



EARLY CHILDHOOD SYSTEMS OF CARE

Lessons from the Field

INTRODUCTION

The “systems of care” model as an organized philosophy and framework was first published in *A System of Care for Children and Youth with Severe Emotional Disturbance* (Stroul & Friedman, 1986). Much of the work on mental health systems of care has focused on efforts to serve older children (i.e., school-age children and youth) with serious emotional disturbances (SED), who require services and supports from multiple agencies. More recently, attention (and federal funding¹) has also been given to developing systems of care for young children, including infants and toddlers. This expanded focus has brought to light a number of challenges in applying the system of care framework to a very young population.

The purpose of this document, which is an updating of the original March 2006 publication by Kaufmann, Horen and Perry is to illuminate the unique challenges inherent in developing early childhood systems of care (EC SOC), and—new to this edition—to offer guidance on how to address these issues based on lessons learned from the early childhood system of care grantee community. Much has happened since the original *Lessons from the Field* document was issued: nine new early childhood communities were awarded grants; significant changes to cooperative agreement requirements specific to early childhood took place; and grantees acquired five additional years of knowledge and experience. This Update reflects all of these changes and it is hoped that current and future EC SOC grantees will use this information to avoid “reinventing the wheel” and to best serve the young children and families in their states and communities.

THE UPDATING PROCESS

Since the state of Vermont was awarded the first EC SOC cooperative agreement in 1997, many opportunities for peer learning and sharing have taken place including conference calls/webinars, conference sessions, and email exchanges via the Early Childhood Community of Practice (EC COP) listserv. A number of challenges have been identified through these forums over the years and solutions (or, at a minimum, creative strategies) reached through dialogue, compromise, and collective problem solving. To capture this valuable information for this Update, the early childhood technical assistance providers at Georgetown University and the Technical Assistance Partnership shared learnings from their

¹ At the time of this publication, the Substance Abuse and Mental Health Services Administration (SAMHSA) had awarded cooperative agreements to 17 communities with an exclusive focus on young children.

work with state and community-level system of care efforts. In addition, to ensure a comprehensive picture of the critical challenges facing EC SOC communities and to gauge which of those challenges were most pressing, each community was surveyed. All 15 Project Directors from formerly and currently funded EC SOC communities² worked with their staff/partners to rank (from least to most challenging) the ten issues identified in the original *Lessons from the Field* document, and highlight additional challenges not reflected in that list. EC SOC communities also shared strategies and lessons learned for addressing those challenges when possible.

Somewhat surprisingly, there was very little consistency in the rankings across communities. Further investigation revealed that this variance was attributed to several factors:

- existing state/community infrastructure that facilitated or impeded systems development;
- effective strategies or approaches to address some of the challenges; and/or
- each community’s developmental trajectory (i.e., some communities, particularly newer communities, had not tackled some of the issues yet and ranked them less challenging than issues with which they were currently struggling).

It is also worth noting that individuals *within* some communities ranked the issues differently, depending on their specific role/responsibility (e.g., Project Director, Family Support Specialist, Lead Evaluator, etc.). Given the variance in rankings, the challenges listed in this document are not prioritized in any way

HOW TO USE THIS DOCUMENT

As previously mentioned, the primary purpose of this document is to help those developing early childhood systems of care anticipate and plan for the typical hurdles associated with this important, but challenging task. More specifically, it is hoped that the information provided in this document will help states and communities to:

- Assess readiness for an EC SOC grant
- Guide a community assessment/mapping to evaluate (1) which of these issues are/will be most challenging for YOUR community; and (2) what work still needs to be done in your community to address these issues?
- Identify possible solutions to these issues from other EC communities; is it a “fit” for your community, and if not, how might it be adapted?
- Provide guidance around sustainability planning for new/existing communities
- Communicate the challenges inherent in developing EC SOCs to those less familiar with EC issues
- Facilitate ongoing information-gathering about EC SOCs as the field continues to evolve

It is important to note that this document does not present an exhaustive list of all the major challenges encountered in building early childhood systems of care. Rather, it highlights those that are unique to this population. There are a variety of issues with which all grantee communities must struggle, such as sustainability, which is discussed below. For more information on these areas of overlap, see *Systems of*

² The survey was sent in September 2010; at that time there were 15 early childhood grantee communities currently or formerly funded through SAMHSA.

Care: A Framework for System Reform in Children's Mental Health (Stroul, 2002) and *Updating the System of Care Concept and Philosophy* (Stroul, Blau & Friedman, 2010).

Finally, this document offers brief synopses of major early childhood system-building challenges as well as some key strategies and/or resources. For additional exploration of these topics and accompanying strategy ideas, please refer to *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children's Mental Health, n.d.) and *Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems* (Perry, Kaufmann, & Knitzer, 2007).

SIMILARITIES ACROSS SYSTEMS OF CARE

Before exploring the differences in systems development for young children, it is important to first acknowledge core commonalities across all systems of care, regardless of age. Several areas of convergence are noted below.

- **All systems of care are rooted in the same core values:**
 - *child centered and family focused, with the needs of the child and the family guiding the types and mix of services provided;*
 - *community based, with the locus of services as well as management and decision-making responsibility resting at the community level; and*
 - *culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve*
- **All systems of care grapple with sustainability issues.**

Regardless of the age range, significant challenges exist in the ability to continue funding for both infrastructure and service delivery once the flow of federal dollars has ended. Successful sustainability plans for any age group require blending and braiding of local, state, and federal funds, as well as integration and coordination of services among service providers at the local level.
- **All systems of care rely on strong interagency collaboration.**

While key state/local agencies/partners may differ for different age groups, collaboration among agencies is critical for the purpose of improving access to services and expanding the array of coordinated community-based, culturally and linguistically competent services and supports for all children and youth with or at risk for a serious emotional disturbance and their families. As mentioned previously, collaboration is also critical in sustaining systems of care.
- **All systems of care must infuse a solid governance structure.**

It is essential to create a strong governance structure(s) into systems of care early on. Governing bodies should be diverse, with representation from both professionals and family members, and the demographics of the group should mirror those of the community being served. Further, the governing body(s) should be well-integrated into decision-making processes impacting the development, implementation and ongoing quality enhancement efforts surrounding the system of care.
- **All systems of care promote services and supports that are individualized and provided in natural settings.**

Consistent with the guiding principles of System of Care, all children with or at risk for serious emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan. Children should receive services within the least restrictive, most normative environment that is clinically appropriate.

- **All systems of care face challenges stemming from mental health stigma.**

Systems of care serving children and youth of all ages encounter inevitable challenges by virtue of their association with “mental health”. While progress has been made over the years to address the stigma associated with mental health, it still prevails, and can hinder one’s willingness to seek out or accept services and supports for mental health issues.

EARLY CHILDHOOD SYSTEMS OF CARE: WHAT MAKES US UNIQUE!

Below is a listing of key issues that capture how systems of care for young children and their families are different than systems of care for older populations and, consequently, present unique challenges to grantees working to develop strong, sustainable early childhood systems of care.

1. It’s not a MENTAL HEALTH System of Care

As one Project Director summarized, “This [issue] is the one in which all [other] challenges rest. When the system of care is built from the perspective of [integrating] mental health supports into the existing early childhood systems...many of the other issues fall into place...The stand-alone mental health system of care is difficult to build and sustain, and the readiness of families for an intensive model targeted only to mental health diagnoses has limited effectiveness for this population.”

To this point, it is important to consider that:

- Young children are served in a variety of settings (e.g., child care centers, primary care offices, homes); unlike older children they’re not all in one place like school.
- Young children’s mental health is inextricably linked to the mental health of their caregivers, suggesting a need for concerted effort to provide mental health services and supports to family members and other primary caregivers.
- Mental health is not typically part of the early childhood service delivery system; early childhood mental health is often a new area for those working with young children and their families.
- Consistent with a public health approach, early childhood mental health is inclusive of promotion of social/emotional health, prevention of mental health challenges, and intervention to address mental health concerns.

Thus, it is critical to *infuse* comprehensive mental health services into the various services and settings where young children and their families/caregivers are (i.e., their homes and communities). The field of early childhood mental health is at a new crossroads in understanding how best to identify and treat infants and young children with a mental health disorder and, even more importantly, how to utilize best practices to prevent many disorders from occurring. Because infants and young children’s brains develop so rapidly, and their environment and quality of caregiving relationships is so important to their healthy social and emotional development, an early childhood system of care that strategically incorporates mental health into existing systems is the best “fit” for this population. In essence, to truly optimize outcomes for children and families, early childhood mental health should be everybody’s business.

Progress/Lessons Learned/Resources in this Area:*Resources:*

- A Systems Framework for Early Childhood Mental Health (diagram) (<http://gucchd.georgetown.edu/67639.html>)
- “Building Early Childhood Systems” in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).
- “Building Bridges: Linking Services, Strategies, and Systems for Young Children and Their Families” in *Social and Emotional Health in Early Childhood: Building Bridges Between Services and Systems* (Perry, Kaufmann, & Knitzer, 2007).

2. Partnerships look different

In systems of care for older children and youth, the system partners that are traditionally involved include mental health, juvenile justice, substance abuse, education, and child welfare. Among these partners, there is generally widespread knowledge about serious emotional disorders and mental health diagnoses. The early childhood arena is quite different, as described below:

- EC SOCs engage agencies/programs *not* traditionally partners in systems of care for older children, i.e., Maternal and Child Health, Child Care, Preschool Special Education (619), Part C of IDEA, Head Start/Early Head Start, Primary Health Care, Home Visitation. These partners are often new to systems of care and/or early childhood mental health, requiring time-intensive knowledge dissemination efforts by early childhood grantee communities to achieve meaningful collaboration.
- Further, traditional partners, such as child welfare, are asked to participate in ways that are different than they are accustomed to for older populations. For example, EC SOCs might engage the juvenile justice system to focus prevention efforts on the younger sibling(s) of adjudicated youth or on young children of teen parents who are involved in the juvenile justice system.
- Finally, given a young child’s dependency on his/her caregivers, EC SOCs place particular emphasis on partnering with adult service providers to address caregivers’ needs (e.g., mental health, substance abuse, domestic violence).

Progress/Lessons Learned/Resources in this Area:*Lessons Learned:*

- Refrain from viewing the system of care grant as a project that resides within the mental health arena; rather, approach the work by engaging as many partners as possible. For example, one community contracted out to many local organizations as a way to increase the amount of active support and “buy-in”.
- Think about partnerships at many levels—state, community, and individual; large agencies, small organizations, and everything in between. To enhance community engagement, one community formalized “Community Network Teams” comprised of local agencies, organizations and individuals committed to strengthening the communities’ capacity to meet the needs of children and families dealing with mental health issues.
- Be mindful that as a “mental health program” you may encounter some resistance from the early childhood community. Work to slowly develop trust and strong partnerships by focusing on the opportunity a system of care provides to be a support to the early childhood community. Also emphasize the strengths of a system of care, especially the values and principles, which tend to resonate broadly.

- Put concerted effort into building a strong governance structure with representation from a broad and strategic mix of child and family serving systems, local organizations, family members, and other key stakeholders.

Resources:

- For detailed strategies, key questions to consider, and more information on this topic, see the “Partnerships” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).
- “Building Partnerships with Families” in *Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems* (Perry, Kaufmann, & Knitzer, 2007).
- *Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Their Families* (Rosman, Perry & Hepburn, 2005).
<http://gucchd.georgetown.edu/72374.html>

3. It’s important to use a developmental perspective

While it is important to understand typical development at all ages, it is critically important in the early years of a child’s life for a variety of reasons:

- a. The younger the child, the harder it is to distinguish mental health issues from other developmental areas (i.e., speech and language, motor, cognitive). These domains are interrelated and emotional problems in infants and toddlers often manifest through disturbances in eating, sleeping and regulating.
- b. Behaviors that are developmentally appropriate at one age, are warning signs at another age (e.g., separation anxiety); differences in frequency and intensity rather than a particular behavior are important to identifying children in need of services (i.e., tantrums).
- c. Early identification (and treatment) of behavioral or emotional challenges can significantly and positively impact the long-term trajectory of a young child’s life.

Progress/Lessons Learned/Resources in this Area:

Lessons Learned:

- To increase early detection and intervention, integrate screening and assessment efforts throughout the early childhood system of care, including settings such as child care centers and primary care offices. Early childhood mental health consultation³ is one strategy EC SOCs are using to improve early identification in early care and education settings and to promote overall social/emotional well-being.
- Ensure that assessments are conducted by a cross-disciplinary team of highly-trained professionals who have a strong knowledge base in both typical and atypical early childhood development, especially in the social/emotional domain.
- Foster strong collaboration among cross-disciplinary teams to ensure that when multiple needs are identified (e.g., sensory, motor, language, behavior), cross-disciplinary strategies/interventions are employed.

³For a description of and resources on early childhood mental health consultation, see <http://gucchd.georgetown.edu/67637.html>

4. Diagnostic issues are challenging

Diagnosing an infant or young child with a mental health disorder can present logistical, emotional, and philosophical challenges. Although EC SOC communities have been granted permission by SAMHSA to use the DC: 0-3R diagnostic tool, which allows for more appropriate diagnoses of infants and toddlers than the DSM:IV that is widely used with older populations, communities must use a “crosswalk” to map DC:0-3R diagnostic codes to the DSM:IV diagnostic codes or the ICD-9-CM diagnostic codes for billing purposes. Further, communities must ensure that there is a cadre of mental health clinicians who are trained to skillfully administer the DC: 0-3R—often a gap in the existing workforce.

- a. Beyond the logistics, some families/caregivers and early childhood advocates struggle with diagnosing an infant or young child because of concerns about labeling or concerns about the use of diagnostic classification systems that are not developmentally appropriate for this age group. Over the years, grantee communities have indicated that the requirement of an Axis I mental health diagnosis for entry into the system of care has dissuaded some families—many of whom are finding out for the first time that their child has a mental health issue—from accessing system of care services.

Progress/Lessons Learned/Resources in this Area:

Progress:

Significant progress has been made on this issue within the EC SOC community since this document was originally published. In 2007, representatives from the six currently-funded grantee communities formed a Diagnosis and Eligibility Workgroup to draft a report to SAMHSA highlighting the difficulties facing EC SOCs because of the existing diagnostic requirements and proposing that eligibility criteria be expanded for young children. In early 2009, the report was submitted to SAMHSA and later that year the agency amended eligibility criteria as follows, per the group’s recommendations.

For children 3 years of age or younger there must be significant behavioral or relational symptoms that meet the criteria for a DSM-IV diagnosis, a diagnosis as identified in the Diagnostic Classification of Mental Health Development Disorders of Infancy and Early Childhood-Revised (DC-0-3R), including an Axis II Relationship Disorder with a PIRGAS Score of 40 or below (which indicates a Relationship Disorder in the “Disturbed” Category), or a diagnostic impression of “imminent risk” that is identified through an intake process that includes a standardized measure (e.g., Baby’s Emotional and Social Style (BABES)) and an approval by a licensed mental health practitioner with knowledge and experience with early childhood development.

For children who are 4 or 5 years of age the Diagnostic Interview Schedule for Children (DISC) may be used as an alternative to the DSM-IV and the imminent risk diagnosis can be identified through an intake process that includes a standardized measure (e.g., Strengths and Difficulties Questionnaire (SDQ)) and an approval by a licensed mental health practitioner with knowledge and experience with early childhood development.

This change is significant in that it allows mental health clinicians the flexibility in determining a diagnosis, reaches and includes those children in the “prevention” category, and lessens the stigma

related to a mental health disorder in an infant or young child. Communities still struggle with a trained infant mental health therapist workforce, and questions have surfaced about a definitive definition and criteria of “imminent risk” as well as how to fund imminent risk enrollees beyond the grant period.

Resources:

- Florida’s Crosswalk between DC: 0-3R and ICD-9-CM, and accompanying narrative of the process used to get the crosswalk in place: www.thefloridacenter.org/pdfs/Fl_Crosswalk_June_2010.pdf

5. Engaging families of young children is particularly difficult

Family engagement can be a struggle for any system of care community, but there are added challenges for EC SOCs. Typically, families involved in the older child/youth system of care population have prior involvement with the mental health system and some have long histories with family advocacy organizations, such as the Federation of Families for Children’s Mental Health.

Conversely, many families of infants and young children with mental health disorders are in uncharted waters. They are most likely hearing the words “mental health disorder” for the first time and may not be ready to enter the mental health system. This discomfort can stem from a number of factors including uncertainty or distress about the possible diagnosis, fear that the child will be labeled, and/or fear that they will be blamed for their child’s behavior. Even when families do seek system of care services for their young children, it can be difficult for them to engage with EC SOCs at the program and/or policy level (e.g., participating in advisory councils, advocating for policy changes), given the pressing and often unpredictable demands of caring for an infant or very young child. Another barrier to family involvement encountered by some EC SOC communities is perinatal depression. In general, systems-level engagement of young families usually does not begin to happen until they are out of crisis, have greater familiarity with early childhood mental health, and have the supports needed to attend meetings, conferences and other functions (e.g., transportation, child care, financial assistance). Given all of the above, EC SOCs must find creative ways to address these barriers to participation for families of young children.

Progress/Lessons Learned/Resources in this Area

Lessons Learned:

- Seek out existing, active parent advocacy groups that focus on early childhood and/or mental health issues overall and work to integrate early childhood mental health (ECMH) into their action agendas. Consider collaborating across organizations to build a coalition around ECMH.
- Integrate a formal “family engagement process” into your EC SOC. For example, begin by initiating a supportive relationship between new parents and a parent mentor/advocate who has walked in their shoes and understands their fears and frustrations. The parent mentor can assist greatly in reducing stigma and providing education and information about systems of care. Families are much more likely to enroll in a strengths-based system of care where they feel empowered as the expert at the table for their young child. With the guidance and support of the parent mentor they learn how to “drive” their care plan within their family team meetings and the formal and informal supports they want to invite to the table. Be patient as the engagement process takes time and can be disrupted by child/family crisis.

Resources:

- For detailed strategies, key questions to consider, and more information on this topic, see the “Family Engagement” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).
- “Building Partnerships with Families” in *Social & Emotional Health in Early Childhood: Building Bridges Between Services & Systems* (Perry, Kaufmann, & Knitzer, 2007).

6. “Youth involvement” looks different for this population

Historically, youth involvement, including the position of a “Youth Coordinator⁴” as a key staff position within system of care communities, has been a grant requirement for all system of care communities. This makes sense when you are working with older children and youth with a serious emotional or mental health disorder. As a consumer of services, they need to be driving the system at both the individual and community level. However, EC SOC were quick to discover that this role—as it has been traditionally defined—does not make sense for early childhood systems of care. Even though two year olds might be the recipients of services, they do not have the cognitive or emotional capacity to make decisions regarding their own care nor should their behaviors be interpreted by others in an attempt to guide policy per the young child’s direction. Significant changes have been made to the “youth involvement” requirements since this document was first issued. These changes and some examples of how EC SOC are now operationalizing this role are detailed below. The current challenge for early childhood grantees is determining the best “fit” for youth involvement in their communities.

Progress/Lessons Learned/Resources in this Area

Progress:

Concurrent with efforts around diagnosis and eligibility, EC SOC communities and technical assistance providers spent considerable time and energy brainstorming creative solutions to the youth involvement “disconnect” and communicating developmentally appropriate recommendations to SAMHSA. Once again, the SAMHSA was responsive and amended the youth involvement/youth coordinator requirement as follows:

How do we address the requirement for a Youth Coordinator if we are an early childhood site that is focusing on young children?

The relatively new role of the Youth Coordinator is one that is evolving. Currently, Youth Coordinators are charged with facilitating youth involvement in the development of systems of care and ensuring that youth voice is part of service planning and implementation. These youth empowerment activities have enhanced services and supports in communities working with older children and youth, however, many activities that would be best practice in communities serving older children and youth are developmentally inappropriate when the population of focus is infants, toddlers and very young children.

In response to this disconnect and in accordance with developmentally appropriate practice, CMHS is giving those sites serving only children younger than age 9 an option to employ a youth

⁴The title of “Youth Coordinator” has evolved over the years. Some individuals in this role now are referred to as “Youth Engagement Specialists,” “Youth Empowerment Specialists,” or other similar titles.

coordinator. For communities serving children 9 years of age and older, hiring a youth coordinator is required, consistent with existing best practice guidance. The functional title for this position should be “Youth Engagement Specialist” or “Youth Empowerment Specialist.”

For communities who opt not to hire a youth coordinator, it is essential that they use their funds to build, enhance and extend the involvement of families of infants, toddlers and very young children in ways that are developmentally appropriate, and ensure that these families are actively included in all areas of program and policy development and implementation. Further, these grantees should develop transition plans that engage partners serving children who age out of the early childhood system, particularly school personnel (e.g. principals, teachers, school psychologists) and that address areas such as school-wide positive behavior supports and the transition from IFSPs to IEPs.

For communities serving only children under the age of 9 who choose to employ a youth coordinator, there is a need to assure that the activities they engage in are developmentally appropriate. For example, they should not work directly with the population of focus nor should they bring the voice of very young children to the planning and policy table (that role should be provided by the families being served). However, Youth Coordinators should be encouraged to work with community partners who do reach out to older youth and support their learning and empowerment. Further, Youth Coordinators can participate in program and policy planning (bringing their own experience to the table), collaborative activities, and community outreach activities. In close partnership with the Lead Family Contact and Clinical Director, Youth Coordinators may assist in the support provided to teen parents and older siblings (i.e., ages 9 and up).

As a result of this new guidance, the role of Youth Coordinator has been operationalized in a variety of ways across EC SOC communities. For example, some communities have retained the youth coordinator position, while others have found that channeling funds for the youth position into a Co-Lead Family Contact position is the best fit for their individual communities.

Resources:

- For detailed strategies, key questions to consider, and more information on this topic, see the “Youth Engagement” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).
- Youth Matter! Early Childhood-Focused Youth Engagement Is Possible (Couch, Sawyer, Moor, & Taylor-McDowell, 2011). www.tapartnership.org/newsletter/archives/201104_ym.php

7. Putting the necessary array of services and supports in place is challenging

A continuum of services and supports can be found in most communities for infants and young children with or at risk for physical disabilities or those with developmental delays. Primary care physicians and nurses are much more likely to screen and or refer for screening an infant or young child with a possible physical or developmental problem. Many communities have a developmental screening system in place that families and child care providers can access. Unfortunately, many of these systems do not screen for emotional or behavioral delay or disorders, or if they do include social/emotional screening, children often do not meet the criteria for enrollment into a system that can pay for services (Part C, Part B).

Young children and their families need a full array of individualized services and supports that are embedded “where young children and families are” and that span the continuum of promotion to prevention to intervention. Unfortunately, EC SOC communities face a number of obstacles in providing these services given the disconnect between “traditional” methods of service delivery and best practice in early childhood service delivery. These obstacles are briefly described below.

- a. Early childhood services are best provided in child care settings and homes—relatively uncommon venues for mental health service delivery.
- b. While agencies and organizations that serve young children are well-versed in the promotion/prevention/intervention service continuum, this holistic approach is relatively new to mental health agencies that have traditionally focused predominantly on treatment/intervention.
- c. There is a relatively small number of evidence-based practices for children under 8, compared to older children and youth. For infants and toddlers, there are significantly fewer evidence-based practices.
- d. Best practice services/interventions for infants and young children often involve methods that are difficult to fund given billing structures that are designed for one-on-one work between a clinician and client. Dyadic and relationship-based therapies, which are central to high quality early childhood service delivery, and indirect services, such as mental health consultation, fall outside of these parameters.
- e. The Wraparound process often requires adaptation to best meet the needs of infants, young children and their families. Given the intensity of the Wraparound process, some EC SOCs have found that less intense levels of service delivery (e.g., fewer individuals on the planning team) are better options for families new to the system of care. Once a family is ready, they may segue into Wraparound, but another challenge can be the availability of professionals that are trained in using Wraparound for young children.
- f. While natural supports are a critical element of systems of care, some families of young children are reluctant to divulge sensitive information about their children’s challenges to friends, neighbors or members of their faith communities.

Progress/Lessons Learned/Resources in this Area

Resources:

- *A Public Health Approach to Children’s Mental Health: A Conceptual Framework* (Miles, J., Espiritu, R.C., Horen, N., Sebian, J., & Waetzig, E., 2010)
- CSEFEL Teaching Pyramid: An Organizing Framework for Promotion, Prevention and Intervention Strategies: <http://csefel.vanderbilt.edu>
- Scan of evidence-based and promising practices being used across the early childhood system of care communities: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- Center for Effective Mental Health Consultation: www.ecmhc.org
- Project LAUNCH website: <http://projectlaunch.promoteprevent.org>
- Section on Infusing Mental Health Promotion, Prevention, and Intervention into Early Childhood Services and Supports in *Social and Emotional Health in Early Childhood* (Perry, Kaufmann & Knitzer, 2007)

- For detailed strategies, key questions to consider, and more information on this topic, see the “Services and Supports” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).

8. Workforce issues heightened in this population

In recent years, thanks in part to federal efforts (e.g., SOC, Project LAUNCH⁵, Early Childhood Comprehensive Systems Initiative⁶) and research on high preschool expulsion rates stemming from challenging child behavior (Gilliam, 2005), there has been heightened awareness of the need to attend to infants’ and young children’s social and emotional development and to secure help for those showing early “warning signs” of a possible mental health challenge. Unfortunately, there are many gaps in the workforce that hinder attempts to create a responsive and comprehensive early childhood mental health service delivery system.

First, there is a lack of early childhood providers who are trained in the promotion of social and emotional development and the early identification of mental health issues, as well as a shortage of mental health clinicians who are trained to work with the birth to five population (Ounce of Prevention Fund, 2000, p.6). Further, many pediatricians and other primary care providers, who offer critical access points to early identification and treatment of mental health issues, report that they do not feel they are sufficiently trained or skilled in evaluating the mental health of an infant or young child. Some also state that they are uncertain where to refer infants and young children if a mental health problem is suspected; a problem that is particularly acute when the issue isn’t a lack of awareness, but an actual dearth in supply of qualified infant and early childhood mental health professionals.

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

Progress/Lessons Learned/Resources in this Area

Resources:

- “Developing the Work Force for an Infant and Early Childhood Mental Health System of Care” in *Social and Emotional Health in Early Childhood* (Perry, Kaufmann & Knitzer, 2007)

⁵ Project LAUNCH is a SAMHSA-funded grant program designed to help communities expand the use of evidence-based practices, improve collaboration among child-serving organizations, and integrate physical and mental health and substance abuse prevention strategies for children, ages birth to 8, and their families.

⁶ The Early Childhood Comprehensive Systems (ECCS) Initiative is funded by the Maternal and Child Health Bureau and is designed to support states and communities in their efforts to build and integrate early childhood service systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education, and family support.

- *What to Expect and When to Seek Help: Bright Futures Developmental Tools for Families and Providers*: www.brightfutures.org/tools
- For detailed strategies, key questions to consider, and more information on this topic, see the “Prepared Workforce” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).

9. Funding sources are different

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

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

Progress/Lessons Learned/Resources in this Area

Resources:

- “Strategic Financing of Early Childhood Mental Health Services” and “Spending Smarter: A Funding Guide for Policy Makers and Advocates to Promote Social-Emotional Health and School Readiness” in *Social and Emotional Health in Early Childhood* (Perry, Kaufmann & Knitzer, 2007).
- Matrix of Early Childhood Mental Health Services and Supports⁷ in *Social and Emotional Health in Early Childhood* (Perry, Kaufmann & Knitzer, 2007)
- *What to Expect and When to Seek Help: Bright Futures Developmental Tools for Families and Providers*: www.brightfutures.org/tools
- For detailed strategies, key questions to consider, and more information on this topic, see the “Financing” section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children’s Mental Health, n.d.).

⁷The matrix outlines potential funding sources at the federal, state, local and non-governmental levels.

10. Evaluation brings up more issues

Historically, system of care funding has been targeted to school-age children and adolescents with serious mental health disorders, and measures used for evaluating outcomes have focused on these specific age populations. With the increase of early childhood sites in 2005, evaluators within sites focusing on very young children faced challenges since several of the measures lacked relevance or were developmentally inappropriate for an infant/young child population. Some sites realized early on that in addition to the National Evaluation data required by SAMHSA, local data was needed to capture specific outcomes most relevant to the early childhood community.

Gathering local data required additional time and resources but proved to be an important element in 1) knowing how well the system of care community was serving their young children and their families and 2) providing information to National Evaluation and SAMHSA on the differences in the infant/young child population so that changes might be made at both the policy and National Evaluation levels. As a result, changes have been implemented and continue to be made with National Evaluation efforts specific to the young child population.

Although the National Evaluation team has been responsive to the issues raised by the early childhood community and implemented adaptations to the protocol, challenges continue to exist within the early childhood mental health system itself. There is no collective set of identified outcomes for infants/young children and their families and few standardized tools to measure identified outcomes or key early childhood constructs. This is a work in progress for EC SOC's striving to advance the field of early childhood mental health.

Progress/Lessons Learned/Resources in this Area

Progress:

- Using aggregated data from three EC SOC communities on enrollees' exposure to different types of trauma, early childhood evaluators were able to bolster efforts to include imminent risk as part of the eligibility criteria for enrollment into EC SOC's. Aggregated descriptive and outcome data from these three sites, as well as additional data from the entire EC SOC community, is informing enhanced service delivery for young children and their families within the federal grant program and beyond.

Resources:

- Early Childhood Measures Profiles. (Child Trends, 2004). <http://aspe.hhs.gov/hsp/ECMeasures04>
- Matrix of local evaluation measures being used across early childhood system of care communities: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- Audio recording of "Lessons Learned from EC Evaluators" conference call, November 2010: http://gucchdtacenter.georgetown.edu/early_childhood_SOC.html
- For detailed strategies, key questions to consider, and more information on this topic, see the "Evaluation" section in *Putting the Pieces Together: A Toolkit on Developing Early Childhood Systems of Care* (National Technical Assistance Center for Children's Mental Health, n.d.).

CONCLUSION

The early childhood system of care communities have advanced their learnings significantly over the years. Through sharing of information, collaboration, trial and error, and commitment to the mission of creating best practice, comprehensive early childhood mental health systems of care, infants and young children with or at risk for a mental health disorder and their families are doing better. Barriers to best practices in system of care development in early childhood mental health, especially in the areas of eligibility criteria for enrollment and youth involvement, have been identified and resolved through a mutually respectful partnership with SAMHSA.

One of the valuable lessons learned during the updating of this document was that system-building challenges manifest differently in each community. There was no real consistency in ranking of challenges, not even among the more established sites. This reiterates that just as we value individualized care for our children and families, we must value the individual character, culture and context of each community. What works for one community may not work for another and there is no “cookie cutter” way of developing systems of care or addressing the challenges inherent in this task. However, using the collective knowledge of the entire EC SOC community can mitigate these challenges by offering field-tested strategies that can be adapted locally and collaboratively generating creative solutions to remaining barriers.

While major advancements have been made in a relatively short period of time, there is much work yet to be done to ensure the best outcomes for the young children and families served by systems of care. Hopefully, this document will become a useful resource for communities traveling this tough, but rewarding road.

Attributions

This document was authored by Frances Duran, Georgetown University National Technical Assistance Center for Children’s Mental Health (NTAC), and Kathryn Shea, President/CEO, The Florida Center for Early Childhood and community partner with the Sarasota Partnership for Children’s Mental Health. It reflects an updating of the original *Lessons from the Field* developed by Roxane Kaufmann, Neal Horen and Deborah Perry at NTAC.

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