Massachusetts Partnership for Early Childhood Mental Health: LAUNCH/MYCHILD Model

An Innovation Station Best Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	Massachusetts	**Title V/MCH Block Grant Measures Addressed**
Category:	Best	**NPM#6** Developmental Screening **NPM#11** Medical Home
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Practice Description

Massachusetts Project LAUNCH and MYCHILD were Substance Abuse and Mental Health Services Administration (SAMHSA) funded programs focused on emotional, social, and behavioral health promotion, prevention and intervention; designed to build the capacity of pediatric medical homes to support infants, young children, and their families. LAUNCH/MYCHILD was developed as an integrated behavioral health model that embeds an Early Childhood Mental Health Clinician and a Family Partner (the ECMH team) in pediatric primary care to provide early identification, brief intervention, and facilitated referrals to services and resources, in order to promote nurturing relationships, prevent concerning behaviors and reduce the families' stressors.

Purpose

Project LAUNCH was initially awarded to the Massachusetts Department of Public Health (DPH) in 2009, and evaluation of the project was conducted by the Institute of Health Equity and Social Justice Research (IHESJR) at Northeastern University. The Massachusetts Young Children's Health Initiative for Learning and Development (MYCHILD) was funded in 2009 by SAMHSA as a local System of Care grant of the Children's Mental Health Initiative (CMHI). The Massachusetts Executive Office of Health and Human Services (EOHHS) was awarded the grant; evaluation of the project was conducted by Abt Associates, Inc. Both grants were administered by the Boston Public Health Commission's (BPHC) Early Childhood Mental Health Team. With permission from SAMHSA, Massachusetts linked the LAUNCH and MYCHILD programs together under a state/local *Partnership for Early Childhood Mental Health,* which was

coordinated by DPH, BPHC and EOHHS. Over 10 years, The LAUNCH/MYCHILD model was developed with seven pilot implementation partner agencies in Boston, and then replicated in six expansion partner sites across the state.

The Goal of the Partnership for Early Childhood Mental Health is to assure a family centered system of care around early childhood mental health (ECMH) that

- responds to infants, young children and families with a spectrum of needs,
- has the capacity to meet families where they are, and
- integrates child and family serving systems with a particular focus on pediatric primary care.

To do this we prioritize the following Principles:

- Continuum of promotion, prevention, intervention
- Family-centeredness
- Relationship-based, trauma informed, intergenerational and dyadic approach
- Racial justice; health equity
- Integration of ECMH across systems

The LAUNCH/MYCHILD model is based within the medical home and designed to improve the social and emotional wellness of young children, including infants, and their families. The LAUNCH/MYCHILD model is inherently a health equity intervention in that it supports families' engagement in care, and equitably enhances family-centered care provided by the ECMH team and primary care providers.

Practice Foundation

LAUNCH /MYCHILD is an early childhood mental health model of care, with a focus on behavioral health integration into pediatric primary care. **Infant and early childhood mental health** is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, community, and culture.[1]

The LAUNCH/MYCHILD model draws from life course theory, social determinants of health theory, and the social ecological model.

Social Ecological Approach: Taking a social ecological approach is based on the Bioecological Theory of Human Development,[2] positing that conditions in the environments where children are developing affect their successful development. Relationships and interactions with caregivers are shaped by these conditions. LAUNCH/MYCHILD recognizes the critical impact of caregiver health on infant and child health, and offers a two-generation approach to behavioral health care and supports for families with young children. The infant or young child receives health promoting, preventative, or intervention level of behavioral health supports and services, and the caregiver's needs are also identified and addressed within the treatment. When appropriate, referrals are made for caregivers to receive their own behavioral health treatment. Also drawing from this theory is the importance of addressing of the families' social determinants of health, as described below.

Life Course Theory[3]: The model's focus on providing a continuum or services to infants and very young children is grounded in the theory that efforts to promote healthy attachment relationships and healthy social and emotional functioning early in life will lead to positive outcomes in many domains throughout life, including improved physical health outcomes, improved outcomes in the education system, decreased rates of incarceration, and improved employment status later in life.

Social Determinants of Health: LAUNCH/MYCHILD focuses on addressing the social determinants of health by identifying the family's needs in each of the contexts where they are spending time – at home, childcare, schools, neighborhoods, receiving services and others. For each context, areas of need are identified by the LAUNCH/MYCHILD team, such as lack of affordable housing, underemployment, poverty, exposure to violence, lack of childcare, etc. A Family Partner is paired with the caregiver to help the caregiver learn and to practice navigating complex systems.

The LAUNCH/MYCHILD model builds on a robust body of literature describing **peer support workers and community health workers** as core components of the health service delivery system in the U.S.[4] We used the term Family Partners for this role, which prioritized the importance of providing family-centered care coordination on topics that they themselves have had experience with; in the case of ECMH, these experts have experience navigating systems and accessing services to meet their own child's ECMH needs. These experts help link families to community services, provide peer support, and advocate for the family.[5]

Family voice and choice was supported by the Family Partner's presence, support, and encouragement for families to be honest about what would be most effective and helpful at any given time in the process. If concrete needs were more pressing to the family, then the Family Partner could support them with helping advocate for public benefits, find a food pantry, or join them at an Individualized Education Plan (IEP) meeting at the child's school.

The MYCHILD program was a SAMHSA-funded System of Care grant, and as such, the model of care was structured to be consistent with **SAMHSA's System of Care Values and Guiding Principles**. The System of Care values embedded in the LAUNCH/MYCHILD model include the care being a family-driven process, to which both the strengths and needs of the family are attended. Families served by the LAUNCH/MYCHILD model were the drivers of the care planning process, and determined which goals were priorities for them. Services were designed to be delivered flexibly in a community setting, and families were able to choose whether they wanted to receive services in their health center, their home, or in another place in the community. Community health center teams prioritized hiring culturally competent staff whose language skills matched the linguistic diversity of the communities being served. MYCHILD also utilized an adaption of the Wraparound Model,[6] which is part of the System of Care approach.

When family therapy was used, clinicians followed **evidence-based treatments** such as Parent Child Interaction Therapy (PCIT), Parent-Child Psychotherapy, Attachment, Self-Regulation, and Competency (ARC), and the Incredible Years. The LAUNCH/MYCHILD model is Wraparound-informed. LAUNCH/MYCHILD sites also included some evidence-based practices on the menu of services that could be used with the whole family, depending on family choice and the care plan. These included the Pyramid Model for early childhood positive behavior support and the Family Nurturing Program.

Core Components

The LAUNCH/MYCHILD model is designed to improve the social and emotional wellness of young children, including infants, and their families. The model is delivered by a unique two-person Early Childhood Mental Health (ECMH) team in partnership with primary care providers and families. The ECMH team consists of an early childhood mental health clinician specially trained to intervene at the earliest signs of mental health problems in infants and young children, and a family partner who is a highly trained professional with lived experience of navigating systems to support healthy social emotional development for their child. The ECMH team provides services spanning the continuum of promotion, prevention, and intervention/treatment. Families are referred to the ECMH team by the primary care provider or they self-refer. Services are provided in the medical home or in community-based settings convenient for the family, including at their home or early education/school. After the initial referral, families participate in a thorough engagement and assessment process to identify strengths and discuss potential areas of need and growth for the family. The assessment helps shape a care plan, using a multi-generational approach to identify and work towards meeting goals for optimal social and emotional wellness of the young child and family. In collaboration with primary care providers, the ECMH team works with families to identify skills and resources within themselves and their communities to achieve their goals. The team promotes healthy relationships and nurturing environments to address and mitigate a child's concerning behaviors and the stressful impact of social determinants of health on families. LAUNCH/MYCHILD focuses on enhancing the capacity of parents and providers to prevent minor behavioral problems from becoming increasingly challenging, disruptive, and more costly over time.

Practice Activities

Core Component	Activities	Operational Details
Referral Process	Self-referral or referral by primary care provider (PCP), ideally by warm hand off, based on criteria established by the medical home.	The referral process identifies and connects families to ECMH services. The referral process involves communication between the family, PCP, and family partner (FP)/mental health clinician (MHC). A well-developed and clearly articulated referral system forms the foundation of the service delivery model.
Engagement and Assessment	The FP and/or MHC 1) engage family by orienting to ECMH services and identifying a concrete action/next step that is useful to the caregiver, and 2) Assess strengths and needs of the child, caregiver, and family.	The engagement and assessment process builds a trusting FP/MHC-caregiver relationship as well as identifies the child/caregiver/family's strengths, needs, and culture in relation to the social emotional wellness of the child.
Care Planning Process	Caregiver and FP/MHC collaboratively create a Care Plan reflecting the strengths, needs, and goals of the family identified during the assessment visit(s). The plan records goals, measurements, referrals, and evidence-based interventions and is communicated	During the care planning process, the FP/MHC, caregiver, and others identified by the caregiver, review the family's current strengths and needs and write-up specific goals related to supporting the social emotional wellness of the child and reducing the impact of stressors on the family. The Care Plan identifies actionable strategies and services to be implemented

	to medical home staff and appropriate community partners.	with indicators to track progress towards goals. Care Plans are comprehensive, holistically considering the needs and strengths of the family. Care Plans serve as a communication tool between the caregiver, FP/MHC, and PCP to monitor progress towards goals and track acquired resources.
Service Implementation Process	FP/MHC deliver services including: 1) Referral to and coordination with community services 2) FP/MHC and caregiver/child visits, and 3) enhanced primary care visits including FP/MHC. The caregiver and FP/MHC monitor progress and revise the Care Plan as needed.	During the service implementation process, the caregiver and FP/MHC work to achieve Care Plan goals. They ensure services are coordinated and that caregiver voice and perspective drive services, revisiting the Care Plan as needed to try new strategies, identify new goals, and ensure ongoing or maintained progress. Action steps are repeated until the family is ready to transition from ECMH services.
Transition Process	FP/MCH work with families to develop an intentional plan for transition from LAUNCH/MYCHILD services, with continued engagement in medical home and community services.	During the transition process, the caregiver and FP/MHC work to end family participation in ECMH services. By the end of the transition process the FP/MHC no longer provide direct services to the family; however, the family should continue to participate in other medical home and community services as appropriate. Transition differs from disengagement, in which families stop engaging without an intentional exit.

Evidence of Effectiveness (e.g. Evaluation Data)

LAUNCH (2010-2015)

The results from the evaluation study of Project LAUNCH were published in the Journal of Maternal and Child Health.

1. Molnar, B. E., Lees, K. E., Roper, K., Byars, N., Méndez-Peñate, L., Moulin, C., ... & Allen, D. (2018). Enhancing early childhood mental health primary care services: evaluation of MA Project LAUNCH. *Maternal and child health journal*, *22*(10), 1502-1510. Free to download: https://rdcu.be/YR2z

Evaluation

All families who received LAUNCH services were eligible and invited to participate in the evaluation study; records for those families who consented were transferred to the evaluation team for analyses. The sample included 225 children and 186 primary caregivers. Data were collected as part of service delivery. The family partner and clinician team conducted comprehensive assessments with the families at intake, 6-month follow-up and 12-month follow-up appointments. Satisfaction surveys were also conducted with a sample of parents to assess their experience with LAUNCH services.

At baseline, the mean age at intake of children participating in the evaluation (N=225) was 3.36 years (SD=2.01). Sixty-two percent of children were male. Fifty-three percent of children were

Hispanic/Latino, 34% were African-American/Black, 4% were White, 4% were Biracial, 2% were Multiracial, 2% were Unknown, and 0.4% were Asian.

The mean age of the primary caregivers was 30.19 years (SD=7.84). Most primary caregivers, 97%, were female. Similar to the race/ethnicity of the children, 46% of primary caregivers were Hispanic/Latino, 38% were African-American/Black, 6% were White, 5% were Unknown, 2% were Multiracial, 1% were Asian, and .55% were Biracial.

The Ages & Stages Questionnaire: Social and Emotional (ASQ-SE) was administered for measurement of social emotional and behavioral issues among children who were 5 years and younger, and the Child Behavior Checklist (CBCL) was used with children 6–8 years. The Patient Health Questionnaire-9 (PHQ-9) and the Parenting Stress Index-Short Form (3rd Edition) (PSI-SF) were used to measure caregiver functioning.

Descriptive statistics were run to explore the distribution of the data. Individual growth models were used to analyze CBCL and ASQ-SE scores for children and PHQ-9 and PSI-SF scores for primary caregivers. We used multilevel models with restricted maximum likelihood estimation for mixed models using SAS version 9.3. Sensitivity analyses were conducted with participants who completed two time points instead of three for each measurement tool in order to confirm that results were not biased due to missing data.

Outcomes

Findings indicate that both children and their caregivers benefited from their participation in LAUNCH. Analyses using individual growth modeling showed improvement in the children's scores (n = 183) on the ASQ-SE during their participation in Project LAUNCH. The analyses revealed that on average children showed a steady decline in risk level, that by the third timepoint they tended to be below the cutoff score, which is clinically meaningful.
Similar results were found for older children (age 5 - 8 years) who were assessed using the Child Behavioral Checklist (CBCL). The results indicate that children who were at increased risk at baseline tended to be within the non-clinical range at time 3.

Results based on individual growth analyses of the PSI indicated that caregivers (n = 131) who entered Project LAUNCH at clinically significant levels of stress on average reported declines in stress that brought them within the normal range by the second assessment point, with further declines reported by the third timepoint. Caregivers also completed an assessment for depression, the Patient Health Questionnaire (PHQ9). Analysis indicated that parents who were at moderate levels of depression at baseline tended to be within the non-clinical range by the third assessment point. Results based on growth analysis that examined change over time in the children's scores on the ASQ-SE as a function of difference with time on the caregiver's PSI revealed that as caretaker parent stress declined, there was a corresponding improvement in children's social-emotional functioning. Likewise, when caregivers at high levels of parental stress did not improve with time, there was a corresponding worsening in their children's social-emotional functioning.

Among the families enrolled in LAUNCH, 141 families had someone in the family/household with mental illness, 38 families had someone in the family/household with a substance abuse problem, and 111 families had a child aged 0-8 years in the household who had been a victim of trauma or abuse. Approximately 80 families had a primary caregiver who was a teen mother, 233 were in single parent households, 109 had a primary caregiver with less than a high school diploma, 174 had a primary caregiver who was unemployed, and 252 were on some form of public assistance.

LAUNCH was designed to focus on families experiencing child abuse or neglect, domestic violence, substance abuse, maternal depression or other parental mental health problems. The findings indicate that LAUNCH reached its target population of underserved children ages 0 to 8, and families who are at substantial socioeconomic risk and social-emotional risk.

Parent Satisfaction: The 59 parents we surveyed by telephone reported overall satisfaction with Project LAUNCH services, including the helpfulness of the services for children, parents, and for family issues. They responded very positively about the quality of pediatric services received, and about how Project LAUNCH has been helpful with previous problems they had in accessing services. In the general satisfaction question, all 59 parents reported being very (88%) or somewhat (12%) satisfied with the LAUNCH services they received.

MYCHILD (2010-2015)

Evaluation

Data used for the MYCHILD evaluation were collected through interviews with caregivers at baseline and every 6-months up to 24-month follow-up; focus groups held yearly; record extraction for demographics and service plan goals; and surveys with primary care providers. The total sample includes 369 children and caregivers who received MYCHILD services. Of those 369 children and caregivers, 155 enrolled in the child and family outcome study.

At baseline, 14.2% of children in the evaluation (n=155) below the age of 1 year and 7.1% were six years and older. Fifty-five percent of the children were male. Fifty-nine percent of the children were White, 48.5% were African-American/Black, 2.2% were American Indian or Alaskan Native, 1.5% were Vietnamese, 0.7% were Chinese, and 0.8% were Other. Twenty-seven percent of the sample were Hispanic and Puerto Rican. Thirty-two percent were Hispanic of another country of origin.

The Ages & Stages Social and Emotional questionnaire (ASQ-SE) and the Children's Behavioral Health Checklist (CBCL) were used to measure children's social and emotional development. The Patient Health Questionnaire-9 (PHQ-9) and the Parenting Stress Index-Short Form (3rd Edition) (PSI-SF) were used to measure caregiver functioning.

Quantitative data analyses included descriptive statistics, and bivariate analyses using chi-square and t tests. Multivariate analyses using General Linear Models and Growth Curve Models were also conducted. Paired sample t-tests were used to examine changes in each measure from baseline to six-month follow-up. Growth curve modeling was also used to examine changes in child behavior problems over time, comparing children in the CBCL clinical range at baseline, to children whose scores who were in the normal range at baseline. Similarly, growth curve modeling was used to explore changes in parenting stress over time, comparing parents who experienced very high stress at baseline, to parents who experienced typical parenting stress at baseline.

Outcomes

Total Problem Scores on the Child Behavior Checklist (CBCL) improved over time. Over 34% of young children showed statistically significant improvement on externalizing behaviors as measured by the CBCL. Almost 29% showed statistically significant improvement in internalizing behaviors. Parents enrolled in the evaluation reported significantly reduced stress, as measured by the Parenting Stress Index Short Form through their twelve-month interviews ($p < .02$).

Families served by MYCHILD had many needs and faced many challenges. Problems leading to referral included housing problems (46.3 %), disruptive behaviors in young children (45.3%), maternal depression (42.8%), other maternal mental disorders (31.2 %), anxiety (24.1 %), hyperactivity (20.1%), and maternal substance use disorders (18.7%). Children faced an average of four problems at MYCHILD referral. These disaggregated data indicate that MYCHILD served a population experiencing a variety of inequities.

Family partners and caregivers worked with families on a wide range of goals from development of parenting skills to education and employment for the caregiver, to assistance with legal and housing issues and basic resources. Focus groups were conducted with caregiver participants. Participants reported that they had received assistance, including support in use of positive parenting methods and helping their children to express their feelings, from MYCHILD. As one participant shared,

"The program is already helping me a lot with… with my child….. and also to help her learn… what's going on in her head because at her age my child is unable to talk about her problem, so she can learn to vocalize what's going on with her in a positive manner … sometimes a child experiencing a problem does not know how to tell you, then he/she hits, does this and that…and the school, not knowing what's happening, may say the child lacks discipline … so I can teach her to verbalize, express in a positive manner without any fighting…I've achieved a lot of progress… whenever she's feeling bad about things they give me the support I need."

As another participant shared,

"How MYCHILD has been helpful to our family is, they have kind of filled-in all the blanks. And to give a few examples of the things that I like about MYCHILD is MYCHILD doesn't feel invasive. They encouraged, they've encouraged me to advocate for myself and for my child. MYCHILD has definitely helped our family to be and to feel supported."

MYCHILD teams provided training and consultation to primary care providers. About 70% of respondents to the 2014 provider survey reported that they had received mental health consultation from MYCHILD staff in the past year. Although only a small number of pediatric providers responded to the provider surveys (n= 7, 14, and 11 over the three years), all respondents at each timepoint reported that they agreed with the statement that integration of early childhood mental health and primary care was important. In 2014, the last survey year, all the 11 provider respondents reported that they regularly refer young children who screen positive for a developmental or behavioral concern.

Replication

LAUNCH Expansion (2015-2019)

The purpose of the evaluation study of the Project LAUNCH Expansion was to assess the fidelity of the expansion to the original LAUNCH/MYCHILD program model and to evaluate the success of the expansion at achieving its stated aims. The outcomes were assessed by examining children's social and emotional and behavioral functioning, caregiver stress and depressive symptoms, parental satisfaction with LAUNCH expansion services provided, parental perspective on the LAUNCH/MYCHILD model, and provider feedback from the primary care physicians.

To assess fidelity to the original LAUNCH/MYCHILD model, as well as current Project LAUNCH expansion implementation, the Springfield and Worcester LAUNCH expansion teams completed a baseline assessment in June 2017 using the fidelity checklist created by the evaluation team.

The teams again completed the fidelity checklist in June 2018 and June 2019. The Boston team did not complete the checklist in 2017 since the site had just begun to implement LAUNCH expansion services and not enough time had elapsed to assess model fidelity; however, they did complete the checklist in 2018 and again in 2019. The checklist was also filled out by the technical assistance team from the Boston Public Health Commission (BPHC). Questions covered the following domains: 1) provider experience and training; 2) program design; and 3) program delivery. The LAUNCH expansion consistency demonstrated fidelity to the LAUNCH/MYCHILD model. Across the three expansion sites, fidelity to provider experience and training, program design, and program delivery rose between Year 2, Year 3, and Year 4. In Year 4, these scores remained in the high 80-98% range, indicating that the implementation was successful.

Preliminary analyses indicate that the LAUNCH expansion significantly decreased caregiver depression (PHQ-9) and caregiver stress (PSI-SF) over time, $p < .05$. Further analyses of outcome data including the effects of the LAUNCH expansion on children's social and emotional functioning is presently ongoing.

As part of the LAUNCH Expansion evaluation, a random subset of 60 caregivers were selected to participate in the parent satisfaction survey. Of these, 40 responded to and completed the survey. The surveys were conducted over the phone in both English and Spanish in order to reach a more representative sample of families. Overall, most caregivers reported that the LAUNCH services were very helpful (78%), and that they were very satisfied (88%). They also reported that the LAUNCH program helped them to understand their children and their emotions better, and that the LAUNCH/MYCHILD model helped them to be a better parent. Finally, they reported that the LAUNCH/MYCHILD model helped them to access specific information they needed, were sensitive to their customs and beliefs and used a parent-centered approach making them feel like they were the expert on their child and knew them best.

In addition, the LAUNCH expansion evaluation assessed parental perspectives on the LAUNCH/MYCHILD model and the role of the family partner. We conducted key informant interviews with a convenience sample of LAUNCH expansion families (n=6) who had received at least 3 months of services. Interviews were conducted in English or Spanish, dependent on caregiver language preference. The interviews were translated into English (when appropriate), transcribed and thematically coded by members of the evaluation team in NVivo. We also conducted focus groups with clinicians and family partners involved with the grant. Findings revealed that lived experience is central for Family Partner engagement, allowing for the forging of meaningful relationships. Family Partners were critical in helping families navigate complex systems/agencies, parenting skills, provider interactions and daily challenges. Family partners also contributed to alleviating caregiver stress and mental health concerns.

As one Family Partner shared,

"I understand where they are coming from, I have been there. I have been frustrated with the school system, I have been frustrated with the medical services… I sometimes say wait. I understand where this is coming from, I could understand you in seconds, you are being upset, you are irritated, and I can feel it. And usually I, I understand them, I try to meet them where they are and then being there for them."

As one caregiver participant shared,

"[Family Partner and clinician] actually gave me more support and …more faith in me, like okay, you're gonna get this done, you know you're gonna get this done…so it's like, they didn't doubt me. And eventually I did. I got my apartment, [my son] is in kindergarten, I'm trying to get [the baby] in daycare, hopefully I can go back to working soon."

In November 2018 an online survey was conducted with providers at each of the three LAUNCH expansion sites to assess changes in their practice as a result of having the LAUNCH program at their site. Respondents included nurses, doctors, social workers, clinicians and others who either referred to LAUNCH expansion or attended trainings put on by the ECMH team. In total, 16 providers responded to the survey. Most providers indicated that LAUNCH created substantial or some change to their practice regarding their knowledge of children's social and emotional and behavioral development and their use of mental health consultation. Providers indicated an increase in referrals for at-risk families, alongside faster referrals, use of behavioral health more efficiently integrated into primary care, an expanded scope of families served, and better support of parents around children with behavioral needs as a result of the LAUNCH program.

Taken together these findings suggest that the LAUNCH expansion was a successful replication of the MYCHILD/LAUNCH model.

Massachusetts Multi-City Young Children's Mental Health System of Care Project (2015-2019)

The LAUNCH/MYCHILD model was also used as the foundation for the Massachusetts Multi-City Young Children's Mental Health System of Care Project (SOC). This project expanded and adapted the model to a different setting. The SOC model paired dedicated teams of family partners and intensive care coordinators (ICCs) in community service agencies to provide family-centered ECMH services for very young children (birth to six years) with serious emotional disturbance. Intensive care coordination is a service provided under the Children's Behavioral Health Initiative (CBHI), an interagency statewide initiative in Massachusetts to build a system of care for children and youth under the age of 21 with behavioral health needs.

SOC teams were placed at designated community service agencies and received referrals for eligible families from partnering primary care practices. Local health departments supported and facilitated this model of behavioral health integration into primary care.

As part of the evaluation for SOC, we conducted focus groups and semi-structured key informant interviews with staff and stakeholders involved with SOC over the four years of the grant. Focus groups were conducted in year 1, year 3, and year 4 of the project with family partners and ICCs across sites. Semi-structured key informant interviews were conducted with leadership teams at the participating CSAs, pediatric primary care practices, and local health departments in year 2 and year 4. The coding team conducted thematic analysis in NVivo and used group discussions to identify final themes.

Participants discussed capacity-building as an essential tool to improve service-delivery and build cross-sector collaborations. Meaningful working relationships were prioritized at both the individual and systems-level. Sustainability was identified as a lens that permeates all aspects of implementation. Use of creative strategies were deemed necessary to deal with systemic barriers. Challenges identified included navigating within a health system that is not set up for ECMH; high rates of administrative burden and staff turnover; communication challenges

between leadership and field staff; and lack of financing mechanisms to sustain the work. These findings suggest that this replication and adaptation of the LAUNCH/MYCHILD model is an effective model for improving direct services, increasing behavioral health integration into primary care, as well as for cultivating and expanding an inter-agency system of ECMH at the state-level.

Internal Capacity

The LAUNCH/MYCHILD model features a multidisciplinary team of professionals who provide comprehensive services to achieve family and program goals. The core team that supports the model in the primary care site includes a:

- Family Partner
- Mental Health Clinician
- Primary Care Provider Champion
- Program Administrator Champion

Recruiting, training, supervising, and orienting the members of this team is key to successfully implementing the model. Section 1: Building a Core Team to Champion Children's Social and Emotional Health in our *Early Childhood Mental Health Toolkit: Integrating Mental Health Services into the Pediatric Medical Home* provides resources for recruiting team members, orienting them to the medical home and its goals, selecting professional development plans, and supervising the team members.

The Family Partner-Mental Health Clinician relationship is a unique and powerful collaborative relationship central to this model. The Family Partner and Mental Health Clinician work together to provide the family with comprehensive services tailored to each family's needs. It is critical that this relationship is seen as non-hierarchical, and the contributions of both the family partner and mental health clinician are valued equally. Reflective supervision for the two together supports a successful, healthy relationship with both members feeling supported and valued.

Implementation support and capacity building has been critical to develop and replicate this model to fidelity. Elements of the implementation support included:

- Project Coordinator
- Regular Technical Assistance to sites
- Reflective Supervision Consultant
- Training and professional development for ECMH team and primary care team in ECMH, integration
- Family leadership and voice at all levels of the project design and implementation
- Learning Collaborative and CQI

Collaboration/Partners

The LAUNCH/MYCHILD model was developed and implemented with the following structure for stakeholder engagement:

Group	Function	Representation
Collaborative Leadership Team	Drives model implementation	Project coordinator, core team members, and evaluators
Learning Collaborative	Cross site learning and continuous quality improvement	All core teams and project leadership

Family Leadership Council	Keeps family voice in all aspects of implementation	Families receiving services and family partners
State Level Council	Interagency alignment of ECMH priorities	Representatives from state agencies, medical and behavioral health providers, community-based organizations, families

Family voice is central to the LAUNCH/MYCHILD model. See the ECMH Toolkit Section 3: Creating Medical Home Systems to Support Mental Health Integration section on Parent Voice in Shaping Medical Home Services/Systems (starts on page 40).

In addition, collaboration with early childhood community partners that support social emotional development of children and families is a critical piece of LAUNCH/MYCHILD services. The ECMH Toolkit, Section 1 (p32-38) provides suggestions for surveying and connecting to clinical and family support resources. Section 2: Providing Family-Centered Care for Children's Social and Emotional Health provides more examples (p 145) of early childhood specific resources to consider as potential partners to improving capacity of the medical home on early childhood mental health.

Practice Cost

LAUNCH/MYCHILD was designed to be a multi-site project, supported by a central Project Director to oversee fiscal operations and provide site support and technical assistance to maintain model fidelity. These supports include facilitating the delivery of uniform training and reflective supervision, implementing a cross-site learning collaborative to support practice transformation, and providing on-site coaching, mentoring and problem solving. The budget below includes funding for the Program Director, three teams (one per site), and associated reflective supervision, training, program development and operational costs. Note that depending on how this might be replicated, the Program Director might sit at a separate coordinating agency (e.g., a city health department) and work with 3 individual community health centers, or the PD could be located at a large agency that had multiple sites/teams.

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Program Staff	1 FTE ECMH Clinician and Family Partner and .1 FTE Pediatric Champion per site	3 sites	$393,000
Program Director and Supervisory Support	1 FTE Program Director, fringe, travel, supplies and indirect; Reflective Supervision consultant	1	$123,000
Training, Program Development and Operational costs	Training for site staff and learning collaborative across sites		$19,000
		Total Amount:	**$535,000**

Practice Timeline

Practice Timeline				
Phase	**Description of Activity**	**Date/Timeframe**	**# of hours needed to complete/ oversee activity**	**Person(s) Responsible**
Planning/ Pre-implementation	Recruitment and Hiring: Program Director Site Staff	Month 1-2 Month 2-4	20 hours 30 hours per site	Coordinating Agency Director Site Leadership; Program Director
	Implementation Planning	Month 1-4	20 hours (some cross site, some individual)	Program Director and Site Leads
	Establish any needed agreements and fiscal contracting between coordinating and implementation agencies	Month 2-3	15 hours	Program Director and Site Leads
	Establish governance including family leaders	Month 3-4	10 hours	Program Director and Site Leads
Implementation	Training/Orientation	Month 4-5	20-40 hours	Program Director
	Start Up	Month 5-6	As needed	Program Director and Site Leads; Site Teams
	Bi-monthy Technical Assistance Monthly Reflective Supervision	Month 4-ongoing	2 hours/month per site/team I-2 hours per team/month	Program Director and Site Leads; Reflective Supervision consultant
	Data Collection	Month 6-ongoing	As needed	Program Director and Site Leads
Sustainability	CQI/Evaluation	ongoing	2+ hours/month	Program Director and Site Staff; Advisory
	Bi-Annual Sustainability Planning Meeting	Month 7- ongoing	4 hours/year	Program Director and Site Leads and Staff; Advisory

Resources Provided

The ***Early Childhood Mental Health Toolkit: Integrating Mental Health Services into the Pediatric Medical Home*** is a comprehensive collection of tools and tips for incorporating early childhood mental health personnel and practices into the pediatric primary care setting. It is available at:
http://www.ecmhmatters.org/ForProfessionals/Pages/MedicalHome.aspx#toolkit

Lessons Learned

Embedding a team of an ECMH clinician and a family partner with lived experience into a pediatric/family medicine team in a community health setting promotes healthy social and emotional development in children, prevents little problems from turning into big problems, and reduces caregiver stress and depression. It also contributes to practice transformation around ECMH and responsiveness to caregiver (across various races, cultures, ethnicities, and languages) and community needs.

The model only works if it is supported with effective funding mechanisms that aren't currently widespread, including value-based payment for ECMH promotion and prevention and support of two-generation work in pediatrics. The model is effective when both the embedded staff and existing primary care team are supported with EMCH training, reflective supervision and support for continuous quality improvement, in the context of a learning a community across sites, which also needs fiscal support and infrastructure.

The ECMH clinician and family partner team need to be trained and supported to function as a team, working with caregivers as a dyad and without hierarchical power dynamics. Each member brings unique skills, knowledge and competencies that work best when truly combined. Family partners bring their lived experience, knowledge of the community and culture, and ability to connect with and be trusted by the caregivers. EMCH clinicians bring the art and science of their training and clinical competencies. Each of these roles can learn from and share their approaches with the other and with other staff members on the primary care team.

Having strong results and a strong model does not guarantee sustainability. The management team for these projects have participated in numerous efforts to address sustainability for the model, without success. Ultimately, we need to fund a system that integrates ECMH promotion and prevention practices.

Next Steps

The Partnership for Early Childhood Mental Health continues to work toward a reality that allows all children and families – particularly the most marginalized – to have equitable access to high quality ECMH-enhanced medical homes.

We currently have a manuscript in progress on the role of the family partner in engaging and supporting young children and their families in ECMH services. We have also submitted an oral presentation to the American Public Health Association 2020 Conference titled "The impact of the family partner in infant and early childhood mental health service-delivery in Massachusetts: A qualitative study." We believe that the success demonstrated in over 10 years of

implementation of the LAUNCH/MYCHILD model merits further replication and research on the effectiveness of the family partner role and the ECMH “power team” in promoting early childhood mental health.

While we currently do not have funding for expansion to new primary care sites, the Early Childhood Mental Health Family Independence, Resilience, Support, and Treatment (ECMH FIRST) project began in October 2019 and expands the LAUNCH/MYCHILD model to a novel setting. The direct-service goal of ECMH FIRST is to improve access to high-quality, culturally competent, evidence-based behavioral health services through an innovative Family Partner/Clinician service model for children age 0-48 months and their caregivers who are involved with the Massachusetts child welfare system. The project will employ a family partner, clinician, and service coordinator to implement the evidence-based LAUNCH/MYCHILD model. The project is in the early stages of implementation and replication.

The Partnership for ECMH is in the process of completing a ***LAUNCH/MYCHILD Early Childhood Mental Health Practice Manual***. Please contact us for more information!

Practice Contact Information

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