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A Toolkit for Implementing Parental Depression Screening, Referral, and Treatment Across Systems

Dana Schultz • Kerry A. Reynolds • Lisa M. Sontag-Padilla
Susan L. Lovejoy • Ray Firth • Patricia Schake • Jilan Hawk
Sue Killmeyer • Erin Troup • Michele Myers-Cepicka • Melva Perich

Prepared for the Community Care Behavioral Health Organization
Preface

The purpose of this toolkit is to provide information and resources for implementing depression screening within the early intervention system, strengthening cross-system collaborations, and implementing relationship-based care in the early intervention and behavioral health systems.

The toolkit was developed as part of the *Helping Families Raise Healthy Children* initiative implemented in Allegheny County, Pennsylvania. The initiative identified some of the challenges faced when attempting to implement depression screening in early intervention, develop cross-system referral processes, and increase capacity for providing relationship-based services. The lessons learned from the initiative helped shape the recommendations for implementing the type of effort outlined in this toolkit. The toolkit has three main parts: an introduction, a step-by-step guide to implementation, and a concluding section with supporting resources.

The initiative’s organizing partners included Community Care Behavioral Health, The Alliance for Infants and Toddlers, and RAND Health. Community Care Behavioral Health is a nonprofit behavioral health managed care organization founded by the University of Pittsburgh Medical Center that manages the delivery of behavioral health services in the northeastern part of the United States. Community Care’s mission is to improve the health and well-being of the community through the delivery of effective, cost-efficient, and accessible behavioral health services. Community Care’s network comprises more than 1,600 service providers and 1.5 million members. The Alliance for Infants and Toddlers, Inc. was established in 1988 by a federal grant to assist families of infants with low birth weights. In 1992, The Alliance became the early intervention service coordination agency for families who have concerns about their child’s development, handling children from birth to the age of three years. The Alliance conducts developmental assessments and provides a broad array of services and support to children with identified delays.

We would particularly like to thank the members of our Family Advisory Council, who provided valuable insights and feedback for the planning and implementation of the initiative. We would also like thank the many organizations and individuals who contributed to this project, including Achieva, the Early Learning Institute, Integrated Care, Early Intervention Specialists, Pediatric Therapy Professionals, the Allegheny County Department of Human Services (Office of Behavioral Health, Maternal and Child Health Program), Allegheny Family Network, Every Child, Family Resources, Family Services of Western PA, Holy Family Institute, Matilda Theiss Child Development Center, Mercy Behavioral Health, Milestone Centers, Mon Yough Community Services, Resolve Crisis Network, Sojourner House, Turtle Creek Valley MH/MR, Wesley Spectrum Services, Children’s Hospital Primary Care Practices, Sto Rox Family Health Center, The Birth Circle, The Children’s Home of Pittsburgh, Early Head Start/Council of Three Rivers American Indian Center, Family Centers of the Allegheny Intermediate Unit, Family Foundations Early Head Start, Healthy Start, McKeesport Perinatal
Depression Collaborative, National Fatherhood Initiative, Western Pennsylvania School for the Deaf, UPMC Family Medicine, Primary Health Care Centers, Inc. (Alma Illery), KidsPlus Pediatrics, UPMC for You, Gateway Health Plan, and Unison Health Plan.

The *Helping Families Raise Healthy Children* initiative and this work were supported by the Robert Wood Johnson Foundation Local Funding Partnership grant program, the Highmark Foundation as the nominating funder, and other local funding partners UPMC Health Plan, The Pittsburgh Foundation, The Fine Foundation, FISA Foundation, and the Jewish Healthcare Foundation, with additional support from the Allegheny County Department of Human Services, Office of Behavioral Health, and the Pennsylvania Department of Public Welfare. The research was conducted within RAND Health, a division of the RAND Corporation. The RAND Health Quality Assurance process employs peer reviewers, including at least one reviewer who is external to the RAND Corporation. This study benefited from the rigorous technical reviews of Jill Cannon and Milena Nigam, which served to improve the quality of this report. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health.
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<tr>
<td>Alliance</td>
<td>The Alliance for Infants and Toddlers, Inc.</td>
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<td>CES-D</td>
<td>The Center for Epidemiological Studies Depression Scale</td>
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<td>Community Care</td>
<td>Community Care Behavioral Health</td>
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<td>DSM</td>
<td>standardized psychiatric diagnostic criteria</td>
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<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<tr>
<td>IFSP</td>
<td>Individualized Family Service Plan</td>
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<tr>
<td>MDE</td>
<td>multidisciplinary developmental evaluation</td>
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<tr>
<td>NREPP</td>
<td>National Registry of Evidence-Based Programs and Practices</td>
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<tr>
<td>PHQ-2</td>
<td>two-question Patient Health Questionnaire</td>
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<tr>
<td>PHQ-9</td>
<td>nine-question Patient Health Questionnaire</td>
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<tr>
<td>PIPE</td>
<td>Partners in Parenting Education</td>
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<td>PSI-SF</td>
<td>Parenting Stress Index Short Form</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse Mental Health Services Agency</td>
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<td>UPMC</td>
<td>University of Pittsburgh Medical Center</td>
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CHAPTER ONE

Introduction

This toolkit provides information and resources for implementing depression screening within the early intervention system, strengthening cross-system collaborations, and implementing relationship-based care in the early intervention and behavioral health systems. While the implementation steps recommended in this toolkit were based on the Helping Families Raise Healthy Children initiative implemented in Allegheny County, Pennsylvania (Schultz et al., forthcoming), the toolkit was designed to help provide guidance for implementing depression screening within early intervention in any community. The initiative helped identify both the successes and challenges of implementing depression screening within early intervention and developing referral pathways to behavioral health. The recommendations and strategies presented here have been developed in light of these on-the-ground experiences.

Background

Research shows that healthy early childhood development is directly linked to the quality of the parent-child relationship (Davies, Winter, & Cichhetti, 2006; Sroufe et al., 2005) and that maternal depression poses a serious risk to this relationship and healthy child development (Cummings et al., 2008; Elgar et al., 2007; Goodman & Gotlib, 1999; Lim, Wood & Miller, 2008). Conversely, a child’s developmental delays can increase maternal stress, heightening risk for depression (Davis et al., 2003; Singer et al., 1999; Singer, 2006). Each year more than 340,000 infants and toddlers nationally are referred for early intervention services due to concerns about cognitive, social/emotional, or developmental issues that can negatively affect their future learning, behavior, and health (Danaher, Goode, & Lazara, 2010). A majority of these children have caregivers, typically mothers, at increased risk for depression compared with the general population. This increased risk may be due to adverse life circumstances, including poverty, lack of social supports, and stress linked to hardship, as well as increased stress in response to a child’s developmental delay. The dual challenge of an adult at increased risk for depression and a child at risk for developmental delays threatens the well-being of caregivers and their families.

Screening, referral for treatment, and engagement in treatment for caregiver depression early in a child’s development may offset this negative cycle and improve outcomes for children and their families. Yet, as the 2009 National Research Council and Institute of Medicine Consensus Report emphasized, “the delivery of adequate screening and successful detection and treatment of a depressive illness, and prevention of its effects on parenting and the health of children is a formidable challenge to modern health care systems” (National Research Coun-
Despite recent recommendations to screen for maternal depression in health care settings (U.S. Preventive Services Task Force, 2009), general screening rates remain fairly low in both primary care (Heneghan et al., 2000; Heneghan, Morton, & DeLeone, 2007; Olson et al., 2002) and early intervention settings (Children’s Defense Fund of Minnesota, 2011); rates are below 10 percent in community settings that lack established screening protocols.

While traditional behavioral health treatment can be effective, the negative effect of caregiver depression on healthy child development can also be ameliorated by services that focus on the quality of the parent-child relationship. Using a two-generation approach (i.e., parent and child) with caregivers at risk for depression can help them cope with the parenting challenges of having a child with developmental delays, while offering enhanced support for the child. Intensive intervention efforts that have focused specifically on mother-child interactions have shown improved developmental outcomes among children of depressed mothers (Cicchetti, Rogosch, & Toth, 2000), as well as improved interactions between mother and child (Clark, Tluczek, & Wenzel, 2003; Cicchetti, Rogosch, & Toth, 2000).

There are a number of challenges to developing systems for screening, referral, and treatment to address caregiver depression. Few providers report using a validated tool to screen for maternal depression (Heneghan et al., 2007; Heneghan, Morton, & DeLeone, 2007; LaRocco-Cockburn et al., 2003; Olson et al., 2002; Seehusen et al., 2005). When providers do screen for depression, they often use their own questions about mood or mental health—or rely on mothers’ behavior, appearance, and complaints—to identify depression rather than using validated screening tools (LaRocco-Cockburn et al., 2003; Heneghan, Morton, & DeLeone, 2007; Olson et al., 2002). Such practices raise concerns, given recent findings indicating poor accuracy among pediatric providers in recognizing depression without the use of a validated screening tool (Heneghan et al., 2000).

Although the need to screen for caregiver depression is evident, little to no benefit has been found for depression screening programs in the absence of referral systems or interventions (O’Connor et al., 2009). For providers, the lack of an established process to refer and treat individuals who screen at risk for depression is a major barrier to connecting caregivers to services in the mental health system (Boyd et al., 2011; Children’s Defense Fund of Minnesota, 2011). Further, a lack of established communication channels between the adult behavioral health care system and the pediatric health care system makes coordination across systems difficult (Abrams, Dornig, & Curran, 2009; Boyd et al., 2011; Children’s Defense Fund of Minnesota, 2011). These barriers, along with other provider-level barriers (e.g., lack of training in identifying signs of depression in ethnically diverse populations), contribute to poor engagement rates in treatment for women identified as at risk for depression. Furthermore, caregivers’ negative beliefs about mental illness and treatment, as well as personal constraints (e.g., child care, transportation), also prove to be major barriers to treatment (Abrams, Dornig, & Curran, 2009; Sit et al., 2009). These reasons point to the need for a formal system that provides both routine depression screening with a validated tool and processes for referral to behavioral or mental health services, while lowering barriers that families face in getting treatment.
Improving Systems to Address the Challenges of Parental Depression and Early Childhood Developmental Delays

As this brief overview suggests, many families experience the dual challenges of parental depression and early childhood developmental delays, posing unique threats to both the caregiver and child. Children with developmental delays may require greater levels of responsiveness and engagement to meet the daily challenges associated with physical health problems, cognitive delays, and behavioral problems, and depression may hinder a parent’s ability to provide such additional support. Additionally, the stress of managing the added needs of a child with a developmental delay, as well as concern about long-term outcomes, may exacerbate or prolong depression. Although these conditions often co-occur, local systems traditionally identify and treat them separately, without coordination and communication across systems.

Services within the early intervention system are supported through the Individuals with Disabilities Education Improvement Act of 2004, Part C for Infants and Toddlers. While Part C implementation varies across states, Pennsylvania’s requirements for early intervention (25 percent delay or clinical opinion) enable a significant portion of children who are at risk for developmental delays to receive treatment. Beyond that, the development of infants/toddlers not currently eligible for intervention services can be monitored through tracking services if certain risk factors are present. These services regularly track qualified children for the emergence of any developmental delays and link families to services as soon as a need is identified.

While the federal early intervention legislation does not provide support for parental depression screening, regulations released in 2011 encourage states to increase opportunities for children under the age of 3 who are at risk for developmental delays. Consequently, some states recognize parental depression as an eligible risk factor for tracking early childhood development. However, early intervention services generally focus on addressing the specific developmental delays experienced by children and may not consider the emotional impact on parents or adult needs for support and services. Conversely, behavioral health providers, physical health providers, and community agencies that serve adults with depression often do not consider the impact of parental depression on young children in the family or address the adult’s role as a parent.

While physical health providers may be identifying those at risk for depression and referring them for support and possible engagement in behavioral health treatment (e.g., Chaudron et al., 2004; Sheeder, Kabir, & Stafford, 2009; Yonkers et al., 2009), few caregivers at high risk for depression are getting the treatment they need, as shown by low engagement rates in early intervention and primary care settings (Agency for Healthcare Research and Quality, 2004; Miranda et al., 2003; Skaer et al., 2000; Wang, Berglund, & Kessler, 2000; Vesga-López et al., 2008; Young et al., 2001). According to one study, only 20 percent of low-income minority women with depression engage in behavioral health treatment (Miranda et al., 2003). Moreover, many community agencies do not have established practices for referring parents and their children to needed services across local systems of care (e.g., Boyd et al., 2011). The lack of systematic practices for identifying parental depression in settings focused on children (e.g., pediatric offices or early intervention programs) and the lack of coordinated referral pathways between pediatric and adult systems of care impede the ability of providers to connect depressed caregivers with appropriate services (Boyd et al., 2011; Children’s Defense Fund of Minnesota, 2011). Without established practices for referring parents and children across the
two systems, opportunities to identify at-risk parents and infants/toddlers and engage them in appropriate care are missed.

Because the early intervention system focuses on young children and the behavioral health system typically focuses on adult mental health issues, many caregivers do not receive the support and services they need to manage both their depression and their child’s developmental needs. Relationship-based care is an approach that addresses the parent-child relationship; it assumes that every child develops in the context of a family and that healthy development depends on healthy primary attachment, physical and emotional safety, and predictable routines (Mahoney & Perales, 2005; Rauh et al., 1988). Actively employing relationship-based techniques that address the needs of the child and the parent requires that providers in each system expand their view of their role and responsibility in addressing caregiver depression. Early intervention providers must place greater emphasis on fostering the parent-child relationship in addition to attending to children’s other needs, and behavioral health providers must place greater emphasis on the adult’s role as a caregiver and the impact of a caregiver’s depression on the child (Reynolds et al., 2012).

A cross-system approach that improves the way local systems of care work together can begin to address the challenge of providing support and services to families facing the related and often co-occurring challenges of parental depression and early childhood developmental delays. With the goal of establishing an integrated system of care for families experiencing or at risk for parental depression and early childhood developmental delays, a systems-change effort needs to focus on three main objectives:

1. Improving the identification of families with primary caregivers at risk for depression and infants/toddlers at risk for developmental delays.
2. Enhancing access to support and services for these families by establishing a process for referring family members to services across traditionally separate systems of care.
3. Better serving these families by offering integrated, home-based, relationship-centered treatment options that address the needs of both caregivers and young children in the context of the parent-child relationship.

To achieve these aims, research and evidence-based practice suggest that three components of service delivery should be targeted for improvement at the systems level: screening, referral, and services (National Research Council and Institute of Medicine, 2009). Meeting these goals means that the system of care can better address the needs of the parent with or at risk for depression, the child with or at risk for developmental delays, and the overall needs of the family. Further, there are potential two-generational (caregiver and child) benefits of screening for and treating caregiver depression that may reduce costs across multiple publicly funded systems, including public assistance, physical and behavioral health, early intervention, education, and child and family welfare.

Overview of the Helping Families Raise Healthy Children Initiative

This toolkit provides information and resources for achieving these goals by (1) conducting depression screening in the early intervention system, (2) facilitating cross-system referrals, and (3) providing services to address the needs of families affected by caregiver depression and
child development issues. The steps recommended in this toolkit are based on a community-wide initiative implemented in Allegheny County, Pennsylvania, called Helping Families Raise Healthy Children. This initiative is an innovative cross-systems quality-improvement effort designed to change the way local systems serve families experiencing the related and often co-occurring challenges of parental depression and early childhood developmental delays—creating a brighter, healthier future for children and parents. The primary focus of the initiative was to conduct depression screening within the early intervention system. However, at-risk families identified by community partners in the maternal and child health care system were also referred to the early intervention system for developmental assessments and appropriate child-level referrals and family-level referrals for behavioral health treatment services and other community supports.

The Helping Families Raise Healthy Children initiative was designed to ensure that both caregivers and infants are well served by integrating the local early intervention system for infants and toddlers with the infrastructure that supports caregiver mental health and child health care. The initiative has transformed the way care is provided to families in Allegheny County. Families experiencing or at risk of parental depression and/or early childhood developmental delays are now identified and linked with enhanced and coordinated services that are home-based, culturally competent, family-centered, and relationship-based to address the needs of both infants/toddlers and parents as well as the parent-child relationship.

Who Is Involved with Helping Families Raise Healthy Children?
The initiative represents a collaborative effort of more than 35 community partners led by a project team comprising representatives from the initiative’s organizing partners: Community Care Behavioral Health (Community Care), a nonprofit behavioral health managed care organization; The Alliance for Infants and Toddlers (The Alliance), a service coordination unit for children ages birth to 3 who are involved with the early intervention system; the RAND Corporation, a nonprofit institution that helps improve policy and decisionmaking through research and analysis; and a Family Advisory Council composed of caregivers with personal experiences with the early intervention system and/or depression. The initiative was supported by a grant from the Robert Wood Johnson Foundation Local Funding Partnerships, a consortium of local funders (The Highmark Foundation, University of Pittsburgh Medical Center [UPMC] Health Plan, The Pittsburgh Foundation, The Fine Foundation, FISA Foundation, and the Jewish Healthcare Foundation), and additional support arranged through the assistance of the Allegheny County Department of Human Services and the Pennsylvania Department of Public Welfare. Community partners include agencies from the early intervention, behavioral health, physical health care, and community social service systems.

How Was Helping Families Raise Healthy Children Implemented?
To support the goal of establishing a sustainable cross-system approach for families experiencing or at risk for caregiver depression and early childhood developmental delays, the initiative had three components: screening and identification, referral, and engagement in services (Figure 1.1). To implement each of these components, the project team developed protocols and processes that outlined the steps for caregiver depression screening and family functioning assessment, cross-system referral, and relationship-based care implementation. The protocols and processes also detailed the roles and responsibilities of all participating partners (described briefly in the next sections). Throughout implementation of each component, the project team
provided training, technical assistance, infrastructure support, and data collection and communication tools to facilitate interactions within and across systems.

**Screening and Identification.** The first component provided depression screening to all families involved with early intervention in Allegheny County. The protocol involved a two-step depression screening process for all new and existing families at The Alliance (see Figure 1.2). For new families coming to The Alliance for child developmental screening and assessment, service coordinators completed the screening process during the initial home visit whenever possible. For families that were already enrolled in early intervention services at the start of the project, the service coordinators conducted the screening during their next scheduled visit or evaluation of the family after project implementation. The service coordinator explained to caregivers that The Alliance was completing a routine screening process with all of its families that involved questions about how they had been feeling over the past several weeks. The service coordinator then asked the caregiver to sign the project consent form.

The initial screen consisted of the Patient Health Questionnaire (PHQ-2), a two-question depression screen that is widely used in community health settings. If the caregiver responded positively to either initial question, they were given a nine-question screen (PHQ-9) to further assess risk for depression. For each item in the PHQ-9, the response options are “not at all,” “several days,” “more than half the days,” and “nearly every day,” scored as 0, 1, 2, and 3, respectively. Caregivers who scored 10 or higher on the PHQ-9 were considered to be at risk for depression, and in those cases the service coordinator attempted to complete a baseline assessment consisting primarily of the Parenting Stress Index Short Form (PSI-SF), a 36-question survey that is widely used to assess stress in a parent-child relationship. The assessment also included a series of questions related to the caregiver’s health and safety and the child’s health.
To monitor changes over time, attempts were made to rescreen all families at six, 12, 18, and 24 months after the baseline screening. Families who screened positive at any point received referrals and access to relationship-based services.

As a secondary focus of the screening and identification process, at-risk families were identified by partners in the maternal and child health care systems. Community-based providers were able to refer families with a caregiver at risk for depression to The Alliance for screening, developmental assessment, and family-centered care and service coordination.

**Referral.** The second component of this initiative involved providing family-centered care and service coordination to families who had been identified as being at risk for caregiver depression either at The Alliance or by community partners from the maternal and child health care system. As noted above, the families were identified through The Alliance depression screening process or depression screening and referral to The Alliance by community-based partners within the maternal and child health care system. The family-centered care management was operationalized through a referral protocol. When a caregiver screened as being at risk for depression or had been referred for depression risk by a community-based partner, The Alliance service coordinator explained that children (from birth to 3 years old) of caregivers who were identified as being at risk for depression were eligible to have their development monitored, even if they did not qualify for The Alliance’s Individualized Family Service Plan (IFSP) or existing high-risk tracking services to monitor the child for the emergence of any developmental delays. For children with identified developmental delays or risk factors, typical service coordination and tracking services were initiated, engaging support from project-funded mental health specialists as needed. If the family’s only risk factor was depression (or another behavioral health concern), one of the project-funded mental health specialists at The Alliance followed the family, offering more intensive high-risk tracking services.
To determine which referrals were appropriate, the service coordinator and the caregiver discussed any prior experiences with depression or other behavioral health issues and any treatment received, reviewed responses to the paper-and-pencil family assessment to discuss the types of stressors the caregiver faces, and assessed whether the family has a support system. Based on this discussion, the service coordinator suggested referral and service options and determined whether the caregiver wanted a referral. If the caregiver declined, the service coordinator provided options for family support, including tracking by the project mental health specialist, and checked in with the caregiver periodically. If the caregiver accepted a referral, the service coordinator discussed some of the common barriers to accessing behavioral health services and informed the project’s mental health specialists about the referral request. The mental health specialists worked toward connecting the caregiver and family to the appropriate services and supports.

Engagement in Relationship-Based Interventions and Services. The third component was to provide services to caregivers that addressed behavioral health issues as well as their parenting approach and relationship with their child, along with early intervention services that considered the parent-child relationship and its impact on child development. The project team selected three possible relationship-based models or approaches, all of which are evidence-based or promising models of dyadic relationships that help caregivers interpret and respond to infants’ cues, express their own emotions, and prevent or repair damage to the parent-child relationship. Those used by early intervention and behavioral health providers in the Helping Families Raise Healthy Children initiative included Promoting First Relationships (Kelly et al., 2003), Partners in Parenting Education (Dolezol & Butterfield, 1994), and Nurturing Parenting (Devall, 2004). These relationship-based interventions met the needs of our target population and, at the same time, aligned with the interests of our local service providers to work with the caregiver in the context of the parent-child relationship. Behavioral health and early intervention providers were offered training in each model, and then families who expressed an interest in relationship-based services were referred to a trained provider.

The Impact of Helping Families Raise Healthy Children
An evaluation of the program, conducted by RAND, found that the initiative had positive effects on both the systems involved and families (Schultz et al., forthcoming). Specifically, the initiative resulted in the following:

- Increased capacity and coordination in the early intervention and behavioral health systems by establishing cross-system networks, communication channels, and referral processes.
- Training of more than 300 early intervention and behavioral health practitioners working in partner agencies on relationship-based practices.
- Increased communication and coordination of services across systems by establishing a Learning Collaborative for early intervention and behavioral health providers.
- High screening, referral, and engagement rates (Figure 1.3):
  - Through ongoing data collection and analysis, we were able to measure our results and compare them to established benchmarks.
- Widespread screening and identification of caregivers at risk for depression:
Early intervention service coordinators screened 4,185 caregivers over a 28-month time period with a positive screening rate of 9 percent, thus identifying more than 300 caregivers at high risk for depression.

Community-based partners identified and referred to early intervention 228 families with caregiver depression as a qualifying tracking risk factor; for 41 of these families, a child was identified as having a developmental delay and linked to services within early intervention.

More than 150 other caregivers who did not screen at high risk for depression self-identified a need for support for a behavioral health or life stressor issue.

Changes over time for caregivers identified as being at high risk for depression:

- Caregivers who screened positive at baseline showed statistically significant improvement over time in depressive symptoms and levels of parenting stress. This was true for both caregivers who engaged in treatment services and service coordination and those who engaged only in family-centered/relationship-based service coordination.
- Caregivers’ self-reported health also improved over time in several domains, including physical health, diet, sleep, and emergency room visits.
Lessons That *Helping Families Raise Healthy Children* Offers

**Screening and Identification**

- Screening for caregiver depression using validated tools can be integrated into routine care in the early intervention system.
- Community-based child and maternal health organizations can take advantage of the system’s increased capacity for screening, referral, and treatment services for depression without overburdening the system with these additional referrals.
- Discussing how the caregiver feels can create an opening for offering support and referrals even when the caregiver declines screening or does not screen at high risk for depression.
- Initial and follow-up screenings can be challenging to complete during family visits because of limited time or the presence of other service providers. Providing training and ongoing support to service coordinators on the screening process, how to introduce the screen, and how to discuss the results can help prioritize the completion of the depression screening.
- When implementing depression screening for caregivers in a new system, it is important to – provide those conducting the screening with initial training and ongoing support on the screening process.  
  – educate those conducting the screening about all local resources available to families for support, including crisis services, domestic violence resources, behavioral health and community social service supports.

**Referral to and Engagement in Services**

- Expanded capacity for relationship-based practice in early intervention through training and ongoing support can increase engagement for families experiencing caregiver depression who are receiving early intervention services.
- Established relationships among providers across systems and defined cross-system referral protocols enable knowledgeable and personal referrals that can contribute to a high rate of referral acceptance by families.
- Referrals and direct transfers to other services and supports from a trusted provider (e.g., an early intervention service coordinator who has come to the home) can increase engagement in treatment services (e.g., behavioral health provider).
- Access to home-based behavioral health services can increase engagement rates and eliminate a significant barrier to accessing behavioral health services.

**Summary**

Many families experience the challenges of caregiver depression and early childhood developmental delays. In spite of the need for relationship-based services for these families, numerous obstacles prevent adequate screening and identification, referral, and service delivery to this population. The *Helping Families Raise Healthy Children* initiative addressed these challenges by training and supporting both early intervention and behavioral health providers in relationship-based care. The relationship-based care approach helped providers in both systems focus on the
parent-child relationship in their work with the family. The initiative also addressed some of the logistical barriers to engagement in behavioral health treatment by providing in-home behavioral health services to families in need. This toolkit was developed in response to a clear need for improved systems of care for families struggling with the often co-occurring challenges of caregiver depression and early childhood developmental delays. Developed through a collaboration among RAND, The Alliance, and Community Care, this toolkit provides step-by-step recommendations for developing a cross-systems approach to address caregiver depression—including screening for depression in early intervention, developing cross-system networking and referral processes, and providing relationship-based care within the early intervention and behavioral health systems. This step-by-step guidance also includes information on estimating and planning for the costs of implementation and resources that might be useful during implementation. Based on our experience implementing the Helping Families Raise Healthy Children initiative, we hope that the toolkit provides concrete guidance on what to anticipate in planning and implementing depression screening, referral, and treatment within the early intervention system. Further, this toolkit could be used to encourage dialogue among providers interested in better addressing behavioral health issues for this population.
This toolkit was developed to provide the tools necessary to implement an initiative similar to *Helping Families Raise Healthy Children*, a program designed to screen for depression in early intervention, develop cross-system networking and referral processes, and provide relationship-based care within the early intervention and behavioral health systems. Each of the following four sections of this chapter provides guidance for implementing depression screening within early intervention. The following checklist provides an overall guide to the recommended steps in this process.

**Recommendations Guide**

**Screening for Depression in Early Intervention**

- **Step One: Select a Depression Screening Tool**
  - What are some possible depression screening tools?
  - How should the appropriate screening tool be selected?
- **Step Two: Develop a Process for Conducting Depression Screening**
  - Who will be screened?
  - When should the initial and follow-up depression screenings take place?
  - How should the depression screen be introduced and conducted?
  - How should screening results be communicated and documented?
- **Step Three: Train Early Intervention Service Coordinators on the Depression Screening Process and Provide Follow-Up Support**
  - What should training on depression screening cover?
  - What ongoing supports are needed for those conducting depression screening?

**Developing Cross-System Networking and Referral Processes**

- **Step Four: Conduct Cross-System Orientation and Networking Sessions**
  - What are the reasons for educating providers on the importance of cross-system referrals?
  - What methods can be used to foster cross-system collaboration?
- **Step Five: Develop Referral Processes for Early Intervention Service Coordinators**
  - When should referrals be made?
  - What are the referral options?
  - How should referrals be made?
- What are some considerations when making a referral to behavioral health services?

• Step Six: Develop a Process for Community Partners to Refer Families to Early Intervention for Parental Depression

• Step Seven: Train and Support Early Intervention Service Coordinators in the Referral Process
  - What training on the referral process is needed for early intervention service coordinators?
  - What ongoing supports related to the referral process are needed for early intervention service coordinators?

• Step Eight: Convene a Learning Collaborative for Providers Across Systems
  - What should Learning Collaborative meetings cover?
  - How should Learning Collaborative meetings be conducted?

Providing Relationship-Based Services

• Step Nine: Select a Model or Approach
  - What is relationship-based care?
  - How to select the appropriate model or approach?
  - What are some possible relationship-based care models or approaches?

• Step Ten: Train and Support Early Intervention and Behavioral Health Providers in Relationship-Based Care
  - What should training on relationship-based care cover?
  - What ongoing supports are needed for those providing relationship-based care?

Implementation Planning and Monitoring

• Step Eleven: Plan for the Costs of Implementation

• Step Twelve: Monitor the Implementation Process and Results

Each of these steps is described in more detail in the rest of this chapter. It is recommended that Steps 1–11 be completed before implementation begins.

Screening for Depression in Early Intervention

This section outlines the steps to implement depression screening within early intervention, including selecting a screening tool, developing a process for conducting screening, and training and supporting early intervention service coordinators to conduct the screening. Before starting to screen families in early intervention, it is critically important to identify referral pathways and develop referral processes (Steps Five and Six) so that families identified as at risk for depression can be connected to appropriate services.
Step One: Select a Depression Screening Tool

**What are some possible depression screening tools?**

There are many tools and measures that assess depression or depression risk. However, not all of them are appropriate for use in the early intervention setting. The following criteria can help focus the search for an appropriate depression screening tool:

- The depression screening tool is widely used in community-based settings and accepted in the field.
- The depression screening tool can be administered by a lay person as well as a clinician.
- The questions on the tool generally take no more than 10 minutes to complete.
- The depression screening tool is available free of charge.

The following depression screening tools are examples that meet these criteria.

*Edinburgh Postnatal Depression Scale (EPDS).* The EPDS has ten questions that ask about how the person has been feeling over the last seven days. It was designed for use in the period before and just after giving birth and has been well validated during pregnancy and the postpartum period (Cox, Holden, & Sagovsky, 1987). The EPDS is not linked with standardized psychiatric diagnostic criteria (DSM) and is not recommended for use in monitoring changes resulting from services or treatment. It has a maximum score of 30 with a validated cut-off score of 10–13.

*Patient Health Questionnaire (PHQ-9).* The PHQ-9 has nine questions that ask how often the person has been bothered by specific problems over the past two weeks. The questions are linked to the DSM-IV depression criteria, and scores can be used for tracking changes in depression in response to treatment. The PHQ is not specifically designed for perinatal use but is well validated for detecting depression in both general and low-income populations (Arroll et al., 2010; Cutler et al., 2007). The maximum score is 27, and a score of 10 or higher is typically considered positive. Another version of this tool, the PHQ-8, includes the first eight questions of the PHQ-9 but does not include the ninth question about potential self-harm.

*Patient Health Questionnaire (PHQ-2).* The PHQ-2 consists of the first two questions of the PHQ-9. It is also well validated for detecting depression (Arroll et al., 2010; Kroenke, Spitzer & Williams, 2003). It can be used alone or followed up with the PHQ-9.

*The Center for Epidemiological Studies Depression Scale (CES-D).* The CES-D asks how the person felt or behaved over the past week (Irwin, Artin & Oxman, 1999). It is available in both a 20- and 10-question format. For the 10-question screen, a cutoff score of 10 or higher is typically used.

There are additional commonly used tools available that do not meet the criteria established above, including the Beck Depression Inventory (20 questions), which is available for a fee, and the Hamilton Depression Scale, which is designed to be administered by a health care professional.

**How should the appropriate screening tool be selected?**

When selecting a screening tool, there are several important issues to consider:

- How much time is available for administering and scoring the responses?
- How will the scores be used (e.g., for treatment tracking purposes)?
• Are the individuals administering the screen equipped to address issues that may arise as a result of conducting the screen (e.g., the risk of suicide if it is indicated)?
• Will the screening be conducted with non-English-speaking caregivers?

Table 2.1 provides a comparison of the tools described above along these and other dimensions to support the selection process. These screeners typically take about five minutes to administer and a minute to score.

Step Two: Develop a Process for Conducting Depression Screening

Who will be screened?
Once the screening tool has been selected, a decision must be made about which caregivers in the family will be screened. Regardless of the family situation, the guiding principle is to screen the person who has primary responsibility for the child. This is the person who knows the child best, who cares for the child on a daily basis, and who makes the decisions about what’s best for this child most of the time (like bedtime, when he or she goes to the doctor, what the child eats for meals). Some of the options are:

• Primary caregiver only:
  – Consider whether this will include a grandparent or foster parent who is caring for the child.
• Primary caregiver and spouse/partner:
  – Consider whether the spouse/partner typically attends the visits

When should the initial and follow-up depression screenings take place?
Programs must determine whether it is feasible to screen caregivers at the first visit or wait until a subsequent visit. Consideration should be given to the length of time required for the initial visit (and the resulting burden on the family) and the subsequent opportunities for screening. Also, programs should weigh the benefit of potentially detecting depression earlier versus taking some time to develop a relationship with the family/caregiver before screening. An at-risk caregiver may be more willing to complete a depression screening after becoming more familiar and comfortable with a service coordinator. Table 2.2 shows both advantages and disadvantages to screening at the initial home visit.

Table 2.1
Comparison of Depression Screening Tools

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Number of Items</th>
<th>Reference Period</th>
<th>Linked to DSM</th>
<th>Used for Treatment Tracking</th>
<th>Designed for Perinatal Use</th>
<th>Question About Self-Harm</th>
<th>Available in Spanish</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPDS</td>
<td>10</td>
<td>7 days</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>9</td>
<td>2 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PHQ-8</td>
<td>8</td>
<td>2 weeks</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>PHQ-2</td>
<td>2</td>
<td>2 weeks</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>CES-D</td>
<td>10</td>
<td>7 days</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*The period of time referred to in the questions (e.g., “In the last 2 weeks, how often have you been bothered by the following?”).*
A schedule for follow-up screening should be developed for all caregivers regardless of the results of the initial screen. Consideration should be given to the current interval of visits and the length of time the family will be receiving early intervention services.

- For those who screen positive, subsequent screening can help the provider working with the family to determine whether the caregiver is improving and what additional services or resources might help. A common follow-up interval for tracking depression is six months.
- For those who screen negative, a suggested follow-up interval is one year, since annual screening matches the recommended protocol for general depression screening.

**How should the depression screen be introduced and conducted?**

There are a number of things the person conducting the screening can do or say to introduce the depression screen to the caregiver and make him/her comfortable with the screening process:

- Let the person know that all caregivers are being asked to complete a routine screening consisting of a few short questions that ask about their mood and how they are feeling.
- Emphasize that the questions are about how she or he has been feeling over the past (one or two) week(s), not just today.
- Normalize the process by saying, “We are screening all of the caregivers we visit to see how they are doing emotionally. We know this can be a difficult time for families, and there is help available if you need it.” Using an approach like this can be an effective way to ease the anxiety of caregivers.
- Determine the need for language assistance. If the caregiver does not read or speak English, questions will need to be read aloud or through an interpreter, or a non-English version of the tool should be provided as available.
- As much as possible, ensure that caregiver has some privacy when completing the questions.

**How should screening results be communicated and documented?**

Some caregivers may become distressed as they are completing the screen or when they learn that they have screened positive for depression. Training for those conducting screening is very important (see Step Three) so that service coordinators can engage with caregivers in sometimes difficult conversations about the screening results and next steps. The person conducting the screening can offer empathy and support in the following ways:
• Affirm that what the caregiver is going through is difficult and overwhelming: “You have really been going through a lot!”
• Validate their distress: “This has been really hard for you.”
• Offer support: “There is help available. Let’s talk about what kind of help you might need.”
• Ask if the caregiver is OK to continue or if it would be better to finish the screen later: “We can talk about this another time if you need to.”

The person conducting the depression screen should document the screening results so that the appropriate follow-up screening occurs. Programs may want to consider entering this information into a database that is capable of producing monthly reports to track when follow-up screens are due, provided that the appropriate data safeguarding procedures are in place to protect sensitive personal information. If the caregiver gives permission, the screening results may be shared with others working with the family, such as mental health agencies or early intervention providers.

Step Three: Train Early Intervention Service Coordinators to Conduct the Depression Screening and Provide Follow-Up Support

Equipping service coordinators and supervisors with knowledge, tools, resources, and confidence in their ability to support caregivers is critical. Training for depression screening can be provided separately or in conjunction with training about referral options (Step Seven). However, actual screening should not begin until referral processes are in place (Step Five).
Helping Families Raise Healthy Children Case Example: How an Early Intervention Service Coordinator Conducts Screening

A door opens and a young mother named Chanel invites Ann, an early intervention service coordinator, into her small apartment, one of many in her large, low-income, inner-city housing complex. Chanel is single, a new mother of twins, and has little support.

“Pardon the mess; I haven’t been able to pick up.” Chanel clears a space on the sofa littered with baby clothes, and invites Ann to sit. After asking about how Chanel is doing and getting little response, Ann invites her to talk about why the pediatrician referred the twins for a developmental evaluation. As Chanel quietly shares her concerns, Ann notices she is speaking very slowly, with little expression. Ann carefully reflects her understanding of Chanel’s concerns, then wonders aloud if this might be a really hard time for Chanel, with no help with the babies, and being worried about what the pediatrician said. Chanel nods wordlessly, making eye contact for the first time.

As they make their way through the paperwork required to set up the multidisciplinary evaluation, Ann, as usual, makes notes about family supports and family routines. It is here that Ann likes to introduce the depression screener she uses for every initial home visit. Handing the screener to Chanel, she says, “This is a screener we offer to all families who are participating in early intervention services. It can be useful to identify symptoms of depression that a lot of people with young children can experience. It just takes a few minutes...” Ann smiles and Chanel takes it and fills it out seriously and carefully. When she hands it back, Ann sees that Chanel is demonstrating a high risk for depression. When Ann discusses the results of the screener with her, Chanel holds her hand up and closes her eyes. “I don’t like that word ‘depression’—it makes me feel like I might be crazy or something. All of the people around here are having a hard time, that’s just how it is...” She drops her hand suddenly as her shoulders slump and she opens her eyes to look again at Ann. “But I can’t keep on like this, I feel like I just want to go to sleep and never wake up, you know? I just want to leave the babies in their cribs all the time, and I know that’s not right.”

What should training on depression screening cover?

Training for those conducting the screening should describe depression and its effects on child development, provide instructions on how to conduct the screening, and discuss how to provide support to families who complete the screening. Service coordinators may not feel they have the confidence or skills to introduce a depression screen or engage the caregiver in a discussion about the results. Training sessions that include specific language and offer role-playing situations can help service coordinators develop communication skills and ease concerns about how to effectively engage with parents on difficult topics. Trainings on the depression screening process for service coordinators should include the following:

1. Depression
   a. Prevalence, symptoms
   b. Effect on childhood development
   c. Effect of childhood developmental delays on caregiver depression
2. Screening process
a. Screening tool
b. Who, when, how to screen
c. How to introduce the screen
   ◦ Provide specific language and role play
d. How to communicate results
   ◦ Provide specific language and role play
e. How to respond to crisis situations
   ◦ Provide specific language and role play

3. Ongoing support to caregivers/families
   a. Follow-up
   b. Referrals to community services

4. Documentation
   a. Record screening score
   b. Billing for depression screening

What ongoing supports are needed for those conducting depression screening?

Even after training, service coordinators may need further reassurance and support for screening and talking to caregivers about possible mental health issues. Supervision that encourages mutual sharing, reflecting, and planning (i.e., reflective supervision) is one way of supporting service coordinators (Shahmoon-Shanok, 2009). Reflective supervision in this context aims to increase engagement between the supervisor and service coordinator to help process the experience of working with the family and partner on ways to move forward. There are several things that can be done to demonstrate support and provide reflective supervision:

• acknowledging service coordinators’ anxiety and the challenges related to screening
• addressing concerns about feeling helpless when caregivers reveal problems
• reminding them that they are providing support to the caregiver just by asking and listening
• offering consultation and specific guidance on how to approach challenging situations
• preparing to address issues that may arise, such as caregiver trauma or domestic violence
• providing a regular time for supervision and encourage staff to join the supervisor in reflecting about the work
• providing guidance on how to bill for time spent screening
• providing additional and/or ongoing opportunities to practice and improve skills.

The training and ongoing support also need to ensure that service coordinators are prepared to respond to crisis situations.

Developing Cross-System Networking and Referral Processes

This section outlines the steps to develop cross-system networking and referral processes. The goals of cross-system collaboration are to improve communication between systems and improve referral and engagement of caregivers in services. These collaboration goals can be met through cross-system orientation and networking meetings, the development of refer-
Tips for Responding to Crisis Situations

Any time a caregiver expresses thoughts about self-harm (e.g., positive response to a specific question about self-harm, or expressed thoughts about self-harm during discussion), it is especially important to address these thoughts with the caregiver. The person conducting the screening should explain that the caregiver’s safety is very important, as is making sure that he/she is safe and his or her child stays safe. Here are some possible follow-up questions if the respondent indicates having had thoughts of being better off dead or performing self-injurious behavior in the past several weeks:

- Can you tell me a little more about these thoughts?
- Does anyone else know you are feeling like this?
- Who do you turn to first for help? (record name)
- Have you had thoughts like this before? Have you acted on them?
- Have you thought about ways that you might act on these thoughts?
- Have you thought about how it would be for your child if you weren’t here for her?

Once these or similar follow-up questions have been asked, it is important to discuss with the caregiver what can be done to ensure safety and to emphasize the importance of talking to people who can help and understand what it’s like to have these feelings. It is also important to involve family member(s) as soon as possible and discuss crisis services available in the community. Here are some possible next steps:

- Engage family support systems.
- Determine whether emergency or crisis contact is required.
- Initiate referral to crisis services, if necessary.
- Document response and inform supervisor.
- Call a supervisor for support.
- Call 911 if there is a threat to anyone’s immediate personal safety.
- Contact crisis services if necessary.
- Follow up after departure (Check-in calls to assure safety).

Crisis services are a very important resource for caregivers who are experiencing overwhelming stress to the point of endorsing suicidal thoughts or even harming someone else. These situations do not occur frequently, but when they do, it is important that staff who are screening know the appropriate emergency services to contact and have access to consultation with supervisors in their agency while dealing with a crisis situation.

It is recommended that screening agencies connect with local area crisis services (mental health and domestic violence) and have a representative speak to the group so that all are familiar with what crisis looks like and what to expect from the agency once a call has been placed. If 24-hour crisis services are not available, make connections with law enforcement and local mental health professionals to help guide the process. It is always important to prepare for a potential crisis situation rather than trying to come up with solutions as one is happening.
Frequently Asked Questions on Conducting Depression Screening

**Q:** What if multiple caregivers are present or if multiple people feel they are equally involved?

*A:* Offer the screening to the primary caregiver. If another caregiver wants to complete the screen or both caregivers share responsibility equally, it is fine to offer the screening to both.

**Q:** What if the caregiver declines to be screened?

*A:* The screening is entirely voluntary. The screen may be offered again at a subsequent visit after using judgment about their readiness, especially if the initial reaction was strongly negative.

**Q:** What if there is an existing diagnosis of depression or the primary caregiver has already been screened by the physical health provider?

*A:* Document the diagnosis or screening result on the screening tracking form. If the primary caregiver is willing to complete the depression screening again, then this is preferable. However, this is not required when there is an existing diagnosis of depression or the primary caregiver has already been screened.

**Q:** How do you introduce the initial screen?

*A:* Introduce the initial screen by saying something like “We are screening all of the caregivers we visit to see how they are doing emotionally. We know this can be a difficult time for families, and there is help available if you need it.”

**Q:** What if two caregivers are screened, but the one who screens positive is not normally the one at home with the child?

*A:* If the caregiver who screens positive is not the primary caregiver, try to refer to adult behavioral health services rather than the relationship-based interventions.

**Q:** What if I have very little contact with the primary caregiver (e.g., the primary caregiver is present for initial home visit and evaluation, but ongoing contact is primarily with a sitter, relative, or child care provider)?

*A:* If the primary caregiver screens positive, indicating high risk for depression, then it will be important to follow up with the caregiver. If the caregiver is not present for subsequent visits, then contact the supervisor, who can attempt to reach the caregiver.

**Q:** What should I do if the caregiver reveals that she is in an abusive relationship?

*A:* Ask if she would like information about local domestic violence programs or a national hotline and provide any requested information.

**Q:** How do I bill for the time spent on screening?

*A:* One way to bill for screening time is to document the activity using the context of the relationship. For examples, document the depression screen as “screened for family social/emotional well-being.”
eral processes, training and support for early intervention service coordinators on the referral processes, and a Learning Collaborative that brings together early intervention and behavioral health providers.

**Step Four: Conduct Cross-System Orientation and Networking Sessions**

*What are the reasons for educating providers on the importance of cross-system referrals?* Educating providers about the interconnectedness between depression and early childhood developmental delays lays the foundation for connecting systems through referrals and increased communication. When providers understand the potential impact of a parent’s mental health on the child and the child’s health and developmental issues on a parent, it becomes easier for them to value the role they can play in ensuring that families are linked to the services they need. For example, an adult mental health therapist working with a severely depressed mother would typically be focused only on her. The therapist typically may not “keep the baby in mind” or may not consider the impact of depression on the child or the parent-child relationship. Likewise, many individuals working with young children in early intervention do so because they enjoy working with children. Helping early intervention service coordinators understand the role that the caregiver’s mental health can play in impeding healthy development reinforces the importance of making referrals to the behavioral health system.

*What methods can be used to educate providers and foster cross-system collaboration?* Cross-system referral workshops and trainings can address the reasons why it is so valuable to make referrals across systems and how coordinated services can make a difference for families. Orientations and networking meetings can bring together a broad community target audience of system champions, administrative leadership, and direct care staff to establish relationships and a commitment to improving care for families. Key partner systems include early intervention, behavioral health, and maternal and child health care.

**Orientation Sessions**

These sessions can be used to introduce large groups to the concept of a dyadic approach to caregiver depression, to present an overview of the components of system change necessary to address parental depression, and to serve as an opportunity for staff across systems to meet.

Orientations should offer the following:

- An overview of the interconnectedness between parental depression and early childhood development.
- The vision for system change and the components included (i.e., screening for parental depression in early intervention, cross-system referral, tracking services based on parental mental health issues, home-based behavioral health services, training early intervention and behavioral health providers in relationship-based practice).
- An overview of the role of each system (early intervention, behavioral health, maternal child health care, and other community-based agencies) and the array of services each offers.
- The family perspective, presented by a parent willing to share his/her experience if possible or told as a story from a provider’s caseload, to illustrate the barriers and challenges that traditionally disconnected services and systems pose to families coping with these issues.
Networking Meetings

Multiple small group cross-system networking meetings can be held among supervisors and service coordinators from the early intervention service coordination agency, early intervention providers, behavioral health providers, maternal child health providers, and pediatricians or family medicine doctors to further strengthen system knowledge and relationships and to jointly develop clear and simple cross-system referral processes. Collaborative relationships strengthened through cross-system networking meetings help providers understand the role of each system and enable providers to learn how they can support each other and families, through cooperative and collaborative efforts.

Step Five: Develop Referral Processes for Early Intervention Service Coordinators

When should referrals be made?

Cross-system referrals can be made through early intervention under a variety of circumstances. First, caregivers who screen positive on the depression screening tool can meet the criteria for a referral. The score on the screening that will trigger a referral for support and services needs to be defined. For example, it may be determined that all individuals with a score of 10 or more on the PHQ-9 will be considered at high risk for depression and offered a referral. There are several considerations when determining what score to define as a positive depression screen and what score warrants a response (e.g., a referral). These considerations include the predefined clinical threshold for the screening tool being used, provider capacity to respond to positive screens, and the potential burden and cost on the systems involved with using a lower threshold score to indicate depression risk, which may increase the number of positive screens.

Second, caregivers who decline the screening or who screen negative may express a need for or interest in supports and services. Depending on system capacity, it is appropriate to offer referrals to these caregivers. For example, anxiety often co-occurs with depression, but the depression screening tool may not detect anxiety. By asking the parent how he/she is feeling emotionally, in addition to offering the depression screening, the parent may reveal other significant life stressors for which a referral to services and support could be helpful.

In determining when to make a referral, service coordinators should gather as much information as possible through discussion with the family members about their needs. This will help identify the appropriate referral options, which may differ based on a variety of factors:

- family’s strengths, needs, and problems
- insurance coverage of family members
- location of family (geographic area)
- previous experience with services
- current services (if any).

What are the referral options?

While early intervention service coordinators are knowledgeable about resources that address early childhood developmental delays, they are often less familiar with services available through the behavioral health system for parents experiencing depression and other community supports that may help the entire family. Therefore, when integrating parental depression screening into the early intervention system, it is important to educate service coordinators about the referral options open to families who screen positive for depression risk (as well as
those who screen negative but request a referral to behavioral health supports) and develop referral protocols for matching needs to referrals in these behavioral health and community services and supports.

Referral options generally fall into three categories:

**Relationship-based early intervention services**, which can be provided to families with a child receiving early intervention services through qualifying developmental delays and with an IFSP, which may include such services as speech therapy, physical therapy, occupational therapy, developmental specialist, vision, nutrition, or social work services. Early intervention social work services are an option for families without insurance coverage for behavioral health services. The services are home-based and can help link parents to needed supports for themselves as well as the child.

Providers of these services can be trained in relationship-based techniques (see Step Eight), such as reflective listening, speaking for the child, positive instructive feedback, and giving supports to families during the therapy session with the child. These techniques are then used in working with the child and parent on the specific therapy being delivered. Early intervention providers trained in relationship-based techniques have skills in engaging parents and tools to help support the parent-child relationship and promote attachment between the caregiver and child. For these reasons, relationship-based services should always be considered as appropriate referrals for families with a parent experiencing depression and a child with an established developmental delay and an IFSP. It is important to note that relationship-based early intervention therapists are not expected to provide counseling, but specialized training in relationship-based care enables them to effectively engage parents and children, recognize and attend to the interconnectedness of child and parent, and function as a therapeutic presence in that family’s life.

**Behavioral health services**, which can be offered based on the clinical needs of the parent. Agencies may provide traditional clinic-based mental health services as well as community or home-based mobile mental health services. Examples of traditional ambulatory services available to families include the following:

- evaluation and psychiatric assessment
- outpatient therapy
- crisis management
- mental health service coordination
- substance abuse services.

Home-based behavioral health services are also available in many areas, primarily for individuals eligible for Medicaid. Home-based services are effective at overcoming typical barriers to treatment that families often experience, such as lack of transportation, difficulty obtaining child care, stigma associated with mental health treatment, and the barrier of depression itself, which can make it difficult for a parent to attend outpatient therapy. Home-based behavioral health services provide a unique opportunity to deliver depression treatments within the context of a relationship-based approach and to support and strengthen the parent-child relationship. Specialized training in relationship-based care enables providers to effectively engage parents and children, recognize and attend to the interconnectedness of child and parent, and may help ameliorate the effects of parental depression on the child (Mahoney & Perales, 2005; Rauh et al., 1988). Examples of home-based behavioral health services include the following:
• mobile outpatient therapy
• mobile crisis intervention services
• team-delivered mobile mental health and service coordination services.

It is important to note that early intervention service coordinators can refer families to behavioral health agencies that will complete a thorough assessment of mental health needs and, in partnership with the family, determine the appropriate services and level of care.

**Community-based services** vary across geographic areas, but can serve as an important resource. Some examples of community-based services that often include a home-visiting component are Early Head Start, Healthy Start, and nurse home visiting programs such as Nurse-Family Partnership. Many community-based social services offer social work services, parenting supports, social supports, or a mental health component, and are valuable resources for families. By identifying local agencies that offer services to families and forging connections with these agencies, community-based supports can be a place to refer families involved with early intervention. One consideration when referring to community-based services is that some programs may have eligibility criteria. It may be helpful to record the basic inclusion criteria for each program in a reference guide for service coordinators conducting screenings and referrals.

**How should referrals be made?**
The process for making referrals from early intervention to multiple agencies can be challenging, as agency requirements may differ. Referral protocols that can be integrated into existing processes can help keep things simple and user-friendly for early intervention service providers.

An important first step is to determine the specific information and format required by the agencies accepting referrals so that service coordinators know specifically how to refer to each participating agency. Examples of needed information may include:

• Will the agency accept a telephone referral or is there a referral form that must be completed?
• Must the parent call to self-refer or can the service coordinator complete a referral with the family’s permission?
• Will the agency accept a universal referral form?

A universal referral form can be a useful tool that provides a list of referral options for the family and gathers the information the service providers will need about the family. The form should be as simple as possible and should list the eligibility criteria for each referral option. Keeping eligibility criteria clear makes it easier for those being referred to understand why they are there and what services are available. Eligibility criteria may include a specific age range, geographic area, or specify that referred families cannot be involved with the foster care system.

The referral form should also include the family’s information (e.g., parents’ names, child’s name, address, and phone numbers) and the referring party’s information. Information about who is referring the family is helpful when the service provider cannot reach the family or wants to keep the referring party informed about the status of the referral. The caregiver’s insurance information is also important to help determine which services are available and to coordinate with appropriate providers. Check boxes noting concerns or answering key questions for the child and family may also be helpful to determine the appropriate pathway for the referral (e.g., was the child in the neonatal intensive care unit? Is there a concern for a devel-
Helping Families Raise Healthy Children: Referral Processes

When a caregiver screens at risk for depression, The Alliance service coordinator explains that all children from birth to age 3 whose caregivers are identified as being at risk for depression are eligible to have their development monitored, even if they do not qualify for The Alliance’s IFSP or existing high-risk tracking services. If the family’s only risk factor is depression (or another behavioral health concern), then one of the project-funded mental health specialists at The Alliance follows the family, offering more intensive high-risk tracking services. For children who qualify for tracking services or an IFSP based on other risk factors or delays, the service coordinator follows the family, engaging support from the mental health specialists as needed.

To determine which referrals may be appropriate, the service coordinator and the caregiver discuss any prior experiences with depression or other behavioral health issues and any treatment received, the types of stressors the caregiver faces, and whether the family has a support system. Based on this discussion, the service coordinator suggests referral and service options and determines whether the caregiver would like a referral. If the caregiver declines a referral, the service coordinator provides options for family support, including tracking by the project mental health specialist, and checks in with the caregiver periodically. If the caregiver accepts a referral, the service coordinator discusses some of the common barriers to accessing behavioral health services and informs the project’s mental health specialists about the referral request. The mental health specialists work toward connecting the caregiver and family to the appropriate services and supports. On an ongoing basis, the mental health specialists coordinate services and supports with the community-based providers.

What are some considerations when making a referral to behavioral health services?

Many factors may affect a caregiver’s willingness to engage in behavioral health treatment services. Stigma, the role of culture, past experiences with services, insurance coverage, and availability of transportation or child care are all factors that can present barriers to accessing treatment. The tips in the next box provide strategies for reducing some of these barriers to families accepting referrals for behavioral health services. For concerns about insurance coverage, it is helpful to be familiar with the different insurance options. Managed-care organizations or insurance agencies may have care managers who can be reached by calling the number on the back of the insurance card. Connecting a caregiver with his/her primary care physician may also open opportunities for referral or help with medication and services. Families may also

opmental delay? Is child protective services involved? Are there other parental mental health issues or concerns?). Checklists such as these can help prompt the person making the referral to think more closely about the needs of the family.

Depending on the service provider, there are a number of methods for making referrals (e.g., fax, phone, email, mail). The referral form should specify the options for making a referral. It may be possible for the caregiver to be involved directly in the referral by speaking to the relevant individual at the provider agency. This type of referral, known as a “warm handoff,” can produce good results because it enhances caregivers’ comfort with the service agency they are being referred to.

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Tips for Supporting Cross-System Referrals

- Provide concrete guidance to service coordinators making referrals about the supports and resources available to assist them in making cross-system referrals (e.g., referral and resources guide).
- Recognize the challenges in making changes to existing processes, such as resistance to new procedures, perceptions about potential increased burden and workload from the changes, and concern about whether there will be follow-through on the referral, when training service coordinators on making referrals.
- Support providers who make and receive referrals in developing and maintaining an open dialogue with each other.
- Develop a simple and clear referral process to increase the likelihood of successful referrals.

have access to behavioral health services through an employer-sponsored employee assistance program that provides for a number of sessions with a licensed therapist.

It is important for service coordinators to talk with the family, explore their feelings about seeking help, and share information about available supports. Service coordinators should discuss potential barriers with families, providing information about options and acknowledging that the families are the experts regarding their own needs. Sharing the message that accessing services for depression can be tremendously helpful for their children can help motivate caregivers to engage in services.

Step Six: Develop a Process for Community Partners to Refer Families to Early Intervention for Parental Depression

Early intervention services are available to children from birth to age 3 who are experiencing developmental delays or who have a diagnosed condition that has a high probability of resulting in a developmental delay. Any child can be referred to early intervention for developmental screening and evaluation to determine eligibility for services. Community-based agencies often make referrals for developmental delays. When community partners screen and identify parents at risk for depression, they should refer the family to early intervention to determine whether the child is experiencing any developmental delays.

Some state systems, including Pennsylvania’s, provide services for children with specific risk factors that could lead to a developmental delay. In Pennsylvania, children with established risk factors receive “tracking services” that regularly monitor the child for the emergence of any developmental delays and then link families to services as soon as a need is identified. Parental depression can be designated as a risk factor for child developmental delay, based on evidence of the negative effects of parental depression on early childhood development.

For community-based agencies that offer universal depression screening (such as family medicine, pediatric practices, and Healthy Start), a policy whereby families with a caregiver who screens positive for depression risk are referred for developmental screening and evaluation of the infant/toddler can be a welcome option. To implement this process, it is important to develop a referral process that makes it straightforward for the community-based agency to connect families identified as being at risk for depression to early intervention. A referral form
with clear instructions that can be faxed to the early intervention agency can help facilitate these referrals (see the example in Chapter Three). Further, education and outreach efforts to the community-based partners who will be identifying and referring families to early intervention should be conducted. These community-based agencies need to be able to share with families why caregiver mental health is important for their child’s development and what early intervention and behavioral health services have to offer. Some families easily accept referral to early intervention, whereas others need more support for engagement and may need to be re-referred before they are ready to commit. Outreach meetings can provide information and resource materials about depression, its impact on child development, the importance of behavioral health services and treatment, and the referral process to staff at the partner agencies that might be referring families.

Referral sources that screen for parental depression should be made aware that it is not appropriate to refer families in need of crisis services to early intervention. If a community partner identifies a caregiver in severe distress, staff should refer the caregiver directly to mental health services, crisis services, or other emergency services as appropriate before referring to early intervention.

Step Seven: Train and Support Early Intervention Service Coordinators in the Referral Process

**What training in the referral process is needed for early intervention service coordinators?**

Early intervention service coordinators should have solid knowledge of all the local community supports available to assist families experiencing depression and early childhood developmental delays. Simple and specific referral protocols for cross-system referrals should be developed, and service coordinators should receive training to understand when such referrals are appropriate and how to complete them. Service coordinator training for the referral process should include:

1. Referral options by system
   a. Behavioral health—range of services available
   b. Crisis services
   c. Community-based resources (e.g., Nurse Family Partnerships, Family Support Centers, Early Head Start, Healthy Start, other local resources)
2. Relationship-based care with early intervention or behavioral health providers
3. Referral processes and documentation
   a. How to communicate and discuss results
      ◦ Provide specific language and role play
   b. How to engage in difficult discussions with families
      ◦ Provide specific language and role play
   c. How to respond to crisis situations.

**What ongoing referral process supports are needed for early intervention service coordinators?**

Administrative and clinical support related to the referral process are critical for early intervention service coordinators. Supervision and consultation with a supervisor regarding referrals can help support service coordinators as they expand their knowledge of available resources for families in other systems, particularly the behavioral health system for adults. Service coordinators also need ongoing support related to having difficult conversations with families about referrals.
A resource guide that provides a complete list of referral options within the community, including eligibility criteria, target populations, and referral processes, can be a helpful tool for service coordinators. This guide should be updated periodically and distributed to service coordinators.

**Step Eight: Convene a Learning Collaborative for Providers Across Systems**

After initial training is complete, providers may still desire ongoing support and training in cross-system learning. One method of providing this support in a sustainable way is to convene a Learning Collaborative. A Learning Collaborative is a means of providing ongoing education and support based on the premise that knowledge can be created and skills strengthened within an emerging community of practice in which members actively interact by sharing their successes and challenges (Reynolds et al., 2012). The coordinators of the Learning Collaborative can be leaders or champions from early intervention provider agencies, behavioral health agencies, or organizations within the maternal and child health care systems. Providers from both the early intervention and behavioral health systems trained in the cross-system referral processes (Step Seven) and/or on relationship-based care (Step Nine) can be invited to participate. A Learning Collaborative can offer providers, agencies, and systems opportunities for

- developing individual relationships between practitioners from the systems that help families with parental depression and child development issues
- strengthening relationships across systems through networking
- sharing experiences with other providers who work with families touched by parental depression and early childhood developmental delays
- strengthening individual providers’ skill development and knowledge; providers may feel isolated and lack opportunities for regular professional peer contact and support
- improving cross-systems knowledge and integration
- learning from the collective experiences of other utilizing relationship-based practices.

**What should Learning Collaborative meetings cover?**

The primary purpose of the Learning Collaborative meetings should be to provide ongoing educational support, peer mentoring, and continued relationship building among providers committed to changing and transforming services through cross-system collaboration and relationship-based care (Reynolds et al., 2012). Specifically, the Learning Collaborative forms a network of early intervention, behavioral health, and maternal child health care providers and provides a forum for them to share their experiences with cross-system referrals and relationship-based care. Learning Collaborative meetings and possible training topics should reflect the needs and interests of collaborative participants. Possible discussion and training topics could include

- cultural competency
- engagement strategies
- infant mental health
- motivational interviewing
- relationship-based practice
- discussing and working with families on difficult issues
- self-care for therapists
- trauma-informed care.
How should Learning Collaborative meetings be conducted?
Learning collaborative meetings should occur at regular intervals and be facilitated by an experienced group leader who champions cross-systems collaboration and relationship-based care. Guest facilitators who are recognized experts in their field also can provide participants the opportunity for additional learning and training. Another option would be to have Learning Collaborative members take turns investigating and presenting on given topics of interest. Frequency can be determined by demand, but face-to-face meetings are recommended on a quarterly basis to sustain momentum.

Providing Relationship-Based Services
This section outlines the steps to providing relationship-based care and services within early intervention and behavioral health, including selecting an approach and then training and supporting early intervention service coordinators and providers. Relationship-based practice in early intervention has been discussed and advocated since the early 2000s (Edelman, 2004). Relationship-based approaches recognize that “all learning takes place in the context of relationships and is critically affected by the quality of those relationships” (Norman-Murch, 1996). As described in this section, providers can be trained in relationship-based models and supported in incorporating the approaches into their work with the child (in the case of early intervention providers) and the caregiver (in the case of behavioral health providers).

Step Nine: Selecting a Model or Approach
What is relationship-based care?
Relationship-based care begins with the assumption that every child develops in the context of a family, and that healthy development depends on healthy primary attachment, physical and emotional safety, and predictable routines (Edelman, 2004). Some other foundational concepts of relationship-based practice include:

- forming a collaborative, culturally responsive partnership with families (Miller & Hanft, 1998)
- considering the parent-child dyad as the “Unit of Service” (Foley & Hochman, 1997)
- promoting healthy give-and-take interactions (Edelman, 2004)
- using reflective observations to identify cues and signals by both caregiver and child (Norman-Murch, 1996)
- delivering intervention from a strengths-based perspective, utilizing positive perceptions to support service goals, strategies, and outcomes (Wilcox, 2001)
- using empathetic and reflective listening, respectful wondering about family challenges, and encouragement for families to draw on past experiences as they work on changes (Pilkington & Malinowski, 2002).

Historically, both early intervention and behavioral health home-based service providers have focused exclusively on working with a single individual as the target of service. Relationship-based services in either system are directed toward and shaped by the needs of the relationship, and consider the unique dynamics of the caregiver-child dyad. Professionals who
begin looking at their therapeutic work through a relationship-based lens report that interactions with stressed families actually become easier.

Relationship-based practices do not require early intervention providers to deliver behavioral health therapy, which is, appropriately, the domain of behavioral health providers. Rather, relationship-based care within early intervention involves added focus on the parent’s experience. Simply asking about how the parent is doing and feeling can change the dynamic of the first encounter and open the door for a relationship-based approach to serving the family. Likewise, relationship-based practice does not require mental health therapists to be child development specialists, but rather encourages increased attention on the parent-child relationship when serving the family. Relationship-based practice is a way of helping a caregiver and child that moves outside of traditional disciplinary boundaries, focusing on the relationship to enhance engage-

Helping Families Raise Healthy Children Case Example: How a Provider Team Delivers Relationship-Based Care in Early Intervention and Behavioral Health

Service coordinator Ann has already been out to see Chanel, a young single woman living in a low-income apartment building who has a new set of twins. After reviewing the concerns stemming from the pediatrician’s referral, Ann completed paperwork to schedule today’s multidisciplinary developmental evaluation (MDE). At that first early intervention visit, Ann administered a depression screen, which indicated that Chanel was struggling with symptoms of depression. They agreed at the first visit to follow up with a discussion of the treatment options at the time of the MDE. As Chanel opens the door today, Ann can see that Chanel remains overwhelmed and exhausted. She greets the assessment team at the door with a few barely audible words and motions them in without smiling.

As the team moves through the evaluation activities, they begin to notice some significant differences between the babies. The female twin, Jade, is alert, smiling, and actively soliciting attention, and the mother smiles tiredly as she watches her. The male twin, Luke, is sitting in an infant seat across the room, silently watching the shadows on the ceiling. When asked about him, Chanel shakes her head. She says he never smiles and even cries when she picks him up much of the time. She whispers to the service coordinator that he’s mean, and he doesn’t like anyone. In sharp contrast, it seems that the only person that can make Chanel smile is Jade, who wiggles and coos, and Chanel talks almost exclusively to her. As the evaluator handles Luke, she notices that he has overall low muscle tone, a head tilt, and is beginning to develop a flat place on one side of the back of his head.

As she shares some of her observations, Chanel voices guilt that it might be her fault if something is wrong with him, since she didn’t have a lot of money for healthy food when she was expecting.

The Service Coordinator, Ann, using a relationship-based approach, talks with Chanel about the difficulties of having new twins, how it felt to do it alone, and her worries about her son. She listens empathetically and lets Chanel tell her story. Using the depression screen that is offered to all families, she shares with Chanel the fact that many caregivers of young children experience symptoms of depression. After the MDE is com-
ment and optimal attachment between the parent and child. It is important to note that it is not necessary to use a particular model or curriculum to provide relationship-based care.

The case example illustrates the general approach of providing relationship-based care.

**How to select the appropriate model or approach?**

There are several relationship-based models that are compatible with both the behavioral health and early intervention systems. No single model has been agreed upon by clinicians or researchers as the “best” model for providing care. Communities interested in implementing a relationship-based approach to early intervention and behavioral health services should explore the different options for evidence-based models of family-focused behavioral health care. Using a participatory process with representation from all collaborative stakeholder groups (includ-

completed, Ann discusses options, including home-based mobile mental health services, to help her cope with these feelings. Chanel, feeling heard and responded to, agrees to have the service coordinator make a mobile mental health referral.

*The Physical Therapist,* Lynne, who now visits the family, has had relationship-based training too. At the beginning of each visit, she asks Chanel how things have been going for her, before she turns to the news about Luke’s skills and progress. When she introduces a stretch or a way to hold the child, she notices when Luke is paying attention to Chanel so she can comment: “Look, he wants to see where you are, because he is most comfortable with you, isn’t he?” She is careful to have Chanel introduce interesting new play or therapy objects herself; creating space for Chanel and Luke to take in this new experience together as opposed to having Chanel look on alone. Lynne knows her efforts to strengthen the relationship and increase routine-based strategies throughout the week are working well when she overhears Chanel explaining to a visitor how she stretches Luke’s neck muscles. “After she shows me how to do it, Lynne likes me to be the one to do it even when she’s here, because he’s more relaxed when I do it.” By keeping the focus on the relationship rather than on the baby alone, Lynne magnifies the power of the intervention and maximizes engagement between the parent and child.

*The Mobile Mental Health Therapist,* Holly, begins visiting Chanel shortly after the start of early intervention services. Although Chanel was unsure at first, she begins to look forward to Holly’s visits every week, and her mood seems to lighten significantly over time. They talk about her family tree, and Chanel realizes as she talks about her family that she is not the first person in her family to experience depression, and that many of the women she remembers as strong from her family tree needed extra support too. They also spend time together with Luke and Jade during their sessions, listening and wondering together about what Luke might be trying to tell them when he is fussing. They also discuss how his fussing makes Chanel feel, and why. Holly begins to notice that Chanel is keeping Luke closer to her and Jade, and that she is holding him more. She also notices that Luke’s fussing is not distressing Chanel as much as it seemed to at first and that she repeats the words that she and Holly talked about during their “listening sessions” at times, like, “Luke-Luke, you are good and safe and I am here for you!”
ing families who received early intervention services), communities should consider their goals and their target population and determine the needs of all collaborative partners before selecting an approach. Further, within the community, providers in both systems can select the relationship-based model or approach that is compatible with their agency’s goals and objectives.

When selecting a relationship-based care model or approach, there are several important issues to consider for each option:

- Is the model grounded in attachment/relationship theory?
- Does the model already have an existing, available curriculum?
- Has the model been identified as an evidence-based program or promising practice?
- Has the model already been implemented locally?
- Is the model easily replicable?
- Does the model match to the target population?
- Does the model fit with a home-based approach to service delivery?
- Does the model allow flexibility to tailor sessions to meet the needs of the family?

Other considerations include the cost of the model, the level of practitioner experience needed for implementation, and the training time required.

What are some possible relationship-based care models or approaches?
There are several possible models or approaches for providing relationship-based care within early intervention and behavioral health. Training providers in the foundational concepts of relationship-based care, as described earlier, can provide useful tools for engaging families and partnering with families to improve outcomes for children and parents. Furthermore, established curricula can be used in whole or in part to address the needs of caregivers and children. We have listed examples of some models that meet the criteria outlined above.

Nurturing Parenting
http://www.nurturingparenting.com
Nurturing Parenting was originally developed to prevent and/or treat child abuse and neglect (Kelly et al., 2003; Kelly, Zuckerman, & Rosenblatt, 2008). Nurturing Parenting follows a 48-week program that addresses several components of the parent-child relationship, including child development, emotional connections, discipline, communication, and coping with stress. However, the program is flexible and can be adapted to meet the needs of the particular family. The provider and caregiver work together for the first hour of each visit, then the parent spends the last half-hour practicing new skills, getting coaching when needed. The program can be delivered as a home-based or group-based intervention. Several training opportunities are available, including “train the trainer” workshops.

Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are to

- teach age-appropriate expectations and neurological development of children
- develop empathy and self-worth in parents and children
- utilize nurturing, nonviolent strategies and techniques in establishing family discipline
- empower parents and children to make healthy choices
- increase awareness of self and others, developing positive patterns of communication while establishing healthy, caring relationships.
Partners in Parenting Education

http://www.howtoreadyourbaby.org

Partners in Parenting Education (PIPE) aims to promote healthy infant-parent relationships by developing and maintaining secure attachments between children and caregivers (Appleyard & Berlin, 2007; Dolezol & Butterfield, 1994; Hepburn, 2004; Robinson, Emde, & Korfmacher, 1997). The program can be delivered as a home-based intervention, and the curriculum is divided into three parts: Listen, Listen, Listen (e.g., communication skills); Love Is Layers of Sharing (e.g., emotional connections and trust), and Playing Is Learning (e.g., stabilization and socialization). At each session, the provider goes through four phases with the family: Presentation of Concepts, Demonstration, Supervised Parent-Child Interaction, and Evaluation. Several training opportunities are available, including “train the trainer” workshops.

Curricula are designed to support infant mental health by increasing the emotional availability of those caring for children. They have the following attributes:

- based on sound educational and psychological research
- focused on the child
- utilize the expertise of all of the partners in the process
- are experiential
- aim to positively affect the emotional relationship between a parent and his or her child.

Promoting First Relationships: A Curriculum for Service Providers to Help Parents and Other Caregivers Meet Young Children’s Social and Emotional Needs

http://www.ncast.org/index.cfm?fuseaction=category.displayandcategory_id=23

Promoting First Relationships emphasizes the importance of attachment between parents/caregivers and infants/toddlers and aims to ameliorate the potentially negative impacts of poverty, family stress, special needs, and behavioral problems on the parent-child relationship (Cowen, 1998; Devall, 2004). The program can be delivered in home-based or group-based settings and follows a curriculum that uses handouts and videos to strengthen the parent-child relationship. Several training opportunities are available, including “train the trainer” workshops.

The Promoting First Relationships curriculum covers issues critical to supporting and guiding caregivers in helping them build nurturing and responsive relationships with children:

- theoretical foundations of social and emotional development in early childhood
- consultation strategies for working with parents and other caregivers
- elements of a healthy relationship
- promoting the development of trust and security in infancy
- promoting healthy development of self during toddlerhood
- understanding and intervening with children’s challenging behaviors
- developing intervention plans for children and caregivers.
Step Ten: Train and Support Early Intervention and Behavioral Health Providers in Relationship-Based Care

Training and supporting early intervention and behavioral health service providers with the knowledge, tools, resources, and confidence in their ability to provide care through a relationship-based lens are critically important to successful implementation. In this step, more general training on relationship-based care described in this step should precede training specific to the relationship-based intervention model or approach selected in Step Nine.

What should training on relationship-based care cover?

Training for those planning to provide relationship-based care should at a minimum briefly describe the neurobiology of attachment and discuss engaging depressed caregivers while providing home-based services before focusing on the core concepts of relationship-based practice.

1. Neurobiology of attachment
   a. Introduction to foundational elements of attachment
   b. Introduction to core concepts of early brain development
   c. Review of current information about depression
   d. Discussion of the effect of depression/adversity on early attachment and brain development

2. Engaging depressed caregivers in the context of home-based services
   a. Role of depression and impact on early intervention and behavioral health service delivery
      ◦ Identification during home visits
      ◦ Ways of talking about depression with families
      ◦ Relevant cultural norms
   a. Reworking typical home visits using a relationship-based perspective
      ◦ Scheduling and planning to support depressed caregivers
○ Managing distractions and barriers with depressed caregivers
○ Initial home visit: Valuing relationships from the start

3. Relationship-based practice: core concepts
   a. Centrality of the relationship as the focus of service provision
   b. Joining strategies for parent and child
   c. Reflective listening techniques
   d. Positive feedback
   e. Joint observation and problem solving
   f. Reflective practice
   g. Addressing challenging behaviors when working with children
   h. Building relationship-based practice into early intervention therapy
   i. Case examples and break-out group work

4. Additional training
   a. Specific training in selected relationship-based approaches.

**What ongoing supports are needed for those providing relationship-based care?**

Providers who are new to using relationship-based care could benefit from follow-up training sessions and consultative support, including the reflective supervision described in Step Three. The Learning Collaborative meetings described in Step Eight can function as a forum to reinforce and review the essential elements of relationship-based practice for providers and create a community of peer support. Meetings such as these provide the opportunity for professionals from the early intervention and behavioral health systems to network and share their successes and challenges with incorporating a broad relationship-based focus into their practice as well as the opportunity to discuss specific strategies and techniques.

**Implementation Planning and Monitoring**

**Step Eleven: Plan for the Costs of Implementation**

There are some costs to consider when planning to implement services for families with parental depression and early childhood developmental delays. This section describes the types of costs that programs are likely to encounter: the direct and indirect costs of conducting a particular activity; and the billable costs, which refer to the actual costs of service provision that can be billed to Medicaid or another relevant payer. This section also discusses how programs can plan for each of these types of cost for the following activities:

- screening and identification of parental depression in early intervention
- including caregiver depression as a qualifying risk factor for tracking services in early intervention (not available in all states)
- training on implementation processes for conducting screening, making cross-system referrals, and providing relationship-based care.

Formulas provided for cost estimation are based on the actual expenses and experience of the Helping Families Raise Healthy Children initiative. Overall, implementation of parental depression screening in the early intervention system results in few direct and indirect costs to the early intervention agency. Increases in the amount of service coordination units billed
resulting from a positive screen are modest and occur within existing service coordination visits with the child and family. When considered in the context of the research on the effectiveness of early intervention and treatment for depression (Children's Defense Fund, 2011; National Research Council and Institute of Medicine, 2009), screening for parental depression within the early intervention system may reduce the need for long-term early intervention services, ultimately reducing costs to the system (Diefendorf & Goode, 2005; Hebbeler et al., 2007).

Screening for and Identifying Parental Depression in Early Intervention
There are several cost components to implementing parental depression screening in the early intervention system, but none are prohibitive. They are described below.

Direct/Indirect Costs to the Early Intervention Agency
As previously mentioned, many depression screening tools are available at no cost. Administration and scoring of the screening takes only a short amount of time when incorporated into a regularly scheduled visit. Training service coordinators to administer and score the screening tool represents costs that will vary from agency to agency depending on the number of staff involved and the amount of training hours required.

- Cost of depression screening tool: $0.00
- Additional time to administer and score screen: 5–10 minutes or less
- Hours to train service coordinators to administer and score the screening tool: Variable (see the next section on billable costs)

Billable Costs
Administration and scoring of the screening is incorporated into the family assessment component of the early intervention visit. When a parent screens positive for depression risk, service coordinators can expect to spend, on average, an extra half-hour during the visit discussing the results with the family and exploring referral options. The additional time spent linking the family to supports is a billable service coordination activity. There are two steps to estimate the annual billable service coordination units for positive screens. First, determine the estimated number of annual positive depression screens:

Total number of families served by early intervention annually multiplied by 10 percent (expected positive depression screening rate) equals the estimated number of positive screens annually.

Second, based on the assumption that a positive screen will add an estimated half-hour to the early intervention visit, determine the estimated total annual billable service coordination costs for positive depression screenings:

Estimated number of positive screens annually multiplied by local cost of half-hour of service coordination equals the estimated total annual billable service coordination costs for depression screening.

Including Caregiver Depression Screening as a Qualifying Risk Factor for Tracking Services in Early Intervention
Adding caregiver depression as a qualifying risk factor category for tracking services will impose an annual cost on the early intervention system. For the purposes of estimating this
Step-by-Step Guide to Implementation

Cost, tracking services are defined as coordination of services for "at risk" children and may or may not be available depending on local and state regulations.

**Indirect Costs**

Time needed to train community partners who screen for depression on referral process to early intervention.

**Billable Costs**

In states and counties where applicable, families who are referred to early intervention with caregiver depression as the qualifying risk factor may receive tracking service coordination that includes developmental screening services and referral. Where applicable, tracking costs may be covered by Medicaid (if the child is enrolled in Medicaid) or another relevant payer (e.g., local county funding). If the infant/toddler shows a developmental delay upon screening, the family will be transferred to IFSP early intervention services.

Based on the experience of the *Helping Families Raise Healthy Children* initiative, we have developed a formula to estimate a range of billable costs for offering tracking services to children “at risk” for developmental delay due to parental depression. The following guidelines can be used to estimate billable costs:

- The average amount of time required to meet with a new family for early intervention services based on caregiver depression qualifying the child as “at risk” is two hours.

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**Example from *Helping Families Raise Healthy Children***

1. Determine the average range of billable hours per family per year.
   
   Assume one unit of service cost = $18.26
   Assume one hour of service cost = $73.04
   Six hours x $73.04 = $438.24
   Nine hours x $73.04 = $657.36
   $438.24 + $657.36 = $1095.60/2 = $547.80

   **Average cost of billable tracking services per family for caregiver depression is $547.80**

2. The early intervention service coordination unit typically serves 3,000 children per year (IFSP and tracking services). A 4 percent increase in referrals was seen with the addition of caregiver depression as a qualifying “at risk” factor for tracking services resulting in an additional 120 children served per year.
   
   $3,000 \times 0.04 = 120$
   $547.80 \times 120 = 65,736$

   **Total average billable costs annually for tracking services for children “at risk” due to caregiver depression is $65,736.**

   Please note that billable costs may be broken out further by relevant payer.
• The average range of billable hours of service per family/per year for caregiver depression may vary depending on the child’s age. Children up to 12 months old may require more intensive tracking services for that first year than children ages 1–3 years.
• Rates will vary by community, but expect a minimum of a 4 percent increase in total annual early intervention referrals when adding the “at risk” due to parental depression tracking service category.

To determine the estimated billable costs for adding caregiver depression as an “at risk” tracking service category, first determine the average range of billable hours per family/per year:

• If the child is age 0–12 months, assume that at least nine hours of service will be provided annually: two hours to open the family to services and seven hours of additional service coordination.
• If the child is age 1–3 years, assume that at least six hours of service will be provided annually: two hours to open the family to services and four hours of additional service coordination.

The average range, therefore, is six to nine hours per family per year.

Second, determine the expected number of new families: Take 4 percent of the average total number of families served by early intervention service coordination unit annually.

Finally, to determine the estimated annual cost range of billable tracking service coordination, multiply the expected number of new families by the cost of nine hours of service (high end of the range) and then multiply the expected number of new families by the cost of six hours of service (low end of the range). Average these two figures to calculate the average billable costs (to Medicaid or other relevant payer) for tracking services for children “at risk” due to caregiver depression.

Training on Implementation Processes for Conducting Screening, Making Cross-System Referrals, and Providing Relationship-Based Care

Total training costs will depend on the number and type of training sessions that are needed to implement the different components in the service area. For example, cross-system training efforts may include some or all of the following types of sessions:

• trainings on the screening (Step Three) and cross-system referral processes (Step Seven) before implementation begins for existing staff and during implementation as needed for new staff
• orientation sessions for early intervention and behavioral health providers (Step Eight) before implementation begins
• cross-system networking meetings (Step Eight) before implementation begins and ongoing during implementation as needed
• relationship-based care workshops (Step Ten) before implementation begins and ongoing during implementation as needed
• learning collaborative meetings (Step Eight) quarterly throughout implementation.

Direct costs to consider may include:
• facilities
• instructors
• training materials
• intervention model curriculum
• staff time to develop training content and materials
• food
• continuing education credits for providers attending training sessions or workshops.

Direct costs such as continuing education credits provide added incentives for participation and can help engage providers. Table 2.3 provides details on the training costs for the *Helping Families Raise Healthy Children* initiative.

**Step Twelve: Monitor the Implementation Process and Results**

As with any complex initiative, it is important to incorporate ongoing assessment and monitoring of implementation in a systematic way to assess implementation progress. Programs should establish a schedule for generating and reviewing progress on the implementation process, including screening, referral, and engagement in treatment or services. By continuously monitoring the implementation of the primary service delivery components, program staff can identify deficiencies and address them as they arise. For example, screening rates may be very high immediately after training but start to decline over time. This might prompt discussions with those conducting the screening about barriers to screening, refresher training, or a change in the screening schedule.

The following are suggested measures for tracking each component and potential sources for the information. The costs associated with monitoring implementation include staff time.

<table>
<thead>
<tr>
<th>Table 2.3</th>
<th>Training Costs for Helping Families Raise Healthy Children</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Session</strong></td>
<td><strong>Target Audience</strong></td>
</tr>
</tbody>
</table>
| Orientation (parental depression, early childhood development, overview of initiative components) | All participating system partners | 2 hour session | • Staff time to prepare content and materials  
• Handouts |
| Screening/assessment tools | Early intervention service coordinators | 2 hour session | • Staff time to prepare content and materials  
• Snacks  
• Handouts |
| Cross-system referral processes and cross-system networking meetings | Early intervention service coordinators, behavioral health providers, community partners | 1–2 hour session | • Staff time to prepare content and materials  
• Snacks  
• Handouts |
| Relationship-based practice workshops | Early intervention service coordinators, early intervention providers, behavioral health providers | 2 full days for initial training  
Half-day follow-up session regarding implementation and Learning Collaborative follow-up meetings | • Staff time to prepare content and materials  
• Lunch  
• Handouts  
• Intervention model curricula (1–2 per provider agency)  
• Continuing education credits |
to collect data, database development, and information systems support. Note: The measures that look at rates by individual screener are intended to help identify individuals who need additional support and are not intended for punitive purposes.

Tracking the Screening Process and Results
Possible measures:

• number of caregivers screened
• rate of screening (caregivers screened/eligible caregivers)
• rate of screening, by individual screener
• number of declined screens
• number of declined screens, by individual screener
• rate of positive screens
• change in individual screen scores (if using PHQ-9) over time.

Source: Service coordinator documentation

Tracking the Referral Process and Results
Possible measures:

• number of caregivers referred
• number of referrals, by type (e.g., outpatient behavioral health, support group, etc.)
• rate of referrals for those who screened positive
• rate of referrals, by service coordinator.

Source: Service coordinator documentation

Tracking Engagement in Services
Possible measures:

• number of referrals resulting in caregiver utilization of behavioral health services
• number of referrals resulting in relationship-based interventions
• rate of uptake of behavioral health and relationship-based services.

Sources: Service coordinator documentation (based on self-report from caregivers), reports from the organizations to which the caregiver is referred, or claims data.

Communicating Across Systems
An assessment of the quality of communication across the early intervention and behavioral health systems requires periodic check-ins with service coordinators and providers in those systems. Potential areas for discussion include:

• changes in the quantity or quality of communications
• changes in amount/type of collaboration among various providers since the initiative has been in place
• challenges related to communication/collaboration among various providers
• recommendations to enhance communication/collaboration among various providers.
The step-by-step recommendations in the preceding chapter are based on our experience in Allegheny County, Pennsylvania, implementing the *Helping Families Raise Healthy Children* initiative. The 12 steps are laid out to provide the information necessary to screen for depression in early intervention (Steps 1–3), develop cross-system, networking and referral processes (Steps 4–9), provide relationship-based services (Steps 9–10), and plan and monitor implementation (Steps 11–12). We recommend that Steps 1–11 be completed prior to implementation.

While this toolkit was developed based on our experiences, we believe it provides useful guidance to other communities interested in planning and implementing depression screening, referral, and treatment within the early intervention system. In the remainder of this chapter, we provide some resources that may be useful for implementation:

- a booklet of Self-Help Tips for Overwhelmed Caregivers
- an example of a form for community-based partners to use when referring families to the early intervention agency for caregiver depression
- an example of a screening/assessment tracking form
- an example of a referral tracking form
- a list of websites providing additional information about caregiver depression, early childhood developmental delays, evidence-based practices, and relationship-based care.
Figure 3.1
Self-Help Tips for Overwhelmed Caregivers
Taking care of young children can be very demanding. Often things happen that make taking care of infants and toddlers even harder.

When a family goes through hard times, as all families do at different points in time, things can seem like they are falling apart. Some people have struggled with their mood all of their lives.

No matter what the cause, people who are caring for small children need to know the symptoms of depression and take care of themselves.

People don’t feel depression in the same way. Some people have a lot of very bad symptoms. Other people have just a few symptoms. We all feel sad and have negative thoughts sometimes.

You might be depressed if you feel sad and have negative thoughts almost all the time and if nothing seems to help you feel better.

Some of the symptoms of depression are:

**Depressed mood.** People who experience depression often feel very sad and hopeless. They might feel like giving up. They might cry a lot. They might feel empty or have no feelings. Some people who are depressed, especially children and teenagers, become angry.

**Less interest or pleasure in activities.** Many people who are depressed don’t like the activities they used to enjoy. They don’t want to be with other people. They might lose interest in sex. They might not take care of how they dress or look. They might not keep themselves clean.

Taking care of young children sometimes feels like more than we can handle.
Problems sleeping. Some people with depression have trouble falling asleep. Other people can’t sleep all through the night or wake up too early in the morning. Some people sleep too much.

Feeling tired. Even with enough sleep, some people who are depressed feel tired all the time. Because they feel tired, they don’t have much energy.

Feeling nervous or slowed-down. Some people feel nervous or restless because of depression. Other people slow down.

Feeling guilty and useless. People with depression often feel bad about themselves and feel guilty for things that are not their fault. They often feel useless.

Problems with memory. Depressed people often forget even simple things. They have trouble concentrating on their work. It is hard for them to make decisions.

Weight change. Some people with depression gain weight. Others lose weight.

Suicidal thoughts, plans, or attempts. People who are depressed might think about killing or hurting themselves.

Alcohol or drug use. Overusing alcohol or drugs might be a symptom that a person is depressed. Talk with your doctor or therapist about your use of drugs or alcohol.

Physical symptoms. Some people with depression have physical symptoms. Headaches, stomach pain, and feeling sick are common.

Are you having some of these feelings? If so, you are not alone! If your child is at risk for, or has, a developmental delay, you are twice as likely to experience depression.

Having depression is not your fault. It is not a weakness; it is a medical illness. And, depression is treatable.

Children are healthiest when they have a healthy parent or caregiver.

Talk to your doctor if you are having any symptoms of depression.

Can my feelings of depression have an effect on my child?

Research shows that when parents are depressed, their children are more likely to have problems with development and relationships as they grow. They are more likely to:

• Have behavior problems.
• Have academic difficulties.
• Have health problems.
• Have delays in cognitive and motor development.
• Be depressed themselves.

1 www.childtrendsdatabank.org
How might my moods affect my child?

- We might not talk with them as much as we used to.
- We may feel disconnected from them emotionally.
- It may be too hard to be consistent with setting limits or rules.
- We may be irritable and unpredictable about how we respond to them.
- We might leave them in front of the television a lot because we are unable to find the energy to do other things.
- We might not have the energy to provide reliable and predictable routines.

Can my child’s developmental issues affect my mood?

Having a child who is at risk of having or has a developmental delay can be very stressful and places a caregiver at a higher risk for depression.

Some of the things that may have added more stress to your life and put you at risk for depression include:

- An NICU experience with your baby.
- Having twins or triplets.
- Caring for a child who has qualified for Early Intervention Services.
- A child welfare intervention.

Your moods can impact how your child learns about secure, predictable relationships, and the way he or she learns about the world.

Help yourself to feel better by taking care of yourself and taking care of your relationships. Reaching out to your friends and family and talking with your partner will help you and your child feel better.

Can my child’s developmental issues affect my mood?

Taking care of myself.

- Eat healthy small meals every three hours or so. Avoid sugar, caffeine, and alcohol.
- Go to sleep at the same time every night. My child and I will both sleep better when routines are predictable.
- Get moving. Physically active people are less likely to experience depression. I will go for a walk every day, even if it’s short, with my child or by myself.
- Be generous with myself. I am doing the best I can right now.
- Celebrate small steps: I made myself a healthy lunch today!

Help yourself feel better by taking care of yourself.

Taking care of yourself will help you and your child feel better.
Figure 3.1—Continued

Reaching out to my friends and family.
- Reach out to my closest friends and family members and tell them what I am going through.
- See who can join with me to provide physical help, or just listen when I feel like I need to talk.
- Make sure I am letting them in when they call to visit or to go out together.
- Not be oversensitive to what my friends and family say even though I am feeling fragile right now. They might be trying to understand in their own way.

Talking with my partner.
- Tell him/her how I am doing.
- Explain clearly what I need.
- Ask what he/she needs too, and we can share our thoughts.
- Tell him/her that things will improve soon, especially with support from everyone around me. I can’t do it alone!
- Recognize that my partner might be feeling alone and overwhelmed, too.

In order for you and your child to have a secure relationship, your child needs the following “ingredients.”

**RICE...**
- **Redo.**
  My child loves it when she knows I will sing the same song each time I change her diaper. She likes to know what is going to happen next!
- **Interact.**
  I can talk to my child when I take care of him, letting him know what we are doing using words. I can wait for him to smile, coo, or talk back to me.
- **Connect.**
  When my child needs me, I can always be there for her. She will learn that I will help her even if she is being fussy or upset. This is how she learns trust.
  I will not use empty threats when she is misbehaving. If she doesn’t listen, I can get up and move her from what she is doing and help her do something else.
- **Expect.**
  I can find out what is reasonable to expect of my child for his age or ability. He might know what he should be doing but cannot yet stop himself.
  I can help him stop negative behaviors with love and effort. I don’t want him to think he is a bad person.

Reach out to friends and family for support. Talk with your partner about your needs.

Your child needs RICE and PEAS for a secure and healthy relationship.
...and PEAS!

- **Plan a routine.**
  I can try to keep the same daily routine for my child, giving her meals, naps, and bedtimes at the same time every day. My child will learn to treasure special routines before bedtime, like a bath and a book read to her specially. My child feels relaxed when she knows a routine.

- **Excite!**
  My child loves when I play with him and get him excited by playing “peek-a-boo” or “I’m gonna get you!” He will need to learn from me how to calm down after our games, too.

- **Affection.**
  I can always pick up my child and hold her close to me when I can, to let her know how much I love her. This can never spoil her. It comforts and calms her so that she will know she always has me to count on.

- **Sensitive.**
  I can speak to my child in a calm voice and use gentle hands when I dress him and when I lift him, even if I am feeling anxious and irritable. I know that yelling, angry gestures, and spanking only make all of us anxious and sad. Chronic anger hurts everyone.

---

**Call for support!**

I can reach out to resources in my area to get more support if I am not feeling better.

There are many resources available through early intervention, behavioral health, and community organizations that can provide additional support for you.

In areas where 211 is available, dialing this number can connect you with local resources for help with food, housing, employment, health care, counseling, and more. Call 211 for free, confidential information and referrals.

**Connecting with Behavioral Health Support**

- The Substance Abuse and Mental Health Services Administration’s Health Information Network (SHIN) can help you find affordable mental health services in your area. www.findtreatment.samhsa.gov.

- Your local Mental Health America affiliate is an excellent resource for information about local programs and services. www.nmha.org.

- If you have medical insurance, you can contact the number on the back of your insurance card for help with finding services.

- Talk with your doctor.

---

**Ask for support if you are not feeling better. You are not alone.**
Community Support

There are organizations, groups, and activities in the community that may be helpful. Sometimes just talking to other people with young children can be comforting.

The National Parent Helpline® is open to parents and caregivers of children and youth of all ages. 1-855-4APARENT (1-855-427-2736); www.nationalparenthelpline.org

The National Domestic Violence Hotline 1-800-799-SAFE (7233); TTY 1-800-787-3224

Alcoholics Anonymous (www.aa.org) Narcotics Anonymous (www.na.org) Telephone numbers for AA and NA are often listed in local telephone directories.

Sometimes just talking to other people with young children can be comforting.

Many families experience caregiver depression and early childhood developmental delays (a developmental delay is when a child does not reach developmental milestones at the expected times). Although these conditions are closely related, many health systems identify and treat them separately. As a result, many caregivers are not receiving the support and services they need to manage their depression as well as their child’s developmental needs.

If you or someone in your family is experiencing overwhelming stress or depression and/or if you have an infant or toddler and are concerned about his or her development, please reach out to resources in your community for support. Many behavioral health, early intervention, and medical providers offer support and services that can help.

If YOU ARE EXPERIENCING A CRISIS, or just need to talk to someone RIGHT NOW, call your local crisis center.

If you have a child under the age of 3 and think that your family would benefit from services, call your local early intervention provider for information about available services.

About the Helping Families Raise Healthy Children Initiative

This initiative is a collective effort of 35 partner agencies in Allegheny County, PA to create a healthier future for children and parents by addressing the related challenges of parental depression and early childhood developmental delays. The program is operated by Community Care Behavioral Health Organization, a nonprofit, recovery-oriented behavioral health managed care company, in collaboration with The Alliance for Infants & Toddlers and RAND-University of Pittsburgh Health Institute. Support for the program is provided by the Robert Wood Johnson Foundation, Highmark Foundation, UPMC Health Plan, The Pittsburgh Foundation, The Fine Foundation, FISA Foundation, the Jewish Healthcare Foundation, the Allegheny County Department of Human Services Office of Behavioral Health, and the PA Department of Public Welfare.
Figure 3.1—Continued

Creating a brighter, healthier future for children and parents.
Sample Forms

Figure 3.2
Community-Based Partner Referral

Referral Form
The Alliance for Infants and Toddlers
Fax: ___________ Attn: __________

Referral Source Contact Information
Agency/Practice: ________________________________________________

Person Making Referral: ________________________ Phone #: _______________

Date of Referral: ________________________________________________

Caregiver Information
Caregiver Name: ________________________________________________

Caregiver Birth Date: ________________________________________________

Caregiver Address: ________________________________________________

Caregiver Phone: Home ___________________ Cell ___________________

Caregiver Signature: ________________________________________________

Comments: _______________________________________________________

Insurance Information
Does this caregiver have Medical Assistance?

Yes □ No □

MA ID #: __________________________________________

Does this caregiver have private insurance?

Yes □ No □

Specify: __________________________________________

Child Information
Child Name: ________________________________________________

Child Birth Date: ________________________________________________

Child Sex: _______________________ Ethnicity: ___________________
Caregiver Needs

To help tailor services, determine if the caregiver has any of the following (check all that apply):

- Alcohol use/abuse or past history
- Drug use/abuse or past history
- Transportation needs
- Domestic violence
- Diagnosed mental health disorder (e.g., bipolar disorder)
- Currently pregnant or has had a baby within six months
- Other needs

Specify: _______________________________________

Is the caregiver *currently* receiving behavioral health services?

- Yes "☐" From whom: _______________________________
- No "☐"

If yes, would caregiver like a re-referral to this agency/individual?

- Yes "☐"
- No "☐" Why not: _______________________________

Has the caregiver *ever* received behavioral health services?

- Yes "☐" From whom: _______________________________
- No "☐"

If yes, would caregiver like a re-referral to this agency/individual?

- Yes "☐"
- No "☐" Why not: _______________________________

*Currently*, would the caregiver like a referral to behavioral health services or other supports?

- Yes "☐"
- No "☐" Why not: _______________________________
Figure 3.3
Screening Assessment Tracking Form

Family Information
Child Name: ____________________________
Child Birth Date: ____________________________
Child Sex: ____________________________ Ethnicity: ____________________________
Caregiver Name: ____________________________
Relationship to Child: ____________________________ Caregiver Sex: ____________________________

Referral Information
Referral Source (AFIT): ____________________________
Depression Only (Project): ____________________________
Date of Referral: ____________________________

Alliance Information
Service Coordinator: ____________________________
☐ New Alliance Family
   ○ IFSP
   ○ Tracking
   ○ Tracking with depression as only risk factor

☐ Existing Alliance Family
   ○ IFSP
   ○ Tracking
   ○ Tracking with depression as only risk factor

Screening Information
Screen Date: ____________________________
Screen Result: ____________________________
## Screening Tracking Information

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<th>Event</th>
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<th>Positive</th>
<th>Score</th>
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<td>(Initial home visit, 3-, 6-, 9-month contact, other)</td>
<td>(Yes, No, Refused)</td>
<td>(Yes, No)</td>
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<td>Baseline Screen (PHQ-2)</td>
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</tr>
<tr>
<td>Baseline Screen (PHQ-9)</td>
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<tr>
<td>6-Month Screen (PHQ-2)</td>
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<td>24-Month Screen (PHQ-9)</td>
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</table>

Comments/reason screens were not offered or declined:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
## Assessment Tracking Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Event (Initial home visit, 3-, 6-, 9-month contact, other)</th>
<th>Completed (Yes, No, Refused)</th>
<th>PSI-SF Score</th>
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<tr>
<td></td>
<td>Baseline Assessment</td>
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<td></td>
<td>6-Month Follow-Up Assessment</td>
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<td>18-Month Follow-Up Assessment</td>
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<tr>
<td></td>
<td>24-Month Follow-Up Assessment</td>
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</tbody>
</table>

Comments/reason assessments were not offered or declined:

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Figure 3.4
Referral Tracking Form

Caregiver Information

Caregiver Name: ____________________________________________________

Caregiver Birth Date: ________________________________________________

Caregiver Contact Information: _________________________________________

Does this caregiver have Medical Assistance?

Yes ☐ MA ID #: ________________________________
No ☐

Does this caregiver have private insurance?

Yes ☐ Specify: ________________________________
No ☐

Comment: _________________________________________________________

Child Information

Child Name: _________________________________________________________

Child Birth Date: ____________________________________________________

Project ID: __________
Caregiver Needs

To help tailor services, determine if the caregiver has any of the following (check all that apply):

- Alcohol use/abuse or past history
- Drug use/abuse or past history
- Transportation needs
- Domestic violence
- Diagnosed mental health disorder (e.g. bipolar disorder)
- Currently pregnant or has had a baby within 6 months
- Other needs
- Specify: _______________________________________

Is the caregiver currently receiving behavioral health services?

Yes  □  From whom: _______________________________
No   □

If yes, would caregiver like a re-referral to this agency/individual?

Yes  □
No   □  Why not: __________________________________

Has the caregiver ever received behavioral health services?

Yes  □  From whom: _______________________________
No   □

If yes, would caregiver like a re-referral to this agency/individual?

Yes  □
No   □  Why not: __________________________________

Currently, would the caregiver like a referral to behavioral health services or other supports?

Yes  □
No   □  Why not: __________________________________
### Referral Tracking Information

<table>
<thead>
<tr>
<th>Date</th>
<th>Referred To</th>
<th>Referral Type</th>
<th>Agency Name</th>
<th>Contacted Infant Mental Health Specialist about Referral (Y/N)</th>
<th>Outcome of Referral</th>
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</tbody>
</table>

**Referred To**
- BH= Behavioral health provider
- EI= Early Intervention provider
- CC CM= Community Care care manager
- MCO CM= Managed Care Organization care manager
- OBH= Allegheny County Office of Behavioral Health
- RES= Re:solve Crisis Network
- FSC= Family Support Center
- EHS= Early Head Start
- HS= Healthy Start
- OCBS= Other Community-Based Services
- HFRHC= Infant Mental Health Service Coordination
- CYF= Children, Youth and Families

**Referral Type**
- 1= In-home mobile therapy
- 2= Family-focused therapy
- 3= Outpatient therapy
- 4= Relationship-based intervention through The Alliance
- 5= Community-based services (Early Head Start, parenting classes, family support centers, etc.)
- 6= Crisis intervention
- 7= Other
- 8= Family-based therapy
Websites

http://www.childtrauma.org
The Child Trauma Academy is a nonprofit organization dedicated to “working to improve the lives of high-risk children through direct service, research, and education.” A major activity of the academy is to translate emerging findings about the human brain and child development into practical implications for the ways we nurture, protect, enrich, educate, and heal children.

http://www.developingchild.harvard.edu
The Center on the Developing Child at Harvard University was founded in 2006 on the belief that the vitality and sustainability of any society depend on the extent to which it expands opportunities early in life for all children to achieve their full potential and engage in responsible and productive citizenship. The website has tremendous resources for providers, policymakers, and families regarding early childhood development, toxic stress, and science-based public policies that promote healthy development. Available resources include reports, working papers, briefs, videos, lectures, and presentations.

http://www.nrepp.samhsa.gov
The National Registry of Evidence-Based Programs and Practices (NREPP) is a searchable online registry of more than 250 mental health and substance abuse interventions that assist the public in identifying scientifically based approaches to the prevention and treatment of mental health and/or substance use disorders. The interventions have been reviewed and rated by independent reviewers.

http://www.postpartum.net
Postpartum Support International “is a nonprofit organization whose mission is to promote awareness, prevention, and treatment of mental health issues related to childbirth in every country worldwide.” The website offers support, education, and local resource information for professionals and parents.

http://www.samhsa.gov
The Substance Abuse Mental Health Services Agency (SAMHSA) provides leadership and devotes its resources toward helping the nation act on the knowledge that:

- Behavioral health is essential for health
- Prevention works
- Treatment is effective
- People recover from mental and substance use disorders.

The website provides resources related to depression that providers may find useful in their work, as well as publications to share with families.

http://www.zerotothree.org
Zero To Three is a national, nonprofit organization that informs, trains, and supports professionals, policymakers, and parents in their efforts to improve the lives of infants and toddlers. The website has a wealth of information on brain development, attachment, parenting, and many resources for behavioral health and early intervention providers.
References


A Toolkit for Implementing Parental Depression Screening, Referral, and Treatment Across Systems


