Collaborative in Healthy Parenting in Primary Care and *Parenting Matters* Stakeholder Meeting

On Tuesday, March 7, 2017, the Board on Children, Youth, and Families at the National Academies of Sciences, Engineering, and Medicine partnered with the Collaborative on Healthy Parenting in Primary Care in hosting a stakeholder action meeting on the 2016 report *Parenting Matters: Supporting Parents of Children 0-8*[1]. This meeting focused on engaging in a dialogue with stakeholder across sectors and disciplines on aligning supports for parents of young children, specifically to achieve the following objectives:

- bring together a range of stakeholders interested in supporting parenting, such as educators, health care providers, representatives from federal, state, and local agencies, and parents,
- explore how parents of young children are supported and engaged in primary care settings, schools, and through child welfare and social services,
- generate ideas together for specific approaches to coordinate and align parent engagement and support for parents across these settings and services,
- facilitate the development of specific individual or organizational action commitments to support parents, and
- connect stakeholders who may be interested in creating ongoing working relationships.

Dr. Thomas F. Boat, Cincinnati Children's Hospital Medical Center and Healthy Parenting in Primary Care Collaborative Member
Overview of the Healthy Parenting in Primary Care Initiative

Dr. Thomas Boat at Cincinnati Children's Hospital Medical Center and steering committee member of the Collaborative on Healthy Parenting in Primary Care began the day's discussion by introducing the Collaborative's overarching goal of improving the cognitive, affective, and behavioral health outcomes for children by enhancing parental support and nurturing through encounters in the primary health care system. The Collaborative emerged from the Forum on Promoting Children's' Cognitive, Affective, and Behavioral Health after its first workshop on Strategies for Scaling Effective Family-Focused Preventive Interventions to Promote Children's Cognitive, Affective, and Behavioral Health (2014), and is led by Dr. J. David Hawkins at the University of Washington. Dr. Boat emphasized that primary health care is a nearly universal touchpoint for families and children, with opportunities for early influence during prenatal visits, newborn exams, and twelve total visits in the first three years of a child's life. These visits provide physicians time to interact with the family in a trusted, non-stigmatizing setting in order to learn about issues the family experiences and to identify and provide proper supports to improve child and family outcomes.

Dr. Boat continued the discussion by asking if pediatric primary care is prepared to play a role in integrating preventive family-focused interventions. In his comments, he notes the following:

[1] http://sites.nationalacademies.org/DBASSE/BCYF/Parenting_Matters/index.htm

- While pediatric primary care has embraced the medical home model, it has been child-focused rather than multi-generational or family-focused.
- Anticipatory guidance is well entrenched in pediatrics, but without a focus on behavioral and social-emotional development.
- Interdisciplinary, integrated practice is nascent and health professionals need appropriate interdisciplinary and team-based training to align with this practice.
- Compensation is oriented to diagnosis and treatment rather than health promotion and prevention.

To move this work forward, the Collaborative engages in a number of activities, including:

- Identifying promising programs,
- Defining outcome measures,
- Addressing the return on investment of parenting interventions,
- Seeking an endorsement from the United States Preventive Services Task Force[2],
- Educating the general public, payers, policy makers, and health professionals on parenting in primary care,
- Developing a learning collaborative proposal that will support up to 15 primary care practice sites to integrate family-focused preventive interventions and stay connected over a period of three years in order to share learnings, and
- Engaging in preparing the workforce, which included a National Academies workshop on training the future child health care workforce (www.nas.edu/healthcareworkforce).

Partnerships with Other Sectors

Primary care may have the greatest opportunity to impact parenting of children in their first 2-3 years of life. From the beginning and particularly with increasing child age, primary care should partner with schools and community agencies to improve parenting and cognitive, affective, and behavioral health outcomes for children. Most children ages 6-8 interact only sporadically with the health care system, e.g., as a necessity for engaging in school sports and for illness or emergencies. Schools rather than health care systems may be the most opportune primary point of engagement for families. And while children with chronic illness regularly interact at all ages with the health care system, it is often with subspecialty providers, not primary care. As chronic disease is often associated with family stress, services must be made available to the entire family to mitigate risks and support the behavioral health of the patients, their caregivers and other children in the family.

Several resources that demonstrate the effectiveness of providing parenting and family-focused supports in primary care settings in order to improve children's cognitive, affective, and behavioral health outcomes are listed below:

Boat, T.F., M.L. Land, L.K. Leslie, K.E. Hoagwood, E. Hawkins-Walsh, M.A. McCabe, M.W. Fraser, L. de Saxe Zerden, B.M. Lombardi, G.K. Fritz, B.K. Frogner, J.D. Hawkins, M. Sweeney. 2016. *Workforce Development to Enhance the Cognitive, Affective, and Behavioral Health of Children and Youth: Opportunities and Barriers in*

[2] https://www.uspreventiveservicestaskforce.org/

Child Health Care Training. Discussion Paper, National Academy of Medicine, Washington, DC.

Briggs, R. D., Silver, E. J., Krug, L. M., Mason, Z. S., Schrag, R. D. A., Chinitz, S., & Racine, A. D. (January 01, 2014). *Healthy Steps as a moderator: The impact of maternal trauma on child social-emotional development.* Clinical Practice in Pediatric Psychology, 2, 2, 166-175.

Leslie, L. K., Mehus, C. J., Hawkins, J. D., Boat, T., McCabe, M. A., Barkin, S., Perrin, E. C., Metzler, C.W., Prado, G. Tait, F. Brown, R., and Beardslee, W. (October 01, 2016). *Primary Health Care: Potential Home for Family-Focused Preventive Interventions.* American Journal of Preventive Medicine: Supplement 2, 51, 4.)

Pantin, H., Prado, G., Lopez, B., Huang, S., Tapia, M. I., Schwartz, S. J., Sabillon, E., Brown, C. H., Branchini, J. (January 01, 2009). *A randomized controlled trial of Familias Unidas for Hispanic adolescents with behavior problems*. Psychosomatic Medicine, 71, 9, 987-95.

Perrin, E. C., Sheldrick, R. C., McMenamy, J. M., Henson, B. S., & Carter, A. S. (January 01, 2014). *Improving parenting skills for families of young children in pediatric settings: a randomized clinical trial*. Jama Pediatrics, 168, 1, 16-24.

Marshall "Buzz" Land, University of Vermont, American Board of Pediatrics, and Healthy Parenting in Primary Care Collaborative Member
Primary Care Perspective

"Weight, measurements, inoculations, feedings, check-ups for general health – these are important…but I feel the essence of such visits is really the exchange of feelings and insights."
T. Berry Brazleton, M.D., 1970

"I began to feel with young parents the burden of self-questioning that our society places upon them…so parents become tense about decision-making… children feel their parents' indecision, become anxious themselves, and we are perpetuating unnecessarily tense generations, with no joy in each other."
T. Berry Brazleton, M.D., 1970

"My concern as a pediatrician has been to find ways to dispel some of this destructive self-recrimination, to shore up parents so they can feel more adequate, can even learn to enjoy being parents."
T. Berry Brazleton, M.D., 1970

Although Dr. Buzz Land, from the University of Vermont and the American Board of Pediatrics, brought the perspective of a general pediatrician, his remarks throughout the day also reflected that of a teacher, a parent, and a grandparent.

Dr. Land described that the 1970s, the period in which he was in training, was a period of innovations and discoveries in medicine. It was a time of discovery of cures for cancer, treatments for infectious diseases, and new technologies in the care for premature babies. It was a time of innovations and discoveries in physical medicine; it was exciting. The focus in training therefore was on physical health, and what was not emphasized during this period, he noted, was the importance of the emotional and mental health of children and families.

There was some recognition of this gap. Dr. Land again referenced one of his mentors, Dr. T. Berry Brazleton when he stated that "what you as a pediatrician think is good for a child - and what you can do to effect that good - is almost meaningless unless you can establish a good relationship with parents". And it was also during this time the *Future of Pediatric Education Task Force Report* (1978) called for residency programs to provide more training in behavioral, developmental, and adolescent issues, to improve physicians' skills in working with other health professionals. One generation later, the *FOPE II Pediatric Generalists of the Future Workgroup Report* (2000) recommended that "extra training in children's mental health must be provided, particularly with respect to the initial assessment, diagnosis, and treatment of common childhood psychiatric conditions and the use of pharmacotherapy and other modalities."

Despite these voices, Dr. Land shared some familiar yet disconcerting numbers to provide context of the current state of children's behavioral health:

- 20 percent of children and adolescents in the U.S. meet diagnostic criteria for a mental health disorder,
- Half of adults in the U.S. with mental health disorder had symptoms by 14 years of age,
- Hospitalization for mental health conditions increased by nearly 50 percent for 10-14 year olds between 2006 and 2011,
- Between 2001 and 2011, childhood disability related to developmental or mental health conditions increased by 21 percent; the prevalence of disability attributable to physical health conditions declined 12 percent,
- Suicide is the second leading cause of death among 10-14 year olds, and
- 63 percent of children with behavioral or emotional problems had the onset of their problem at 7 years of age or younger, and as an indication that conduct disorders begin at an early age, preschool children are expelled from school at 3 times the rate of children K-12.

Based on these figures, Dr. Land emphasized that the key is prevention, early identification and early intervention.

Dr. Land also provided results from a recent survey from the American Academy of Pediatrics (2015[3]) that showed not all pediatricians are prepared to deal with this crisis:

[3] http://www.aappublications.org/news/2015/11/17/Research111715

- 65 percent of pediatricians say they lack training in treatment of children/adolescents with mental health problems,
- 40 percent report lacking confidence to recognize mental health problems, and greater than 50 percent report lack confidence to treat mental health problems,
- 70 percent report lacking time to treat for children's mental health disorders; 40 percent report reimbursement as a barrier to treating children's mental health disorders, and
- 44 percent of pediatricians in 2013 reported interest in receiving further education on identifying mental health problems in children, down from 65 percent in 2004, and 40 percent of pediatricians are interested in learning about treating, managing, and co-managing mental health disorders, down from 56 percent from 2004.

Still, pediatricians are in the best position to see children. The majority (90 percent) of children see pediatricians for well child visits during their first 5 years of life. Between ages 6-8, these visits decrease significantly; pediatric visits for early elementary students are commonly due to illness or injury. An important question to consider is how to better engage children and families in behavioral and emotional issues in health care settings during this important developmental period.

The American Board of Pediatrics (ABP) is working to integrate behavioral health services and family-focused interventions into every child's health care visit. To this end, Dr. Land stressed four initiatives of the ABP: to enhance education and training through robust training and assessments; to improve initial certification processes; to improve pediatrician's ability to address mental health in practice; and to link with other advocacy groups and efforts – and these four initiatives all involve engaging with and learning from parents.

Primary Care Advantage

- Longitudinal, trusting relationship,
- Family centeredness,
- Unique opportunities for prevention and anticipatory guidance,
- Understanding of common social-emotional and learning issues in the context of development, and
- Experience in coordinating with specialists in the care of children with special health care needs.

Improved Opportunities for Mental Health Care in a Medical Home

- Prevention and promotion: Screening, risk assessment
- Early intervention: Recognition; plan a diagnostic assessment
- Treatment: Alliance building; management, co-management, and community service provider referral

Dr. Land noted that primary care is only part of the solution and there is a need for partnerships and collaborations from different perspectives, including parents and families. There is a groundswell of interest in primary care and across disciplines in parent and family engagement in behavioral and mental health, and there is a need to do more. In a final note, Dr. Land reminded the stakeholders in the room that the key is to listen to parents in order to make them surer of

themselves and their decisions, which will make children feel surer of themselves. Pediatricians in primary care have both the opportunity and the obligation to see this move forward.

Dr. Richard P. Barth, School of Social Work, University of Maryland, and Parenting Matters Committee Member
Parent Engagement in Social Services and Child Welfare Services

Dr. Richard P. Barth at University of Maryland School of Social Work, opened his presentation by addressing the question "What do parents need?" He noted essential needs, the absence of which has been empirically shown to be associated with higher risk of child abuse and neglect, including: income support; adequate housing; strategies to safely manage family conflict; techniques for managing depression; strategies for family planning; the ability to understand the impact of responsive and positive parenting; and health care that points parents toward healthy behaviors. Dr. Barth also noted that in order to engage parents, it is necessary to provide help that feels like help to families. Many professionals provide help that feels right to them; it is important, however, to understand if this help aligns with the experience of the families.

Engaging Families
Dr. Barth discussed how Department of Social Services (DSSs) and Child Welfare Services (CWS) engage families. In this component of their work, they:

- help parents see the importance of their parenting role;
- engage parents in believing in the need for and possibility of change in their relationship with their child;
- help parents to be responsive by being actively involved in the family change effort;
- help families obtain sufficient program completion – and ensure programs last long enough to see change; and
- assist families in connecting to services provided by others, including mental health services and mentoring.

Exploring beyond a child's first years of life, Dr. Barth noted the types of engagement needed for children at the early elementary school age (ages 6-8). He touched on engaging parents in planning for supervision of their children, promoting the behavioral health of parents (including substance abuse services); engaging in responsive and non-coercive parenting; and obtaining health care and strategic support for implementing health care recommendations.

Who Engages with DSS and CWS?
DSSs (which operate Financial Assistance Programs like the Temporary Assistance for Needy Families [TANF] program) engage with about 4 million families a year, and despite growing needs, participation is decreasing due to confusion on what services and programs are available to families. DSS financial assistance programs focus on parents' participation in the labor force, yet Dr. Barth recognizes that this has an indirect impact on parent-child relationships. An important and often lost opportunity for families involved with DSS is that the DSS offices are also where families typically link to Medicaid for children and The Supplemental Nutrition

Assistance Program (SNAP)(, and their offices are a good setting for information/public awareness campaigns as well as resources for making paper referrals to other services.

CWS engages parents only in crisis, receiving 4 million calls annually that involve 7.2 million children. Nearly half of these calls are screened out without any parent engagement efforts, and nearly 40 percent of all children will have a CWS investigation in their lifetime. Most families receive no ongoing services. The CWS engagement with families is generally investigative with brief and episodic contact, thereafter. The child welfare workforce is beginning to train in motivational interviewing, yet the system in place is still prescriptive and correctional and unlikely to engage families in ongoing parenting classes or coaching.

Parents access parenting services and interventions through their engagement with DSS and schools, which have partnerships to family-focused community centers and grassroots organizations. School-based partnerships, specifically, may provide parent support and training groups and integrated student services that provide universal, targeted, and intensive supports.

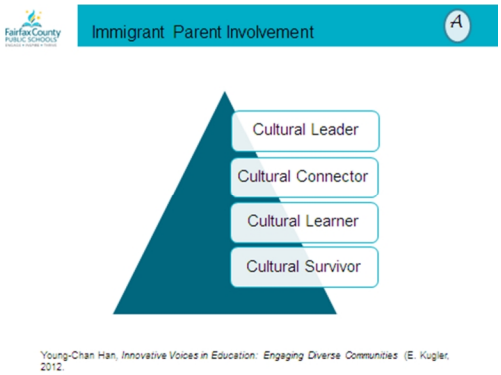
Moving Forward
To further the conversation, Dr. Barth identified ways in which the social services and the child welfare system can better engage and collaborate with parents. Some ideas are listed below:

- Implement universally available (if not having universal coverage) evidence-based parenting programs that do not require referral from CWS
- When CWS contact is made and no ongoing services are offered, provide a home visit by financial assistance program staff who can increase family's awareness and participation.
- Emphasize the Family Check-Up model which builds on the idea that to support a family's psychological wellbeing, families should be assessed, given some basic parenting instruction and checked back in with annually
- Integrate referral services from primary care for all families
- Screen families in primary care with options for non-child welfare system referrals that address all contributors to difficult parenting.
- Create a home for parenting engagement research and improvement in the federal government.

Robin Hamby, Fairfax County Public Schools, Office of Professional Learning and Family Engagement
Family Engagement: The "Reader's Digest" Version

What Does Engaging with Parents Mean in the Context of Schools?
Robin Hamby from the Office of Professional Learning and Family Engagement in Fairfax County Public Schools (FCPS) talked about the variety of programs, resources, and outreach that are offered to help families navigate FCPS, support learning at home and at school, and make important community connections. She started by discussing how school are transitioning from "parent involvement" to a more systemic school culture of "family engagement." Although Parent Involvement (PI) is part of family engagement (FE), PI more specifically refers to opportunities for parents to participate in a variety of school activities. FE refers to ongoing, goal-directed

relationships between school staff and families that are mutual, culturally responsive, and that support what is best for children and families both individually and collectively. FE must be systematic, integrated, and comprehensive. The benefits of family engagement in the schools are well documented. Outcomes include higher grades and test scores, better attendance, positive attitudes and behavior, greater enrollment in college, and benefits to parents from being involved.



Young-Chan Han, *Innovative Voices in Education: Engaging Diverse Communities* (E. Kugler, 2012)

Family engagement begins with school staff accepting and welcoming parents/families where they are. This includes where they are culturally, acculturation and education levels, life experiences, school perceptions, language, etc. Parent engagement goes on behind the scenes all the time: Nurturing, nourishing, providing for, checking backpacks, setting expectations, maintaining positive attitude, parenting practices, etc. When parents don't "show up" at school functions, it is easy to dismiss them as not caring. This is not the case, especially with our immigrant community.

In addition to the culture and personal experiences of parents some further challenges to parents actually coming to the school can be economic such as:

- Difficulty finding affordable child care,
- Inflexible work schedule; works long hours; works more than one job,
- Focus is on basic needs such as housing, food, health, safety,
- Lack of transportation, and
- Change in socio-economic status.

Or, language:

- Parents don't understand information sent home from school due to limited English or literacy.
- No one at school is available to answer questions in parent's first language.
- Interpreters are occasionally provide, but not always.
- Parents are embarrassed to request an interpreter or use headphones offered at programs.

When a school or school district clearly decides to invite parents to be partners in their children's education, we consider them a "partnership school": All families and communities have something great to offer-we do whatever it takes to work closely together to make sure every single student succeeds. (Henderson, Anne). A school creates and sustains this culture through policies and practices where parents are valued-assumptions are positive vs. deficit model of parent involvement. (Constantino, Steve)

Karen Mapp's three part Joining Process says that for parents to be involved in their child's school, the school community:

- Welcomes parents into the school,
- Honors their participation, and
- Connects with parents through a focus on the children and their learning.

Welcoming and Communicating Effectively

Fairfax County Public Schools offers:

- Getting to Know FCPS: A Parent Orientation
- Welcome Center and Registration (satellite sites)
- Community Liaisons and English Language Learner Family Partnerships Specialist at registration sites
- School-based Parent/Family Centers
- Welcoming Atmosphere Walk Throughs
- Parent Information Phone Lines (English plus 7 languages)
- Multicultural outreach and parent panels for professional development
- Various TV channels and programming for parents (including "In Other Words")
- Various social network sites

Supporting Student Success

Fairfax County Public Schools offers:

- Volunteer Programs
- Home Visits
- Family Engagement Region Representatives (central office staff working with schools)
- Parent Liaisons
- Early Literacy Parent Education Program and HIPPY (Home Instruction for Parents of Preschool Youngsters)
- Immigrant Family Reunification Program
- School–based parent centers
- Parenting Education Workshops and Classes
    - One time seminars
    - Comprehensive parenting programs, such as Parent Project®, Active Parenting, Parents as Educational Partners (PEP)
- Parent Resource Center (central based library and extensive workshop program)
- Family Literacy Programs (on-going, comprehensive parents + children)
- Study skills programs
- Enhanced ESOL programming
- Head Start preschool program (strong parent component)

Sharing Power and Connecting to the Community

Fairfax County Public Schools offers:

- Connections from families to school and community resources (counselors, parent liaisons, social workers, community liaisons, etc.)
- Leadership training/capacity building (ongoing leadership program for post Early Literacy parents and Family Literacy parents)
- Community partnerships/leveraging resources
- Neighborhood Colleges in partnership with Neighborhood and Community Services, Fairfax County government

Dr. Heather Johnson, Graduate School of Nursing, Uniformed Services University of the Health Sciences
Parent Engagement: A Parent's Perspective

Dr. Heather Johnson is a nurse practitioner, an educator, a student, wife, and a mother. She has two children, a son and a daughter. At this meeting, Johnson spoke of her role as a mother of a child with special needs and how what she has learned over the last 13 years has informed what and how she teaches her students and how she works with families to engage them in their advocacy and care for their children.

Dr. Johnson noticed that her son was not developing language skills as other children were at 15 months of age. The guidance she received from his pediatrician was "Watch and wait". Dr. Johnson noted in the discussion that "Watchful waiting is no longer the standard of care." At 18 months, she discussed this with her pediatrician again, only to hear the same advice. She then connected with Babies Can't Wait[4] through Georgia's Department of Public Health, a resource she had been aware of through her role as a nurse practitioner. Babies Can't Wait evaluated her son within one month and determined that he needed speech services. This was the beginning of her journey navigating through the complex systems and services across the health and education sectors in her role as a parent.

During the last 13 years, Dr. Johnson has experienced a crash course on a range of topics related to the health of her son – specifically, on health services, interventions, insurance programs, filing claims, appealing claims, developmental disabilities, special education, and law. Her vocabulary expanded to include terminology related to behavioral health, education services, policy, and funding. Dr. Johnson was prepared, willing, able, and educated. She was willing to ask questions, advocate for her son, and thus learned how to navigate the system and identify resources.

The expertise Dr. Johnson acquired over the course of her journey led her to become an essential resource for families who faced similar experiences. In her role as a parent educator, she shared advice with parents that allowed them to advocate for their children. She gave permission for parents to accept autism as a diagnosis in order for them to receive services, since as she stated, "it's not about the diagnosis, it's about the services they can get." In addition, she helped parents ask questions of the professionals and practitioners working with their children rather than accepting services and educational plans on blind faith. For parents and families who did not feel empowered to ask questions without feelings of intimidation or fearing retribution, she provided guidance and tools – because unfortunately, as she noted, while there are resources available for families and practitioners, they are sometimes difficult to find and access.

The journey has been far from perfect, Dr. Johnson noted, and it is ongoing. However, she and her family have strived to turn the obstacles and roadblocks they have experienced into building blocks so both children can become collaborative, independent contributors to their community.

[4] http://dph.georgia.gov/Babies-Cant-Wait

Working Group Exercises

During the meeting, stakeholders were asked to identify action steps around the following areas:

- Delivery Points for Implementation/Referral
- Workforce Training
- Guidance for Delivery Service to Increase Access
- Toolbox for Parenting Engagement/Joint Decision Making

Note that action items that did not fit into one of these areas are labeled "other." Below is a brief summary of the participants' brainstorming efforts.

Delivery Points for Implementation/Referral

1. If pilot is successful, test in an array of settings/communities
    - Augment information flow about the needs and resources of individual families
    - Share information among preschools, schools, social services, home visitation, and health care
    - Test in a pilot study of feasibility and benefits of obtaining parent consent for information sharing among parenting programs
2. Refugee parent engagement
    - Needs survey (do they have essentials, what's lacking, what's needed, what's level of trauma, help prioritize supports available)
    - Connect with social service and education agencies
    - Create cross-sector liaisons to facilitate program directors, connect their work and those they serve
3. Develop a standardized framework for delivering services to incarcerated parent (i.e. deliver a baseline of best practices consistently across the nation)

Guidance for Service Delivery to Increase Access

1. Supporting methods that will make warm referrals more effective
    - Co-location
    - Data sharing
    - Joint/shared funding
    - Relationships
2. Many families need wrap around assistance to improve family functioning but one organization can't do it all. Make it easy for parents to follow up on warm referrals.

Workforce Training on Supporting Parents' Knowledge/Practices

1. Development of Parent Community Health Workers to work in FQHC's
    - Serve health education/literacy/advocacy role for parents and children
    - Would build human capacity with a low-income community for health advocacy and leadership while supporting parenting
2. Integrate parenting curriculum into Family, Women's Health and Psych-Mental Health NP programs.
    - Need curriculum
    - Materials and evidence-based interventions
    - Timing to be performed during a visit

- Brief, tiered, evidence-based intervention

1. Partnership to help parents in parenting programs to address their traumas, support their efforts to overcome and heal
    - Develop models and train professionals for delivery
2. Dissemination of universal, evidence-based parenting practices through a free, online portal, akin to Early Edu (formerly Head Start University) that is administered through the Federal Early Childhood TA system
    - Practitioners from analogous sectors (such as adult behavioral health clinicians) would be able to access this content
    - Training grants, such as the ones administered by HRSA (for healthcare professionals), for development of curricula content on parenting administered in pre-service training programs
3. Interprofessional graduate coursework for nurses, doctors, social workers, and others to learn parent engagement, brief screening, and core elements of parenting interventions.
    - Video materials for social service agencies that demonstrate parenting practices (like the Boston Basics)
4. Parent leaders to help other parents with information about resources to help their children

Toolbox for Parenting Engagement/Joint Decision Making

1. Develop a "home" for ideas/programs/tools/measures that is available to the network of stakeholders
    - Partner pediatrics, nursing, nurse practitioners, psychologists, schools, advocates, parents, psychiatrists, juvenile justice system etc.
    - Develop appropriate website/tools – person/organization to manage
2. Electronic National Clearinghouse or Index of Resources and Programs along the Parenting Continuum
    - Parenting Support → Parent Education → Parent Advocacy → Parent Leadership

Other

1. HHS Father-Parenting Engagement Review
    - Review what HHS programs are doing to engage fathers with a specific focus on parenting programs; possible next steps
    - Identify key information to collect from each program, offices/people to engage
    - Pull together findings and recommend some next steps
2. Publish the Stepped Care Model for Mental Health Promotion for Parenting in Primary Care
    - Identify key components of parenting program for an online course.
3. Promote integration of self-regulatory interventions into health platform (e.g. mediation, mindfulness, yoga, breastfeeding) as first live treatment to increase functioning, connection and self-regulatory capacity.
    - Exercise, diet/nutrition, and sleep as core interventions for well-being and self-regulation
4. Facilitate partnerships between social service providers, health networks and school systems.
    - Cross-train and inform each about the services and resources of others

- Identify collaboration points for all agencies that are introduced to each other.
- Develop formal agreement, information memoranda or guidance document on joint projects.
- Share informational resources to distribute to families.