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# Transforming Systems for Parental Depression and Early Childhood Developmental Delays

Findings and Lessons Learned from the *Helping Families Raise Healthy Children* Initiative

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The research described in this report was prepared for the Community Care Behavioral Health Organization and was conducted within RAND Health, a division of the RAND Corporation.

**Library of Congress Control Number: 2012955401**

ISBN: 978-0-8330-7857-5

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Published 2013 by the RAND Corporation  
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## Summary

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### **The *Helping Families Raise Healthy Children* Initiative**

Depression affects millions of Americans each year and is much more likely to affect women. Among low-income and other underserved populations (e.g., minority women), the estimated prevalence rates for maternal depression ranges from 25 to 35 percent (Lanzi et al., 1999; Miranda and Green, 1999; Onunaku, 2005; Siefert et al., 2000). This is markedly higher than depression rates of the general population, which are around 12 percent for women (Narrow, 1998). Untreated maternal depression has potentially serious consequences for a woman's overall well-being, her functioning as a mother, the family's functioning, and her child's development (Onunaku, 2005; Field, 2000). Further, parental depression and the risk of childhood developmental problems often co-occur. Children of depressed parents experience more social and emotional problems than children whose mothers are not depressed, and these children may also experience delays or impairments in cognitive and linguistic development and social interactions. In addition, children of parents with chronic depression are more likely to develop long-term behavioral problems and are at greater risk of behavioral and emotional problems later in life, including depression, anxiety, and conduct disorders. In turn, a child's developmental delays can heighten parental stress, ultimately increasing the risk for parental depression and perpetuating a cycle that affects both parent and child.

Despite the close connection between parental depression and childhood developmental risks, the systems that treat these problems rarely intersect. Part C of the Federal Individuals with Disabilities Education Act (IDEA) provides for a federal grant program that assists states in operating comprehensive early intervention programs for children ages 0–3 with disabilities. Thus, the early intervention system for children at risk of developmental problems is likely to miss opportunities to screen parents for risk of depression—while, conversely, the maternal health care and behavioral health systems treating caregivers with depression are unlikely to identify child development issues that may be increasing family stress and contributing to caregiver depression.

To address this disconnect, a group of partners in the Pittsburgh area involved with the behavioral health, early intervention, and maternal and child health care systems undertook an effort to improve care for families facing the dual challenges of caregiver depression and early childhood developmental delays. This initiative—called *Helping Families Raise Healthy Children*—began in 2009 under the auspices of the Allegheny County Maternal and Child Health Care Collaborative, a broad-based community coalition that has been operating in Pennsylvania since 2002. The initiative's overarching goal was to build a sustainable cross-system infrastructure that improves local capacity to identify and engage families with care-

givers experiencing or at risk for depression and children at risk for developmental delays using relationship-based approaches.

To accomplish this goal, the initiative had three specific objectives:

- improve identification of families with primary caregivers at risk for or experiencing depression and infants/toddlers at risk for or experiencing developmental delays
- enhance access to support and services for these families through cross-system referrals for assessment or services in the Medicaid maternal and child health, behavioral health, and early intervention systems
- offer and support engagement in relationship-based services in the early intervention and behavioral health systems that address the needs of both caregivers and young children in the context of the parent-child relationship.

### **Key Stakeholder Groups**

To achieve the initiative's three aims, the Collaborative convened seven stakeholder groups to work together. These groups and their roles and responsibilities relate to the aims of the initiative as follows:

- Families at dual risk for depression and early childhood developmental delays were the target population of the initiative and provided advice during the planning and implementation phases on the initiative implementation protocols, strategies, and materials through a Family Advisory Council.
- Community Care Behavioral Health Organization (Community Care), which is the Medicaid behavioral health managed care organization (MCO), provided care management and ensured access to available resources and services for identified families in an effort to increase the likelihood that they would effectively engage in behavioral health treatment. Community Care provided the organizational and project leadership and facilitated the involvement of the behavioral health network of providers.
- The Alliance for Infants and Toddlers (The Alliance), which is the central intake and service coordination unit for families of children (birth to three years of age), screened and identified families at high risk for depression and took steps to link them to available supports, services, and treatments. The Alliance also educated and supported all service coordinators in a relationship-based approach to service coordination.
- Early intervention service provider organizations (birth to three years of age) provided in-home, relationship-based services for the child's developmental delays.
- Behavioral health provider organizations offered a range of well-established treatments meeting the needs and preferences of referred families with very young children. Community Care developed a network of behavioral health providers able to offer home-based mental health treatment services for families receiving Medicaid.
- Maternal and child health care providers and organizations in the community identified families at high risk for depression and referred them to The Alliance for screening and developmental assessment.
- State and local purchasers and policymakers supported practice and policy changes aimed at enhancing the ability of systems partners to carry out their agreed-upon roles.

Other organizations in the community also offered supports (such as funding, data collection and analysis, and access to requisite resources and services outside the maternal and child health care system) to contribute to successful and sustainable systems change.

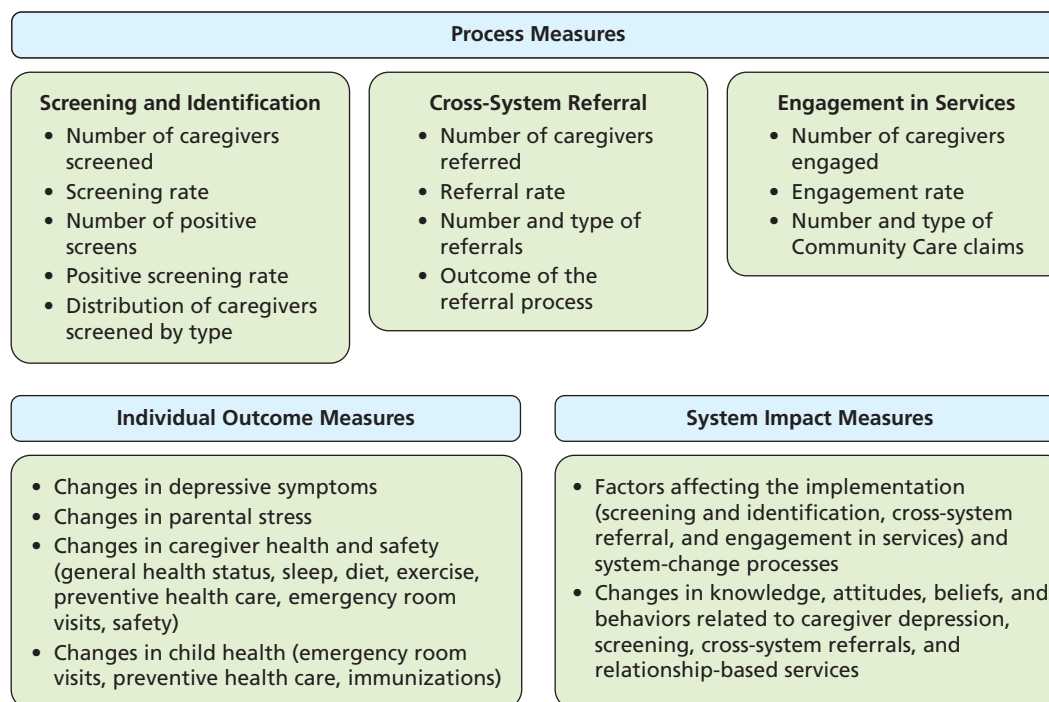
This report presents the results of the process, individual outcomes, and system impact measures; offers lessons drawn from a comprehensive evaluation of the program's impact; and concludes with recommendations for practice and policy change designed to expand and sustain the initiative's achievements.

## Evaluation Approach

To evaluate the initiative's success in accomplishing its goals, a team from RAND used a mixed-methods approach drawing on both quantitative and qualitative data using three types of measures: process, individual outcome, and system impact (Figure S.1).

Process measures helped determine the extent to which the initiative components were being implemented according to plan, thus providing vital information for potential real-time course corrections. Individual outcome measures indicated whether the implementation components (i.e., screening and identification, referral, and engagement in relationship-based services and treatment) were associated with decreases in depressive symptoms and parenting stress at the caregiver level and with improvements in caregiver and child health. System impact measures at the provider and system levels provided information on the factors affect-

**Figure S.1**  
Process, System Impact, and Outcome Measures



ing implementation and improvements in provider knowledge, attitudes, beliefs, and behaviors regarding caregiver depression, infant-caregiver attachment, and relationship-based care.

## Evaluation Results

### Implementation Process Results

The initiative’s implementation strategy was designed to achieve sustainable improvements in processes and outcomes by seeking to

- foster understanding of and response to families’ needs and preferences
- establish a cross-system collaborative network
- improve providers’ capacity to deliver relationship-based care
- establish cross-system practices and policies for these efforts.

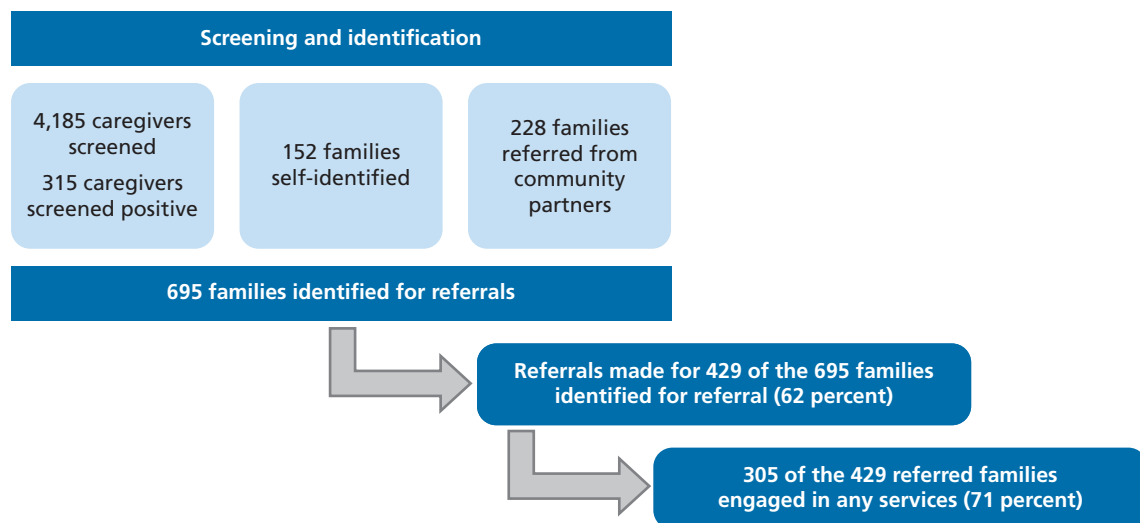
To support these aims, the initiative implemented processes for screening and identifying at-risk families, providing referrals, and supporting engagement in services (Figure S.2).

### Screening and Identification

Screening and identification occurred through three pathways:

1. a depression screening process for caregivers involved with early intervention services at The Alliance
2. self-identification by families at The Alliance who did not complete the depression screen or screened negative
3. community partners who recognized families as experiencing or being at risk of depression and referred them to The Alliance.

**Figure S.2**  
**Key Components of the Initiative**





During the 28-month data collection period, service coordinators at The Alliance completed 4,185 depression screens. The overall screening rate for families new to The Alliance was 63 percent, which compares favorably with rates found in descriptive, intervention, and quality improvement studies. Among those screened, 315 caregivers screened positive and were thus identified for the referral component of the initiative. A total of 152 families who did not complete a screening for depression or screened negative self-identified a need for assistance with caregiver depression, and a total of 228 families were identified by community partners as being at risk of caregiver depression and referred to The Alliance for family-centered care, even though their children had not been identified as at risk for developmental delay.

### **Referral**

A total of 695 families were identified for referrals from the three pathways combined: 45 percent from the depression screening at The Alliance, 22 percent from self-identification, and 33 percent via referral from a community partner. Of these 695 families, 429 were referred for services and supports, representing a referral rate of 62 percent. Survey estimates of referral rates following a positive depression screen typically average around 52 percent, although these vary widely according to setting and available follow-up. The initiative's relatively high rate of referral suggests that its cross-system orientation and collaboration, training on referral processes, and additional program supports were effective in helping to ensure that appropriate referrals were made.

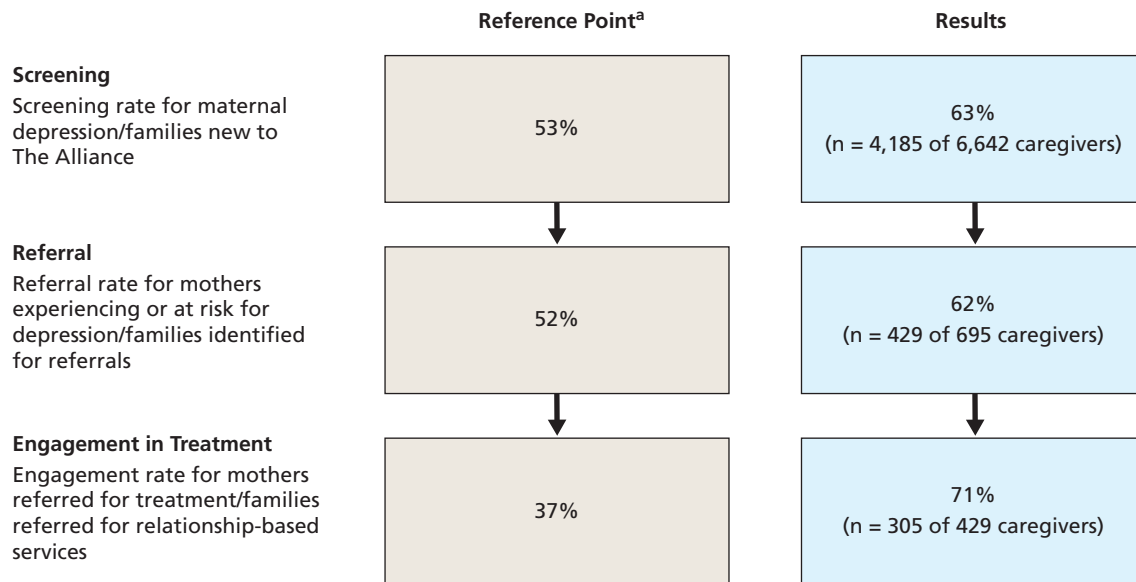
### **Engagement in Services**

Of the 429 caregivers referred, 305 engaged in services, for an overall engagement rate of 71 percent. Caregivers were counted as having engaged in services if the family received at least one session of one of the services for which they were referred. For each referred family, The Alliance was able to confirm with the provider whether the family had received any services, but was unable to determine the number of sessions received. This limitation in data collection necessitated a relatively liberal definition of *engagement*, but it is consistent with how other studies define the term (see Table D.3 in Appendix D). This engagement rate was relatively similar across the three different screening and identification pathways: 67 percent for those screened at The Alliance, 75 percent for those self-identified, and 73 percent for those referred by a community-based partner.

Based on comparisons to rates among comparable populations, the engagement rate for the *Healthy Families* initiative was high. Studies of depressed low-income women reported an average baseline engagement rate of approximately 37 percent. One contributing factor to the success of Healthy Families may be the relative ease with which caregivers could obtain services; other factors could include the “warm transfer,” in which service coordinators or mental health specialists directly connected caregivers seeking treatment with behavioral health providers; the relationship-based approach that helped caregivers understand the benefits of services for themselves and for their child; and having the referral and connection to services come from a trusted service coordinator.

Figure S.3 summarizes the results of the evaluation of the implementation process.

**Figure S.3**  
**Summary of Implementation Process Results (Reference point/initiative)**



<sup>a</sup> The reference points represent rates found in the literature for similar at-risk populations (e.g., screening: Armstrong and Small, 2007; Garcia, LaCaze, and Ratanasen, 2011; LaRocco-Cockburn et al., 2003; referral: Chaudron et al., 2004; Sheeder, Kabir, and Stafford, 2009; Yonkers et al., 2009; and engagement: Miranda et al., 2003; Smith et al., 2009).

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### System Impacts and Factors Affecting Implementation

To assess the initiative's overall impact, we gathered information about changes to the involved Part C early intervention and behavioral health systems as a result of the new processes for three areas: screening and identification of at-risk families, referrals, and engagement in relationship-based services. The system impact measures included changes in knowledge, attitudes, beliefs, and behaviors related to caregiver depression, screening, referrals, and relationship-based services, as well as perspectives from providers and caregivers on the implementation process. We explore the results in the following sections.

#### Screening and Identification

**Appropriate Tools and Protocols for Depression Screening.** The consistent screening rate throughout implementation indicates that service coordinators understood and followed the protocol and caregivers accepted the depression screening as a normal part of their interaction with early intervention. This result suggests that with validated tools and well-defined processes, screening for parental depression can be integrated into routine care in the Part C early intervention system.

**Training and Ongoing Support for Those Conducting the Screening.** Service coordinators and their supervisors reported that being equipped with knowledge, tools, resources, and confidence in their ability to support caregivers is critical to successfully integrating a depression screening protocol into existing processes.

**Efforts to Involve the Maternal and Child Health Care System.** To engage the maternal and child health care system in making referrals to early intervention based on the caregiv-

er's depression risk, the initiative conducted extensive outreach activities to related community agencies. The results suggest that community-based child and maternal health organizations can take advantage of the system's increased capacity for screening, referral, and treatment services for caregiver depression without overburdening it.

### ***Cross-System Networking and Referrals***

**Cross-System Networks and Communication Channels.** The current systems have evolved in a manner that fosters specialization and fragmentation in treatment and interventions. To improve communication among these systems (thereby cultivating referral and engagement of caregivers in services), the initiative facilitated cross-system trainings and networking meetings that addressed the rationale and importance of referrals and the potential impact on families. Collaborative relationships at every level within and across systems were developed and strengthened through networking meetings, which helped administrators and providers understand each system's role and how to support each other in providing services for at-risk families through cooperative and collaborative efforts. Overall, the efforts to develop cross-system networks and communication channels increased service capacity, communication, and coordination within and between the Part C early intervention and behavioral health systems.

**Integration of Referral Processes into Routine Practice.** The referral process was developed in conjunction with service coordinators and supervisors. The results suggest that defined protocols and concrete guidance about options enable providers to make knowledgeable and personal referrals that match needs and contribute to a high rate of referral acceptance by families.

**“Warm Transfer” Process for Referrals.** The referral protocol emphasized directly connecting caregivers to behavioral health services during the early intervention home visit. This “warm transfer” strategy capitalized on the developing relationship and trust between the service coordinator and the caregiver. This type of referral and direct transfer from a trusted provider to other services and supports increased engagement in treatment services.

**Coordination and Supports for Referrals.** Early intervention programs have historically focused primarily on the child's developmental delays or disabilities in terms of cognition, communication, movement, vision, and hearing. Although social/emotional development has always been an eligible domain for evaluation and treatment in early intervention, needs in this area were generally perceived as the purview of the mental health system. To increase communication and coordination of services across systems, the initiative funded two full-time mental health specialists at The Alliance. These specialists bridged the gap between the behavioral health system and early intervention, which had not previously addressed caregiver depression. Most caregivers found the referral process to be quick and easy and felt that the service coordinator provided the support and encouragement needed to accept and follow through with the referral. However, caregivers also noted a need for improved communication and follow-up after the initial referral. Together, the efforts of the mental health specialists streamlined the referral process and contributed to high referral acceptance rates.

### ***Engagement in Services for At-Risk Families***

**Capacity-Building Around Relationship-Based Practices.** Overall, more than 300 early intervention and behavioral health practitioners working in partner agencies were trained on relationship-based practices. These providers showed increased knowledge about effectively

engaging caregivers, infant-caregiver attachment, and relationship-based care. While the relationship-based care approach helped providers in both systems focus on the parent-child relationship, some caregivers noted that providers were not always equipped to meet needs or address issues. Within early intervention, service coordinators were supported with reflective supervision: Supervisors worked closely with service coordinators both to process the experience of working with the family and to develop strategies for the family to move forward. The results suggest that expanded capacity for relationship-based practice in early intervention and behavioral health through training and ongoing support, along with a two-generational approach (i.e., parent and child), can increase engagement in services and treatment across both systems for families experiencing parental depression.

**Peer Support and Learning Opportunities.** Service providers also benefited from a mechanism referred to as the learning collaborative, which was established to improve their relationship-based approaches through educational support and peer mentoring. Both a group and a process, the learning collaborative allowed providers from the Part C early intervention and behavioral health systems to share experiences and receive regular professional peer contact and support, which helped strengthen individual providers' skill development, knowledge, and comfort level with relationship-based care and allowed for continued interaction and relationship-building with providers from other systems.

**Addressing Barriers to Treatment.** The initiative also addressed some of the barriers to engagement in behavioral health treatment. The factors of cultural context and stigma were considered during development of the processes for offering depression screening within early intervention and making referrals for behavioral health services and treatment. Cultural framework can affect how individuals communicate about life stressors, their openness to discussing issues, and their willingness to access resources and services. The screening process training for service coordinators, which incorporated discussion and role playing, demonstrated how to affirm the caregiver's feelings, validate their distress, and offer support. The cross-system training sessions and learning collaborative activities emphasized the need to be sensitive to cultural beliefs and concerns when working with families to make referrals and support engagement in services and treatment.

Providing in-home behavioral health services to families in need helped address some of the typical barriers to engaging in treatment, such as lack of transportation, difficulty obtaining child care, the stigma associated with going to a clinic for mental health treatment, and the barrier of depression itself, which can make it difficult to attend traditional outpatient treatment. Community Care and the behavioral health network of providers collaborated to plan an expansion of services that would increase access to and engagement in behavioral health services for this target population. Overall, access to home-based behavioral health services can increase engagement rates and eliminate a significant barrier to accessing behavioral health services.

### **Individual Outcomes**

The assessment of individual outcomes was designed to track caregivers at risk for or experiencing depression and assess their outcomes over time. Outcomes for families involved in the initiative were measured using depression screening measures collected at baseline and at six and 12 months afterward. When a caregiver screened positive for depression, an assessment of parental stress, caregiver health and safety, and child health was administered.

Nearly one-third of caregivers (30 percent) who screened at baseline with the two-question Patient Health Questionnaire (PHQ-2) depression screen also received a six-month follow-up screen. Following the screening protocol, all caregivers who completed the nine-question PHQ-9 at baseline were sought for rescreenings at six and 12 months. Among the 904 caregivers who completed a baseline screen, 16 percent completed a six-month follow-up depression screen (n=149). Overall, few caregivers completed 12-month follow-ups (see Table S.1). There are several possible reasons for the low rates of follow-up in depression screening. Families are discharged from the Part C early intervention system when the child reaches the age of 3 or when the child's functioning has improved to the point where they no longer have a developmental delay. Those discharged were no longer in contact with The Alliance and thus could not be tracked for the follow-up depression screens. Service coordinators also reported that some families declined the follow-up screen because it was stressful to complete during visits with the service coordinator or when there were other service providers in the home.

Nineteen percent of those who took the initial PHQ-2 scored positive. These caregivers were then given the longer PHQ-9 screen. Overall, 9 percent of the caregivers screened positive for depression on the PHQ-9. Studies examining positive screens in low-income mothers report an average rate of 18 percent, with estimates varying across screening tools. Therefore, the initiative population's risk of depression was relatively low by comparison.

Our outcome analysis for those with both baseline and six-month follow-up screens revealed a significant reduction in depressive symptoms both for caregivers who engaged in relationship-based services within the early intervention or behavioral health systems and for those who did not (see Figure S.4). This overall downward trend may reflect a gradual process of adjusting to the stressful situation of identifying a developmental delay for the caregiver's child. The black line in Figure S.4 shows the cut score (10) used to determine depression risk. Both groups were above the cut score at baseline but were, on average, below the cut score at six months.

### ***Assessment of Parental Stress***

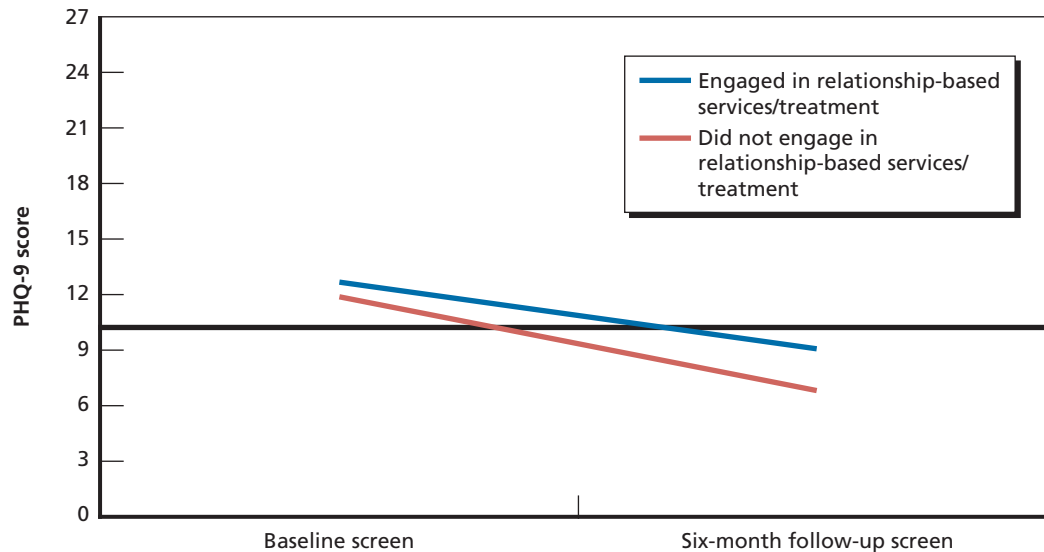
Those caregivers screening at high risk for depression were asked to complete an assessment that included a parental stress measure as well as caregiver and child health items. A total of 401 caregivers actually completed the assessment, including 290 of the 395 who had screened positive for depression. Results showed that 60 percent of the 290 caregivers who screened positive registered very high levels of parental stress. With respect to different subscales, 79 percent of the sample reached clinical levels of distress on the parental subscale, 37 percent did so on the parent-child dysfunctional interaction subscale, and 45 percent did so on the difficult child subscale.

Our analysis showed that caregivers who completed the assessment at both baseline and follow-up experienced decreased levels of stress. Parental stress scores decreased significantly

**Table S.1**  
**Completed Baseline and Follow-Up Depression Screens**

Measure	Number Completed at Baseline	Number (%) Completed at Six-Month Follow-Up	Number (%) Completed at 12-Month Follow-Up
PHQ-2	4,185	1252 (30%)	653 (16%)
PHQ-9 (follow-up screen)	904	149 (16%)	88 (10%)
PHQ-9 (positive)	395	94 (24%)	55 (14%)

**Figure S.4**  
**Change in PHQ-9 Scores from Baseline to Follow-Up by Engagement**



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from baseline to six months and from six months to 12 months both overall and for caregivers who engaged in relationship-based services within the early intervention or behavioral health systems.

Overall, the results of the outcomes analysis suggest that caregivers involved in the initiative experienced better outcomes at six months, regardless of whether they engaged in relationship-based services.

## Recommendations

The RAND team built its recommendations off of the *Helping Families Raise Healthy Children* initiative results that have implications for policy and practice in three areas. The recommendations are meant to provide a framework for moving the relevant systems toward a more integrated and coordinated approach to the dual risks of caregiver depression and early childhood developmental delays. Specifically, we offer recommendations to

- improve screening and identification of caregiver depression (Table S.2)
- enhance cross-system referral and coordination (Table S.3)
- increase engagement in services and treatment (Table S.4).

These recommendations are targeted toward decisionmakers and practitioners at the state, county, and provider levels, depending on the jurisdiction. For each area of policy and practice, we present recommendations for the following general groups of stakeholders, with the relevant Pennsylvania entity named in parentheses:

**Table S.2**  
**Recommendations to Improve Screening and Identification of Caregiver Depression**

Stakeholder	Recommendation
State legislature (Pennsylvania General Assembly)	Mandate universal screening for depression in the Part C early intervention system. Add parental mental health challenges as a qualifying factor for early intervention at-risk tracking services statewide.
State and/or county early intervention agencies (Pennsylvania Department of Public Welfare, Office of Child Development and Early Learning; county early intervention coordination units)	Support referral of infants and toddlers in families with a primary caregiver at risk for depression to early intervention for developmental screening. Add depression as tracking category for early intervention services. Develop protocols for depression screening using a validated screening tool. Provide initial and ongoing training and support on depression screening to service coordinators implementing the screening protocol. Establish performance monitors to assess progress and develop strategies for improving screening rates.
State and/or county behavioral health agencies (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services; county behavioral health administrators)	Support referral of infants and toddlers in families with a primary caregiver experiencing or at risk for depression to early intervention for developmental screening.
Behavioral health provider agencies	Refer infants and toddlers in families with a primary caregiver experiencing or at risk for depression to early intervention for developmental screening. Provide initial and ongoing training and support on caregiver depression, its effect on child development, and the need for developmental screening and assessment for the child.
Providers within the maternal and child health care system	Provide depression screening using a validated tool. Refer infants and toddlers in families with a primary caregiver at risk for depression to early intervention for developmental screening.

- state legislature (Pennsylvania General Assembly)
- state and/or county early intervention agencies (Pennsylvania Department of Public Welfare, Office of Child Development and Early Learning; county early intervention coordination units)
- early intervention provider agencies
- state and/or county behavioral health agencies (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services; county behavioral health administrators)
- behavioral health managed care organizations
- behavioral health provider agencies
- providers within the maternal and child health care system.

## Concluding Observation

The *Helping Families Raise Healthy Children* initiative represents a significant step forward in addressing the problem of caregiver depression and childhood developmental risks among families in Allegheny County. Those involved with the initiative will continue efforts to improve care systems within the county and to serve as a catalyst for other communities across the Commonwealth of Pennsylvania.

**Table S.3**  
**Recommendations to Enhance Cross-System Referral and Coordination**

Stakeholder	Recommendation
State and/or county early intervention agencies (Pennsylvania Department of Public Welfare, Office of Child Development and Early Learning; county early intervention coordination units)	<ul style="list-style-type: none"> <li>Promote cross-system collaboration and communication among the early intervention, behavioral health, and maternal and child health care systems.</li> <li>Develop cross-system referral protocols for families identified as needing behavioral health services and other supports.</li> <li>Facilitate cross-system collaboration and communication among providers in the early intervention, behavioral health, and maternal and child health care systems.</li> <li>Provide initial training and ongoing support to service coordinators on cross-system referral protocols. Establish performance monitors to assess progress and develop strategies for improving the cross-system referral process.</li> </ul>
Early intervention provider agencies	<ul style="list-style-type: none"> <li>Facilitate networking and communication with providers in the behavioral health and maternal and child health care systems.</li> </ul>
State and/or county behavioral health agencies (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services; county behavioral health administrators)	<ul style="list-style-type: none"> <li>Promote cross-system collaboration and communication among the early intervention, behavioral health, and maternal and child health care systems.</li> <li>Develop cross-system referral protocols for families identified as needing behavioral health services and other supports.</li> <li>Facilitate cross-system collaboration and communication among providers in the early intervention, behavioral health, and maternal and child health care systems.</li> </ul>
Behavioral health provider agencies	<ul style="list-style-type: none"> <li>Facilitate networking and communication with providers in the early intervention and maternal and child health care systems.</li> </ul>
Behavioral health managed care organizations	<ul style="list-style-type: none"> <li>Support cross-system collaboration and communication among the early intervention, behavioral health, and maternal and child health care systems.</li> </ul>

**Table S.4**  
**Recommendations to Increase Engagement in Services and Treatment**

Stakeholder	Recommendation
State and/or county early intervention agency (Pennsylvania Department of Public Welfare, Office of Child Development and Early Learning; county early intervention coordination units)	<ul style="list-style-type: none"> <li>With behavioral health, implement a training curriculum for providers from both systems on the interconnectedness of caregiver depression and early childhood developmental delays, the science of early childhood brain development, the impact of toxic stress, relationship-based care practices, and reflective supervision.</li> </ul>
Early intervention provider agencies	<ul style="list-style-type: none"> <li>Provide ongoing support and reflective supervision for providers on relationship-based approaches to working with families.</li> </ul>
State and/or county behavioral health agencies (Pennsylvania Department of Public Welfare, Office of Mental Health and Substance Abuse Services; county behavioral health administrators)	<ul style="list-style-type: none"> <li>With early intervention, implement a training curriculum for providers from both systems on the interconnectedness of caregiver depression and early childhood developmental delays, the science of early childhood brain development, the impact of toxic stress, and relationship-based care practices.</li> <li>Support expansion of in-home behavioral health services for families with caregivers at risk for or experiencing depression and infants/toddlers at risk for developmental delays.</li> </ul>
Behavioral health provider agencies	<ul style="list-style-type: none"> <li>Expand capacity to provide in-home behavioral health services.</li> <li>Provide initial and ongoing training and education for providers on relationship-based approaches to working with families.</li> </ul>
Behavioral health managed care organizations	<ul style="list-style-type: none"> <li>Allow access to in-home behavioral health services for families with caregivers at risk for or experiencing depression and infants/toddlers at risk for developmental delays.</li> </ul>