Executive Summary

Infant and early childhood mental health is an interdisciplinary field of research, clinical practice and public policymaking concerned with maximizing the well-being of infants, toddlers and preschool age children, and their caregivers. New Mexico ranks 48th in the nation for having the highest percentage of children living in poverty (26%) and living in neighborhoods with a high poverty rate (45%). Twenty-one percent of children in New Mexico have no health insurance and 18 percent live in high-risk families. Given the state of early childhood mental health training and knowledge around New Mexico, and the interest in developing a behavioral health work force development that had specialized training and proven competencies in infant mental health, through the New Mexico Association for Infant Mental Health (NMAIMH) Competency and Endorsement process, the New Mexico Department of Children, Youth and Families contracted with Deborah Harris, LISW, Infant Mental Health Mentor, of Early Childhood Mental Health Consultation and Training, to organize a series of regional state-wide summits on Early Childhood Mental Health Systems of Care and to assist communities to assess their strengths, challenges and needs for building a comprehensive, coordinated and effective continuum (prevention to treatment) of mental health services for families and their children pre-natal to three.

Under this contract, in the fall of 2008, Ms. Harris implemented three Summits on Infant and Early Childhood Mental Health in Moriarty, Las Vegas and Window Rock. Over four hundred participants attended the Summits whose primary purpose was to:

1) **Increase and/or enhance awareness of early childhood mental health needs including a coordinated specialized system of care and specialized work force;**

2) **Inform participants about the New Mexico Association for Infant Mental Health’s on Competencies Endorsement process and how this is integral to defining and building a specialized work force;**

3) **Introduce the new infant mental health treatment service definition (in
process) and the qualifications needed to provide treatment under this definition;
4) Increase awareness of the New Mexico Home Visiting Initiative;
5) Collect a completed community assessment to ascertain the readiness and capacity for regional next steps in building local early childhood mental health systems of care.

The themes that Summit participants brought up repeatedly when describing greatest unmet needs in their communities included a demand for increased collaboration and coordination among agencies (state as well as local level) serving infants, young children, and their families; increased public awareness about existing infant and early childhood mental health programs; availability of, and access to professional development and training in infant, toddler and early childhood mental health assessment and treatment; professional development and education based on the New Mexico Association for Infant Mental Health’s Competency Guidelines and Endorsement; increased parent education, and family involvement; and programs to address teen pregnancy and parenting.

It was clear from all of the summits, including the ones held in prior years, that infant mental health, when defined for the audience, made a huge impact. Participants responded with requests for more information, training and resources. The noted services most lacking are assessment and treatment by qualified infant mental health specialists, as per the New Mexico Association for Infant Mental Health (NMAIMH) competency guidelines, and opportunities for behavioral health work force development based on the NMAIMH competencies. This is critically related to the up and coming infant mental health treatment service definition which participants were also eager to hear more about.

Recommendations and next steps emerging from the Summits included: 1) expand interaction between existing infant and early childhood programs and services (along the continuum of prevention to treatment), within and between state agencies; 2) encourage the Behavioral Health Purchasing Collaborative to address the needs of infants and toddlers in their priorities for planning by including an infant mental health work group; 3) expedite the implementation of the infant mental health service definition; 4) encourage the Collaborative to incorporate infant mental health needs as they intersect with the adult behavioral health system; 5) address the need and requests for work force development by offering more training opportunities based on the New Mexico Association for Infant Mental Health’s competency-based Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health (including the provision of qualified reflective supervisors); 5) increase outreach and partnership with behavioral health providers; and 6) provide follow-up support to communities that expressed interest and readiness for next steps in creating a regional early childhood mental health system.
Background

The state of New Mexico has made substantial progress in the development of a comprehensive early childhood mental health system of care. A number of the initiatives, including the regional Summits on Early Childhood Mental Health Systems of Care have been funded in part by a SAMSHA Behavioral Health Transformation grant.

Infant and early childhood mental health is an interdisciplinary field of research, clinical practice and public policymaking concerned with maximizing the well-being of infants, toddlers and preschool age children, and their caregivers. Early childhood mental health specialists focus on the psychological, social and emotional well-being of infants and young children in relationship with their caregivers, environment and culture – with respect for each child’s uniqueness. These specialists strengthen infant/parent relationships, build secure attachments and social emotional wellness, help reduce child abuse and neglect and strengthen protective factors that combat mental illness.

In order to create a comprehensive and effective system of care for children’s mental health, fundamental changes in standard service delivery models are necessary. Professionals from various disciplines must work together more collaboratively within and between agencies. Such collaboration demands a shared understanding of early childhood mental health priorities and principles. Because early childhood mental health is an interdisciplinary field of practice, specific competencies, rather than a single academic program, define the knowledge, skill base and practices for effective service delivery. Proficiency and endorsement in these specific competencies, as defined by the New Mexico Association for Infant Mental Health is critical in for the development of a qualified infant mental health work force in New Mexico. Besides these competencies, collaboration for children’s mental health requires several critical elements:

- An awareness of all components of the service systems that affect infants, young children and their families;
- The development of a continuum of integrated services;
- A plan for effectively “turning silos into circles of caring;” and
- State support to implement and evaluate such a system of care.

A number of different service systems, including healthcare, education, and childcare, involve and affect very young children. These systems do not easily engage with mental health services.
In most rural areas a continuum of behavioral health services is unavailable and if mental health services do exist, specialty providers, including counselors, social workers, psychologists and psychiatrists with expertise in early childhood mental health, are lacking. As a result, identification and treatment of mental health needs of young children are not addressed early in development, when intervention and treatment have the greatest impact. These gaps in service availability are especially glaring in rural New Mexico, and the initiatives described are a response to the need for a competent, multi-disciplinary early childhood mental health work force in New Mexico’s rural communities.

Early childhood mental health is a priority. Many studies and statistics could be cited, but a groundbreaking study done by Kaiser Permanente (Felleti, 1998) on adverse childhood events in non-clinical patients (i.e. not seeking mental health services) shows especially clearly why this stage of life, specifically the birth to five age group, is so important.

Researchers found that (without intervention) there is a correlation between adult emotional/social dysfunction and an upbringing in a household where there is recurrent physical abuse; recurrent emotional abuse; sexual abuse; an alcohol or drug abuser; an incarcerated household member; someone who is chronically depressed, suicidal, institutionalized or mentally ill; only one or no parent; or emotional or physical neglect. Remarkably, persons who reported exposure to four or more of the above categories demonstrated a four to 12-fold increase in risk for alcoholism, drug abuse, depression, and suicide attempt compared to those who had none.

Research and empirical evidence tells us that good mental health during the earliest years lays the foundation for healthy relationships and learning later in life. Specifically, attention to social and emotional well being in the first years of life can prevent these risk factors from destroying our children.

New Mexico ranks 48th in the nation for having the highest percentage of children living in poverty (26%), living in extreme poverty (11%) and living in neighborhoods with a high poverty rate (45%). Twenty-one percent of children in New Mexico have no health insurance. Eighteen percent of children live in high-risk families.

Given the state of early childhood mental health training and knowledge around New Mexico, and the interest in behavioral health work force development, the State of New Mexico Dept of Children, Youth and Families contracted with Deborah Harris, LISW, IMH-E (07), Infant Mental Health Mentor of Early Childhood Mental Health Consultation and Training, to organize a series of state wide summits on infant and early childhood mental health systems of care and to assist communities to assess their strengths, challenges and needs for building a comprehensive Early Childhood Mental Health System of Care. Building a quality system of integrated and continuous services for infants and young children is a cornerstone of the CYFD’s Strategic Plan. This priority is being actualized in the recent re-organization of the Children, Youth and Families Department, which now includes an Early Childhood Division.
Ms. Harris began this process in late 2006 and the spring of 2007, when she organized a series of one-day Summits, funded by the Children, Youth and Families Department, on early childhood mental health. The first three Summits were held in Farmington, Las Cruces, and Albuquerque; another was held in 2007 in Las Cruces, and one in early 2008 in Roswell. These Summits were aimed primarily at an audience composed of anyone working with, creating policy for, or interfacing with systems that serve infants and young children. Attendees represented early childhood providers from the areas of education, child care, early intervention which is the Family, Infant, Toddler program for infants birth to three with or at risk of developmental delays or with a disability (part C) under the Department of Health, primary care, behavioral health providers, child protective service workers, home visitors, parents, teachers, funders and policy developers. Following her earlier work, Ms Harris developed and facilitated three regional Summits in the fall of 2008 on early childhood mental health, held in three regions; the Central Region (Moriarity, Belen, Los Lunas, Albuquerque), the North Central Region (Las Vegas, Mora, Taos, Raton, Santa Fe), and the Northwest Region (Navajo Nation, Gallup, Grants, Shiprock, Crownpoint, Farmington),

The third Summit, held in Window Rock was developed in response to a specific request following the first Summit in Farmington (2006), to have a Summit that would focus on the Navajo Nation.

The primary purpose of these Summits on Early Childhood Mental Health System of Care was to increase and/or enhance awareness of:

- Early Childhood Mental Health needs by providing training and practical information on the current status of Early Childhood Mental Health System of Care in the state;
- Infant Mental Health Competencies and Endorsement process;
- The Infant Mental Health Service Definition; and
- The New Mexico Home Visiting Initiative.

The secondary purpose of the Summits was to have participants (grouped by community/ region) share information about each other’s community experience, network and complete a community assessment form on early childhood mental health systems of care in New Mexico.

**Process**

Three one-day Summits were held in three distinct regions of New Mexico in order to reach a broad range of communities with varying kinds of infant and early child mental health needs, as follows:
♦ October 6, 2008, in Moriarty. This Summit had 76 registered participants representing the Central Region, including Albuquerque, Belen, Bernalillo, Carlsbad (there was no separate Summit for the Southeast region of New Mexico), Los Lunas, and Torrance County;

♦ October 29, 2008, in Las Vegas. This Summit had 54 registered participants representing the North Central Region, including Mora, San Miguel, Santa Fe and Taos, Union and Colfax Counties, and one participant from the Ute tribe in Southern Colorado (Towaoc); and

♦ November 13, 2008, in Window Rock. This Summit drew an enormous crowd of participants, most of whom were Navajo – the group overflowed the meeting space and some had to “participate” remotely from a separate space. This Summit had 250 participants most of whom represented Navajo Nation, as well as a few participants from San Ildefonso and Hopi Pueblos.

Community Assessment

Participants at each Summit were asked to complete a modified Georgetown community needs assessment tool [see Attachment I] which challenged participants to examine infant and early childhood mental health systems of care in their own community. At the Moriarty and Las Vegas Summits, participants were grouped by community to complete the questionnaire; at Window Rock, because of the wide range of agencies/geographic diversity represented, individuals completed the community assessment questionnaire. Questions covered the areas of policy, professional development, service delivery and advocacy.

Finally, all respondents were asked what they feel are the most important “next steps” for their community in infant and early childhood mental health; what specific new service should be given highest priority; and how ready they thought their community is for follow-up consultation on building a local infant and early childhood mental health system of care.

Community Assessment - Moriarty and Las Vegas Summits

Does your Community or Local Behavioral Health Collaborative have a plan for infant and early childhood mental health? If so, what agencies are involved?

♦ Moriarty Summit: Most respondents replied that they do not – and that the local
Behavioral Health Collaborative seems to focus more on adults. One group mentioned that there is a children’s subcommittee that is looking at systems of care for children, but that there are no known results at this time. The only agencies specifically mentioned were Maternal Child Health Councils.

♦ Las Vegas Summit: All respondents in this group answered yes and mentioned specifically local multi-systemic therapy, Parents as Teachers/Noches de Familia in San Miguel County, local Children Youth and Family Department, Primeros Pasos in Santa Fe, Mora and San Miguel Counties Santa Fe, and community-based/medical services in general.

*What is the focus of the infant and early childhood mental health initiative, and is there a “lead agency”?*

♦ Moriarty Summit: One group (Santa Fe) responded that the focus of their community’s initiative is to increase home visiting, case management and prenatal care. The lead agencies mentioned included Children, Youth and Families Department, Department of Health Family Infant Toddler Program, Children’s Medical Services, Healthy Families First and Primeros Pasos, Las Cumbres Community Services, and United Way. The Albuquerque/Bernalillo group stated that there is no “lead agency” but did list some individuals and semi-active programs.

♦ Las Vegas Summit: Two groups mentioned lead agencies – Quay County Community Health Council and Parents As Teachers – Noches de Familia, whose focus is on prevention and promoting healthy families.

When asked to rank their community in terms of infant and early childhood mental health policy on a scale from one to five, responses averaged “2.5” with a range from a low of “1” in Carlsbad, to a high of “3.5” in Santa Fe, Quay, Mora and San Miguel counties.

*Does your state/community/local collaborative address the need for well-trained providers in infant and early childhood mental health?*

♦ Moriarty Summit: All groups responded “no” to this question, and one noted that Training and Technical Assistance Programs are emerging as trainers for behavioral problems at childcare centers, home visiting programs (but not in Bernalillo County).

♦ Las Vegas Summit: One group said yes – through Colfax/Taos/Union Counties and the Training and Technical Assistance Programs at Eastern New Mexico University
Does your community/region provide training in infant and early childhood mental health to service providers?

♦ Moriarty Summit: The Santa Fe-based group mentioned that The Community Infant Program and Las Cumbres provide some training, but Maternal Child Health Council had to drop their training component. A Bernalillo group stated that each agency gets training, but not together.

♦ Las Vegas Summit: Only one group said yes – as above – the Training and Technical Assistance Programs at Eastern New Mexico University.

Does your community/region recognize a set of infant and early childhood mental health competencies?

♦ Moriarty Summit: Two groups said no, one group said in part, and one group said that this is being recognized but that it is in its infancy (no pun intended).

♦ Las Vegas Summit: Only one group said yes their community does recognize these competencies (Taos, Colfax and Union Counties).

Does your community/region infuse competencies into the broader early childhood professional development system?

♦ Moriarty Summit: One group (Santa Fe) stated that this is being done a little, but not well. The other groups said no.

♦ Las Vegas Summit: One group (Taos, Colfax and Union Counties) said yes.

When asked to rank their community in terms of professional development in infant and early childhood mental health on a scale from one to five, responses averaged “2.1” with a range from a low of “0.5” in Bernalillo/Albuquerque, to a high of “3.0” in Santa Fe, Quay, Mora and San Miguel counties.

Does your community/region have a comprehensive array of infant and early childhood mental health services and supports? If so, are they available throughout the community or region?

♦ Moriarty Summit: All groups but one reported that they do have a comprehensive array of
services and supports – and that yes, they are at least “somewhat” available throughout the region. The group without services was from Albuquerque, and stated that the “Metro area [Albuquerque] seems to have been overlooked. Santa Fe has done much better. Key players need to organize and strategize how to represent ourselves.” This group added that, “in the metro area, services are very ‘siloed’, agencies are just trying to stay alive.”

♦ Las Vegas Summit: Two out of three groups responded that they do have a comprehensive array available throughout the region (mentioned Headstart, Teambuilders, Consejos Program, Ayudantes, Somos Familia, New Mexico Highlands University programs) and a third group said that they do not have a comprehensive array due to insufficient providers.

**How do families or children access infant and early childhood mental health services and are there multiple entry points?**

♦ Moriarty Summit: All groups responded that there are multiple entry points, and means of access included referral gateway agencies (Santa Fe); through telehealth, Early Childhood Evaluation Program, providers (Carlsbad); CYFD, domestic violence, WIC, Childfind local providers (Albuquerque, Bernalillo).

♦ Las Vegas Summit: All groups stated that there are multiple entry points, and means of access included Headstart program (Quay, Mora, San Miguel Counties); through provider referrals, law enforcement, CYFD (Mora, San Miguel, Las Vegas); and “hit or miss” (Taos, Colfax and Union Counties).

**What family supports are available and how are families informed about them?**

♦ Moriarty Summit: Family supports mentioned included “everything from WIC nutritional to Centers for Medicare & Medicaid Services to child support enforcement to developmental delays/New Vistas (Santa Fe); early Intervention, Family Infant Toddlers Program, telehealth, physicians, Early Childhood Evaluation Program (Carlsbad); parenting classes, home visitation programs, local agency project offices, home Presbyterian Medical Service, Early Headstart nutrition classes, Alta Mira, CYFD, Court Appointed Special Advocates, faith communities (Albuquerque/Bernalillo). Ways by which families are informed about support services include through gateway agencies such as WIC, Centers for Medicare and Medicaid Services, CYFD, providers, assessments from home visits, by case management service coordinators, resource guides, word-of-mouth, fliers, community meetings and health fairs.

♦ Las Vegas Summit: Family supports mentioned included “time limited reunification – soy
ISO” (Raton) – Teambuilders, Headstart, Health Council (Quay, Mora, San Miguel Counties); and Somos Familia; Family Adolescent Services; Ayudantes; Parents as Teachers-Noches de Familia; Rio Grande outpatient program (Mora, San Miguel, Las Vegas, Santa Fe). Ways by which families are informed about support services include “when Child Protective Services gets involved”, public advertising, health fairs, radio stops, Noches de Familia’s monthly newsletter, flyers, brochures and trainings for WIC mothers.

When asked to rank their community in terms of service delivery on a scale from one to five, responses averaged “3.4” with a range from a low of “2.0” in Bernalillo/Albuquerque, to a high of “4.5” in Santa Fe County.

**What advocacy groups have been involved in the planning of your infant and early childhood mental health plan?**

♦ Moriarty Summit: All but one group (Albuquerque/Bernalillo) listed examples of advocacy groups involved in planning. These included Maternal Child Health Council, Department of Health, CYFD, Court Appointed Special Advocates, providers, Alta Mira, Early Childhood Action Network, Center for Development and Disability (UNM), RCI, Local Collaborative 2, Office of Child Development and Bernalillo County Children’s sub-committee.

♦ Las Vegas Summit: In Colfax Taos and Union Counties, CYFD, providers have served as advocacy groups. In Mora, San Miguel, Las Vegas and Santa Fe Counties, advocacy groups include Parents As Teachers-Noches de Familia, 21st Century, West Las Vegas Schools, East Las Vegas Schools, Luna Community College, Mora, San Miguel and Guadalupe Counties Group, mental health services.

**Have families of young children been included in your planning and implementation efforts?**

♦ Moriarty Summit: Of these respondents, only the Carlsbad group said that families had been included. Others were unsure, and suggested that it is difficult to get families involved.

♦ Las Vegas Summit: All groups said yes – families have been included in planning and implementation.

**Is your infant and early childhood mental health collaborative seeking input from a diverse representation of community members? If so, how?**
♦ Moriarty Summit: The Santa Fe group said that they do seek input from a diverse representation of community members via Maternal Child Health Council. One Albuquerque/Bernalillo group said that they also seek input, and the other ABQ/Bernalillo group said that they do not do it well: there is a mental health collaborative but not infant mental health.

♦ Las Vegas Summit: All groups stated that they do seek input from diverse community representatives – via health fairs, schools, Parents As Teachers-Noches de Familia events, creative recruitment, presentations at local collaborative meetings, WIC program, flyers, newsletters and presentations of DWI classes and responsible driving classes.

When asked to rank their community in terms of advocacy on a scale from one to five, responses averaged “2.8” with a range from a low of “1.8” in Bernalillo/Albuquerque, to a high of “4.0” in Santa Fe County.

What do you think are the most important “next steps” for your community in infant and early childhood mental health?

♦ Moriarty Summit: The Santa Fe group responded with “comprehensive training plan” and “parent involvement” and support for that to happen – gas money, childcare, time off work. The Carlsbad group also mentioned training as what they consider to be the most important next steps for their community, as well as continued collaboration and mutual support. The Albuquerque/Bernalillo groups listed community and agency awareness, identifying potential need at birth – before family goes home from hospital – and expanding mental health into infant mental health.

♦ Las Vegas Summit: The only group (Quay, Mora, and San Miguel Counties) to respond to this question stated that the most important next step is the need for a continuous assessment process.

What specific new service should be given highest priority?

♦ Moriarty Summit: The Santa Fe group listed training providers, community building around infant mental health, comprehensive client path for undocumented families, and “daddy-ing initiatives” as specific new services that should be given highest priority. Representatives from Albuquerque/Bernalillo felt that community-based professional endorsement should be given highest priority.
Las Vegas Summit: No group responded to this question.

How ready do you think your community is for follow-up consultation on building a local Infant and Early Childhood Mental Health System of Care?

Moriarty Summit: Groups at this Summit all indicated that they are ready – some even stated “beyond” ready: “People are beyond ready... there are many people from a variety of agencies who want to discuss, organize – need help organizing.”

Las Vegas Summit: The only group responding to this question (Quay, Mora, and San Miguel Counties) stated that “on a scale of 1 to 10 for being ready, we are a 5.”

Community Assessment – Window Rock Summit

We are treating the Window Rock Community Assessments apart from the previous two Summits’ Community Assessments because, unlike the first two Summits where participants completed the community assessment forms as a community/regional group, Window Rock participants completed the Community Assessment forms as individuals. In addition, the form was shortened and had slightly different questions.

Does your community within Navajo Nation have a behavioral and/or health council?

Of the 47 individuals who answered this question, over three-quarters (79%) indicated that “yes” they do have a behavioral and/or health council, and 21 percent said “no” or “don’t know.” Specific agencies mentioned included Indian Health Services in Chinle, Emergency Nurses Association, DBHS Outpatient Treatment Center (Crownpoint), Early Learning for Success (Gallup), Disability Services, Inc. (DSI) Behavioral Health Department (Shiprock); Presbyterian Medical Service; Navajo Nation Division of Social Service; Program, Karigan Child Care Center (AZ); Dine Local Collaborative #15; Shiprock Anti-meth Task Force; Navajo Nation Program for Self Reliance (located throughout the Nation); and the Winslow Indian Health Care Center (AZ).

Are you part of a regional partnership council on Navajo Nation?

Of the 48 respondents to this question, the overwhelming majority (90 %) said ‘no,’ they are not part of a regional partnership council. Those few who said yes, mentioned specifically Torreon Day school’s Family and Child Education Program, Dine’ for Our Children Kayenta, Navajo Nation Regional Council, First Thing First, Navajo Office of
Does your community within Navajo Nation have an array of early childhood mental health services and supports? If so, please describe.

Over half of respondents (61%) responded that their community does have some kind of early child mental health services. The most commonly mentioned examples of services/supports included Growing in Beauty (Flagstaff, AZ), Indian Health Services, Navajo Nation Headstart (Window Rock, AZ), DBHS Outpatient Treatment Center (Crownpoint); Individual Family Services Plan, Presbyterian Medical Services, and Early Intervention Programs.

How do families or children access early childhood mental health services?

Fifty one people answered the question, and answers covered a wide range of possible avenues for access. Mostly people simply said that families or children access services by “referral.” The most often mentioned specific means of access included, in order of frequency: Indian Health Services, doctors/hospitals, Growing in Beauty, school, Headstart, and child care.

What do you think are the most important “next steps” for your community in developing infant and early childhood mental health services?

This question drew a wide range of responses ranging from “screen babies” to “community assessment.” Three of the more frequently articulated themes included 1) the need for increased collaboration, teamwork, partnership among existing organizations that work in infant and early childhood mental health services – sharing information so that each organization knows about the others; 2) the need to increase parent training and education in infant and early childhood mental health – start parent organizations; and 3) the need to increase collaboration with the school district to educate the educators and early childhood mental health. As one Summit participant succinctly noted,

...mental health is really sacred and important for the growth of the child. Teenagers today do not know how to deal with mental emotions in which they are pressured to turn to alcohol, drugs and relationship. In a way it would be helpful to educate children as early as birth to set an understanding and communication between the baby/child and parents.

What specific new service should be given highest priority?
In response to this question, three of the most common themes were 1) the need to work with families on infant and early childhood mental health services, to include parents in education, to visit and work with families/parents in their home; 2) the need for increased workforce development and training in infant and early childhood mental health services – building a network of providers; and 3) services for teen pregnancy, teen parents and family planning were mentioned.

**Summit Evaluation**

The evaluation form [see Attachment II], completed by 61 percent of Summit participants in Moriarty, 76 percent of participants in Las Vegas, and 37 percent of participants in Window Rock, asked respondents to rate the Summit’s impact on their levels of knowledge over six subject areas relating to infant and early childhood mental health.

The subject area covered in the Summit receiving the highest rank at the Moriarty Summit was “Infant Mental Health Competencies and the Endorsement Process,” with 79 percent of those who responded to this question indicating that they “strongly agree” that the Summit increased their knowledge. The area receiving the highest rank at the Las Vegas Summit was “New Mexico Home Visiting Initiative” with 35 percent of those responding to this question answering “strongly agree.” Finally, the area receiving the highest rank at the Window Rock Summit was the broadest – simply “Infant and Early Childhood Mental Health” with 44 percent of those who responded to this question answering “strongly agree.”

No one subject area was given strongly negative rankings, and those few evaluation forms that did have a negative ranking on one or more subject areas, were qualified with comments such as “Sorry, I already knew most of this from previous training with IMH”… or “I have previous experiences working with CYFD”… or simply “previous knowledge.”

**Did you learn about an agency in your community that you hadn’t already known about?**

The evaluation form asked participants to state whether they had learned about an agency in their own community that they had not already known about, and if so what did they learn. Of those who answered this question in Moriarty, 87 percent said that they had learned something about their own community or made a useful contact; in Las Vegas 65 percent said they had and in Window Rock, fully 94 percent stated that they had learned about an agency in their own community or made a useful contact. Some sample comments from participants on what they learned about their own communities:
I did not know that our local CYFD does adoptive services... [I didn’t know about] home visiting initiative – and I work for CYFD!... I’ve not heard of KIDI before and will go home and look it up – also didn’t know about portfolio advisor for infant mental health... [I learned that] the family support Professional Development System exists and how it could benefit those of us in the North...[I learned] more about what was happening in the treatment program and how the Navajo Behavioral Health will be addressing children’s mental health needs.... I learned that there is home visitation for children and infants... I didn’t know there are programs that can help special needs... I learned about a program that helps the public get items that they need for their special needs child by offering them a loan of the product they need... I learned about collaboration within the three states [on Navajo Nation]...

**Most important unmet issue/need in your community?**

Respondents were then asked to note what they feel is the most important infant/early childhood mental health unmet need/issue in their community, and to state what service would address that need. In Moriarty, the most commonly mentioned issues were tied between a need for increased collaboration and coordination between agencies, and a need for increased parent/family involvement, training and education. In Las Vegas, the most commonly mentioned issues were a need for infant mental health services; home visiting programs; programs to address teen pregnancy/parenting classes for teen parents; and quality childcare.

In Window Rock, participants noted that the most important unmet issues in their community included a need for more ways to increase public awareness about existing programs and resources that relate to infant and early childhood mental health; a need for increased infant mental health information and education; and finding more ways to educate and provide training for parents on infant and child mental health, and improved parental relationships with their children. Of note was some brutal honesty where several participants (although certainly not a majority) listed as “most important issues” those relating to neglect, child abuse, domestic abuse, substance abuse, family violence, and “the impacts of trauma, due to divorce, domestic abuse, such as yelling at infant, shaking infant and not showing love to young age…”

**Interested in learning more about endorsement? Are you a part of a community/regional team that is ready to benefit from consultation or support?**

Of those who completed the Evaluation Forms at the Moriarty Summit, over half (59%) stated that they are “interested in learning more about endorsement” in infant mental health and nearly a quarter (22%) stated that are “part of a community/regional team that is ready to benefit from consultation or support to initiate local or regional Early Childhood Mental Health Systems of...
Care activities.” At the Las Vegas Summit, those percentages were 50 percent and 44 percent, respectively; and in Window Rock, 73 percent stated they are interested in learning more and 35 percent stated that they are a part of a community that is ready to benefit from consultation or support.

**Observations**

In examining the outcomes from these summits, the evaluation forms certainly suggest that there was a tremendous increase in knowledge regarding early childhood mental health systems of care across the board – with highest levels of “increased knowledge” reported at the Moriarty Summit, followed by the Window Rock Summit, then the Las Vegas Summit.

**Negative feedback:**

The most negative comments on the Summits, in general, came from the Las Vegas Summit where criticisms included complaints about having “heard all this before,” lack of hand-out materials, uncomfortable meeting venue and “do you have the right audience?” (implying that the audience had already received this training.) It is interesting to note that these kinds of criticisms did not emerge in the evaluations of the other two Summits. It is also interesting to note that these comments were in contrast to the behavior of the participants at the Las Vegas Summit, the majority of whom appeared engaged, asked questions and repeatedly asked for more time in their community groups to discuss services and gaps. All of groups reported back to the general audience in some detail and length about their respective areas services as needs as they pertain to infant and early childhood mental health services.

**Positive feedback:**

Positive feedback, both anecdotally as well as comments captured in the evaluation form, was plentiful at all three Summits (despite the few negative comments emerging in Las Vegas). Many participants indicated that they really appreciated the training and look forward to further and more in-depth Summits. Some comments: ....very helpful to gain a better understanding as a student about resources available and what they lack... Excellent info about linkages!... great facility and well put together!...

A number of communities have requested follow up and consultation regarding the development of services, training and reflective supervision. Many participants came away not only with increased knowledge about infant and early childhood mental health, but also with a specific person or contact for furthering their work with babies and families.

As a result of the 2007 Summits in the southern part of the state, Las Cruces and Deming
agencies made a year-long commitment to receiving infant mental health training and on-going reflective supervision. These communities also convened a group of stakeholders to move the early childhood mental health agenda forward.

After the Window Rock Summit, Navajo Nation requested follow-up as well and incorporated a presentation on infant mental health into a two-day training for their child welfare adoption workers.

Moriarity expressed both a readiness and willingness to take the “next steps” in developing a coordinated early childhood mental health system of care for their community.

Most communities expressed a strong desire and need for regular reflective consultation and infant mental health training as well as behavioral health providers who could work with infants and families.

**Next Steps**

In considering next steps for the communities participating in these Summits, it is important to note the themes that participants brought up again and again when describing greatest unmet needs in their community. A demand for increased collaboration and coordination among agencies, and increasing public awareness about existing programs came up loudly in both the Moriarty and Window Rock groups. Both of those groups also raised the need for increased parent training and education, and family involvement. In Las Vegas, and Window Rock, the demand for more infant mental health services, information and education was given a high ranking, as well as expanded programs to address teen pregnancy and teen parenting.

As mentioned above, with regard to those interested in learning more about endorsement, nearly three-quarters of participants at the Window Rock Summit noted that they were interested – a significantly higher proportion than at either of the other two Summits. There appears to be tremendous ‘hunger’ in this group, composed mostly of Navajo, for more information, education and training in the field of infant and early childhood mental health systems.

Based on the different communities’ reports of “readiness” for increased support in infant and early Childhood Mental Health Consultation for System of Care development, the contractor will schedule face-to-face meetings and/or phone consultations with identified communities, and provide assistance/mentorship to interested community members in becoming endorsed in Infant Mental Health.

Also noted was the absence of certain stakeholders and interest groups. The need to have more behavioral health providers as well as protective services staff and managers was evident.
Likewise, the summits did not attract many primary health care providers (family practice doctors, pediatricians, nurses) or law enforcement personnel. Policy makers and philanthropists were also poorly represented. This information is important in guiding future efforts and specifically targeted audiences to engage those who were not represented at the summits.

**Recommendations**

The following recommendations regarding next steps as they relate to Infant and Early Childhood Mental Health Strategic Plan emerged from these Summits:

1) Expand interaction between existing infant and early childhood programs and services (along the continuum of prevention to treatment), within and between state agencies;

2) Encourage the Behavioral Health Purchasing Collaborative to address the needs of infants and toddlers in their priorities for planning by including an infant mental health work group;

3) Expedite the implementation of the infant mental health service definition;

4) Support the Behavioral Health Purchasing Collaborative Committee in incorporating infant mental health needs as they intersect with the adult behavioral health system (domestic violence, substance abuse, dual diagnosis, etc.);

5) Address the need and requests for work force development by offering more training opportunities, reflective supervision, both pre-service, higher education and for post-degreed professionals which address the New Mexico Association for Infant Mental Health’s competency-based Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health;

6) Increase outreach and partnership with behavioral health providers (who were underrepresented in the summit audiences);

7) Provide follow-up support to communities that expressed interest as well as readiness for next steps in creating a regional infant and early childhood mental health system of care.

Attachment I: Community Assessment Tool for each Summit
The systems/agencies represented at the Moriarty Summit included: Albuquerque Public Schools; RCI; University of New Mexico/Center for Development and Disability Focus (Albuquerque); New Mexico Child Development Board, City of Albuquerque, Office of Child Development; YWCA-Cariño (Albuquerque); Sage Neuroscience Center (Albuquerque); private practice clinical social workers; Fourth Circle; Children, Youth, and Families Department; Jewish Community Center (Albuquerque); Department of Health/Family Health Bureau/Maternal Child Health; CARC, Inc. (Carlsbad); Healthy Families First/Primeros Pasos (Santa Fe).

At the Las Vegas Summit, systems/agencies represented included Children, Youth, and Families Department (Las Vegas, Santa Fe Taos); Department of Health/Family Health Bureau/Maternal Child Health/Public Health Division; Center for Development and Disability (Raton); Las Clínicas del Norte (El Rito); Taos/Colfax Early Childhood Resource Center; Luna Community College (Las Vegas); Healthy Families First/Primeros Pasos (Santa Fe); New Mexico Behavioral Health Institute (Las Vegas); West Las Vegas Schools; Children’s Medical Services (Las Vegas); New Mexico Highlands University (Las Vegas); Centers for Medicaid and Medicare Services (Las Vegas); Team Builders; Early Childhood Resource Center (Taos).

The systems/agencies represented at the Window Rock Summit included Navajo Behavioral Health and Fetal Alcohol Effect outreach; various agencies of the Indian Health Services (Chinle, Winslow); Emergency Nurses Association; Early Learning for Success (Gallup); Disability Services, Inc. FACE Home Visiting program, DBHS Outpatient Treatment Center (Crownpoint); Navajo Treatment Center for Children and their Families (Chinle, Crownpoint, Shiprock, Ft. Defiance, Dikon); Comprehensive Community Support Services; Navajo Nation Department of Behavioral Services (Shiprock, Farmington); Navajo Nation Division of Social Services; Karigan Child Care Center (St. Michael’s, AZ); Shiprock Anti-meth Task Force; Kayenta Outpatient Treatment Center (Kayenta, AZ); Dine for Our Children (Window Rock, AZ); Navajo Nation Office of Special Education & Rehabilitation Services (Gallup, Window Rock, AZ); Navajo Headstart (Window Rock, AZ); Growing in Beauty on Navajo Nation (Flagstaff, AZ); and Family And Early Childhood Services (FACES).