REPORT

Promoting the Social-emotional Wellbeing of Infants and Toddlers in Early Intervention Programs

Promising Strategies in Four Communities

Taniesha A. Woods | Sheila Smith | Janice L. Cooper

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National Center for Children in Poverty
Mailman School of Public Health
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The National Center for Children in Poverty (NCCP) is the nation's 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.

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SECTION 1

Introduction, Study Rationale, and Methodology

State Early Intervention programs provided through Part C of the Individuals with Disabilities Education Improvement Act (IDEIA) offer unique opportunities to enhance children's chances of realizing their full educational and personal potential. Early Intervention (EI) services provided to infants and toddlers, birth up to age 3, with identified disabilities can greatly reduce the long-term negative consequences of early developmental delays.[1] In states where program eligibility is extended to children who are at-risk for serious developmental delays, EI services can help prevent disabilities and set children on a healthy developmental path toward school readiness, academic success, and positive social adjustment.[2, 3, 4] In addition to intervening very early in children's lives, a strength of EI as a preventive program lies in its mandate to address problems across all areas of young children's development including cognitive, communication, social, emotional, and physical delays.

There is strong evidence that young children's social-emotional wellbeing provides the foundation for success in school and the ability to pursue positive life goals.[5, 6] Children who enter school able to manage their emotions, engage in trusting relationships with adults, and use social skills that help them get along with peers have been shown to be more engaged in classroom learning than children lacking these competencies.[5, 6] Because children with strong social-emotional competencies can make the most of learning opportunities, they experience greater academic success and are less likely to develop problem behaviors that often occur together with learning difficulties.[5, 6] In contrast, young children's difficulties with challenging behavior, weak social skills, and other social-emotional problems tend to persist or worsen in the absence of interventions and create significant obstacles to learning and social adjustment throughout their schooling.[6]

Despite our current knowledge about the importance of young children's social-emotional wellbeing, EI programs across states show highly varying levels of attention to the social-emotional needs of infants and toddlers. For example, most states do not require that a professional with expertise in early social-emotional development sit on the evaluation team that determines infants' and toddlers' eligibility for EI services.[1] However, promising policies and practices are emerging in some states and communities, and these suggest strategies for strengthening the efforts of EI programs to promote children's social-emotional growth across the country.

Project Overview

This brief presents promising approaches to support the social-emotional wellbeing of infants and toddlers through the Part C Program. The strategies discussed in this brief were identified through case studies carried out in four communities: Boston, Massachusetts; Los Angeles County, California; Doña Ana County, New Mexico; and Southeast Kansas. These case studies were part of a larger project designed to show different policy options that states use to support strategies that target social-emotional development as part of a comprehensive approach to early intervention services. The project included a 50-state survey of Part C Program coordinators, the individuals who are responsible for administering the Part C Program in compliance with federal and state requirements. Findings from this survey are reported in *Promoting Social-Emotional Wellbeing in Early Intervention Services: A Fifty State View.*[1] As a companion to the survey report, this brief examines exemplary policies and practices that highlight the potential of the Part C Early Intervention Program to play a major role in reducing the risk of long-term social-emotional and behavioral difficulties of vulnerable children.

This brief is organized into three sections:

1) A review of the Part C Program and the case-study methodology;
2) Promising Strategies:
   - approaches to screening, eligibility, and support of at-risk children;
   - methods for enhancing the skills of professionals who provide Early Intervention services;
   - interagency collaborations that strengthen supports for young children's social-emotional wellbeing;
   - funding strategies that support promising programs; and
3) A summary of key findings and related recommendations for expanding states' and communities' use of promising early intervention strategies that support the social-emotional wellbeing of infants and toddlers.

The Part C Early Intervention Program

The program now called Part C of the Individuals with Disabilities Education Improvement Act (IDEIA) was originally created in 1986 when Congress passed landmark federal education disability legislation, P.L. 99-457.[7] Under IDEIA, states receive assistance to implement a statewide coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families. While participation is voluntary, all states currently have Part C programs. A lead agency appointed by the governor, most often the department of health or education, administers this program and works to ensure that federal requirements are met. According to these requirements, states must implement public awareness activities known as "Child Find," a set of activities for identifying and referring children with disabilities; establish and use clear eligibility criteria; and provide evaluations to determine eligibility using these criteria. For children found to be eligible for services, EI programs must work with families to design an Individualized Family Service Plan (IFSP) and provide appropriate early intervention services in settings that are typical for children who do not have disabilities. In addition, states must develop personnel standards for providers of EI services, develop a comprehensive system of personnel development, and create a state Interagency Coordinating Council to help ensure the availability of the full range of needed supports for infants and toddlers with disabilities and their families, and to support the identification of exceptionally vulnerable children.

Subsequent reauthorizations of the Individuals with Disabilities Education Act have strengthened the law's intent to ensure that highly vulnerable children gain access to EI services. In 2004, the reauthorization of the Individuals with Disabilities Education Act [renamed Individuals with Disabilities Education Improvement Act (IDEIA)] required states to include a description of their policies for referral to the Part C system for infants and toddlers involved in substantiated cases of child abuse or neglect, affected by illegal substance abuse, or experiencing withdrawal symptoms resulting from prenatal drug exposure. This change was spurred by the 2003 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). Under CAPTA, child protective agencies are required to refer a child involved in a substantiated case of child abuse or neglect to the Part C Early Intervention program for developmental screening or evaluation.[8]

Case-study Methodology

NCCP invited four communities in states that responded to its survey of Part C coordinators to participate in a more detailed study. These communities were selected on the basis of regional, linguistic, and racial-ethnic diversity and promising features of their Part C Early Intervention programs. Key informants (such as early childhood and mental health leaders) along with community and state-level Part C professionals were interviewed during site visits and in follow-up discussions. The case studies focused on the Part C program's history and goals, interagency collaboration, eligibility, workforce capacity and development, and funding.

SECTION 2
Study Findings

Promising Approaches to Screening, Eligibility, and Support of At-risk Children

A promising finding from the 50-state survey of Part C coordinators shows that 70 percent of the state EI programs recommend the use of validated screening tools for identifying possible social-emotional delays in infants and toddlers. The most frequently cited tools were the Ages and Stages Questionnaire (ASQ) which includes a social-emotional component and the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) which provides a more focused assessment of difficulties in the social-emotional domain. These are the primary tools used across the four case-study communities in a wide range of settings including health clinics, home visiting, and early childhood programs. For example, the current county-wide use of the ASQ-SE in Head Start programs in Los Angeles was supported by the Early Identification and Intervention Collaborative whose members include Part C service providers and other early childhood professionals.

Wide scale screening practices with validated tools increases the chance that vulnerable infants and toddlers will be referred to Part C programs.[9] However, states' eligibility criteria determine which children can be served. Two of the case study sites, Boston and Doña Ana County, operate in states with eligibility criteria that helps ensure the provision of Part C Early Intervention services for infants and toddlers who are at risk of social-emotional problems. In these communities, clearly defined risk factors are used as eligibility criteria and may qualify a child as eligible, even in the absence of an identified delay. This practice is consistent with research that suggests there is a negative and cumulative impact of risks on child health and developmental outcomes.[10, 11]

Massachusetts Risk Factors for Eligibility

Child Characteristics:

- Birth weight less than 1,200 grams (2 pounds 10 ounces)
- Gestational age less than 32 weeks
- NICU admission more than five days
- Apgar less than five at five minutes
- Total hospital stay more than 25 days in six months
- Diagnosis of Intrauterine Growth Retardation (IUGR) or Small for Gestational Age (SGA)
- Weight for age, or weight for height, below fifth percentile; weight for age dropped more than two major centiles in three months (child under 12 months of age) or in six months (child 12-36 months of age)
- Chronic feeding difficulties
- Insecure attachment/interactional difficulties
- Blood lead levels measured at 15 mcg/dl
- Suspected Central Nervous System abnormality
- Multiple trauma or losses

Family Characteristics:

- Maternal age at child's birth less than 17 or maternal history of three or more births before age 20
- Maternal education less than or equal to 10 years
- Parental chronic illness or disability affecting caregiving ability
- Family lacking social supports
- Inadequate food, clothing or shelter, including homelessness
- Open or confirmed protective service investigation, including child in foster care
- Substance abuse in the home
- Violence in the home

In Boston, a child can receive EI services if four or more of the 20 risk factors used to determine eligibility in Massachusetts are present (see box).

The 12 child risk factors include low birth-weight, chronic feeding difficulties, attachment problems, and the experience of multiple trauma or losses. The eight family level risk factors reflect families' inability to meet basic needs (such as inadequate food, clothing, or shelter, including homeless).

New Mexico also serves at-risk children in its Part C program. Doña Ana County uses state-specified medical and environmental factors to determine children's eligibility for Part C Early Intervention services. Medical risks include a diagnosed medical or biological condition such as prematurity or drug exposure that places an infant or toddler at increased risk of a developmental delay. Environmental risks include factors that pose a serious threat to children's development such as a parent's substance abuse, parent's developmental or psychiatric disability, or domestic violence.

In Doña Ana County, the EI program uses an assessment developed by the state to identify the presence of these and other environmental risks that may make an infant or toddler eligible for Part C EI services. This tool, the New Mexico Family Infant Toddler Program Environmental Risk Assessment (ERA), identifies a wide range of risk factors in different areas including family health and mental health, age of child's primary caregiver, child's experience of multiple caregivers, and parent's behavior toward child (such as display of affection versus negative feelings). A unique feature of the ERA is that both moderate and serious risk factors are evaluated. A child becomes eligible for EI services when four or more "medium" risk factors are present (for example parent was 17 to 20 years old at time of child's birth, parent shows a mix of affection and negative behavior toward child) or when at least two of the most serious risks are identified (for example, substance abuse by household members, a member of the household with an untreated psychiatric condition). (See the ERA in Appendix A or access www.fitprogram.org).

States' use of eligibility criteria that include risk factors can help infants and toddlers who are at risk of serious social-emotional delays or behavior problems gain access to EI services. However, the extent to which the social-emotional needs of these children are actually met also depends on the adequacy of the evaluation. NCCP's 50-state survey of EI coordinators found that fewer than half of the states include individuals with expertise in social-emotional development as part of the interdisciplinary team that conducts evaluations to determine eligibility of EI services for infants and toddlers.[1] For one of the sites in this study, we found that in accordance with state policy, mental health providers in Southeast Kansas participate in EI evaluations when a social-emotional delay is suspected. Specifically, if results of a screen with the ASQ-SE show the possibility of a social-emotional delay, a mental health professional from a community mental health clinic joins the evaluation team. In addition to helping determine the child's eligibility for services, this professional assists in the identification of needed services and provides ongoing consultation as services are delivered.

Enhancing the Skills of Professionals who Provide Early Intervention Services

Perhaps the most important factor affecting the quality of interventions that infants, toddlers, and their families receive in Part C programs is the knowledge and skills of the professionals who provide early intervention services. In the case study sites, promising approaches to ensuring a high level of skill among these professionals also included efforts to increase the knowledge about infant and toddler mental health among the larger group of practitioners in the communities' family-serving programs.

A "vision statement" developed by the Massachusetts Interagency Coordinating Council (ICC) has promoted new initiatives designed to strengthen EI providers' skills in responding to the social-emotional needs of infants and toddlers (see Appendix B). In accordance with ICC recommendations for implementing this vision statement, the Massachusetts Department of Public Health is currently revising the guidelines concerning competencies for EI specialists. The new guidelines will require that EI specialists demonstrate knowledge about "how children learn through relationships," and skills in using strategies to "engage and support caregivers in positive interactions with their infants and toddlers that promote healthy social-emotional development."

In July 2009, the Massachusetts ICC conducted an "Infant and Early Childhood Mental Health Training Resources Scan" to identify individuals and organizations currently offering training in social-emotional wellbeing and examine how the content of available training matches up with the recommended competencies for EI providers. The state is currently taking steps to embed the new competencies into training for EI providers.

New Mexico and Kansas have adopted the Michigan Association for Infant Mental Health (MI-AIMH) competencies and endorsement system. This system, which any state can purchase, specifies the education, training, and knowledge needed by different types of professionals who work with infants and toddlers, including early intervention specialists, child care providers, parent educators, and program supervisors. An endorsement by the Michigan-AIMH shows that individuals have "a level of education as specified, participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, other caregivers and families." The system is used not only to endorse providers who demonstrate needed levels of training, but also to help providers develop individual professional development plans that lead to endorsement. (Additional information on the Michigan Association for Infant Mental Health competencies and endorsement system can be found at: http://www.mi-aimh.org/endorsements_overview.php).

In New Mexico professionals at levels three and four of the four-level Michigan-AIMH competencies and endorsement system – which would include EI specialists and program supervisors – participate in a two-year training institute in Infant Mental Health, followed by a written test. As of May 2010, about 45 professionals had completed this training. The training institutes and endorsement system are managed by the New Mexico Association for Infant Mental Health.

Kansas purchased the Michigan-AIMH competencies and endorsement system in 2007 through its Department of Social Rehabilitation Services, and later transferred management of this system to the Kansas Association for Infant and Early Childhood Mental Health (KAIMH). Approximately 13 professionals around the state have completed training at the highest levels, including six early interventionists. Additional early intervention professionals are expected to take the exam in the fall of 2010. Funding from the American Recovery and Reinvestment Act (ARRA) is being used to finance training of more providers. Although this funding will not achieve KAIMH's goal of ensuring adequate numbers of trained professionals in all regions of the state, it helps establish a foundation to build upon when more funds become available. In addition, the KAIMH plan for the endorsement system calls for professionals achieving endorsement at levels three and four to voluntarily provide training and mentoring for other providers across all levels of endorsement.

California has a long history of efforts to improve the competencies of early childhood mental health providers and other professionals who work with young children. Most recently, the California Infant-Family and Early Childhood Mental Health Training Guidelines Workgroup released *Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health* (2009) (http://www.wested.org/cpei/forms/training-guidelines.pdf). This workgroup is part of the California Infant, Preschool, and Family Mental Health Initiative, a collaborative effort involving eight county departments of mental health and their interagency community partners, whose goal is the development of relationship-based early intervention services for children birth to five and their families. The manual provides training guidelines and recommended competencies for core providers, which include early intervention professionals, nurses, occupational and physical therapists, speech and language pathologists, and early childhood mental health specialists. In an effort to build workforce capacity, this resource also specifies the training and competencies needed for individuals who support the development and effective practice of core providers and infant mental health specialists. The recommendations call for these individuals, known as "reflective practice facilitators," to have training and experience as core providers or infant mental health specialists, and to have

skills in modeling and supporting healthy relationships so that colleagues experience and apply these practices to their own early intervention work. This professional development model emphasizes qualitative improvement in professionals' work with young children and their families, which is different from the previous emphasis on administrative supervision and the mechanics of case management.

Interagency Collaborations that Strengthen Supports For Young Children's Social-emotional Wellbeing

In each of the four communities, the agency providing EI services operates in close collaboration with other programs serving young children and their families, and uses regular meetings of collaborating organizations, formal agreements, and other forms of communication to strengthen supports for infants and toddlers.

Local EI providers in Boston have forged working collaborations with other agencies and programs that reflect recommendations for meeting young children's social-emotional needs drafted by the state's Part C Interagency Coordinating Council. In accordance with the Child Abuse Prevention Treatment Act (CAPTA), the Harbor Area Early Intervention Program (EIP) of the North Suffolk Mental Health Association receives referrals from the local Department of Children and Families (DCF), ensuring assessments of the social-emotional needs of infants and toddlers who have experienced abuse or neglect. Unusually close working relationships between DCF case workers and EIP staff supports timely evaluations. This close working relationship is facilitated by a partnership between the staff at the organizations that dates back about 30 years. Individuals initiated this working relationship and it has been continued through specific institutionalized practices. Direct service staff, along with managers and supervisors from both EIP and DCF, participate in quarterly meetings where they discuss families involved with both agencies. Each year, joint trainings are provided for early intervention and DCF staff, and new hires at the DCF attend an orientation at the Harbor Area EIP. These events help staff at each agency learn about early intervention and child welfare policies and services, and collaborative practices that can support families across agencies.

For infants and toddlers who receive EI services, DCF case workers cooperate with EI providers to help families obtain child care through a daycare center that is located on-site at the EIP. At this early childhood program, nurses, therapists, and service coordinators work with the center's teachers to provide supports to DCF-involved children with or at-risk of developmental delays. Other services offered to families include social work assistance, family therapy, family/domestic violence prevention, and substance abuse treatment.

Another interagency collaboration that supports children's social-emotional development and mental health involves the Early Intervention, Early Head Start, and Healthy Start programs in Doña Ana County. The Healthy Start Program provides services to high-risk pregnant women, and families with infants ages 0 through 3. The Healthy Start Program is embedded within the La Clinica De Familia, Inc., a Community Health Care Center system, which provides comprehensive health services to migrant, uninsured, under-insured and Medicaid eligible children and adults. Healthy Start outreach efforts include multi-component assessments for pregnant women and mothers, including depression and substance use screening. Once families are enrolled in the Healthy Start Program, their needs are addressed through care plans and progress is evaluated a minimum of four times a year. By supporting maternal mental health and healthy family functioning, Healthy Start in turn promotes healthy relationships and the social-emotional development of young children.

The Healthy Start Program, in collaboration with the Early Head Start and EI programs, has implemented a process they call "Plan, Do, Study, Act" to quickly identify and assess young children who may have developmental delays. Through this process, Healthy Start, Head Start, and Part C providers meet and discuss specific children and families where they believe there is a need for rapid intervention. This process allows children to be more quickly identified for assessment and given cross-system referrals than they would be if the three agencies did not meet to

discuss their specific cases. Working together in this way also makes it possible for the programs to discuss the services they each provide to children and families so that services are not duplicated, and as a group, they are able to evaluate their system-wide performance. This local-level initiative does not have dedicated funding, but the professionals from the participating programs have made a personal commitment to integrate their services to meet the unique needs of this population.

Funding Strategies that Provide a Foundation for Effective Prevention and Intervention

As designed by Congress, Part C of IDEIA is intended to be a comprehensive interagency system of early intervention service and supports. Part C funds are intended mainly to support the coordination of funding from several other programs that can finance direct services to children and families. These sources for direct services include Title V (Maternal and Child Health), Title XX (Medicaid), and Head Start. States also draw on a variety of state, local, and private funding for both direct services and workforce development. Each case-study community used a unique approach to financing and enhancing the quality of their early intervention programs.

In New Mexico, the state's Children, Youth, and Families Department (CYFD) promotes and supports personnel training that is aligned with the Michigan-AIMH competencies and endorsement system. Much of the infant and young child mental health work funded by CYFD is accomplished through the non-profit New Mexico Association for Infant Mental Health (NMAIMH). Members of the NMAIMH led an initial assessment of the training needs of EI service providers and the subsequent adoption of the Michigan-AIMH competencies and endorsement system, which the organization currently manages. When the competencies were first implemented, CYFD, through a grant from the federal Substance Abuse and Mental Health Services Administration, provided training for EI providers across the state. CYFD currently funds infant mental health institutes that specifically focus on the treatment of mental health problems.

In Massachusetts, the recently updated competencies for EI providers and related demonstration process for showing that EI personnel have achieved them was funded using federal Part C dollars. In Boston, early intervention services, such as the Harbor Area EIP, are funded through a combination of the Department of Health's state-appropriated dollars and Part C federal dollars. Programs at the local level also have the capacity to bill private insurers and Massachusetts Health, which is the state Medicaid program. Local-level programs also use a combination of United Way; foundation grants such as those from the community-based Merrimack Valley Millennium Fund; private donors; and fund-raising to support their EI efforts.

Kansas purchased the license to use the Michigan-AIMH competencies and endorsement system and customized this system for Kansas' EI program with funding appropriated by the state legislature through the Department of Social and Rehabilitation Services. Personnel training has been financed by Head Start and Early Head Start, as well as Part C funds. ARRA funds have also been used to support EI providers' efforts to achieve the Michigan-AIMH endorsement. EI training opportunities will also be expanded with ARRA funds through the creation of web-based training modules.

In California, funding for the *Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health* came from private sources and was awarded to Children's Hospital Los Angeles. Additionally, Early Start Family Resource Centers in LA County, which provide support and referrals for parents of children with developmental delays and collaborate in training initiatives, receive funding from Part C, grants from the Substance Abuse Mental Health Services Administration, the state Department of Mental Health, and the Title V (Maternal and Child Health) Program. The Centers also receive in-kind support, especially space and phone service, from local school districts, hospitals, universities, and family-serving organizations such as Head Start programs.

SECTION 3

Key Findings, Conclusion, and Recommendations

Summary of Key Findings

Screening, Evaluation, and Eligibility

Across the case study sites, The Ages and Stages Questionnaire (ASQ) and Ages and Stages Questionnaire-Social Emotional (ASQ-SE) were the most commonly used screening instruments. These sites exemplify the use of screening tools that are valid, reliable, appropriate for use with diverse populations, and capable of identifying lags in young children's social-emotional development.

Southeast Kansas is the one case study site that requires the participation of a mental health professional in the child's evaluation for eligibility when a social-emotional delay is suspected.

Massachusetts and New Mexico have developed standardized tools for assessing the presence of child, parent, and family risk factors that place young children at risk of social-emotional and other developmental problems. These risk assessment tools are used in the process of determining children's eligibility for Part C Early Intervention services.

Enhancing the Skills of the Early Intervention Workforce

New Mexico and Kansas have adopted the Michigan-AIMH competencies and endorsement system to specify skills needed by different Early Intervention professionals working with infants and toddlers and to inform their state's design of training opportunities for these professionals.

Massachusetts and California sites are using state-developed guidelines for Early Intervention professionals that emphasize the need for competency in helping parents and other caregivers support infants' and toddlers' social-emotional development. Both states are aligning these guidelines with training for EI professionals.

Interagency Collaborations

In Boston, Early Intervention and Child Welfare professionals meet throughout the year to discuss families involved in both systems and to identify systems-level practices that can improve services and family engagement in supports for high risk infants and toddlers. Joint trainings that help providers understand policies and resources in each system also support effective referrals from the Child Welfare agency to Early Intervention and efforts to complete EI evaluations and engage families in services.

In Doña Anna County, providers in the community-based Healthy Start, Early Head Start, and Early Intervention programs meet regularly in order to identify families in need of rapid assessments and referrals across programs. This process has also reduced duplication of services within the "system" comprised of these three programs, and allows regular evaluation of the system's performance.

Funding

The case study communities are using a variety of funding streams to integrate supports for infants' and toddlers' social-emotional wellbeing into Early Intervention services. These include third-party reimbursement, state appropriations, federal funding sources that reflect the engagement of different agencies in program collaborations (such as, Title V, Medicaid, Part C), and private funding. In addition, program partners in Los Angeles and Kansas are contributing in-kind resources and taking advantage of one-time ARRA funding to support program and workforce development efforts.

Conclusion

The strategies used by communities highlighted in this brief are illustrative of ways to promote the social-emotional wellbeing and healthy development of infants and toddlers through supports provided by the Part C Early Intervention Programs. These efforts represent both state policy choices, including funding decisions and state eligibility criteria, as well as community level innovation and cross-systems collaboration. Children's experience of positive social-emotional health and development in the first three years is critical to their future educational success, health and life prospects. Given these high stakes, the strategies used by these communities provide valuable examples to other states and communities. The recommendations that follow suggest key opportunities for using the Part C program to support young children's social-emotional wellbeing in every state and community.

Recommendations

Establish policies and practices that increase the participation of young children at high risk of social-emotional problems in Early Intervention services.

- States that use narrow eligibility criteria in their Part C Early Intervention (EI) Programs should expand their eligibility criteria to include children at-risk of serious delays, including social-emotional problems. Early Intervention with at-risk children can reduce the chance of costly long-term conditions that limit children's prospects for good educational outcomes.
- States and community programs should consider the use of standardized risk factor assessments, such as New Mexico's ERA tool, that help identify a range of parent and family risk factors associated with serious social-emotional problems in young children. Use of these assessments in evaluations to determine children's eligibility for EI services can ensure that children who are at-risk for social-emotional problems receive early interventions needed to prevent later learning and adjustment problems in school.
- Community programs should use validated screening instruments that can identify possible social-emotional delays in infants and toddlers. Available instruments include tools that assess multiple domains, including social-emotional growth, and tools that provide specific screening for problems in this area. States should require and provide information about the use of these tools.
- Screening instruments that can identify possible social-emotional delays should be used by trained community providers across a wide range of settings, including early childhood programs, home visiting, health care settings, and family resource centers. This practice can increase the chances that a young child with social emotional delays or risk factors for developing serious problems in this domain will be identified and provided with needed interventions.
- Early intervention programs should strengthen their capacity to respond to young children's mental health needs by requiring the participation of a professional with expertise in infant-toddler social-emotional development during the multi-disciplinary evaluation that determines eligibility for EI services. States should set a policy requiring this practice.

Invest in efforts to promote the skills and knowledge of professionals who help identify children for participation in the Early Intervention program, and who deliver early intervention services to children and their families.

- States should consider establishing formal guidelines for competencies related to professionals' support of infants' and toddlers' social-emotional development. As demonstrated in this report, states can purchase established competency guidelines or develop their own.
- States and communities should invest in efforts to use social-emotional competency guidelines to train all professionals who play a role in supporting infants' and toddlers' development, including child care providers, child welfare workers, and the many different professionals who provide EI services (such as, occupational therapists, speech-language specialists).

- States and communities should establish special competency guidelines and related training for professionals who supervise EI service providers. This training should include guidance about helping all EI providers respond to the social-emotional needs of infants and toddlers and supervision methods that support providers in this work.

Use cross-systems collaboration and funding strategies to support effective Early Intervention practices.

- Community programs and agencies serving Part C Early Intervention families should establish formal procedures for supporting timely, successful referrals and family engagement; these procedures should include regular, joint reviews of families served across programs to identify strategies for ensuring that children receive evaluations and interventions following referrals.
- States and communities should assess a range of federal, state, and local funding sources for supporting the initial development or purchase of training and competency guidelines for Early Intervention professionals and for ongoing training of this workforce. Two options for using these sources should be considered: Integrating funds for workforce development across agencies and programs, or creating continuous funding by using funds from separate agencies in sequence over time.
- State and community-level systems serving young children and their families should specify shared outcomes for the social-emotional wellbeing of infants and toddlers, and identify shared funding strategies to support the services and program coordination that can achieve these outcomes.

APPENDIX A

New Mexico Environmental Risk Assessment (ERA) Tool

NEW MEXICO Family Infant Toddler Program

Environmental Risk Assessment (ERA) Tool

Child's Name:
Date of Birth:

Mother:
Father:
Primary Caregiver:

FOR ITEMS 1 TO 3: Add number of protective factors present to obtain risk (A through F).

1. Child's Basic Needs

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

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

2. Support Network

A. Primary caregiver has a partner that is involved and is a positive influence	A._____
B. Positive, supportive relationships from extended family living nearby	B._____
C. Positive support of friends	C._____
D. Reports affiliation to community group (church, support groups, AA/NA)	D._____
E. Has telephone or message phone	E._____

Add number of protective factors present to obtain risk (A through E)
4-5 = *No risk* **3 = *Medium risk*** **0-2 = *High risk*** ***No M H***

3. Home Structure/Environment

A. Is adequately organized, and there is evidence of a routine	A._____
B. Is not overly crowded or substandard	B._____
C. Has appropriate noise level	C._____
D. Has safe, developmentally appropriate toys	D._____
E. Has been adapted to meet safety needs of the child	E._____
F. In a neighborhood that is reportedly safe.	F._____

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

For additional information on the background, administration, and scoring of the tool, please refer to the following website: www.fitprogram.org.

FOR ITEMS 4 TO 15: Circle the appropriate risk level.

4. 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)

No M H

5. Family Health

No. Immediate family members living in home have no chronic illness, or debilitating disability.

M. Immediate family member has a chronic illness and is compliant with treatment regimen OR has a debilitating disability with sufficient adaptations in place to care for the child independently.

H. Immediate family member has a chronic illness and is NOT compliant with treatment regimen OR has a debilitating disability that impairs the ability of the family to care for the child OR has died in the last six months.

No M H

6. Family Substance Use

No. No recent history of inappropriate substance use by individuals living in household.

M. Minimal, recent history of or infrequent inappropriate substance use by individuals living in the household.

H. Consistent inappropriate substance use by individuals living in the household.

No M H

7. 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.

No M H

8. 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.

No M H

9. Abuse and Neglect

No. Immediate family has never had CYFD Protective Services (CYFD PS) involvement.

M. Immediate family has been the subject of unsubstantiated CYFD PS investigation(s).

H. Immediate family has an open CYFD PS investigation, had a substantiated CYFD PS investigation, and/or child is in state custody. ***No M H***

10. Justice System Related Legal History

No. Parent(s) or household member(s) have no history of jail time or probation.

M. Parent or household members have a previous history of jail time or probation.

H. Parent(s) or household member(s) have a history of jail time or probation since the child's birth. ***No M H***

11. Primary Caregiver Age at Child's Birth.

No. Primary caregiver is twenty-one years old or over.

M. Primary caregiver is seventeen to twenty years old.

H. Primary caregiver is sixteen years old or younger. ***No M H***

12. Multiple Placements

No. Child has had one primary caregiver in the last year.

M. Child has had 2 -3 different primary caregivers in different homes in the last year.

H. Child has had 4 or more different primary caregivers in different homes in the last year. ***No M H***

PRIMARY CAREGIVER DISPOSITION

13. 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. ***No M H***

14. Primary Caregiver Expectations of Child

No. Very realistic and primary caregiver has good knowledge of (or good feelings for) age-appropriate behaviors.

M. Somewhat realistic, but open to improvement. Primary caregiver has fair knowledge of age appropriate behaviors, but child sometimes held in too high or too low standards.

H. Unrealistic or not open to improvement. Primary caregiver either has very poor understanding of age-appropriate behaviors, or makes unrealistic demands of children despite some knowledge of development. ***No M H***

15. Primary Caregiver Interpretation of Child Cues

No. Interprets and responds appropriately to cues most of the time.

M. Interprets and responds appropriately to cues half of the time.

H. Rarely interprets and responds appropriately to cues. ***No M H***

16. 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 appropriately to cues.

H. Rarely responds to cues. ***No M H***

17. Other physical, social, economic and/or caregiver/family member disposition factors that may pose a substantial risk to development (rate <u>each</u> additional factor):

_____ ***No M H***

_____ ***No M H***

SCORING

_____a) a "High" rating in one, or more of the following: No. 6, 7, 8, 9, *or*

_____b) a "High" rating in a minimum of two risk factors; *or*

_____c) a "Medium" rating in four risk factors.

<u>Family Infant Toddler (FIT) Program Eligibility Determination</u>:

The above combination of risk factors has led to the determination of eligibility for FIT Program services based on the "Environmental At Risk" for developmental delay criteria:

Yes _____ No _____

Agency:_____ Clinician:_____ Date:_____

Does this child qualify for Family Infant Toddler Program due to any other Eligibility Criteria?

- ☐ Developmental Delay
- ☐ Established Condition
- ☐ Biological or Medical Risk

Primary Eligibility_____

APPENDIX B

Excerpt from Massachusetts Interagency Coordinating Council Vision Statement on Training of Early Intervention Personnel

Massachusetts Interagency Coordinating Council Vision Statement

DRAFT RECOMMENDATIONS

The Department of Public Health (DPH) recognizes and highlights the importance of the principals of relationship-based practice and reflective supervision within the Early Intervention (EI) system, through:

1) Training and support to the EI system

   The committee discussed a tiered approach to relationship based training in ongoing training initiatives. We recommend the DPH include the following components to support the EI system:

   - Introductory presentation to Program Directors
   - Massachusetts Early Intervention Training Center (EITC) to embed principles in Building a Community orientation
   - EITC to develop a core training on relationship-based practice
   - Training on "Relationship based Practice" to be offered to providers prior to implementation of a universal tool.
   - Training for supervisors in reflective supervision; offer regional groups for supervisors to support their supervision
   - EITC to incorporate training on the tool, implementation, and relationship-based training in ongoing training initiatives
   - Other recommended training approaches include special sessions and mentorships
   - DPH to develop a training plan for the implementation of screening statewide
   - Early Childhood Mental Health Online Training (Birth to Five) -an early childhood work group has been meeting to develop the content and possible format for a "relationship-based practice" online module for home visitors.

2) The Program Planning Committee will work with the Standards committee to embed the language of relationship-based practice in the EI Operational Standards.

Permission to reprint MA ICC vision statement was granted by: Ron Benham, Director of the Bureau of Family Health & Nutrition and Part C Coordinator for Massachusetts and Patti Fougere, Assistant Director, Early Childhood Programs, Division for Perinatal, Early Childhood and Special Health Needs, Massachusetts Department of Public Health.

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