on mental health professionals than on other professional and paraprofessional service providers. Table 13 summarizes the impact of IFMH training and consultation on mental health and other professionals and paraprofessionals.

<table>
<thead>
<tr>
<th>Table 13</th>
<th>Impact of IFMH training and consultation on mental health providers and other service providers (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Providers</td>
<td>Not at all</td>
</tr>
<tr>
<td>Increased demand for training</td>
<td>0%</td>
</tr>
<tr>
<td>Heightened awareness of need for qualified IFMH providers</td>
<td>0%</td>
</tr>
<tr>
<td>Increased awareness of IFMH concepts and approaches to services</td>
<td>0%</td>
</tr>
<tr>
<td>Prepared mental health providers to implement infant-family mental health concepts and approaches to services</td>
<td>0%</td>
</tr>
<tr>
<td>Prepared mental health professionals to collaborate with other early childhood and early intervention service providers</td>
<td>5%</td>
</tr>
<tr>
<td>Other:</td>
<td>0%</td>
</tr>
</tbody>
</table>

Other Professional and Paraprofessional Service Providers:

| Increased demand for training | 0% | 5% | 23% | 55% |
| Heightened awareness of need for qualified IFMH providers | 0% | 9% | 23% | 55% |
| Increased awareness of IFMH concepts and approaches to services | 0% | 14% | 23% | 50% |
| Prepared other professional and paraprofessional service providers to implement infant-family mental health concepts and approaches to services | 0% | 27% | 41% | 18% |
| Prepared other professional and paraprofessional service providers to collaborate with mental health professionals | 5% | 14% | 27% | 36% |
| Other: | 0% | 0% | 0% | 0% |

**Improvement in the Capacity to Serve Infants and Families**

In response to a general question, respondents indicated that over the past year county mental health systems have moderately (23%) to significantly (55%) improved their capacity to serve infants and families. Table 14 contains this data.
Table 14

<table>
<thead>
<tr>
<th>Over the past year, to what extent has your county mental health system ... (N=22)</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved capacity to serve infants and their families?</td>
<td>0%</td>
<td>5%</td>
<td>23%</td>
<td>55%</td>
</tr>
</tbody>
</table>

Other Outcomes from Capacity Building Efforts

Capacity building efforts included the provision of training, technical assistance and consultation and the addition of new mental health providers hired, contracted or reassigned to provide mental health services to infants and families. Responses from open-ended questions regarding the impact of training, technical assistance and consultation and challenges in increasing the availability of mental health and other professionals qualified to provide infant-family mental health services have been summarized in terms of What happened as a result of capacity building efforts? and What needs and challenges were identified?

What happened as a result of capacity building efforts?

- Enhancement of the knowledge and understanding of the needs of infants and families
- A forum for all providers of services for infants and families to come together under a common perspective
- Maintained an interest and focus on infant-family mental health concepts and relationship-based approaches to services for mental health and other service providers
- Heightened awareness, which promoted dialogue between agencies and a common knowledge base
- Development of a core of mental health providers with knowledge and expertise in infant family mental health
- Development of a growing body of specialists able to provide local training and consultation

What needs and challenges were identified?

- The shortage of infant family mental health specialists available and able to provide ongoing training, consultation and supervision
- The need to address funding barriers to pay for staff training time
- That "pre-service training is lacking and insufficient. Graduate programs need help developing adequate curriculum for the 0-5 population."
- The need for certification of infant-family mental health expertise

Discussion and Recommendations for Capacity Building

Over the past year the county mental health systems have improved their capacity to serve infants and families. Interest in and awareness of infant-family mental health concepts and relationship-based approaches to services was increased for both mental health and other professionals and paraprofessionals. However, as with resource identification efforts, capacity building efforts have had a somewhat greater impact on mental health professionals than on other professionals and paraprofessionals. This is true particularly in terms of preparation for implementation of infant-family mental health concepts and relationship-based approaches to services and preparation for collaboration with other service providers.
Small group training and consultation focused on the mental health professional, was by far considered the most effective type of training to increase capacity. More of this type of training for mental health professionals is clearly warranted. Large group interagency training, although important in increasing awareness of infant-family mental health concepts for all service providers, was viewed as a less effective in increasing capacity than the small group training and consultation. To enhance the role of other professionals and paraprofessionals in the infant-family mental health service delivery continuum, it appears that small group training and consultation geared to meet the specialized needs of these service providers should be developed and implemented. Sending individuals to national conferences, considered least effective in building capacity, probably does not justify the expense of this type of training.

The shortage of infant-family mental health specialists available to provide ongoing training, consultation and supervision requires each county to utilize the available resources to develop and train local mental health clinicians to become infant-family mental health specialists. Continued development of local infant-family mental health training resources is necessary to build local ongoing training and consultation also considered to be highly effective in capacity building.

Building partnerships with institutions of higher education is needed to develop and improve pre-service training in infant-family mental health concepts and relationship-based approaches to services and treatment/intervention to further expand and sustain capacity building efforts.

The development and articulation of competencies for the continuum of infant-family mental health services as well as a certification process is needed to promote development of infant-family mental health specialists and to validate this area of expertise.

**Goal 3: Collaboration**

Facilitate interdisciplinary and interagency collaboration for services and staff training.

The development of an effective system for the collaborative delivery of a continuum of infant-family mental health services requires the establishment of relationships with groups that are able to provide training resources, a broad range of providers of services for infants and families and advisory groups with an interest in infants and families. An assessment of the types of organizations that county mental health systems have established relationships with in each of these areas provides an indication of the progress that counties have made in developing collaborative services and resources.

**Relationships with Training Resources**

With regard to training resources the largest percentage of respondents indicated a relationship with infant-family mental health provider specialists (82%) followed by centers with expertise in infant-family mental health (73%) and teaching hospitals with infant-family mental health programs (55%). Fewer respondents indicated relationships with institutions of higher education providing education and training in infant-family mental health (41%) and other types of training resources (23%).

**Relationships with Service Providers**

Relationships with various types of service providers are most common with private mental health providers (68%), collaborative health and human services delivery projects (64%) and Early Head Start/Head Start programs (64%). Large percentages of respondents also indicated relationships with Public Health (59%), childcare/child development programs and agencies (55%), Family Resource Centers (55%), child protective services (55%), foster care agencies (50%) and Department of Developmental Services Regional Centers (50%). Less than half of the respondents indicated relationships with Regional Center vendors (45%), local education agencies (36%), alcohol and drug rehabilitation programs (27%) and other social service agencies (18%).
Relationships with Advisory Groups

In terms of advisory groups relationships with local Proposition 10 Commissions (73%) were most often reported along with multi-agency collaborative infant and early childhood advisory committees (68%) and infant-mental health advisory committees (50%). Less commonly reported were relationships with mental health advisory councils (36%) child abuse prevention councils (32%), childcare coalitions or advisory committees (23%) and pediatric advisory groups (9%).

Overall great strides have been made in establishing relationships with groups in all three areas, but there's still plenty of room for expansion. Table 15 provides a listing of the percentage of respondents who have established relationships with various types of organizations in developing infant-family mental health services and resources.

### Table 15

The following types of organizations county mental health systems have established relationships with in developing IFMH services and resources

<table>
<thead>
<tr>
<th>Training Resources (N=22)</th>
<th>% Resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Centers with expertise in infant-family mental health</td>
<td>73%</td>
</tr>
<tr>
<td>• Infant-family mental health provider specialists</td>
<td>82%</td>
</tr>
<tr>
<td>• Institutions of higher education providing education &amp; training in infant-family mental health</td>
<td>41%</td>
</tr>
<tr>
<td>• Teaching hospital with infant-family mental health program</td>
<td>55%</td>
</tr>
<tr>
<td>• Other:</td>
<td>23%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Providers (N=22)</th>
<th>% Resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Private mental health providers</td>
<td>68%</td>
</tr>
<tr>
<td>• Collaborative health and human services delivery projects</td>
<td>64%</td>
</tr>
<tr>
<td>• Department of Developmental Services Regional Center</td>
<td>50%</td>
</tr>
<tr>
<td>• Regional Center vendors</td>
<td>45%</td>
</tr>
<tr>
<td>• Local Education Agencies</td>
<td>36%</td>
</tr>
<tr>
<td>• Childcare/Child development programs and agencies</td>
<td>55%</td>
</tr>
<tr>
<td>• Child Protective Services</td>
<td>55%</td>
</tr>
<tr>
<td>• Foster Care Agencies</td>
<td>50%</td>
</tr>
<tr>
<td>• Family Resource Center</td>
<td>55%</td>
</tr>
<tr>
<td>• Early Head Start/Head Start</td>
<td>64%</td>
</tr>
<tr>
<td>• Alcohol and drug rehabilitation programs</td>
<td>27%</td>
</tr>
<tr>
<td>• Public Health</td>
<td>59%</td>
</tr>
<tr>
<td>• Other Social Services Agencies:</td>
<td>18%</td>
</tr>
</tbody>
</table>
Advisory Groups (N=22)

<table>
<thead>
<tr>
<th>Advisory Group</th>
<th>% Resp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-agency collaborative infant and early childhood advisory committee</td>
<td>68%</td>
</tr>
<tr>
<td>Local Prop. 10 Commission</td>
<td>73%</td>
</tr>
<tr>
<td>Infant-family mental health advisory committee</td>
<td>50%</td>
</tr>
<tr>
<td>Child Abuse Prevention Council</td>
<td>32%</td>
</tr>
<tr>
<td>Childcare Coalition or advisory committee</td>
<td>23%</td>
</tr>
<tr>
<td>Mental health advisory council</td>
<td>36%</td>
</tr>
<tr>
<td>Pediatric advisory groups</td>
<td>9%</td>
</tr>
<tr>
<td>Other:</td>
<td>14%</td>
</tr>
</tbody>
</table>

Progress in Collaboration

The development of teamwork skills and the establishment of collaborative staff development and service delivery are also indicative of progress in collaboration. Respondents show that they've made significant progress increasing linkages and interagency multi-disciplinary collaboration (55%). Moderate to significant progress has been made in collaborative staff development and service delivery as well as enhancement of teamwork skills of mental health professionals and interdisciplinary services providers. **Table 16** shows the progress in these aspects of collaboration as a result of the Initiative.

**Table 16**

<table>
<thead>
<tr>
<th></th>
<th>Not yet a focus of development</th>
<th>Initial progress</th>
<th>Moderate progress</th>
<th>Significant progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased linkages and interagency multi-disciplinary collaboration?</td>
<td>0%</td>
<td>18%</td>
<td>27%</td>
<td>55%</td>
</tr>
<tr>
<td>Established collaborative staff development?</td>
<td>5%</td>
<td>9%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Established collaborative service delivery?</td>
<td>9%</td>
<td>27%</td>
<td>27%</td>
<td>32%</td>
</tr>
<tr>
<td>Enhanced the teamwork skills of mental health professionals?</td>
<td>5%</td>
<td>23%</td>
<td>36%</td>
<td>36%</td>
</tr>
<tr>
<td>Enhanced the teamwork skills of interdisciplinary service providers?</td>
<td>9%</td>
<td>23%</td>
<td>41%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Impact of Collaboration

Collaboration has had a significant impact in the development of infant-family mental health services in a number of areas. Collaboration has significantly: increased awareness of the need to identify funding resources (86%), increased demand for training (77%), promoted awareness of infant-family mental health needs in the county (64%), and increased demand for services (64%). Collaboration has also significantly expanded resources for training and technical assistance (50%), and promoted further linkages and collaborations (50%). To a lesser degree respondents indicated that collaboration has significantly expanded referral sources (41%), and expanded the opportunity to promote and develop interdisciplinary
resources for infant-family mental health (41%). A more moderate impact was shown as a result of collaboration for enhancement and facilitation of service delivery (59%), improvement in access to infant-family mental health services (41%) and facilitation of model development (41%). Table 17 provides a complete breakdown of the impact of collaboration in these areas.

Table 17

<table>
<thead>
<tr>
<th>The impact of collaboration on the development of infant-family mental health services in the following areas: (N=22)</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoted awareness of infant-family mental health needs in the county</td>
<td>0%</td>
<td>0%</td>
<td>36%</td>
<td>64%</td>
</tr>
<tr>
<td>Expanded referral sources</td>
<td>0%</td>
<td>27%</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>Expanded the opportunity to promote and develop interdisciplinary resources for infant-family mental health</td>
<td>0%</td>
<td>18%</td>
<td>41%</td>
<td>41%</td>
</tr>
<tr>
<td>Expanded resources for training and technical assistance</td>
<td>0%</td>
<td>5%</td>
<td>45%</td>
<td>50%</td>
</tr>
<tr>
<td>Promoted further linkages and collaborations</td>
<td>0%</td>
<td>9%</td>
<td>36%</td>
<td>50%</td>
</tr>
<tr>
<td>Improved access to infant-family mental health services</td>
<td>0%</td>
<td>23%</td>
<td>41%</td>
<td>36%</td>
</tr>
<tr>
<td>Enhanced and facilitated service delivery</td>
<td>0%</td>
<td>18%</td>
<td>59%</td>
<td>23%</td>
</tr>
<tr>
<td>Increased demand for training</td>
<td>0%</td>
<td>0%</td>
<td>23%</td>
<td>77%</td>
</tr>
<tr>
<td>Facilitated model development</td>
<td>0%</td>
<td>23%</td>
<td>41%</td>
<td>36%</td>
</tr>
<tr>
<td>Increased demand for services</td>
<td>5%</td>
<td>18%</td>
<td>14%</td>
<td>64%</td>
</tr>
<tr>
<td>Increased awareness of the need to identify funding resources</td>
<td>0%</td>
<td>5%</td>
<td>9%</td>
<td>86%</td>
</tr>
</tbody>
</table>

Other Outcomes from Collaboration

Collaboration is a foundation to success in the development of a system of infant-family mental health services. Responses to open-ended questions concerning the most significant outcomes in the area of collaboration have been summarized in terms of What happened as a result of collaborations? and What needs and challenges were identified?

What happened as a result of collaborations?

- Information sharing and knowledge of referral sources
- Development of interest, understanding and commitment
- Collaborative staff development
- Expanded resources for training
- Expertise for model development
- Preventive and strength-based approach to services
- Multidisciplinary team development
• Development of an infant and early childhood mental health system development group
• Development of a detailed funding grid for early childhood mental health
• Additional impetus for infant-family mental health service development
• Movement toward interagency collaborative care for children and families
• A team to plan and coordinate appropriate treatment in a multi-disciplinary setting with partnering agencies
• Decrease in the redundancy of services
• Richness in the quality of knowledge of the provider team and quality of the overall service
• Positive outcomes for families when all agencies are able to work together and develop parallel plans

What needs and challenges were identified?
• The need for training and service models that meet the diversity of needs in the county
• Funding barriers
• Confidentiality issues
• The need to overcome the perception of mental health as a deficit-based model of service
• The need for time to develop and support relationships with other agencies and service providers
• Challenge of whole system development—bringing together the continuum of service delivery providers focusing on promotion/prevention and treatment

Discussion and Recommendations for Collaboration

A strong foundation of collaborative relationships has been established with a variety of training resources, service providers and advisory groups. However, all county mental health systems should be encouraged to meet the goal of whole system development—bringing together the continuum of service delivery providers for collaborative training in and coordination of the full range of infant-family mental health services. Areas that clearly need additional attention include: collaborations with institutions of higher education, as also identified under capacity building; greater investment in the development of interdisciplinary resources and referral sources for the establishment of collaborative service delivery; the need to address, explore and develop funding resources.

The benefits of collaboration have clearly impacted infant-family mental health system development and have begun to impact service delivery. Collaboration has been a driving force in propelling system development forward. It has inspired new and continued interest and commitment and provided the expertise and resources necessary for infant-family mental health system development. In addition, benefits to families are beginning to emerge. Initiative participants have noticed a decrease in redundancy of services, richness in the quality of the overall service and positive outcomes for families.

The challenges of collaboration are ongoing and will require increased efforts in collaboration to address them:

➢ **Confidentiality issues should be addressed as part of the development of collaborative service delivery.** The development of relationships with all service providers and familiarity and understanding of various agency cultures will facilitate collaborative development of guidelines for confidentiality to be shared by all.

➢ **Continued statewide and local promotion of infant-family mental health as a preventive and strength based approach to services is needed to overcome the perception of mental health as a deficit-based model of service.**
Funding barriers and strategies to overcome them may be addressed through a forum sponsored by the Initiative with representatives from all of the various agencies serving infants and families and experts equipped with information about all of the major funding streams in attendance.

Ongoing collaborative resource identification and development is needed to customize training and service models to meet the diversity of needs in the county.

The development of collaborative service delivery requires time to develop and support relationships with other agencies and service providers. The Initiative should continue to model, promote and support collaboration as it encourages counties to do the same.

**Goal 4: Model Development**

Model development serves as a vehicle for exporting the experience and knowledge gained by each county in the development of a system of service delivery and resources for infant-family mental health. Successful completion of model development requires thoughtful articulation of the process, strategies, resources and expected outcomes in the form of written materials, presentations or training that can be utilized by others in ongoing efforts or new efforts in infant-family mental health system development.

**Progress in Model Development**

For all areas of model development but one, respondents most often indicated that they are in the beginning stages of model development. These areas include the establishment of plans for countywide mental health service delivery for infants/families (41%), establishment of new strategies for resource sharing and funding for infant/family services (45%), establishment of specific recommendations for replicable service delivery and funding of infant-family services statewide (50%), development of materials and resources for dissemination (32%), and establishment of plans for ongoing training programs to be implemented after the project period (41%). More progress in model development was indicated in the establishment of plans for ongoing collaborative service delivery after the project period. Fifty percent of respondents said they were in the mid-stages of development in this area. Table 18 presents the various stages of development for each area of model development.

<table>
<thead>
<tr>
<th>Table 18</th>
<th>County progress in the following areas of model development (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not yet a focus of development</td>
</tr>
<tr>
<td>Establish plans for countywide mental health service delivery for infants/families</td>
<td>14%</td>
</tr>
<tr>
<td>Establish new strategies for resource sharing &amp; funding for infant/family services</td>
<td>9%</td>
</tr>
<tr>
<td>Establish specific recommendations for replicable service delivery and funding of infant-family services statewide</td>
<td>27%</td>
</tr>
<tr>
<td>Develop materials and resources for dissemination</td>
<td>23%</td>
</tr>
<tr>
<td>Establish plans for ongoing training programs to be implemented after the project period</td>
<td>9%</td>
</tr>
<tr>
<td>Establish plans for ongoing collaborative service delivery after the project period</td>
<td>9%</td>
</tr>
</tbody>
</table>

**Changes in Service Delivery as a Result of Model Development**
Changes in service delivery have been implemented as a result of infant-family mental health model development. Model development seems to have had the greatest impact on interagency collaboration, where the largest percentage of respondents indicated large-scale implementation. Most respondents indicated small-scale implementation of changes in the access and referral system (45%), screening and assessment (50%), service planning (45%), intervention/treatment (64%), and ongoing training programs (55%). Model development has had the least impact on billing as shown by 41% of respondents indicating that these changes are still in the process of development. Table 19 describes the changes in service delivery implemented as a result of infant-family mental health model development.

<table>
<thead>
<tr>
<th>Table 19</th>
<th>Changes in service delivery implemented as a result of infant-family mental health model development (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not yet a focus of development</td>
</tr>
<tr>
<td>Access and referral system</td>
<td>14%</td>
</tr>
<tr>
<td>Screening and assessment</td>
<td>5%</td>
</tr>
<tr>
<td>Service planning</td>
<td>14%</td>
</tr>
<tr>
<td>Intervention/treatment</td>
<td>5%</td>
</tr>
<tr>
<td>Ongoing training programs</td>
<td>9%</td>
</tr>
<tr>
<td>Interagency collaboration</td>
<td>9%</td>
</tr>
<tr>
<td>Billing</td>
<td>18%</td>
</tr>
<tr>
<td>Other:</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Other Outcomes from Model Development**

As indicated by the progress in model development described above, model development is still in the beginning stages of development. When asked to describe models ready to be shared, very few respondents provided responses. However, respondents were able to explain challenges and difficulties in model development. The challenge reported most often is finding the time to map out and articulate the plans, strategies, approaches and implementations that have emerged as models that might have the potential for replication. Another challenge concerns the lack of clarity in the expectations for model development. The Initiative has not as yet clearly specified the requirements or guidelines for a replicable model.

Respondents were more willing to provide descriptions of their priorities for model development in the coming year. These priorities along with the description of models that respondents felt ready to share are summarized and listed below. For additional information about models that are being explored, developed and articulated refer to the section on model development in the county accomplishments section of the report.

**Alameda County:**

- Infant-Family Mental Health Training Seminar
Early Childhood Mental Health System Development Committee
Feasibility Study process and tools
Process of beginning to impact the ACCESS system
Preparing for larger scale implementation of models
Plans to develop interdisciplinary focus

**Fresno County:**
- Refine model for delivering services to families and agencies with differing needs
- Developing group curriculum for mother-infant attachment based parenting group
- Developing early intervention plan which involves infant-family mental health from the time at-risk infants are born
- Link interventions to assessment and treatment planning
- Better alignment between infant-family mental health goals and managed care goals
- Work to expand out-stationed folks; show that home visits are effective use of time; document and develop model to show change with regional center clients; get autistic clients and moms covered
- To work more with childcare centers and schools to try to identify children at risk who need intervention to prevent more serious problems down the road

**Los Angeles County:**
- Regional service delivery, collaboration and linkages
- Feasibility Study process and intervention model

**Sacramento County:**
- Building Blocks outpatient services
- Foster care model from the Oregon Social Learning Center
- Birth and Beyond mental health/child development complement
- Infusion of infant-family mental health concepts and relationship-based approaches to the Birth and Beyond multidisciplinary team and support for the home visitor

**Discussion and Recommendations for Model Development**

County teams have explored and developed models for screening, assessment, prevention, intervention, collaboration, delivery systems and training. Most of these models are in the beginning stages of development and have only been implemented on a small scale. Clearly, more time, experience and effort in development are needed to produce replicable models. In the meantime recommendations to support model development follow:

- **Clarify the expectations and guidelines for model development to provide a clear understanding of outcomes or products that facilitate the ability to replicate the model.**
- **Assemble resources and materials developed thus far to be used as references for future and continued model development.**
- Encourage county systems of mental health and their partners to continue model development efforts.
- Encourage county teams to set aside time and resources for model development.
- Provide a statewide forum for discussion of ongoing model development.

**Goal 5: Feasibility Study**

Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families.

**Importance of the Feasibility Study in the Development of IFMH Services**

The Feasibility Study compelled the counties to prepare for service delivery. Preparations for service delivery required that the counties work with the infant–family mental health specialist to develop: relationships with referral sources, a screening and identification process for families, an intervention model incorporating assessment, and ongoing training to prepare mental health clinicians for service delivery. Respondents were asked to rate the importance of the Feasibility Study in influencing the development of infant-family mental health services in the county. The respondents most often rated all but one of the five indices as "very important". These include: the encouragement and facilitation of an ongoing working relationship between the county and the infant-family mental health specialist (50%); the provision of experience in developing and refining models for screening, assessment, intervention and treatment and training (45%); the provision of the opportunity to develop ongoing training to prepare mental health professionals to deliver infant-family mental health treatment services (45%); and the provision of the opportunity for experience in delivery of infant-family mental health treatment services (41%). The provision of the opportunity to identify and collaborate with service providers of at-risk populations that might benefit from infant-family mental health services was more often rated "moderately important". **Table 20** describes the influences of the Feasibility Study and the importance ratings for each.

<table>
<thead>
<tr>
<th>Table 20</th>
<th>The importance of the Feasibility Study in influencing the development of infant-family mental health services in the county: (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not applicable</td>
<td>Minimally important</td>
</tr>
<tr>
<td>Provided opportunity to identify and collaborate with service providers of at-risk populations that might benefit from infant-family mental health services</td>
<td>14%</td>
</tr>
<tr>
<td>Provided the opportunity for experience in developing and refining models for screening, assessment, intervention and treatment and training</td>
<td>14%</td>
</tr>
<tr>
<td>Encouraged and facilitated an ongoing working relationship between the county and the infant-family mental health specialist</td>
<td>9%</td>
</tr>
<tr>
<td>Provided the opportunity for experience in delivery of infant-family mental health treatment services.</td>
<td>14%</td>
</tr>
<tr>
<td>Provided opportunity to develop ongoing training to prepare mental health professionals to deliver infant-family mental health treatment services.</td>
<td>14%</td>
</tr>
</tbody>
</table>

**Importance of Various Aspects of the Feasibility Study**

Respondents also rated the importance of various activities in facilitating the development and implementation of the Feasibility Study. Most respondents rated these activities as "moderately important" or "very important". Those activities considered the most important to development and implementation of the Feasibility Study include: leadership and coordination by the Initiative; collaboration with infant-family mental health specialists to develop local plans for implementation of the Feasibility Study; development of the assessment protocol; and preparation for intervention/treatment. **Table 21** provides a complete listing of the activities and the importance ratings for each.
Table 21

The importance of various activities in facilitating the development and implementation of the Feasibility Study: (N=22)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Not applicable</th>
<th>Minimally important</th>
<th>Moderately important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration between the four counties in the development of the Feasibility Study guidelines</td>
<td>5%</td>
<td>18%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Collaboration with IFMH specialists to develop local plan for implementation of the Feasibility Study</td>
<td>14%</td>
<td>0%</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Collaboration and information sharing with other counties at bimonthly meetings</td>
<td>5%</td>
<td>23%</td>
<td>14%</td>
<td>32%</td>
</tr>
<tr>
<td>Leadership and coordination by the Initiative</td>
<td>5%</td>
<td>14%</td>
<td>23%</td>
<td>36%</td>
</tr>
<tr>
<td>Collaboration with community partners in identifying and screening families</td>
<td>14%</td>
<td>18%</td>
<td>18%</td>
<td>36%</td>
</tr>
<tr>
<td>Development of and experience in using the screening tool</td>
<td>5%</td>
<td>23%</td>
<td>32%</td>
<td>14%</td>
</tr>
<tr>
<td>Development of the assessment protocol</td>
<td>5%</td>
<td>14%</td>
<td>23%</td>
<td>32%</td>
</tr>
<tr>
<td>Preparation for intervention/treatment</td>
<td>5%</td>
<td>9%</td>
<td>23%</td>
<td>32%</td>
</tr>
</tbody>
</table>

Impact of the Feasibility Study

During the first year of the Initiative the Feasibility Study was in the process of development. By the end of the first year counties were identifying families to participate in the study and finishing up preparations for assessment and intervention/treatment. Some counties had begun the assessments and intervention/treatment. Respondents described the challenges and results of the Feasibility Study at this point in development. The summary of the responses below provides a list of key outcomes from the Feasibility Study to date:

What happened as a result of the Feasibility Study?

- Development of an identification system (previously nonexistent) for families appropriate for the study
- Introduced infant mental health (not just for kids with disabilities) to mental health providers and other professionals providing services to infants and families
- Enhancement of intervention and assessment with the use of videotaping
- Intervention model development
- Exposure to other professionals working in this field, sharing expertise and knowledge, having an opportunity to observe how other counties approached and implemented the study
- Collaboration with the IFMH specialist
- Enhanced the development of assessment tools and intervention strategies geared for home visitation
- General growing awareness that indeed, infants and toddlers are human beings with feelings-- that they are impacted by the environment in which they live
What were the challenges?

- Establishing clarity, direction and consensus among the experts
- Finding the time and energy to develop and implement it in the midst of providing ongoing services
- Gaining experience in and awareness of the time it takes to develop trusting relationships with community service providers

Discussion and Recommendations for the Feasibility Study

The Feasibility Study was a challenge for everyone involved. It stretched the knowledge and abilities of the leadership, IFMH specialists, mental health clinicians and community partners. As yet incomplete, the Feasibility Study’s greatest impact concerned the knowledge and experience gained in the development and implementation of various aspects of the study. Those involved gained experience in collaborating with the IFMH specialist in developing a plan for implementation, screening and identification of moderate risk families to participate in the study, promoting awareness and collaborating with referral sources, use of assessment tools including videotaping, development of intervention models integrating assessment as part of the intervention and conducting intervention in home and community settings. Although also considered a challenge, collaboration and information sharing among the four county teams was a valued benefit and added to the knowledge and experience gained as a result of the Feasibility Study.

Addressing the challenges of the Feasibility Study might best be accomplished by using the knowledge and experience gained in the first year of the Initiative as a foundation for a clinical research and evaluation study for the second year. Recommendations follow:

- Conduct a thorough assessment of each county’s screening, identification, assessment and intervention and implementation process. Descriptions of agencies, personnel and families involved in the study would be included.
- Provide the opportunity for county teams to present their findings and recommendations regarding the process, tools, models of intervention and preliminary outcomes for families.
- Assemble a team of experts to use the information and recommendations gathered to develop new guidelines with more specific instructions for process, tools and timelines for a study to be conducted in year two of the Initiative.
- Conduct a clinical research and evaluation study of infant-family mental health intervention using the new guidelines and provide routine oversight and monitoring of the study.

The Initiative:

Leadership, coordination, facilitation, provision of resources, training and technical assistance and promotion of infant-family mental health development
Helpfulness of the Initiative

A general assessment of the leadership and coordination of the Initiative at the state level provides information about the helpfulness of the Initiative in several key areas of focus. Fifty percent or more of the respondents indicated that the Initiative was "significantly" or "extremely" helpful in 7 of the 11 areas of focus. When the percentage of responses in these two categories are added together, the Initiative is shown to be most helpful in the provision of resources for training and consultation (77%), promoting infant-family mental health and relationship-based practices statewide (68%), coordination and implementation of training (64%), establishment of plans for training and resource development (50%), facilitation of team building (50%), facilitation of collaboration between county mental health and the infant-family mental health specialist (50%), and overall technical assistance and consultations (50%).

When the added percentage of responses in the "significantly" or "extremely" helpful categories are less than 50%, the Initiative may be considered to have been moderately helpful in those areas of focus. Those areas include dissemination of information and materials among the counties (45%), facilitation of collaboration among the four county teams (41%), promotion and provision of resources and training for model development (37%), and facilitation of resource identification and needs assessment (32%). These findings should be interpreted with particular caution because the goal of the Initiative coordinators was to meet the individual needs for facilitation and coordination of each county. Each county has its own unique strengths and required different levels of help depending on their particular circumstances. Table 22 provides a listing of Initiative activities and the ratings of "helpfulness" for each.

<table>
<thead>
<tr>
<th>Table 22</th>
<th>Helpfulness of the Initiative in each of the following areas: (N=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Facilitation of resource identification and needs assessment</td>
<td>0%</td>
</tr>
<tr>
<td>Establishment of plans for training and resource development</td>
<td>0%</td>
</tr>
<tr>
<td>Coordination and implementation of training</td>
<td>0%</td>
</tr>
<tr>
<td>Provision of resources for training and consultation</td>
<td>0%</td>
</tr>
<tr>
<td>Facilitation of collaboration between County DMH and IFMHI specialists</td>
<td>0%</td>
</tr>
<tr>
<td>Facilitation of collaboration among the four county teams</td>
<td>5%</td>
</tr>
<tr>
<td>Dissemination of information and materials among the counties</td>
<td>5%</td>
</tr>
<tr>
<td>Facilitation of team building</td>
<td>5%</td>
</tr>
<tr>
<td>Promotion and provision of resources and training for model development</td>
<td>0%</td>
</tr>
<tr>
<td>Overall technical assistance and consultations</td>
<td>0%</td>
</tr>
<tr>
<td>Promoting infant-family mental health &amp; relationship-based practices statewide</td>
<td>5%</td>
</tr>
</tbody>
</table>

Discussion and Recommendations on the Helpfulness of the Initiative

The Initiative was considered most helpful in the provision of resources for training and consultation, coordination and implementation of training, and promotion of infant-family mental health statewide. These
same areas of focus are the most visible areas of responsibility for the Initiative. Most respondents directly experienced the benefits of Initiative efforts in these areas. Within these efforts, county teams and community partners may have received funding for training, received training from National experts in infant-family mental health concepts and relationship-based approaches to services and/or received support and guidance for system development from the State Department of Mental Health. Thus, high marks in helpfulness would be predictable in these areas.

Diversity in the strengths and needs of each county somewhat confound the conclusions that might be drawn from areas of need not equally shared by all counties. The role of the Initiative in aiding each county in developing plans, team building, collaboration between the county and the infant-family mental health specialist and overall technical assistance and consultation varied depending on the strengths and needs of the county. The absence of any reference to these areas under "additional needs" may imply that counties needing help in these areas received it.

The Initiative was considered moderately helpful in the area of resource identification and needs assessment. Counties for the most part worked independently in this area. The Initiative encouraged each county to focus on the identification and development of local resources. Counties established priorities and needs and developed plans for infant-family mentally health system development based on the maximization of strengths in the county. The Initiative recognized and sanctioned each county's unique approach to development.

The Initiative's help in the provision of resources and training for model development was also viewed as moderate.
Additional Needs, Challenges and Suggestions

In order to gain a richer understanding of the participants overall experience with the Initiative, respondents were given an opportunity to articulate their thoughts in open-ended questions referring to the overall Initiative. Respondents provided descriptions of additional needs and challenges along with suggestions for the Initiative in the coming year. A summary of the additional needs, challenges and suggestions are listed below.

Additional Needs:

☑ Technical assistance in the areas of:
  - Infant-family mental health program models
  - Screened training videos
  - Helpful therapeutic interventions making best use of home visitation structure
  - Recommendations for what makes programs work.

☑ More coordination of the Feasibility Study

☑ Help in identifying funding sources and strategies

☑ Support, resources and recognition of importance of infant-family mental health from county mental health administration

Challenges:

☑ Understanding the vision of the Initiative and developing the roles of the participants

☑ Feasibility Study

☑ Finding time for meetings, balancing regular duties with requirements of the Initiative

☑ Group processing with the four counties

Suggestions:

☑ Continue promotion of infant-family mental health and help counties to develop their own identities

☑ Continue to value and support the individual plans and needs identified by each county in the development of its infant-family mental health system

☑ Develop a work group or task force to focus on development of infant-family mental health competencies and certification

☑ Make it easier to contact Initiative Staff. Perhaps have certain office days when staff are available

☑ Need better lead time for training, better flyers earlier.

☑ Bring training and technical assistance to programs to facilitate more comprehensive infusion of infant-family mental health concepts

☑ Address fiscal constraints in serving this population and methods to address State/Federal legislation
For the Feasibility Study establish a small task force to refine protocol and establish criteria for different components and measuring outcomes.

Help to promote the status and importance of infant-family mental health within the county mental health system.

Communicate the demands and needs of an efficient infant-family mental health program to county mental health administration.

Encourage the development of a system of countywide collaboration, with Fresno’s success as a model.

Discussion and Recommendations in Response to Additional Needs, Challenges and Suggestions

The results of the Impact Assessment will be used to guide and improve the direction and development of the Initiative in the coming year. To maximize the use of the experience gained from the first year of the Initiative in plans for the second year, the Initiative has generated recommendations in response to the additional needs, challenges and suggestions of the respondents. To provide continuity and objective reference points in addition to the findings of the Impact Assessment, the recommendations are based on information from multiple reports and research generated over the past few years directly related to development of a collaborative system of care for young children and their families.

Promote the Importance and Resource Needs of Infant-Family Mental Health

Respondents describe the need for support, resources and recognition of importance of infant-family mental health from county mental health administration and provide suggestions on how to address this need. They asked for help in promoting the status of infant-family mental health within the county mental health system and for the Initiative to communicate the demands and needs of an efficient infant-family mental health program to county mental health administration. Development of infant-family mental health services is one project among many competing for resources within county mental health systems. As a mental health program in its first year of development, infant-family mental health is still in the process of gaining support and prominence at both the state and local level. However, support, resources and recognition from county mental health systems are fundamental to success in sustaining current efforts and to ensuring the future development of mental health services for young children and their families.

The substantial statewide and local accomplishments of the Initiative over the past year along with ongoing collaborative activities and plans for expansion provide evidence and support for promotion of the importance of infant-family mental health. The growing body of knowledge and experience gained from the first year of the Initiative can facilitate and support communication with county mental health administration about resource requirements for the development and delivery of mental health services for infants and their families. The Initiative should make a concerted effort to gain the active support of administrators in county mental health systems by:

Promoting the importance of infant-family mental health within county systems of mental health supported by evidence of the accomplishments of the Initiative

Communicating the demands and needs of an effective infant-family mental health program based on the knowledge and experience gained from the Initiative

Facilitate Model Development

Model development has already been identified as a goal area needing additional support and guidance from the Initiative. Specific needs in this area are described by respondents in terms of technical assistance in
areas of: infant-family mental health program models; screened training videos; helpful therapeutic interventions making best use of home visitation structure; and recommendations for what makes programs work. The Initiative carries the resources to meet this need with more effective use of the expertise and resources for model development available from teams within the Initiative. This would involve the establishment of:

- More opportunities, avenues and structure for exchanging expertise, information, products and strategies across counties
- Direction and resources for overall model development and exemplary service delivery systems
- Replicable strategies for screening, assessment, intervention and evaluation of effectiveness - based on local service delivery resources and relationships and through the Feasibility Study

**Develop Competencies, Funding Sources and Coordination of the Feasibility Study**

The importance of prominent issues identified under other goal areas is emphasized as they are again addressed in suggestions for the overall Initiative. These issues include development of infant-family mental health competencies and certification, fiscal constraints or funding issues in serving this population and coordination of the Feasibility Study. All three of these issues require a dedicated effort to research, develop and coordinate the information and expertise necessary to effectively address them. In the future the Initiative might establish small group task forces to work on these issues and others in response to specific goal areas and objectives over time. These task forces may begin by establishing:

- Standards/guidelines to ensure that only qualified and appropriately trained personnel assess child/family needs and authorization for intervention and treatment within each service system
- An educational forum focusing on the identification and use of existing and new funding sources for both service delivery and staff training and development
- Clear structure, leadership and consistent efforts to refine and implement the Feasibility Study based on initial findings and need for expansion

**Continue to Support the Unique Approaches of the Counties**

The Initiative's acknowledgement and support of each county's individual approach to system development has encouraged each county to develop its own particular strengths. The suggestions that the Initiative continue to promote and help counties build their own identities and continue to value and support the individual plans and needs of each county indicate that counties clearly value the opportunity to pursue their own path toward building system capacity to provide mental health services to infants/toddlers and their families. To ensure clarity and compatibility between county plans and Initiative goals the Initiative should provide:

- A consistent framework for development of county-specific plans that address the overall Initiative goals and acknowledge local priorities

**Move Toward Whole System Collaborative Service Delivery**

At the same time, respondents apparently recognize the need for whole system development as indicated from the suggestion that the Initiative encourage the development of a system of countywide collaboration. Countywide collaboration among all providers of services to very young children and their families is critical to development of the continuum of infant-family mental health services including promotion, prevention and treatment/intervention. All agencies and personnel from administrators to home visitors need information, education and coordination for effective collaborative service delivery. Effective service delivery is not possible in isolation. Mental health clinicians must be connected to and develop relationships with frontline
service providers that engage with infants and families on a regular basis. To facilitate the development of a system of countywide collaboration the Initiative should:

- Establish interagency and interdisciplinary advisory, leadership and oversight groups to provide structure, content, accountability, enhanced service delivery and collaboration
- Provide information, training and technical assistance for administrators, service providers, parents, community members and policy makers
- Fund and develop training and on-going supervision for mental health specialists to carry out clinical work with young children and their families within county systems of care, in community settings and in coordination with other agencies and service providers
- Provide realistic time and support for effective and on-going service coordination and integrated service delivery
- Expand case finding and service delivery from a focus on “medical necessity” to one of early identification, consultation and collaborative intervention between service providers
- Include indicators of social-emotional development and early mental health in all screenings and assessments of young children and their families across service delivery systems

**Develop Training for Non-mental Health Service Providers**

The need for specialized training for providers at the promotion/prevention end of the infant-family mental health service continuum is voiced in the suggestion to bring training and technical assistance to programs to facilitate more comprehensive infusions of infant-family mental health concepts. Effective collaborative service delivery requires that all service providers understand their role in the continuum and have the knowledge and expertise necessary to effectively implement infant-family mental health concepts and relationship-based approaches to services and as well as to determine when intervention/treatment services are needed. To address the need the Initiative should:

- Identify funding sources and effective strategies/models for providing training and reflective supervision for non-mental health specialists working with families at high-risk for mental health and relationship difficulties and families of children with special health and developmental problems

**Strengthen the Structure of the Overall Initiative**

Efforts toward improvement in the coordination, communication and structure of the overall Initiative are a natural outcome from experience in the first year of the Initiative. The challenge of understanding the vision and developing the roles of the participants and respondent suggestions to make it easier to contact Initiative staff and to provide better lead time for training and better fliers earlier fall under this general area of Initiative development. The Initiative would be strengthened by more structure by establishing:

- Clear goals, specific objectives and more direction to achieve specific outcomes - within the context of an overall evaluation plan
- An overall and county-specific calendar with major meeting dates, training events and special activities scheduled well in advance
- Templates for announcing major trainings and Initiative activities throughout the State
- Templates for routine activities and reports-training evaluations, quarterly reports, resource and needs identification, baseline measures, assessment of competencies, etc.
- Clear guidelines, expectations and support for counties to connect with the overall Initiative and visa versa
Expand Evaluation Efforts

In addition to the needs and suggestions described by respondents, is the need for expanded evaluation efforts. Movement toward whole system development and expanded collaborative service delivery will require the development of new and expanded goals and objectives with measurable outcomes. Evaluation of the first year of the Initiative only assessed outcomes from system development. To evaluate the effectiveness of service delivery an assessment of outcomes for service providers and families should be incorporated to an overall plan for evaluation. To meet this need the Initiative should:

Expand evaluation efforts to include assessment of outcomes for mental health and other service providers and outcomes for families

Additional Comments

The final question on the Impact Assessment Survey asked respondents to provide any additional comments they might have about their experience with the Initiative. A sample of those comments is listed below.

- It has been invaluable to my agency and me. We're not alone.
- Thank you! Wouldn't trade it for the world. I am especially grateful for relationships that have enriched my life and given me opportunities for personal growth.
- Good overall, even if we were understaffed and over worked. I have been happy to be a part of this!
- It is hard to document, but there has been a major attitudinal shift in the positive direction, with the IFMH Initiative coming through the Department of Mental Health.
- It couldn't have happened without CEITAN leadership.
- I believe that infant-family mental health has established a presence. It is possible to make a difference at the micro and macro levels in small but significant steps.
- It has generally been an exciting venture and has enhanced our county's effort to provide family-oriented services
- Love the idea of IFMH! I see it working in the lives of families I work with daily.

Comments of the respondents are a testimony to the positive energy created by the Initiative. Appreciation is expressed for the collaboration, coordination and leadership of the Initiative. The relationship-based approach to administration of the Initiative supported and enriched the experience for participants and helped to move the project forward despite limited resources. Infant-family mental health has indeed established a presence. It has helped to develop family oriented services and has begun to make a difference in the lives of families.
Summary of Key Findings from the Impact Assessment

**Resource identification and development** clarified the necessity for county mental health system recognition, support and resources to sustain current efforts and ensure continuing development of mental health services for young children and their families. The process of resource identification and development efforts promoted widespread interest by all types of service providers in the development of the continuum of infant-family mental health services. Initiative participants discovered that effective resource identification requires the development of relationships between mental health and other providers and opportunities for routine communication to ensure a clear understanding of the resources and services available to families and effective coordination of those resources.

**Capacity building** efforts promoted awareness of infant-family mental health concepts and relationship-based approaches to services. Small group training and consultation with a focus on the mental health provider was considered the most effective type of training followed by ongoing local training and consultation. Other professionals and paraprofessionals need access to similar types of training and consultation. A shortage of infant-family mental health specialists available to provide ongoing training and consultation was identified along with the need to develop and improve pre-service training related to infant-family mental health. Development of competencies and a certification process is needed for the continuum of infant-family mental health services.

**Collaborations** were established with a variety of training resources, service providers and advisory groups. Whole system development will require greater investment in the development of interdisciplinary resources and referral sources, and a strong need to address, explore and develop funding resources. Collaboration inspired new and continued interest and commitment and provided expertise and resources needed for system development. Benefits to families are beginning to emerge: a decrease in redundancy of services; richness in the overall quality of service; positive outcomes for families.

**Models** for screening, assessment, intervention, prevention, collaboration, delivery systems and training were explored and developed. Most models are in the beginning stages of development and have only been implemented on a small scale. More time, experience and effort in development are needed to produce replicable models.

**The Feasibility Study** provided the greatest challenges for participants in the Initiative. This clinical research and evaluation study intended to demonstrate the feasibility of providing mental health services to infants and their families was in the beginning to mid stages of implementation at the time of the Impact Assessment Survey. The greatest impact of the Feasibility study was the knowledge and experience gained in the development and implementation of various aspects of the study. Experience was gained in collaborating with the IFMH specialist, screening and identification of moderate risk families, collaborating with referral sources, use of assessment tools including video-taping, development of intervention models integrating assessment as part of the intervention and conducting intervention in home and community settings. The knowledge and experience gained will provide the foundation for clinical research and evaluation to be conducted in the next year of the Initiative.

**The leadership and coordination** of the Initiative was considered most helpful in the provision of resources for training and consultation, coordination and implementation of training and promotion of infant-family mental health statewide. Respondents articulated additional needs in: support from county mental health administration, model development, coordination of the Feasibility Study, identification of funding sources and strategies, and clearer vision of project goals and roles of the participants from the onset. These needs and other suggestions by the respondents for important areas of development for the next phase of the Initiative were addressed by the Initiative with specific recommendations for action.
Summary of Recommendations by Goal Area

Recommendations for the second year of the Initiative were generated based on the results of the Impact Assessment and toward the goal of developing an integrated collaborative whole system of care for children under age 3 and their families. They were developed in response to the key findings of the Impact Assessment and the needs articulated by Initiative participants.

**Resource Identification and Development:**

County mental health systems must recognize, support and provide resources for mental health services for children under three and their families within the county mental health system.

Broaden the focus of resource identification efforts toward development of a countywide interagency collaborative system of infant-family mental health.

Establish interagency infant-family mental health committees or advisory groups to promote networking and routine opportunities for communication to facilitate resource identification and coordination.

Continue to build on the unique strengths of the individual counties.

**Capacity Building:**

Develop a work group or task force to develop infant-family mental health competencies and certification.

Provide a full range of training, technical assistance and consultation opportunities designed to meet the information and training needs of all stakeholders from policy-makers to home visitors.

Utilize local knowledge and expertise gained in the first year to provide training, consultation and interagency resource development for others in the second year.

**Collaboration:**

Build on success of the first year to broaden linkages and further develop collaborative relationships and activities toward whole system development.

Build partnerships with institutions of higher education to develop and improve pre-service training in infant-family mental health concepts and relationship-based approaches to services and treatment/intervention.

**Model Development:**

Focus on development of models for whole system, countywide collaborative service delivery.

Continue to encourage and facilitate model development by providing resources and guidelines for the development of replicable models and opportunities for sharing information and successes.

Provide an educational forum to address the funding issues associated with serving infants and families.

**Feasibility Study:**

Use experience gained from the Feasibility Study in the first year of the Initiative to design a more clearly defined and expanded clinical research and evaluation study to be conducted in the second year.

**Overall Initiative:**

Strengthen the structure of the overall Initiative with clarity in goals, objectives, and expectations for support, schedules and communication.

Expand evaluation efforts to include outcomes for mental health and other service providers and outcomes for families.
Conclusion

The Infant Family Mental Health Initiative has made significant progress in expanding county mental health system's capacity to serve infants, toddlers and their families. The Initiative increased interest and awareness in infant family mental health concepts and relationship-based approaches to service and expanded the expertise of mental health professionals. Counties established a variety of collaborative activities and made progress in collaborative service delivery. A broad array of models supporting infant-family mental health training, system development and service delivery were developed and implemented and are in the process of further development. The Feasibility Study provided knowledge and experience in model development and preparation for service delivery. The Initiative was a positive and productive experience for everyone involved.

The statewide and local accomplishments in infant-family mental health development in year one of the Initiative along with the plans for expanded system development and service delivery in year two of the Initiative provide a substantial contribution to the resources, knowledge and expertise available for use in the promotion and continued development of mental health services for children from birth to age three and their families. The Initiative, equipped with a strong foundation of accomplishments and ongoing efforts in development of the continuum of promotion, prevention and intervention/treatment services, is well on its way toward the goal of developing an integrated statewide collaborative system of care for very young children and their families.
Appendix A

Infant Family Mental Health Initiative (IFMHI):
Status Report Form
September 3, 2000

To: County Department of Mental Health Participants in the Infant Family Mental Health Initiative (IFMHI) Project

From: Penny Knapp, MD - California Dept. of Mental Health, IFMHI Project Monitor
Sheila Wolfe - WestEd/CEITAN, IFMHI Project Coordinator
Cindy Arstein-Kerslake - IFMHI Project Evaluator

Re: Infant Family Mental Health Initiative (IFMHI) Status Report
For the period August 1 - August 31, 2000

Thank you for completing and submitting the IFMHI Status Report for July 1, 2000 through July 31, 2000. The information gathered from the Status Reports has served to document the continuing evolution of the Initiative and the progress of the four counties in building collaborative infant family mental health services.

Attached is the IFMHI Status Report Form for the period beginning August 1, 2000 and ending August 31, 2000. It should be returned by September 15, 2000. Please provide an updated report of the progress your county has made in each of the four goal areas. Include new accomplishments, new activities and new plans as well as updated progress in ongoing activities. Under "Observations, comments or challenges" be sure to include what you've learned during the process.

Instructions: The Status Report form is being sent by e-mail and fax to each of the four County DMH project coordinators. County DMH project coordinators are responsible for working with their team and subcontracted organizations in gathering the requested information for the various components of the project and reporting the information on the Status Report. Only one Status Report with all relevant information from participants in the Initiative should be sent from each county. In the e-mail version of the Status Report, the amount of space available for each response will be increased automatically as needed when you are entering information in the report. However, if you choose to respond using the printed copy version that was sent via fax, then you may attach additional pages as needed if your response exceeds the space provided on the printed form. You are encouraged to also send printed materials that have been developed as part of your accomplishments.

The Status Report form consists of four pages. Each page addresses one of the four major goals of the Initiative. The goals are stated at the top of each page. Below the goal in the left hand column is a list of outcome components associated with the goal. The outcome components are intended to clarify the objectives of the goal area and provide focus for the descriptions of the accomplishments, ongoing activities and challenges requested in the next column.

For the second goal area, Capacity Building, you are asked to provide numbers of personnel trained, number hired, contracted or reassigned to provide infant family mental health services and numbers of infants/families served through various resources and funding during the report period. Please provide your best estimates for these numbers and use the same process for
accessing the numbers each time they are reported. If you have difficulty accessing the numbers or must qualify the numbers reported please explain those problems or qualifications in the report.

Please complete and return the Status Report by September 15, 2000 by e-mail, regular mail or fax as indicated at the end of the report. For questions call Sheila Wolfe at (916) 492-9999 or Cindy Arstein-Kerslake at (916) 631-0948.

Thank you for your time and effort.
## Goal 1: Identification of early childhood/infant family mental health needs, resources and services

<table>
<thead>
<tr>
<th>Outcome Components:</th>
<th>(Describe most important accomplishments or steps completed as well as ongoing activities and challenges related to goal area)</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Identify existing resources, and services throughout the county</td>
<td>Accomplishments:</td>
</tr>
<tr>
<td>➢ Identify priorities and areas of need</td>
<td>Ongoing activities:</td>
</tr>
<tr>
<td>➢ Establish plan for training, technical assistance, and resource development</td>
<td>Observations, comments, or challenges:</td>
</tr>
<tr>
<td>➢ Promote awareness of resources and services</td>
<td></td>
</tr>
<tr>
<td>➢ Utilize new services and resources</td>
<td></td>
</tr>
</tbody>
</table>
### Goal 2: Capacity Building - Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings

**Outcome Components:** Estimate numbers applicable to the reporting period 8/1/00 - 8/31/00

- Trained _________ (number)* mental health professionals
- Trained _________ (number)* interdisciplinary service personnel
- Hired, contracted, or reassigned _________ (number) new mental health providers to provide services to infants aged 0-3 and their families
- Served _________ (number) infants aged 0-3 and their families through County DMH providers and funds
- Served _________ (number) infants aged 0-3 and their families through IFMHI resources and funds
- Served _________ (number) infants aged 0-3 and their families through other resources and funds (i.e., health, social services, regional center, other special grants)

*Indicate the number of those involved in any type of IFMHI training or staff development activities (ongoing or one-time) during the reporting period.

(Describe training and implementation activities related to this goal. Attach copy of training agendas or flyers.)

**Trainings completed:**

**Other learning opportunities provided:**

**Ongoing training and staff development activities:**

**Other ongoing capacity building activities:**

**Observations, comments, or challenges:**
Goal 3: Collaboration - Facilitate interdisciplinary and interagency collaboration for services and staff training

<table>
<thead>
<tr>
<th>Outcome Components:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase linkages and interagency multidisciplinary collaboration</td>
</tr>
<tr>
<td>Establish collaborative staff development</td>
</tr>
<tr>
<td>Establish collaborative service delivery</td>
</tr>
<tr>
<td>Enhance teamwork skills of mental health professionals</td>
</tr>
<tr>
<td>Enhance teamwork skills of interdisciplinary service providers</td>
</tr>
</tbody>
</table>

(Describe most important accomplishments or steps completed as well as ongoing activities and challenges related to Goal area)

Collaborative activities established (Identify type of agency or service provider and type of collaboration):

Ongoing efforts in developing linkages and other collaborative efforts:

Observations, comments, or challenges:
**Goal 4: Model Development - Develop replicable strategies for ongoing training, service delivery, and funding of infant family mental health services**

<table>
<thead>
<tr>
<th>Outcome Components:</th>
<th>(Describe model development activities and accomplishments. Include descriptions of models developed.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Establish plans for countywide mental health service delivery for infants/families</td>
<td>Accomplishments in model development:</td>
</tr>
<tr>
<td>➢ Establish new strategies for resource sharing and funding for infant/family services</td>
<td>Ongoing activities in model development:</td>
</tr>
<tr>
<td>➢ Establish specific recommendations for replicable service delivery and funding of infant/family mental health services statewide</td>
<td>Observations, comments, or challenges:</td>
</tr>
<tr>
<td>➢ Develop materials and resources for dissemination</td>
<td></td>
</tr>
<tr>
<td>➢ Establish plans for ongoing training programs to be implemented after the project period</td>
<td></td>
</tr>
<tr>
<td>➢ Establish plans for ongoing and collaborative service delivery after the project period</td>
<td></td>
</tr>
</tbody>
</table>

---

**Please return completed report by September 15th, 2000.**

**You may return the report by E-mail to:**

Sheila Wolfe, IFMHI Project Coordinator at swolfe@WestEd.org
... with cc's to: Cindy Arstein-Kerslake at carstein@pacbell.net
Erika Thomason at ethomas@WestEd.org

**Or, you may return the report by regular mail or fax to:**

Sheila Wolfe, IFMHI Project Coordinator
429 J Street
Sacramento, CA 95814
Phone: (916) 492-9999 and Fax: (916) 492-9995
Appendix B

Infant Family Mental Health Initiative (IFMHI): Impact Assessment Survey Form
November 10, 2000

To: Participants in the Infant Family Mental Health Initiative (IFMHI)

From: Cindy Arstein-Kerslake - IFMHI Project Evaluator

Re: Infant Family Mental Health Initiative (IFMHI) Impact Assessment Survey
For the project period ending October 31, 2000

Thank you for participating in the Infant Family Mental Health Initiative. As the first year of the project comes to a close, it is time to assess the impact of the Initiative. The Impact Assessment serves to quantify changes in county mental health delivery systems as well as to evaluate the Initiative and its various components. It also provides the opportunity for you as participants to share what you've learned and provide feedback about your experience with the project. Results will be used to guide future efforts in infant-family mental health development.

Attached is the Impact Assessment Survey. It consists of seven sections. The first section asks for identifying information, which will be kept confidential and used for follow-up and categorization purposes. The next five sections address the impact of each of the five goal areas including the Feasibility Study. The final section addresses the impact of the Initiative as a whole. Please read the entire survey before beginning to complete the form. That will help you to focus your responses to the specific topic areas. Please skip any questions that address activities or areas of the Initiative that you are unfamiliar with.

The Impact Assessment Survey will be completed by at least six participants in the Initiative from each county. Respondents should include: the project coordinator; a county administrator; the infant-family mental health resource specialist; primary community collaborators; at least one mental health provider and at least one other professional or paraprofessional service provider.

Shortly after you receive this IFMHI Impact Assessment Packet, the project evaluator, Cindy Arstein-Kerslake or her assistant, will call you to answer any questions you may have about the survey. At that time a follow-up telephone interview will be scheduled, if needed, to review your responses to open-ended questions and to allow you to provide additional information and comments.

All surveys should be completed and returned in the enclosed envelope by November 22, 2000. Return surveys to:

Cindy Arstein-Kerslake
11508 Soda Springs Way
Gold River, CA  95670

For questions call Cindy Arstein-Kerslake at (916) 631-0948 or e-mail at carstein@pacbell.net.

Thank you for your time and effort.
Infant Family Mental Health Initiative (IFMHI):
Impact Assessment Survey
For the Project Period Ending October 31, 2000

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone #:</th>
<th>( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-mail:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. County Name: ≤ Alameda ≤ Fresno ≤ Los Angeles ≤ Sacramento

2. Role in the Infant Family Mental Health Initiative:
   ≤ County IFMHI Coordinator ≤ County Administrator
   ≤ Infant-family Mental Health Resource Specialist ≤ Community Partner
   ≤ County Mental Health Service Provider ≤ Other Professional or Paraprofessional Service Provider

3. Place of Employment: 

4. Position: 

---

**Goal 1** Resource Identification: Identification of early childhood/infant-family mental health needs, resources and services

5. Which of the following types of local resources have been identified, developed, and/or utilized as part of the Initiative in your County? (Check all that apply.)

   **Mental Health Resources**
   ≤ Mental health resources and support within the existing county mental health system
   ≤ Mental health resources and support within other county/local agencies and organizations
   ≤ Mental health providers interested in developing infant-family mental health expertise
   ≤ Mental health providers with previous experience in infant-family mental health or related expertise

   **Other Professional and Paraprofessional Resources:**
   ≤ Health, education, developmental disabilities, and/or social service providers with experience in using relationship-based approaches and infant-family mental health concepts and approaches to services
     Health, education, developmental disabilities, and/or social service providers interested in learning
     more about using relationship-based approaches and infant-family mental health concepts and approaches to services

6. To what extent do you think the process and results of resource identification and development contributed to the promotion and awareness of infant-family mental health services in your county?
   ○ Not at all ○ Minimally ○ Moderately ○ Significantly

7. To what extent do you think the process and results of resource identification and development increased the demand for infant-family mental health services in your county?
   ○ Not at all ○ Minimally ○ Moderately ○ Significantly
8. To what extent has your county's plan for training, technical assistance and resource development been successful in addressing the identified priorities and areas of need?
   - Not at all
   - Minimally
   - Moderately
   - Significantly

9. What has been the most significant outcome in the area of resource identification?

10. What were your greatest problems or challenges in resource identification?

11. How have you addressed those problems or challenges?

12. What are your priorities for resource identification in the coming year?

### Goal 2
**Capacity Building:** Increase the number and availability of mental health specialists and other professionals able to provide infant-family and early childhood mental health services in a variety of clinical, community and home settings

13. Indicate the effectiveness of each type of training that has been offered in your county.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Not offered</th>
<th>Minimally effective</th>
<th>Somewhat effective</th>
<th>Very effective</th>
<th>Highly recommend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large group interagency training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smaller group training/consultation with focus on the mental health provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Onsite consultations and technical assistance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local ongoing training and staff development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National conferences and training</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
14. To what extent has the IFMH training and consultation provided in your county impacted ... 

<table>
<thead>
<tr>
<th>Mental Health Providers</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased demand for training</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Heightened awareness of need for qualified IFMH providers</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Increased awareness of IFMH concepts and approaches to services;</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Prepared mental health providers to implement infant-family mental health concepts and approaches to services</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Prepared mental health professionals to collaborate with other early childhood and early intervention service providers</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Other:</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Professional and Paraprofessional Service Providers:</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased demand for training</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Heightened awareness of need for qualified IFMH providers</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Increased awareness of IFMH concepts and approaches to services;</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Prepared other professional and paraprofessional service providers to implement infant-family mental health concepts and approaches to services</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Prepared other professional and paraprofessional service providers to collaborate with mental health professionals</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
<tr>
<td>Other:</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
<td>≤</td>
</tr>
</tbody>
</table>

15. To what extent has your county's mental health system's capacity to serve infants and their families improved over the past year?

○ Not at all ○ Minimally ○ Moderately ○ Significantly

16. What has been the most significant impact of the training, technical assistance and consultation provided in your county?

17. What challenges or difficulties have you had in increasing the availability of mental health and other professionals qualified to provide IFMH services?
18. What have you done to address those challenges?

19. What are your priorities for **capacity building** in the coming year?

---

**Goal 3**

**Collaboration: Facilitate interdisciplinary and interagency collaboration for services and staff training**

20. Which of the following types of organizations has your county mental health system established a relationship with in developing IFMH services and resources:

### Training Resources
- Centers with expertise in infant-family mental health
- Infant-family mental health provider specialists
- Institutions of higher education providing education & training in infant-family mental health
- Teaching hospital with infant-family mental health program
- Other: _________________________________________________________________

### Service Providers
- Private mental health providers
- Collaborative health and human services delivery projects
- Department of Developmental Services Regional Center
- Regional Center vendors
- Local Education Agencies
- Childcare/Child development programs and agencies
- Child Protective Services
- Foster Care Agencies
- Family Resource Center
- Early Head Start/Head Start
- Alcohol and drug rehabilitation programs
- Public Health
- Other Social Services Agencies: ___________________________________________

### Advisory Groups
- Multi-agency collaborative infant and early childhood advisory committee
- Local Prop. 10 Commission
- Infant-family mental health advisory committee
- Child Abuse Prevention Council
- Childcare Coalition or advisory committee
- Mental health advisory council
- Pediatric advisory groups
- Other: ____________________________________________________________________
21. As a result of participation in the Initiative, to what extent has your county made progress in the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Not yet a focus of development</th>
<th>Initial progress</th>
<th>Moderate progress</th>
<th>Significant progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased linkages and interagency multi-disciplinary collaboration?</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Established collaborative staff development?</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Established collaborative service delivery?</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Enhanced the teamwork skills of mental health professionals?</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Enhanced the teamwork skills of interdisciplinary service providers?</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

22. To what extent has collaboration impacted the development of infant-family mental health services in your county in the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Not at all</th>
<th>Minimally</th>
<th>Moderately</th>
<th>Significantly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promoted awareness of infant-family mental health needs in the county</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Expanded referral sources</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Expanded the opportunity to promote and develop interdisciplinary resources for infant-family mental health</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Expanded resources for training and technical assistance</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Promoted further linkages and collaborations</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Improved access to infant-family mental health services</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Enhanced and facilitated service delivery</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Increased demand for training</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Facilitated model development</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Increased demand for services</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Increased awareness of the need to identify funding resources</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

23. What is the most significant outcome from collaboration in your county?

24. What has been your greatest challenge or difficulty in the area of collaboration?
25. How have you addressed that challenge or difficulty?

26. What are your priorities for collaboration in the coming year?

Goal 4 Model Development: Develop replicable strategies for ongoing training, service delivery and funding of infant-family mental health services

27. What progress has your county made in the following areas of model development?

<table>
<thead>
<tr>
<th>Area</th>
<th>Not yet a focus of development</th>
<th>Beginning stages of development</th>
<th>Mid-stages of development</th>
<th>Successfully completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish plans for countywide mental health service delivery for infants/families</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Establish new strategies for resource sharing and funding for infant/family services</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Establish specific recommendations for replicable service delivery and funding of infant-family services statewide</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Develop materials and resources for dissemination</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Establish plans for ongoing training programs to be implemented after the project period</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Establish plans for ongoing and collaborative service delivery after the project period</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>
28. To what extent have changes in service delivery been implemented as a result of infant-family mental health model development in the following areas?

<table>
<thead>
<tr>
<th>Area</th>
<th>Not yet a focus of development</th>
<th>In process of development</th>
<th>Small-scale implementation</th>
<th>Large-scale implementation</th>
<th>County-wide implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access and referral system</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Screening and assessment</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Service planning</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Intervention/treatment</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Ongoing training programs</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Interagency collaboration</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Billing</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
<tr>
<td>Other:</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
</tr>
</tbody>
</table>

29. What models are you ready to share with other counties?

30. What has been your greatest challenge or difficulty in model development?

31. How have you addressed that challenge or difficulty?

32. What are your priorities for model development for the coming year?
Goal 5 Feasibility Study: Demonstrate the feasibility of providing clinical services to children ages 0 to 3 and their families

33. In what ways has participation in the Feasibility Study influenced the development of infant-family mental health services in your county? Indicate the importance of each of the following:

<table>
<thead>
<tr>
<th>Provided the opportunity to identify and collaborate with service providers of at-risk populations that might benefit from infant-family mental health services</th>
<th>Not applicable</th>
<th>Minimally important</th>
<th>Moderately important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provided the opportunity for experience in developing and refining models for screening, assessment, intervention and treatment and training</td>
<td></td>
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<tr>
<td>Encouraged and facilitated an ongoing working relationship between the county and the infant-family mental health specialist</td>
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<tr>
<td>Provided the opportunity for experience in delivery of infant-family mental health treatment services.</td>
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<tr>
<td>Provided the opportunity to develop ongoing training to prepare mental health professionals to deliver infant-family mental health treatment services.</td>
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</tr>
</tbody>
</table>

34. Indicate the importance of each of the following in facilitating the development and implementation of the Feasibility Study:

<table>
<thead>
<tr>
<th>Collaboration between the four counties in the development of the Feasibility Study guidelines</th>
<th>Not applicable</th>
<th>Minimally important</th>
<th>Moderately important</th>
<th>Very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration with IFMH specialists to develop local plan for implementation of the Feasibility Study</td>
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<tr>
<td>Collaboration and information sharing with other counties at bimonthly meetings</td>
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<tr>
<td>Leadership and coordination by the Initiative</td>
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<tr>
<td>Collaboration with community partners in identifying and screening families</td>
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<tr>
<td>Development of and experience in using the screening tool</td>
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<tr>
<td>Development of the assessment protocol</td>
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<tr>
<td>Preparation for intervention/treatment</td>
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</tbody>
</table>

35. What were your greatest challenges in developing and implementing the Feasibility Study?
36. What has been done to meet those challenges?

37. What are your priorities and needs for the Feasibility Study in the coming year?

38. What was the greatest impact of the Feasibility Study on your county?

The Initiative: Leadership, coordination, facilitation, provision of resources, training and technical assistance and promotion of infant-family mental health development

39. Indicate how helpful the Initiative has been in each of the following areas:

<table>
<thead>
<tr>
<th>Area</th>
<th>Not applicable</th>
<th>Minimally helpful</th>
<th>Moderately helpful</th>
<th>Significantly helpful</th>
<th>Extremely helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitation of resource identification and needs assessment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Establishment of plans for training and resource development</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Coordination and implementation of training</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Provision of resources for training and consultation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Facilitation of collaboration between County DMH and IFMH specialists</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Facilitation of collaboration among the four county teams</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Dissemination of information and materials among the counties</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>Facilitation of team building</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Promotion and provision of resources and training for model development</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Overall technical assistance and consultations</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Promoting infant-family mental health and relationship-based practices statewide</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
40. In addition to the support and services you received from the Initiative what else might have been helpful?

41. What were your greatest challenges in being a part of the Initiative?

42. What suggestions and recommendations do you have for the Initiative in the coming year?

43. Additional comments about your experience with the Initiative:

Please complete and return by **November 22, 2000** to:

Cindy Arstein-Kerslake
11508 Soda Springs Way
Gold River, CA  95670

For questions, call Cindy at (916) 631-0948 or e-mail Carstein@pacbell.net