

Early Childhood Mental Health TOOLKIT

Integrating Mental Health Services
into the Pediatric Medical Home



Section 1

Building a Core Team to Champion Children's Social and Emotional Health



The first step toward implementing an integrated early childhood mental health model in the medical home is developing the Core Team that will spearhead this effort. Recruiting, training, supervising and orienting the members of this team is key to successfully implementing the model.

This section provides resources for recruiting team members, orienting them to the medical home and its goals, selecting professional development plans and supervising the team members. With the best Core Team possible, you will be on your way to an efficient, caring and well-managed early childhood mental health model.

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1) Identifying and Hiring Core Team Members

The Core Team is comprised of a Health Practice Administrator, Primary Care Provider (PCP) Champion, Family Partner (FP) and Mental Health Clinician (MHC). Generally, the Administrator and PCP Champion are internal staff with a particular interest in the integration of mental health and primary care. The FP and MHC will likely need to be hired as new staff to truly increase service capacity to support children with social, emotional and behavioral health needs within the medical home.

Materials in this section provide step-by-step support for building a Core Team in your medical home. It is a good idea for health practices to adapt all sample materials to reflect their unique organizational and cultural environments.

SITE ADMINISTRATOR REQUIREMENTS AND ROLES

Required Background: A manager either from the pediatrics department or behavioral health department at the health practice.

Suggested Background:

- Longstanding relationships in the health practice; well respected by Primary Care Providers and behavioral health providers
- Ability to access and influence medical home service systems, including documentation records, office space, clinic scheduling, provider meeting agendas
- Ability to advocate for the needs of the Core Team incurred by implementing this model (e.g. training time, mileage reimbursements for home visits, etc.)
- Experience as a clinical provider (RN, mental health provider, PCP) additionally beneficial in designing service protocols
- Experience participating in quality improvement processes
- Experience with or interest in early childhood social and emotional health, a currently under-resourced area of health services

Role in Core Team:

Start-up Phase:

In the start-up phase, the Administrator spends considerable time hiring a Family Partner and Mental Health Clinician, orienting new staff, and facilitating discussions with the Core Team to develop a vision, clear goals and service delivery models.

Ongoing Leadership:

The Administrator facilitates Core Team meetings to continually guide implementation, assess barriers, and facilitate collaborative solutions for service and systems improvement. Depending on the background of the Administrator, he/she may serve as the supervisor of the FP or MHC.

PRIMARY CARE CHAMPION REQUIREMENTS AND ROLES

Required Background:

A Primary Care Provider (NP, MD, or DO) who provides clinical care to children at the health practice.

Suggested Background:

- Interest in championing a model for integrating mental health and child development services into primary care
- A leader among PCPs in the practice; ability to advocate for this initiative at pediatric department and medical home meetings, provide ongoing education and guidance to PCPs on new services, propose strategies and processes to colleagues on improving services for children's social and emotional health
- Experience with or interest in early childhood social and emotional health

Role in Core Team:

Start-up Phase

The Primary Care Provider Champion plays a role in hiring the Family Partner and Clinician, developing a vision and goals for new services, educating other PCPs on the initiative and protocols for referrals and communication. The Champion orients new Core Team members to primary care pediatrics at the health practice. He/she participates in Core Team discussions on components such as the role of the FP, partnering with families on care, and supporting the Family Partner-Clinician dyad. He/she can also participate in trainings to foster clinical and educational skills on early childhood mental health.



Ongoing Leadership

The PCP Champion participates in monthly Core Team meetings to improve services and represent the voice of other PCPs in these meetings. The Champion continues to facilitate professional development activities for PCPs and other medical home providers on topics related to childhood social and emotional development. This likely includes advocating for presentations from the Clinician and FP, as well as community-based providers, on social, emotional and behavioral health topics at medical home meetings.

RECRUITING AND HIRING A MENTAL HEALTH CLINICIAN

Many medical homes have co-located Mental Health Clinicians (MHCs); however, this model strives for true integration of children's behavioral health and primary care services, rooting a MHC in the primary care setting and emphasizing collaboration with pediatricians. Primary care is the hub for the clinical work, care coordination, and consultation services the MHC offers families and providers. The MHC believes in the value of behavioral health and primary care integration as an approach to holistic care for the child and family.

Most importantly, the Clinician must want to work alongside a Family Partner. While most Clinicians collaborate with family support providers as collaterals, the dyadic work of the FP and MHC requires a higher level of partnership. The Clinician must recognize and truly believe in the complimentary expertise of the FP. For some Clinicians, the peer relationship with the FP requires a paradigm shift from traditional hierarchies in mental health services.

Thus, recruiting a Clinician for this model may require deviation from existing hiring materials your health practice has used to fill positions for MHCs in the past.



Early Childhood Mental Health (ECMH) is a highly specialized field.

As a result, finding an appropriately trained clinician can be a challenge. Essential is a clear understanding of child development and the signs and symptoms of a developmental concern. Very few social work or counseling Master's programs focus on *early childhood* mental health.

Generally, a clinician develops this expertise through experience. It is common that a candidate who identifies as an ECMH-focused clinician became a clinician after having a career working with young children in another setting. A clinical degree with employment experience as a daycare provider or teacher often provides an excellent combination of skill development.

Also, it is common that early childhood clinicians will be young and/or newly graduated from a Master's program. As long as they have a few years of experience working with young children and a passion for working with the young family, recent graduation is not an area of concern.

Additional Considerations for MHC Selection

Experience

Although experience working with children and families can be helpful, if all a candidate's experience is with older children, it is really not adequate. A passionate and skilled Clinician whose experience is solely with school-age children, as long as some of that experience is with children as young as 6 or 7, could be appropriate.

But a Clinician whose family treatment experience is only with latency age and/or adolescent youth is likely to lack the kind of experience necessary to understand normal and atypical early childhood development, nor be skilled in techniques appropriate for families at this stage.

Dyadic Approach

Most children come attached to parents. Clinicians who love working with children but are challenged to be empathic toward or engaged with adults will not be able to provide the appropriate range of services. This treatment is and should be a dyadic-focused model.

You should avoid a candidate who does not have experience with and/or interest in dyadic treatment.

Being a Parent

Being a parent is helpful. This is not a requirement, but parents who are experiencing behavioral or emotional/social challenges with themselves or their children are quick to experience judgment.

Often parents report feeling more comfortable and less criticized when working with someone who really understands the inherent challenges of being a parent. Being a parent may also help the Clinician to form a strong partnership with the Family Partner.



Culturally Responsive

It is essential for all Clinicians to be culturally responsive.

When working with very young children and their families, where the primary goal is to support the healthy social and emotional development of that child, a Clinician's strong support and understanding of and commitment to that family's values, customs and beliefs are a great necessity. Those beliefs will be the umbrella under which that child will be raised and taught.

Sample Job Descriptions

Template 1: Mental Health Clinician Job Description

The [health practice] will be launching a new initiative aimed at improving the quality of social, emotional and behavioral health care for children ages _____. The initiative will use a team approach to care for integrating social and emotional health services into pediatric primary care, thus improving the capacity of [health practice] to respond to the increasing need for developmental and mental health services.

The Mental Health Clinician will be a critical member of a Core Team leading this initiative at [health practice]. The Core Team consists of the Clinician, a Family Partner, Primary Care Provider and Health Practice Administrator, who together offer expertise in child development, child mental health and family support services. Services provided through this initiative will be family-centered, individualized, culturally-responsive and continuous, thus enhancing [health practice] as a medical home for families. Services will span a range of promotion, prevention and therapeutic intervention services for children and families with varying levels of social, emotional and behavioral health needs.

The Clinician will spend a significant amount of time each week at [health practice] conducting evaluations of children and families whose preliminary screening results indicate the need for further assessment or care, intervening to engage those who need services and providing brief therapeutic treatments, and providing service linkage to specialty clinical providers. The Clinician will offer mental health consultation to PCPs at [health practice] and have designated hours for co-location in the primary care clinic. The Clinician will also provide clinical support for the FP to follow through on mental health and family support referrals. He/she will also spend time each week in community-based settings (e.g. schools), where he/she will facilitate meetings with providers and consult teachers regarding classroom management as well as the behavioral health needs of specific children.

The Mental Health Clinician will:

- Conduct assessments of children's social, emotional and behavioral health as well as family stressors impacting the child's development
- Provide culturally-responsive family engagement, mental health consultation, therapeutic interventions and service linkages to children ages ____ and their families in the health practice as well as natural environments (home, school, childcare)
- Screen caregivers for mental health concerns and respond with service connection
- Conduct home visits as needed
- Promote awareness of children's mental health in schools and community-based settings
- Document all service work in accordance with standards of [health practice]
- Participate in weekly meetings with the FP to review families enrolled and coordinate services as a team

- Participate in regular Core Team meetings focused on service improvement and systems development for integrating services in primary care
- Participate in training and supervision
- Perform other tasks as required

Skill/Experience Requirements:

- Strong ability to connect and partner with culturally diverse children and families
- Academic and professional training in child development and children's mental health
- Experience with and commitment to interdisciplinary care; ability to work effectively with diverse health practice colleagues, including other Clinicians and with paraprofessionals
- Training and/or experience with care coordination, patient navigation or a similar systems-oriented approach to primary care
- Strong organizational, communication and writing skills
- Knowledge of basic data reporting methods
- Ability and willingness to schedule flexibly to meet the needs of families
- PC literate with knowledge of Microsoft Word, PowerPoint, Excel and the Internet

Background Required:

- Master's degree or higher in social work, psychology or related field
- Experience and extensive knowledge of mental health practices with young children and their families
- Experience working with low-income and multi-cultural communities; sensitivity to socio-economic and psychosocial elements impacting communities of color

Template 2: Early Childhood Mental Health Clinician

Job Description

The Early Childhood Mental Health Clinician is a critical member of a team with expertise in child development, early childhood mental health and family support, working to integrate family-centered behavioral health for children aged __ to __ into pediatric primary care.

In partnership with a full-time Family Partner, he/she provides a full range of clinical mental health services including a focus on promotion and prevention. He/she provides direct service and support to children and families, and fosters partnerships with community agencies and programs internally and externally to promote healthy social-emotional development and early identification and treatment of mental health concerns. The Clinician will spend a significant amount of time each week consulting with primary care providers (pediatricians, nurse practitioners, nurses) and other Clinicians, conducting evaluations of children and families whose preliminary screening results indicate need for further assessment or care, intervening to engage those who need services, and providing direct care and service linkage information.

Job Performance Responsibilities:

- Collaborate with FP to develop and implement comprehensive care plan for coordinated clinical and home-based services to children and families
- Perform psychosocial assessments, including identification and evaluation of complex family risk factors and caregiver mental health screening
- Assign diagnosis to children when appropriate
- Provide on-going play and dyadic therapy when appropriate
- Facilitate groups and special events for children, caregivers, and/or families
- Conduct outreach to early education and care settings and other community-based child and family serving settings
- Provide targeted observations and consultation to educators and caregivers in early education and care settings and elementary schools
- Participate in pediatric and mental health departmental team meetings on-site
- Participate in regular meetings with FP to review enrolled families and coordinate services as a team
- Participate in regular team meetings with FP, Administrator and Primary Care Provider Champion focused on service improvement and systems development for integrating behavioral health services into primary care
- Complete all necessary referral paperwork and manage patient utilization in accordance with managed care plans and all applicable regulations
- Complete medical record keeping in accordance with administrative requirements, standards of care and all applicable regulations
- Prepare patient reports, correspondence, referrals and other materials for community agencies, schools, and others as needed in a timely fashion

- Provide accurate documentation of programmatic and therapeutic activities and expenses, including mileage, group activities and use of flexible funds;
- Maintain and develop professional knowledge and skill through participation in reflective supervision, trainings, professional organizations, attendance at conferences and continuing education programs
- Perform other tasks as required

Skill/Experience Requirements:

- Demonstrated ability to connect and partner with culturally diverse children and families
- Demonstrated ability to form solid collateral contacts with diverse community partners and service providers
- Strong assessment skills in infant, toddler and preschool mental health, including assessment of parent-child relationship and natural supports
- Capacity to provide primarily dyadic interventions
- Experience with play therapy and trauma focused treatment interventions for young children
- Academic and professional training in child development and early childhood mental health
- Experience with and commitment to interdisciplinary care and an ability to work effectively with other clinicians and paraprofessionals
- Training and/or experience with a medical home approach to pediatric care
- Training and/or experience in care coordination, patient navigation or a similar systems-oriented approach to primary care
- Commitment to quality improvement and a quality improvement approach to care
- Strong organizational, communication and writing skills
- Knowledge of basic data reporting methods
- Ability and willingness to schedule flexibly to meet the needs of families, including conducting visits in the community
- PC literate with knowledge of Microsoft Word, PowerPoint, Excel and the Internet
- Reliable transportation or ability to move efficiently by public transportation

***Highly Preferred:** Capacity to serve families in English and at least one other language [*identify specific language if required for patient population*]

Background Required:

- Master's degree or higher in social work, psychology or related field (LCSW/LMHC required, LICSW preferred)
- Experience and extensive knowledge of mental health practices with young children and their families
- Experience working with low-income and multi-cultural communities; sensitivity to socio-economic and psychosocial stressors impacting communities of color

RECRUITING AND HIRING A FAMILY PARTNER

The Family Partner is a new role in pediatric medical homes and differs significantly from the more common roles of case managers and community outreach coordinators. FPs have both personal experience and professional skills that enable them to uniquely identify with and nurture families.

To best engage families on sensitive topics of relationships, emotions and behaviors, it is critically important that FPs have lived experience caring for a child with social, emotional, behavioral or developmental needs.

Hiring a FP who meets this background requirement will also link him/her into the growing network of FPs in Massachusetts employed by child-serving agencies as part of the Children's Behavioral Health Initiative and best position the health practice to obtain third-party reimbursement for a FP.

As demonstration sites have all experienced, it can be hard to find candidates for the role of the FP. In addition to seeking lived experience and interest in serving others, FPs should have the cultural and linguistic background that represents families served by the health center. The role also requires flexible scheduling hours, both to optimize accessibility of services to families and to accommodate the needs of FPs as parents of children with special healthcare needs. Both the candidate and the medical home need to recognize this need for flexibility to successfully hire a FP.

The following materials will support your health practice in understanding the role of the Family Partner, recruiting candidates for the position, and interviewing and hiring a FP.



Considering ECMH when Searching for a Family Partner

Prevention Focused: One could say that all of Early Childhood Mental Health is prevention. Sometimes the intervention is clearly a promotion or prevention-focused intervention, such as focusing on strengths rather than concerns with a family or helping a parent recognize typical behavior in a young child, even if it is frustrating. Family Partners are often the team member that helps the parent gain a clearer understanding of child development and provides the parent a “strength-based view.”

Other times, an intervention is more traditionally tertiary, yet one of the goals is to *prevent* the challenges or concerns from getting worse as the child gets older. Research shows that the earlier a challenge is addressed, the better the outcome will be. This is demonstrated even if a concern is identified before the age of 2, rather than waiting until 4 or 5. The main refrain in early childhood mental health is “catch it early.” FPs help a parent to see that by addressing an issue early on, they could reduce the possible difficulties in the future, often by citing their own experiences.

Dyadic Nature: Some of the concerns one may identify, particularly with infants and very young children, is really a concern in the primary dyadic relationship. Healthy attachment is the initial psychosocial task for all children. If there is a concern with the primary attachment figure (i.e. trauma history, poverty, racial oppression, postpartum emotional complications, depression, anxiety, victim of domestic abuse or suffering from substance abuse), then clearly the intervention will need to be dyadic - focused on the primary relationship rather than the child him/herself.

Also, even if the issue is more of a biological, genetic or developmental concern with the child, the primary attachment figure will be the single most therapeutic agent in the child’s life. Often

the goal is to provide the parent with the necessary support and resources so they can provide the infant or young child with necessary support. FPs play an essential part in helping a parent recognize the role they play in their child’s social-emotional development.

Family’s First Introduction to “Mental Health”:

Mental health has gotten a bad rap, often associated with stereotypes of mental illness. This association can be particularly alienating for families with young children. Unlike FPs serving older children, FPs focusing on early childhood are often the child and family’s first provider of social and emotional health supports. Young children and their families do not have the same familiarity or experience with the mental health system, thus making the FP the first encounter with mental health services.

The FP can help the parent understand when there is a mental health concern (often identified as a social-emotional development concern) by sharing their initial experiences with the mental health field. An “I’ve been there” approach often reduces the sense of shame a parent may feel if a doctor is identifying a mental health concern.

Partnership with Pediatricians: Due to the frequency of well-check visits for young children, the pediatrician’s office is often the first opportunity to identify and support young children with social and emotional health needs. Thus, FPs focusing on early childhood must work in close partnership with pediatricians to support young children and their families. The care coordination with primary care providers is a more salient aspect of the work of FPs serving young children than FPs serving older children and adolescents.

Sample Job Descriptions and Recruitment Documents

Template 1: Family Partner Job Description

The [health practice] will be launching a new initiative aimed at improving the quality of social, emotional, and behavioral health care for children served. The initiative will use a team approach to care for integrating social and emotional health services into pediatric primary care, thus improving the capacity of [health practice] to respond to the increasing need for developmental and mental health services.

The Family Partner will be a critical member of a Core Team leading this initiative at [health practice]. The Core Team will consist of the FP, Clinician, Primary Care Provider and Health Practice Administrator, who together offer expertise in child development, child mental health and family support services. Services provided through this initiative will be family-centered, individualized, culturally- responsive and continuous, enhancing [health practice] as a medical home. Services delivered will span a range of promotion, prevention and intervention services for children and families with varying levels of social, emotional and behavioral health needs.

The FP will serve a critical role in connecting with families, as a professional and as a parent. The FP will provide child and family engagement services, family education and parenting support, and resource linkage in the medical home, community settings and family's homes. He/she will divide time between direct services to families in varying locations, consultation to primary care providers on family engagement and social and emotional health, and outreach to staff and families at local community agencies.

The Family Partner will:

- Educate families about early childhood screening and about the importance of early screening and care for children with emotional, behavioral and developmental needs
- Conduct preliminary screening of children for emotional, behavioral or developmental needs
- Provide emotional support and education to families dealing with concerns about child development and/or parenting
- Support families in identifying service goals and monitoring progress toward goals
- Support caregivers in accessing self-care and mental health resources
- Support caregivers in developing organizational and leadership skills needed to advocate for their child, navigate healthcare systems, and coordinate their child's care
- Conduct home visits to families and sites visits to local community partners (childcare, schools, early intervention, etc.)
- Collaborate closely with the MHC and other staff to assure coordinated, comprehensive care
- Serve as a voice for high-quality, family-centered services
- Document all service work in accordance with standards of [health practice]

- Participate in weekly meetings to review families enrolled and coordinate services as a team
- Participate in regular Core Team meetings focused on service improvement and systems development for integrating services in primary care
- Participate in training and supervision
- Perform other tasks as required

Skill/Experience Requirements:

- Strong ability to connect to, support and partner with culturally diverse children and families
- Knowledge of and insight into child development and healthy parenting
- Professional or volunteer experience in a pediatric clinic, childcare center or other setting that serves children and families
- Ability to work well as part of a team and collaborate with professionals
- Familiarity with _____ neighborhoods and agencies
- Strong organizational and communication skills
- Good writing skills
- Ability and willingness to schedule flexibly to meet the needs of families
- PC and Internet literate

***Highly Preferred:** Experience as a parent, guardian or mentor to a child needing mental health, developmental or Special Education services

Background Required:

- B.A. or high school diploma/GED with a minimum of 3 years of community-based experience in early childhood, mental health and/or family support services
- Cultural and linguistic diversity highly preferred

Template 2: Recruitment Poster

Work as a Family Partner

"As a parent, it meant the world to me to have someone in the room on my side pleading the case for my son when I was at the breaking point."

JOB OPPORTUNITY!

The _____ is collecting a list of applicants for a **Family Partner** employment opportunity. The **Family Partner** will be employed by a local health organization to work with young children and their families.

Interested applicants should send an email to _____ at _____. Questions can be addressed to _____ at _____.

The **Family Partner** will promote family-centered, culturally responsive, supportive care for children and families with behavioral health needs.

Applicants should have experience as a parent of a child with developmental or behavioral health needs, feel comfortable working in a variety of settings with culturally diverse clients, and understand healthy child development and parenting strategies.

The position requires:

- Some schedule flexibility
- Familiarity with Boston neighborhoods
- Good computer/Internet skills.

Applicant must have a high school diploma/G.E.D. with at least 3 years of experience as an advocate for children and/or families.

Cultural and linguistic diversity is highly preferred.

Having an advocate on your side sends a message: "Here is a person, child or family someone else thinks is important, I better pay attention and do a good job."

-Kathy parent and advocate

IMPROVING FAMILY PARTNER RECRUITMENT

Quality Improvement Project: Joseph Smith Community Health Center, October 2012

Sonia Mee, LICSW, Director of Counseling



Improvement Goal

To increase the number of applicants for the vacant Family Partner position.

Rationale

The Family Partner is a critical member of the MYCHILD team at Joseph Smith Community Health Center. This position became vacant on March 12, 2012. As FPs play a key role in providing individualized support to caregivers and coordinating care among medical home and community providers, the vacancy led to more limited communication with caregivers and less time allocated to care coordination. Due to a limited number of applicants between March 2012 and July 2012, we choose to examine the hiring and recruitment processes for the FP position.

Strategic Approach

1) Defined Preferred Family Partner Characteristics

- Bilingual: Large proportion of MYCHILD patients are Spanish speaking

- “Lived” Experience: Families who have children with special needs can often use their life experiences to uniquely support caregivers

2) Revised Family Partner Job Description

- Added descriptive context of the position including (1) health center description and (2) description of MYCHILD
- Removed acronyms from the posting (e.g. SED)
- Broadened requirement of parent of child with SED to parent of child with special healthcare needs
- Removed requirement of Bachelor’s degree
- Removed label as “part-time” position

3) Consulted Parent Organization for Recruitment Materials

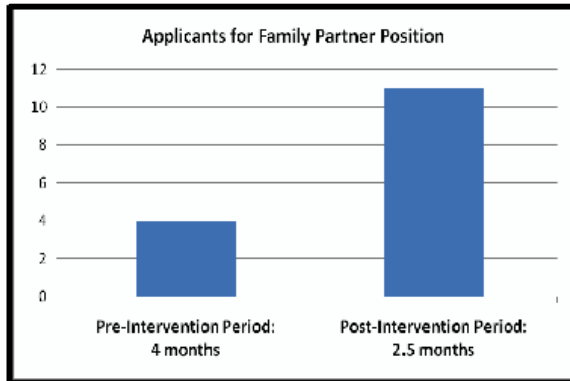
- Parent/Professional Advocacy League provided sample flyers and job descriptions
- Obtained sample interview questions to use with candidates, from Children’s Behavioral Health Initiative Family Support Partner Hiring Packet
- Involved the MYCHILD Lead Family Partner in second-round interviews to gain additional perspective

4) Outreach to Networks Reaching Parents and Spanish-Speaking Families

- Email posting to community contacts: Brighton Resource Center, Federation of Children with Special Healthcare Needs, Parent Provider Consortium, Jamaica Plain Neighborhood Development Corp., Hyde Square Task Force, Sociedad Latina, Latino Mental Health Contacts

Data Analysis

Between March 2012 and July 2012 we received 4 resumes for the position of Family Partner. Between July 2012 and September 2012, we have received 11 resumes for the position of FP.



Outcomes

During the 4 month period prior to the revision of the job description, there seemed to be low interest in the FP position. We received a total of 4 resumes only. During the 2.5 months after the job description revision, we received 11 resumes. We do think that by broadening the job description (mainly removing the Bachelor's degree requirement) and making the language more understandable to parents, we were able to increase interest in the position.

Conclusion

The overall applicants for the FP position increased by 275% following implemented strategies (from 4 to 11); this increase may be due, at least in part, to the employed strategies. We also learned of more external networking resources to advertise a well-scripted FP job description, including parent organizations. We became more prepared to interview candidates for this unique position after reading sample materials used for FP hiring by other organizations. For these reasons, our goal has benefited Joseph Smith CHC.



Lessons Learned

- Job descriptions should be worded in as common language as possible to encourage applicant resume submission; this is particularly important in reaching parents who may be interested in the Family Partner role.
- Acronyms within job descriptions can discourage qualified applicants from applying because they may believe that they do not meet baseline criteria.
- Although recruitment through external networking is important, recruitment within an organization should not be overlooked because often colleagues are looking for advancement within the organization.

MYCHILD Team Members:

*Sonia Mee - Director of Counseling
Maria Celli - MYCHILD Clinician
Emily Hall - Primary Care Champion
J'Myleisy Nazzario - New Family Partner*

Template 3: Sample Interview Questions



Early Childhood-Focused Questions for FP Candidates:

- 1) What would you identify or imagine as the most common reasons a family would be referred to the early childhood mental health services? (*looking for awareness of the issues of the community*)
- 2) How would you describe your approach to parent guidance? (*hoping for a more trauma informed/motivational interviewing style than a solution focused*)
- 3) What are some of the resources you could imagine pointing a parent of a child under 6 to? (*understanding and experience of community resources for young children and families*).
- 4) How would you advise a parent whose two-year-old is regularly having tantrums? How about if the child was 5? (*understanding of typical and atypical behavior*)
- 5) How would you approach a parent who appeared not interested in the services offered? (*parent engagement techniques*)
- 6) How would you talk to a parent who may have a different cultural understanding of an important parenting approach than you, such as corporal punishment? (*cultural sensitivity/non-judgment*)

Example Early Childhood Scenario for Interviewing FP Candidate:

Serena is a single mom with five children ages 10, 7, 5, 2.5 and 10 months. Needless to say, she is a very busy mom and she works hard to address all of her children's need. She gets little to no help from any of her children's fathers. Upon entering kindergarten her five-year-old was diagnosed with ADHD and her pediatrician was willing to put him on medication. This appears to be helping with learning and behavior in the classroom. Since the birth of her youngest, Serena is noticing that her 2.5-year-old is acting out more, crying, having tantrums, will not settle down and having a lot of trouble sleeping. She has asked the pediatrician to put her 2.5-year-old on the same medication as her five-year-old. The doctor is unwilling to do this for a child so young, and the doctor tells you he does not think this is ADHD but rather that it is impossible for the 2.5-year-old to get enough attention from her mother. How would you talk to the mom about this and what would you suggest to her?

Resources for Identifying and Interviewing Family Partner Candidates

Common Community Partners for Early Childhood Mental Health:

- Pre-schools and day care centers, including Head Start programs
 - Department of Children and Families
 - Area home visiting programs
 - Early Intervention Programs
 - WIC
- Special Education programs at the area district school system

Recruiting from Early Childhood Mental Health Training Programs in Massachusetts

There are a few early childhood mental health training programs in Massachusetts that could be sources of clinicians with specific ECMH training. The [Massachusetts Early Childhood Mental Health Professional Resource and Development Guide](#)¹ highlights these training programs and offers contact information. Consider having your job description for a clinician posted at these training programs to increase your chances of recruiting a clinician with early childhood experience.

The Children's Behavioral Health Initiative (CBHI) developed a Family Partner Hiring Packet to support agencies hiring FPs that meet the job requirements of the position and demonstrate the critical skills needed to thrive in this role. The [full packet is available online](#)² from CBHI's Family Partner Forum (1/27/2012). Click on [FS&T/FP Hiring Packet](#)³, or view the introduction here:

The attached Family Support and Training/Family Partner Hiring Packet has been designed to assist those child serving agencies that are recruiting candidates for one of the most unique advocacy positions: Family Partners (FPs).

- 1) **Section one** defines 12 Family Partner (FP) "profile points" and the qualities that will determine the highest probability of a successful hire. Each interviewer should review section one prior to an interview.
- 2) **Section Two** is a set of interview questions developed to coincide with the 12 profile points. Each interview question is accompanied with a brief recommendation as to what would constitute a positive response to the questions.
- 3) **Section Three** consists of four scenarios detailing real-life situations that FPs frequently experience, coupled with the opportunity for the FP candidate to indicate in writing how they would probably respond to similar situations.
- 4) **Section Four** is an evaluation tool designed to track each candidate's number of positive indicators. This grid style evaluation tool will facilitate comparison of the 12 profile points recognized in the interview questions, responses to the four scenarios and overall impression of the candidate by the interviewer.

2) Orienting Core Team Members and Creating a Shared Dream

The goals of orientation are three-fold:

- 1) Equip newly hired Core Team members with background information about the health practice
- 2) Engage the whole Core Team on key components of this model, including introduction to the term “medical home,” the unique role of a Family Partner, and Family Partner-Clinician partnerships.
- 3) Developing a shared “dream” among the Core Team that includes members’ vision for how the model will improve the health practice.

New Core Member Orientation

Generally, at least the FP will be newly hired through this initiative; ideally the Mental Health Clinician will be newly hired as well to truly build the practice’s capacity to promote children’s social and emotional health. Ensuring that these newly hired team members get a thorough orientation to the health practice will help them quickly become equal voices on the Core Team as you shape the model of integrated care within the practice. Orienting new team members to the health practice includes introductions to health practice systems, patient population and the surrounding community. Discussion of topics may be led by existing health center staff under the leadership of the Core Team Administrator.

Orientation for the Whole Core Team

After new members have been oriented to the health practice, the Core Team may allocate time to team-based discussions on the following topics: the term pediatric “medical home,” Core Team roles in the medical home, the unique role of a FP, and strategies for successful Family Partner-Clinician partnerships. The Core Team Administrator facilitates discussion of these topics.

The following section provides information and resources to guide the Core Team to meaningfully discuss these topics, building shared understanding of the model and mutual respect for the diverse perspectives of Core Team members.

ORIENTATION CHECKLIST

FOR NEW CORE TEAM MEMBERS

This checklist provides suggested tasks for completing orientation of new Core Team members coming into the health practice.

	Information Content	Date Completed
Administrative		
Intro to integrated primary care/behavioral health model	<input type="checkbox"/> Provide staff with this toolkit so that all Core Team members have input into service and systems design for integrated care.	
Intro to pediatric team/ behavioral health team structures, meetings and colleagues	<input type="checkbox"/> Introduce staff at pediatric team meetings. The Core Team should discuss with providers the model and integrated care concepts to build awareness among all providers.	
Supervision structure	<input type="checkbox"/> All Family Partners and Mental Health Clinicians have a clear designated supervisor; the MHC should not be the supervisor for any FP. <i>(See part 3 on Supporting Professional Development for more details.)</i>	
Staff supports	<input type="checkbox"/> Communicate with new staff about budget allotments and line items to cover staff and family support materials (educational materials, flex funds, foods for meetings, supplies etc.).	
Safety protocols	<input type="checkbox"/> A safety protocol, specific to the health practice, is provided to all Core Team staff that encompasses clinic and home visit procedures.	
Continuing education and training policy	<input type="checkbox"/> Discuss with staff the practice-specific policy about continuing medical education (CMEs) and attendance at professional development opportunities.	
Service Systems		
Overview of sample service delivery protocol	<input type="checkbox"/> Provide new staff the sample service delivery model <i>(See section 2 of this toolkit on Providing Family-Centered)</i> , emphasizing dyadic approach of Clinician and FP.	
Scheduling systems and clinical space	<input type="checkbox"/> Provide training on how the FP and Clinician can schedule appointments in the health practice; ensure they have access to a private space to provide confidential care.	

CHECKLIST CONTINUED ...

	Information Content	Date Completed
Billing system for services	<input type="checkbox"/> Provide training on billing procedures for the Clinician, and if the practice allows, the FP. Include billing for collateral and case consultation services. <i>(See section 4 of this toolkit on Financing and Sustaining the ECMH model.)</i>	
Documentation systems and electronic medical records (EMR)	<input type="checkbox"/> Provide training on documentation systems, including templates to use for notes and strategies for communicating between providers in the documentation system (i.e. flags in electronic medical record systems).	
CANS Virtual Gateway orientation	<input type="checkbox"/> Provide training required by all MA behavioral health clinicians. See information online ⁴ .	
Patient Population (Who are the families at the health practice?)		
Social and cultural context of families served by the health practice	<input type="checkbox"/> Provide demographic information available and common strengths and challenges faced by families served. Have parent/patient representatives' perspectives represented.	
Community Resources for Families		
Existing health practice partnerships with community resources and supports for families	<input type="checkbox"/> Provide resources lists, key websites and contact information for accessing community resources useful to families served by the health center (community centers, cultural groups, basic resource links, recreational activities, libraries, etc.). Connect new staff with any existing case managers or resource specialists to learn of health practice partnerships for family resources.	
Highlight connections to early childhood resources or referrals in the neighborhood	<input type="checkbox"/> Childcare centers, Women, Infants and Children, Early intervention, Nurturing programs, Mom's groups, etc.	

THE PEDIATRIC MEDICAL HOME: WHAT DOES IT MEAN TO YOUR CORE TEAM?

The “pediatric medical home” is a widely used term. The American Academy of Pediatrics defines “medical home” as:

Medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. It should be delivered or directed by well-trained physicians and mental health clinicians who provide primary care/behavioral intervention and help to manage and facilitate essentially all aspects of pediatric care. The physician should be known to the child and family and should be able to develop a partnership of mutual responsibility and trust with them. These characteristics define the “medical home.” (Source: <http://pediatrics.aappublications.org/content/110/1/184.full>)

There are many resources on medical homes that offer definitions, principles and tools to understand the concept and potential impact on the health of children. These resources offer provider and patient perspectives and recognize the necessary role of both in transforming healthcare practices to true medical homes for families.



Medical Home Resources

1) National Center for Medical Home Implementation (NCMHI): The NCMHI is a cooperative agreement between the [Maternal and Child Health Bureau](#)⁵ and the [American Academy of Pediatrics](#)⁶. The goal of the NCMHI is to ensure that all children and youth, including children with special needs, have a medical home where health care services are accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent. The website provides information on what it means to be a pediatric medical home as well as specific tools to move practices forward in operationalizing principles of accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally competent care. It provides tools geared to both providers and families, as both play a role in transforming practices into medical homes.

Useful links:

[What is a Medical Home?](#)⁷

[Tools for Implementing Medical Homes](#)⁸

[Resources for Families](#)⁹



2) HealthyChildren.org: “A Medical Home Where Everybody Knows Your Name”: [HealthyChildren.org](#)¹⁰ is the only parenting website backed by the American Academy of Pediatrics and committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. The site provides an overview of the medical home from a parent’s perspective.

Discussing Medical Homes with the Core Team

Now that you understand more about the definition of “medical home,” get together with the Core Team and determine others’ thoughts on this term and how to model it. The Administrator facilitates this orientation process and discussion. Designate a note-taker for the discussion as well.

Prep

First encourage Core Team members to individually glance through the resources above. If your health practice has written material on the term “medical home” or written strategic plans on this topic, share appropriate materials with Core Team members prior to discussion.

Discuss

Designate 45 minutes for team discussion. Use the questions below to guide your discussion.

- 1 Prior to reading the materials, had you heard of the term “medical home”?
- 2 How would you describe the term “medical home” now?
- 3 What principles of medical homes do you think are most important?
- 4 Have you had an experience as a provider or patient that brings to life a principle of the medical home? Describe the situation.
- 5 What challenges has this health practice faced in providing a true medical home for families? *(The Administrator and PCP Champion may have insight on this.)*
- 6 What’s the role of our Core Team in moving this health practice forward as a pediatric medical home? *(Consider the importance of integrated behavioral health and primary care services, including promotion and prevention services for young children. Consider the dual role of the Family Partner as both a professional and parent.)*

Summarize and Share

When time runs out, have the note-taker summarize the key points regarding the role of the Core Team in moving the health practice forward as a pediatric medical home.

Write a Concise Summary

The Administrator should write a quick summary of the salient points of the discussion after the meeting. These notes will help in integrating the Core Team with existing health practice structures, advocating for resources for the Core Team in the health practice, and developing the Core Team’s dream *(See the next information on Creating a Dream)*.

Discussing the Unique Role of the Family Partner

Some demonstration sites faced challenges in integrating the FP into the medical home. These challenges may have been mitigated by the Core Team engaging in meaningful discussions around the role of the FP prior to implementing services. This Tip Sheet (below) and the video [here](#), support the Core Team in discussing the role of the FP in the medical home.

Tip Sheet: How to Integrate Family Partners in Medical Homes

- 1) Recognize the Uniqueness of the Family Partner Role.** The FP is *not* another care coordinator, case manager, or outreach coordinator. The FP is a unique role that combines lived experience as a parent with professional training and experience as a healthcare provider.
- 2) Recognize the “Expertise” of Lived Experience.** The asset of lived experience (as a parent of a child with special healthcare needs) uniquely positions the FP to relate to families differently from typical providers. By personally relating to the experiences of caregivers, FPs can engage caregivers who distrust providers and the medical systems, especially around developmental and mental health services. Using a personal story to engage parents on issues of social and emotional health is an expertise in itself.
- 3) Not “Just” Parents: Ask About Training and Experience.** FPs often bring a wide range of expertise on linking to community resources, navigating healthcare systems, organizing family programs, assessing community needs and providing health education. Some bring more formal education on social services, child development, or education. Ask about experience and don’t make assumptions.
- 4) Think Beyond Traditional Medical Hierarchy.** Medical hierarchy is a salient, and often unspoken, aspect of healthcare systems. There is often the perception that physicians have a different level of power and status than family support staff and mental health clinicians. To be true partners in the Core Team, there must be commitment to be equal peers with complimentary expertise. This takes time, but recognizing that the Core Team requires a shift from traditional paradigms is important.
- 5) Build Awareness in the Medical Home.** Take the time to educate other medical home providers (PCPs at large, nutritionists, outreach coordinators, receptionists, behavioral health clinicians, etc.) about the role and background of the FP. Concretely describe the expertise and services provided by the FP so that colleagues understand and truly utilize the FP’s expertise.
- 6) Ask for Support from Other Agencies with Family Partners.** Seek the experience of a FP or Core Team at MYCHILD or LAUNCH demonstration sites for support on challenges. Also, medical homes are not the first organizations to use a FP. Draw on the experience of FPs through the Children’s Behavioral Health Initiative to give support for integrating FPs in health practices.
- 7) Expect Differences and Challenges in Partnership.** With a four-person multidisciplinary team, expect differences in perspective and some level of conflict. Define processes for discussing challenges. Identify a forum to discuss conflict, the process by which challenges are raised, and other neutral colleagues who can coach you through issues.

CREATING A DREAM AND IDENTIFYING SERVICE PRIORITIES

Prior to launching services, it is a good idea for the Core Team to engage in team-building exercises to develop a shared vision for this initiative within the health practice. That includes a “dream” for how the medical home will change as a result of this initiative and a consensus on service priorities for the Family Partner and Clinician within the pediatric primary care population.

This start-up phase is a unique opportunity to strategize on how to make the biggest impact on social and emotional health given the vast potential and clear time limitations of a Family Partner-Clinician dyad. The Core Team should expect that the Clinician will not have any many billable service hours during this phase, but that the time planning will lead to better resource allocation and potentially more reimbursement in the months to come.



Example Dreams from Demonstration Sites

“Increased practice capacity to support our families’ social-emotional mental health and concrete needs through relationship-based practice and the addition of clinical personnel with the capacity to provide home visiting, early screening, and preventive support to ensure successful school readiness.”

“Project LAUNCH will support the entire health center community –staff and families – in reaching an integrated approach; so that families will feel empowered to learn to self-advocate, and will be comfortable seeking social-emotional support from the health center. The services will be embedded, on-site, wonderful and comprehensive.”

“Our dream is to connect families to resources that will provide efficient, affordable, comprehensive, and easily

accessible mental health service.”

“Our dream is to have a strong, cohesive team that helps families to feel safe and supported in a non-stigmatized way and enables them to help themselves – and that we can continue to pay for it.”

“Before Project LAUNCH there was not anyone to support children (0-8) and their families. Providers and nurses would act as social workers and do what they could to help families. At the end of this project, we will continue to be a medical home that incorporates early childhood mental health. We will have team players specifically for this work, in addition to doctors and nurses. We will help empower parents and children feeling good about themselves.”

“Our dream is to increase and improve services to kids and families through:

- *Family driven/consumer driven*
- *Improved access*
- *Cultural competence*
- *Partnerships with community resources*
- *Improved communication systems”*

“Our dream is to empower families to advocate for themselves and their children by providing, culturally and linguistically, behavioral health services within the health center and the community. These services will foster community awareness, so that behavioral health concerns can be identified early, or prevented, by on-site support groups – overall resulting in improved physical, social and mental health for the community at large.”

Core Team Exercise: Defining *YOUR* Team's Dream

Creating a shared dream focuses efforts, builds morale, and lends understanding to diversity within the Core Team. This activity was completed by demonstration sites at the first Learning Collaborative Learning Session, prior to implementing services. The Core Team can use this team-building exercise (including the following worksheet) to help identify your dream for the health practice—how your practice will be different as a result of this initiative.

- 1) **Identify** who will facilitate the discussion, who will serve as timekeeper, who will take notes, and who will report out for you. These should be four different people.
- 2) Begin with **brainstorming**. Have each person write a one-sentence statement about how your site will be different at the end of the project. Keep doing this until you run out of ideas. Aim for quantity; don't worry about wording or starting with the most important change you'd like to see. *(Don't spend more than 10 minutes on this part of the discussion.)*
- 3) **Review** your list. Make sure you understand all the statements, and revise for clarity if needed. Consider your site's initial reason for participating in the project: Do any of the statements reflect what you hoped to achieve when your practice decided to launch this initiative?
- 4) Decide if you need to **add** anything to the list.
- 5) See whether there are statements that reflect closely-related concepts. **Combine** them into a more limited number of statements, but make sure you don't lose important content by doing this.
- 6) **Prioritize**. Are there two to three ideas that most clearly reflect your shared hopes for the project? Now do some word-smithing: Put those ideas together in a paragraph of a few sentences reflecting the elements of your dream and the way those elements fit together.
- 7) When you are satisfied with the paragraph, have your spokesperson **read it aloud**.
- 8) **Revise** it so that it resonates with the whole team.
- 9) Identify two ways to **share** your dream with your medical home colleagues to build awareness of this new initiative.



Worksheet: Identifying and Developing the Dream

Brainstorm: How will your site be different after launching new Family Partner and Clinical Services?

Group Dream List

“Our Dream” (Combining your top 2-3 hopes)

3) Surveying Existing Resources and Identifying Target Population

The start-up phase offers a unique opportunity for Core Team members to explore the existing resources in the medical home and community that support children's social, emotional and behavioral health.

It is important to connect with providers and agencies that already offer family support and clinical services prior to focusing on a specific target population for service delivery. The Core Team should think broadly when identifying resources related to children's social and emotional health; it is not just "mental health services," but also programs that support families in reducing stress, supporting child development, building trusting relationships between children and caregivers, caring for caregivers, and fostering parent voice in healthcare decision making. By reaching out to existing providers, the Core Team will better understand the distribution of resources related to mental health and systems for coordinating care.

The Administrator and Primary Care Champion may know of existing resource surveys within the medical home and community, which should be shared across the Core Team so you are not duplicating efforts. The Core Team can then use information from meetings and existing resource guides to identify gaps in services across the pediatric population and across the spectrum of needed promotion, prevention and intervention services. This information will help identify your target population for this initiative as well as potential community partners for care coordination and shared promotion efforts.

This section provides sample questions and templates to identify the current services providers and agencies, understand the barriers providers face in delivering services, and explore how multiple services interface within a system of care. Also find information on identifying your target population so you can make the most of limited resources.

SURVEYING CLINICAL RESOURCES

Goals

- To understand the clinical services currently available at your medical home and community to support children's social and emotional health and the mental health of entire families
- To better understand the unmet *need* for additional social, emotional and behavioral health services within your health practice
- To introduce the Family Partner and Mental Health Clinician to other staff providing clinical care services for children and families focused on social, emotional, developmental or behavioral health
- To foster coordination between clinicians that serve families and children within the medical home and community and identify steps for coordinating care
- To foster a team approach to addressing the comprehensive needs of families at the practice

Starting Steps

- 1) **Identify** children's behavioral health providers, adult behavioral health providers (for caregiver resources), developmental pediatricians and other clinicians providing related services at your health practice. Then identify community clinicians that provide similar services to families in the community. Ask the Core Team Administrator for contacts.
- 2) Set up a **meeting** to:
 - Discuss the services each colleague offers families
 - Introduce this Core Team's new services
 - Discuss how these other advocates see the need for additional social, emotional and behavioral health services in the health practice and/or community
 - Discuss how your programs might work together
- 3) Prior to your meeting, **brainstorm questions** to ask aimed at understanding child and family services offered, strategies for coordinating care with other providers and resources, lessons learned in delivering services, and potential ways to collaborate on family services. (*See the following template for helpful questions.*)
- 4) **Record** notes from your conversation to help the Core Team build new medical home services that best meet the needs of families. (*See the following template as an example.*)

Template 1: Questions for Clinical Resources

Provider:	Contact:
Date:	Phone:
Location:	Email:
Office Hours:	Insurance Accepted:

Child and Family Services Provided

❖ **Assessments and Services:**

- What types of clinical services do you offer children and families?
- Do you specialize in services targeting a particular age range or a specialized issue?
- What screening and assessment tools have you used with children and families?
- What assessment tools have you used to screen or assess for caregiver depression?
- What modes of therapy do you use with children? With families?

❖ **Demographics:** How many families can you serve currently? Do families served reflect the diversity of the health center?

❖ **Access:** How are families referred to you? Can you serve families who speak primary languages other than English?

❖ **Family Voice:** In what ways have parents or consumers influenced how you deliver services?

Collaborative Care

- ❖ Who do you refer children to for any other specialized behavioral health services (substance abuse, trauma exposure, etc.)?
- ❖ How do you coordinate care with other providers?
- ❖ Are you familiar with the role of a Family Partner? Have you worked with FPs?

Lessons Learned

- ❖ What are the biggest barriers you have faced in providing services to families? How have you responded to these barriers?
- ❖ What strategies have been successful?

Working Together

- ❖ Once our new services are launched, in what ways can we work together as providers in this medical home or community?

SURVEYING FAMILY SUPPORT RESOURCES IN THE MEDICAL HOME

Goals

- To understand the family support resources currently available for families and children at your health practice
- To better understand the need for additional family support services related to children's social and emotional health within your health practice
- To introduce this initiative to other staff working with children at the health practice
- To foster coordination between programs/initiatives that serve families and children within the medical home and identify steps for working together
- To foster a team approach to addressing the comprehensive needs of families at the practice

Starting Steps

1) **Identify** outreach workers, community advocates, family advocates and/or case managers at your health center to talk with. Ask the Core Team Administrator for contacts.

2) Set up a **meeting** to:

- Discuss the services each colleague offers families
- Introduce this new Core Team initiative
- Ask: How do these other advocates see the need for additional social, emotional and behavioral health services in the health center?
- Discuss how your programs might work together



3) Prior to the meeting, **brainstorm questions** to ask regarding services, community partnerships, perceived need for new services, lessons learned and potential ways to collaborate. (*See the following sample template for examples of useful questions.*)

4) **Record** notes from your conversation to help the Core Team build medical home services that best meet the needs of families. (*See the following template as an example.*)

Template 2: Questions for Family Support Resources in the Medical Home

Person:
Date:
Contact Info:
Program/Role:

Child and Family Services Provided

- ❖ **Services:** What services do you provide to children and families?
- ❖ **Demographics:** What are the ages of children you serve? Number of families you serve currently? Do families served reflect the diversity of the health practice?
- ❖ **Access:** How are families referred to you? How do caregivers whose primary language is not English access services?
- ❖ **Family Voice:** In what ways have parents or consumers influenced how you deliver services?

Community Partnerships

- ❖ Do you partner with other community agencies or organizations? Which ones?
- ❖ Have partnerships included agencies that serve young children (birth-5)?



Lessons Learned

- ❖ What barriers have you faced in providing services to families through the health practice? How have you responded to these barriers?
- ❖ What strategies have been successful?

Working Together

- ❖ Once our new services are launched, in what ways do our programs/services work together?
- ❖ Do you have written resources guides for families that can be shared?

SURVEYING FAMILY SUPPORT RESOURCES IN THE COMMUNITY

Goals

- To identify community-based agencies close to your health practice that support social and emotional development for children and families
- To introduce this initiative to potential partnering community-based agencies
- To understand how staff at these agencies relate to the terms “children’s social and emotional health” and “children’s mental health”
- To identify what types of challenges community organizations face in promoting healthy social and emotional health
- To identify what types of training and support community-based staff would like to better support children with social, emotional and behavioral health needs
- To assess the degree of interest from staff and management at local organizations in partnering with the medical home on children’s mental health

Starting Steps

- 1) **Identify** key community partners in proximity to the health practice (schools, community centers, parenting groups, family-led organizations, family support programs, preschools/childcare, etc.).
- 2) Set up a **meeting** with the director or a staff member at the community agency to learn about the children served, staff present and general perspective on the need for social, emotional and behavioral health.
- 3) Prior to the meeting, **brainstorm questions** to ask regarding services offered, staff composition, perception of children’s mental health and potential ways to collaborate. (*See the following sample template for examples of useful questions.*)
- 3) **Record** notes from your conversation to help guide the Core Team in building systems that best meet the needs of families. (*See the following template as an example.*)

Template 3: Questions for Family Support Resources in the Community

Organization:	Contact Person:
Date:	Phone:
Location:	Email:

Child and Family Services Provided

- ❖ What services do you provide to children and families?
- ❖ Who are the families you serve? (ages, cultural background)
- ❖ **Healthcare:** Where do most families served receive pediatric care for their child?
- ❖ **Family Voice:** In what ways have parents or consumers influenced how you deliver services? Is there a decision-making council that includes consumer voice?

Staff

- ❖ Who comprises the staff at the agency?
- ❖ Are there social workers, case managers, or family advocates? What services do they provide families?

Mental Health and Social/Emotional Health

- ❖ What do you think of when you hear the term “children’s mental health”? What about “social and emotional health”?
- ❖ How do you see the current needs of the community regarding children’s mental health?
- ❖ Are there trainings offered to your staff related to child development or mental health?
- ❖ What types of additional supports would be useful to staff who work with children with social, emotional, or behavioral health needs?

Working Together

- ❖ Once our new services are launched, in what ways do our programs/services work together?

IDENTIFYING YOUR TARGET POPULATION FOR NEW SERVICES

Given the shortage of mental health services, there are many families that a Mental Health Clinician and Family Partner could serve in pediatric primary care. The need for mental health and developmental services spans the whole pediatric age range as well as promotion, prevention and intervention levels of care.

Staff capacity will be a limiting factor given that you have one FP and one MHC. Therefore, a clear identification of your target audience for this model will help focus your services to make the biggest impact with the resources you have.

In defining your target population, consider the following questions:



1) Needs Assessment: Where are the gaps in your current services to support children's social, emotional, and behavioral health?

Consider the age range and span of services (i.e. promotion, prevention and intervention) of current medical home and community resources.

2) Impact: How can you focus new services to make the most significant impact on the social and emotional health of children?

Consider the impact of early screening, identification, and treatment on the life course of a young child.

3) Reimbursement: How much time does the Clinician need to dedicate to assessment and treatment of diagnosable mental health disorders for reimbursement purposes?

Consider the average reimbursement for a mental health clinician at your practice and the reimbursement necessary to sustain the new Clinician's position in the context of the health practice's budget.

The following materials will provide process guidance and facts to help answer the questions above. Materials can be used to organize the existing resources in your health practice and community related to social and emotional health and the subsequent gaps in services that arise. Information gathered from the previous section on Surveying Existing Resources can help identify your niche within the medical home and help foster a coordinated network of care.

Next, materials will provide a rationale for prioritizing early childhood as a key component of your target population. And finally, they will provide sample reimbursement data from demonstration sites and help you identify additional strategies to explore for optimizing Clinician reimbursement while still allowing for prevention services.

Why Focus on Early Childhood Mental Health?



MA Partnership for ECMH “Elevator Speech”

The “elevator speech” below was written by the MA Partnership for Early Childhood Mental Health to describe the rationale for investing in this model. The speech may be a useful tool to advocate for young children in the target population becoming part of the new services at your health practice.

“Why wait? Investing in young children’s mental health yields big returns further down the road.

What helps young children bloom to their fullest is nurturing and responsive relationships. And while it may be hard to believe, the latest research tells us that even infants can show signs of mental health difficulties, especially when families face the stress that comes with hard times. The Boston-Mass Partnership for Early Childhood Mental Health is demonstrating ways to attend to the very youngest children’s social and emotional needs, in order to prevent small hurdles from becoming bigger challenges down the road.

In Boston, our LAUNCH and MYCHILD programs place a two-person team into the pediatric medical home, to work with both the doctors and families to support children’s well-being. The early childhood mental health clinician helps to recognize and address mental health needs in children and the family partner offers parents mentorship, guidance and support.

We need to take what we are learning in Boston, to invest more in services that provide a good social-emotional foundation for children to be ready to learn, and to lead healthy and productive lives. And we believe that our model is a strong investment.”

Where are Your Service Gaps?

The process below outlines questions to answer and information to gather to support the move to focus on early childhood mental health in your service setting.

1) Who does your health practice serve?

- What demographic information do you have about the pediatric population?
- What percentage of this population has MassHealth for insurance?
- Are there unmet needs in your health practice's population that have already been identified?



2) What services related to children's social, emotional and behavioral health does your health practice currently offer directly or via partnership with community resources?

Use the chart below to identify and organize the existing developmental, social/emotional and behavioral health services your health practice and community already has.

Intervention Services	Promotion Efforts	Prevention Services	Intervention/Treatment Services
Infant/Toddler (Birth-3 yrs)			
Preschool-1 st grade (4-8 yrs)			
School age-preadolescence (9-12 yrs)			
Adolescence (13-18 yrs)			
Transition age (18-21 yrs)			



3) Based on the your assessments of patient population and existing resources, where are the notable gaps in services for your patient population?

- Do your services cover the whole age spectrum, including early childhood?
- Do your services include promotion and prevention efforts that do not require a behavioral health diagnosis?



4) What skills or expertise do the current Core Team members bring to this initiative with regards to social, emotional and behavioral health services?

Consider the training and experience of the whole medical home, but in particular the Family Partner and Mental Health Clinician as they will be the main service providers for this initiative.

- Does the FP or MHC have experience in early childhood mental health?
- Does the FP or MHC have specific training in an evidence-based practice related to the social, emotional or behavioral health of children?
- What ages and levels of need are these evidence-based practices targeting?
- Does the background and experience of the FP and MHC particularly lend to serving a certain age population?



5) Based on identified service gaps and team assets, how would you like to focus your services for this model?

Based on your assessments above, identify the target population for this model.

Write a referral criteria for medical home providers to use in understanding your service. (See the following examples in this section.)



6) Where will children who are not included in the eligibility criteria receive services?

Use the information above to devise a resource chart that shows how different medical home and community providers compliment each other in a coordinated network of care.

Create a resource allocation chart that directs providers to other key medical home and community resources if they identify a family who wants or needs social, emotional or behavioral health services, but does not meet your referral criteria. (See sample resource allocation chart provided next.)



7) Share your summary of services and needs with the medical home so resources allocation can be optimized to best meet the needs of families.



Table 1: Sample Resource Allocation Chart
Boston Medical Center, LAUNCH

Inclusion Criteria	Exclusion Criteria	Possible Alternative
Lives in Boston or willing to come to Boston Medical Center	Does not live in Boston and wants home visits	Social work refer to other service (P #3647)
Parent aware and interested in referral	Parent unaware and not expressing interest in extra support	Check in during next visit
Parent aware of intake process	Parent interested in sporadic check-ins	Social work referral
Normal child behavior - tantrums, sleep, parenting strategies	Significant behavioral challenges that need psychological/psychiatric evaluation	Behavioral Health (ext. 45245), In-Home Therapy, etc.
Normal parental anxiety - information on normal child development and temperament	Significant parent mental health issues that need more intensive services for parent and child	In-Home therapy, dyadic therapy, etc.
Dyadic Relationship - information about temperament and child development	Trauma-related relationship disturbances	Child Witness to Violence Project (CWVP) (ext. 44522) or other clinical services
Development support – need for support around Early Intervention, Boston Public Schools and Development Assessment Clinic, and parents interested	Pervasive developmental disorders	Autism Specialists (ext. 43666)
Behaviors not related to traumatic events	Behaviors may be related to traumatic events	CWVP (ext. 44522), Trauma Institute, Children's Advocacy Center
Family is not receiving any other support	Family receiving other services like in-home therapy, school counseling, behavioral health, etc.	Check in with other providers first and refer to Intensive Care Coordination
Family not involved with Dept. of Children and Families (DCF) - or closing case	Family actively involved with DCF	Social work referral (Pager #3647)

Table 2: Sample Referral Criteria

Project LAUNCH, Boston Medical Center (BMC)



As a reminder, referral criteria are:

- 6 months – 8 years old
- Boston residents or willing to come to BMC for visits
- Family not getting other services like In-Home therapy
- Prevention/Promotion cases, i.e., not families with Pervasive Development Disorders (PDD) diagnosis or trauma-related concerns or in need of weekly or Intensive Behavioral Health services
- Family interested in services and aware that there is an intake process

*Language Capacity: English and Portuguese

Remember, we do help with resources, but the reason for referral should be related to social-emotional development!



Referral Criteria (Support Around...)	Example	Possible Intervention
1) Normal Child Behavior	3 year old that has tantrums and mother reports not knowing what else to do	Brief intervention around parenting
2) Normal Parental Anxiety	Mother that has asked you several times the same question regarding baby's eating, sleep or crying	Parental support, normal child development information
3) Dyadic Relationship	Mother that reports opposite behavior than the one observed by you (e.g. "child is impossibly hyperactive")	Discussion about temperament, expectations, normal child development
4) Development	Child with possible language delay that concerns mother and/or might impact behavior	Referrals to Early Intervention, Boston Public Schools and work around parenting strategies

Table 3: Sample MYCHILD Referral Criteria



Who Should I Refer to MYCHILD?

Children birth to 1st grade who:



Have a known behavioral health diagnosis and are not receiving adequate treatment services

OR

Display significant emotional needs or behavioral challenges that are not typical for their age

OR

Have concerning interactions or relationship with a caregiver that affects the child's social/emotional development

Consider the following areas for referrals:

- | | |
|------------------------------------|----------------------------|
| • Known behavioral health history | • Atypical behaviors |
| • Emotional regulation | • Hyperactivity, attention |
| • Behaviors in preschool/childcare | • Exposure to trauma |
| • Anxiety, depression | • Self Harm, aggression |
| | • Parent-Child interaction |
| | • Attachment to caregiver |

Target Population Reimbursement Considerations

The process below outlines questions to answer and information to gather to financially support the move to focus on early childhood mental health in your service setting. (*See additional financial information in section 4 of this toolkit.*)

1.	Insurance Plan	% Patient Population	Reimbursement Rates

2.	Staff Position	Potential Salary (with benefits)	Reimbursement Rates

3.	Other strategies	Pros	Cons
	Co-visits		
	Increased PCP Productivity		

3) Supporting Professional Development: Training and Supervision of the Core Team

Supervision is a requirement for any human service intervention to be viable, helpful and humane. The challenge in the medical home model is that generally medical practitioners do not think of oversight or supervision in the same way as is essential in human services.

Another challenge is that although it is common for mental health providers to have regular clinical (direct care) supervision, how to provide supervision to a peer mentor role such as the Family Partner could be a question. The last challenge is that not only do both the Clinician and the FP need both administrative and clinical supervision for the dyad to function well; the team also needs specific dyadic supervision as well. This may sound like a lot of support - and it is - yet each team can determine how frequently each process is needed as long as every component is covered sufficiently.

This section provides information and examples on supervising and training Core Team members in these new roles, as well as continuing professional development plans.

SUPERVISION FOR THE FAMILY PARTNER AND MENTAL HEALTH CLINICIAN

For the Clinician and the FP, administrative and direct service (clinical) supervision will be necessary. Often the same supervisor can provide both functions, but if not, administrative supervision can generally be less frequent or for shorter periods of time, or even as needs arise only. What is essential is for the staff to know exactly how to get their administrative questions answered and to whom they need to report to regarding potential policy or procedural concerns.

Administrative supervision for both members of the team should include:

- ✓ Determining schedules, time off and payroll concerns
- ✓ Adherence to policies and procedures of the facility
- ✓ Managing benefits
- ✓ Arranging and possibly facilitating performance reviews

Below we will discuss the different Direct Service supervision needs.

Supervising the Clinician

Mental Health Clinicians of any type need regular opportunities to discuss the clients they are working with and the goals for treatment.

Clinical supervisors need to be mental health clinicians themselves so that they can provide specific support that is informed by clinical theories and practices. For the medical home team, it is imperative that the supervisor have specific experience working with children and families. Direct care work of any kind can be emotionally taxing and often the clients referred to the medical home team are suffering from a variety of highly stressful concerns. Clinicians need the opportunity get support for these challenges as well as direction as to alternative approaches for providing support or guiding behavior change.

Whenever a Clinician is providing services, this treatment should be guided by an individualized treatment plan. The treatment plan should have measurable goals, feasible objectives and thoughtfully determined interventions. Input into this treatment plan may be the one concrete way a supervisor can provide direction. Tracking progress in cases as it relates to the treatment plan is also a way of providing oversight.

Clinical supervision must also include opportunities for the clinician to reflect on their own internal experience while providing this work. When humans support other humans who are suffering, it is common and normal for intense emotion to arise, or thoughts to occur that are more related to the clinicians' own

experience than that of their clients. We no longer imagine that Clinicians are a "blank slate," able to avoid any internal reaction when working with someone else's challenges. We do want them to be observers of these reactions and recognize them as generally separate from the direct work.



Having a supervision space to bring these reactions is essential. Discussing these internal reflections is an opportunity for the Clinician to learn more about themselves as a helper, and sometimes it is an opportunity to understand on a deeper level the experience of the client. Sometimes this element of supervision is called "reflective supervision." More traditionally it is called "tracking counter-transference."

Regardless of the name, having an opportunity to learn from these reflections is essential to maintaining the necessary boundaries helpers need to maintain with clients.

Supervising the Family Partner

Many of the same concepts from Supervising the Clinician apply to Family Partners, but there are some differences. It is just as essential for FPs to have opportunities to reflect on their internal experiences, and in some ways even more so.

Our very definition of a FP is “lived experience as a parent of a child with special needs” or put another way, as a peer mentor. The likelihood that providing support to parents from this particular lens will illicit internal reactions or trigger specific experiences and/or memories is high. The delicate balance between using this lived experience as a tool for engagement and losing track of the role of being a helper is one that needs regular and thoughtful support. Reflective supervision is paramount when hiring peers to provide interventions.



Often FPs are the initial point of entry for families referred to the medical home. Supervision for the challenges and techniques for client engagement is a particular need for this group. This area also includes responding to what could be considered “resistance,” or more appropriately, engaging the family that responds to a referral with fear or distrust. This can be challenging work and quite draining, so regular support for both alternative techniques and maintaining empathy is essential. Equally,

support for maintaining the principles of “wraparound” or most importantly “Family Voice and Choice” are other key components to the supervision of FPs.

The actual supervisor for the FP is less clear cut. It is essential that the person who “clinically” supervises the FP has experience working with families and children, understands the principles of “wraparound services” and has a good handle on the peer mentor role and its inherent challenges. This can be a clinician well versed in the above or it can be a management-level FP, or in our particular model one of the supervisors of the team is titled Lead Family Partner. The Lead Family Partner is a person with lived experience parenting a child with special needs as well as management experience and extensive experience with family/parent engagement.

One resource to tap into for support in supervising the FP is the Children’s Behavioral Health Initiative (CBHI)—the statewide initiative to increase home and community based mental health services for children. CBHI has contracted with agencies throughout the state to provide clinical and FP services. These agencies have experience in training and coaching FPs on delivering individualized services for children with mental health needs, and the more experienced FPs may be able to offer direct coaching to new FPs. There are also regional FP specialists that provide cross-agency coaching and could fulfill the role of a Lead Family Partner if collaboration with the community agency is established.

For more information about CBHI services and contracting agencies, [visit their website](#)¹¹.

Supervising the Dyad

Ideally, your Core Team is working closely together for the families referred new services. In order for this dyad to remain a team with excellent communication and complimentary roles, the team itself will need support.

This can take on many forms. If the same supervisor is supervising both people in the dyad, then providing regular opportunities for dyadic supervision could work. If they are separate supervisors, we strongly recommend that for dyadic supervision models, the dyadic work occurs when both supervisors in the room.

The dyadic supervision, by whoever is providing it, is a time to provide team-based technique suggestions, dyadic reflections and ongoing role clarification. In this model we see dyadic supervision as a key element to successful supervision of the medial home team.

Essential Tip: For the team to be supported as equal and essential parts, neither team member should be the supervisor for the other!

This supervision model destabilizes the team approach and even if it is occurring on a subtle level, this needs to be addressed immediately.



TRAINING

THE FAMILY PARTNER AND MENTAL HEALTH CLINICIAN



It is a good idea for Family Partners and Clinicians to have a personalized professional development plan that enhances their ability to provide evidence-based interventions for children's social and emotional health.

We recommend that FPs and Clinicians collaboratively develop this plan with their respective medical home supervisor and the Core Team. The most useful set of trainings for each FP and Clinician will vary based on medical home and individual factors, such as target population for services, time allocation across the span of promotion through intervention, and the professional/personal background of the FP and Clinician.

Thinking broadly, the Core Team may also consider the existing knowledge gaps across current medical home providers. Facilitating FP and Clinician training on these gaps may enhance the overall capacity of the medical home to meet families needs. This would enable the FP and Clinician to serve as the point person in the medical home on new topics on children's social and emotional health.

Training on Early Childhood Mental Health (ECMH) in Massachusetts

While it is increasingly recognized that early childhood social and emotional development has a lifelong impact on the health of a child, few mental health providers are trained in this unique field. Thus, particular attention must be given to selecting trainings on ECMH that can equip Clinicians and FPs with the skills they need to serve young children and their families.

ECMH Professional Development Resource Guide

In Massachusetts, a compendium of such resources was developed by the Young Children's Council (YCC) Professional Development Working Group. The YCC represents a collaboration of cross-disciplinary and interagency stakeholders in the field of early childhood mental health in Massachusetts and is led by ECMH Partnership. The YCC Early Childhood Mental Health Professional Development Workgroup was developed in order to capitalize on the MYCHILD and LAUNCH grants as opportunities to bolster and enhance the visibility of the ECMH field in the state.

This working group has developed a [Professional Development Resource Guide](#)¹², which serves as an environmental scan to identify training gaps, duplications and opportunities for collaboration/expansion as well as a professional development resource guide for child and family-serving professionals.

Considerations for Selecting Professional Development Plans

Carefully selecting trainings is important, especially given time and cost. The following questions may help in selecting trainings that are the best fit for the Family Partner and Clinician on your Core Team:

Family Partner and Clinician Experience

Consider the specific training needs for each provider.

Background: What experience or expertise does the provider already have? What trainings has the provider already participated in? Which of these trainings are evidence-based practices?

Gaps: How well does the background of the provider match the target population selected by the Core Team? Where are the gaps in knowledge or skills between the provider's experience and assumed roles/responsibilities within the medical home?

Training Objectives and Logistics

Consider the utility and feasibility of each possible training.

- What are the objectives of the training?
- How do those training objectives align with your Core Team's vision for children's social and emotional health in your medical home?
- What knowledge and skills will the provider gain from participation?
- How will the training contribute to the provider's practice of family-centered care?
- How much coaching will be required after the training to ensure the provider can implement the new practice?
- What training resources or materials will be obtained that can be directly applied to improve family-centered care? (videos, handouts, etc.)
- How will the provider communicate lessons learned from the training with colleagues throughout the medical home?
- Are there possibilities for implementing this training in partnership with community providers? (e.g. childcare providers, school nurses, Early Intervention providers etc.)
- What is the cost and time commitment to participate in the training?
- Can this cost be shared across community partners for co-training?

Training Examples across Demonstration Sites

Across Early Childhood Mental Health Partnership demonstration sites, Family Partners and Clinicians participated in a wide array of trainings to acquire the skills needed to provide prevention and intervention services for young children's social and emotional health. Some of these trainings were dyadic (FP and Clinician together), some role-specific (e.g. Clinicians across sites), and some individualized to meet the identified needs of one provider.

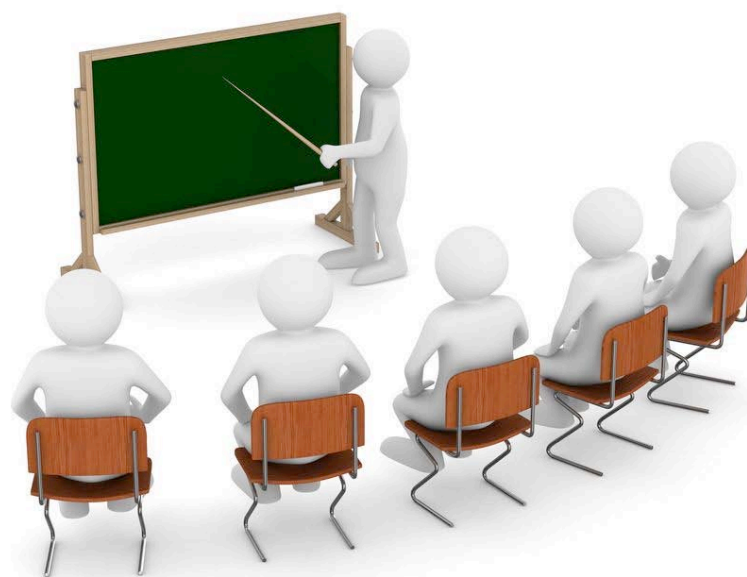


Individualized Trainings

With joint support from the ECMH Partnership and medical home demonstration sites, individual Clinicians and FPs had opportunities to attend trainings on evidence-based practices that would enhance their services for families. Each training was selected by the FP or Clinician in conjunction with their site-specific supervisor. FPs and Clinicians had to articulate specific learning objectives for the training and describe how participation would impact care for families.

Furthermore, Clinicians and FPs were expected to provide a recap of their learning experience in either the cross-site Family Partner Forum (led by the Lead Family Partner) or Clinician Seminar Group (led by the Clinical Consultant) to facilitate cross-site discussion and learning. The following are examples of individualized trainings:

- [Parent-Child Interaction Therapy](#)¹³
- [Incredible Years](#)¹⁴
- [Circle of Security](#)¹⁵



Team-based Trainings

The following trainings were implemented as Core Team trainings for the Family Partners and/or Clinicians across demonstration sites. The content and logistics of these trainings reflect principles of team-based care, community collaboration, and a capacity-building approach.

All three trainings were done with FPs and Clinicians together, with the goal of enhancing provider partnerships through joint learning and shared reflection. Demonstration site Primary Care Champions and Administrators received open invitations to attend parts of these trainings, which some chose to do, despite barriers of time and cost.

The fact that these trainings were developed for child-serving providers outside the traditional medical system emphasizes the importance of coordinated, collaborative interventions across child-serving agencies. The CSEFEL and IN-TIME trainings were implemented as cross-trainings of early education providers, Early Intervention providers, and demonstration site FPs and Clinicians, thus building bridges between medical homes and community agencies.

By participating in “train the trainer curriculums,” multiple administrators of the ECMH Partnership served as co-trainers for these core trainings, thus building capacity for ECMH training across the state. Similarly, the Lead FP and Clinical Consultant, the respective experts for the demonstration site FPs and Clinicians, were trained as coaches for the Wraparound training.

Of note, the time commitment for these trainings reflects modified curriculums developed specifically for the MYCHILD and LAUNCH projects.

Table 1: Family Partner and Clinician Training Examples

Training	Description	Logistics
<i>Pyramid Model: Center for Social & Emotional Foundations of Early Learning (CSEFEL)¹⁶ with Connected Beginnings¹⁷ in Massachusetts</i>	A model of evidence-based practices for promoting young children's social emotional competence and preventing and addressing challenging behavior. The center has developed extensive, user-friendly training materials, videos, and print resources available directly from this website to help early care, health and education providers implement this model.	<p>Audience: Family Partners and Clinicians</p> <p>Time: Infant/Toddler modules: 2 full days Family modules: 2 full days</p> <p>Trainers: Connected Beginnings and ECMH Partnership Administrators</p>
<i>Wraparound Model</i>	Wraparound is an evidence-informed approach for meeting the needs of families of children with serious emotional disturbances (SED). "The process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family," National Wraparound Initiative ¹⁹ .	<p>Audience: MYCHILD Family Partners and Clinicians</p> <p>Time: 4 full days and 1 year weekly coaching to each FP/MHC dyad</p> <p>Trainers: Vroon VanDenBerg¹⁸, LLC</p> <p>Coaches: Lead Family Partner and Clinician Consultant</p>
<i>IN-TIME Training, Connected Beginnings</i>	IN-TIME Training in Infant Mental Health ²⁰ is designed to support practitioners in integrating a mental health perspective into assessments and interventions with infants, toddlers, and their families. It is based on current research about the central role of relationships and their influence on early brain development.	<p>Audience: Family Partners and Clinicians</p> <p>Time: 4 hours/week for 10 weeks</p> <p>Trainers: Connected Beginnings</p>

Glossary of Links

A complete list of the online links to Web and PDF resources found in this section of the toolkit.

Foot note #	Subsection Title	Link Title	URL
1	Resources for Identifying and Interviewing Family Partner Candidates	Massachusetts Early Childhood Mental Health Professional Resource and Development Guide	http://www.ecmhnmatters.org/ForProfessionals/Documents/ECMH%20Professional%20Development%20Resource%20Guide%20-%20Booklet%20Format.pdf
2		CBHI Family Partner Forum	http://www.masspartnership.com/provider/index.aspx?lnkID=CBHIFamilyPartnerForum.ascx
3		Family Support and Training/Family Partner Hiring Packet	http://www.masspartnership.com/provider/pdf/FSandTFPHiringPacket.doc
4	Orientation Checklist	CANS Virtual Gateway Orientation	https://masscans.ehs.state.ma.us/login.aspx?ReturnUrl=/
5	The Pediatric Medical Home	Maternal and Child Health Bureau	http://mchb.hrsa.gov/
6		American Academy of Pediatrics	http://www.aap.org/
7		What is a Medical Home?	http://www.medicalhomeinfo.org/about/medical_home/
8		Tools for Implementing Medical Homes	http://www.medicalhomeinfo.org/how/
9		Resources for Families	http://www.medicalhomeinfo.org/for_families/
10		HealthyChildren.org	http://www.healthychildren.org/english/family-life/health-management/pages/A-Medical-Home-Where-Everybody-Knows-Your-Name.aspx
11	Supervising the Family Partner	Children's Behavioral Health Initiative Services	http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/

Foot note #	Subsection Title	Link Title	URL
12	Training the Family Partner and Mental Health Clinician	Professional Development Resource Guide	http://www.ecmhatters.org/ForProfessionals/Pages/YCCProfessionalDevelopment.aspx
13	Training Examples across Demonstration Sites	Parent-Child Interaction Therapy	http://www.pcit.org/
14	Training Examples across Demonstration Sites	Incredible Years	http://incredibleyears.com/
15	Training Examples across Demonstration Sites	Circle of Security	http://circleofsecurity.net/
16	Family Partner and Clinician Training Examples	Center for Social and Emotional Foundations of Early Learning	http://csefel.vanderbilt.edu/
17	Family Partner and Clinician Training Examples	Connected Beginnings	http://connectedbeginnings.org/professional-development/training/csefel
18	Family Partner and Clinician Training Examples	Vroon VanDenBerg	http://www.vroonvdb.com
19	Family Partner and Clinician Training Examples	National Wraparound Initiative	http://www.nwi.pdx.edu/
20	Family Partner and Clinician Training Examples	IN-TIME Training in Infant Mental Health	http://connectedbeginnings.org/professional-development/training/in-time