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REPORT

Building Strong Systems of Support for Young Children's Mental Health

Key Strategies for States and a Planning Tool

Sheila Smith | Shannon Stagman | Susan Blank | Christine Ong | Kendra McDow

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NCCP

National Center for Children in Poverty
Mailman School of Public Health
Columbia University

The National Center for Children in Poverty (NCCP) is a leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

BUILDING STRONG SYSTEMS OF SUPPORT FOR YOUNG CHILDREN'S MENTAL HEALTH
Key Strategies for States and a Planning Tool

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Introduction

Young children's mental health provides an essential foundation for early learning and development. In the early years, children's mental health can be seen in a wide range of behaviors that promote engagement in social relationships and learning. An infant who joyfully participates in "conversation" with parents is acquiring a capacity for strong social relationships while learning language and the patterns of communication. A toddler shows positive mental health by actively investigating her environment while gaining new cognitive and motor skills during play and exploration. A preschooler who helps his friend build a robot, shares his favorite markers, and rebuilds his block tower after it tumbles is learning social and problem-solving skills that will fuel learning in preschool and beyond. In sum, young children's "mental health" refers to emotional well-being and positive social development from birth through age 5.[1]

Young children with mental health problems miss out on developmental experiences that promote early learning. The behavior problems of some children result in actual expulsion from early care and education settings.[2] For other children, mental health problems and challenging behavior may limit positive engagement in learning by contributing to conflictual relationships with teachers and classmates.[3] Young children experiencing sadness or anxiety may find it hard to fully participate in growth-promoting play and learning activities. At home, young children with problem behaviors may be caught in a cycle of negative interactions with parents that disrupt a nurturing parent-child relationship and further limit support for the child's healthy development.[4]

What's Inside…

This report describes key strategies for creating a comprehensive system of supports for young children's mental health and provides examples from states using these strategies. It also includes a tool that state planners can use to assess progress and plan steps toward building a strong system of early childhood mental health supports.

Recent estimates suggest that between nine and 14 percent of children under age 6 experience emotional and behavioral problems.[5] The prevalence of mental health problems is markedly higher for children in families facing economic hardship and other stressful circumstances, such as maternal depression.[6] In the absence of interventions, mental health conditions that emerge in the early years tend to persist and interfere with healthy development and learning.[7]

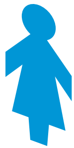
State leaders increasingly recognize the critical link between young children's mental health and later social adjustment and success in school. In recent years, states have begun to develop new policies and programs that help establish supports for young children's mental health across a wide range of settings, including pediatric offices and community clinics, early childhood and home-visiting programs, and child welfare agencies.[8] These efforts focus on promoting positive mental health, preventing potential mental health problems, and treating identified delays or difficulties in social-emotional development. Many states' efforts include the use of evidence-based models and training experiences for service providers to increase their knowledge and skills.

Part I of this report describes key strategies that should be part of a comprehensive system of supports for young children's mental health and examples from states that are developing and implementing them. These strategies are:

- promoting early childhood mental health (ECMH) in home visiting and parenting programs;
- enhancing supports for ECMH in early care and education programs;
- screening parents for depression;
- screening children for social-emotional problems;
- developing a better-trained workforce to address the social-emotional needs of young children;
- using evidence-based practices and evaluation to promote effective ECMH programs; and
- supporting the well-being of exceptionally vulnerable children.

Part II of this report presents a simple tool that state planners can use for two purposes: 1) to assess the current status of the state's ECMH supports; and 2) to plan for specific enhancements in the state's current system, including expansion of certain ECMH strategies, such as child screening or training for early childhood teachers, and improvements in the quality of interventions. Since the creation of strong systems of ECMH supports requires collaboration among multiple agencies and programs, this tool may be especially useful for Early Childhood Advisory Councils, Early Childhood Comprehensive Systems initiatives, and similar state-level planning entities that bring together leaders from different sectors.

PART I
Key Strategies



Promoting ECMH in Home Visiting and Parenting Programs

Home visiting and parenting programs offer unique opportunities to address young children's mental health needs. Through outreach and targeting of services, these programs can reach infants, toddlers, and preschoolers at high risk of mental health problems due to family economic hardship and other risk factors. While varied in their scope and content, these programs typically aim to promote nurturing parent-child relationships and healthy child development beginning very early in life. In this section we describe Louisiana's use of mental health consultants in the Nurse Family Partnership home visiting program. We also describe North Carolina's use of an evidence-based parent training program, Incredible Years, in community-based parenting programs.

Louisiana's Use of Mental Health Consultants in the Nurse-Family Partnership Program

Louisiana has been operating a *Nurse Family Partnership (NFP)* home-visiting program since 1999.[9] *NFP* is a nationally recognized, evidence-based program that serves first-time mothers living below 200 percent of the federal poverty level.[10] In Louisiana, *NFP* is funded through the federal Maternal and Child Health Bureau Block Grant, Medicaid, the Temporary Aid to Needy Families (TANF) program, state general funds, and some private foundation support. Currently 16 *NFP* teams operate in 52 of the state's 64 parishes. The teams annually serve about 3,000 women with infants, approximately 14 percent of eligible families in Louisiana. A typical *NFP* team consists of eight nurses and a supervisor. Each nurse carries a caseload of 25 clients. At present, the state is able to assign a half-time mental health professional to half of these teams.

The mental health consultants offer guidance to the *NFP* team and also work with individual clients. By offering this support to the *NFP* teams and the families they serve, the state hopes to address two concerns. First, the state has a shortage of mental health providers who can provide prenatal and infant mental health services to families. Second, many families face obstacles to seeking mental health services, including transportation difficulties, fears about mental health services, and the stigma associated with seeking these services.

The *NFP* mental health consultants address a wide range of mental health problems that can affect the mother's ability to provide safe and nurturing care to her infant. The problems include major mental illnesses such as depression, anxiety, and less frequently, psychotic disorders. Parenting problems related to the mother's own history of abuse and neglect as well as current family discord, violence, and instability are also reasons for consultation. Consultants are available during case conferences to offer guidance to the *NFP* teams. Topics that a consultant might discuss with a team include indicators of depression, how to respond to aspects of parent-infant interactions that cause concern, and strategies for working with clients who resist additional mental health support that they may need.

The mental health consultants spend about half to two-thirds of their time providing direct, home-based services to *NFP* mothers whom the nurses think would benefit from this intervention. If a mother agrees, the nurse introduces the consultant to the client and the consultant can then schedule a separate time to provide further assessment and services such as guidance on caregiver-infant

interaction or psychotherapy. The number and length of visits as well as the type of interventions provided are tailored to the needs of the mother and child. The consultants also help the *NFP* teams access appropriate psychiatric or other supportive services for their clients when it is determined that these services are needed and available. The consultants work closely with the nurses and supervisors to ensure that the services to which the women are referred are accessible and coordinated.

The federal Maternal and Child Health Services Block Grant is the primary source of support for the consultants, along with some private foundation funding. Due to limited funds, the state has been unable to make mental health consultation available to all *NFP* teams. However, one of the *NFP* teams has recently secured support from a community funding partner to enable a psychiatrist specializing in perinatal services to work four hours a week with the team's clients, adding to the support provided by the mental health consultant. Team members welcome this enhancement because the psychiatrist has expertise treating women who are pregnant or have just given birth; it is anticipated she will be able to prescribe and monitor medications when needed, or provide consultation to physicians in the community who are providing medication management for *NFP* clients.

The mental health consultants are mostly licensed mental health professionals who have experience working with children and families. Once consultants begin work with families, they are given intensive in-service training in assessment and treatment of perinatal and infant mental health issues through the Tulane Institute of Infant and Early Childhood Mental Health.[11] Topics covered include assessment of infant-parent relationship difficulties and evidence-based treatments for these problems, identification and treatment of perinatal depression, and the impact of exposure to trauma on parents and infants. Consultants receive this training over approximately nine months for a total of 128 hours of on-site training with Tulane Institute faculty. In addition, ongoing weekly supervision is provided by the *NFP* clinical director or an experienced *NFP* mental health consultant.

The Incredible Years Parent Training Program in North Carolina

A version of *The Incredible Years (IY) Parent Training Program*, designed for parents of young children, is being implemented in 19 organizations statewide in North Carolina.[12] The intervention, *IY Parent Training Program: BASIC-Early Childhood*, is an evidence-based model that targets parents of children between the ages of 3 to 6 who are experiencing behavioral difficulties. Through a series of 14 interactive group sessions led by trained facilitators using a standardized curriculum, parents learn about positive parenting strategies to promote children's social-emotional competence and reduce challenging behaviors.[13] The program is being implemented in community-based organizations that have experience serving parents with young children.

The North Carolina Alliance for Evidence-Based Family Strengthening Programs has supported the planning and funding for statewide implementation of the *IY Parent Training Program*. This Alliance is a coalition of public and private funders, state agencies, and other partnerships and organizations committed to evidence-based practices that support families and children's healthy development. An important feature of the state's efforts to promote the use of the *IY Parent Training Program* is its focus on high-quality implementation of the model. *Prevent Child Abuse North Carolina*, a statewide nonprofit organization, provides technical assistance and coaching to the facilitators who lead sessions in the *IY Parent Training Program* to help ensure that they are well-trained in the curriculum and able to deliver it effectively.

Prevent Child Abuse North Carolina also assisted community organizations that implemented the *IY Parent Training Program* in eight sites across the state that participated in a 2008-2009 pilot demonstration sponsored by *Smart Start*, a member of the Alliance. *Smart Start and the North Carolina Partnership for Children* is North Carolina's system of local partnerships in which stakeholders and organizations work to build stronger supports for

young children's healthy development. In the *IY Parent Training Program* demonstration, the parent training sessions were led by facilitators who had received training from the *IY* national office. Almost half of the families participating in pilot sites had incomes below $30,000. Results of a rigorous evaluation showed a significant decrease in children's problem behaviors and an increase in positive parenting behaviors.[14]

An important goal for *Prevent Child Abuse North Carolina*, *Smart Start*, and other members of the Alliance is to build an even stronger infrastructure of supports for the *IY Parent Training Program* so that it can be implemented more widely while maintaining fidelity to the evidence-based model. A key element of this infrastructure will be a cadre of both certified facilitators who lead the parent training program and certified coaches. *IY*-certified coaches are facilitators who have extensive experience effectively delivering the program, and who can support other facilitators to deliver the model with a high degree of fidelity. Because it takes time and resources for facilitators to become certified, this process will extend over several years.

The *Incredible Years Parent Training Program* in North Carolina is funded by private foundations and public agencies and partnerships belonging to the Alliance, including the Division of Social Services (DSS), the Division of Public Health, and *Smart Start*. Support from The Duke Endowment and DSS is focused on helping the state build the infrastructure of training and technical assistance that will ensure high-fidelity implementation of this program.

In the next fiscal year, a more in-depth coaching model will be implemented by *Prevent Child Abuse North Carolina.* This model, developed in collaboration with the IY national office, will include pre-implementation support to the local organizations and stakeholders involved in the delivery of the IY program, initial coaching, and an assessment of program fidelity. Following the fidelity assessment, organizations will receive additional assistance, including coaching that provides a video review of the facilitator leading a session and the chance to participate in regional consultation meetings that focus on complex areas of practice. This model will also support an ongoing evaluation using instruments suggested by the national office (for example, standardized surveys assessing parenting and child behavior).

Enhancing Supports for ECMH in Early Care and Education Programs

More than 11 million infants, toddlers, and preschoolers are in early care and education settings, including home-based and center-based child care, Head Start, and prekindergarten programs.[15] It is clear that large numbers of young children can benefit from strong supports for mental health in these settings. Research suggests that interventions aimed at supporting young children's social-emotional growth and mental health in early care and education settings can reduce expulsion due to behavior problems, decrease challenging behavior, and increase children's social-emotional competence. Promising approaches include early childhood mental health consultation, training of teachers and child care providers that is focused on strategies for supporting young children's social-emotional growth, and curricula that provide explicit supports for social-emotional learning.[16]

Early childhood mental health consultants typically help teachers learn strategies for promoting children's social-emotional growth and reducing challenging behaviors. Consultants may focus their work with teachers on building supports for all children in the early childhood setting, on addressing the needs of individual children, or on both. They may also work directly with children and parents.[17] Training for teachers and providers in the area of social-emotional growth is highly varied in format and scope. This training may range from one-time workshops to more intensive on-site assistance to help a teacher or provider practice new skills in

promoting children's social-emotional development. Sometimes group training is linked to on-site coaching. There is growing evidence that teachers need more than brief workshop-style training to acquire complex new skills and to apply them in early care and education settings.[18] Another strategy, implementing a social-emotional curriculum, can help teachers provide intentional supports for social-emotional learning through read-alouds, small-group activities, and explicit instruction. Examples of social-emotional curricula that have been found to promote young children's social-emotional competence and positive behavior include Dinosaur School and PATHS.[19]

This section highlights approaches used in four states to integrate supports for early childhood mental health into early care and education settings: mental health consultation in the early childhood programs of Arkansas and Connecticut; Ohio's use of the Program for Infant/Toddler Caregivers to train infant-toddler care supervisors, specialists, teachers, and home-based care providers; and Colorado's implementation of the Pyramid Model developed by the Center for Social-Emotional Foundations of Early Learning.

Arkansas' Early Childhood Mental Health Consultation Project

Arkansas currently fields three teams of mental health consultants who offer their services to the state's licensed child care programs.[20] Each team works with up to seven centers of varying sizes, dividing up the centers among consultants. Most consultants are masters- or doctorate-level professionals and may work part-time on a team. Consultants work with programs, individual children, and sometimes with parents. Activities include screening children for behavioral concerns and protective factors; formal observations of the classroom environment; teacher training, including assistance in designing classroom activities to strengthen children's social skills; and work with teachers and parents to develop plans to address behavior problems of individual children.

The consultant teams are based in three of the state's community mental health centers in the northern part of the state. Each team sends outreach letters offering assistance to licensed programs. For programs that request it, consultation is currently structured as a year-long partnership with a center. The teams work annually with an average of 80 program staff, including lead and assistant classroom teachers and center directors. The consultation initiative is supported by the quality improvement dollars in the federal Child Care and Development Block Grant.

The consultants within each team meet regularly to discuss their work and exchange peer-to-peer support. Often, one team member has specialized knowledge and can help another consultant develop an intervention plan for a child. The initiative's director is also planning to convene monthly meetings that will provide additional supervision and peer support to the consultants by bringing members of all three consultant teams together to share experiences and expertise.

The program, which began in 2004, initially served Head Start programs and Arkansas Better Chance (ABC) programs, the state's prekindergarten programs for children at high risk of school failure. Since 2008, services have shifted to licensed child care providers who typically have fewer resources than Head Start and ABC programs. Currently in a planning year, the consultation initiative is anticipating an expansion to new areas of the state in 2011. Since this expansion may include services to a wide range of early care and education programs, planners wanted to gain experience with child care programs. In addition, the state hopes to add one or two consultants who could serve exceptionally vulnerable children, such as children in foster care who are at risk of losing their child care placements due to behavior problems.

Evidence from the first three years of a nearly-complete evaluation conducted by the University of Arkansas for Medical Sciences/Partners for Inclusive Communities indicates that teachers who received these consultation services displayed

higher levels of sensitivity compared to teachers who had not worked with the consultant teams. By the third year of the project, children at the intervention sites scored higher on teacher ratings of protective factors and were rated by teachers as having fewer behavioral problems compared to children in other settings. A report of evaluation results will be available in 2011.[21]

Connecticut's Early Childhood Consultation Partnership

Connecticut's statewide Early Childhood Consultation Partnership (ECCP) offers mental health consultation to the state's early care and education programs, including licensed center-based and home-based child care, Head Start, and Early Head Start.[22] The consultation services are intended to strengthen these settings' social-emotional environments and promote the social-emotional and behavioral health of the children served in the settings. ECCP is funded through Connecticut's State Department of Children and Families, with dollars appropriated by the state legislature. The initiative is managed by Advanced Behavioral Health (ABH®), a nonprofit behavioral health care management organization.

To operate ECCP, ABH subcontracts with 10 non-profit behavioral health clinics for the services of 20 Early Childhood Mental Health Consultants. The ECCP services can be requested by center directors, teachers, home-based providers, or families. Within any setting, a consultant might help teachers or providers learn to respond effectively to children's challenging behavior or help improve the emotional climate of a classroom or home-based setting. Consultation focused on individual children often aims to help teachers and parents work in partnership with one another to address a child's behavioral and social-emotional difficulties.

The duration of the consultation services averages six weeks for a child, 14 weeks for a classroom, and nine months for a center. Rather than expecting the maximum amount of progress to occur during the consulting period, consultants work with teachers and families to build their capacity for positive change and problem-solving beyond the time of the consultation. In the state's fiscal year 2010, ECCP provided mental health consultation services to 188 classrooms and child-specific consultations to 375 children. Consultation services to home-based providers typically focused on individual children and comprised a relatively small portion of ECCP's activities.

ECCP uses a mix of strategies to balance the demand for the services with the supply of consultants. If consultants are working at capacity, programs that request their services can be placed on wait lists, with the waiting periods typically lasting no longer than three months. To support programs or classrooms until the service begins, the teachers and directors who requested the consultation are invited to attend a monthly consultation group that an ECCP consultant offers in their local areas. Because it is usually important to address the problems that trigger requests for child- and family-specific consultations as soon as possible, ECCP tries to avoid wait lists for these individualized services. Instead, if a consultant in one area of the state has a full caseload, another consultant who is in close proximity to the child or family is assigned to the case.

ECCP consultants are masters-level mental health clinicians. New consultants participate in an intensive orientation and training process with sessions held twice a week over a period of six months. This training is comprised of six modules developed by ECCP that cover such topics as the role of the consultant, early childhood and social emotional development, early care and education settings, and community systems and resources. In a module on assessment and observation, consultants learn to administer the Classroom Assessment Scoring System (CLASS) and child assessments, such as the Child Behavior Checklist.[23] The CLASS is an observation-based classroom assessment that focuses on the quality of teacher-child interactions, including teachers' provision of emotional support.[24] Training methods include the use of vignettes, videos, and small-group discussions. Consultants are also offered follow-up in-service training, organized

around six additional training modules, some offering more in-depth treatment of topics in the initial training; topics for these modules include atypical development – advanced, preschool classroom and child strategies, and infant-toddler classroom and child strategies. During the orientation phase, consultants receive individual supervision every other week, while established consultants are given individual supervision for two hours once a month. In addition, all consultants meet together for an ECCP staff meeting every three weeks, and as part of this meeting, receive small-group supervision.

ECCP's centralized information system, designed and managed by ABH, generates data on a wide variety of topics, including the demographics of the classrooms or programs that consultants serve, the kinds of activities consultants are engaged in, assessment results, the child behaviors that prompt referrals to mental health and other services, and the content and duration of training for consultants. The system produces reports on the progress of individual children, action plans for classrooms and centers, and reports on referrals, including type of referral and projected start date, and initial follow-through by family. The system can also generate reports on the operation and outcomes of the entire ECCP project.

Six-month follow-up data show that 92 percent of classrooms that were served demonstrated improvement in the overall quality of care, based on assessments with portions of the CLASS[25] conducted by consultants before and after consultation. In addition, a rigorous evaluation conducted by the Yale Child Study Center in 2007 showed that the program reduced classroom behavior problems in children.[26] Most recently, a 2009 Georgetown University study, "What works? A study of effective early childhood mental health consultation programs," designated ECCP as one of six evidence-based best-practice models in the country for mental health consultation services. [27]

Ohio's Implementation of the Program for Infant/Toddler Care

The Program for Infant/Toddler Caregivers (PITC) emphasizes responsive, relationship-based caregiving that provides a foundation for infants' and toddlers' social-emotional growth.[28] PITC can be used in direct training and coaching activities with teachers and providers who work with infants and toddlers. The program is also used to train infant-toddler specialists, college instructors, and program supervisors to use PITC in their work with infant-toddler caregivers. Through train-the-trainer models and other activities, WestEd, a nonprofit organization that developed PITC, has helped Ohio and other states use PITC to raise the quality of infant-toddler care while embedding strong supports for infants' and toddlers' social-emotional growth in this care.

Ohio has been a leader in efforts to use the PITC approach to enhance the quality of the state's infant and toddler care settings. This work began in 2004 when the Ohio Department of Job and Family Services (ODJFS) launched the First Steps initiative, convening a group of 75 early childhood practitioners, mental health specialists, advocates, and other leaders to consider how the state could do more to support the development of infants and toddlers. In two one-week sessions, WestEd staff oriented First Step participants to PITC concepts by presenting the entire series of PITC training modules.

One of the most important outcomes of First Steps was the unprecedented alliance of early childhood professionals from 71 Ohio agencies and organizations serving infants and toddlers. These professionals joined with faculty from WestEd to develop and publish *Ohio's Infant Toddler Guidelines*.[29] Based on PITC principles, *Guidelines* describes six domains of infant and toddler development at different ages, including social and emotional development. This information is presented in simple language, using the "voice" of infants and toddlers, along with guidance about how to support development in each domain (see box). *Guidelines* has been widely disseminated to early childhood service providers,

Excerpt from Ohio's *Infant and Toddler Guidelines* Birth to Eight Months

During the early days and months of my life, I am primarily focused on security. I am learning about what I can expect from life.

When I feel discomfort, I cry. Someone comes to help me. She helps me – when I'm hungry – when I'm tired – when I'm out of sorts.

When she helps, I feel everything is going to be all right, and I can relax. I like to look at her face. I like to listen to her voice. I feel her warmth. I feel the care she gives me – time after time. I feel content. I coo. As I get older, I smile when I see her face and hear her voice. I try to make the sounds she makes. Her responses make me feel so good. I've learned to expect her to come when I call.

I often don't have to cry. She knows what I need by watching me and by listening to me. She puts me in places where I can move around. That's exciting! I can count on her to help me when I need help and to play with me when I'm ready to play.

All of this is very important! I have to feel emotionally secure in order to have the confidence to learn new things. My level of confidence will influence how I approach the opportunities coming my way. I know it seems like a long way off, but my ability to take chances and adapt to change will allow me to be successful in both school and in life.

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community college instructors, mental health specialists, and pediatricians around the state.

Working in collaboration with ODJFS and WestEd, the coordinator of the Infant Toddler Specialist network and this network's specialists created two levels of training courses based on PITC. The first level, *Guidelines Training*, covers the basics of infant and toddler development in six modules related to Ohio's *Infant-Toddler Guidelines,* and was launched in 2006. Typically offered in child care resource and referral agencies or other group settings, these trainings are open to all center-based and home-based infant-toddler caregivers. While there are no data currently available on the mix of home-based and center-based providers who have used the trainings, anecdotal evidence suggests that home-based caregivers are fairly well represented among trainees. Building on the *Guidelines* training, Ohio's more advanced PITC-based training sequence, known as *Best Practices*, focuses on how caregivers can apply the principles of infant and toddler development to their work. Training topics in this sequence include understanding temperament, observation and assessment, and guidance and discipline. Most participants in this training are staff from center-based programs.

The state's 24 infant-toddler specialists, who are based in local child care resource and referral agencies, also work to embed the PITC approach into practice. Their work is supported by the infant-toddler set-aside funds for quality improvement activities in the federal Child Care Development Block Grant. The state sponsors all of these specialists to become certified PITC trainers. To earn certification, specialists participate in four intensive training modules offered by WestEd, one of which is focused on supporting infant-toddler social-emotional development. The specialists must also write a paper for each module that describes both the content and methods they will use to train infant-toddler caregivers. Ohio's infant-toddler specialists must become certified in all four modules within six months of employment.

Once the specialists have earned certification, they offer *Guidelines* and *Best Practices* training to teachers and caregivers around the state. PITC also guides the on-site technical assistance the specialists provide to programs that are working to increase their ratings in Step Up to Quality, the state's Quality Rating and Improvement System (QRIS) for early care and education programs. While this on-site assistance is available to larger home-based programs, relatively few home-based providers currently participate in the state's QRIS. In another application of PITC, Ohio requires that all infant-toddler teachers and providers at QRIS-rated programs (approximately 25 percent of all programs in the state) take at least 10 hours of *Guidelines* training, which is equal to participation in four out of the seven modules. In fact, most of these teachers and providers complete all seven training modules because that is a prerequisite for training offered in the more in-depth *Best Practices* Series.

While there has been no full-scale formal evaluation of PITC training in Ohio, the state uses feedback from surveys of trainees to assess the usefulness of the training and to refine training practices. Currently, Ohio is exploring the possibility of using learning communities to support the professional development of its infant-toddler care providers. Learning communities involve peer learning experiences, which might include child care providers' initial discussion of certain aspects of infant and toddler social-emotional development, trying out strategies to promote development in these domains, and reconvening for group reflections on how well the strategies worked. If that approach is taken, the state intends to conduct a formal evaluation of whether learning communities make a difference in classroom practice. Because PITC-related training would be central to the learning communities, this training would be a focal point of the evaluation.

Colorado's Pyramid Plus: The Center for Social Emotional Competence and Inclusion

Colorado's supports for the well-being of young children have recently been strengthened by *Pyramid Plus: The Center for Social Emotional Competence and Inclusion.*[30] Established in 2009, this Center is an institutional home for training, technical assistance, planning, and information dissemination that aims to promote the use of several evidence-based approaches to caring for and educating young children in early childhood settings throughout Colorado.

One approach that is central to the work of Pyramid Plus is the *Pyramid Model for Promoting Social and Emotional Competence in Young Children*. This model was developed by the Center on the Social and Emotional Foundations of Early Learning (CSEFEL), a national organization that disseminates research, information about evidence-based practices, and training resources to early childhood programs around the country.[31] The three bottom tiers of the Pyramid Model show elements that should be part of all early care and education programs and that promote the positive mental health of all young children; these elements that form the foundation of the pyramid are "*an effective early childhood workforce*, *nurturing and responsive relationships,* and *high-quality supportive environments*." In the middle tier, "*targeted social-emotional supports*" help higher-risk children acquire social-emotional competencies, including skills in getting along with peers and managing negative feelings. The third and top tier – "*intensive intervention*" – consists of individualized approaches for children with serious and persistent behavior problems.[32]

Since 2007, Colorado has been one of a group of selected states that CSEFEL has partnered with to conduct an evaluation of the Pyramid model and CSEFEL's training resources. Approximately 400 early care and education providers that are participating in the evaluation have received training from CSEFEL. Results of this evaluation, which will assess program, teacher, and child outcomes, will be available in 2011.[33]

A central goal of Colorado's Pyramid Plus Center is to scale up high-fidelity use of CSEFEL's Pyramid Model and training modules. The Center is currently developing a cadre of certified trainers and coaches who will be available to provide on-site training and mentoring in early care and education

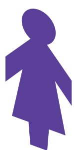
Pyramid Model*

* Reprint with permission from the Center on the Social and Emotional Foundations for Early Learning.

programs throughout the state. The certification process was developed by the Center. Candidates for certification participate in multi-day training events, create their own professional development plans, participate in distance training, submit videos of coaching and training, and submit trainee evaluations of the training that they offer. The Pyramid Plus Center aims to certify at least 40 coaches and 40 trainers throughout the state by 2012. Certified trainers and coaches will be fully qualified to provide Pyramid Plus training and coaching to early care and education settings in their communities, providing assistance that is focused both on supports for young children's social competence and on practices that promote effective inclusion of children with special needs.

In a related approach, Pyramid Plus has established a Pyramid Plus certification process for entire programs – known as "Pyramid Sites." This process offers intensive support to programs to help them build their capacity to initiate and sustain high-fidelity Pyramid Plus practices. Currently five sites are working toward certification – four early childhood programs and one community-wide effort that includes child care, Head Start, and early intervention programs, which are both center-based and home-based. Pyramid Plus requires participants in this intensive process to establish and meet quality benchmarks. In addition, sites are asked to follow a pro-inclusion and no-expulsion policy consistent with the training they receive. Part of this training, developed by the federally funded SpecialQuest center in California, focuses on practices that ensure inclusion of children with disabilities in high-quality early care and education programs.

The Pyramid Plus Center receives funding from three branches of the Colorado Department of Human Services – the Division of Child Care, the Division for Developmental Disabilities – Early Intervention, and the Division of Behavioral Health. Additional funding is provided by The Colorado Health Foundation. Federal dollars for quality improvement in the Child Care and Development Block Grant provide substantial support for the Center's professional development, mentoring, and coaching activities.



Screening Parents for Depression

In a recent report, the American Academy of Pediatrics called for routine screening of mothers for depression during prenatal and postpartum visits to health care providers.[34] Low-income mothers with young children have shown rates of depression ranging as high as 40 to 60 percent across several studies. One important reason for concern about the high prevalence of maternal depression is that depressive symptoms in a child's primary caregiver are associated with increased risks of problems in early development and learning. Mothers who experience depression during pregnancy and after giving birth often lack the energy and enthusiasm needed to provide their children with responsive caregiving. These mothers may be unable to provide consistent comforting or engage in playful interactions that help children acquire a sense of security along with social-emotional and language skills. The negative effects of maternal depression on young children include lower cognitive functioning, weaker language skills, and behavior problems. Fortunately, recent research indicates that several interventions for treating low-income mothers' depression show promise for reducing depressive symptoms and improving young children's outcomes.[35]

Several states have taken action to increase the identification and treatment of mothers with depression.[36] In this section, we highlight efforts in Illinois to support legislatively mandated screening of women by health care providers and Ohio's maternal depression screening initiative, which is being integrated into the Help Me Grow Home Visiting program.

Screening and Treatment for Maternal Depression in Illinois

Illinois has passed legislation and developed innovative resources aimed at helping women who are experiencing depression and related mental health problems before and after their children are born.[37] *The Perinatal Mental Health Disorders Prevention and Treatment Act (PA 95-0469)* requires all licensed health care professionals in Illinois who provide prenatal, postnatal, and infant care to inform women and their families about perinatal mental health disorders and to invite mothers to complete a screening questionnaire.[38] This landmark legislation, passed in 2007, requires Medicaid to reimburse providers for perinatal depression screening occurring at either the woman's or infant's health care visit. In addition, hospitals providing labor and delivery services are required to give mothers, and when possible, fathers and other family members, information about perinatal mental health disorders prior to discharge. The Illinois Department of Human Services, Department of Healthcare and Family Services, and other state agencies are currently working with providers to develop policy, procedures and educational materials to meet these requirements.

Legislation requiring maternal depression screening in Illinois was developed over several years with support of the Illinois Children's Mental Health Partnership (CMHP), which was also created by a state law, The *Children's Mental Health Act of 2003.* CMHP is a coalition of representatives from state agencies; state chapters of national organizations, including the American Academy of Pediatrics; advocacy organizations; and service providers. The work of this group has also led to advances in early childhood mental health screening, consultation, and other supports for the well-being of young children and families.[39]

Information about rates of maternal depression screening in Illinois suggests some variation across health care settings and populations. In 2009, approximately 30 percent of Illinois women who were continuously enrolled in Medicaid and who delivered during the calendar year received a prenatal depression screening, 23 percent received a postpartum screening, and 15 percent received both a prenatal and postpartum screening.[40] These rates reflect screenings performed during prenatal and postpartum visits that mothers made to their Medicaid health care providers. Higher rates of screening were found for women receiving family case management services through community-based organizations and health departments that have contracts with the Illinois Department of Human Services to serve low-income pregnant women. In the first quarter of 2010, 78 percent of women in this population were screened during pregnancy and 71 percent were screened within 12 months of giving birth. The Department of Human Services uses screening rates as a performance measure and requires screening of all enrolled women at least once prenatally and once postpartum.

Illinois agencies have developed several resources to help health care professionals implement provisions of the new law. The Illinois Department of Human Services created a brochure in English and Spanish, *Is it Baby Blues or Something More?,*[41] that can be used by hospitals to fulfill requirements of PA 95-0469. This brochure helps women distinguish between short-term changes in mood after giving birth and more serious signs of postpartum depression. It includes a crisis hotline number for women who need immediate assistance and another phone number for obtaining additional information and referrals.

The state-funded *Illinois Perinatal Mental Health Project,* operated by the University of Illinois at Chicago, offers online information for health care providers about common mental health disorders during the perinatal period, perinatal depression screening and assessment instruments, methods of billing for screenings, and training opportunities.[42] The project also offers direct training and consultation. Between 20 and 40 workshops are offered each year; workshop topics include basic training in identifying and treating perinatal depression and anxiety disorders as well as advanced training in the use of medication and clinical approaches for treating these disorders. Shorter versions of the advanced workshops are available to providers who lack time but need to know the standard of care for the perinatal

population. The briefer workshops are conducted on-site in clinical settings for groups of 15 to 100 providers. Health care providers can also call the project's *Perinatal Mental Health Consultation Service* to receive information about detecting and treating perinatal depression and related conditions.[43] Approximately 150 to 200 providers – mostly psychiatrists, social workers, nurses, and family practice doctors – contact the consultants each year.[44]

The *Illinois Perinatal Maternal Health Project* operates with funding from a federal Maternal and Child Health Bureau Perinatal Depression Grant and the Illinois Department of Healthcare and Family Services. The project also receives support from the Michael Reese Health Trust, a Chicago-based foundation.

The *Illinois Perinatal Mental Health Project* is currently implementing a stepped-care system for delivering interventions to women with perinatal depression in Chicago community health centers. The model is being implemented at health centers that work with some of the most underserved, at-risk women in Cook County. During the perinatal period, the centers aim to have women complete four depression screenings. The health care provider scores the screening and responds to a positive screen by paging a behavioral health specialist. Usually this specialist is able to meet with the woman immediately and determine her needs, including referral to on-site or community providers. Lessons from implementing the stepped-care model will be used to design a statewide perinatal prevention and treatment program.

Ohio Maternal Depression Screening in Home Visits

Ohio's *Help Me Grow* home-visiting program is developing the capacity to identify and help secure treatment for women who may be experiencing depression during pregnancy or after giving birth.[45] *Help Me Grow,* which operates in all 88 of the state's counties, provides home visitation to first-time parents with family incomes up to 200 percent of the federal poverty level. Most families enter the program during pregnancy or the first six months of the infant's life. In addition, the program can serve children under age three who were involved in a substantiated case of abuse or neglect, or whose parent is engaged in active military duty. Services are provided through the child's third birthday.

Maternal depression screening in *Help Me Grow*'s home-visiting program grew out of the Ohio Department of Mental Health (ODMH) *Maternal Depression Screening Program* (MDSP) originally developed by Dr. Amy Heneghan at Case Western Reserve University in 2004 and transferred in 2006 to Dr. Frank Putnam at Cincinnati Children's Hospital Medical Center (CCHMC). The project was first funded through the state's general revenue fund and then expanded through a Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation-State Incentive Grant and ODMH general revenue funds. In 2010, the Ohio Department of Health also provided funds to help support the screenings.

Following a pilot phase in seven counties, the program was expanded in 2006 as part of the Commonwealth Foundation's Access to Better Care (ABC) initiative. Through an RFP process, the program was funded and implemented in 15 Mental Health (MH) Boards across 17 counties in Ohio. Participating MH Boards received 10,000 dollars each year to help cover direct program costs; mental health consultation services to participating Help Me Grow providers; assistance to help mothers not eligible for Medicaid cover copayments for services; and other supports, such as transportation and child care, to promote family participation.

The home visitors in this project administered the Edinburgh Postnatal Depression Scale (EPDS) to expectant or new mothers. Each mother who is screened in MDSP receives a brochure, *A Guide for Moms: Resources for mothers-to-be and mothers of young children,* that provides sources of relevant information available at local, state, and national organizations as well as web-based materials. A web-based data system designed for the MDSP and implemented program-wide in 2008 allows the home visitor to easily identify women with positive screens or a response indicating risk of self-harm,

and to email a referral to a local partner mental health agency. The mental health agency then contacts the mother to arrange an appointment. Using the data system, CCMHC staff check whether referred women kept the appointment at 30 and 90 days after the referral, and call the provider in cases where the mother did not follow through. Home visitors can log onto the system to see if a mother kept an appointment.

In 2010, the MDSP expanded to include a total of 23 Ohio counties. At this time, the program began a transition toward becoming a sustainable, statewide program within *Help Me Grow*. In July 2010, the *Help Me Grow* Program established a requirement that home visitors offer depression screening to all women in the program, across all 88 Ohio counties where *Help Me Grow* operates. An initial statewide training was conducted in January 2011 and the statewide implementation of MDSP as a part of the *Help Me Grow* system will be effective on July 1, 2011.

The MDSP model that will be implemented statewide will continue to rely on local partnerships between the home visitors and mental health agencies. However, the Ohio Department of Health's web-based data collection system that is used by *Help Me Grow* providers will not have the capacity to generate facilitated referrals to providers. However, it is expected that *Help Me Grow* home visitors will provide referrals, with the women's consent, to local mental health practitioners when screening scores indicate the need for further evaluation. The home visitor will discuss a positive screen with the mother "on the spot," and with the mother's consent, will call the mental health agency with the mother present to arrange an appointment.

Since 2006, the starting point for collecting data on participants, over 4,100 Ohio women have been screened for maternal depression through MDSP. Approximately 15 percent of women have shown a positive screen, indicating high risk of depression or self-harm. Over 62 percent of these women have been referred for further assessment and services. Once MDSP is implemented statewide through *Help Me Grow*, an evaluation of the program will be conducted as part of the larger evaluation of the home visiting program.

Ongoing training and support for providers have been an integral part of MDSP. In addition to semi-annual meetings, the program offers periodic training on maternal depression and screening, as well as monthly technical assistance phone calls. MDSP has also produced training videos on maternal depression screening and the impact of maternal depression on mothers and children which are available online.[46]

Screening Children for Social-Emotional Problems

Social-emotional and behavior problems are fairly common among young children, with the prevalence of these problems ranging from about 20 to 30 percent in samples of children from low-income families.[47] Without intervention, behavioral difficulties tend to persist.[48] Identifying and addressing the social-emotional problems of young children as early as possible can limit the negative effects of these difficulties on learning, school performance, and relationships with peers and teachers. There is evidence that reliable identification requires the use of a standardized developmental screening tool and that tools focused on social-emotional screening are more reliable than global screening tools.[49] Developing effective social-emotional screening practices at the state level is a complex task requiring the development of resources and training for the professionals who will administer the screenings and help connect families to needed evaluation and intervention services. In this section, we describe the efforts of three states – Arkansas, Minnesota, and California – that are working toward early and effective identification of social-emotional problems in young children. Efforts in these three states

highlight the diverse settings where child screenings can occur and a variety of methods that can be used to support screening activities and promote follow-up assessments and interventions.

Arkansas' Pilot Screening Projects

Arkansas' Early Childhood Comprehensive Systems (ECCS) initiative and the state's Division of Child Care and Early Childhood Education (DCC/ECE) are operating a pilot project that helps selected child care programs around the state use standardized screening instruments to identify children who may have problems in different areas of development, including the social-emotional domain.[50] The project is using the Ages and Stages Questionnaire (ASQ) and its companion, the Ages and Stages Questionnaire Social-Emotional (ASQ SE), a screening instrument that focuses on social-emotional development. Both instruments are completed by parents and results of the screens are shared with children's primary health care providers.

The project grew out of the state's participation in the National Academy for State Health Policy's ABCD (Assuring Better Child Health and Development) Screening Academy. During the project's first phase, which ended in August 2010, funds from the federal American Recovery and Reinvestment Act were used to support screening in 31 child care centers. Since fall 2010, an additional 84 centers have joined the project for Phase Two. Work at 36 of these centers is supported by funds for child care quality improvement available under the federal Child Care and Development Block Grant. Screening activities in the remaining 48 centers are supported by state general revenue targeted by the legislature to fund community prevention programs that are part of the state's system-of-care initiative. This funding flows through the state's Division of Behavioral Health Services within the Department of Human Services, which is charged with improving the state's behavioral health system.

Using a train-the-trainers approach, staff of the states' child care resource and referral (CCR&R) agencies took part in a two-day course on the ASQ and ASQ SE screening instruments provided by Brooks Publishing, the company that markets these instruments. CCR&R staff, in turn, trained child care teachers and directors at the participating centers to provide support to parents who complete the ASQ instruments. The training of child care providers also focused on how to score the completed interviews, interpret results, and follow up with classroom activities designed to address any developmental delays and emotional and mental health difficulties that came to light through the screenings.

Child care staff arranged visits to children's primary care physicians to tell them that the parents would be asked to complete the screens and center staff would send screening results to the doctors. The aim of this outreach was to encourage doctors to review and make use of the screening results during their appointments with young children and families, and whenever warranted, to refer children to needed services. To help ensure that doctors, especially those who are unfamiliar with ASQ screens, were receptive to the idea of using the results to make referrals, the child care providers gave them a copy of a letter from the Arkansas chapter of the American Academy of Pediatrics that strongly endorses the project.

A formal evaluation of the pilot project is being conducted by Partners for Inclusive Communities, a department of the University of Arkansas for Medical Sciences. The evaluation, which is being supported with funds from the state's Division of Behavior Health Services, is expected to yield information about whether the use of the screenings improves practice among both child care centers and physicians. The final evaluation report will be available on the Division of Child Care and Early Childhood Education's website by summer 2011.[51] State planners involved in the Early Childhood Comprehensive Systems initiative and state agencies will use the evaluation results to assess options for strengthening and expanding this initiative.

Minnesota's Young Child Screening Programs

Together, Minnesota's *Follow Along* and *Early Childhood Screening* programs exemplify a comprehensive approach to identifying social-emotional problems of young children from birth through age 5.[52] As a support to the communities implementing these programs, the Minnesota Department of Health provides online information about both general developmental screening tools and social-emotional assessments for children of different ages. The site also provides a tutorial on developmental and social-emotional screening of young children.[53] Another online resource is a quality indicators tool that describes specific features of a high quality screening.

Local public health agencies in Minnesota operate a child screening and monitoring program for children birth to 36 months called *Follow Along*. With support from the State Department of Health, the local agencies screen infants and toddlers using the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social-Emotional (ASQ SE), which screens for social-emotional and behavior difficulties. In 2009, approximately 12 percent of the state's infants and toddlers (25,448 children) were screened in *Follow Along* programs.

Across the state, almost every county operates a *Follow Along* program. About two-thirds of the counties use birth records to automatically enroll children by sending letters to parents, explaining the program and attaching an ASQ questionnaire. Families not reached through a letter from *Follow Along* may be visited by public health staff who invite the parent to participate, obtain consent, and provide a screening questionnaire. Children are also referred to *Follow Along* by WIC (the federal nutrition program for women, infants and children), hospitals, friends and families, and social service agencies. Once enrolled, parents typically receive a screening questionnaire every four to six months. The counties send the ASQ SE at varying intervals. On average, nearly 90 percent of the questionnaires are completed and returned by parents.

Older children, age 3 to 5, are screened by school districts in Minnesota through the *Early Childhood Screening Program* (ECS). Each year approximately 80 percent of children in this age range are screened in the ECS program prior to school entry. All school districts are required to conduct screens using validated instruments, and to include a screen for social-emotional problems. State law mandates that these screens occur before or within 30 days of kindergarten entrance. Most districts use the ASQ SE. The ECS program operates with state funding appropriated by Minnesota's legislature.

The ECS program reaches out to parents with a brochure that is available in five languages in addition to English.[54] The brochure describes the free screening and invites parents to prepare for the screening by noting questions they have about their child's development that can be discussed at the screening appointment. Parents find out about screening locations by calling a school district number on the brochure. Although screening is mandatory for entrance into kindergarten, parents are encouraged to obtain screens earlier to address concerns before the child begins school. Almost five percent of children screened in ECS are identified as having possible social-emotional problems. When children show a positive screen, they are referred to either their health care provider or the state's *Help Me Grow* Preschool Special Education program for further evaluation.

California Statewide Child Screening Collaborative

The California Statewide Screening Collaborative (CSSC) was first convened in 2007 as part of the Early Childhood Comprehensive Systems (ECCS) grant from the federal Bureau of Maternal and Child Health.[55] CSSC builds on California's participation in the Assuring Better Child Health and Development (ABCD) II Consortium[56] in 2004-2007 and in the ABCD Screening Academy in 2007-2008. CSSC brings together state agencies, organizations, and special initiatives that focus on young children's mental health and wellness. The collaborative aims to increase coordination across state agencies and organizations involved in early identification of developmental challenges. The group also seeks to promote the use of standardized screening tools, particularly by health care professionals, and to identify funding opportunities to do this work.[57]

First 5 California, a statewide nonprofit agency focused on the needs of young children and funded by tobacco tax revenue, has financed a significant portion of CSSC's collaborative efforts. In-kind support has been provided by 25 member agencies, including the state's health and education departments; Head Start; Early Head Start; local chapters of the American Academy of Pediatrics; and county First 5 Commissions, the local-level coalitions that develop and implement First 5 programs.

CSSC members have engaged MediCal, the state's managed care Medicaid program, and other health insurance programs, in discussions about ensuring reimbursement for developmental screenings. As CSSC has given providers guidance about billing for screenings in local trainings, providers have reported an increase in rates of reimbursement for screening. CSSC has also identified obstacles to obtaining information about reimbursement through MediCal, and ongoing discussions are focused on both the data needed to better document rates of reimbursement for screenings and on strategies to ensure rising rates of screening and reimbursement.

In partnership with First 5 California, CSSC has developed a website with information about child screening.[58] This website provides a review of validated screening tools, including social-emotional measures, and a guide to help providers determine when a referral is necessary and what developmental services and resources are available. The site also provides a link to a valuable resource developed by CSSC, *Information Sharing Toolkit for Community Providers*.[59] This Toolkit includes sample forms including HIPAA-compliant consent forms for obtaining parents' permission to share information with other providers, a form for parents to track their child's care, referral follow-up forms to track the results of referrals, and an *Ages and Stages Questionnaire (ASQ) Age Administration Calculator*[60] to guide providers in their selection of the appropriate Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire Social-Emotional (ASQ SE) forms to use with a family.[61] The Toolkit is designed for use by health care professionals, staff working with WIC participants, and childcare providers.

Future work of the collaborative will include the development of a universal consent form that would allow agencies to share information related to screening results, continued dissemination of information related to screenings, and support of partnership initiatives such as a recent application for a replication of Connecticut's *Help Me Grow* program. A recent survey of agency representatives who participate in CSSC cited numerous benefits of participating in the collaborative, including the support they receive for promoting developmental screening in their agencies and identifying referral resources, as well as the chance to learn about effective practices being used by other agencies.

Developing a Better-trained Workforce to Address Early Social-emotional Problems

An essential element of a strong system of supports for early childhood mental health is a workforce that has the knowledge and skills needed to promote positive social-emotional growth in young children and to identify and address problems in this domain. Many states have identified a set of competencies relevant to promoting early childhood mental health for professionals who work with young children and families.[62] Most states that have competency guidelines also have a process by which professionals can demonstrate their knowledge and skills by documenting training, practice, and supervision experiences. These "endorsement" systems can stimulate expansions in training opportunities related to the competency standards. Although the content of the competencies typically reflect research-based knowledge about young children's development and experiences that promote positive mental health, there has been little research to date that shows how an endorsement of competencies

at a particular level relates to professional practice and child outcomes. In the future, such research may help identify particular endorsement systems or features of these systems that promote effective practice. This section examines the competency guidelines and endorsement systems of two states, Michigan and California.

The Michigan Association for Infant Mental Health Endorsement

Over 360 infant and family professionals currently hold an endorsement from the Michigan Association for Infant Mental Health (MI-AIMH).[63] The primary aim of the MI-AIMH competency guidelines and endorsement program is to promote the career development of infant and family professionals by formally documenting their use of culturally sensitive, relationship-based practices as well as their learning and work experiences related to infant mental health. The core competencies outlined in the guidelines include theoretical foundations (covering such topics as pregnancy, early parenthood, and family dynamics); law, regulation and agency policy; direct service skills; working with others; and reflection.

The guidelines were originally published in 2002 after several years of work by MI-AIMH leaders involving a review of relevant research and policy, formulation of the core competencies, and reaching consensus on specific requirements for endorsement. Initial funding to implement the competency guidelines and endorsement system in Michigan came from the W.K. Kellogg Foundation. Current funding to administer the endorsement program comes from revenue generated through annual memberships, endorsement fees, training contracts, and sale of MI-AIMH publications and tools such as the *Preschool stages: A parent's and caregiver's guide to social and emotional development in the preschool years (2-5 years)*. This guide provides age-specific information about social-emotional milestones and strategies for supporting young children's mental health.[64]

Applicants can apply for endorsement at four different levels ranging from Infant Family Associate (Level I) to Infant Mental Health Mentor (Level IV). Detailed requirements related to education, specialized work experience, training, and reflective supervision for each endorsement level are outlined in endorsement guidelines.[65]

While applicants represent a wide range of professions, there are some general trends in the types of applicants seeking endorsement at particular levels. For example, Level I applicants are often from the early care and education field. Applicants for Level II, who tend to be the most diverse group, include staff from Early Head Start and the Part C Early Intervention program, parent educators, home visitors, and infant mental health practitioners. Individuals at Level III must have a minimum of two years of direct service as infant mental health practitioners. Level IV endorsement applicants must demonstrate three or more years of clinical, policy, or research leadership activities in the infant-family field.[66] Applicants submit a portfolio that includes educational transcripts, and descriptions of specialized training, work experiences, and involvement in reflective supervision and consultation. In addition, applicants for Level III and IV endorsements must pass an exam. The costs of applying for or renewing an endorsement are modest.

There are many paths that applicants can take to accrue education and training experiences needed for an endorsement. Three university-based graduate certificate programs in infant mental health have been developed in Michigan, each meeting all competencies required for Level III endorsement. Applicants can also pursue endorsement by completing in-service training experiences sponsored by the Part C Early Intervention program, Early Head Start, MI-AIMH's Training Institute, conferences, or programs such as Parents as Teachers.

MI-AIMH works to fill training gaps identified in its annual review of endorsement portfolios and the endorsement exam. In 2009, for example, many endorsement applicants demonstrated that they had difficulty documenting competency in

the area of pregnancy and early parenthood. In response, MI-AIMH collaborated with another statewide organization to sponsor a low-cost training series on relationship-based practice with pregnant women, particularly for families experiencing domestic violence and substance abuse.

During the time that the MI-AIMH competency guidelines and the endorsement system have been implemented, they have played a key role in shaping training opportunities and professional requirements for early mental health professionals within Michigan as well as in other states. In 2007, for example, the Michigan Department of Community Health (MDCH) began to require that all early childhood mental health consultants working in Child Care Expulsion Prevention programs earn an Infant Family Specialists (Level II). In 2009, MDCH enacted regulations requiring all home-based staff serving children birth to 47 months of age to earn endorsements as Infant Family Specialists (Level II). These requirements have led to an increased demand for reflective supervision related to infant mental health promotion and practice across the state. Some applicants receive reflective supervision through their employers, while others must find and pay for this experience. Many individuals and agencies have found it more economical to form small reflective-supervision groups. MI-AIMH assists in this process by providing an online list of qualified providers of reflective supervision as a part of the Infant Mental Health Training Faculty Registry.[67] MI-AIMH and MDCH also offer free trainings for reflective supervisors (and those who wish to become reflective supervisors) three to four times a year.

Thirteen states[68] have purchased licenses to use the MI-AIMH Competency Guidelines and Endorsement system and are referred to as the *League of States*. (Two additional state infant mental health associations are currently seeking to purchase a license for the program.) *League of States* representatives participate in monthly phone calls as well as an annual meeting to discuss key topics, which include ways to define and evaluate the role of reflective supervision.

Michigan Association for Infant Mental Health
U.S. League of States

The following organizations have entered into or are preparing a licensing agreement with the Michigan Association for Infant Mental Health (MI-AIMH) to use the MI-AIMH Competency Guidelines and the MI-AIMH Endorsement®.

- Alaska Infant Toddler Mental Health Association
- Arizona Infant Toddler Children's Mental Health Coalition
- Connecticut Association for Infant Mental Health
- Colorado Associate for Infant Mental Health
- Idaho Association for Infant Mental Health
- Indiana Association for Infant and Early Childhood Mental Health
- Kansas Association for Infant and Early Childhood Mental Health
- Minnesota Association for Infant and Early Childhood Mental Health
- New Mexico Association for Infant Mental Health
- Oklahoma Association for Infant Mental Health
- Texas Association for Infant Mental Health
- Wisconsin Alliance for Infant Mental Health
- Virginia Association for Infant Mental Health

For more information see:
http://www.mi-aimh.org/league-of-states

MI-AIMH has begun field-testing a new online system for endorsement applications and reviews. The Endorsement Application System (EASy) is designed to be user-friendly and to facilitate a secure, paperless application process and more efficient review of portfolios. League states will be able to purchase a license to use EASy software after field testing is completed. MI-AIMH anticipates that EASy will make outcomes related to the application and endorsement process easier to track in Michigan and in other states that are part of the *League of States*.

California's Early Childhood Mental Health Workforce Training and Competency Guidelines

In 2009, California's *Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health*[69] was completed and disseminated statewide.[70] This revision updates and expands the original guidelines, published in 2003. California's training and competency guidelines were developed over many years through interdisciplinary work groups that examined research, practice in other states, and experiences of professionals in the field. The Revised Guidelines describe competencies needed by professionals who work with young children and families in order to promote the mental health of infants, toddlers, and preschoolers. These competencies and the processes for acquiring them are tailored to different groups of professionals. The three categories of professionals are: 1) infant-family and early childhood mental health core providers – professionals in multiple fields who have frequent contact with infants, young children, and their families, and who are well-positioned to promote positive mental health and help prevent problems (examples of these providers are child development specialists, home visitors, and special education teachers); 2) infant-family and early childhood mental health specialists – professionals with a graduate degree or license in the mental health field who provide early childhood mental health treatment services; and 3) infant-family and early childhood mental health reflective practice facilitators – professionals who can support the clinical work of core providers or specialists by helping them apply appropriate knowledge and skills related to early childhood mental health in their work with young children and families.[71]

Guidelines for each group are further specified according to the age of children with whom the professionals work (that is, whether they work with groups of infants and toddlers, preschoolers, or all children birth through age 5). For each group, the guidelines outline requirements for achieving and demonstrating competencies, including coursework, clinical experience, an understanding of key concepts, and the ability to use specific skills. The guidelines' emphasis on promoting strong supports for core providers and specialists is reflected in the three levels of endorsement for "reflective facilitators" – professionals who help providers reflect on their practices. The first level qualifies a professional to provide support to core providers and the second to specialists. The third and highest level of endorsement equips professionals to help others learn to provide reflective facilitation to enhance the work of core providers and specialists.

Currently, the California Center for Infant-Family and Early Childhood Mental Health administers the endorsement process with guidance from an expert panel. Housed at WestEd, a non-profit research and program development organization, this Center provides online information about the guidelines and endorsement process. Funding for the development and operation of the endorsement process has come in part from First 5 California, a state agency funded by tobacco tax revenue, and has been supplemented by endorsement application fees, which cover administrative costs of reviewing endorsement applications.

Training programs around the state, including higher education and post-doctoral internship programs, are working to align themselves with the guidelines' endorsement requirements. The Center's website will describe these training opportunities as they grow. A recent pilot of the guidelines resulted in 50 professionals receiving endorsements. Applicants included three core providers, seven specialists, and 40 reflective facilitators. Plans are currently underway to implement the endorsement program statewide in 2011.

Using Evidence-based Practices and Evaluation to Promote Effective ECMH Programs

Like a well-trained workforce, the use of evidence-based interventions and practices can help ensure desired outcomes for children and their families in early childhood mental health initiatives. Evidence-based interventions are models that have been evaluated in previous research, often in randomized control trials, a type of rigorous study in which participants are randomly assigned to treatment and control groups. Since the field of early childhood mental health is relatively new, many practices in use have not yet produced evidence of efficacy. Here we briefly review examples of evidence-based models and models currently being tested in rigorous evaluations. We also highlight examples of states that are incorporating evaluations into their ECMH initiatives.

Among the state examples examined in this report, North Carolina is notable for its use of an evidence-based model, The Incredible Years BASIC Parent Training Program – Early Childhood, and for its efforts to ensure high-fidelity implementation of this model. In addition, the pilot implementation of this model in North Carolina included an evaluation that found results similar to findings from studies the developers had conducted.[72] This additional evidence is valuable since the impact of any evidence-based model implemented in a new setting may differ from outcomes of studies that established the model's effectiveness. Features of implementation, such as the quality of training for individuals delivering the intervention and characteristics of families and communities, such as high poverty or lack of transportation, can influence program outcomes in a new setting.

Two other states are using training models that are currently undergoing rigorous studies to assess their effectiveness. CSEFEL training and coaching strategies, part of the Pyramid model being implemented in Colorado, are being tested in a multi-site demonstration that includes early childhood programs in Colorado and other states.[73] The Program for Infant-Toddler Caregivers (PITC), in use across Ohio, is also being tested in a multi-site study.[74]

In several states that are not using established evidence-based models, evaluations of state-developed initiatives are expected to provide information that will guide decisions about expansion or refinement of a model. The evaluation of the pilot early childhood consultation model in Arkansas has already yielded promising results. This state is also evaluating its pilot child screening program. Connecticut's early childhood mental health consultation program (ECCP) was rigorously evaluated in 2005 and 2006.[75] In Ohio, the results of the Maternal Depression Screening Program will be evaluated as it is implemented statewide within the *Help Me Grow* home-visiting program. Ohio also has plans to evaluate an enhanced version of its training, which is based on the Program for Infant-Toddler Caregivers and which will use learning communities that allow teachers to share their knowledge about best practices in caring for infants and toddlers.

State child and parent screening initiatives discussed in this report are using valid screening instruments, including the Ages and Stages Questionnaire Social-Emotional (ASQ SE) and the Edinburgh Postnatal Depression Scale. Valid screening instruments are instruments that have been shown in research to be effective in identifying individuals who have a high likelihood of actually having the condition they are being screening for, as determined by a more extensive evaluation. The use of valid screening instruments is a strength of state initiatives in Arkansas, Minnesota, California, Illinois, and Ohio.

It is important to emphasize, however, that screening in these states is part of larger efforts to ensure that children and parents receive appropriate evaluations and interventions. Some studies of child screening initiatives in primary care settings have found that despite high rates of screening, relatively few children needing further evaluation are referred

for this next step, and few providers track whether appointments of referred children are completed.[76] More research is needed to determine effective strategies for attaining important outcomes related to screening, especially ensuring that identified children and parents actually receive and benefit from evaluations and interventions.

There are now many promising and evidence-based early childhood mental health models that states can consider as they expand supports for young children's social-emotional well-being. (see box). These include models across the continuum from promotion and prevention to intervention. Promotion and prevention approaches include teacher training, parent education, child and parent screening, and early childhood social-emotional curricula. In addition, evidence-based programs are available for parents with young children who are experiencing behavior problems and for young children who have experienced trauma, such as abuse, loss of a parent, or witnessing violence. For example, Parent-Child Interaction Therapy (PCIT) – including newer versions of the PCIT model that are of shorter duration and intensity than the original – helps parents of preschoolers with behavior problems learn positive parenting and effective strategies for reducing challenging behavior.[77]

Information about Evidence-based ECMH Models

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Supporting the Well-being of Exceptionally Vulnerable Children

Most current state ECMH initiatives are targeting young children who are at risk of poor developmental outcomes, including social-emotional difficulties. For example, ECMH consultation in Louisiana's home-visiting program reaches low-income families since family income that is below 200 percent of the federal poverty line is an eligibility requirement for the Nurse Family Partnership program. Similarly, consultation and staff training initiatives that target early care and education serve low-income children who attend subsidized early childhood programs. This general trend makes sense given the high rates of social-emotional and behavioral problems among families experiencing economic hardship.[78]

At the same time, a critical element of a comprehensive system of supports for young children's mental health is intentional outreach to exceptionally vulnerable children whose life circumstances place them at very high risk for the development of mental health problems in early childhood and beyond. These children include infants, toddlers, and preschoolers involved in the child welfare system; young children who are homeless; and young children whose families are experiencing multiple risks, such as extreme poverty, parental psychiatric or physical illness, substance abuse, or domestic violence. States are beginning to develop outreach and intervention efforts for their most vulnerable

New Mexico's Family Infant & Toddler Environmental Risk Assessment (ERA) Tool: Excerpt

1. **Child's Basic Needs**
   - A. Child supplies available (car seat, clothes, food, etc.)
   - B. Stable housing for at least 3 months
   - C. Receives steady source of adequate income
   - D. Accesses needed social support services (ISD benefits, WIC, etc.)
   - E. Has transportation or access to public transportation
   - F. Has adequate and appropriate child care, as needed

   Add number of protective factors present to obtain risk (A-E) 4-6 = No risk 3 = Medium risk 0-2 = High risk

2. **Family Educational History**
   - No. No history of the following:
   - M. History of one of the following:
   - H. History of two or more of the following:
     - – Family history of school dropout
     - – Family history of speech/language delay(s)
     - – Family history of learning disability(ies) or special education
     - – Family history of social/emotional or behavioral disorder(s)

3. **Family Mental Health**
   - No. No psychiatric diagnoses identified for individuals living in the household.
   - M. Managed and/or treated psychiatric diagnosis in any individual living in household.
   - H. Active non-treated psychiatric diagnosis in any individual living in the household.

4. **Family Violence**
   - No. No past physical, sexual, or emotional abuse in the child's home.
   - M. Parental history of physical, sexual, emotional abuse.
   - H. Child has been exposed to physical, sexual, or emotional abuse of some member in the family.

5. **Primary Caregiver Acceptance of and Affection toward Child**
   - No. Very accepting and affectionate. No negative statements made about the child.
   - M. Variable acceptance and affection. Demonstrates affection toward child, but also makes negative comments about the child.
   - H. Very little affection demonstrated towards child, frequently makes negative statements about the child or handles child roughly.

6. **Primary Caregiver Responds to Child Cues**
   - No. Responds appropriately to cues of child most of the time.
   - M. Responds appropriately to cues half of the time.
   - H. Rarely responds to cues.

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children. This section highlights examples of outreach and provision of mental health supports to exceptionally vulnerable young children.

Two states, Massachusetts and New Mexico, use risk assessments to determine the eligibility of infants and toddlers for the Part C Early Intervention (EI) Program.[79] All 50 states participate in the EI program, which provides assessment and intervention services to address a range of developmental delays.[80] Massachusetts and New Mexico are among several states whose EI programs incorporate strong supports for addressing the mental health needs of infants and toddlers.[81] The assessments include many child, parent, and family risks known to increase the chances that infants and toddlers will experience developmental or mental health problems. Examples of these risks are low birthweight; feeding difficulties; the child's experience of trauma, such as a significant loss; homelessness; parent substance abuse; parent psychiatric illness; or domestic violence, and evidence of parenting difficulties (see box for an excerpt from New Mexico's *Family Infant & Toddler Environmental Risk Assessment Tool)*.

Each assessment has a scoring system that indicates eligibility for EI services above a certain level; children with four of 20 risks are deemed eligible based on the Massachusetts assessment, while children with four "moderate" or two "serious" risks can receive EI services in New Mexico.

The 2003 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) requires child protective service agencies to refer young children involved in a substantiated case of neglect or abuse to the Part C Early Intervention program for screening or evaluation.[82] Ohio goes beyond this requirement to reach many vulnerable children through its *Early Childhood Mental Health/Child Welfare Demonstration* (ECMH/CW).[83] This demonstration, being implemented in 14 counties, provides mental health assessment and referral services to children birth to 6 years who are involved in the child welfare system. In addition to serving children involved in substantiated cases of abuse and neglect, the project reaches children identified through Ohio's Alternative Response System (ARS), which allows the protective services agency to avoid an investigation to determine abuse or neglect in the absence of high risk to a child's safety. Instead, the ARS can quickly provide supports to families while children remain at home. Many children identified through this system live in very low-income families that are experiencing high levels of stress related to economic hardship and other factors, such as parent health or mental health problems. The ECMH/CW demonstration uses the Devereux Early Childhood Assessment (DECA)[84] to assess protective factors in children as well as problem behaviors. The demonstration also uses the Childhood Trust Events Survey,[85] which screens children for trauma. Consultants refer children and families to treatment services, which are delivered, to the extent possible, in homes, early care and education settings, and other natural environments. In addition, ECMH/CW serves children entering foster care and children at risk of being removed from a foster care placement due to behavioral problems.

Some of the state initiatives discussed earlier also target exceptionally at-risk children. Connecticut's Early Childhood Consultation Partnership serves young children in foster homes and safe houses. Arkansas also plans to extend its early childhood consultation services to young children in foster care. By screening very low-income pregnant women for maternal depression, and offering depressed women support and treatment, Illinois' *Stepped Care* demonstration in community health centers reaches vulnerable children even before birth.

PART 2
Building State Systems of Support for Early Childhood Mental Health: A Planning Tool for States

Investing in supports for young children's mental health can return rich dividends – increased numbers of children who succeed in school and realize their full potential as productive adults, and reduced mental health and behavior problems at both early and later ages. The many state efforts profiled in this report illustrate the increasing interest in this investment. Another such effort is the replication of Connecticut's *Help Me Grow* model in eight states. *Help Me Grow* is a comprehensive model that includes surveillance for early detection of developmental and social-emotional concerns, easy access to locally-based screening and services, ongoing monitoring of program operations, and expansion over time to statewide implementation through state agency and program collaboration.[86]

Most states are deeply engaged in work to strengthen and better integrate supports for young children's well-being and optimal development. This work is occurring in states' Early Childhood Advisory Councils, Early Childhood Comprehensive Systems initiatives, and other state-planning efforts.[87] State-level planners may wish to use or adapt the **ECMH Progress Monitoring and Planning Tool**, presented in this final section. This tool can be used by a workgroup or larger planning council to do the following:

- assess the current scope and quality of a state's supports for young children's mental health (for example, screening, ECMH supports in early care and education settings, and outreach to highly vulnerable groups of children);
- specify goals related to the scope and quality of ECMH supports, including such initiatives as a pilot to test a support not currently present in the state, an expansion of a service such as ECMH consultation, an effort to gather data on the quality of services, or an initiative to enhance the quality of the workforce;
- identify funding for these efforts;
- formulate strategies, such as legislation or design of training program; and
- set benchmarks for short-term and longer-term progress.

Planners may wish to adapt the **ECMH Progress Monitoring and Planning Tool** in a variety of ways – for example, by adding ECMH elements to the tool, adding more specificity to existing elements, or requiring identification of key persons and agencies who will lead efforts to achieve a goal or benchmark. In this way, the tool can be used flexibly to help planners maintain a vision of comprehensive supports for young children's mental health while pursing strategies to establish, expand, and raise the quality of specific elements in a comprehensive system.

ECMH Progress Monitoring and Planning Tool

ECMH Strategy The top row of this table describes information, goals, funding sources, strategies and benchmarks that can be documented for each ECMH strategy as part of a planning process.	**Stage of Implementation** • scope (e.g., none yet, pilot, part-state, statewide) • location (e.g., rural versus urban counties) • reach of implementation (percent/number of 4-year-old children are screened)	**Expansion and Quality Improvement Goals** • e.g., number of new sites, children served. • e.g.,number of sites showing high fidelity to model	**Funding Source(s)** • Current • Potential	**Strategjes** (e.g., legislation, regulations, program design,training for providers, rfp process)	**Benchmarks** (3-6 months; 12-month)
ECMH supports in home-visiting and parenting programs					
ECMH supports in early care and education programs					
Parent screening for depression					

ECMH Progress Monitoring and Planning Tool

ECMH Strategy The top row of this table describes information, goals, funding sources, strategies and benchmarks that can be documented for each ECMH strategy as part of a planning process.	**Stage of Implementation** • scope (e.g., none yet, pilot, part-state, statewide) • location (e.g., rural versus urban counties) • reach of implementation (percent/number of 4-year-old children are screened)	**Expansion and Quality Improvement Goals** • e.g., number of new sites, children served. • e.g.,number of sites showing high fidelity to model	**Funding Source(s)** • Current • Potential	**Strategjes** (e.g., legislation, regulations, program design,training for providers, rfp process)	**Benchmarks** (3-6 months; 12-month)
Child screening for social-emotional problems					
Developing a strong ECMH workforce					
Using evidence-based services and evaluation					
Reaching/supporting exceptionally vulnerable children					

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To find out more about the Program for Infant/Toddler Caregivers (PITC), visit their website at http://www.pitc.org.

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58. Find the website here: http://www.first5ecmh.org/.

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64. See: http://www.mi-aimh.org/products/wheels.

65. See: http://www.mi-aimh.org/endorsement.

66. At present, there are 14 endorsed as infant family associate (Level I), 145 endorsed at infant family specialist (Level II), 66 as infant mental health specialist (Level III), and 45 as infant mental health mentor (Level IV) in Michigan; these individuals along with endorsed professionals in affiliate states are included within an online endorsement registry.

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68. The 13 states that purchased licenses are: Alaska, Arizona, Colorado, Connecticut, Idaho, Indiana, Kansas, Minnesota, New Mexico, Oklahoma, Texas, Wisconsin, and Virginia. For more information about how to purchase a license, see http://www.mi-aimh.org/documents/fee_schedule_2011_rev._aug._2010.pdf for details about purchasing a license.

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