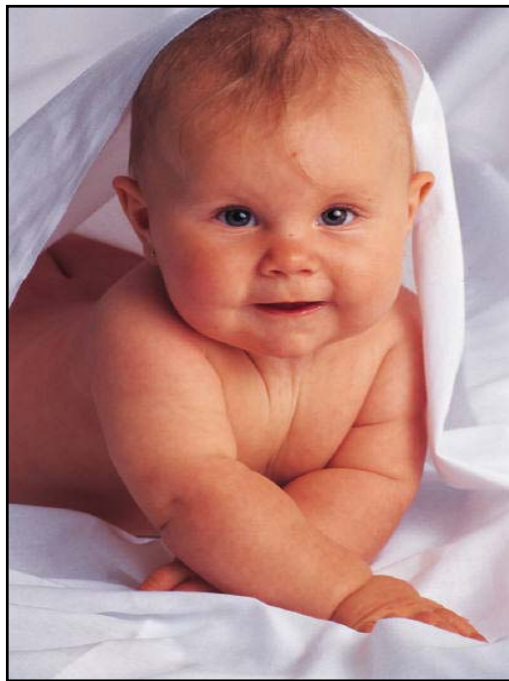


# Behavioral Health Planning and Coordination Study

May 2004



Final Report by Christopher Walsh, M.F.T.  
Conducted for the First 5 Commission  
of San Diego

With special thanks and appreciation to:

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## PURPOSE

The Behavioral Health Planning and Coordination study is one of three planning studies undertaken for the First 5 Commission of San Diego as part of an overarching strategic planning process to help direct advocacy and funding activities in the areas of physical health, cognitive development, and behavioral health.

The purpose of the Behavioral Health Planning and Coordination Study is to:

- Provide a review of current research on early childhood mental health issues as they relate to and support school readiness.
- Identify and collaborate with local groups and agencies within the county that provide early childhood mental health services.
- Conduct community conversations with behavioral health stakeholders discussing needs, assets, best practices and coordination opportunities.
- Provide a systems analysis of early childhood behavioral health in San Diego County identifying how services are linked, coordinated, and integrated.
- Review and summarize best practices of local, state and national agencies including other local First 5 Commissions.
- Build upon local planning efforts in formulating a regional plan to improve behavioral health services for children 0-5, with recommendations prioritizing needs, solutions and next steps for Commission funding, advocacy and collaboration.

## METHODOLOGY

The following methodology was utilized to complete this report:

- Reviewed and analyzed recent advances in infant research, attachment theory, developmental psychology, psychiatry, and neurobiology, as well as various studies and research efforts that address the link between emotional and social well-being and school readiness.
- Analyzed the current behavioral health service delivery system for children 0-5 and how the various subcomponents/subsystems integrate and coordinate services. Part of this effort includes the mapping of the behavioral health programs and services in the 6 geographic regions of San Diego County.
- Conducted two workshops for families focusing on emotional, social, and behavioral well-being for children 0-5 at the 3<sup>rd</sup> Annual Parenting Conference sponsored by the San Diego Commission on Children, Youth, and Families to obtain direct family feedback regarding parenting issues, concerns, and need for behavioral health services for younger children and their families in the community.
- Utilized a provider survey to not only identify services in the community, but also to obtain direct feedback from providers regarding system design and priorities for early childhood behavioral health services.
- Reviewed behavioral health service delivery systems for children 0-5 within the state and nationally.
- Interviewed key stakeholders and conducted both informal and formal community meetings to identify priorities, needs, and recommendations for an early childhood behavioral health service delivery system. The Early Childhood Mental Health Committee in particular, has been tremendous asset to the study as participants represent a broad coalition from public and private agencies, private practitioners, schools, the Child Care Counsel, and members of several Committees including CoCoSer Social and Emotional Cluster, the San Diego Children Youth and Family Commission- Early and Comprehensive Educational Support Committee (ECES), Earliest Relationships Network, among others. Out of this collaborative work group, came a number of the findings and recommendations found in this report.

**“An important lesson to draw from the entire literature on successful early intervention is that it is the social skills and motivation of the child that are more easily altered – not IQ. These social and emotional skills affect performance in school and in the workplace. We too often have a bias toward believing that only cognitive skills are of fundamental importance to success in life.”**

**James J. Heckman, Ph.D.**

Nobel Laureate of Economic Sciences

From a Children Youth and Families Brief (2000)

## INTRODUCTION

From the earliest moments of life, we are engaged in emotional and social experiences. We now have a far greater awareness of the critical nature of these earliest years. We know now that a young child's social and emotional experiences impact a lifetime trajectory of learning, social engagement, and personal development. Over the past ten years, there has been a confluence of research from various fields including neurobiology, infant psychiatry, attachment theory, and developmental psychology. This research is leading the way to a new understanding of how early relationships not only shape emotional and social regulatory processes, but actually help to influence brain development as well.

This information is now beginning to inform and influence treatment, policy and funding in new and creative ways. We are beginning to infuse the concept of social emotional competencies throughout the early childhood system of care. In California, the First 5 Commission is leading the way, creating a vision for children 0-5 and their families. This vision includes the promotion of secure attachment relationships and the achievement of basic social and emotional competencies to ensure school readiness and to lay the foundation for school success.

Secure Attachments: A Foundation for Social and Emotional Competence

A healthy attachment is associated with a sense of resilience and security. It provides the confidence necessary to explore the world at large. It is also associated with positive developmental outcomes in the social, emotional, and cognitive domains. Healthy infant and child development occurs within the context of a primary attachment relationship. An attachment relationship develops from a sequence of responsive, emotionally attuned (Stern 1985) interactions between parent and child spanning the first 3 years of life.

Before there are words, or any conscious thought, there is emotion, and it is emotion that is primarily transacted in these early exchanges between parent and child. Emotions fill the earliest and deepest of our core experiences. Joy, elation, loss, and frustration – all are present at birth, but not yet the capacity to manage and regulate them. For that, infants are highly dependent upon the caregiver surround – upon their parents to compensate for their immature, undeveloped regulatory system (Schore, 1994). This first, all-important relationship creates the mold or “internal working models” (Bowlby, 1988) for which all other social relationships will be measured. It is the secure attachment bond and the creation of the

emotional/physiological “holding” space provided by the parent that allows the child to not only meet his or her potential, but to thrive. Infants do not exist in isolation of the caregiver. To the infant, there is no “I” ness, only the parent/child relationship, and it is this

crucial relationship that makes up the fabric of the infant's world. It is within this crucial primary relationship that the child's emerging sense of self, and of others, begins to unfold.

Most children are born with the biologically driven motivation to attach to their parents. They have innate emotional and social capacities and intuitively seek a secure relationship to develop further. Due to the immature nature of the infant's brain at birth, experience plays a significant role in determining the unique features of brain connections, structures, and mental processes (Siegel, 2003). Positive attachment experiences help children to develop the capacity to regulate feelings both internally and interactively, and develop the capacity to balance their emotions, thinking, and empathic connections with others. A secure attachment also helps in the regulation of physiological states.

Approximately two thirds of all children are considered to be securely attached (Main 1995, Ainsworth 1978), while the remaining one third tend to have one of three different insecure attachments patterns - avoidant, ambivalent, or disorganized. The disorganized attachment pattern is considered the most severe of the insecure patterns. In a longitudinal study by Alan Sroufe (1999), children that were securely attached grew up with leadership abilities, avoidant children were later shunned by peers, ambivalently attached children were anxious and lacked confidence, and disorganized children had the most trouble in peer relationships and tended to have difficulty managing their emotions. He also found that these attachment patterns persisted over time.

What is the significance of disrupted attachments for parents and teachers?  
Child development experts are

beginning to understand just how impactful a disrupted attachment can be. According to Daniel Hughes (1997), children that have significant attachment difficulties will exhibit psychopathology in many areas of development including:

- ◆ Social relationships- aggressiveness toward others, lack of empathy, difficulty cooperating and getting along, may be indiscriminately friendly, and have a tendency to manipulate or control others.
- ◆ Emotional development – limited capacity to recognize and express emotions, or experiences low frustration tolerance, chronic depression, anxiety, and shame. It also shows up in the inability to regulate emotions internally, and/or inability to regulate emotions interactively.
- ◆ Behavioral development – increased impulsivity, unpredictability, hypervigilance, tends toward the repetitive, disorganized, passive. Requires external source of structure (e.g. the teacher's guidance) to maintain behavioral control. Poor response to discipline.
- ◆ Cognitive development – impaired ability to learn from new or novel situations, difficulty understanding cause and effect, impaired inner state language (language to describe internal experience), stuck in dualistic thinking (i.e. all good or all bad), impaired sense of competency/mastery, diminished motivation, sense of self that is somehow bad or incomplete.

To a child, a disrupted attachment is in itself, a traumatizing experience. Hughes cites the work of Speltz (1995) and Greenberg (1993) in the central role of insecure attachments and later development of oppositional defiant disorder and conduct disorder. He goes on to say that while many of the above characteristics may also be related to the immediate effects of trauma, that the persistent expression of them, despite quality caregiving, is more associated with disrupted attachments. The relevance for foster parents and other caregivers is clear. Often foster children experience many of these challenges, and services that help parents address these concerns typically are not easy to find. Unfortunately, most treatments or interventions are primarily focused on the child's problematic behaviors, not the underlying foundation for the behavior.

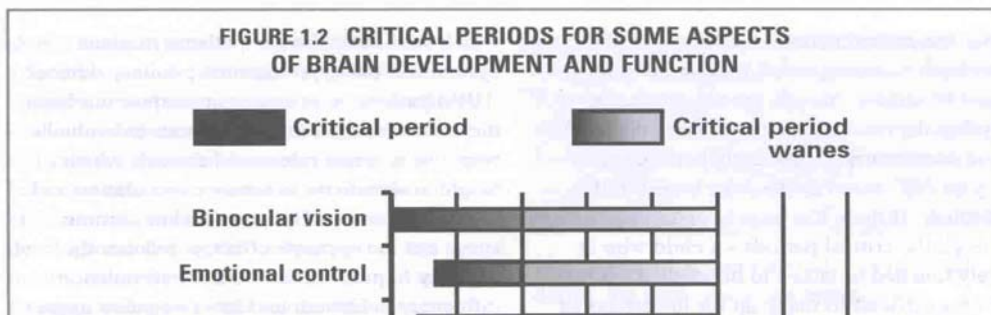
If the attachment pattern is insecure, anxious, and fragmented, the child's developmental trajectory is significantly altered. Lacking a consistent, mirrored response, the insecurely attached child does not learn to identify feelings, the developing self remains poorly differentiated, and there is little pleasure

immediate need gratification and can begin to engage in self-destructive behavior patterns. There are multiple risk factors that may influence and impact the development of social and emotional competencies. These include family violence, poverty, drug and alcohol abuse, and parents that have mental health issues including maternal depression. Subject to enough risk factors, the child's social and emotional competence may be severely compromised<sup>1</sup>. By Kindergarten, if these competencies have not yet developed, the child will need to go through remedial support services in order to be ready to learn and succeed in school. According to Bruce Perry, M.D. (1995), the infant's brain is more malleable to experience than the adult's brain, and "while experience may alter and change the functioning of an adult, experience literally provides the organizing framework for the infant." A young child's brain is plastic and receptive to environmental input. It appears that the infant's brain is not only receptive to input, but dependent upon these inputs to shape and actually establish neural pathways or connections in the brain.

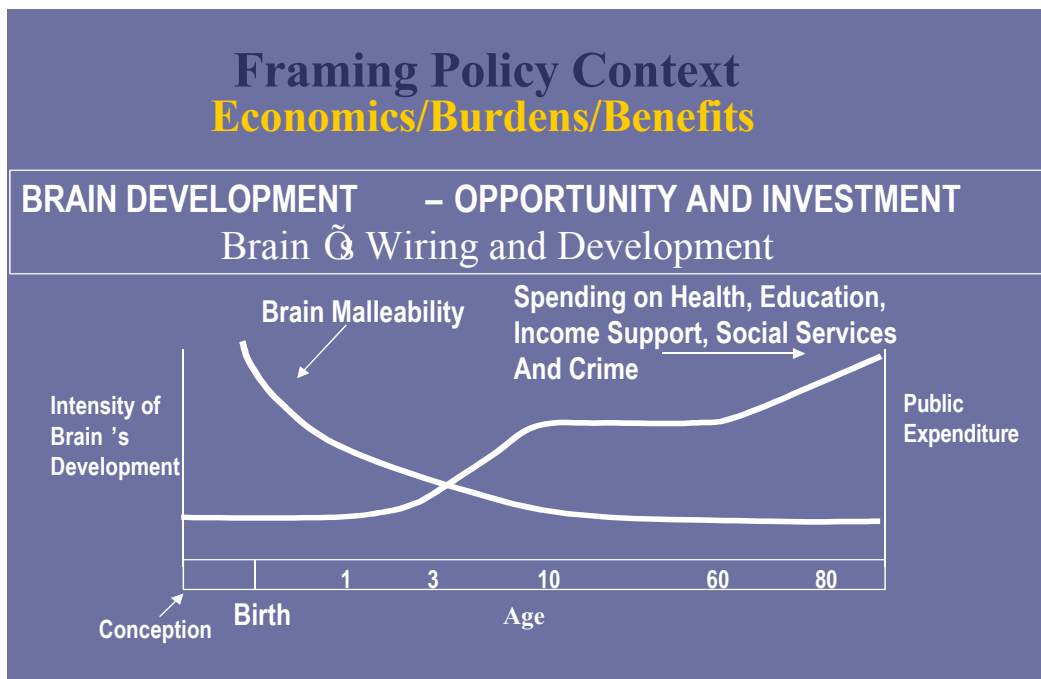
There are critical periods for this shaping and development, which has been depicted in the chart on the next page.

derived from engagement with the world around. Children become focused on

<sup>1</sup>Research on maternal depression indicates that infants of depressed mothers are more irritable, less active, less responsive with higher rates of developing symptoms that imitate the mother's depressed behavior (Stuart, 2000), as well as higher rate for attention deficits, separation anxiety, aggressiveness, poorer social skills, insecure attachments. Depressed mothers tend to be more intrusive and controlling, and fail to respond adaptively to infants emotional signals. Infants of depressed mothers exhibit less motivation to master new tasks, have elevated heart rates, and elevated cortisol levels. (Perry, 2003).



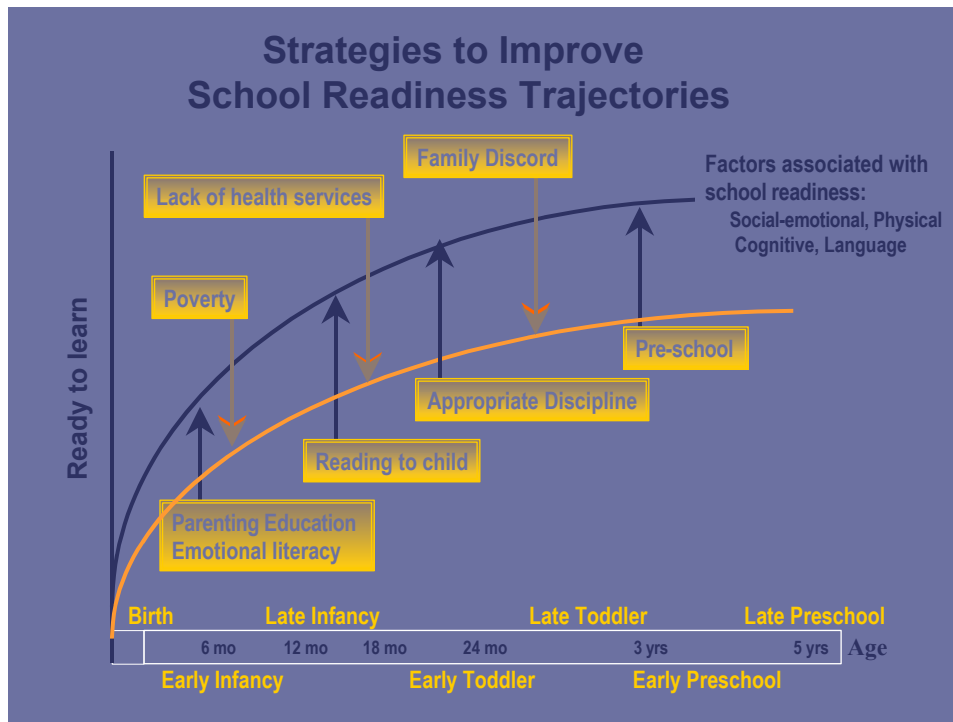
As represented in the diagram above, the critical period for emotional control is from nine months to two years. The critical period for habitual ways of responding also occurs before the age of two. For peer relations, the critical period is from 3- 6. Social and emotional competencies are developed in these early critical years. The time to impact a child's social and emotional development, therefore is prior to the age of three. Although the brain has developed about 90% of its core structure by age three (Perry, 2001) less than 5% of public spending is dedicated to children in this age range. In other words, we invest the least amount of funding at a time when the brain is the most amenable to change, a time when critical periods of development are occurring.



## LINK TO SCHOOL READINESS

There is increasing evidence that emotional and social development in the earliest years serves as a core foundation for later school success. As suggested in the National Academy of Sciences study “From Neurons to Neighborhoods: The Science of Early Childhood Development,” the 3 qualities that children need in order to be ready for school are: intellectual skills, motivation to learn, and strong socioemotional capacity. The California

Department of Education (CDE) also acknowledges the link between school readiness and social and emotional competence and has listed social and emotional competency as one of the core components of the Desired Results Program, a revised set of standards for early childhood education. By addressing social and emotional at the developmental critical time periods, we can effectively impact the trajectory of a child’s readiness for school.



As indicated earlier, in order to have strong socioemotional capacity, children must first have secure attachments and consistently loving and supportive relationships at home and/or in early care and education settings. Without such a relationship, emotional, and later behavioral problems can occur. “Many

of the children who have had disruptions in their early development and attachments present with challenging behaviors in the classroom. They may appear fearful, disorganized, inattentive and unresponsive to learning” (Kauffman, 2002). In one sense, the primary *learning* task of children 0-3 is

the development of social and emotional competencies. If they do not develop these competencies early on, the foundation for later learning is compromised, and the child will require remedial support in order to take full advantage of their educational opportunities.

National statistics from epidemiological studies are scarce, but the best estimates are that about 10% of the children in the 0-5 age group have significant emotional problems, and for the at-risk groups, the number of children with serious emotional difficulties may be as high as 27%. Researchers are reporting that “across a range of studies, the emotional, social, and behavioral competence of young children predict their academic performance in first grade, over and above their cognitive skills and family backgrounds” (Raver and Knitzer, 2002). Between 30-40 % of younger children pose ongoing problems to classroom teachers due to behavioral or mental health issues meaning they are

not yet fully ready for school. Further, there is a concern that many children with emotional or behavioral problems simply go unrecognized or fall through gaps in services since not all emotional problems are externally expressed.

In his book “Building Healthy Minds” Stanley Greenspan, M.D. takes the concept of a link between emotional competence and school success even further. He suggests that emotional interactions play a far more critical role in intellectual functioning than believed in that they “enable the child to understand how the world works, and eventually to think, solve problems, and master academic challenges.” Greenspan concludes that emotions are actually the “internal architects, conductors, or organizers of our minds.” Further, that “most of a child’s varying intellectual and social gifts, including his creativity and abstract thinking skills are *not only interrelated, but rest on common building blocks that surprisingly involve emotions.*”

#### A note about nomenclature:

As we move to a more comprehensive and integrated understanding of human development, the need for a common base of language in which we can more readily discuss concepts, objectives and goals becomes evident. In a comprehensive system, it is not simply about mental health, or physical health, or cognitive development, but how all three areas weave together toward optimal well-being. Because the concept of infant “mental health” still has considerable stigma attached to it, it is perhaps important to find an approachable language from which to work. A focus on behavior does not capture the full depth of what is actually happening within the child (internally) and between the child and parent/caregiver (interactively). Behavior, especially to a child, is merely the outward expression of internal feeling states. Without adequate means to identify and articulate feelings, a child utilizes behaviors as a means to communicate their ongoing internal state to others. To address only behavior is to miss the underlying emotional core, or the role of relationships in shaping that core.

It is suggested that the current focus on school readiness provides a useful framework for the re-conceptualization of this issue. To more readily integrate concepts, objectives, and goals of a comprehensive system of care for early childhood services under the unifying concept of school readiness, a shift is possible from a focus on “mental health” to the development of social and emotional competencies.

## CALIFORNIA FIRST 5 COMMISSION BEHAVIORAL HEALTH INITIATIVES

**Infant, Preschool, and Family, Mental Health Initiative (IPFMHI)**. Initially the Infant, Preschool, and Family Mental Health Initiative was funded by the California State Department of Social Services, and then later, by the State First 5 Commission. This Initiative has been in effect for the last several years and is nearing the end of its implementation. As it was originally conceptualized, objectives of the IPFMHI were to:

1. Develop new mental health services for children 0-5 with a focus on the parent-child interaction.
2. Provide education and training activities focused on working with young children and their families.
3. Expand interagency collaboration.
4. Develop the necessary infrastructure to carry goals out.
5. Conduct an evaluation throughout the project.

There have been 8 Counties participating in the Initiative since its inception, although it was initially open to all counties. San Diego County, through the efforts of HHSA – Children’s Mental Health, attempted at one point to be added to the Initiative but was not successful because it was determined that the program was not to be expanded. Instead, the State First 5 Commission made the decision to roll the IPFMHI into the upcoming Special Needs Project.

**Discussion:** There is still an opportunity to capitalize on the training component of the Infant, Preschool, and Family Mental Health Initiative. The State Department of Mental Health is supporting the continuation of training and technical assistance efforts with services being developed through a grant with California Institute of Mental Health (CIMH). This training and technical assistance program will be offered to counties throughout California. Stakeholders in San Diego listed training as one their top priorities.

**Special Needs Project.** The Special Needs Project represents a \$20 million investment by the State First 5 Commission to support children with disabilities and other special needs including social and emotional needs. Emotional needs have been defined to include problems around the child/parent attachment relationship, behavioral problems, and emotional disturbance. An important provision of this project is the focus on meeting the service needs of children that have emotional problems but do not yet meet eligibility criteria for other services. To ensure an effective program that identifies and serves children in need of early intervention, strong interdisciplinary and interagency partnerships are required.

Objectives of the Special Needs Project include:

1. Assist families in navigating and accessing services.
2. Provide consultation, education, and training for interdisciplinary teams of parents, early childhood educators, health, mental health, and social services.
3. Develop services to promote emotional health from early intervention to treatment strategies.
4. Achieve specific project outcomes.

Components of the Special Needs Project include:

- A. Demonstration Sites: Up to 10 Demonstration Sites will be funded throughout California to be collocated at selected School Readiness Sites. The proposed funding will be up to \$10 million total over 4 years from the State First 5 Commission, plus matching funds from the local First 5 Commissions where the Demonstration Sites are established.
- B. Statewide Project Coordination and Training: Proposed funding will be up to \$5 million total for 5 years. Sonoma State has been selected to oversee the project and will be managing the Coordination and Training component. They are currently developing the RFP to go out later this year.
- C. Program Evaluation: total funding of up to \$1.5 million over 5 years.
- D. Infant, Preschool, and Family Mental Health Initiative (IPFMHI) will continue to be funded for another 2 years for a total of \$3.5 million. As indicated earlier,

there is no planned expansion of the IPFMHI to other counties.

Goals for the Special Needs Project include:

1. Universal access to screening for early identification/diagnosis and referrals for physical, developmental, social, emotional and behavioral issues. Comprehensive screening strategies will be improved and/or developed and provided to all children within the boundaries of the School Readiness site catchment area.
2. Improved access to and utilization of screening, assessment, services and supports through coordination and reallocation of existing resources and building of new resources.
3. Inclusion of young children with disabilities and other special needs in appropriate typical childcare and development settings with the provision of necessary supports to help the child succeed in that environment.
4. Evaluation to identify effective practices and to improve programs.

**School Readiness Initiative:** The purpose of the School Readiness Initiative is to improve the ability of families, schools, and communities to adequately prepare children to be ready to enter school, and ready to succeed. This will be accomplished through incentive matching funds to Prop. 10 County Commissions that fund locally tailored School Readiness Programs in communities served by schools primarily in the lowest 3 deciles of the Academic Performance Index (API). Special focus

will be given to developing these skills through parents and early childhood educators with a strong evaluation of these areas.

The local School Readiness Sites will restructure and coordinate the delivery of quality early care and education, health and social services, parental education/ involvement and support, plus improve schools' readiness for children through family-friendly environments in school-based or school-linked settings. School Readiness Programs use the National Education Goals Panel (1997) definition of school readiness, which addresses:

- ◆ Physical well-being and motor development
- ◆ Social and emotional development
- ◆ Approaches to learning
- ◆ Language development
- ◆ Cognition and general knowledge

There are 7 School Readiness Sites in San Diego: Cajon Valley USD, Chula Vista, Escondido, Oceanside Unified School District, National City School

District, San Diego Unified School District, San Ysidro School District, Vista Unified School District

There is wide variance between the School Readiness Sites with regard to behavioral health services. One program, the Chula Vista School District, has an exemplary program located at Greg Rogers Elementary School. The program is called the Parenting Intervention Program (PIP). The parent and the child are enrolled together. Services are provide by three woman who have had children graduate from the program. Parent and child participate for 3 hours/ day and 3 days a week for as long as they need (usually until the behavior has sufficiently diminished). Staff observes interactions between the parent and child through a one-way mirror and work with the parent in supportive ways to modify their approach to their child. It ultimately raises the competence of the parent, strengthens the parent-child relationship, and parents have reported that the results are generalizable – they are using the skills learned with other children in the home with success.

## Review of Various County First 5 Funded Behavioral Health Programs and Services

In **Contra Costa County**, there is an example of blended funding effort between EPSDT and First 5 to support three local nonprofit infant mental health service providers that offer individual and family therapy, case management, consultation to day care and preschool providers, and therapeutic nursery school services to children 0-5 and their families. Services also include day care and preschool consultation, therapeutic nursery schools, caregiver therapy/education, family and individual therapy, home visiting, play therapy, wraparound (child-family team facilitation), and school transition services for children birth to five.

There are two components of Contra Costa's approach that are notable. Both include the bridging of service sectors. The first bridging is established in the creative blending of MediCal (EPSDT) funds and First 5 funds to support mental health services in their county. A second bridging of systems occurs with the establishment of therapeutic nursery school services. In this case, First 5 of Contra Costa, together with the mental health service sector and the childcare service sector, are connecting in support of specialized services for very young children. There has been much discussion about the merits of both therapeutic daycare and preschool programs for San Diego. Contra Costa County's efforts may provide a useful model for a similar development here.

**Riverside County** has an extensive array of behavioral health services. An Early Intervention Program targets services to children with severe emotional and behavioral problems and their families in order to maintain

placement in the least restrictive environment (childcare, home and preschool). For those children unable to maintain placement in the least restrictive setting, the Early Intervention Program provides a structured, therapeutic preschool / kindergarten setting so those children may experience success in an educational setting and transition to a regular school.

Riverside First 5 supports a "Parents as Teachers" (PAT) Program as an addition to their existing Foster Care and Kinship Care Program. The focus is to enrich and stimulate the child's emotional, physical and intellectual environment while facilitating the child's attachment to the primary caregiver. This approach is designed to overcome deficiencies and delays in the child's development caused by abuse, abandonment and neglect, and initiated their entry into the foster care system.

Riverside First 5 also supports three School Readiness Sites, each promote social and emotional competencies; one has established a mental health clinic on campus.

**Sacramento County** has an example therapeutic preschool day rehabilitation classes at the River Oak Center for Children. Sacramento First 5 is also funding a capital improvement project for the renovation of a facility that will serve as a crisis nursery. Services include 24-hour residential continuous care services for children, from birth to age five, on a short-term (24 hours to four days) or long-term (up to 30 days) basis, depending on the individual needs of the family. And finally,

Sacramento First 5 also funds one FTE psychologist to provide clinical consultation to other clinicians working in the field, to provide community trainings on early childhood social/emotional development, and support the development of 0-5 specialized programs. The position is contracted through University of California, Davis, Department of Psychiatry.

**Los Angeles County** has developed multiple programs that specifically address mental health concerns of children 0-5 and their families.

The Early ESTEEM project provides:

- ◆ Workshops and consultation to child care providers about mental health symptoms of children 0-5.
- ◆ Mental health assessments, individual play therapy, family therapy and parent-child video treatment.
- ◆ Consultation to parents and childcare providers of children 0-5 having difficulty adjusting to childcare and/or exhibiting mental health symptoms.
- ◆ Mental health services are included as part of a mobile multidisciplinary team.

The Building Blocks: Early Intervention program focuses on providing mental health services to 11 Los Angeles Unified School District Early Education Centers. Service delivery focuses on providing increased mental health access and services to children whose behavior and emotional problems places them at risk for future problems and school failure. Mental Health services occur either on-site at the Early

Education Centers or are Clinic based and include:

- ◆ Assessment screening
- ◆ Behavior management
- ◆ Referral to other clinic based services

The Interagency Special Needs Health Resource Collaborative (SNHRC), which includes Children's Hospital Los Angeles, the Los Angeles County Department of Mental Health, the Family Resource Center/Network of Los Angeles County and the Los Angeles Unified School District (LAUSD) has designed a program to increase and improve services and school readiness for children with special health care needs in 20 LAUSD Children's Centers. Services are developed through: interdisciplinary assessments, integrated service delivery plans, consultation, training and support to match child, parent and provider needs. Culturally and linguistically diverse materials will be developed/collected and disseminated for parents and providers. Goals of the program include:

- ◆ Increased health and mental health education for families of all young children in the targeted child care centers.
- ◆ Increased integrated physical and mental health services and family consultation, training and support for children with special physical health, nutrition and mental health needs in child care.
- ◆ Improved level of health and mental health training, education and supports for 290 children care providers in the 20 targeted Centers.

## National Designs in Early Childhood Mental Health Services

National trends are moving toward the development of early childhood mental health systems that address the continuum of services from promotion to treatment. This effort is being led by the Georgetown University Child Development Center's (GUCDC), National Technical Assistance Center, which set about an ambitious project surveying multiple states regarding efforts to establish early childhood mental health services. The Center offers technical assistance and guidance to states attempting to develop their own mental health programs. The GUCDC has developed a "tool kit" as a means to guide the strategic planning process.

**Maryland:** In order to assess the mental health needs of children 0-5, Maryland set up 5 community stakeholder meetings throughout the state to obtain feedback and recommendations for a strategic plan. As part of the pilot project, Maryland adopted universal testing of children entering Kindergarten. The testing assesses 7 different domains of functioning; one is called Personal/social. According to Deborah Perry, Ph.D., from Georgetown University Child Development Center, (who provided technical assistance for the pilot project), preliminary results indicate that about 35% of the children were not yet ready to enter Kindergarten based on the scores on the personal/social scale.

This finding is consistent with other research projects (Knitzer and Halfon), which also indicate that approximately 1/3 of young children are not yet emotionally, socially ready to enter

school. Maryland still hasn't gone past the assessment stage at this point. Some regional referrals do go to the Reginald S. Lourie Center for Infants and Young Children, located in Montgomery County, Maryland for treatment. The Lourie Center offers a broad range of services for at-risk children 0-5 and their families designed to help them acquire the emotional stability and social skills needed for success in school. The array of services includes a therapeutic daycare and preschool facility, an outpatient clinic, a research and training component, and a "Fussy Baby" Program among other programs. The therapeutic nursery has been set up with ability to videotape and/or use a one-way mirror for research and training purposes.

**Vermont:** Vermont is considered to have the most established statewide mental health service system for young children, 0-5 and serves as a national model for behavioral health care system design. The Vermont program, entitled Children's Upstream Project, or CUPS, now receives funding from the federal Children's Mental Health Services Program and from SAMSHA. The model has a set of shared standards across the network system. The network is comprised of a partnership between mental health, substance abuse services, domestic violence services, and public health agencies.

The Vermont early childhood mental health system is designed with enough flexibility so that services can be established according to the unique needs of each community. Mental health

consultation is provided as needed to childcare providers, Head Starts, and preschool programs. A home-visiting program has been established for all newborn infants. Some communities have mental health providers stationed in pediatrician's offices. Wrap-around services are provided to children identified with significant emotional problems. Vermont has established a statewide task force to address sustainability and blended funding issues. This task force has funded a consortium of colleges and universities to provide training on early childhood mental health to providers and families.

**Florida:** Like other states, Florida engaged in a statewide strategic

planning process for early childhood mental health service. As a result of that effort, three pilot projects have been funded to provide infant and toddler mental health services that include prevention efforts to support responsive parenting, as well as specialized treatment for young children with severe emotional problems. Perhaps the most extraordinary aspect of the Florida system is the level of involvement of the legislature, which updated the Medicaid standards to include relationship-based therapy and services for children 0-5. A cross-walk was developed between the DSM-IV (1994) and the Diagnostic Classification for children aged 0-3 (DC 0-3, 1994) as part of the guidance standards.

## BEHAVIORAL HEALTH SERVICES IN SAN DIEGO COUNTY

This section of the study is comprised of three components. The first section is an overview of behavioral health services for children 0-5 in San Diego County. The second component contains a review of local planning efforts regarding early childhood behavioral health services. The third component includes a matrix that was developed as part of the mapping of early childhood behavioral health services in San Diego. The matrix itself and can be found as an addendum to this report.

### A. OVERVIEW

The most recent data from SANDAG (Profiles, 2000) estimates that there are 198,621 children under the age of 5 in San Diego County. A breakdown by selected cities indicates:

City	Children 0-4	% total population	# in nursery/preschool
Escondido	11,712	8.8	2,155
Oceanside	12,194	7.6	2,557
Vista	7,726	8.6	1,540
Poway	2,895	6.0	956
San Diego	82,523	6.7	19,769
El Cajon	7,752	8.2	1,641
National City	4,410	8.1	720
Chula Vista	13,565	7.8	2,920

The major sectors that provide services to children 0-5 include the Health and Human Services Agency and HHSA contracted programs, the San Diego Regional Center for the Developmentally Disabled and affiliate programs, Head Start and Early Head Starts, and Early Care and Educational Services. With some sectors, services are fully directed to providing behavioral

health care (e.g. Children's Mental Health), while with others, behavioral health is one of a number of services offered (e.g. Early Care and Education).

Of the 16,593 unduplicated children served by Children's Mental Health Services, 10.3% or 1709 were children under the age of 6 (CMHS Fact Sheet FY03-4). The vast majority of these

children were seen in Outpatient Clinic settings. There are several providers that utilize Early and Periodic Screening, Diagnosis, and Treatment (EPSDT-MediCal) funding to provide treatment for the 0-5 population, but the number is relatively small suggesting that this service opportunity is currently underutilized. Recently, EPSDT funding has been extended to Therapeutic Foster Care agencies in San Diego to provide mental health services to the children in the dependency system, including those children in the 0-5 age group, but it is unclear at this time how this might impact the total numbers served. Ensuring adequate treatment services for children in the dependency system remains an area of great concern to many stakeholders throughout the county.

### **San Diego Regional Center / Early Start**

San Diego Regional Center for the Developmentally Disabled is one of 21 centers across the state serving persons with developmental disabilities. Regional Center services are defined by the Lanterman Act and there are four qualifying conditions: mental retardation, epilepsy, cerebral palsy, or autism. A variety of services are available in the areas of health, welfare and education. Behavioral health, although a relatively small component of the service continuum, is still considered to be an important area of focus for the families served. Early Start is a federally funded program serving infants and toddlers (0-3) and their families. Data indicates that there are 1666 children 0-3 currently receiving services in the Early Start Program. Of that group of children, approximately 25% move into the Regional Center service continuum when they turn age 3. It is perhaps important to know that California Early

Start and the Regional Centers have differing qualifying criteria, and this in part, may contribute to the appearance that the number of children moving from one program to the other seems to be low.

### **Head Start and Early Head Start**

Head Start and Early Head Start Programs are federally funded programs that provide early care and educational services to children 0-3 and 3-5. Eligibility is based on age and income guidelines.

There are three contracted Head Start/Early Head Start providers in San Diego County: The MAAC Project; Episcopal Community Services, and Neighborhood House. While social, emotional, and behavioral health issues are important concerns of the Head Start Programs, it is in the Early Head Start programs where services that specifically focus on social and emotional competencies have been more commonly established.

The MAAC Project serves 997 children, 3-5, in their Head Start programs and 187 children, prenatally to 3, in their Early Head Start programs. Services occur mainly in the North Coastal and North Inland regions. The program offers twice a week parenting groups similar to “Mommy and Me” programs and also provides home visits twice a month. Parenting skills and the importance of the parent-child attachment bond are emphasized. The programs have Mental Health Consultants, and Family Development Specialists who deal with issues of challenging behavior and family stress.

Episcopal Community Services provides services mainly in the South Bay area. A unique aspect of their programs is the

bridging of services through a link with Para las Familias, and EPSDT provider that exclusively works with children under the age of 6.

Neighborhood House works with over 10,000 children in its Head Start and Early Head Start Programs. Services are located throughout San Diego. Neighborhood House has 500 children enrolled in ten Early Head Start programs making it one of the largest providers in the state. One of the Early Head Start Programs is located in Polinsky Children's Center. Neighborhood House Head Start and Early Head Start programs currently utilize a model that centers around the development of Family Partnership Agreements with families that identify and address social and emotional competencies. Teachers integrate identified components into the child's classroom experience, and where necessary, make referrals to the community for intensive treatment needs. Neighborhood House will be enhancing their Early Head Start programs in the near future with the incorporation of Desired Results curriculum.

### **First 5 Commission of San Diego**

Over the past few years, First 5 of San Diego has become an important contributor to behavioral healthcare services locally, developing another service sector in its own right. As with

other funding silos, First 5 has its own mandate and unique characteristics. By strategically complimenting, not supplanting other funding streams, service gaps are being addressed, and much needed expansion of the service continuum has begun. Services are focused between 18 months through age 5. Funding is not seen as a long-term source, rather as a means to establish needed services and programs with ongoing sustainability developed from other resources. There is a flexibility, or fluidity to the funding not seen in the other silos (e.g. services open to all children in San Diego), allowing for bridging of service sectors and the development of an eclectic array of services promoting social and emotional well-being including: early care and education consultation and treatment services, home and center based therapies, parent education programs, development of print materials, newscasts, and other promotional services, and a referral information telephone line for parents.

Partnerships have been developed with Hospitals, School Districts, community based organizations, and Universities among others in the community. With First 6 leadership and vision, there is an opportunity to develop a system of care that begins to integrate and coordinate services across the spectrum from promotion through intervention, as well as between behavioral health services and allied health service providers.

## B. LOCAL PLANNING AND COORDINATION EFFORTS

**The San Diego Commission on Children, Youth, and Families**, Early Comprehensive Educational Support Committee (ECES) completed a community based, collaborative process resulting in the development a concept paper advocating for the establishment of the “Young Child Institute: San Diego’s Hub for Social Emotional Development and School Readiness” (September, 2003). Advocacy for a comprehensive, interdisciplinary “hub” for social and emotional well-being developed in response to the lack of formal coordination, integration, and linkage between behavioral health service providers in San Diego. The major objectives of the Young Child Institute would be to:

- ◆ Promote the optimal mental health and development of infants and young children in San Diego County.
- ◆ Provide education and training in mental health clinical intervention and issues related to social and emotional well-being in collaboration with institutions of higher education.
- ◆ Provide research regarding best practices, attachment and early childhood disorders, impact of parental depression, family violence and other risk factors.
- ◆ Provide advocacy and address policy issues on county, state, and federal levels.
- ◆ Develop a comprehensive resource and referral network for early childhood mental health services.

- ◆ Provide direct services including: needs assessment and referral, outpatient clinic services, therapeutic preschool, consultation and supervision services.

### **First 5 Commission of San Diego - Strategic Planning Process**

**Stakeholder Meeting**. The First Commission conducted a Behavioral Health Strategic Planning meeting in December 2002 utilizing the Early Childhood Mental Health Committee to bring stakeholders together to discuss and provide recommendations for early childhood mental health services in San Diego. Information from the meeting was integrated into the Strategic Plan, 2003-2006.

Two primary recommendations came forward from the stakeholders:

1. Ensure that behavioral health services are linked and coordinated.
2. Train providers about identifying and addressing behavioral issues.
  - Train child care providers (formal and informal) about caring for children with severe behavior problems
  - Train mental health providers about attachment and bonding issues
  - Train medical provides and residents about how to identify early behavioral health issues

**Early Childhood Mental Health Committee** (ECMH). The Early

Childhood Mental Health Committee has been meeting on a regular basis for over two years. It developed out of a growing desire by stakeholders across disciplines, agencies (both public and private) and service sectors, to address the needs of early childhood mental health in a collaborative, coordinated way. The ECMH Committee is committed to the promotion of the social, emotional, and behavioral competencies of young children in San Diego. The ECMH Committee has been utilized as a forum to deliberate and advocate for advancement of early childhood mental health services over the past two years in several ways:

- ◆ The Committee was involved with bringing Penny Knapp, M.D. from the State Department of Mental Health and Sheila Wolfe from WestEd to discuss the

possible participation of San Diego County in the Infant, Preschool, and Family Mental Health Initiative.

- ◆ The First 5 Commission of San Diego utilized the ECMH Committee as a venue to host a community conversation during its strategic planning process to obtain community feedback regarding the behavioral health needs in San Diego County.
- ◆ And finally, the ECMH Committee was involved in co-sponsoring a presentation by Bruce Perry, Ph.D., M.D., as part of a strategic planning meeting to discuss and develop the “Young Child Institute” as conceptualized by the San Diego Commission on Children, Youth, and Families.

## C. MATRIX OF BEHAVIORAL HEALTH SERVICES IN SAN DIEGO

A matrix of the various behavioral health services for children 0-5 by geographic region was completed as part of this study. The 6 regions were delineated by Health and Human Services Agency guidelines and include:

1. **North Coastal:** Carlsbad, Oceanside, Rancho Santa Fe, Encinitas
2. **North Inland:** Escondido, Julian, San Marcos, Fallbrook
3. **North Central:** La Jolla, Linda Vista, Mira Mesa, Miramar, Tierrasanta.
4. **Central:** Downtown, Encanto, College Grove, Paradise Hills.
5. **South:** Chula Vista, San Ysidro, Coronado, Imperial Beach.
6. **East:** El Cajon, Alpine, Campo, Spring Valley.

\*Note: the list of cities in each region is not an inclusive list

### **Behavioral health services were segregated within the matrix into the following categories:**

**Promotional services** - defined as those services that inform, and educate the community at large regarding behavioral health issues, social and emotional well-being, or mental health of younger children. As noted in the mapping results, there are very few examples of services that fit into this category.

**Prevention** – generally defined as those services that are designed to provide in depth knowledge and support, particularly to high risk groups (pregnant teens, families experiencing substance abuse, or domestic violence, and with

those parents with mental health concerns such as maternal depression) and would include home visitation programs, mental health consultation in daycare, preschool and other settings, caregiver supports, family supports, and the development of social skills curricula.

**Early Intervention** – includes such services as on-site consultation, developmental assessments or use of screening tools for maternal depression.

**Treatment** - involves the provision of a direct clinical intervention service such as relationship-based therapy, Parent Child Interaction Therapy (PCIT), or Parent-Infant Psychotherapy.

## FINDINGS

Through various formal and informal stakeholders meetings, in addition to a review and analysis of various state and national design efforts, the following findings regarding behavioral health services in San Diego for children 0-5 were developed. The principal method of obtaining stakeholder feedback was to utilize the ECMH Committee as a platform for discussion and deliberation. The ECMH Committee brought together members from other Committees that had similar goal of advancing a collaborative system of care for behavioral health services in San Diego. Participants included CoCoSer Social and Emotional Cluster, the San Diego Children Youth and Family Commission- Early and Comprehensive Educational Support Committee (ECES), Earliest Relationships Network, representatives from the Regional Center, County Mental Health, and multiple community-based organizations.

### **Finding 1: Social and Emotional well-being is linked to school readiness, later school success, and success in life.**

A secure attachment and social and emotional competencies establish the foundation for learning. It is important to find ways to address social and emotional competencies early enough to adequately prepare children to be ready to enter school and optimize their educational experience. In light of this understanding, in order to facilitate school readiness, it is important to: Strengthen family bonds and support opportunities to develop more secure attachments and nurturing parent-child relationships; Improve childcare by promoting social and emotional competencies and by strengthening the training and awareness of early care and education providers; Support the transition to kindergarten; Attend to the needs of vulnerable children who come from homes that experience such concerns as domestic violence, drug and alcohol problems and other at-risk backgrounds; Provide treatment services for disrupted attachments, or insecure/disorganized attachments and other social and/or emotional problems before entering school.

**Finding 2: There is no lead agency, organization, or entity that serves to directly link, coordinate, and advance behavioral health services for children 0-5 and their families in San Diego County.**

Behavioral health services in San Diego have not yet been organized into a system of care for children 0-5 and their families. There are only informal linkages established between service providers and often awareness of available behavioral health services is limited. There is little coordination within the behavioral health service sector, and little coordination between service sectors (e.g. physical health care providers). What is missing in the design is a core entity that would serve as a “hub” to organize and galvanize the system. Without such an entity, opportunities will continue to be missed, the system will remain fragmented, and the service continuum underdeveloped.

Additionally, there is no centralized resource and referral base for families, mental health professionals, and allied health professionals to consistently rely upon. Stakeholders have placed a high value on developing a coordinated and integrated system of care for children 0-5 and their families.

**Finding 3: There is a lack of qualified clinicians who have the specialized training to provide early childhood mental health services.**

Early childhood behavioral health service is a relatively new field and consequently there are few clinicians who have, as of yet, specialized in this area of treatment. Treatment is primarily relationship based since very young children do not have the ability to formulate and articulate thoughts and verbally identify feelings. The attachment relationship is the natural medium for a young child to learn how to regulate emotions and physiological states. Approaching treatment from a relational perspective preserves and strengthens family attachment bonds and increases the family’s emotional literacy so that they can support children’s readiness for school. Supporting the parent’s own social and emotional competencies allows the parent to then support their child’s social and emotional development.

Stakeholders have consistently listed training as a top priority. It is needed to not only increase the competency of providers, but to expand the provider base as well. Local Universities have not yet begun to establish curricula in the area of infant mental health, nor are there any local training Institutes with this specialty. There is need to weave the most recent research findings into a variety of settings – from childcare programs to parent education, to various professionals both in mental health as well as in primary care.

**Finding 4: There is a lack of behavioral health service availability for children 0-5 in San Diego County throughout the spectrum of care from promotion, to prevention, and most critically, treatment services.**

Families, mental health practitioners, and allied health professionals alike have expressed concern that there are not adequate resources available to meet the need for behavioral health services for children 0-5 and their families in San Diego. In a review of services across the region, it has been noted that promotional efforts are almost non-existent across the county. Screening and assessments do not always focus on social and emotional competencies and subsequently attention to emotional development often takes a back seat to other areas including physical and cognitive development. Increasing numbers of clinicians and allied health professionals are recognizing the importance of including social and emotional competencies as part of general screening and assessment tools, however there is not consistency among providers regarding which tools to use. Treatment services have been expanding with the advent of First 5 funding but all regions are experiencing shortages of qualified mental health professionals. Relationship based treatment is highly valued and understood to be developmentally appropriate.

**Finding 5: Stakeholders place a high value on services that are culturally competent, family centered, and community based.**

Cultural and linguistic competency standards include not only bilingual service providers in the threshold languages, but providers that are bicultural as well. This is considered to be an important criteria of any service delivery system in San Diego, but especially so when working with families around sensitive issues of parenting practices, values, and norms. Parents are partners in treatment. Resource materials should be in threshold languages, and any results of assessments and treatment planning should be in the language preferred by the family. It is critical that treatment professionals be able to work with the parent/child dyad, not the child in isolation so that the parent is provided with the tools needed to establish secure attachment bonds and promote optimal social and emotional well-being. It is important to support the parent, so that they in turn can provide for their children. Stakeholders value family centered community based services that seek to preserve and enhance the primary attachment and family, and community relationships

**Finding 6: Services need to be responsive to high-risk populations that can be highly transient at times.**

Nationally, the number of children entering foster care in the birth to 5 age range has risen over 110% in the past decade as compared to a 50% increase for other age groups (NCCP, 2001). Penny Knapp, M.D., from the Department of Mental Health reported that in California, over 50% of the children in out-of-home care (e.g. foster care) are 4 and under, and now this age group represents the largest segment of the population in out of home care. Further, children under the age of two tend to stay in out-of-home placements twice as long as other children in foster care (NCCP, 2001). Locally we find that over 60% of the children entering Polinsky Children's Center are demonstrating developmental delays.

Rates of behavioral health problems for at-risk populations (e.g. children in the foster care population) can be up to be 2-3x higher than for other children (Raver and Knitzer, 2002). Foster parents have long expressed the concern that there are not adequate behavioral health services set-up in communities to address the special needs of the children they care for. Abuse studies indicate that if a child doesn't experience emotional attachments and positive peer interactions early in life, that their brain development, both of caring behaviors toward others and their cognitive capacities, is damaged in a lasting fashion (Perry, 2002). When children go through these traumatic experiences, especially very young children, they need intensive treatment to heal. It is the foster parents who are the primary therapeutic agents. It is within the context of an ongoing caring relationship that disrupted attachments, and compromises to social and emotional competencies are worked through and resolved. Without adequate training and support, however, the foster parents work is that much harder and the child is at –risk for yet another change in placement.

**Finding 7: There is need for the development of guidelines for treatment and standards of behavioral health care in order to optimize the service delivery system and it's connection to school readiness.**

In order to advance the system of care and begin to integrate services across sectors, baseline standards for social and emotional competencies will need to be established. This is a complex issue that crosses various service sectors and as such, will take time and extensive, collaborative effort to complete. There are useful models that can be as referenced such as the California Department of Education, Desired Results for Children and Families, or the Maternal and Child Health Bureau's State Early Childhood Comprehensive Systems (SECCS) Initiative. With the development of a core group of competencies, it will be possible to create a unified strategic plan of comprehensive early childhood services.

## RECOMMENDATIONS

The following recommendations for behavioral health services for children 0-5 in San Diego County were developed after careful consideration of feedback from the various stakeholders meetings, from families, and conversations with experts in the field of early childhood mental health.

1. **Increase public awareness about the critical nature of the earliest years of life and promote public policy that acknowledges the importance of early social and emotional development and the primacy of attachment relationships. Identify, integrate and standardize social and emotional competencies in all sectors of early childhood care including health, mental health, and cognitive development with the overarching goal of preparing children to be ready to enter school, and ready to succeed.**
  
2. **Ensure that existing behavioral health services for younger children, 0-5, are coordinated and integrated into a formal behavioral health system of care by supporting the establishment of a local resource center such as the Commission on Children, Youth, and Families' Young Child Institute. The Young Child Institute would provide the leadership to link, integrate, coordinate, and advance behavioral health services in San Diego. Potential objectives of the Young Child Institute would be to:**
  - a. **Build a formal collaborative network for behavioral health services for children 0-5 utilizing existing community resources of early childhood programs, services, and providers.**
  - b. **Coordinate training/educational services to the community.**
  - c. **Provide consultation, technical and programmatic support to service providers including child care centers, family daycare providers, Head Start / Early Head Start, to clinicians and allied health professionals regarding social and emotional competencies and the importance of secure attachment bonds. Establish a "warm line" for consultation and supervision.**
  - d. **Develop a centralized resource and referral base to improve the organization and accessibility to services. The development of a Website is also recommended featuring important links, relevant articles regarding social and emotional competencies for providers and families alike, and to provide resource information to the community.**

- e. **Develop a data coordination center for early childhood behavioral health services to evaluate outcomes and effectiveness of services.**
  - f. **Pursue funding opportunities to sustain services over the long-term.**
- 3. Improve professional development opportunities to raise the competencies of those currently working with younger children, as well as to increase the overall number of qualified professionals available to provide service to the community. Potential areas of training:**
- a. **Promoting attachment relationships and social and emotional competencies.**
  - b. **Relationship based treatment modalities.**
  - c. **Curriculum development for childcare providers regarding social emotional competencies.**
  - d. **Specialized training geared toward foster parents and other caregivers of infants, toddlers, and preschool children at-risk for compromised emotional development and disrupted attachments.**
  - e. **Develop cross-training/ interdisciplinary trainings between service sectors to promote integration of services.**
  - f. **Expand educational opportunities for families that emphasize the importance of secure attachment relationships and social and emotional competencies. Use Community Educators to raise the general awareness of stakeholders in the community.**
- 4. Expand the continuum of services– from promotion, to prevention and intervention to more adequately address service gaps in the system and the service needs of children 0-5.**
- a. **Support prevention and treatment services for high-risk populations and expand the competencies of non-familial caregivers.**
  - b. **Increase promotional efforts throughout the county that focus on social and emotional competencies and the importance of a secure attachment/bond.**
  - c. **Increase relationship-based treatments that serve to preserve, strengthen and enhance attachment and optimize social and emotional competencies.**
  - d. **Support treatment services for children 0-18 months and their parents at-risk for disrupted attachment relationships.**
  - e. **Support the development of Community Centers of Service, which are responsive to the unique needs of the families they serve.**
  - f. **Capitalize on State First 5 and other Initiatives to maximize funding opportunities for San Diego.**

5. **Ensure that the service delivery system is culturally competent, family centered, and community based.**
  - a. **Competency includes not only bilingual service providers that are proficient in the threshold languages, but providers that are bicultural as well.**
  - b. **Ensure that resource and promotional materials, assessments, treatment plans are written in family's language so that parents can be active participants in treatment.**
  - c. **Develop respectful practices when working with families around issues of parenting, family values, and norms.**
  - d. **Provide services that are family centered and strength based to diminish the stigma associated with mental health. Support services that preserve family and community relationships.**
  - e. **Capitalize on existing community-based services, which have established trusting, supportive relationships within their respective communities.**
  - f. **Build platforms of early childhood services at local community centers to help families reduce barriers to care.**
  
6. **Develop guidelines for treatment and standards of behavioral health care for children 0-5 in order to optimize the service delivery system and it's connection to school readiness. Promote partnerships between human service agencies, mental health, early care and education, and school readiness sites to address this complex issue in order to:**
  - a. **Develop baseline competencies for social and emotional development for use across sectors such as early care and education, medical care, mental health, parent education, Head Start/Early Head Start and other settings.**
  - b. **Make recommendations regarding Assessment / Screening instruments that more adequately address social and emotional competencies, including attachment relationships and the cross-walk between DSM IV-TR and DC 0-3.**
  - c. **Recommend effective practices, outcomes and desired results for early childhood behavioral health care.**
  
7. **Support the establishment of an interagency, multidisciplinary council that would:**
  - a. **Identify policy and process changes to improve coordination, linkage, and accessibility of mental health, health and developmental services for children 0-5. Develop a plan to coordinate potential funding opportunities, linking with such collaborative efforts as the Special Needs Project, SB 1703, and Child Welfare Reform.**

- b. Review and analyze the Maternal Child Health Board State Early Childhood Comprehensive Systems Initiative or other such initiatives that move toward building comprehensive, integrated systems of care inclusive of health, behavioral health, and cognitive development.**
- c. Develop guidelines for bridging systems and make recommendations for linking, coordinating and advancing such a system design. Develop core competencies of a comprehensive system of care for children 0-5 and their families, which would unify under the overarching goal of school readiness.**
- d. Develop a matrix of agency responsibilities, eligibility requirements, and coverage for mental health and developmental services.**
- e. Ensure that underserved children, and those that fall into the gaps between traditional service sectors, are identified and provide care (those that are at-risk for, or with emerging mental, behavioral, or developmental problems).**

## APPENDIX I – Survey Instrument for Providers

**Behavioral Health Planning and Coordination Study**  
**First 5 Commission of San Diego**  
**Christopher Walsh – Mental Health Consultant**  
<mailto:cwalsh2@san.rr.com>

**Thank you for taking the time to complete this survey. You will be providing valuable information regarding behavioral health services for children age birth to five in San Diego. One purpose of the survey is to identify and map behavioral health services, programs, resources and other assets in each of the 6 geographic areas of San Diego (North Coastal, North Inland, North Central, Central, East, South). Services will be categorized into three areas: Promotion, Prevention, and Intervention. Some of the programs and/or services may fall into more than one category. The survey will also be used as a means to identify service gaps, needs, and priorities in each region. And finally, the survey will be used to establish a central database with the goal of linking, coordinating, and developing a network or system of care for children birth to 5 and their families.**

**Please forward this survey to any stakeholder that you believe may be interested in providing feedback.**

**Below, I have listed some of the objectives of the Behavioral Health Planning and Coordination Study. Please feel free to contact me should you have questions or additional input. Again, thank you for your time.**

### **OBJECTIVES:**

- Review and summarize current research early childhood behavioral health issues as they relate to support school readiness.
- Review and summarize best practices of local, state and national agencies including other local First 5 Commissions.
- Identify and collaborate with local groups and agencies within the county that provide early childhood mental health services.
- Conduct community conversations with behavioral health stakeholders discussing best practices, needs, assets and coordination opportunities in each county region.
- Building on current planning efforts, prepare a countywide plan for each county region to improve behavioral health services for children 0-5 prioritizing needs, results, solutions and indications of change.
- Recommend long term priorities and next steps for Commission funding, advocacy, and collaboration

**Behavioral Health Planning and Coordination Study: Early Childhood Behavioral Health Survey for children, birth to five.**

1. What is the name of your agency and in what geographic region(s) are services provided?
2. Would you please provide a brief description of the services your program provides related to early childhood mental health (behavioral health, social emotional well-being)?
3. What is the population served (e.g., 0-3 only, or birth to five, demographic data, etc), How many children are served by the program(s) annually?
4. What assessment/screening tools do you use?
5. What treatment approach does the program utilize?
6. Who qualifies for services?
7. How is the program funded?
8. Does your program collaborate with other programs, and/or with allied health professionals?
9. From your perspective, what are some of the barriers to providing early childhood behavioral health services?
10. Have you noted any service gaps in your geographic area related to early childhood behavioral health?
11. From your perspective, what are the top priorities in your geographic region for developing early childhood behavioral health services?
12. What kind of organized system of care would you recommend for early childhood mental health services. Could you prioritize the three top needs of such a system?
13. Additional Comments:

## APPENDIX II – List of Stakeholders / Stakeholder meetings / Experts

Alfredo Aguirre, Director, Children’s Mental Health  
Andrea Muratet, Spring Valley Family Resource Center  
Barbara Mitchell, Ph.D, Therapeutic Services, Inc.  
Barrie Owens, KIT and San Diego County Childcare and Development Planning Council  
Betsy Jones, Director Escondido Community Children Development Center  
Carlos Flores, Assistant Director, San Diego Regional Center  
Carmello E. Salas, Neighborhood House, Head Start  
Catherine Dickenson, Children’s Care Connection  
Claire Hawood, Poway Unified School District  
Desiree Flores, Logan Heights Family Resource Center  
Diane Storman, Exceptional Family Resource Center  
Dominic Barragan, Episcopal Community Services  
Henry Tarke, Assistant Deputy Director, Children’s Mental Health  
Helen Hayden-Wade, Ph.D., Children’s Care Connection, CASRC  
Gail Coonce, San Diego City Schools: Infant Toddler Program  
Heather Grant, Parenting Link  
Ida Cross, Chicano Federation  
Jan Gallo, Hope Infant Family Support Program  
Jan Jacobsen, Therapeutic Services, Inc.  
Jeanne Gordon, Developmental Screening and Enhancement Project  
Jill Weckerly, Ph.D., CASRC, Mental Health Resource Center-San Diego City Schools  
Joan Reese, M.D., San Diego Regional Center  
Judy Anderson, Hope Infant Family Support Program  
Julie Becker, Ph.D., Harmonium  
Kristin Gist, Ph.D., Director, Developmental Services, Children’s Hospital  
Lily Cosico-Berge, Ph.D., Children’s Care Connection  
Mark Chenven, M.D., Medical Director, Vista Hill  
Marty Giffin, Ph.D, Therapeutic Services, Inc.  
Maxine Willey, YMCA - Childcare Resource Service  
Molly Coughlin, R.N, San Diego City Schools - Allcott Infant Toddler Program  
Nancy Cohen, Children’ Care Connection  
Nancy Deutsch, San Diego City Schools - Allcott Infant Toddler Program  
Nick Montano, M.F.T., Clinical Director, Para las Familias  
Nina Garrett, L.C.S.W., California Early Start  
Patti Shields, L.C.S.W., YMCA - Childcare Resource Service  
Phyllis Tyson, Ph.D., Professor, UCSD Department of Psychiatry  
Richard Stowell, L.C.S.W, Palomar Family Counseling Services  
Roseann Myers, Executive Director, San Diego Commission on Children, Youth, and Families.  
Ruth Newton, Ph.D., St Vincent de Paul, UCSD Department of Psychiatry  
Sherry Hartwell, M.F.T., Earliest Relationships Network  
Sylvia Selverston, L.C.S.W., SAY San Diego and San Diego County Childcare and Development Planning Council  
Tamara Crittenden, San Diego Regional Center  
Tresa Ganger, North Park S.E.E.D.S – Family Resource Center  
Wai-Ling Rubic, Neighborhood House, Polinsky Children’s Center Head Start

## **Stakeholder Meetings**

**Early Childhood Mental Health Committee**

**CoCoSer Social and Emotional Cluster**

**The San Diego Children Youth and Family Commission- Early and Comprehensive Educational Support Committee (ECES)**

**Earliest Relationships Network**

**American Association of Pediatricians**

In addition to the local stakeholders listed above, consultations occurred with the following experts in the field of early childhood mental health.

**Bruce Perry, M.D., Ph.D.**, ChildTrauma Institute

**Deborah Perry, Ph.D.**, and **Roxanne Kauffman, M.S.** of the Georgetown University Child Development Center.

**Henry Tarke, L.C.S.W.**, Assistant Deputy Director, Health and Human Services Agency, Children's Mental Health

**Joan Reese, M.D.** –San Diego Regional Center for the Developmentally Disabled and the American Association of Pediatricians

**Mark Chenven, M.D.** – Medical Director, Vista Hill, and San Diego Academy of Child and Adolescent Psychiatry

**Penny Knapp, M.D.**, Medical Director, California State Department of Mental Health and Professor of Psychiatry and Pediatrics at University of California, Davis.

**Phyllis Tyson, Ph.D.**, Professor of Psychiatry, U.S.C.D. / Children's Outpatient Psychiatry

**Roseann Myers**, Executive Director, San Diego Commission on Children, Youth, and Families.

**Sheila Wolfe**, WestEd. Program Director of the Infant, Preschool, Family Mental Health Initiative.

**Shulamit Ritblatt, M.D.**, North Park Family Resource Center – S.E.E.D.S.

**Traceye Poisen, L.C.S.W.** Director of the Therapeutic Nursery Program at the Reginald S. Lourie Center for Infants and Young Children, Montgomery County, Maryland.

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