Healthy Development Summit II:

Changing Frames and Expanding Partnerships to Promote Children's Mental Health and Social/Emotional Development

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The Bolger Center for Leadership Development
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Healthy Development Summit II:

Changing Frames and Expanding Partnerships to Promote Children's Mental Health and Social/Emotional Development

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This report represents discussions among participants in the day long Summit process. It does not represent the views or policies of those organizations that sponsored or sent a representative to the Summit nor does it commit those organizations to any activities described therein.

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Table of Contents

Executive Summary 1

Summit Overview 6

Summit Planning and Format 8

Summit Proceedings 10

- Changing Frames 10
  - Children's Mental Health as a Public Health Issue. 10
  - The Importance of Framing for Public Understanding. 11
  - The Science behind Implementing Evidence-based Programs 12
- Expanding Partnerships 14
  - Working Group Session # I: Domains of Child Mental Health 14
  - Importance of mental health for normal child development 14
  - Everyday challenges for parents 15
  - Prevention opportunities in child mental health 15
  - Effective treatment for childhood mental health problems 16
- Response: Reflecting Back and Looking Forward 17
  - Working Group Session # II: Sectors of Society. 18
  - Practitioners and Scholars. 18
  - The Public and Families. 19
  - Policymakers 19
  - Organizations and Agencies 20
- Closing Remarks 21

Overarching Themes 22

- *Patient Protection and Affordable Care Act* (ACA) 24

The Way Forward 25

References 27

Appendix A: Biosketches of Presenters and Summit Planning Committee. 29

Appendix B: Summit Agenda 36

Appendix C: Summit Participants 38

Appendix D:Feedback from Participants 42

Appendix E: Related Resources 43

Executive Summary

Child mental health is an essential part of healthy development with long-term implications for a child's and family's quality of life. *It should be addressed where children live, play, work, and grow*. Investing early in young children's mental health can lead to savings downstream in areas such as special education, child welfare, juvenile justice, work productivity, and physical health.

However, public policy currently addresses these issues when there are problems, which is not a good fit for children or for fostering healthy development. Instead, policies should look upstream toward mental health promotion and prevention, and retain an emphasis on the accessibility of evidence-based practices for *all* families.

Healthy Development Summit II: Changing frames and expanding partnerships to promote children's mental health and social/emotional wellbeing assembled a diverse group of stakeholders who might not otherwise be drawn together to generate ideas for new ways to move forward to promote young children's mental health.

As indicated in the title, this is the second of two summits. This Summit focused on the application of the research to practice and policy across sectors of society; that is **using what we know to inform what we *do*.** The Summit was designed to convene unlikely partners across society representing "opportunity structures" for promoting child mental health. It built on the success and interdisciplinary consensus developed at the 2009 summit that focused on what we *know* about young children's mental health. (Full report is available at http://www.apa.org/pi/families/summit-report.aspx).

With these factors in mind, the Summit was designed with the following goals: encourage effective and shared framing about the importance of child mental health for healthy development, increase effective collaboration across sectors of society, and arrive at consensus regarding feasible and actionable recommendations that could be implemented across disciplines to assure continued progress in promoting young children's mental health.

The Summit included presentations that were designed to catalyze discussion or change frames among the Summit participants in subsequent small working groups. Morning speakers each provided a different but critical perspective on young children's mental health that provided a foundation for the afternoon's work. These perspectives included public health, communication science, and implementation science.

The first working group session consisted of four working groups (groups 1-4) each focused on a domain of child mental health as described by Tolan and Dodge (2005). The domains included the importance of mental health for normal child development; everyday challenges for parents; prevention opportunities in child mental health; and effective treatment for childhood mental health problems. Each of the four working groups reported their key priorities to all Summit participants for discussion.

These reports were followed by a presentation that emphasized the challenges that still face the early childhood field and the importance collaboration among the sectors involved in young children's development. This helped to focus the second working group session on enhancing partnerships.

The second working group session also consisted of four working groups (groups 5-8) that represented sectors of society with the opportunity to promote child mental health and social/emotional wellbeing: practitioners and scholars; the public and families; policymakers; organizations and agencies. They were tasked with identifying key outcomes and next steps. Key opportunities identified by groups 1-4 are provided below followed by priority outcomes and next steps developed by groups 5-8.

Key opportunities identified for the domains of child mental health are provided on the next page.

The Importance of mental health for normal child development

Key Opportunities:

- Identify and leverage over time the opportunities to promote children's social/emotional wellbeing provided by overlapping policies and priorities in domains such as, health care, education, and

economics (i.e., Patient Protection and Affordable Care Act[1] (U.S. Department of Health and Human Services, 2010), Common Core State Standards (National Governors Association and Council of Chief State School Officers, 2012), Early Learning: America's Middle Class Promise Begins Early, (U.S. Department of Education, 2013)).

- Leverage social media and other technologies. Review children's and parent's media diets and technology used with the goal of creating and disseminating positive and supportive messages using those media and technologies.
- Improve existing, and establish new, relationships and coalitions among those who come into contact with children where they live, grow, work, and play (i.e., early childhood settings, schools, after-school summer programs, medical care facilities, faith-based and community–based settings) to create a healthy overall environment for children.
- Educate those who work with young children and families in various settings (i.e., education, medical and mental health care, clergy) about the importance of early childhood mental health and its importance in healthy child development and social/emotional development.

Everyday challenges for parents[2]

Key Opportunities:

- Develop positive messages for diverse parents about the importance of day-to-day relationships and parenting, early child development, child mental health and social and emotional development that will give them a sense of hopefulness and improve child outcomes.
- Identify and utilize existing community platforms and networks to disseminate effective, supportive, and positive messages that promote children's mental health and are appropriate for that community's population.
- Engage community opinion leaders in developing and delivering culturally and locally relevant messages, including cultural and organizational leaders as well as parents with different needs, such as those facing poverty or whose children have disabilities.
- Convey to those who work with families the importance of supporting parents and caregivers, particularly those facing more parenting challenges, to ensure healthy developmental outcomes over the long-term.

Prevention opportunities in child mental health

Key Opportunities:

- Develop a science-based operational definition of prevention that enhances communication between providers and parents, that promotes positive early childhood mental health outcomes and social/emotional development, and that aims to reduce or eliminate mental health disorders.
- Identify existing and establish new broad-based community networks to determine what prevention and health promotion programs exist and, if necessary, how to modify them so the community will obtain the best outcome for children.
- Utilize a 21st century public health approach to bring stakeholders from multiple disciplines and systems together to enhance linkages and to maximize the utilization of existing information, opportunities, and resources that optimize child health and mental health outcomes.
- Restructure the fee-for-service system to compensate providers for time spent with children and families in prevention and promotion efforts

1 More commonly referred to as the *Affordable Care Act* or ACA.

2 Parents are defined in this report as inclusive of other biological and non-biological parental figures/caregivers.

and for similar efforts that require collaboration or collateral contacts across multiple systems and networks.

- Utilize a variety of social media technologies as essential elements for successful and appropriate prevention and promotion messages tailored to specific community audiences.

Effective Treatment for Childhood Mental Health Problems

Key Opportunities:

- Develop new, or redesign the existing, child mental health service delivery infrastructure so that it is dominated by evidence-based practices that are provided by a workforce with the capacity and training to provide culturally, linguistically, and ethnically appropriate services to diverse children and families.
- Advocate for new, or enhance existing, funding for training to encourage people to advance their education as mental health service providers and to train community members to serve and support families (e.g., peer counselors, health coaches).
- Reduce or eliminate barriers to data collection, monitoring and sharing across providers and infrastructures, such as those posed by the *Health Insurance Portability and Accountability Act* (U. S. Department of Health and Human Services, 1996) and *Family Education and Rights Privacy Act* (U.S. Department of Education, 1974).
- Gather and analyze a broad range of functional (i.e., school success, clinical outcomes), process (i.e., provider availability, wait times), and program outcome data; utilize these data in determining whether or not a program should be recommended for new or continuing implementation.
- Utilize a multi-dimensional service model that includes family members, peers, and professionals from multiple child serving agencies to collaborate in fully addressing the often complex array of family and child mental health needs and concerns.

Priority outcomes and next steps for the sectors of society are provided below.

Practitioners and Scholars

Priority Outcomes and Next Steps:

- Capitalize on existing energy at the local level to build new, or strengthen existing, contacts and collaborations across systems where children and families access services (i.e., mental health, primary care, early childhood education, child care, and home visiting programs) so that next steps to improve developmental outcomes can be taken.
- Develop and implement advocacy strategies by identifying personal contacts or points of influence at the community, state, and federal levels and in the business community to advocate for early childhood programs that incorporate social/emotional development and mental health supports.
- Identify and advocate for opportunities and convergences within Surgeon General Satcher's action agenda (U.S. Department of Health and Human Services, 2000), the *Affordable Care Act* (ACA), various other federal initiatives and electronic health records implementation that can be utilized to address child and family mental health needs and improve mental health outcomes.
- Develop a training strategy that includes traditional and non-traditional providers (i.e., business leaders, economists, early childhood educators, child care providers, community care providers, and community members) who interact with children and families and can disseminate science-based messages about the importance of children's mental health for positive developmental outcomes.

Executive Summary

The Public and Families

Priority Outcomes and Next Steps:

- Develop strategies that prioritize and provide appropriate programs and services to those most in need in the community.
- Disseminate science-based, culturally, ethnically and linguistically relevant information about normal child development, social/emotional development, and ways to support children's mental health to broad audiences (i.e., parents/families, child care providers, and educators) using existing community platforms and multiple delivery systems (i.e., social media, families, and grass roots venues).
- Define, or redefine, families to reflect communities' diverse cultural values and beliefs, and recognize their power to communicate effectively within and across communities.
- Provide educators and child care workers with information about healthy social/emotional development and behavior that will give them the necessary tools to determine if a child's behavior is appropriate at a given age and to manage classrooms and child care centers.

This Summit focused on the application of the research to practice and policy across sectors of society; that is *using what we know to inform what we do.*

Policymakers

Priority Outcomes and Next Steps:

- Seize opportunities in the *Affordable Care Act* (2010) to promote children's mental health and social and emotional development by integrating behavioral health into health care, expanding Medicaid coverage, expanding home visiting programs and addressing workforce training issues.
- Make healthy child development a national priority by utilizing and building upon currently available resources (e.g., President's early learning initiative) to develop and disseminate compelling messages and narratives about the importance of healthy development for the success of business and society as well as the wellbeing of the child, family and community.
- Advocate for early childhood programs that are sustainable over time and that move seamlessly to school age programs, thereby continuing to improve child mental health outcomes throughout the developmental sequence.

Organizations and Agencies

Priority Outcomes and Next Steps:

- Utilize a broad range of service providers and consumers to develop navigation systems, staffed by those who are knowledgeable about services and programs, to assure coordinated access to resources and programs in one location for mental health care consumers.
- Work in collaboration with consumers, providers, and communities to promote provider and system transparency (e.g., which services and programs are provided) and accountability (e.g., outcomes of services and programs) in order to enhance both service delivery and child mental health outcomes.

- Educate consumers about available programs, services, and expected outcomes and help them develop the necessary advocacy skills to access appropriate services.
- Continue integration of mental health care providers as equal partners in health care systems, emphasizing their credibility and their unique perspectives, skills, service delivery models and data, in order to improve child mental health and health outcomes.

In addition to key opportunities, outcomes and next steps, several overarching themes emerged across the day in small and large group discussions. They highlight key considerations that cross the domains of child mental health and sectors of society and underlie the foregoing specific recommendations. For example, Summit discussions emphasized the importance of diverse families, existing community platforms, and social media and innovative technology for sharing hopeful messages that promote child mental health. Several key suggestions were made for children and families in the implementation of health care reform; they are included in the full report text. Summit participants expressed a commitment to collaboration as the route to progress in promoting child mental health as a critical part of healthy development. This report summarizes this Summit as a step in that collaboration. ■

Summit Overview

This report provides a summary of *Healthy Development Summit II: Changing frames and expanding partnerships to promote children's mental health and social/emotional wellbeing*. The Summit assembled a diverse group of stakeholders who might not otherwise be drawn together to generate ideas for new ways to move forward to promote young children's positive mental health.

This is the second of two summits. The first summit titled, *Healthy Development: A Summit on Young Children's Mental Health,* was held on April 1, 2009. That summit focused on what we *know* about child mental health. It emphasized collaboration across differing scientific disciplines. It was intended to "generate the difficult dialog inherent in diverse perspectives but necessary for progress." (Report of Healthy Development, 2009, p. 7) (http://www.apa.org/pi/families/summit-report.aspx).

This second Summit focused on the application of the research to practice and policy across sectors of society; that is **using what we *know* to inform what we *do*.** It was held on May 6, 2013, the beginning of Children's Mental Health Week, at The Bolger Center for Leadership Development in Potomac, Maryland. The Summit was designed to convene unlikely partners across society representing "opportunity structures" for promoting child mental health. It built on the success and interdisciplinary consensus that was developed at the 2009 summit that focused on what the research says about young children's mental health.

As with the first summit, this Summit focused on early childhood (birth to age eight) because the science is very solid in early childhood development. This age range provides an important opportunity for promoting children's mental health, preventing early problems and providing early intervention.

The Summit also built on momentum for change from the *Patient Protection and Affordable Care Act*[3](2010), which has multiple components related to prevention and positive mental health that may provide new opportunities for promoting young children's mental health. (http://www.hhs.gov/healthcare/rights/law/index.html).

Finally, this Summit built on heightened public interest in mental health, particularly in young people, due to media and policymakers' attention to school violence, bullying, and youth suicide.

"Child mental health should be addressed where children live, play, work, and grow." (Report of *Healthy Development*, 2009, p.18). Investing early in young children's mental health can lead to savings downstream in areas such as special education, child welfare, juvenile justice, work productivity, and physical health. However, public policy currently "turns on" when there are problems, which is not a good fit for children or for fostering healthy development. Instead, policies should look upstream toward mental health promotion and prevention, and retain an emphasis on the accessibility of evidence-based practices for *all* families.

Public policy currently "turns on" when there are problems, which is not a good fit for children or for fostering healthy development. Instead, policies should look upstream toward mental health promotion and prevention.

Child mental health is an essential part of healthy development with long-term implications for a child's and family's quality of life. The Summit planning committee defined children's mental health as inclusive of mental, social, emotional and behavioral health. This definition is consistent with the National Research Council and Institute of Medicine report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People* (2009), and with the Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda (U.S. Department of Health and Human Services, 2000). A shared definition

3 More commonly referred to as the *Affordable Care Act* or ACA.

is critical for effective collaboration across scientific disciplines, practitioners, policymakers and other stakeholders (McCabe, Wertlieb & Saywitz, 2013[4]).

The planning committee was keenly aware that if we keep doing what we're already doing, we will keep getting what we already have (Osborn & Gaebler, 1993). This point underscores the reason for the Summit, which convened people with diverse perspectives who would not ordinarily have the opportunity to work together but each of whom has a stake in promoting child mental health and might collectively come to a consensus on how to create progress. (See Appendix C for Summit Participants.)

Social psychology research supports the notion that people from diverse perspectives within a group might generate more innovative solutions to stubborn problems, provided that they are able to embody their distinctive point of view in the group: "When people join groups, something magical can happen. Previously unaffiliated individuals may unite and act as one, all eyes riveted on a common set of goals. Working together, individual group members may accomplish objectives that would have been unimaginable if acting alone. Particularly magical…are groups in which members possess varied ideas, knowledge and skills. Such diverse groups…are able to translate their unique perspectives into exceptionally creative solutions to the problems they encounter." (Swann, Kwan, Polzer, & Milton, 2003 p. 1396)

Opening Reception

Children's mental health is defined as including mental, social, emotional and behavioral health.

These research findings led the planning committee to encourage participants to speak up throughout the Summit, using science for shared understanding, and to begin building bridges across different perspectives in order to develop consensus about possible solutions or what to *do* to promote child mental health.

This Summit stimulated building relationships and sharing of participants' diverse perspectives in three ways: First, participants were invited to an opening reception that enabled them to meet and mingle with other Summit participants in advance of the work. Second, at the opening of the Summit, participants were asked to introduce themselves, giving their name and stating the perspective they brought to the discussions. This round of speed introductions gave insight into the depth of expertise and breadth of societal sectors represented at the Summit for the participants. Third, the Summit included a networking lunch where participants were explicitly asked to sit and talk with someone they did not know prior to the Summit. ■

4 This chapter also provides information about summit I and Summit II's history, the role of the Interdivisional Task Force on Children's Mental Health of the American Psychological Association, and the advocacy process that brought the two summits to fruition.

Summit Planning and Format

With those factors in mind, the Summit was designed with the following goals: (1) encourage effective and shared framing about the importance of child mental health for healthy development, (2) increase effective collaboration across sectors of society, and (2) arrive at consensus regarding feasible and actionable recommendations that could be implemented across disciplines to assure continued progress in promoting young children's mental health.

A 12 member, multidisciplinary committee collaborated for 16 months to plan the Summit and consulted with a cadre of advisors. The planning committee used a one-day format built on the convening model of the Johnson Foundation for developing solutions to societal problems. (http://www.johnsonfdn.org/conferences/key-elements)

Specifically, the Summit included presentations that were designed to catalyze discussion among the Summit participants in subsequent small working groups. Morning speakers each provided a different but critical perspective on young children's mental health that provided a foundation for the afternoon's work. These perspectives included public health, communication science, and implementation science. (See Appendix A for biosketches of presenters and the Summit Planning Committee.)

During the afternoon, two working sessions with four small groups in each session were designed to embody "expanding partnerships." These small groups were tasked with defining solutions, developing action plans, and collaborating across disciplines and segments of society that would move the field of children's mental health forward.

The first working group session (groups 1-4) focused on four key domains of child mental health, in keeping with the distinctions made by Tolan and Dodge (2005) and employed in the 2009 summit. These four key domains were: (1) the importance of mental health for normal child development, (2) everyday challenges for parents, (3) prevention opportunities in child mental health, and (4) effective treatment for childhood mental health problems. These four groups focused their discussions on: (a) identifying emerging opportunities and priorities for promoting children's mental health and social/emotional wellbeing *within* this domain that are within reach, and (b) deciding how we might better collaborate to take advantage of these opportunities and address these

Summit Planning Group and Assistants

priorities. Participants were assigned to groups so as to maximize the diversity of perspectives. Each small group presented their recommendations to the full group of Summit participants for further discussion.

These presentations were followed by comments by Joan Lombardi. She reflected on challenges that still face the early childhood field, emphasized the importance of collaboration across the sectors involved in young children's development and made recommendations for moving forward. This helped to focus the second working group session on enhancing partnerships.

The second working group session (groups 5-8) represented sectors of society with the opportunity to promote child mental health and social/emotional wellbeing: (5) practitioners and scholars, (6) the public and families, (7) policymakers, (8) organizations and agencies. These small group discussions focused on: identifying (a) priority outcomes for these sectors, (b) next steps for making the outcomes more likely, and (c) who should undertake these steps.

Again these four groups reported back to the large group those points that they deemed most critical. The small and large group discussions yielded a number of additional overarching themes that can move the field of children's mental health forward. (See Appendix B for the Summit Agenda.) ■

The Summit was designed with the following goals: (1) encourage effective and shared framing about the importance of child mental health for healthy development, (2) increase effective collaboration across sectors of society, and (2) arrive at consensus regarding feasible and actionable recommendations that could be implemented across disciplines to assure continued progress in promoting young children's mental health.

Mary Ann McCabe welcomed the Summit participants and thanked the sponsors and advisors who had helped to make the event possible. She anchored the Summit to the 2009 summit and provided an overview of the day to follow. She encouraged participants to trust their colleagues and to speak up in the working groups so that all perspectives were represented and all voices were heard. Finally, she emphasized the importance of sharing a definition of child mental health and collaborating across stakeholders and settings to promote progress in childhood mental health.

Changing Frames

Children's Mental Health as a Public Health Issue

Ileana Arias, Principal Deputy Director, Centers for Disease Control and Prevention and Prevention (CDC), described child mental health as a public health problem and noted that roughly 75 percent of the $2.5 trillion spent annually on health care is spent on conditions that are largely preventable. The CDC brings the strength of measuring and identifying the problem, then providing communities with population-based prevention programs and early intervention programs to address the identified issues. A key to success is to capitalize on existing partnerships and to make sure that components are complementary.

Ileana Arias

The CDC has long focused on disease prevention among children with childhood immunization programs and with programs that have successfully reduced pre-term births, low-birth weights and infant mortality. Important health challenges for children remain, including overweight, asthma, and multiple chronic conditions. Too many children suffer from multiple chronic conditions that may have direct or indirect effects on their mental health, and far too many children have serious emotional and behavioral difficulties.

"Mental health is fundamental to overall health and well-being. And that is why we must ensure that our health system responds as readily to the needs of children's mental health as it does to their physical well-being." (U.S. Department of Health and Human Services, 2000, p. 20).

The CDC is turning new attention to child mental health, dating back to the release of former CDC Director and U.S. Surgeon General Dr. David Satcher's report (U.S. Department of Health and Human Services, 2000). A new report was previewed at the Summit. This report titled, *Mental Health Surveillance Among Children — United States, 2005–2011* (Centers for Disease Control and Prevention, 2013), summarizes information from ongoing federal surveillance systems that can provide estimates of the prevalence of mental disorders and indicators of mental health among **U.S. children aged 3-17. The information was gathered** from the CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the National Institute of Mental Health (NIMH) data sources for the purpose of informing public health strategies to promote mental health in children. Future annual Morbidity and Mortality Weekly Report (MMWR) supplements on mental health will alternate between adult and child mental health data.

The CDC's three roles in children's mental health are: (1) learn how to protect and promote children's mental health by presenting population data and identifying risks, (2)

develop a science base by evaluating prevention strategies, and (3) put science into action by supporting community programs that protect and promote children's mental health. Because the strategies developed are disseminated to community members or programs for implementation, partnerships are of crucial importance.

Several large scale data sets that illustrate the broad range of mental health and behavioral issues facing young people in every ethnic, cultural and age group were shared with participants. It was noted that, consideration must be given to the context in which children are growing up and to how that context is supporting or limiting the emergence of mental health problems. Using these data, programs that use the public health approach and that involve partnerships can be instituted to promote positive parenting, reduce the impact of poverty, create safe, stable, nurturing relationships, chart mental health developmental milestones, and improve long-term outcomes for children.

Consideration must be given to the context in which children are growing up and to how that context is supporting or limiting the emergence of mental health problems.

The CDC remains committed to assuring that communities will have adequate resources, tools and programs to address the mental health needs of their children and that these tools complement the communities' work with children.

The Importance of Framing for Public Understanding

Nathaniel Kendall-Taylor, Director of Research, FrameWorks Institute, described the power of strategic framing™ for expanding the public's and policymaker's understanding of children's mental health. The underlying premise is that scientifically-based communication can increase understanding and support for science, which in turn can lead to evidence-based public policy. (For additional information regarding the work of FrameWorks Institute in this area, see http://www.frameworksinstitute.org/cmh.html)

Communication science tells us that understanding a message is dependent upon pre-existing cultural beliefs or frames of reference, and that communication is not a literal process of simply sharing information. Strategic framing™ illustrates that the frames that you deliberately embed in a message can be instrumental in the way that people understand and derive meaning from the message. This concept leads to a different way of thinking about communication or messaging about children's mental health.

For example, it is widely understood that there is a gap between what the science says and the public understands. With strategic framing™, embedding an explanatory metaphor in a message can bridge that gap. An explanatory metaphor is an analogy that takes a complex, abstract and difficult concept, and makes it simple, concrete and easy to think about. This is accomplished by comparing the concept to something familiar to the general public. This is an effective way of presenting a body of scientific findings that enables people to understand the interaction between determinants and outcomes, and leads them to think about solutions to societal problems.

FrameWorks has conducted research resulting in explanatory metaphors for early childhood development (Manuel, 2009), child mental health (Erard, Kendall-Taylor, Davey and Simon, 2010), and resilience (Kendall-Taylor, 2012), which was supported by the Center for the Developing Child at Harvard University.

Their work shows that an effective explanatory metaphor for bridging the gap between what science says and what the public understands about risks to child mental health, resilience, and developmental outcomes is to think of development as a balance scale or a fulcrum. Positive factors are put on one side and negative factors on the other, and the way the scale tips symbolizes developmental outcomes at a given point in time. The scale can be counterbalanced such that good outcomes can still occur even where there are many difficult

circumstances, or risks, stacked on the negative side.

For every child, the fulcrum starts in a different place, which influences how the scale works, and this makes some scales easier to counterbalance or tip than others. The fulcrum is not set. It can balance or tip based on experiences over time.

The public understands the properties of a balance scale and this analogy allows otherwise complex science regarding child mental health and development to be communicated. This model incorporates the science demonstrating gene-environment interaction that shapes developmental outcomes.

Nat Kendall-Taylor

Using this model (and others developed by FrameWorks for early childhood development) increases the potential for match between the message intended and the message heard for promoting child mental health, making for more effective communication with the public, policymakers and service providers. In turn, more effective communication can lead to increased support for science and evidence-based policy, and ultimately may improve outcomes for children.

The Science behind Implementing Evidence-based Programs

Karen Blase, Co-Director, National Implementation Research Network and Senior Scientist, Frank Porter Graham Child Development Institute, University of North Carolina, addressed the issue of the time-lag between publication of research knowledge and using that knowledge to deliver evidence-based practice. She noted that this lag must be understood in order to develop a system that moves knowledge to service delivery; this area of study is implementation science. No matter how much is known from research, children and families cannot benefit from evidence-based interventions, supports and services if they do not receive them as they are intended.

Using a framework of implementation science, five components were described that can move scientific knowledge about effectiveness to the delivery of evidence-based practice throughout a community or service delivery system (Bertram, Blase, Shern, Shea & Fixsen, 2011). However, she noted that a variety of agents, such as the Summit participants, are critical to implementing this model and achieving the changes necessary for improved outcomes for children's mental health and social/emotional development.

The five components are: a usable intervention, operational definitions, installation, initial implementation, and an enabling context. Although sustainability and planning are frequently considered separate stages, they are an essential and important part of *every* stage. They must be integrated throughout the process (Fixsen & Blase, 2009).

A *usable intervention* is one that has shown the intended positive effects when rigorously evaluated. Planning has already taken place so that the intervention can be implemented in real world settings; so for example, it is street ready (if the intervention focuses on community settings), home ready (if implemented directly with families), and clinic ready (if in physical and mental health care settings, or other settings that touch the lives of families and children).

Operational definitions enable providers to know what to say and what to do in the environment to make the

essential functions come to life. Operational definitions also allow for performance or fidelity assessment, and to determine "what went wrong" if the outcome is other than intended. *Installation* means getting ready for the program in the specific setting. It is sometimes neglected, but it is an important and necessary step for success.

Initial implementation is the first time the program is activated. Implementation may falter if there is not early exploration and buy-in at the setting, organization, or community level, and across multiple systems (e.g., schools, primary care, child welfare). Ideally, community members join the conversation early so that they have given thought to what they believe their community needs and what is already available to help young children. This allows for a good fit between science and practice in that particular setting. While research demonstrates the importance of keeping the critical core functions unchanged when programs are initially implemented, the model allows for changing certain features of the program to be more culturally responsive and culturally respectful. The goal is to do it "right" first and then innovate within appropriate parameters if necessary to achieve the most effective services or programs possible for that community.

An *enabling context*, or having the existing system change to support the new program, is also an important factor. The current system in place is designed to get the current results, so a context change is needed to enable the current system to support the effectiveness of the innovation. Challenges may arise but they can be overcome by having implementation teams — or the requisite variety of people committed to improving the children's mental health system through introducing and implementing this particular program — to act as systems change agents.

No matter how much is known from research, children and families cannot benefit from evidence-based interventions, supports and services if they do not receive them as they are intended.

She concluded her remarks by saying that the field of child mental health services needs a formula for success that enables providers to move from good intentions to great outcomes. Implementation science provides a model that can move the knowledge of science to the delivery of evidence-based practice. ■

Karen Blase

Expanding Partnerships

Working Group Session # I: Domains of Child Mental Health

After the morning presentations, Summit participants were organized into four multidisciplinary working groups representing the four domains of child mental health (Tolan and Dodge, 2005) emphasized in the first summit. These working groups focused on expanding partnerships within each specific domain. They were designed to foster innovative thinking, the sharing of ideas and perspectives, and to develop shared strategies for promoting child mental health.

Each group was tasked with generating key opportunities in response to these two questions: (1) what are the emerging opportunities and priorities for promoting children's mental health and social/emotional wellbeing *within* this domain that are within reach? And (2) How might we better collaborate to take advantage of these opportunities and address these priorities?

Importance of mental health for normal child development

Key Opportunities:

- Identify and leverage over time the opportunities to promote children's social/emotional wellbeing provided by overlapping policies and priorities in domains such as, health care, education, and economics (i.e., Patient Protection and Affordable Care Act[1] (U.S. Department of Health and Human Services, 2010), Common Core State Standards (National Governors Association and Council of Chief State School Officers, 2012), Early Learning: America's Middle Class Promise Begins Early, U.S. Department of Education, 2013)).
- Leverage social media and other technologies. Review children's and parent's media diets and technology used with the goal of creating and disseminating positive and supportive messages using those media and technologies.
- Improve existing, and establish new, relationships and coalitions among those who come into contact with children where they live, grow, work, and play (i.e., early childhood settings, schools, after-school summer programs, medical care facilities, faith-based and community-based settings) to create a healthy overall environment for children.
- Educate those who work with young children and families in various settings (i.e., education, medical and mental health care, clergy) about the importance of early childhood mental health and its importance in healthy child development and social/emotional development.

1 More commonly referred to as the Affordable Care Act or ACA.

Everyday challenges for parents[1]

Key Opportunities:

- Develop positive messages for diverse parents about the importance of day-to-day relationships and parenting, early child development, child mental health and social and emotional development that will give them a sense of hopefulness and improve child outcomes.
- Identify and utilize existing community platforms and networks to disseminate effective, supportive, and positive messages that promote children's mental health and are appropriate for that community's population.
- Engage community opinion leaders in developing and delivering culturally and locally relevant messages, including cultural and organizational leaders as well as parents with different needs, such as those facing poverty or whose children have disabilities.
- Convey to those who work with families the importance of supporting parents and caregivers, particularly those facing more parenting challenges, to ensure healthy developmental outcomes over the long-term.

1 Parents are defined in this report as inclusive of other biological and non-biological parental figures/caregivers.

Prevention opportunities in child mental health

Key Opportunities:

- Develop a science-based operational definition of prevention that enhances communication between providers and parents, that promotes positive early childhood mental health outcomes and social/emotional development, and that aims to reduce or eliminate mental health disorders.
- Identify existing, and establish new, broad-based community networks to determine what prevention and health promotion programs exist and, if necessary, how to modify them so the community will obtain the best outcome for children.
- Utilize a 21st century public health approach to bring stakeholders from multiple disciplines and systems together to enhance linkages and to maximize the utilization of existing information, opportunities, andresources that optimize child health and mental health outcomes.
- Restructure the fee-for-service system to compensate providers for time spent with children and families in prevention and promotion efforts and for similar efforts that require collaboration or collateral contacts across multiple systems and networks.
- Utilize a variety of social media technologies as essential elements for successful and appropriate prevention and promotion messages tailored to specific community audiences.

Effective treatment for childhood mental health problems

Key Opportunities:

- Develop new, or redesign the existing, child mental health service delivery infrastructure so that it is dominated by evidence-based practices that are provided by a workforce with the capacity and training to provide culturally, linguistically, and ethnically appropriate services to diverse children and families.
- Advocate for new, or enhance existing, funding for training to encourage people to advance their education as mental health service providers and to train community members to serve and support families (e.g., peer counselors, health coaches).
- Reduce or eliminate barriers to data collection, monitoring and sharing across providers and infrastructures, such as those posed by the *Health Insurance Portability and Accountability Act* (U. S. Department of Health and Human Services, 1996) and *Family Education and Rights Privacy Act* (U.S. Department of Education, 1974).
- Gather and analyze a broad range of functional (i.e., school success, clinical outcomes), process (i.e., provider availability, wait times), and program outcome data; utilize these data in determining whether or not a program should be recommended for new or continuing implementation.
- Utilize a multi-dimensional service model that includes family members, peers, and professionals from multiple child serving agencies to collaborate in fully addressing the often complex array of family and child mental health needs and concerns.

Response: Reflecting Back and Looking Forward

Joan Lombardi, Senior Advisor, Buffett Early Childhood Fund, shared her reflections on the reports from the first working group session, emphasizing particular challenges and sharing her own recommendations for public policy that impacts young children and families.

In sharing her reflections she noted that the mental health field faces many of the same challenges today that were true three decades ago. However, communication among those in the field, including across education and health agencies, has improved and has moved toward an emphasis on fostering children's healthy development. Concerns about childhood stress, the chaos in some children's lives, and depression among young mothers and those who are working with children (e.g., caregivers and teachers) were highlighted.

The importance of tying Summit discussions to the policy agenda was emphasized, in particular, the opportunities in the President's early learning initiative (as cited above). The policy agenda must continue to command attention so that social/emotional development is linked to school readiness and to math and reading literacy skill development. It will require constant vigilance to assure that early childhood programs incorporate social/emotional development and mental health supports.

Joan Lombardi

Finally, she cautioned that there is a lack of understanding about what the *Affordable Care Act* (ACA) means for children and, in addition, what it means for mental health. More discussions are needed about the ACA to develop a clearer understanding of what states can and should do around children's mental health issues as they implement the law.

She concurred with the first summit report in saying that services should be provided *where children are* and, for her, this includes child care settings, Head Start, state-funded preschool programs, and home visiting programs. She supported the recommendations above to build on community interest and programs to achieve positive child mental health outcomes and to reduce or eliminate barriers to data collection and sharing. She noted that parenting messages should be positive and realistic and that they should support families.

In her concluding remarks she challenged participants to ask themselves these questions:

- "What can I do personally? What else can I do?"
- "What can my organizations or the organizations that I impact do?"
- "What can the policymakers do?" and
- "What do I want the business community to do?"

Working Group Session #II: Sectors of Society

Following these observations and challenges, the Summit participants were organized into four different working groups, again focused on "expanding partnerships." These groups represented the sectors of society with the opportunity to promote child mental health and social/emotional wellbeing. The overarching questions for discussion were: Given the opportunities and priorities that were identified in the first set of working group sessions, and making linkages among them, (1) what are the highest priority outcomes for these sectors? (2) what are the next steps for making the outcomes more likely? and (3) who should undertake these steps?

These groups reported back to the large group the priority outcomes and next steps that they deemed most critical.

Practitioners and Scholars

Priority Outcomes and Next Steps:

- Capitalize on existing energy at the local level to build new, or strengthen existing, contacts and collaborations across systems where children and families access services (i.e., mental health, primary care, early childhood education, child care, and home visiting programs) so that next steps to improve developmental outcomes can be taken.
- Develop and implement advocacy strategies by identifying personal contacts or points of influence at the community, state, and federal levels and in the business community to advocate for early childhood programs that incorporate social/emotional development and mental health supports.
- Identify and advocate for opportunities and convergences within the Surgeon General's action agenda (U.S. Department of Health and Human Services, 2000), the *Affordable Care Act* (ACA), various other federal initiatives and electronic health records implementation that can be utilized to address child and family mental health needs and improve mental health outcomes.
- Develop a training strategy that includes traditional and non-traditional providers (i.e., business leaders, economists, early childhood educators, child care providers, community care providers and community members) who interact with children and families and can disseminate science-based messages about the importance of children's mental health for positive developmental outcomes.

The Public and Families

Priority Outcomes and Next Steps:

- Develop strategies that prioritize and provide appropriate programs and services to those most in need in the community.
- Disseminate science-based, culturally, ethnically and linguistically relevant information about normal child development, social/emotional development, and ways to support children's mental health to broad audiences (i.e., parents/families, child care providers and educators) using existing community platforms and multiple delivery systems (i.e., social media, families, and grass roots venues).
- Define, or redefine, families to reflect communities' diverse cultural values and beliefs, and recognize their power to communicate effectively within and across communities.
- Provide educators and child care workers with information about healthy social/emotional development and behavior that will give them the necessary tools to determine if a child's behavior is appropriate at a given age and to manage classrooms and child care centers.

Policymakers

Priority Outcomes and Next Steps:

- Seize opportunities in the ACA to promote children's mental health and social and emotional development by integrating behavioral health into health care, expanding Medicaid coverage, expanding home visiting programs and addressing workforce training issues.
- Make healthy child development a national priority by utilizing and building upon currently available resources (e.g., President's early learning initiative) to develop and disseminate compelling messages and narratives about the importance of healthy development for the success of business and society as well as the wellbeing of the child, family and community.
- Advocate for early childhood programs that are sustainable over time and that move seamlessly to school age programs, thereby continuing to improve child mental health outcomes throughout the developmental sequence.

Organizations and Agencies

Priority Outcomes and Next Steps:

- Utilize a broad range of service providers and consumers to develop navigation systems, staffed by those who are knowledgeable about services and programs, to assure coordinated access to resources and programs in one location for mental health care consumers.
- Work in collaboration with consumers, providers, and communities to promote provider and system transparency (e.g., which services and programs are provided) and accountability (e.g., outcomes of services and programs) in order to enhance both service delivery and child mental health outcomes.
- Educate consumers about available programs, services, and expected outcomes and help them develop the necessary advocacy skills to access appropriate services.
- Continue integration of mental health care providers as equal partners in health care systems, emphasizing their credibility and their unique perspectives, skills, service delivery models and data, in order to improve child mental health and health outcomes.

One working group in progress

Closing Remarks

Mary Ann McCabe thanked participants for their commitment and dedication to the tasks required of them during the Summit. The in-depth and complex discussions and exchange of ideas yielded key opportunities for promoting children's mental health within the four domains of child mental health (Tolan and Dodge, 2005) and priority outcomes and next steps in sectors of society with the opportunity to promote child mental health and social/emotional wellbeing. She also noted that there were several overlapping themes which would be captured in this report.

Social psychology research supports the notion that people from diverse perspectives within a group might generate more innovative solutions to stubborn problems.

One theme that emerged consistently was the need to keep messages hopeful, positive, and supportive, especially for parents. This reflected the planning committee's commitment to convening a Summit with a positive frame that focused discussions on opportunities and priorities rather than challenges and obstacles, and that created positive energy for participants to take away with them. ■

Some participants in the large group session

Overarching Themes

Several overarching themes emerged across the day in small and large group discussions. They highlight key considerations that cross the domains of child mental health and sectors of society and underlie specific recommendations.

Individuals

- Work to achieve positive relationships and interactions across those who work with children and families where children live, play, work, and grow.
- Develop and implement advocacy strategies at the personal and professional level to advocate for programs that will improve outcomes for children.

Service Delivery Systems and Communities

- Provide families with multiple supports across systems and in the community, since they play the leading role in their children's health.
- Develop and disseminate positive messages that are linguistically, culturally, ethnically and locally relevant. Fully utilize the expertise of opinion leaders and community members and the capability of existing community networks and platforms.
- Develop a navigation system using a broad range of community providers, consumers, and support people that will provide families with coordinated access to appropriate resources.
- Redesign existing, or develop new infrastructure, in order to increase utilization of, and develop the workforce for, evidence-based practices. Eliminate or reduce barriers to service imposed by the financial or provider systems. Expand and finance education and training.
- Educate a broad base of people who interact with children (i.e., coaches, teachers, nurses, home-visiting counselors, clergy) about child mental health and its role in healthy child development.
- Develop understanding across multiple sectors (e.g., research, built environment, business, education, health care) about critical social/emotional skills and competencies that could be promoted within existing venues.
- Build frameworks and communication strategies that standardize definitions and that allow for sharing data across providers and infrastructures.
- Develop, evaluate, fund and implement sustainable programs that can stand the test of time.

Provide families with multiple supports across systems and in the community, since they play the leading role in their children's health.

Overarching Themes

Social Media

- Use the available and powerful social media and other cutting-edge technologies to disseminate positive messages to children and supportive messages to parents, caregivers, and other adults who can promote children's healthy development.
- Use these media and other technologies to educate parents, caregivers, and other adults about healthy social/emotional development in a way that will promote caregiver skills and competencies that improve developmental outcomes.

Public Policy

- Promote evidence-based practices, programs and services. Such services and providers must be culturally, ethnically, and linguistically competent, and they must address the needs of children and families with particular attention to issues of age, gender, sexual orientation, family composition, mental health condition or disability and socioeconomic status.
- Make children's mental health and social/emotional wellbeing a national priority. It is necessary for the success of families, communities, business, and society.
- Build coalitions of organizations at all levels, from national to local, to support relationships among those who come in contact with children where they live, grow, work, and play to advocate for healthy environments for children (i.e., early childhood settings, schools, after-school and summer settings, medical care facilities, child welfare settings, faith-based contexts, parks and recreation, and other community settings).
- Identify and leverage the opportunities provided by ongoing and overlapping policies and initiatives to promote social/emotional wellbeing and positive outcomes for young children, including healthier behavior, greater school success, improved relationships, and ultimately, benefits to communities and society.
- Summit participants and speakers repeatedly noted that the *Patient Protection and Affordable Care Act* (U.S. Department of Health and Human Services, *2010),* in particular, may provide multiple opportunities to promote children's mental health. Recommendations from the Summit for next steps in the implementation of health care reform are listed on the next page.

Use the available and powerful social media and other cutting-edge technologies to disseminate positive messages to children and supportive messages to parents, caregivers, and other adults who can promote children's healthy development.

Patient Protection and Affordable Care Act (ACA)

Opportunities to promote children's mental health in the *Patient Protection and Affordable Care Act* (ACA)

- Review the ACA in-depth and develop a clear understanding of what it means for the child mental health field and for children and families who could benefit from mental health services.
- Establish strong professional, provider, community, and family advocacy coalitions with the goal of advancing opportunities to promote child mental health through the ACA.
- Encourage a stronger focus on children's mental health and social/emotional development, and education about child development, in the implementation of the ACA so that outcomes are improved.
- Include mental/behavioral health "check-ups" with children during their routine annual visits in primary care; this would allow identification of early warning signs, prevention, and early intervention.
- Identify and leverage ACA funding mechanisms to meet the urgent financing needs in the children's mental health service arena, including workforce capacity and cultural competence
- Identify *sustainable* funding sources to assure long-term implementation of child mental health programs and services in the ACA.
- Identify and leverage policies and initiatives regarding young children in other areas that overlap with the ACA to maximize positive outcomes in children's mental health.
- Develop uniform data collection (e.g., electronic health record, other instruments) and data dissemination linkages to give providers and communities tools to enable full implementation of opportunities in the ACA.
- Develop ACA implementation strategies in communities based on each community's unique needs and demographics to achieve the best possible outcomes in children's mental health.
- Identify opportunities in the ACA to develop new service delivery systems, programs and practices to complement or replace existing models that are not working well.
- Ensure the full integration of mental and behavioral health providers in health care settings serving children and families.

The Way Forward

There are important trends in the public arena that relate to the work of this Summit. Critical attention is being paid by policymakers to early childhood development and early learning environments. Health care reform efforts are emphasizing the role of prevention for improving health across the lifespan. There is enhanced public attention to child mental health and the development of new policies as a result of recent tragedies covered widely by the media.

Unfortunately, these threads remain separate and, as a result, fail to capture the needed momentum and full range of opportunities to improve children's healthy development. There is a lack of widespread public and policy recognition that early childhood is the opportune time to promote child mental health in all environments where children are, that early prevention and intervention may provide the most benefit and cost savings, and that child mental health spans the full continuum from healthy social/emotional development through wellbeing to child mental illness and behavioral disorders. Promoting child mental health and social/emotional wellbeing must be an aim of programs and policies in such diverse areas as: child care, early education, teacher preparation, child welfare, disasters, health disparities, health care reform, mental health service delivery, school safety, bullying, and violence prevention.

Promoting child mental health and social/emotional wellbeing must be an aim of programs and policies in such diverse areas as: child care, early education, teacher preparation, child welfare, disasters, health disparities, health care reform, mental health service delivery, school safety, bullying, and violence prevention.

The experts who participated in this Summit brought their diverse perspectives and expertise to bear on this landscape. They embraced a shared definition and public health perspective for child mental health, an appreciation for the role of science in informing practice with children and families, and a recognition of the need for improved public understanding and collaboration across sectors of society. Summit participants worked hard to generate consensus regarding priorities to move progress.

A few of the priorities that emerged from this Summit are noteworthy for their emphasis in the prior summit that convened scientists of various disciplines: parents, families, caregivers, teachers, and others who work with children need education about child mental health and its critical role in healthy child development. This could help them in recognizing early warning signs of problems, initiating prevention efforts and/or accessing effective interventions. Both information and screening should become routine parts of early learning programs and health visits for children, as well as training programs for professionals. A focus on and significant investment in those children, families and areas most in need may yield the greatest benefit. Yet all parents and families of diverse children need support and will be vital partners going forward.

Summit recommendations highlight the opportunities that can be found in existing programs, structures, communities, and state and federal policy initiatives. They underscore the fact that child mental health and social/emotional wellbeing can be more effectively promoted in these existing platforms if all stakeholders recognize their vital roles in this aspect of children's healthy development. Recommendations acknowledge the importance of culture and other aspects of diversity through reliance on families, communities, and opinion leaders as key messengers and champions in this effort.

Future progress can be accelerated by paying attention

to the lessons from communication science in framing our messages going forward. In particular, research conducted through FrameWorks Institute, supported by the Center for the Developing Child at Harvard University, have shown that public support for investments in child mental health stem from (1) an appreciation that child mental health is a critical component of the future prosperity of society; (2) recognition that ingenuity and innovation can be brought to bear in the development and implementation of effective solutions for problems in child mental health; (3) consideration that child mental health and resilience relate to concepts of levelness, with the balance of positive and negative, genetic and environmental influences determining the outcome at any given point; and (4) appreciation that child mental health and social/emotional wellbeing is but one part of healthy development but inextricably linked to brain development, early learning, self-regulation and executive functions, and relationships with family members and caregivers. The key message elements identified from communication science can be adapted to particular communities in building public understanding and support. For further detail, see http://www.frameworksinstitute.org/238.html.

"Child mental health should be addressed where children live, play, work, and grow" (Report of *Healthy Development*, 2009, p.18). That is, children's mental health and social/emotional wellbeing crosses all the settings in which children can be found, and is the purview of all families and the caregivers and providers who work with them. Viewed in this light, distinctions between health and education, wellbeing and disorder, promotion and prevention can seem arbitrary. Nonetheless, priorities and funding often exist (and compete) within silos.

Therefore, those who work with children must continually seek new ways to collaborate across sectors of society and to support leaders with diverse perspectives in promoting the importance of child mental health and social/emotional development for long-term wellbeing. Indeed, Summit participants expressed a commitment to collaboration as the route to greater progress. As can be seen in Appendix D, participants' evaluations of the Summit frequently included the suggestion to create a cross-discipline, cross-sector coalition to build infrastructure and leadership for this work. Summit participants emphasized the need to engage families, caregivers and communities, and they identified a number of other specific sectors and organizations that will be important to recruit as partners. Participants suggested ways to overcome funding obstacles to organizing such an effort, including greater reliance on social media and technology.

Children's mental health and social/emotional wellbeing crosses all the settings in which children can be found, and is the purview of all families and the caregivers and providers who work with them.

Recent trends in science, practice and policy favor collaboration among previously unlikely partners, from interdisciplinary research teams to interprofessional practice in primary care. Sharp distinctions between the importance of literacy and numeracy skills versus social/emotional readiness for early learning have also softened. Previous emphases on illness and disease have gradually progressed to emphases on health and wellbeing. There is hope that these trends will support the type of "whole child" view and cross-sector collaboration that Summit participants are seeking here. Only then can those with expertise and interest in early childhood mental health ensure widespread recognition that young children's mental health and social/emotional wellbeing is a critical part of their healthy development, academic success, lifelong productivity, and the welfare and prosperity of their community and society.

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Appendix A
Biosketches of Presenters and Summit Planning Committee

Presenters

Ileana Arias, PhD, is Principal Deputy Director for the Centers for Disease Control (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR). In this role, she serves as the principal advisor to the director on all scientific and programmatic activities of CDC/ATSDR. Dr. Arias is responsible for advising the director in all executive responsibilities, and shaping the policies and plans for CDC/ATSDR. Before becoming Principal Deputy Director, Dr. Arias was the Director of the National Center for Injury Prevention and Control (NCIPC) since July 2005, where she worked to prevent injuries and violence, and reduce their consequences. She began her career as a research associate at the State University of New York at Stony Brook and then joined the University of Georgia in Athens as an assistant professor. Prior to joining CDC in 2000, Dr. Arias was the director of clinical training and professor of clinical psychology at the University of Georgia. Dr. Arias holds a BA, from Barnard College, and a MA and PhD, both in psychology, from the State University of New York at Stony Brook and speaks four languages, including German, French, and Spanish.

Karen Blase, PhD, has been a service provider, research, program evaluator and published author in the human service field for over 35 years. Her area of focus is implementation science and best practices to bring science to service. She is a Senior Scientist at the Frank Porter Graham Child Development Institute at the University of North Carolina at Chapel Hill. She is also Co-Director of the National Implementation Research Network (NIRN) and a team member on the OSEP TA Center on State Implementation and Scaling-Up of Evidence-Based Practices. She received her doctorate in Developmental and Child Psychology from the University of Kansas with a focus on school-based interventions, teacher training, and community-based services for high needs youth.

Nathaniel Kendall-Taylor, PhD, is Director of Research and Senior Researcher with FrameWorks Institute. In this role, he employs social science theory and research methods from anthropology to improve the ability of public policy to positively influence health and social issues. This involves studying how cognitive theory can be applied to understand how people interpret information and make meaning of their social worlds. His past research has focused on child and family health and understanding the social and cultural factors that create health disparities and affect decision-making. As a medical anthropologist, Kendall-Taylor has conducted fieldwork on the coast of Kenya studying pediatric epilepsy and the impact of chronic illness on family well-being. He has also applied social science methods in Azerbaijan and Kazakhstan and has conducted ethnographic research on motivation in "extreme" athletes. Kendall-Taylor earned his BA from Emory University and Master's and doctoral degrees from the University of California, Los Angeles

Appendix A

Joan Lombardi, PhD, is a leading international expert on child development and social policy. She currently serves as Director of Early Opportunities LLC, as a Senior Advisor to the Buffett Early Childhood Fund, and as a Senior Fellow at the Bernard van Leer Foundation. Over the past 40 years, Dr. Lombardi has made significant contributions in the areas of child and family policy as an innovative leader and policy advisor to national and international organizations and foundations and as a public servant. She served in US Department of Health and Human Services as the Deputy Assistant Secretary for Early Childhood Development (2009-2011) in the Obama Administration, and as the Deputy Assistant Secretary for Policy and External Affairs in Administration for Children and Families and the First Commissioner of the Child Care Bureau among other positions (1993-1998) during the Clinton Administration. Outside of public service, she served as the founding chair of the Birth to Five Policy Alliance and as the founder of Global Leaders for Young Children.

Summit Planning Committee

Barry S. Anton, PhD, ABPP, is President-Elect of the APA. He is an American Board of Professional Psychology (ABPP) examiner in child and adolescent clinical psychology and serves on their board. Dr. Anton was a distinguished professor at the University of Puget Sound. He transitioned from teaching to pursue full time private practice in an interprofessional mental health practice that he began with a psychiatrist in 1985. Long active in mental health advocacy and public policy, Dr. Anton was on the executive committee of the Washington State psychological Association (WSPA) for 12 years. A recipient of numerous awards from WSPA, he became active in national advocacy efforts through the American Psychological Association (APA). He received the Karl F. Heiser Award for Advocacy and the APA State Leadership Award. Dr. Anton served as an APA Council representative, was a member of eight APA task forces or work groups, and served two terms as APA Recording Secretary.

Richard P. Barth, MSW, PhD, is Dean, School of Social Work, University of Maryland. He previously served as a chaired professor at UC Berkeley and UNC and he authored or co-authored 12 books and more than 200 articles and chapters. His research areas include child abuse prevention, home visiting, services and outcomes of foster care and kinship foster care, adoption, children's mental health, school social work, substance abuse, cost analysis, residential education, evidence-based parent training, and intensive in-home services as an alternative to out of home care. He has done seminal work identifying the high levels of mental health problems among children in child welfare services (CWS) and the significant proportion – especially in nonurban areas – which enter CWS principally because of mental health problems. His current research is on implementing common elements and common factors approaches to providing children's mental health services and parenting programs.

Appendix A

Barbara Fiese, PhD, is Professor of Human Development and Family Studies with affiliated appointments in Psychology and Pediatrics at the University of Illinois at Urbana-Champaign. She is the Director of the Family Resiliency Center and holds the Pampered Chef Endowed Chair in Family Resiliency. Dr. Fiese's research focuses on family factors that promote health and wellbeing in children. She is considered one of the national experts in the role that shared family mealtimes may play in promoting health during early childhood and the elementary school years. She is a Co-Principal Investigator (Co-PI) on the STRONGKids Program, a cells-to-society approach to healthy weight in preschool age children; and Co-PI on the NIH ICAP Project, a series of workshops aimed at developing innovative methods of physical activity measurement in preschool age children in their natural environments, and Principal Investigator on the BackPack Evaluation Project funded by Feeding America aimed at examining the effects of a weekend feeding program on food insecurity and the correlates of childhood hunger. She is President of Division 43 of the American Psychological Association, Society of Family Psychology, and inaugural editor of *Advances in Child and Family Policy* and *Practice*, a publication of the Society for Child and Family Policy and Practice.

Penelope K. Knapp, MD, is Professor Emeritus of Psychiatry and Pediatrics at UC Davis where she served as chief of the Division of Child, Adolescent & Family Psychiatry, and consults to Academy Health/Rutgers University and California Institute of Mental Health. She previously served as the Medical Director, California Department of Mental Health. She has been the project director of the CA First 5-funded Infant Preschool Family Mental Health Initiative, and co-director of the California BEST PCP project as part of ABCD II. She served from 2006-2012 as co-chair of CalMEND: California Mental Health Care Management Program, a quality improvement initiative led by DHCS and DMH. She is a member of Fellow of several national organizations including the American Academy of Child & Adolescent Psychiatry and American Academy of Pediatrics, serving on the Bright Futures Infancy Panel, the Mental Health Task Force and the Developmental Psychosocial toolkit task force. Her current principal interests are prevention and early intervention for high-risk parents, infants and toddlers, evidence-based practices for mental health services and screening and intervention in primary care settings for social/emotional, behavioral, and relationship problems. Dr. Knapp is the 2009 recipient of the American Academy of Child and Adolescent Psychiatry Irving Phillips Award for Prevention and in 2010 of the California Psychiatric Association – Edward Rudin award for Excellence in Government Affairs.

Appendix A

Mary Ann McCabe, PhD, is Associate Clinical Professor of Pediatrics, George Washington University School of Medicine and Affiliate Faculty in Psychology at George Mason University. She is Chair of the Summit Planning Committee as well as the Interdivisional Task Force on Child and Adolescent Mental Health of the American Psychological Association (APA). She is also Chair of the APA Board of Professional Affairs. A licensed clinical psychologist, Dr. McCabe is in independent clinical practice and engages in teaching and consulting regarding bridging research with practice and policy. Dr. McCabe led the planning committee for the first summit in 2009. At that time she was Director of the Office for Policy and Communications, Society for Research in Child Development (SRCD). In her role with SRCD, she oversaw activities in science policy, social policy, and knowledge transfer for practice and policy, and directed the SRCD Congressional and Executive Branch fellowship programs. Prior to assuming this position, Dr. McCabe was the Director of Health Psychology and Director of Training in Psychology at Children's National Medical Center. She has specialized in various aspects of the development and mental health of chronically ill children, and has taught these topics to various health care disciplines, including nursing, pediatrics, psychology, psychiatry, and social work. She serves on the Editorial Boards of *Clinical Practice in Pediatric Psychology and Advances in Child and Family Policy and Practice*. She received her BA in psychology from Clark University and her doctorate at the Catholic University of America, and then completed her clinical internship and an advanced fellowship through Harvard Medical School at Judge Baker Children's Center and Children's Hospital of Boston.

Linda A. Reddy, PhD, is a Professor of School Psychology at Rutgers University. She is the former Founder/Director of the Child/Adolescent ADHD Clinic and Director of the Center for Psychological Services at Fairleigh Dickinson University. She is a research scientist at the Devereux Foundation's Institute of Clinical Training and Research. Her research interests include the assessment and treatment of children with ADHD-related disorders, measurement of classroom instructional and behavioral management practices, and test development and validation. She is on over 10 journal editorial boards including *Journal of School Psychology*, *School Psychology Quarterly*, *Journal of Educational and Psychological Consultation*, and *Psychology in the Schools*. She is currently the Principal Investigator for two measurement grants from the US Department of Education. She is a Fellow of the American Psychological Association (APA). She is currently the President-Elect of APA Division 16 (School Psychology), Chair of the APA Task Force for Children with Emotional Disturbances and their Families; as well as member of the Transition of Science to School Practice Work Group and the APA Interdivisional Task Force on Child and Adolescent Mental Health. Dr. Reddy is a licensed psychologist in New Jersey, New York, and Pennsylvania and is a nationally certified school psychologist who has consulted with school districts and agencies in the US. Dr. Reddy received her PhD in School Psychology and MA in Measurement from the University of Arizona and BA in Psychology from Boston University.

Michael C. Roberts, PhD, is Professor and former Director of the Clinical Child Psychology Program at the University of Kansas. He holds academic appointments in the Departments of Psychology, Applied Behavioral Science, and Pediatrics. Dr. Roberts has published close to 200 journal articles and book chapters revolving around the application of psychology to understanding and influencing children's physical and mental health. He has authored or co-edited 18 books. Dr. Roberts is the current editor for *Training and Education in Professional Psychology*, and has served as the editor for *Professional Psychology: Research and Practice, Journal of Pediatric Psychology; Children's Health Care; and Children's Services: Social Policy, Research, and Practice* and as Associate Editor for *Journal of Consulting and Clinical Psychology*. He has served on grant review panels and as president or chair of several divisions of the American Psychological Association (APA) and boards and committees. He is past chair if the APA Interdivisional Task Force on Child and Adolescent Mental Health.

Karen J. Saywitz, PhD, is Professor in the UCLA School of Medicine, Department of Psychiatry and a Developmental and Clinical Psychologist. For over 20 years, she has directed programs providing mental health services to children and families in the public sector and taught normative child development to students in medicine, law, psychology, social work, and nursing. Her research focuses on the capabilities, limitations, needs, and recovery of children involved in the legal system due to adverse early experiences, such as maltreatment. Dr. Saywitz has co-authored articles applying child development research to legal decision-making that have been cited by the US Supreme Court and numerous US appellate courts. She has won national awards for her pioneering research, distinguished teaching, advocacy and clinical service from organizations such as the American Psychological Association (APA) and the American Professional Society on the Abuse of Children. She has authored handbooks for judges and forensic interviewers, served on the faculty of the National Judicial College, chaired working groups for the CDC on public health strategies to prevent child maltreatment in primary care settings, and founded the APA Interdivisional Task Force on Child and Adolescent Mental Health.

Jean C. Smith, MD, FAAP, is a fellowship trained developmental and behavioral pediatrician with Wake County Human Services in Raleigh, North Carolina, and Clinical Associate Professor of Pediatrics in the Department of Pediatrics at the University of North Carolina, Chapel Hill. Dr. Smith provides clinical services for children and adolescents in the Wake County Public Health Center and is the medical director for Wake County's foster care program that provides comprehensive and coordinated medical, developmental, and behavioral assessment for children entering foster care. Because Wake County Human Services is an integrated agency that includes Social Services and Public Health, she serves as a liaison and consultant to child welfare, school-based mental health, child health, Latino mental health, community physicians, and parent groups in Wake County. Dr. Smith also serves on the Advocacy Committee for the Society for Developmental and Behavioral Pediatrics.

Appendix A

Patrick H. Tolan, PhD, is the Director of Youth-Nex: The UVA Center for Effective Youth Development at the University of Virginia. He has been Professor of Education and Psychiatry and Neurobehavioral Development there since 2009. Previously, he was Director of the Institute for Juvenile Research at the University of Illinois in Chicago, where he was also Professor of Psychiatry and Public Health, for 10 years and is now Emeritus. He conducts programmatic research on child mental health issues, particularly related to promotion of effective development and prevention of disorders. He has published over 150 articles and chapters and 6 volumes on research and practices related to children's mental health. These include his forthcoming co-edited volume *Disruptive Behavior Disorders*, the first volume in the Brain Foundation Series on Development and Psychopathology and "Children's mental health as a primary care and concern: A system for comprehensive support and service" published in 2005 in the *American Psychologist*. He chaired the American Psychological Association's Working Group on Children's Mental Health (1999-2001) that produced the four-pronged focus for advancing children's mental health.

Donald Wertlieb, PhD, is Professor Emeritus and former Chair of the Eliot-Pearson Department of Child Development at Tufts University. He is an applied developmental scientist with a background in clinical-developmental and pediatric psychology. His research interests include understanding the complex processes by which children and families cope with adversity (e.g., marital disruption, chronic illness) and applying these understandings to program development in community settings locally, nationally, and internationally. He served on the National Academies of Science Steering Group of the National Forum on the Future of Children, and was President of the Society of Pediatric Psychology (Division 54, American Psychological Association). He is President of the American Orthopsychiatric Association and the Partnership for Early Childhood Development and Disability Rights. In 2007, he received the Career Contribution Award for outstanding contributions to the advancement of psychology as a science and a profession from the Massachusetts Psychological Association and the APA Lee Salk Distinguished Service Award for outstanding contributions to pediatric psychology. He is the 2009 recipient of the APA Nicholas Hobbs Award for Child Advocacy.

Appendix A

Martha Zaslow, PhD, is Director of the Office for Policy and Communications of the Society for Research in Child Development (SRCD) and a Senior Scholar at Child Trends. As Director of the SRCD Office for Policy and Communications, Dr. Zaslow facilitates the dissemination of research to decision-makers and the broader public through Congressional and Executive branch briefings, research briefs, and press releases focusing on research in Child Development, SRCD's peer reviewed journal. She also monitors and keeps the SRCD membership appraised of social policy and science policy developments related to children and families. She directs the SRCD Policy Fellowship Program, working with the SRCD Policy Fellows who have placements in the Executive Branch and Congress. As a Senior Scholar at Child Trends, Dr. Zaslow conducts research focusing on professional development of the early childhood workforce, and approaches to improving the quality of early childhood programs. Dr. Zaslow served on the Secretary's Advisory Committee for Head Start Research and Evaluation and on the Committee on Developmental Outcomes and Assessments of Young Children of the National Research Council. ■

Appendix B: Summit Agenda

Healthy Development II: Changing frames and expanding partnerships to promote children's mental health and social/emotional wellbeing

May 5 - 6, 2013
Bolger Center for Leadership Development

Day/Time:	Activity/Location: (see property map, inside back cover)
Sunday, 5/5 6:00–7:30pm	Welcome Reception, Patio Gazebo, Hotel Check-in Building (If inclement weather, reception will be held in the Overland Room)
7:30-8:30	Dinner on your own with other summit participants. Dinner buffet at Osgood restaurant (Osgood building) at no charge for Bolger Center overnight guests. Pony Express Lounge also open.
Monday, 5/6 6:00 -8:20am	Breakfast available Breakfast buffet at Osgood restaurant (Osgood building) at no charge for Bolger Center overnight guests. (Note – Light breakfast foods will be available to all participants in the snack area of Franklin Building where summit meetings will be held.)
ALL SUMMIT SESSIONS WILL BE HELD IN THE FRANKLIN BUILDING	
8:00-8:30	Registration – Franklin Lobby
8:30-9:10	Welcome, Overview, and Introductions of Participants – Franklin Building, Classroom 3 (moderated by Dr. Mary Ann McCabe)
9:10-9:50	***Changing Frames*** (*moderated by Dr. Michael Roberts*) **Keynote Address:** *Children's Mental Health: A Public Health Perspective* **Dr. Ileana Arias, Principal Deputy Director, Centers for Disease Control and Prevention**
9:50-10:00	Break
10:00-10:30	***Closing the Gaps between Science-Sense and Common-Sense: Reframing Child Mental Health and Developmental Outcomes*** *Dr. Nat Kendall-Taylor, Director of Research, FrameWorks Institute*
10:30-11:00	***From Good Intentions to Great Outcomes: An Implementation Science Frame*** *Dr. Karen Blase, Co-Director, National Implementation Research Network* *Senior Scientist, Frank Porter Graham Child Development Institute, UNC*
11:00-11:20	Questions and discussion

Appendix B: Summit Agenda

Day/Time:	Activity/Location: (see property map, inside back cover)
11:30-12:20	Lunch – Osgood restaurant (semi-private area) (Please sit with someone you have not known prior to the summit.)
12:30-1:50	**Expanding Partnerships** ***Please see your nametag for your two group assignments*** **Working Group Session #1:** Domains of child mental health Group 1: Importance of mental health for healthy child development (*facilitated by Dr. Karen Saywitz*) – Classroom 3 Group 2: Everyday challenges for parents and child mental health (*facilitated by Dr. Martha Zaslow*) – Room 18 Group 3: Prevention opportunities in child mental health (*facilitated by Dr. Patrick Tolan*) – Room 19 Group 4: Child mental health problems: treatment works (*facilitated by Dr. Penny Knapp*) – Room 15
1:55-2:30	***Reports from working groups and large group discussion – Classroom 3*** *(moderated by Dr. Barbara Fiese)*
2:30-2:50	***Response: Reflecting Back and Looking Forward – Classroom 3*** *Dr. Joan Lombardi, Senior Advisor, Buffet Early Childhood Fund*
2:50-3:00	Break
3:00-4:15	**Working Group Session #2:** Sectors of Society Group 5: Practitioners, Scholars (facilitated by Dr. Jean Smith) - Classroom 3 Group 6: The Public, Families (facilitated by Dr. Barry Anton) - Room 18 Group 7: Policymakers (facilitated by Dr. Don Wertlieb) - Room 19 Group 8: Organizations, Agencies (facilitated by Dr. Linda Reddy) - Room 15
4:20-4:55	***Reports from working groups and large group discussion – Classroom 3*** *(moderated by Dr. Richard Barth)*
5:00-5:15	**Closing Discussion** *(moderated by Dr. Mary Ann McCabe)*
5:15-6:00	**Closing Reception –** Franklin Building lobby or terrace
6:00	Adjournment

Appendix C: Summit Participants

Barry Anton, PhD, ABPP	Managing Partner, Rainier Behavioral Health, Tacoma, WA
Ileana Arias, PhD	Principal Deputy Director, Centers for Disease Control and Prevention
Richard Barth, MSW, PhD	Professor and Dean, School of Social Work, University of Maryland
Rinad Beidas, PhD	Assistant Professor of Psychology in Psychiatry, Perelman School of Medicine, University of Pennsylvania
Karen A. Blase, PhD	Senior Scientist, Co-Director, National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina - Chapel Hill
Kimber Bogard, PhD	Director, Board on Children, Youth, and Families, Institute of Medicine / National Research Council
Lynn F. Bufka, PhD	Assistant Executive Director, Practice Research and Policy Directorate, American Psychological Association
Sandra L. Calvert, Ph.D.	Professor, Department of Psychology Director, Children's Digital Media Center, Georgetown University
Mark Chaffin, PhD	Professor of Pediatrics, University of Oklahoma Health Sciences Center
Susan Comfort	Executive Director, Playworks DC
Emmalie Dropkin, MA	Senior Specialist for Research and Policy, National Head Start Association
John C. Duby, MD, FAAP	Chair, Mental Health Leadership Work Group, American Academy of Pediatrics
Lei Ellingson, MPP, MSSE	Associate Director, The Carter Center Mental Health Program
Dorothy Espelage, PhD	Professor of Child Development, College of Education, University of Illinois at Urbana-Champaign
Lauren G. Fasig, JD, PhD	Director, Children, Youth & Families Office, American Psychological Association
Barbara H. Fiese, PhD	Professor and Director, Family Resiliency Center, University of Illinois at Urbana-Champaign
Ruth Friedman, PhD	Child Policy Consultant
Rosa M. Gil, PhD	President & CEO, Comunilife, Inc.

Appendix C: Summit Participants

Joseph F. Hagan, Jr., MD, FAAP	Clinical Professor in Pediatrics, University of Vermont College of Medicine, Co-editor, The Bright Futures Guidelines
Kimberly Eaton Hoagwood, PhD	Cathy and Stephen Graham Professor of Child and Adolescent Psychiatry, Vice Chair for Research, New York University Child Study Center, Department of Child and Adolescent Psychiatry, New York University School of Medicine
Mary Campbell Hutzler, MS	Writer/Consultant, Alexandria, Virginia
Kim Hymes	Director, Policy and Advocacy, Council for Exceptional Children
D. J. Ida, PhD	Executive Director, National Asian American Pacific Islander Mental Health Association
Ellen M. Katz, MA, MBA	President/CEO, The Children's Home of Cincinnati
Mary Keller, PhD	President & CEO, Military Child Education Coalition
Nathaniel Kendall-Taylor, PhD	Research Director, FrameWorks Institute
Penelope Knapp, MD	Professor Emerita, Department of Psychiatry and Behavioral Sciences, UC Davis MIND Institute
Lisa Lambert	Executive Director, Parent/Professional Advocacy League
Wayne W. Lindstrom, PhD	President and CEO, Mental Health America
Joan Lombardi, PhD	Senior Advisor, Buffett Early Childhood Fund
Valerie Maholmes, PhD	Acting Chief, Pediatric Trauma and Critical Illness Branch, Director, Child and Family Processes/Child Maltreatment & Violence Program, Eunice Kennedy Shriver National Institute of Child Health and Human Development, National Institutes of Health
Sarah Mandell	Policy Assistant, Society for Research in Child Development
Mary Ann McCabe, PhD	Associate Clinical Professor of Pediatrics, George Washington University School of Medicine Affiliate Faculty, George Mason University
Bernadette Melnyk, PhD PhD, RN, CPNP/PMHNP FNAP, FAAN	Associate Vice President for Health Promotion, University Chief Wellness Officer, Dean and Professor, College of Nursing, Professor of Pediatrics & Psychiatry, College of Medicine, The Ohio State University
Jennifer Oppenheim, PsyD	Coordinator, Project LAUNCH, Mental Health Promotion Branch, SAMHSA

Appendix C: Summit Participants

Sangeeta Parikshak, PhD	Postdoctoral Fellow, Johns Hopkins School of Medicine, Department of Psychiatry and Behavioral Sciences
Rebecca Parlakian, MA	Senior Program Manager, Parenting Resources, ZERO TO THREE
Ruth Perou, PhD	Child Development Studies Team Leader, Centers for Disease Control and Prevention
Linda A. Reddy, PhD	Professor, School Psychology, Rutgers University
Michael C. Roberts, PhD, ABPP	Professor, Clinical Child Psychology Program, University of Kansas
Douglas Ronsheim, DMin	Executive Director, American Association of PastoralCounselors
Barbara Roth, MA	National Director, Youth and Family Membership Support and Program Services, YMCA of the USA
Diego Miguel Sanchez, APR	Director of Policy, PFLAG National
Karen J. Saywitz, PhD	Professor, UCLA School of Medicine, Department of Psychiatry and Biobehavioral Sciences
Karen Schulman, MPP	Senior Policy Analyst, National Women's Law Center
Joyce Sebian, MS Ed	Public Health Advisor, Substance Abuse and Mental Health Services Administration
Nadezhda Sexton, PhD	Director, Knowledge Management, Casey Family Programs
Patty Shinseki, MS	Board Member, Military Child Education Coalition
Amy Smith, MS	Educational Consultant , Pennsylvania Training and Technical Assistance Network President, National Association of School Psychologists
Jean Smith, MD, FAAP	Clinical Associate Professor of Pediatrics, University of North Carolina, Chapel Hill
Sheila Smith, PhD	Director, Early Childhood, National Center for Children in Poverty, Columbia University
Rebecca A. Stoltz, MPH	Project Director, Science of Health and Development Initiative, Center on the Developing Child at Harvard University
Jean M. Thomas, MD	Clinical Professor, Psychiatry and Behavioral Sciences, Georgetown University Medical School, Practitioner, Integrated Therapy for Children and Families

Appendix C: Summit Participants

Patrick Tolan, PhD	Professor, University of Virginia Director, Youth-Nex The UVA Center to Promote Effective Youth Development
Deborah Klein Walker, EdD	Vice President, Principal Associate, Public Health and Epidemiology, Abt Associates
Albert Wat, MA	Senior Policy Analyst, National Governors Association
Sara Watson, PhD	Executive Vice President, America's Promise Alliance Director, ReadyNation
Sandra J. Weiss, RN, PhD, DNSc, FAAN	Professor and Eschbach Endowed Chair in Mental Health Nursing, Department of Community Health Systems, School of Nursing, University of California, San Francisco
Donald Wertlieb, PhD	Professor Emeritus, Tufts University President, American Orthopsychiatric Association
Dorinda Silver Williams, LCSW-C	Director, Military Family Projects, ZERO TO THREE
David W. Willis, MD, FAAP	Division Director, Home Visiting and Early Childhood Systems, Maternal and Child Health Bureau, Health Resources and Services Administration
Diane J. Willis, PhD	Professor Emeritus, Pediatrics, University of Oklahoma Health Sciences Center
Michelle Zabel, MSS	Director and Clinical Instructor, The Institute for Innovation and Implementation, University of Maryland, School of Social Work
Martha Zaslow, PhD	Director, SRCD Office for Policy and Communications Senior Scholar, Child Trends
Joan Zlotnik, PhD, ACSW	Director, Social Work Policy Institute, National Association of Social Workers

Appendix D:
Feedback from Participants

Summit participants completed a 16 item evaluation form following the Summit.[5] Respondents agreed that the Summit was an important step in achieving the cross-sector dialogue necessary to share a common message about the critical role of mental health in children's healthy development. Ninety-seven percent agreed that the Summit helped identify opportunities, priorities, and next steps to foster innovative thinking and common policy recommendations. All participants concurred that the Summit heightened their awareness of the need for a shared framing of issues and greater collaboration among unlikely partners in order to garner public support for investment in young children's mental health; ninety-three percent projected that the Summit would influence their future work in teaching, research, advocacy, and communication.

In response to open-ended questions, participants identified opportunities and challenges in carrying the work forward. Many participants recognized that greater cross-sector collaboration is required to adopt a common message. One often repeated recommendation was the creation of a coalition of cross-discipline and cross-sector organizations to build infrastructure and leadership. Although most respondents identified lack of funding as an obstacle, they also suggested low-cost pathways to collaboration, including virtual meetings, in order to continue the momentum. Many individuals highlighted the need to organize in ways that respect divergent perspectives within a broad public health model.

Most frequently, the next step suggested was the identification and implementation of clearly defined action steps built on common ground, given the disparate and competing priorities of varied sectors. Recurring concerns included the need to address the effects of poverty on child development and the complexities of serving a multi-cultural population. The need to develop mechanisms and materials to encourage participation from families, front-line workers, and community organizations was repeatedly mentioned. Some respondents were frank about the need for advocates to enter the national debate on the appropriate role and size of government; others mentioned lack of political will as an additional barrier to implementation.

There was strong agreement that a shared message could and should be crafted around areas of convergence, with participants recommending that a wide array of sectors be involved, including health care, education, social services, business, technology, research, early learning and day care, faith-based efforts, media outlets, justice, law enforcement, consumers, and community development groups. To this end, participants provided a rich catalogue of governmental agencies at the federal, state, and local levels, professional organizations, and consumer groups to be recruited to the task of promoting the importance of early childhood social/emotional development for long term wellbeing. ■

5 66% of the participants who were asked to complete an evaluation did so. The evaluation form included nine questions utilizing a 5 point Likert scale with 1 = strongly agree, 2 = agree, 3 = neutral, 4= disagree and 5 = strongly disagree. There were nine open-ended questions.

Appendix E: Related Resources

(Provided on CD to Summit participants.)

Articles	Links
American Academy of Pediatrics (2013). *Bright Futures.* Retrieved October 7, 2013.	http://brightfutures.aap.org/materials.html
American Academy of Pediatrics (2010). Enhancing pediatric mental health care: Report from the American Academy of Pediatrics Task Force on Mental Health. *Pediatrics*, 125(3). DOI:10.1542/peds.2010-0788C	
American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2011. *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs.* 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Retrieved December 9, 2013.	http://nrckids.org.
American Psychological Association, Division 53, Society of Clinical Child and Adolescent Psychology. Resources on evidence based treatment for children. Retrieved October 7, 2013.	http://www.effectivechildtherapy.com/
American Psychological Association, Task Force on Evidence-Based Practice with Children and Adolescents. (2008). *Disseminating Evidence-Based Practice for Children and Adolescents: A Systems Approach to Enhancing Care.* Retrieved October 7, 2013.	http://www.apa.org/practice/resources/evidence/children-report.pdf

Appendix E: Related Resources

Articles	Links
Bandy, T. (August, 2012). *What works for male children and adolescents: Lessons from experimental evaluations of programs and interventions.* Washington, DC: Child Trends. Retrieved October 7, 2013.	http://www.childtrends.org/files/Child_Trends-2012_08_20_WW_MaleChildrenAdolescents.pdf?utm_source=Gender+Differences+in+What+Works+for+Boys+and+Girls&utm_campaign=WW+Gender+Differences&utm_medium=email
Barth, R., Wildfire, J., & Green, R. (2006). Placement into foster care and the interplay of urban city, child behavior problems, and poverty. *American Journal of Orthopsychiatry,* 76 (3), 358-366.	
Bell, K., Terzian, M.A., & Moore, K.A. (August, 2012). *What works for female children and adolescents: Lessons from experimental evaluations of programs and interventions.* Washington, DC: Child Trends. Retrieved October 7, 2013.	http://www.childtrends.org/files/Child_Trends-2012_08_20_WW_FemaleChildrenAdolescents.pdf?utm_source=Gender+Differences+in+What+Works+for+Boys+and+Girls&utm_campaign=WW+Gender+Differences&utm_medium=email
Benedetti, G. (September 2012). *Innovations in the field of child abuse and neglect prevention: A review of the literature.* University of Chicago: Chapin Hall. Retrieved October 7, 2013.	http://chapinhall.org/research/report/innovations-field-child-abuse-and-neglect-prevention-review-literature
Bertram, R., Blase, K., Shern, D., Shea, P., and Fixsen, D. (2011). *Policy Research Brief: Implementation Opportunities and Challenges for Prevention and Promotion Initiatives.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD). Retrieved October 7, 2013.	http://www.nasmhpd.org/docs/PreventionResources/Policy%20Research%20Brief%20on%20Implementation%20Opportunities%20and%20B_1.pdf
Birth to Five Policy Alliance. Retrieved October 7, 2013.	http://www.birthtofivepolicy.org/Advocacy/SocialMedia/tabid/115/Default.aspx

Appendix E: Related Resources

Articles	Links
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Appendix E: Related Resources

Articles	Links
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Appendix E: Related Resources

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Appendix E: Related Resources

Articles	Links
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Appendix E: Related Resources

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Appendix E: Related Resources

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Appendix E: Related Resources

Articles	Links
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Appendix E: Related Resources

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Appendix E: Related Resources

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