



Young Minds Matter:

A Summit to Address the Social and Emotional Wellbeing of our Youngest Children
CONFERENCE PROCEEDINGS

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YOUNG MINDS MATTER

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Acknowledgements

United Way of Massachusetts Bay and Merrimack Valley wishes to acknowledge and thank the individuals whose notes contributed to the development of this document. We would like to thank Jessica Dym Bartlett, Kitt Cox, Anna Cross, Lei-Anne Ellis, Mei-Hua Fu, Joan Matsalia, Bryce McClamroch, Carol Nolan, Barbara Prindle-Eaton, Kate Roper, Stan Schwartz, and Annie Waddoups. An additional thank you is due to Ellen Powell Kiron for her skillful synthesis of the themes and ideas to emerge from *Young Minds Matter*. United Way also acknowledges the work of Peg Sprague, Caroline Ross, Clare Sanford, and United Way's marketing team for contributing to these proceedings.

We would also like to thank the Schott Fellowship in Early Care and Education for its support and partnership throughout the planning process for *Young Minds Matter* and in developing this documentation report.

ABOUT UNITED WAY OF MASSACHUSETTS BAY AND MERRIMACK VALLEY

Our mission is to bring the community together to help improve people's quality of life.

Our vision is that in ten years, the Greater Boston metropolitan area will be the best place for children in the country.

Among the most important ways to improve the quality of life among our communities is to both strengthen the financial security of parents and ensure that children are getting the nurturing support and educational opportunities that will prepare them for adulthood.

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I. INTRODUCTION AND WELCOMING REMARKS

This paper documents the proceedings of *Young Minds Matter: A Summit to Address the Social and Emotional Wellbeing of our Youngest Children*. The Summit was held at the Omni Parker House on November 1, 2006, and was sponsored by the following organizations:

- United Way of Massachusetts Bay and Merrimack Valley;
- Schott Fellowship in Early Care and Education;
- Together for Kids Coalition;
- Massachusetts Head Start State Collaboration Office, Massachusetts Department of Early Education and Care;
- Massachusetts Early Childhood Comprehensive Systems, Massachusetts Department of Public Health.

The purpose of the day-long Summit was to bring together leaders from elected office, private foundations, not-for-profits, public agencies, families, pediatric and clinical settings, and universities to share information and develop recommendations about the challenge of creating a comprehensive, coordinated, high-quality system of early childhood mental health in Massachusetts.

Dr. Jane Knitzer, Executive Director of the National Center for Children in Poverty, addressed the morning plenary and illuminated major themes and issues facing Massachusetts. In the afternoon, the Summit offered a series of workshops in which participants explored existing early childhood and family support services in Massachusetts, noted key system elements, barriers, and gaps, and identified policy recommendations in response. This paper summarizes the morning and afternoon sessions and provides a recap of the overarching themes and policy recommendations that emerged.

INTRODUCTORY REMARKS

**Milton J. Little, Jr., President and CEO,
United Way of Massachusetts Bay and Merrimack Valley (UWMB)**

This is a pivotal time in which the importance of early childhood mental health is gaining legitimacy from the not-so-usual suspects, including *The Wall Street Journal* (see “Sending the Baby to a Shrink,” Elizabeth Bernstein, *The Wall Street Journal*; Oct 24, 2006). The article is a powerful acknowledgement of work that is normally out of the public eye.

Although the public has been given the invaluable message that focusing on the social and emotional well-being of young children is desirable, we must remember an overarching principle: that is, this work is about getting all children what they need and deserve, regardless of circumstances. Let us begin the work of “knocking down the walls” and move past old barriers to do what is needed and what is right.

**Valora Washington, Executive Director,
Schott Fellowship in Early Care and Education**

All children need intellectual ability, motivation to learn, and social and emotional capacities. Given Massachusetts’ preschool expulsion rates—among the ten highest in the country—we know the needs are great. We also know that early childhood mental health consultation has been effective across the Commonwealth. Let us talk about social and emotional health for all children and let us make Massachusetts the best place to be a child.

Our opportunity today is to make the case for early childhood mental health, describe the elements of a system, share information about what is currently available, explore public-private partnerships, and discuss strategies for achieving desired outcomes. What happens after today is most important.

KEYNOTE SPEAKER

**Dr. Jane Knitzer, Executive Director, National Center for Children in Poverty (NCCP)
Clinical Professor of Population and Family Health, Mailman School of Public Health, Columbia
University**

Dr. Knitzer is nationally regarded as the foremost expert on the topic of early childhood social and emotional development. She proposes a framework for thinking about a single, statewide early childhood mental health system of care. Currently, the prevalence of effective pilot projects in Massachusetts that have not been brought to scale nor effectively connected to one another is emblematic of larger fragmented early childhood and family support systems. To address the fragmentation, Dr. Knitzer recommends that leaders from across systems set common goals, supported by investment of new monies. A cross-system strategic plan and commitment to investing in fiscal infrastructure, she explained, could knit together the disparate system pieces.

To most effectively build the systemic capacity to develop a single system, Dr. Knitzer makes the case for placing supports where children and families are naturally located so that continuity of services and relationships, cultural relevancy, and access are not compromised. Based on national trends, systems and policies that focus on targeted interventions and organize funding streams and eligibility around levels of risk are the most appropriate response to varying levels of need. Children identified as “in need” are, at a minimum, at higher risk than the population at-large. Therefore, intentional strategies must be built to help these children and families. Dr. Knitzer also notes that substance abuse, adult mental health, and domestic violence specialists must all be involved. Targeting all higher risk and Medicaid eligible young children requires finely tuned, strategic program and fiscal planning.

Drawing from her national perspective, Dr. Knitzer observes that only systemic approaches achieve optimal results. She encourages stakeholders to learn from cross-sector models across the country that see issues as systemic problems rather than problems of the child, the parent, or child care provider. While Massachusetts' poverty line is lower than what exists nationally, extreme poverty still exists with dire consequences for all realms of early childhood development.

Dr. Knitzer finds that well-crafted systemic strategies are those that support a network or team approach, bringing together everyone involved for a coordinated, multidisciplinary response. Massachusetts needs to develop the policy structure to support professionals in multidisciplinary work. Dr. Knitzer recommends that attention be paid to findings from evidence-based interventions that demonstrate improved outcomes (e.g., early childhood mental health consultation) such as the Together for Kids Project (TFK) in Worcester, funded by the Health Foundation of Central Massachusetts and the United Way of Central Massachusetts. One-third of the states across the country have made an investment at various levels in mental health consultation. To effectively support expanded consultation, Dr. Knitzer advises that cross-system social/emotional competencies be developed for all teachers, and that children be screened individually with validated, researched based tools. She cautioned against 'garden variety' consultation that is generic, diluted, and produces no effect. Every early childhood mental health consultant should understand the effect of poverty on children and adults, due to the trans-disciplinary nature of the work. Dr. Knitzer also recommends that consultants be linked through a statewide network, and that stakeholders promote public-private partnerships, and universal language, goals, and visions.

Many people do not understand what healthy social/emotional childhood development looks like in concrete terms. For example, one infant-toddler reading program instructor told Dr. Knitzer that she knows nothing about promoting social/emotional development. When Dr. Knitzer asked if she puts her arms around the children when she reads to them the instructor replied, "of course." That early relationship between instructor and infant, with opportunity for connection, promotes healthy social/emotional development and is inextricably intertwined with early cognitive and language development. Most importantly, children need to feel good about themselves in order to become engaged learners. Dr. Knitzer recommends that Massachusetts take a page from Dr. Jack Shonkoff's book, *From Neurons to Neighborhoods*, about the importance of these earliest relationships.

The state needs to articulate common goals and outcomes. What does Massachusetts want to achieve? What does it take from pre-birth to age eight to succeed in school? Considerable attention is given to cognitive development but not necessarily the right attention. Dr. Knitzer urges stakeholders to expand the definition of "quality," pursue what is known about effective learning strategies, and learn from the effects of poor quality child care (e.g., children with behavioral problems). In many cases, clinical intervention with the child may not be necessary—we sometimes simply need to mentor and support providers already doing the right things with children. Early childhood mental health consultants should work where children are being served, and where there is a real possibility to sustain relationships between teachers, children, consultants, and families. That builds systemic capacity for children facing the highest risk factors.

What else can Massachusetts do to get its fragmented system organized? Dr. Knitzer recommends:

- **Provide continuity:** a major principle in early childhood that must be supported by the system fiscally and otherwise;
- **Develop strategic common analysis about parenting:** Powerful, effective, evidence-based research indicates that parents can improve their parenting skills by visualizing themselves using proven tools and techniques. Engaging parents in high-risk families and expanding developmental/anticipatory guidance will advance parents' knowledge about childhood development;
- **Extend the issue of trauma in children into early childhood:** The mental health system is not positioned to look at how trauma affects learning, and how adults' pasts affect parenting.
- Begin to address parental mental health issues in conjunction with well-child visits.
- **Match Medicaid and state dollars to help pay for consultation:** Use fiscal matching so that the state can pay for different aspects of mental health consultation.

PANEL DISCUSSION WITH COMMISSIONERS AND AGENCY REPRESENTATIVES

Ann Reale, Commissioner, Massachusetts Department of Early Education and Care (EEC)

- Challenges;
 - A lack of sufficient data presents significant challenges in understanding which children are affected, what the problems look like, and the results of various strategies.
- Strategies;
 - The best way to help young children is to help those closest to them;
 - The Comprehensive Early Childhood Consultation Program currently supports 14 clinicians in various mental health consultation programs. By the end of the year, another 6 grants for direct, on-site consultation will be awarded to community based programs to focus on eliminating preschool expulsion;
 - A new grant has been released which combines the Massachusetts Family Networks with the Parent Child Home Program (early literacy);
 - Through work with the Massachusetts Early Childhood Comprehensive Systems (MECCS) Project, the Commissioners of the Massachusetts Departments serving young children have come together and will continue to meet on a quarterly basis to focus their efforts around issues of young children, their families, and all domains of their development.

David Driscoll, Commissioner, Massachusetts Department of Education (DOE)

- Challenges;
 - Massachusetts, the home of John Adams and Horace Mann, is a place where we “step up for children” (John Adams). We still operate in silos but we’re doing better;
 - We need to start with the needs of children—too often we start with the needs of adults.
- Strategies;
 - Positive steps were taken in the Commonwealth with the creation of EEC and the appointment of Ann Reale as Commissioner. DOE started a strategic plan to identify goals and major challenges, including addressing the achievement and excellence gaps, and preventing gaps from occurring in the first place;
 - The push for universal pre-kindergarten has turned out to be less expensive than anticipated;
 - Perhaps the most effective and affordable strategy that a school can use to improve student performance is offering school breakfast. DOE conducted a study with Project Bread that showed an increase in academic test scores when children ate breakfast. Central to many children’s academic performance, behavior, and overall well-being—school breakfast should never be sacrificed because resources are shifted towards MCAS.

Elizabeth Childs, Commissioner, Massachusetts Department of Mental Health (DMH)

- DMH’s goals are improved access, decreased fragmentation, and increased coordination. The Massachusetts Department’s guiding principles are early identification and intervention, family collaboration, services within a family context, and comprehensive and evidenced-based programs;
- Challenges;
 - Need better data to identify what works for family and child functioning;
 - Need commitment from early childhood systems; building on successful innovations; honest dialogues among families, providers, educators and policymakers; opportunities for training and setting standards of professional development so that transfer of knowledge and expertise occurs.
- Strategies;
 - Current DMH cross-systems work;
 - MECCS Executive Committee meets quarterly to tackle fragmentation and coordination issues;
 - Collaboration with Parent Advocacy League (PAL) includes parental involvement with courts, DSS, DYS, and education systems;
 - Models to build on and improve include the Comprehensive Mental Health in Child Care (CMHCC) and Massachusetts Child Psychiatric Access Project (MCPAP).
 - Broad policy agenda approaches;

- The Special Governor's Commission on Children's Mental Health prioritized early identification and screening in pediatric offices, reducing high rates of preschool expulsion and ensuring that all mental health interventions are family-focused;
 - The U.S. District Court's landmark decision in *Rosie D. v. Romney* requires the Commonwealth to provide comprehensive assessments, case management, and in-home behavioral supports for all Medicaid-insured children.
- Key elements of a well-functioning mental health system;
 - High quality;
 - Effective;
 - Promotes continuity (consistency of care, services, and people across systems to assure best results when multiple hand-offs occur);
 - Encourages strong family commitment/network to foster the goal of resilient children and families.

Sally Fogerty, Associate Commissioner, Massachusetts Department of Public Health (DPH)

- DPH focuses on early identification, intervention, promotion, and prevention. Jack Shonkoff's research on early brain development has helped affect the best possible level of health and wellness during pre-pregnancy and birth;
- Challenges;
 - Need to integrate primary care settings with mental health settings and support natural linkages;
 - Challenges remain with identifying problems, where to refer, and how to address when no referrals are available.
- Strategies;
 - F.O.R. Families is a strong model for homeless families;
 - Early identification thwarted when substance abuse is involved. DPH is shoring up linkages across substance abuse, behavioral health, and parenting issues.

Neal Michaels, Director of Early Intervention and Special Projects, Massachusetts Department of Social Services (DSS)

- DSS is legislated by CAPTA to refer children ages zero to three with supported reports of abuse and neglect to Early Intervention. The Massachusetts Early Childhood Linkage Initiative (MECLI) existed in pilot form through collaboration with DSS, DPH, and Brandeis University even prior to federal mandate;
- Level of activity and need within DSS is reflected by the following data;
 - 12,000 children ages five and under in DSS system;
 - 14,000 investigations a year on children under age three;
 - 22 percent of children in foster care are age five and under;
 - 26 children in residential care are age five and under.

- Challenges;
 - Disproportionate numbers of open cases are people of color. Annie E. Casey Foundation awarded grant to DSS to address this;
 - Need to think about permanency decisions differently for young children — even more pressing given the substantial increase in the number of children ages birth to five in the DSS caseload — and what research tells us about children placed in substitute care before they are two months old;
 - Families’ experiences vary as internal procedures are inconsistently followed across the state’s 29 area offices.
- Strategies;
 - Collaborating extensively with EEC and received \$5 million dollars this year to eliminate child care waiting lists;
 - Developed alternate response system for families who do not need protective services, just help with basic needs;
 - Working with Children’s Trust Fund on Healthy Families, young parent support, and teen living programs;
 - Shifting from a deficit-based model to one where structures and practice are changed to emphasize prevention, to use a family assessment model, and to establish an agency level family advisory committee;
 - Pioneered a substance-exposed newborn treatment project in collaboration with DPH and community-based organizations.

DR. KNITZER’S REVIEW OF PANEL DISCUSSION

Some structures are in place that address system building needs, such as quarterly MECCS Executive Committee meetings. However, thinking deeply about ways to coordinate these efforts still needs to happen. Preexisting linkages present opportunities for further conversation and deepening commitment until coherence exists in our goals and is socialized into the culture of our systems.

A coordinated goal of preventing and reducing the achievement gap would promote well-being and successful entry into schools. To move forward in this arena, there needs to be focused, honest dialogue across agencies that asks several questions. What is each agency doing to promote effective infant/toddler mental health consultation? What more can we do? What can agencies contribute to existing DMH and EEC mental health consultation models? Where are the overlaps and the gaps?

MECCS can do the staff work to help sort through these questions, but the dialogue must involve family members and address race and language. Progress requires a shared cross-agency agenda and an assessment of achievement markers. Development of a strategic plan starts with each child.

AFTERNOON WORKSHOPS

Summit participants attended afternoon workshops to explore five different aspects of an early childhood mental health system of care. The workshops were:

- A. Moving Toward a System of Comprehensive Early Identification;
- B. Enhancing Professional Training and Capacity;
- C. Components of Effective Early Child Mental Health Consultation;
- D. Paying for an Early Childhood Mental Health System of Care;
- E. Accountability: Tracking Outcomes and Efficacy.

Workshops were organized into three parts: panel presentations described existing approaches to the workshop topic; group discussion identified key system elements, strengths, barriers, and gaps; and policy recommendations offered action steps in the short, mid, and long-term. Below are summaries of workshop discussions and recommendations.

I. MOVING TOWARD A SYSTEM OF COMPREHENSIVE EARLY IDENTIFICATION

Facilitator: **Joan Mikula**, Assistant Commissioner for Child and Adolescent Services, Massachusetts Department of Mental Health (DMH)

Presenters: **Caroline Watts**, Director of Children’s Hospital Neighborhood Partnerships Program, Children’s Hospital Boston; **Robin Adair**, Assistant Professor of Pediatrics at U-Mass Medical, Medical Director, Infant-Toddler and Preschool Clinics, University of Massachusetts Memorial Children’s Medical Center; **Russell Lyman**, Private Consultant.

SUMMARY OF WORKSHOP THEMES

Effective initiatives increase developmental and social/emotional screening and provide access to mental health services in children’s natural settings, including early childhood primary care, education and care, and community based organizations. As microcosms of comprehensive early identification systems, these initiatives break down institutional barriers to take a whole child developmental approach toward mental health. Critical lessons learned from these projects include:

- Solid, cross-system fiscal infrastructure can ensure affordability and access;
- Contextual approaches that take a broader risk perspective to include the child’s family situation provide the bigger payoff. Translated into practice, the contextual approach takes formal screening beyond the child, and facilitates dialogue with the family;
- Prevention and health promotion can be achieved to the extent that the workforce is adequately supported with knowledge, skills, and tools.

Screening efforts in Massachusetts generally exist in isolation from one another and require aggressive networking to connect. Fragmentation presents a challenge to professionals and families seeking referrals for mental health concerns. The early identification system is back-loaded as evidenced by the Governor’s Commission on Early Childhood Mental Health which focused on “stuck kids” — children staying in hospitals and residential programs due to mental health issues. The legislature has added a line item to the Massachusetts Department of Early Education and Care’s budget allocating \$1.4 million for Early Childhood Mental Health Grants to address the issue of preschool expulsion. When such restrictive settings are no longer medically necessary.

The grants move attention to the system’s front end, but many professionals believe that preschool can be too late and that across the Commonwealth we are not identifying children in situations of risk early enough.

Abundant evidence highlights the importance of early screening. Infant mental health is a core component of all other areas of development, and affects a child's capacity to communicate, self-regulate, learn, and explore their environment. Screening early allows providers to determine the quality of early relationships, to promote well-being, and to prevent further issues.

Despite the evidence, social/emotional screening does not occur at optimal levels. Screening activity falls short due to a varying knowledge of validated tools, and limited access to services (though Early Intervention and early care and education systems do present some options). Additionally, positive screens mean confronting the stigma of mental health.

Pediatric care providers (PCPs) play a key role in early identification since a majority of children visit their offices. Most PCPs assess family and child functioning to some extent, however not with validated tools. Social/emotional problems are sometimes caught by broad developmental screens with social/emotional components, such as First Signs®, but time and insurance reimbursement present a challenge. Pediatricians may not be able to fully explore specific items within a fifteen-minute visit, especially when insurance reimbursement declines as time spent with the child accumulates. Increasingly, pediatricians are paid for screening, but an insurance billing code and specific tool recommendations are still needed.

To promote and support pediatricians' screening role, the Massachusetts Department of Mental Health's budget includes \$2.5 million for the Massachusetts Child Psychiatry Access Project which provides 68 percent of pediatricians statewide access to psychiatric consultation services via phone or in-person. On-the-job training for pediatric care professionals could expose pediatricians to early childhood environments — elucidating the child development continuum.

Looking at risk factors as part of the screening discussion pushes providers to view the child as part of a larger system of family, program, and community. Typically, the broader risk perspective is missing from diagnosis discussions. A risk perspective that promotes a wider focus, including contextual factors and solutions, is a preventive and healthy approach to working with adults and children.

The recent *Rosie D. v. Romney* decision creates increased opportunities for voluntary pediatric mental health screening for 400,000 Medicaid-insured children (age 0-21) in Massachusetts. If a child is at certain threshold, an assessment occurs. If a positive assessment is made, services are made available to the family that allow the child to remain at home and out of residential placement. The range of services covered by Medicaid is expected to be announced in 2007. With a price tag of about \$.5 billion dollars from a potential infusion of 15,000 children, this decision marks a big step towards systemic screening.

ELEMENTS OF A COMPREHENSIVE SYSTEM OF EARLY IDENTIFICATION

Family-Focused

- Emphasizes families' strengths;
- Offers accessible and language appropriate services;
- Provides parent questionnaires (as contrasted with Denver Developmental Screening Test or other assessments focused solely on child and provider);
- Informs parental understanding of realistic child development. The Ages and Stages screening tool, for example, offers guidance by explaining what to expect, what to look for, and preempting cultural differences in interpretation of development;
- Ameliorates the effects of environment on children and families;
- Promotes “family friendly” screening systems (*e.g.*, if front-desk person does not keep a supply of pencils, and is unwilling to collect surveys, it can derail the process);
- Offers screening for parental depression and links to services;
- Involves a pediatric health care provider in screening on various issues;
- Offers parent surveys, creating effective dialogue;
- Trains professionals who screen to deal with the stigma and distrust of mental health services.

Multidisciplinary and Integrated

- Integrates different screening and intervention options for children, families, and providers;
- Delivers a continuum of service that runs from prevention to intervention, is not one-size-fits-all, and does not require referrals to a different, fragmented part of the system;
- Involves schools in prevention, and places support personnel in all schools starting in pre-kindergarten;
- Improves quality of services through training and professional development, and builds the capacity of partner organizations such as child care, schools, and pediatric health care providers;
- Adopts a pre-kindergarten and beyond philosophy to education and care;
- Enhances competencies for professionals working with young children across disciplines;
- Networks existing early identification programs;
- Links databases, goals for data, and tools.

Embedded in Community

- Expands mental health services and coordinates services to meet needs of children and families in schools, community health centers, and community based organizations;
- Locates services and practitioners where children and families are found and creates built-in opportunities to work with them;
- Partners mental health practitioners with community-based staff to understand challenges and resolutions, and thereby build long-term relationships.

Workforce Development

- Supports child care's integral role in the early identification system with well chosen, effective tools and adequate training;
- Builds capacity of early care and education professionals to identify symptoms in children, families, and themselves, and what to do if noted;
- Identifies culturally competent (e.g. culture of a public school, culture of a health center, general culture) mental health professionals who live and work in the community as opposed to outside practitioners with no understanding of local culture;
- Connects with staff on-site, witnessing and evaluating struggles first-hand and helping develop resolutions.

WORKSHOP PARTICIPANT POLICY RECOMMENDATIONS

- COMPREHENSIVE EARLY IDENTIFICATION WITH REIMBURSEMENT FOR SCREENING (short-term)
- BETTER COORDINATION BETWEEN PROGRAMS SUCH AS EARLY INTERVENTION, HEAD START, EARLY HEAD START, AND PUBLIC SCHOOL, FOR TRANSITION AND SERVICE INTEGRATION (mid-term)
- AVAILABILITY OF QUALITY CHILD CARE WITH THE RESOURCES TO DEAL WITH CHILD AND FAMILY ISSUES AND CONCERNS (mid-term)
- ENHANCE COMPETENCIES ACROSS ALL DISCIPLINES AND DEVELOP CLINICIAN WORKFORCE (long-term)

II. ENHANCING PROFESSIONAL TRAINING AND CAPACITY

Facilitator: **Peggy Kaufman** Founder and Director of the Center for Early Relationship Support at Jewish Family and Children’s Service.

Presenters: **Libby Zimmerman**, Acting Executive Director of Connected Beginnings: The Massachusetts Birth to Five Professional Training Institute; **Margot Kaplan-Sanoff**, Associate Professor Pediatrics at Boston University School of Medicine and Director of Healthy Steps; **Eda Spielman**, Clinical Director of the Center for Early Relationship Support. **Edward Tronick**, Director, Child Development Unit and Associate Professor of Pediatrics and Psychiatry, Harvard Medical School.

SUMMARY OF WORKSHOP THEMES

Successful models of professional training and capacity building already exist in Massachusetts and other states. Using this pre-existing infrastructure, Massachusetts is well positioned for a comprehensive, systemic effort to grow critical skills and capacity among professionals working with young children and their families. Vast numbers of professionals working in different early childhood settings have the potential to positively impact children’s lives through structured interactions – screenings, home visits, well-child visits – and not insignificantly, through informal interactions such as daily advice and parenting suggestions. The breadth of these interactions provides great opportunities to promote children’s development, and underscores the importance of comprehensive, cross-disciplinary training.

While examples of successful, innovative models exist for post-graduate and professional development training, the state of affairs in Massachusetts suffers from fragmentation and a chronic lack of support (financial, organizational, linguistic). Woven together, these models reveal the missing elements of a statewide system, including public-private partnerships, tuition relief, cross-institution graduate level courses, integrated theoretical frameworks to unite research and practice, reflective supervision, and ongoing cost-effective models such as training the trainer. Efforts to scale up and link existing models must include multiple sectors and prioritize coordination, continuity, and relationships, and ensure that the focus is on the family context.

To advance a systemic approach to professional development and training, an overall communication strategy using a common language is needed. At its core, the communication strategy must convey the importance of early relationships—starting in infancy—in promoting healthy social and emotional development in support of robust cognitive and language development. This strategy should promote intraprogram training for all levels of employees — paraprofessionals, receptionists, pediatricians, and teachers—on basic concepts of social and emotional well-being. It should offer reassurance that specialization can be maintained with overlapping disciplines in training. Politics and fragmentation in higher education have historically complicated discussions of intraprogram training, so the strategy

must convincingly invite support. The strategy should also include a different perspective on outcomes and costs to fully quantify training value and impact.

Pediatricians' role in a single early childhood mental health system of care is integral but insufficient due to reasons of time, cost, and training. The influence and effectiveness of the 'Reach Out and Read' model demonstrated how early childhood professionals' literacy message lay fallow for years, but received validation and rose to new levels of importance in the hands of pediatricians. A specialist in the pediatrician's office—a place where most families, regardless of income/culture, seek treatment approximately 12 times in the child's first three years—could perform necessary screening functions.

KEY SYSTEM ELEMENTS FOR PROFESSIONAL DEVELOPMENT AND TRAINING

Family-Focused

- Looks at children in the context of family and other critical relationships, and uses inclusive language;
- Trains and supports early childhood providers on shifting focus to serving families so that staff can promote the basic concepts;
- Offers services in accessible locations within communities;
- Evaluates eligibility criteria for existing programs and serves beyond diagnostic categories to include all children who need help.

Multidisciplinary

- Promotes specific, targeted, trans-disciplinary training on mental health and social/emotional well-being for cross-system professionals working with infants and young children;
- Communicates a strategy and language that promotes better understanding of social/emotional well-being across disciplines and communities, clarifies terminology such as awareness, prevention, promotion, and intervention, and enables clinicians and non-clinicians alike to share mental health strategies and information;
- Encourages early childhood providers to view themselves influencing positive social and emotional well-being;
- Offers a range of training, including intensive training for mental health clinicians, general promotion and prevention training for all professionals working with children, and infant observation training to nurture understanding and practical knowledge of infant development.

Ongoing, Reflective and Relationship-based

- Promotes sustained training, infused with the importance of continuous education;
- Allows time for ongoing learning and reflection in training and supervision;
- Supports integration of training and practice through supervision;

- Assumes a self-reflective professional, who views young children’s social/emotional development unfolding within a context of relationships;
- Supports child care directors in providing organizational support for professional development such as mentoring and guidance;
- Bases practice and training in relationships.

Culturally Competent

- Includes culture and race discussions in training curricula, and raises awareness of embedded value judgments.

Accessible

- Supports a range of professionals and skill levels across the system;
- Encourages highly trained professionals and paraprofessionals;
- Evaluates training process continuously, and involves a variety of people;
- Provides affordable and understandable training for low-income child care providers who speak English as a second language.

WORKSHOP PARTICIPANT POLICY RECOMMENDATIONS

- DEVELOP PERSUASIVE LANGUAGE FOR POLITICAL CHANGE AND OBTAIN HIGHER EDUCATION BUY IN ON COMMON BODIES OF LANGUAGE AND STUDY (short term)
- BUILD REQUIRED CULTURAL COMPETENCY TRAINING INTO ALL EDUCATIONAL TRAININGS (short and mid-term)
- EVALUATE TRAINING NEEDS AT THE COMMUNITY LEVEL – ONE SIZE DOES NOT FIT ALL (mid-term)
- PAID RELEASE TIME RATHER THAN TUITION-BASED TRAINING FOR STAFF (mid-term)

III. COMPONENTS OF EFFECTIVE EARLY CHILD MENTAL HEALTH CONSULTATION

Facilitator: **Deborah Hirschland**, Consultant to the Early Childhood Mental Health Project in Somerville

Presenters: **Terry O’Neill**, Children Support Service, Lowell Public Schools; **Elizabeth Leutz**, Director of Development for Thom Child & Family Services; **Kathleen Dow**, Director of Children’s Services for the Worcester Community Action Council Head Start Program; **Art Weingarten**, Director of the Social Service Department at South Shore Day Care Services; **Beth Burlingame**, Program Director, South Shore Mental Health’s Department of Social Services; **Lynn Hennigan**, Director of Services for the Young Child at Community Healthlink, and Director of the Together for Kids Coalition.

SUMMARY OF WORKSHOP THEMES

Models of mental health consultation embedded in early education and care, and multiservice settings involve clinicians providing on-site services to children, families, teachers, and whole organizations. Consultants’ activities might include assessment, observation, behavior assistance, professional development, additional training, intensive home visits, mental health consultation for families, or other family services. Each program shares evidence that the intervention returns positive outcomes including improved behavior, increased caregiver skill level, reduced expulsions, special education referrals, and stabilized communities.

The prevalence of families struggling to meet basic needs complicates mental health issues and the role of services. These circumstances necessitate staff with competence working within that context. Flexible funding arrangements (e.g. reimbursement for collateral work) allow clinicians to focus on families’ basic needs (e.g. accessing a food pantry) and greatly increase the likelihood of families becoming positively engaged with the consultant. Clinicians can then build on these relationships to address behavioral issues.

In practice, mental health consultation models avoid ‘mental health’ as a label. Instead, the terminology reflects a strengths-based approach and issues are discussed in terms of developing relationships, helping children experience competence, supporting teachers, and partnering with families to expand their skills. Implementing consultation models requires a commitment to reflective supervision for clinicians and staff, and relevant staff training to support a strengths-based, multidisciplinary team approach among staff and families.

Mental health consultation is a base model for performing clinical work in early childhood settings with a strengths-based approach. Consultants can help early childhood teachers shift their frame from the

management of early childhood difficulties to a mastery of early childhood vulnerabilities. This mindset can be especially useful in communication with parents and caregivers. Effectiveness in this role requires a command of child development issues and issues specific to each community. Given the broad skill set required of these clinicians, providers emphasize the need for rightness of fit between consultants, organization, and staff.

In one community where families are not typically advocacy oriented, the threat of losing a mental health consultation program (due to reduced state funds) led families to come forward and rally for continued services. Thus the consultation model produced the unexpected benefit of community empowerment and mobilization. Despite examples of unanticipated gains, the breadth of communities' struggles addressed by consultation models underscores a system-wide unmet need, and for many, a larger matter of social justice. This need should be met by critical strategies such as consultation, but also through the promotion of healthy support communities, and ultimately, a decreased need for mental health services.

KEY SYSTEM ELEMENTS FOR COMPREHENSIVE MENTAL HEALTH CONSULTATION

Family-Focused

- Offers flexibility in family services, located in communities accessible to families and their children;
- Provides interventions/clinicians with latitude to attend to families' basic needs;
- Offers parent and teacher supports, guidance, and coordination, and promotes a focus on healthy child development;
- Educates and supports parents and families in applying strategies from the classroom in their home;
- Provides continuity of clinician relationship to support families through different transitions (e.g. to public school), and to help identify adult mental health issues;
- Develops collaborative action plans with families that are grounded in issues of culture and race and address goals identified by the family;
- Engages families with outreach models such as home visits, thus creating a strong home-school alliance;
- Reaches children and families who are not in formal care systems.

Multidisciplinary

- Supports multifaceted, strengths-based team models with teacher, parent, and clinician;
- Bridges system gaps through a multi-service framework, weaving together different interventions at the front line;

- Provides training opportunities beyond typical, categorical, and structural limitations (i.e., agency affiliation, income, age, diagnosis).

Embedded in Community

- Promotes trust and comfort among families, facilitates coordination of referrals, and improves accessibility through embedded treatment (clinician on-site);
- Presents support to families as clinician becomes part of the community;
- Serves young children in natural environments;
- Models developmental guidance, relationship-based assistance, reflective supervision, training, mentoring;
- Embeds treatment in natural, frontline settings, and presents opportunities to emphasize screening.

Funding

- Provides sustainable funding;
- Allows for flexible models of funding and support unconstrained by systemic categories;
- Seeks Community Partnership funding and community-driven multi-service models;
- Scales up successful mental health consultation models through public-private funding partnerships;
- Offers reliable funding for birth to age three programs for consultant training or for consultation to teachers/program;
- Ensures continuity of services through flexible funding and incentives to providers for collaboration.

Workforce Development

- Respects community diversity through culturally competent mental health consultants;
- Provides continuity of clinicians for children and families;
- Supports practitioners who can translate concept of a strengths-based approach into practice;
- Creates training that is accessible to staff in multiple ways, including understandable and culturally sensitive language;
- Provides the birth to age three workforce with adequate depth and breadth of skills;
- Trains and supports caregivers to identify and address their own mental health issues.

TOP POLICY RECOMMENDATIONS

- FUNDING TO EDUCATE PARAPROFESSIONALS TO OBTAIN DEGREES WITH FULL SCHOLARSHIPS. (short-term)
- STABLE AND CONSISTENT FUNDING FOR MENTAL HEALTH CONSULTATIONS. (short-term)
- IMPROVE PAY AND MAKE ACCESS EQUITABLE. PARAPROFESSIONALS AND PROGRAMS' PARENTS NEED TO BE SUPPORTED TO ENSURE AN INCLUSIVE WORKFORCE. (short and mid-term)
- VILLAGE BUILDING/COMMUNITY BUILDING TO PROMOTE NATURAL SUPPORT COMMUNITIES. (long-term)

IV. PAYING FOR AN EARLY CHILDHOOD MENTAL HEALTH SYSTEM OF CARE

Facilitator: **John Lippitt**, Project Director for the Identification and Treatment for Infants and Their Families Project, Massachusetts Department of Public Health

Presenters: **Ron Benham**, Division Director of Perinatal, Early Childhood and Special Health Needs, Massachusetts Department of Public Health, **Kathy Betts**, Deputy Assistant Secretary for Children, Youth and Families, Commonwealth of Massachusetts; **Phil Baimas**, Director of Special Projects, Massachusetts Department of Early Education and Care

SUMMARY OF WORKSHOP THEMES

Many lessons can be learned from different early childhood financing structures. The Massachusetts Department of Public Health's Early Intervention (EI) system provides integrated developmental therapeutic service to over 29,000 (FY '07) families of children birth to age three. In a unique public-private partnership to fund services, EI established the state as the payer of last resort, covering uninsured families and costs exceeding insurance caps. Private health insurance covers about 45 percent of direct service costs, and public insurance through the Division of Medicaid Assistance/MassHealth funds about 22 percent of direct services. Additionally, families pay a sliding scale fee and annual participation fee.

The history behind EI's financing structure can inform a single, statewide early childhood mental health system of care. After getting EI services covered by Medicaid, EI leaders looked for legislative funding approval from 1986 to 1990 to require private insurance coverage as well. Insurers were concerned about paying for services delivered by non-clinical, 'developmental educators' because they appeared educational as opposed to 'medically necessary', a criteria for coverage. Insurers may make similar distinctions regarding social/emotional promotion and prevention services as opposed to intervention services. Persistence, and shared visions, will, and priorities among partners contributed to EI's implementation success. Existing infrastructure was adapted to support the financing partnership, including EI's switch from a traditional billing model to unit driven billing with Medicaid. This billing formula involves 'class billing' as opposed to 'individual level billing' so that Medicaid's processing costs are reduced as a result of volume.

The Massachusetts Department of Early Education and Care (EEC) and MassHealth Medicaid leverage cross-system resources to fund fourteen partnerships between child care programs and mental health clinics known as Comprehensive Mental Health in Child Care (CMHCC) pilots. CMHCC pilots offer enhanced social services to children in child care centers with state contracts to provide supportive child care for children with open DSS cases. EEC funding supports a full-time clinician's salary and services not covered by insurance (e.g. classroom observations, consultation and training for teachers, center staff, and families). MassHealth Medicaid (through their contractor Massachusetts

Behavioral Health Program) reimburses for treatment, collateral services, and consultation services for children insured through Medicaid. Private insurance also reimburses for treatment. A critical component for providers in this pilot is reimbursement for non-clinical but essential tasks. The value added is more time spent on family work and an individual plan.

The public-private partnership nature of this Summit can serve as a keystone to identifying next steps and engaging additional investors. A history of collaboration means that relationships have been established between stakeholders and across institutions. Agencies are talking with one another, but are not committing resources in well planned ways or engaging all potential payers/partners. The Rosie D. Decision increases the emphasis on functioning, as opposed to diagnosis for purposes of Medicaid billing, and new opportunities for such a dialogue grow. Additionally, the Massachusetts Department of Mental Health is engaged in the United Behavioral Health Initiative, and one mental health authority for the Commonwealth will be residing in that Department. With mounting potential for a rich dialogue, stakeholders across agencies can also tackle the longstanding question of how to address well-being for children not served through formal programs.

KEY ELEMENTS TO PAY FOR A SINGLE, COMPREHENSIVE EARLY CHILDHOOD MENTAL HEALTH SYSTEM OF CARE

Family-Focused

- Provides needed case coordination by reimbursing for non-clinical tasks;
- Promotes a variety of program models through flexible partnership funding;

Workforce Capacity

- Adopts strategies to develop and sustain well functioning, interdisciplinary teams;
- Promotes cultural competence of practitioners and clinicians;
- Meets the rising trend of young children in need through an adequate number of staff.

Embedded in Community

- Increases cost effectiveness by enhancing on-site staff capacity through training and modeling, and by achieving positive results such as accessible services and behavior improvements;
- Becomes part of a community in children's natural environments with on-site clinicians;
- Engages families with a familiar and comfortable clinician's presence in community settings;
- Locates services within caregiver environment, where clinicians observe children, provide accessible therapy, and develop relationships with families;
- Provides support groups for families, group sessions for children, and intensive home-based work.

Fill Funding Gaps

- Maintains the gains in filling funding gaps through legislative support and resource continuity;
- Invites investment from new payers with new funding formulas;
- Develops better methods for collecting co-payments from privately insured families;
- Expands the use of “disorder not otherwise identified” so more children can get services.

Integrated and Coordinated Infrastructure

- Shares vision, will, and priorities across agencies to move forward in unison;
- Provides options for insurance coding and reimbursement other than diagnoses of ‘disorders of childhood not otherwise specified (NOS)’ when DSMIV diagnoses do not fit;
- Expands use and reimbursement of option to identify impairment of functioning for purposes of billing Medicaid (Rosie D. Decision will put increased emphasis on functioning).

TOP POLICY RECOMMENDATIONS

- REQUEST SPECIFIC STATE INVESTMENT (I.E., DOUBLE CURRENT FUNDING LEVELS) TO EXPAND CHILD MENTAL HEALTH SERVICES. (short-term)
- DEVELOP LEGISLATIVE STRATEGY TO ENSURE CONTINUITY OF RESOURCES AND SUPPORT. (short and mid-term)
- DEVELOP A CLEAR MESSAGE THAT THE PUBLIC RELATES TO AND SUPPORTS (E.G. BUILD BRAIN ARCHITECTURE NOT “INFANT AS PRECIOUS OBJECT”). (mid-term)
- BUILD SHARED VISION AND WILL AROUND EXPANDING RESOURCES. (long-term)

V. ACCOUNTABILITY: TRACKING OUTCOMES AND EFFICACY

Facilitator: **Lisa Lambert**, Assistant Director of PAL Parent/Professional Advocacy League

Presenters: **Bill Deveney**, Assistant Commissioner for Quality Improvement and Professional Development, Massachusetts Department of Social Services; **Carole Upshur**, Associate Dean for Clinical & Population Health Research and Professor Family Medicine and Community Health, University of Massachusetts Medical School

SUMMARY OF WORKSHOP THEMES

Outcome tracking and approaches to accountability vary widely across the state and are shaped by organizational/programmatic cultures and priorities. The current state of affairs does not include a united or overarching plan for coordinated definitions, measures, tools, or comprehensive data exchanges. Commendable efforts to share data, tools, and outcomes exist but only as anomalies. Infrastructure to bridge existing pilots and models across system silos could advance the utility of data already available, and widely improve program impact on child and family social/emotional well-being. Building infrastructure to support better coordination requires a shared vision among the highest level of leadership on down—a vision of programs and outcomes that cuts across different domains in a manner that parallels how children’s and families’ needs cut across traditional agency boundaries.

DSS has deepened its commitment to a strengths-based approach by shifting accountability mechanisms to a learning process framework. State agencies traditionally focus accountability efforts on using data for compliance purposes. Emphasis on compliance often creates defensiveness, performance anxiety, and an adversarial dynamic in unionized environments. DSS’ new frame has a built-in improvement process that gives staff at all levels opportunities and tools to view data that inform decision making in terms of both practice and outcomes. The emphasis on learning from data at multiple levels—clinical, managerial, systemic—has enlisted staff to learn from mistakes, address problems, continually ask how they can do better, and evaluate whether children are improving. By shifting the focus to improvement, accountability naturally follows, and as a whole, the system can maximize the utility of outcome data to achieve better results.

Changes in accountability such as those at DSS highlight a general need to train and support the workforce in interpreting data and consistently using accountability tools. There is a wealth of data available already but systemically practitioners are not well positioned to mine it and make use of it to impact practice and outcomes. Infrastructure improvement can address this challenge. Establishing more professional networks between systems could promote communication across boundaries to reduce overlap, increase cross-sector learning, and address issues of linking different funding streams. Interagency agreements for state agencies pool money for cross-sector training and move the system forward in terms of coordination of vision, goals, outcomes, and network building.

The Together for Kids (TFK) project, Worcester’s multifaceted child care mental health consultation model, conducted a rigorous evaluation — tracking data at child, parent, and classroom levels — that demonstrates compelling results. The project illustrates that small efforts result in positive improvements for children. TFK also accentuates the need for standardized screenings by trained teachers for all children since those screened-in for consultation appear to be developing typically. For children triaged into the intervention, screenings reveal subtle to large deficits in communication, social, emotional, and pre-academic skills. At the parent level, however, research finds that TFK does not positively impact outcomes.

In calculating the cost of its intervention, TFK includes later costs of responding without intervening, such as parents’ lost work time, setting up separate classrooms in school, and even the predicted trajectory for many children not caught early on, including school drop out, jail, and hospitalization costs (according to a national longitudinal study).

In a major leap forward during this workshop, DSS’ Assistant Commissioner for Quality Improvement and Professional Development and the Together for Kids Project evaluator initiated a plan to share evidence-based, social/emotional well-being screening measures. Developed and tested by TFK, the resources would be piloted in a DSS Area Office with all young children in the system. (To date, DSS relies on the same measures for school-age and younger children that emphasize behavioral health, reduction of symptoms and functioning in school). Eliminating traditional boundaries and sharing best practices and resources such as this budding public-private partnership sets an example of needed coordination and shared accountability for the youngest children in our communities.

DSS has launched a Child Welfare Institute (CWI) for staff in collaboration with the University of Massachusetts Medical Center and Salem State College. CWI will provide training in child and social development, and welcome other early childhood professionals into the institute for cross-sector training.

ELEMENTS OF COMPREHENSIVE SYSTEM FOR ACCOUNTABILITY

Family-Focused

- Partners with families in gathering data;
- Collects data from families’ perspective to fully elucidate child’s experience (e.g., PAL’s survey, *Speak out for Access*, which found that 48 percent of parents recognized mental health issues before child reached age four, and that more than half of the children whose families responded received medication before the age of eight and many before age four);
- Promotes home visits as an important component of a comprehensive mental health system.

Workforce Development

- Supports managers in utilizing data and generating meaningful interpretation as a way to make the wealth of information that is already available more useful;
- Builds in opportunities for professionals to persistently ask if children are improving;
- Trains teachers to manage classroom and behavioral challenges;
- Trains teachers to conduct child assessments;
- Promotes strengths-based professionalism by emphasizing learning over compliance;
- Views child care providers and staff as the front line for supporting social/emotional development.

Embedded in Community

- Utilizes schools as an opportunity for continuity in parenting education in addition to primary care settings (especially given decreases in families' participation in well-child visits as immunizations are completed at age two).

Coordination and Integration

- Coordinates data collection and sharing across agencies to yield more powerful information;
- Formalizes networking across systems' professionals to bridge information gaps, promote knowledge transfer, and to reduce overlap;
- Shares screening tools, information, and training;
- Increases capacity and quality of child care through cross-agency, collaborative responsibility;
- Uses accountability systems capable of aggregating data at child, family, and program levels to increase system usefulness.

Valid and Consistent Assessment Tools

- Uses standardized screening instruments universally in child care programs—the natural front line for early identification and intervention.

TOP POLICY RECOMMENDATIONS

- PILOTING TOGETHER FOR KIDS' DEVELOPMENTAL MEASURES FOR YOUNGER CHILDREN BY DSS AREA OFFICES. (short-term)
- INTERAGENCY AGREEMENT TO POOL MONEY FOR COLLABORATIVE TRAINING EFFORT (short and mid-term)
- TARGETING PARENT EDUCATION IN SCHOOLS ON HOW TO RAISE A CHILD TO GROW UP LEARNING ABOUT GOOD PARENTING STARTING IN KINDERGARTEN (I.E., THE FIRST EARLIEST OPPORTUNITY WITH STANDARDIZED CURRICULUM CONTENT. (long-term)

THEMES IN SUMMARY

The following **key themes** were introduced by Dr. Knitzer and echoed and expanded upon in the afternoon workshops:

- ▶ Creating leadership and commitment across agencies to establish common visions and goals;
- ▶ Linking innovative and creative initiatives in comprehensive or systemic ways;
- ▶ Bringing initiatives to scale and linking across administrative and disciplinary boundaries;
- ▶ Developing fiscal infrastructure, public-private partnerships, and a communication strategy;
- ▶ Supporting a multi-service, family focused system of care embedded in the community;
- ▶ Improving systemic capacity supported by trans-disciplinary training, staff demonstrating core competencies and shared language, and coordinated information (e.g. data, tools);
- ▶ Implementing policy structures that acknowledge the larger context of mental health and address overarching issues and challenges for families with young children including: poverty, racial disparities, language, trauma, transitions, and continuity.

Across the workshops, **key system elements** surfaced repeatedly and clustered into several overarching themes. Together these themes reflect a collective vision for a system that prioritizes:

- ▶ Funding infrastructure;
- ▶ Workforce development;
- ▶ Family focus;
- ▶ Community embedded programs;
- ▶ Valid and consistent assessment tools;
- ▶ Multidisciplinary and coordinated approach.

Workshop participants identified **policy recommendations** to serve as action steps in the short, mid, and long-term. Recommendations were identified repeatedly in different workshops. Grouped together, these action steps point the way to a single, comprehensive, and high-quality system of early childhood mental health:

- ▶ Develop cross-agency goals and vision for coordination;
- ▶ Support financial infrastructure and funding commitment;
- ▶ Expand early identification;
- ▶ Invest in coordinated training/professional development.