Facilitated Discussion Notes
Infant and Early Childhood Mental Health
March 17, 2014

Below are notes distilling the comments made by participants during a Facilitated Discussion of this topic. Generally, the comments are made in the order in which they occurred. Redundancy with respect to comments has not been eliminated. This information will be combined with input from other sources and will inform development of Connecticut's Children's Behavioral Health Plan. If you have comments about these notes, please email project staff at: info@plan4children.org.

General Notes

- Hosted by the CT Association for Infant Mental Health
- Location: United Way, Rocky Hill, CT
- 23 people in attendance

Question 1: Strengths

- Workforce
    - "The people sitting around this table"
    - The commitment, energy, experience and skills of the people working on this issue
    - Philanthropic/foundation support
    - Governor's support for the Office of Early Childhood
    - Workforce: the staff doing this work are tremendous
    - Early childhood community of professionals is committed to system building
    - Growing interest in and commitment to Competencies and Endorsement in Infant Mental Health through CT-Association for Infant Mental Health.
- ECCP model: Funding through DCF
    - A recent RBA review revealed the effectiveness of ECCP
- Child FIRST
    - 15 sites across state, infrastructure developed across all DCF Area Offices
        - DCF providing financial and infrastructure support
    - Fidelity monitoring and outcomes monitoring—strong data from RCT and from replication sites
    - HRSA accreditation
    - $10M from philanthropy, public-private partnerships
    - Very strong collaborations in CT that support the model
    - Evidence-based model with strong individualized treatment approach
    - Data collection and fidelity to models are key components
- EPIC program
    - Early identification in pediatric practices; connection to resources
- CT has the Early Child Comprehensive Systems (ECCS) grant, Help Me Grow, Birth to 3, Child Development InfoLine
- Advocacy is strong here. More public awareness of the issue is leading to growing political will
- Collaboration is strong, and getting stronger
    - Lots of synergy across initiatives in the early childhood arena
    - Several constituents coming together to push forward the issue of early childhood
    - Collaboration within community-based agencies: building more early childhood infrastructure right into their agencies

    - Cross-sector coordination and training;
- National eyes on CT and its work in early childhood. Interest from other states and federal entities to replicate CT's work
- Prevention services: Connecting with parents of young children
    - Via Nurturing Families—now in all birthing hospitals
- Discovery Communities
    - There are 52 communities across the state; 40 have local community plans or are working toward them; looking at assets and needs; connecting state and local level capacity building
- DCF-Head Start Partnership
    - Well attended, diverse representation within the field of early childhood
    - Infant Mental Health workshop series through CT-AIMH has transformed practice among participants
- Birth to Three
    - Growing recognition of their workforce and their needs
    - 43 mental health clinicians trained in assessment (using DECA-I/T)
    - Forum among the EC community to educate their MH clinicians as to what is available in the community
    - Working better with other EC programs and services
- Early Childhood Alliance
    - Great place for this community to work together on policy and practice
- Doulas through DMHAS
- Moms Project in New Haven has focus on emotional health and wellness of mothers that leads to better parenting
- American Academy of Pediatrics
- Statewide Diaper Bank
- Circle of Security model

<u>Question 2: Concerns</u>

- Need to do more in hospitals where we have the opportunity to link families w/ services
- Need more infant mental health training across all child-serving systems
    - People working with young children, including many parents, often have a poor understanding of the foundations of early childhood (attachment, brain development, school readiness, etc.)
    - Need an early childhood workforce that is trained and supervised properly
    - There are issues around cultural competency of the workforce
- Capacity and Access throughout the system
    - System lacking clinicians to provide continuum of care
    - Need access to all types of early childhood services
    - One participant noted that "something is better than nothing"
    - Many services only have a 6 month LOS, that is only enough to "scratch the surface"; Child FIRST was mentioned by one participant as the only service that has been with them for longer than that (2 years)
    - Rare to find mental health professionals in early care and early childhood settings
    - Early screening is important, but if there is no place for children to go after screening as at risk--that is a huge problem
    - Need capacity to serve more young children

  - Need capacity to serve more families prenatally
  - Families say they cannot get into CGCs regardless of insurance or system involvement
  - Rare to find clinicians prepared to engage very young children and their families in CGCs.
  - Access barriers: transportation, cost, hours, quality
- Lack of consistency of service access across geographic regions of the state
  - Some areas of state do not have comprehensive continuum of care; what there is may be spread out across multiple agencies
  - Some programs and services are only available in certain areas
  - Some families won't leave a city with good services, others have to move to get services that are not available where they live. Services shouldn't be based on the city you live in
  - Working in geographic areas smaller than the state level, larger than the city level—problematic
- Need more capacity, especially for Child FIRST
  - More capacity, especially in high-need urban settings
  - One site consistently has 25 to 30 families on their wait list; this is a long time in the early childhood world. All sites have waiting lists.
  - If MIECHV fed funds do not get re-authorized, 8 CF sites will go away (without additional state support)
  - 130 families on Child FIRST waitlist, not including families triaged to other services, and not including families in cities that do not have Child FIRST.
- Funding/Reimbursement Issues
  - EC services often closed to privately insured and those who are not "system-involved"
  - Problematic to have to diagnose a child under 5 to get reimbursement for services
  - The funding streams currently are authorized at the individual, rather than the family level. Services for young children require family-level funding streams
- Voluntary Services is problematic
  - Can take 3 months to start; laborious paperwork; many parents do not want to sign up to get involved with an agency that has such stigma
  - Turning custody over to DCF in order to get help is a problem for families
  - The amount of paperwork that needs to be completed to access services is daunting
    - Example from a parent: Voluntary Services was involved for 3 weeks until they linked to services, then they closed the case, then she got 6 months of services, and to get follow up services would have required doing the paperwork all over
- There is a gap between early childhood and school-aged systems of MH care
  - Insufficient linkage/transition between early childhood community and SDE
- Lack of consistency in treatment approaches across early childhood programs
  - Depending on program, you may get very different kinds of service w/different theoretical approaches (attachment-relational vs. CBT-based in other services)
  - When families have participated in other services (IICAPS provided as example which is not designed for children under 6 years), Child FIRST and other attachment-based providers often have to re-train families to "unlearn" what a previous program has done—that can take months
- Data is Insufficient
  - Documentation and tracking does not follow children and families across treatment programs or across the child and family's continuum
- Need for a paradigm shift
  - Behavioral health uses a model that suggests problems can be fixed in 8 to 10 sessions

    - Most families need longer-term follow up, not just a few sessions when the issue is relationship-focused work for young children.
- Despite state's focus on trauma-informed services (again mostly for children over 6 years), some participants do not see trauma-informed services available
- Young parents do not trust the systems involved in treating their children (partly because many of these parents were involved in the systems themselves)
- Crisis intervention among young children
    - EC community could have helped EMPS clinicians in the aftermath of Newtown, as EMPS providers frequently do not have any early childhood training
    - There are unrealized opportunities to collaborate with the EC community to inform that work in the event of crisis

Question 3: Recommendations

- Expand ECCP model to school-age children
- Create continuum of care with families having choices at all levels of services, open to all youth
- School consultation between early childhood providers and schools
- Record keeping and documentation follows the family-- not tied to the program or the agency
- Learn from other states and what they have done
- Achieve blended funding across state agencies
- Dire need to increase infrastructure of CT AIMH (hire reflective supervisors, leveled system of training, connecting competencies with other EC workforce competencies)
- Whoever is funding and overseeing these services needs to bring all people together
    - OEC, DCF, and DDS, doing alright working together
    - SDE not collaborating in this area
    - DMHAS needs to collaborate
    - Housing needs to collaborate
    - DDS needs to consider services at level of child and parent
    - DSS needs to be involved to solve funding and reimbursement issues
    - Medicaid reimbursement and leveraging federal dollars
        - Major challenges getting federal money into the state to increase capacity (e.g., Child FIRST currently does not have Medicaid reimbursement in place)
    - If you're doing the job well you are identifying and serving children before diagnosis
- Transparency in decision-making at state level
    - DCF making a lot of decisions without consulting experts, treatment providers, families
- Need an Early Childhood "Unit" at DCF—they have other "units" such as adolescents
- Promote broader recognition of financial savings associated with investing in young children
- Outcomes analysis
    - What are the outcomes associated with the current early childhood services?
    - Reinvest dollars wasted on services that don't work for very young children
    - Outcomes as reported by parents, not just clinicians
    - State-assigned child IDs that would allow youth to be tracked over time (makes data collection and linkage much easier)
- Regions need to identify the services and resources available in that geographic area
- Need one statewide agency or entity where all programs and services are centrally reporting their capacity and their outcomes

- More focus on health promotion and promotion of social-emotional development among all children, particularly very young children and not just ameliorating problems of children who are already demonstrating problems
    - Need broad endorsement of social emotional promotion
    - Use public health model to structure the continuum of services
    - Would help providers link families to the right services
- Developing an ECCP type model for home-based providers
- Early Head Start-DCF Partnership expansion
- Create an expectation that services often will be lifelong, not one episode at one point in life
- Teach families the basics of child development
    - See wall calendar example from Birth to 3
    - Infant, toddler, and preschool
- Put the ASQ-SE assessment back in the Help me Grow program
- Need to provide schools with information about what to do with students at risk
    - Build capacity of whole schools to work on this issue
- Be more savvy about how we are reaching parents and whether those approaches are effective
- Workforce development and cultural competence: Need a workforce that is more reflective of the communities served
- Pick up on the "Plain Language" movement; many parents can't understand the materials
- The prevention mandate of DCF never happens—consider moving that out of DCF mandate?

<u>Participant Comments on this Facilitated Discussion</u>

- A lot of input opportunities
- Process worked well
- Need to encourage participants to avoid acronyms, facilitators request definition when used
- Continue to get family input integrated in each FD, not just "all family" meetings
- Need to open doors to those who have not been part of this process, so that we aren't "preaching to the choir"