

**Task Force on the Mental Health, Social, and Emotional Needs of
Young Children and their Families
August 25, 2011
North Carolina Institute of Medicine, Morrisville
10:00am-3:00pm
Meeting Summary**

Attendees:

Task Force Members: Beth Melcher (co-chair), Rosie Allen, Patti Beardsley, Karen Appleyard Carmody, Elizabeth Flemming, Catharine Goldsmith, Jill Hinton, Emma Miller, Robert Murphy, Laura Muse, Janice Petersen, Marla Satterfield, Terri Shelton, Jean Smith, William Smith, Joseph Turner

Steering Committee Members: Melissa Johnson, Marcia Mandel, Susan Robinson, Adele Spitz-Roth

NCIOM Staff: Kimberly Alexander-Bratcher, Thalia Fuller, Jen Hastings, Emily McClure, Sharon Schiro, Pam Silberman, Rachel Williams, Berkeley Yorkery

Other Interested Persons: Gary Ander, William Barthel, Kelly Blasky, Robin Britt, Ruby Brown-Herring, Michelle Hughes, Lisa Littlejohn, Melissa Van Dyke, Donna White, Rick Zechman

Welcome and Introductions

Berkeley Yorkery, MP, Project Director, North Carolina Institute of Medicine

Ms. Yorkery welcomed everyone to the meeting.

Early Childhood Advisory Council

Robin Britt, JD, LLM, Executive Director, Guilford Child Development

Mr. Britt gave an overview of the Governor's Early Childhood Advisory Council (ECAC). The goals of the ECAC include developing a strategic plan for the national Race to the Top campaign, strengthening the quality of and access to programs, increasing public awareness, strengthening coordination, and supporting an integrated data system.

Mr. Britt's presentation can be found here: [ECAC](#).

Selected questions and comments:

- Programs should be evidence-based and use implementation science. At-risk children should be identified early. Programs should include families, first line providers, and others. There needs to be engagement of all state resources and stakeholders, and collaboration to achieve the ends. Policy makers need to make a precise and understandable plan with evidence to back it up. The cost of

adverse childhood experiences leading to poor health later needs to be taken into account instead of just the cost of programs.

- Q: Who is applying for the Early Learning Challenge Grant? A: The ECAC is applying on behalf of the governor.

Evidence-Based Programs: Implementation and Bringing to Scale

Melissa Van Dyke, LCSW, Associate Director, National Implementation Research Network, Frank Porter Graham Child Development Institute, UNC-Chapel Hill

Ms. Van Dyke reviewed best practices in implementing evidence-based practices. Successful implementation of evidence-based practices requires that the practice meet the needs of the population, be implemented with fidelity, and have a strong organizational structure.

Ms. Van Dyke's presentation can be found here: [Implementation of EB Programs](#).

Selected questions and comments:

- Q: Where does the concept of sustainability fit in the five steps in moving to scale? A: Sustainability should be thought about throughout. It is a financial and programmatic matter. If a program cannot be sustained then it should not be implemented.
- Q: Sometimes evidence-based practices get a lot of push back since implementers do not know if the practice is best for the population and because they are expensive. How do you address that challenge? A: We want to have a lot of empathy but also have to figure out what evidence-based practices exist that would be beneficial for a specific community. If a community skips certain parts of the practice to save money, then it gives up some potential impact. However, if the new program can show intentionality by collecting information and having good program development, then I think any program can work.
 - If a practice has not been tested on a certain population, then it is important to look at the underlying theory of the practice. Some things will work in all areas (i.e., caring parents, nutrition, etc.). There should be a basic foundational awareness on what works for people that can be built upon.
- Culture adaptation is required for some implementation processes. A concern about adaptation is understanding the active ingredients of a program. It is necessary to find the theoretical basis of model and find what can be tinkered with or not.

Learning Collaborative Framework

Robert A. Murphy, PhD, Executive Director, Center for Child and Family Health

Dr. Murphy summarized the learning collaboratives being implemented by the Duke Evidence-Based Implementation Center. The collaboratives are a multi-faceted and consist of clinical training through intensive instruction, consultation, and guided practice. The collaborative team is made up of individuals from multiple organizations

that are necessary to implement the program with fidelity and sustainability. Topics include trauma focused cognitive behavioral therapy, parent-child interaction therapy, psychotherapy for adolescents, attachment, veteran culture, etc.

Dr. Murphy's presentation can be found here: [Learning Collaborative Framework](#).

Selected questions and comments:

- Q: Medicaid will soon begin paying for value. Incentive payments will be given to providers who are meeting criteria for implementing evidence-based practices. Could a provider use a learning collaborative as a method for that incentive payment? A: Yes. Learning collaboratives can be a vehicle for achieving that level of fidelity needed to receive those payments.
- Q: What is the maximum number of clinicians that can participate for the collaborative to still to be effective? A: It depends on certain key factors including how intensive the training is in a model. It also depends on what the collaborative faculty can support.

Discussion of Potential Recommendations

Sharon Schiro, PhD, Vice President, North Carolina Institute of Medicine

The workgroup discussed possible recommendations relating to social media campaigns, workforce, treatment, and evidence-based programs.

Public Comment Period

No further public comments were given.