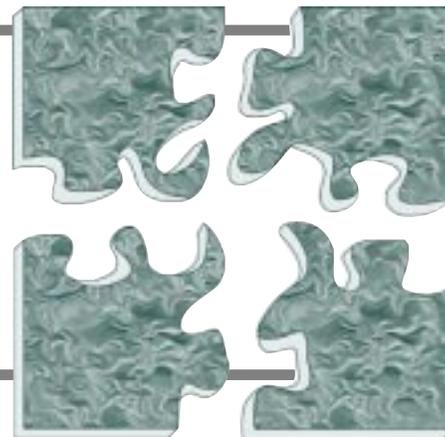


BEST PRACTICE BRIEFS



PUTTING THE PIECES TOGETHER

A COMMUNITY SYSTEM
OF CARE for very young
children and their parents

- includes all children and families
- targets competent development
- is sustained by formal agreements

INVOLVES

- linkages and interconnections
- joint procedures
- systematic processes
- necessary infrastructure

REQUIRES

- collaborative planning
- common vision and values



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A COMMUNITY SYSTEM OF CARE FOR VERY YOUNG CHILDREN AND THEIR PARENTS

***BRIEF** No. 9 explored the general concept of a Community System of Care. This **BRIEF** applies the concept to a specific population—infants/toddlers at risk and their parents. Infants and toddlers are referred to in this **BRIEF** as “very young children.”*

THE FRAMEWORK FOR A COMMUNITY SYSTEM OF CARE

Policy makers pay more attention to the elderly, motorists, gun owners, and troubled adolescents than they do to very young children—newborns, infants, toddlers.¹ Yet what happens in the first years of life can substantially affect the health, mental health, school performance, and economic viability of each birth cohort.

All very young children are vulnerable because of their developmental stage and need for protection. However, some children are subjected to risk conditions that make them more vulnerable than others: in the United States, as many as 22 percent of all children live in poverty and the percentage of births to adolescent mothers, while declining, is still higher than in any other western country.² In recognition of these and other substantial risks to good outcomes for very young children, numerous federal, foundation, and community-funded projects and initiatives have been developed over the past 25 years. Following the requirements of the funding source, these efforts have generally targeted one objective, or a limited number of objectives, for the child or the caregiver:

Health

- improving birth outcomes
- improving health of the child
- immunizing all children

Families

- supporting young mothers
- supporting young fathers
- supporting families

¹ Although pre-school children, ages 3 to 5, are generally included in the definition of very young children, *this BRIEF* is primarily focused on the first three years of life.

² Lee Rainwater and Timothy M. Smeeding (1995), *Doing Poorly: The Real Income of American Children in a Comparative Perspective*. Working Paper No.127, Luxembourg Income Study, Maxwell School of Citizenship and Public Affairs, Syracuse University; and United Nations (1998), *Demographic Yearbook*, pps. 353-64.



Education

- assuring that all children come to school ready to learn
- assuring that children of low-functioning mothers come to school ready to learn
- accomplishing literacy for parent and child

Caregiving

- developing good parenting skills
- preventing child abuse and neglect

Healthy Social-emotional Development

- developing a positive nurturing relationship between caregiver and child
- developing attachment for infants in foster care

The best initiatives recognize that all phases of nurturing and development for the infant and toddler are intertwined. Intervention, therefore, must promote a positive relationship between the very young child and his/her caregivers in order to accomplish other objectives.

For any one community with two or more initiatives targeted at specific populations, the result—with the best of intentions and goodwill—is an incomplete “non-system,” with the various parts usually operating independently and often competing for families. With different eligibility requirements and lengths of service and often tenuously connected to the mainstream health services, these services would better serve the community if they **were organized as a Community System of Care.**

A COMMUNITY SYSTEM OF CARE

is the organization of public and private service components within the community into a comprehensive and interconnected network in order to accomplish better outcomes for a defined population.

THE POPULATIONS OF VERY YOUNG CHILDREN

Based on characteristics and situations related to service needs, three distinct populations of very young children can be identified:

- **“General”**—in more or less positive situations. The infant is wanted and in a reasonably stable family (estimated at 80% of births).
- **“At Risk”**—the characteristics of the infant or the parent’s circumstances create the potential for poor outcomes (estimated at 10-17% of births).
 - The infant is difficult to care for: low birth weight; difficult temperament; or sensitivity

to touch, etc.

■ The infant is born to parents who are poor; lack supportive relationships; are experiencing life crises (divorce, abandonment, and domestic violence); with mental illness, developmental disabilities or substance abuse; or have past histories that hamper parenting.

- **“Special Needs”**—with genetic or acquired disabilities, or delayed in development (estimated at 3% of births).

THE SERVICE CONTINUUM FOR VERY YOUNG CHILDREN³

- **Universal Services** for all very young children and their families:
 - **general information, education, and support**—provided by a variety of public and private agencies: e.g., hospitals, public health, schools, neighborhood centers, university extension
 - **health care**—provided by the health care system with private and public payment sources
 - prenatal care and delivery
 - primary health care
 - **child care/early childhood education**—provided by family day care by for profit/non-profit/employer-based centers for those able to pay, and by Early Head Start/Head Start and school-based programs primarily for poverty populations
- **At Risk Prevention and Early Intervention Services** limited to very young children and parents whose condition or life circumstances involve substantial risk to development:
 - **support and intervention directed at pregnant women** whose psycho-social circumstances or medical condition place them at risk for a poor pregnancy outcome
 - **support and early intervention services for very young children and their families** where the physical characteristics of the child or the life circumstances of the family place the child at risk of poor outcome
- **Special Needs Intervention and Remediation Services** for very young children with disabilities and developmental delays—provided by public and private agencies, with identification

³ Other services and institutions in the community, such as faith-based institutions and the media, can also impact the lives of very young children. Adult services and institutions may or may not take the needs of young children into account, e.g.,

■ world of work ■ welfare to work ■ court determinations in divorce (custody and visitation) ■ prisons for women

and coordination through Part C of IDEA, (known as Early On in Michigan):

■ **specialized health care, service coordination, parent training and support**

READY TO LEARN CHARACTERISTICS⁴

Five year olds who start school ready to learn have certain characteristics promoting school performance that result from their experiences as very young children. Supporting parents and caregivers in developing these characteristics is the task of any system of care.

In addition to having good physical health, a five year old who is ready to learn needs to be

- **Confident**—has a sense of control and mastery of one’s body, behavior, and the world; he or she is more likely than not to succeed at what he or she undertakes; and believes that adults will be helpful.
- **Curious**—proceeds with the expectation that finding out about things is positive and leads to pleasure.
- **Intentional**—possesses the wish and capacity to have an impact and is persistent; related to a sense of competence, of being effective.
- **Self-controlled**—is able to modulate and control one’s own actions in age-appropriate ways; has a sense of inner control; is non-disruptive.
- **Related**—is able to engage with others based on the sense of being understood by and understanding others; is responsive to adults; empathic.
- **Able to communicate**—wishes and is able to use language to exchange ideas, feelings and concepts with others; related to a sense of trust in others and of pleasure in engaging with others, including adults.
- **Cooperative**—is able to balance own need with the needs of others in a group activity.

These characteristics result from families and communities that provide very young children with **responsive caregiving, unhurried time** with a limited number of caregivers, **safe environments,** and **health care.**

A COMMUNITY SYSTEM OF CARE FOR VERY YOUNG CHILDREN AND THEIR CAREGIVERS

A Community System of Care for very young children and their caregivers will be developed by a workgroup of the multi-purpose collaborative body

or a community coalition composed of representatives of the various agencies serving very young children. The workgroup will adopt values for service delivery and will go through the process of developing the various components of a community system of care, as outlined below.

Values For Service Delivery

- **Responsive** to the unique significance of the first three years of life for the child’s overall development
- **Inclusive of,** and responsive to, the needs of **all families** with very young children
- **Seamless** with respect to interconnections and transitions
- **Accessible** in terms of convenient location, times available, and cultural background
- **User-friendly,** recognizing recipients of service as customers
- **Strength-based,** emphasizing assets rather than deficits
- Providing **continuity of service providers**
- **Inclusive of all community resources,** public and private, formal and informal services
- **Collaborative** with respect to interagency planning and pooling of resources

The total community system of care will include the service continuum of Universal Services for all families and the Special Needs Intervention and Remediation Services. The material in the next section outlines the elements in a Community System of Care that should be developed for At Risk Prevention and Early Intervention Services.

A COMMUNITY SYSTEM OF CARE FOR VERY YOUNG CHILDREN WHO ARE AT RISK

- **Early identification of families** who can benefit from support and intervention services.

This element requires systematic screening in prenatal services and in the maternity unit where there is access to parents and infants. Early identification during pregnancy or around the time of birth provides the opportunity to avoid adverse outcomes by providing services at the earliest stages of the developing relationship between parent and infant.

- **Systematic review** by all services that routinely see very young children and families.

⁴ Zero to Three/National Center for Clinical Infant Programs (1992), *Heart Start: The Emotional Foundations of School Readiness*, p.7.

Very young children and families who slip through the early identification process or whose situation changes may be identified by health care professionals, social service workers, and child care providers.

- **Referral to the appropriate service** that can best respond to the situation, rather than either accepting families without regard to the match between their needs and agency capacity or rejecting families because categorical funding has eligibility limitations.

Appropriate referral requires (a) jointly agreed upon criteria for assignment and (b) flexible funds to make access possible for all families that need services.

- An **interagency plan of service**, covering all relevant areas of family life, to keep the various service providers from overlapping contacts and inconsistencies in recommendations and to ensure that needs of families are being addressed.
- Access to a **comprehensive array of concurrent services** as needed across the separate agencies responsible for health, mental health, education, recreation, support and intervention, etc.
- **Smooth transitions** between sequential services, as children move from infant to toddler to preschool child, or as an individual's needs change.

Both access to concurrent services and smooth transitions require interconnections and smoothly functioning institutionalized arrangements for referrals, intake, service planning, and monitoring.

- Facilitating access to **supports for parents**—both formal agency services as well as through the informal connections to family, friends, neighbors, and faith-based institutions.
- A **holistic approach** to service delivery so that physicians, emergency rooms, and service agencies use contacts with families to address issues related to the avoidance of injury, prevention of violence, building of assets, etc., and to assure access to services (“no wrong door”).
- **Cross-agency training** to assure a common base of understanding and competence.
- **Assignment of staff** to (a) attend to systems issues and (b) provide coordination of services for each family.
- A **data system** that provides feedback on how the system of care is operating and on outcomes.

DEVELOPING A COMMUNITY SYSTEM OF CARE: A CASE STUDY⁵

THE NON-SYSTEM NOW

In Ourtown, a typical community in Michigan, there are about 1000 births a year, and people are truly concerned about infants.

People in the professional community—physicians, public health nurses, social workers, and educators—are generally aware of one or more of the following **services**:

- a home visiting service, staffed by paraprofessionals, funded by the Children's Trust Fund, limited to first-time parents;
- a home visiting infant mental health service, staffed by professionals, provided through the community mental health agency; and
- a home visiting time-limited educational service through university extension.

In addition there are

- a family resource center providing mothers' support groups and respite care,
- an alternative school for pregnant and parenting adolescents, and
- the coordination of services for infants with disabilities or developmental delay.

Even with these available services and resources, a **community health assessment** identified a number of disjunctures and barriers in the community's effort to support families:

- Many young families, through lack of insurance or distance from services, are not linked to primary health care services.
- Physicians recognize a need for support in parenting, intervention for psycho-social issues, and access to resources for infants with preventable conditions and for families in crisis, but they do not have the time or knowledge to link families to services.

Continued on next page.

- **Interagency agreements and policies within each agency** that promote and support the community system of care.
- **Adequate payment mechanisms.**

⁵ Experience in Grand Traverse County, Michigan, triggered this description, but it does not entirely represent that situation.

- Although the community has a number of home visiting, parent education, and other support and intervention services for families with very young children,
 - families and many professionals are not really aware of what is available, and there is no definitive listing;
 - enrollment for services is more a matter of a parent being somewhere at the right time than of any systematic access;
 - some parents, highly visible to service providers or knowledgeable about their needs, are being offered multiple services while other families seem to be overlooked;
 - a family might be referred to and enrolled in one service when another would have been more appropriate.
- Each service has developed its own idiosyncratic referral relationships with the hospital, physicians, public health nurses, and protective service workers.
 - Social workers and nurses make referrals and expect families to find their way to services.
 - There is inconsistent feedback to the referral person about what happens to the family.
- Sometimes a service provider would decide after a number of visits that some other service would be more appropriate. As a result, a family gets bounced from one service provider to another.
- When children reach the age limit for one service, there is no assurance that they will be transferred into the next appropriate service.

Most Likely to Receive Services

- ✦ infants with disabilities and their families
- ✦ adolescent first-time mothers

Most Often Overlooked

- ✦ isolated families with several young children
- ✦ parents with developmental disabilities or those with mental illness who, absent a crisis, prefer to maintain a low profile for fear that protective services will take their children away
- ✦ divorcing parents with infants and young children
- ✦ children in families experiencing domestic violence
- ✦ infants in out-of-home care (foster care, child care)
- ✦ women with young children entering the workforce

THE SYSTEM THAT COULD BE

Acknowledging that something was missing in the organization of services for families with very young children, two groups within the community decided to develop a more coherent system.

- The Hospital, as part of its initiative to improve care and reduce costs, appointed a committee to work with physicians to develop a more consistent access to primary care and preventive services.
- The Multi-Purpose Collaborative Body, as one part of its concern about the school dropout rate, asked its Prenatal to Six Committee to make recommendations to promote "Children entering school ready to learn." They requested the formulation of a comprehensive continuum of prevention services.

The concerns identified by the Hospital group and the characteristics of "children entering school ready to learn" identified by the Prenatal to Six Committee (see p. 3) were compatible. The ready to learn characteristics were seen as outcomes that would result from better access to primary health care and preventive services.

Objectives of the Hospital Committee

ORGANIZATION OF SERVICES SHOULD PROVIDE

- ✦ Access to primary health care
- ✦ Access to preventive services that
 - ↳ support parents in raising children
 - ↳ encourage age-appropriate development
 - ↳ assist parents to overcome life crises, problems

The two groups had overlapping membership and decided to work as a single committee. They agreed that their task was to develop a Community System of Care for all very young children and their families. Thus, their primary value for the service system was **INCLUSIVENESS**.

Continued on page 6.

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Anxious to have a product within a short time frame, they decided to undertake two initial tasks:

- a listing of all preventive services currently available in the community, and
- a system to ensure access to primary care and preventive services for all infants born at the Hospital.

Listing of Preventive Services

A systematic survey of agencies, organizations, churches, and libraries resulted in identification of home visiting services, parent education offerings, mothers' support groups and play groups, as well as basic needs and counseling resources. Information was compiled on availability of service, eligibility requirements, costs, etc. This collected information provides a base resource for identifying existing resources as well as possible barriers to a Community System of Care.

Funding from community sources made possible the printing and distribution of (a) 2000 copies of a directory organized by type of service, for use by parents, and by agency, and (b) a single-sheet up-to-date listing issued quarterly for use by physicians and other professionals.

Systematizing Access to Services

The Hospital, physicians, and the Health Department negotiated the organization of **Healthy Futures**, to promote community norms for the healthy development of very young children. **Healthy Futures** established the following plan of action:

- The health department clinic would refer pregnant women who were strongly ambivalent about the pregnancy or were isolated and without resources to the community mental health home visiting program.
- Physicians and nurses, at the first postnatal visit to the hospital, would offer all mothers of newborns (not simply first-time mothers), the opportunity to enroll in **Healthy Futures** with the following benefits:
 - a subscription to an age-appropriate newsletter mailed to the home, six times a year, and
 - at least one home visit from a public health nurse.
- The public health nurse at the home visit

would accomplish the following:

- answer questions and provide information about health issues, including immunizations;
 - provide information about the Hospital's hotline;
 - determine whether the family had a primary care physician;
 - ask who might be available to assist the mother within the family or within the community, indicate the importance of backup from an adult, and suggest possibilities;
 - leave a copy of the service directory;
 - determine whether the family had needs that might be met by available support and intervention programs and, if so, offer the possibility of a referral; and
 - schedule 1-3 additional home visits, if additional support were needed.
- A service coordinator for **Healthy Futures**, employed by the Hospital, would
 - serve as liaison between the Hospital, the physicians, and the health department;
 - make arrangements for a primary care physician for those families that were not connected to one;
 - enroll families in insurance coverage under state programs for low income children, as needed; and
 - facilitate referrals to the support and intervention services.
 - Where families had multiple needs and current or potential involvement with multiple agencies, the service coordinator would put in place a wraparound process during which the family and others they selected would develop a comprehensive service plan. To facilitate this process, the agencies adopted guidelines to protect confidentiality.
 - The service coordinator would be available to families not connected to **Healthy Futures** who were identified by physicians or agencies as needing linkages to insurance, primary health care, or agency services.
 - The Hospital would set up a registry to document all contacts and outcomes, thus permitting monitoring and analysis of the effectiveness of **Healthy Futures**.

Continued on page 7.

As this system was put into place, it was clear that for services to be inclusive, resources had to be available to underwrite the prevention services that were available only to Medicaid-eligible families. The Committee put together a resource pool to accomplish this, with contributions from the Hospital, the community foundation, and a state grant.

Vision and System Values

During this process, the Committee paused and put on paper their vision and their values or guiding principles.

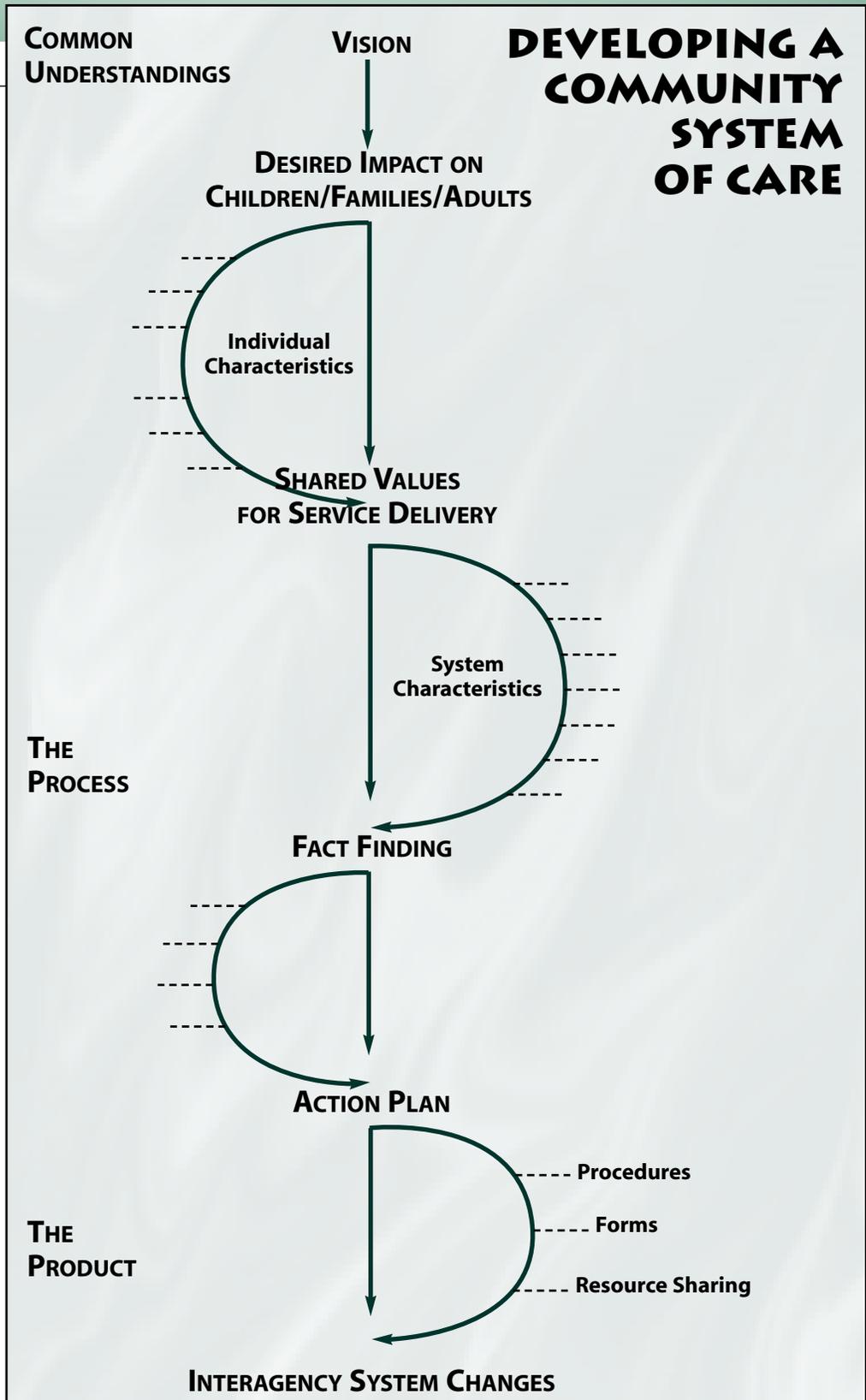
OURTOWN'S COALITION DECIDED THAT ITS VISION WAS

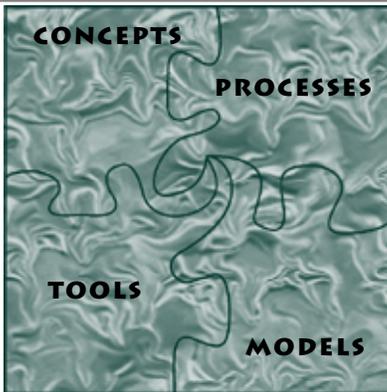
Nurturing communities with a seamless array of services and supports for all pregnant women, very young children, and their families.

Guiding Principles

- All pregnant women and all families of newborns deserve **support and access to appropriate health care.**
- **Preventive services** to reduce risks and build resilience should be available to all families.
- A **systematic collaborative inter-agency approach** will provide the most appropriate and most effective array of services and supports.
- **Every door is "a right door"** into the system of care.
- Services for families must be **user-friendly, family-centered,** and approached from the standpoint of the family's unique **strengths and needs.**
- Services must be **consistent with the family's culture, ethnicity, race, and religion.**

Continued on page 8.





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Work in Progress

Because developing a Community System of Care is always a work in progress, the Committee has identified a full agenda of activities still to be accomplished. The Committee plans to undertake the following actions:

- create a **common intake form**
- create a format for an **interagency plan of service** with agreed upon confidentiality protocols
- promote **parenting education opportunities** for new parents and during the child's first and second years of life as a normal part of other services
- develop neighborhood-based **family resource centers**
- provide **cross-agency training** in 0-3 developmental issues
- organize **cross-agency consultation** so that health and mental health expertise can be made available to paraprofessionals and professionals in child care and other agencies that impact the lives of very young children
- institutionalize the interconnections for a Community System of Care through **interagency agreements**

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ADVISORY GROUP: MARGUERITE BARRATT, Institute for Children, Youth and Families, Michigan State University; ROB COLLIER, Council of Michigan Foundations; DEANNA DEPREE, Life Services System of Ottawa County; JEAN GOLDEN, East Lansing Human Services Commission; CASSANDRA JOUBERT, Mott Children's Health Center; MARCIA KREUCHER, Region II Community Action Agency; FRANK MANNING, Capital Area United Way; JOHN MELCHER, Urban Affairs Center, Michigan State University; DEBORAH STRONG, Children's Trust Fund. **STAFF:** BETTY TABLEMAN, Editor and Writer; ELIZABETH BETHARD, Research Assistant, Public Policy and Administration; OLGA OLOWOLAFE, Administrative Assistant; KATHY BLACK, Designer.



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