

Supporting Social-Emotional and Mental Health Needs of Young Children Through Part C Early Intervention:

RESULTS OF A 50-STATE SURVEY

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The National Center for Children in Poverty (NCCP) is a non-partisan public policy research center at Bank Street Graduate School of Education. Founded in 1989 with endowments from the Carnegie Corporation of New York and the Ford Foundation, NCCP is dedicated to promoting the economic security, healthy development, and well-being of America's low-income children and families. Using research to inform policy and practice, the center seeks to advance family-oriented solutions and strategic use of public resources at the state and national levels to produce positive outcomes for the next generation.

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Introduction

This report examines features of states' Part C Early Intervention (EI) programs that help them identify and serve infants and toddlers with social-emotional (SE) delays and mental health conditions. A 50-state survey conducted by the National Center for Children in Poverty (NCCP) and Georgetown University Center for Children and Families (CCF) asked state Part C Coordinators about their programs' policies and procedures related to screening, evaluation, eligibility, services, and financing that affect the program's capacity to meet the SE needs of infants and toddlers.¹ The survey results are shared in this report, along with information from follow-up interviews with state Part C Coordinators. Overall, the findings point to both critical gaps in the capacity of Part C programs to meet infant-toddler SE and mental health needs and promising strategies some states are using to support children in this domain.

The federal Part C program is the nation's primary system for identifying and serving children ages 0 to 3 years who have developmental delays or disabilities that could seriously limit their opportunities to learn and thrive.² Some states extend eligibility for Part C EI services to children with risk factors that make it likely a child will experience a delay or disability without an intervention.³ Established under Part C of the federal Individuals with Disabilities Education Act (IDEA), the program identifies five domains—physical, cognitive, communication, social-emotional, and adaptive development—in which a child might have a delay that warrants EI services. Children with diagnosed conditions that have a high probability of leading to a delay are also eligible.

In recent years, there has been growing interest in strengthening supports for infants and toddlers with SE delays and mental health conditions. Through federally mandated State Systemic Improvement Plans (SSIPs), each state's Part C program has selected a child or family outcome it will prioritize in its efforts to improve supports, services, and evidence-based practices.⁷ Thirty-one states have chosen the goal of improving outcomes in the SE domain, which includes the child's capacity for strong social relationships and SE skills.⁸ (See Figure 1.) State Part C Coordinators and EI providers are also participating in an increasing number of infant-early childhood mental health (IECMH) state policy groups that are working to expand and improve the quality of IECMH services across sectors, including early care and education, early intervention,

Part C of the Individuals with Disabilities Education Act (IDEA)

Part C of IDEA is a federal grant program to states that supports the provision of early intervention services to infants and toddlers with disabilities. States electing to participate in Part C—all states currently do—designate a lead agency to meet the program's requirements. These requirements are specified in [federal regulations](#) issued in 2011 following the most recent reauthorization of [the law](#) in 2004. The requirements include: maintaining a Child Find system, which provides public awareness programs and activities to identify and refer children to Part C; a rigorous eligibility definition; multidisciplinary evaluation and assessment; service coordination and the development of Individualized Family Service Plans (IFSPs) for eligible children; appropriate early intervention services; a comprehensive system of personnel standards and development; and a state interagency coordinating council.

One of the five domains in which children can qualify for Part C services is a delay in social or emotional development. Children with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay are also eligible. While every state must provide services to children with a delay in the domain of social-emotional development, the definition and criteria for establishing social-emotional delay vary across states (e.g., states differ in the severity of delay that must be documented).⁴ The families of children who are found eligible work with a service coordinator who helps the family develop and implement an IFSP. The IFSP outlines the expected outcomes for the child and family and the specific services they will receive, with an emphasis on their delivery in a natural environment, such as a home or community setting.

In 2018, [Part C served 802,863](#) children from ages birth to 3.⁵ The federal government requires states to report on the progress of families in Part C, and one of the three child outcomes they must report on is social relationships. In fiscal year 2018, 65 percent of Part C children showed greater than expected growth in social relationships and 55 percent exited Part C at or above expectations in their social relationships.⁶

home visiting, and pediatric settings.⁹ These initiatives reflect a growing recognition that infant-toddler mental health and SE competencies are foundational for healthy development.¹⁰ (See box defining infant-toddler mental health.)

Within EI programs, a strong rationale for ensuring attention to children's SE needs is that competencies in this domain, especially the capacity to engage in positive relationships with parents and other caregivers, bolster efforts to support development in other domains. Coaching parents to support their child's development in the course of daily routines is a critical best practice in EI programs and affords opportunities to help parents interact with infants and toddlers in ways that build a nurturing relationship.¹¹ In turn, this relationship supports infant-toddler growth in all areas of development. For example, a parent whose toddler expects the parent's interest and responsiveness during play will likely try to actively communicate with the parent, creating frequent opportunities for acquiring language skills. Similarly, a child learning new motor skills will benefit from a nurturing relationship in which the parent helps the toddler feel safe and supported while exploring and practicing these skills.

Meeting infant-toddler mental health needs is also a core goal of EI—supporting development at the earliest ages to help ensure that children will gain a foothold on a positive developmental trajectory with improved chances to succeed educationally and in all spheres of life. As with conditions in other areas, children with mental health needs are at higher risk of ongoing and worsening problems without appropriate interventions.¹² While some children's primary difficulty may be in the SE domain, it is also important to recognize that children with delays and disabilities in other domains are at higher risk of mental health conditions.¹³

For all of these reasons, taking stock of Part C programs' current capacity in the SE domain is useful and can help guide efforts to improve the many processes in the Part C program that affect the amount and quality of supports children receive, including the identification and eligibility determination processes and service provision. The remainder of this report is organized into the following sections:

Survey Methods

Results

- Part C Early Intervention Promotion, Screening, Referral, and Evaluation
- Referral, Screening, and Evaluation of Infants and Toddlers Involved in Child Welfare
- Services for Children Not Eligible for Part C
- IECMH-Related Services and Supports for Enrolled Children
- Medicaid and Part C EI
- Professional Development and Other Initiatives to Address Needs in the Social-Emotional Domain

Summary

Recommendations

Infant-Toddler Mental Health

Infant-toddler mental health refers to how well the child is developing socially and emotionally in the first three years. This growth entails increasing capacities to:

- form a close, secure relationship with the adults who care for them
- experience and express a range of emotions, and over time, learn to manage these (e.g., cope with frustration)
- feel comfortable exploring their environment

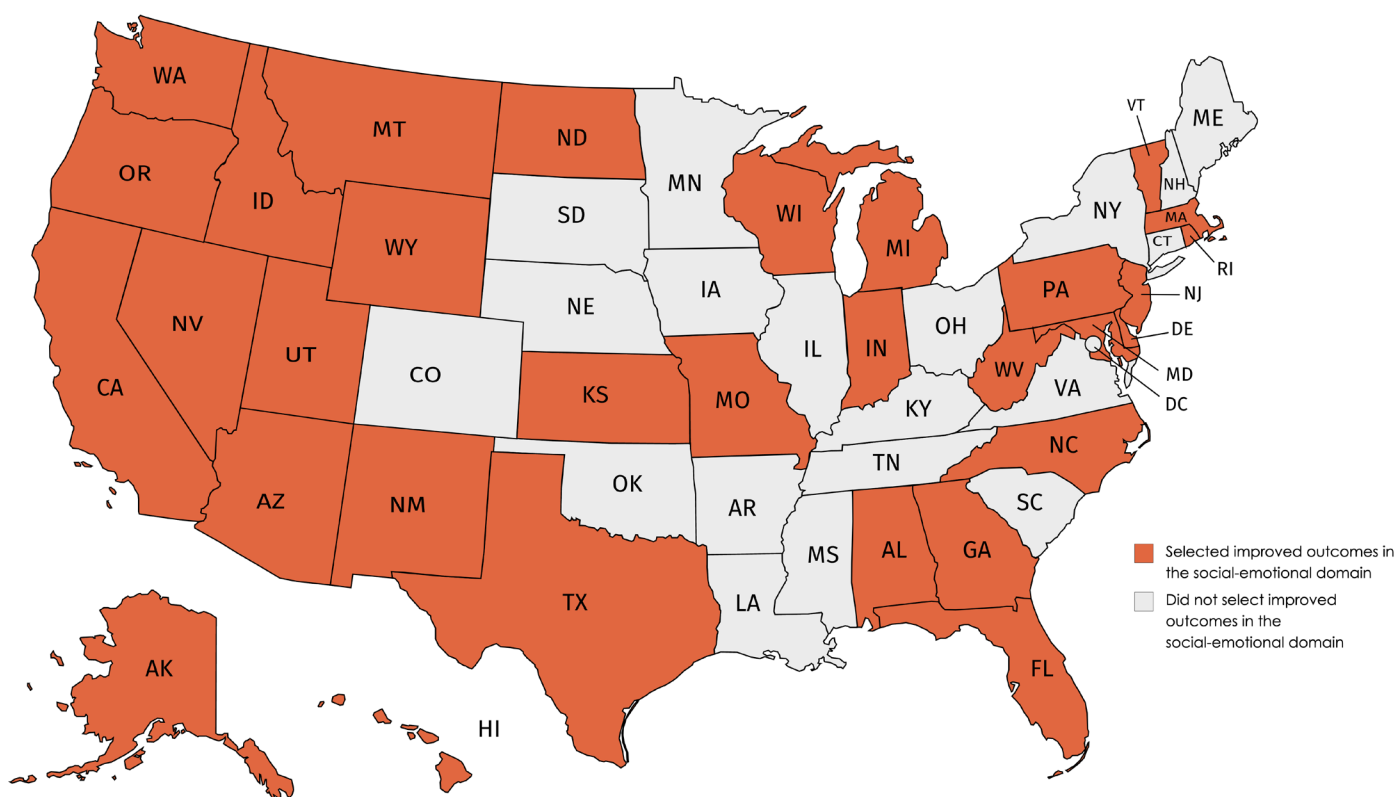
In this report, the terms "social-emotional" and "infant-toddler mental health" are used interchangeably, reflecting the field's growing understanding of these concepts and their close alignment.

Source: Zero to Three, & Manatt Health. (2018). Planting seeds in fertile ground: Actions every policymaker should take to advance infant and early childhood mental health. <https://www.zerotothree.org/document/633>

Survey Methods

From October 2019 to June 2020, NCCP and CCF administered an online survey to 50 states and DC, and conducted interviews with selected states to learn about features of states' Part C programs that increase their capacity to identify and provide appropriate services to infants and toddlers with social-emotional delays and mental health needs. Qualtrics, a web-based platform, was used to administer the survey. In most cases, state Part C Coordinators completed the survey. All states and DC provided completed surveys. Follow-up calls with Part C Coordinators and leaders at organizations that partner with EI were used to gather additional information about promising policies and practices.

Figure 1. States that Selected Improved Outcomes in the Social-Emotional Domain



Results

PART C EARLY INTERVENTION PROMOTION, SCREENING, REFERRAL, AND EVALUATION

Promotion of Social-Emotional Screening and Referrals

One important source of information about a state's Part C program is promotional materials, including descriptions of the program posted on state websites and provided in brochures and flyers. These materials can help parents and providers (e.g., pediatricians, child care teachers) understand the Part C program and decide whether to seek its services for particular children. The survey asked whether the state's promotional materials indicate that social-emotional screening and services are provided by Part C. Thirty-eight states reported that their Part C programs specify social-emotional screening and services in promotional materials.

As part of their efforts to identify children who might be eligible for Part C, state programs are required to educate providers who are primary sources for referrals about the program.¹⁴ For the survey, Part C Coordinators reported on their programs' efforts to promote social-emotional screening and referrals to Part C by infant and toddler providers, including early care and education teachers, home visitors, and pediatricians. More than half the states reported that they provide online and in-person information or training to providers about the program. Providers included: early intervention service coordinators and providers, early care and education providers, home visitors, and pediatricians.

- 30 states provide resources and online guidance to providers
- 30 states conduct in-person training of providers
- 26 states provide consultation to providers through phone and email communications
- 24 states conduct virtual training of providers
- 7 states do not conduct any activities to promote social-emotional screening and referrals

Screening and Evaluation

The survey asked whether state Part C programs recommend or require the use of social-emotional screening tools. The use of a specialized social-emotional screener increases the chance that a child who may be experiencing a social-emotional delay or mental health condition will be identified so that further evaluation of a suspected problem in this domain can be conducted. Research has shown that a social-emotional screener identifies more children who need further evaluation for social-emotional concerns than a broad developmental screener.¹⁵ Overall, states were much more likely to recommend than require the use of a social-emotional screening tool. Among the nine social-emotional screening tools listed in the survey, the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) was the most recommended tool; 30 states recommend this tool (AK, AR, AZ, CA, CO, CT, DE, HI, ID, IN, KS, LA, MA, MD, MN, MS, ND, NE, NH, NV, NY, OK, OR, PA, RI, SD, TX, UT, VT, WY) and 8 states require its use (DC, GA, IL, KY, MT, NM, OH, WA). See Figure 2 for complete results.

Figure 2. Social-Emotional Screening Tools States Recommend or Require

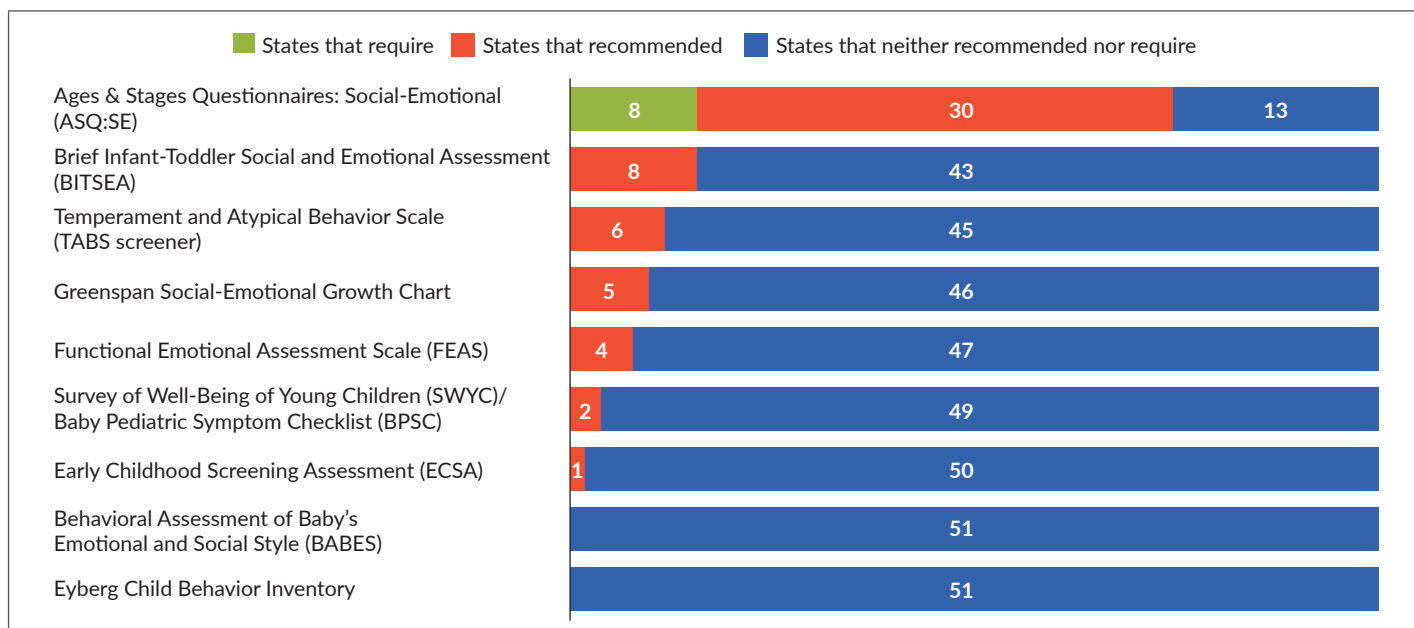
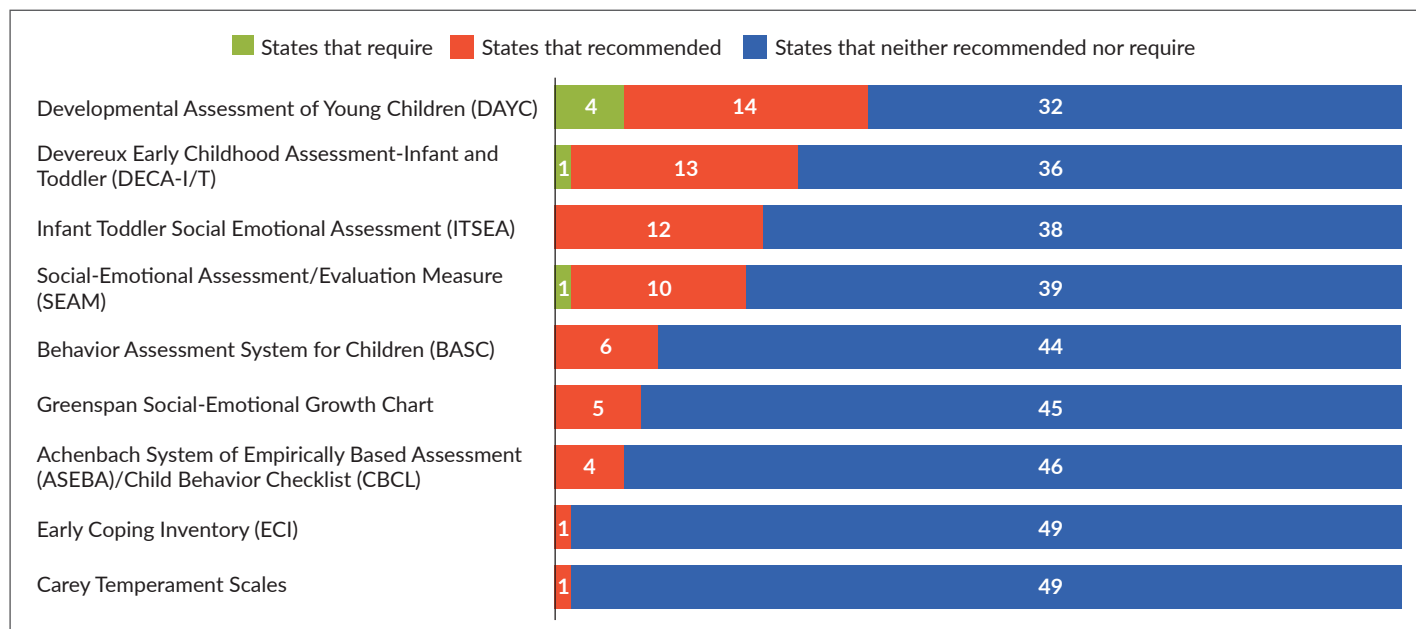


Figure 3. Social-Emotional Tools for Evaluation and Assessment States Recommend or Require



The survey also asked whether state Part C programs recommend or require social-emotional tools for evaluation and assessment. The use of a standardized social-emotional tool in an eligibility evaluation can help ensure an adequate focus on how children are doing in this domain. A social-emotional assessment tool, typically comprised of rating scales completed by someone who knows the child well, is often recommended as one component of an evaluation that also includes an interview with the parent or other adults who know the child, and possibly an observation of the child.¹⁶ Among the nine tools listed in the survey, the Developmental Assessment of Young Children (DAYC), Devereux Early Childhood Assessment-Infant and Toddler (DECA-I/T), Infant Toddler Social Emotional Assessment (ITSEA), and Social-Emotional Assessment/Evaluation Measure (SEAM) were the most recommended or required tools.

- 14 states recommend DAYC (AR, AZ, ID, MD, MT, NE, NV, NY, OR, PA, SD, UT, WV, WY) and 4 states require its use (GA, MO, MS, NC)
- 13 states recommend DECA-I/T (AK, ID, MI, NE, NV, NY, OH, OR, PA, UT, WA, WV, WY) and 1 state requires its use (CT)
- 12 states recommend ITSEA (AK, CO, CT, DC, GA, ID, NE, NY, SD, UT, WA, WV)
- 10 states recommend SEAM (DC, ID, KS, NV, NY, OR, PA, UT, VT, WV) and 1 state requires its use (AL)

As with screening instruments, states were more likely to recommend than require a standardized social-emotional evaluation or assessment tool. (See Figure 3 for complete results.)

Part C Coordinators also reported on the use of additional tools to identify family risk factors and trauma. Children's experience of adverse family circumstances, such as having a parent with a serious mental health condition or substance use disorder, family food insecurity, or a history of trauma, increases the chance that the child has developed or will develop a mental health condition or that a parent has a mental health condition associated with poor child mental health outcomes.¹⁷ These experiences may signal family needs that should be addressed to reduce this risk and enable parents to fully engage in early intervention services that are provided to eligible infants and toddlers. Although standardized screeners that identify family risk factors exist (e.g., SEEK Parent Questionnaire, WE CARE), the survey found that most states do not recommend or require their use.¹⁸

- 36 states neither recommended nor required the use of tools that identify family risk factors and/or trauma
- 1 state (GA) recommends the use of the **Bright Futures Pediatric Intake Form**, which covers parental depression, substance use, domestic violence, and social supports.¹⁹

- While several states reported the use of other tools, these were either not named or are instruments that do not focus on family risk factors.

In qualitative responses and follow-up discussions, some Part C Coordinators indicated that the family interviews used in the assessment process address risk factors. While there is no research on whether a standardized family risk assessment is likely to yield more information about adverse circumstances than an interview, use of a standardized tool in an eligibility evaluation might ensure a more consistent assessment of important risk factors, which could be further examined in an interview.

Identifying Social-Emotional and Mental Health Conditions When Determining Eligibility

In order to determine eligibility for Part C EI services, federal rules require a multidisciplinary evaluation of a child by “qualified” personnel to “identify unique strengths and needs.”²⁰ The inclusion of a professional with expertise in infant-toddler mental health on the evaluation team is arguably essential given the importance of social-emotional competencies and mental health to development in all domains. However, only one-quarter of the states require that this type of professional be a member of the eligibility evaluation team.

- 13 states require that evaluation teams include professionals with expertise in the social-emotional development and mental health of infants and toddlers (AK, AZ, CA, CO, CT, ID, IL, MA, MT, ND, NY, WV, WY)
- Among states that require the participation of professionals with social-emotional and mental health expertise, 11 states reported that the qualifications for this role are written in guidance or policy (AK, AZ, CA, CO, CT, IL, MA, ND, NY, WV, WY)

A few states commented in their survey that they require a professional with infant-toddler mental health expertise when there is suspicion that the child has a delay or condition in this domain prior to the evaluation. However, these states did not require social-emotional screening, reducing the chance that concerns about delays in this domain or a mental health condition would be identified prior to the evaluation.

Social-Emotional Screening in Illinois

In Illinois, 25 local Child and Family Connections offices serve as the system point of entry for families referred to Part C Early Intervention (EI). [State policy](#) requires that at the initial intake meeting and with the family’s consent, a service coordinator administers the [Ages & Stages Questionnaires: Social-Emotional, Second Edition \(ASQ:SE-2\)](#), a validated social-emotional-focused screening tool. The service coordinator uses the results of the ASQ:SE-2, along with information gathered during the [Routines Based Interview \(RBI\) assessment](#) and other sources to determine who will be on the family’s evaluation/assessment team. A positive screen on the ASQ:SE-2 indicates that the evaluation team should consider including a professional with a background in infant-toddler early childhood mental health and social-emotional development. This practice helps ensure that infant and toddler needs in the social-emotional domain will be identified early in the family’s involvement with EI so that interventions to address SE needs can be included in the Individual Family Service Plan.

Source: Ann Freiburg, Part C Coordinator, Bureau of Early Intervention, Illinois Department of Human Services.

The [DC:0-5](#) (*Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*) can strongly support the diagnosis of mental health and developmental disorders in children birth to age 5.²¹ As a developmentally sensitive, relationship-based system of diagnosis, it can help an evaluation team identify mental health conditions in infants and toddlers in order to determine eligibility. The survey asked about the use of the DC:0-5 or DC:0-3 (an earlier version) in the eligibility evaluation process. While some Part C programs recognize DC:0-5, most states do not currently recommend or require its use.

- 3 states require the use of the DC:0-5 or DC:0-3 (ME, NC, NM)
- 5 states recommend the use of the DC:0-5 or DC:0-3 (AK, CO, ID, MN, VT)
- 43 states neither recommend nor require the use of the DC:0-5 or DC:0-3 (AL, AR, AZ, CA, CT, DC, DE, FL, GA, HI, IA, IL, IN, KS, KY, LA, MA, MD, MI, MO, MS, MT, ND, NE, NH, NJ, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV, WY)

Personnel Standards for Infant-Early Childhood Mental Health Specialists

In Colorado, each early intervention agency has social and emotional (SE) service providers available to serve on evaluation teams and provide consultation to EI providers on the social-emotional needs of children and families, as well as direct services to families. The state's Part C EI **personnel standards** include a special section that outlines qualifications for these professionals. These qualifications vary by the professional's degree, but all include a requirement that SE specialists who participate in evaluations have training in **DC:0-5** or **DC:0-3R**. An Infant Mental Health Specialist must also have completed the Infant Mental Health Endorsement at Level III or IV, sponsored by the Colorado Association of Infant Mental Health.

Illinois' **Child & Family Connections Procedure Manual** has an extensive set of recommended qualifications for the Part C EI program's SE consultants. These include "master's degree in child development, special education, psychology, social work, or a related field; supervised clinical experience with children and families; ...training in infant development; ... diagnosis of mental health disorders in infancy...; impact of stress and trauma in infancy; assessment of parent/child relationship; intervention to support parent/child relationship; and knowledge about and skill in providing reflective supervision and consultation."

Source: Laura Merrill, Evaluation Manager, Early Intervention Colorado; Ann Freiburg, Part C Coordinator, Bureau of Early Intervention, Illinois Department of Human Services.

REFERRAL, SCREENING, AND EVALUATION OF INFANTS AND TODDLERS INVOLVED IN CHILD WELFARE.

The Child Abuse Prevention and Treatment Act (CAPTA) recognizes that children involved with child welfare are at high risk of experiencing developmental delays and mental health problems.²² CAPTA requires that states establish procedures for referring children who have experienced substantiated abuse and neglect to the Part C program to receive services, if they are found eligible through an evaluation. Federal guidance indicates that states have discretion about whether to refer children directly from Children's Protective Services (CPS) to a Part C program for a screening or evaluation or to rely on a screening conducted by CPS or other "primary referral sources" to determine whether referral to Part C is appropriate.²³ These primary referral sources include a health care provider or other human services agency.

To better understand this process, Part C Coordinators were asked to report on features of the referral, screening, and evaluation process for children referred from a child welfare agency in cases of substantiated abuse and neglect. Over half the states reported that children are referred directly to Part C for a screening or evaluation.

- 20 states reported that when a child is involved in a substantiated case of child abuse or neglect, the child is referred to Part C for screening, followed by an evaluation, if needed (AR, AZ, CO, DC, DE,

GA, IN, KY, ME, MS, MT, ND, NV, PA, RI, SD, TX, VA, VT, WY)

- 12 states reported that the child is referred to Part C for an evaluation without an initial screening (AK, KS, LA, MA, MI, MO, NH, NJ, NM, SC, UT, WV)
- 18 states report other procedures (AL, CT, FL, HI, IA, ID, IL, MD, MN, NC, NE, NY, OH, OK, OR, TN, WA, WI)
 - ♦ 8 states indicated that the child is referred for either screening or evaluation, with the decision to screen or evaluate made at the program's discretion or on a case-by-case basis, often in response to particular concerns about a child (CT, IA, ID, MD, MN, NE, OH, OK)
 - ♦ In 4 states, some or all children receive a screening conducted or arranged by Child Protective Services, and the child is referred to Part C if a concern is identified (HI, IL, OR, WA)
 - ♦ Some states reported local variation in how children are referred to Part C from a child welfare agency, and a few states appear to lack well-defined policies in this area.

Only nine states reported that the state's Part C program requires the use of a social-emotional screening and/or evaluation tool for children involved in a substantiated case of abuse or neglect, although nearly half recommend a social-emotional tool.

- 9 states require the use of a social-emotional tool (AL, AZ, GA, IL, MA, MT, PA, SD, TX)

- 24 states recommend the use of a social-emotional tool (AK, CO, CT, DC, IA, ID, KS, LA, MI, MS, ND, NE, NH, NM, NV, NY, OK, OR, SC, UT, VT, WA, WV, WT)
- 18 states neither recommend nor require the use of a social-emotional tool (AR, CA, DE, FL, HI, IN, KY, MD, ME, MN, MO, NC, NJ, OH, RI, TN, VA, WI)

SERVICES FOR CHILDREN NOT ELIGIBLE FOR PART C

Some children may fail to reach the eligibility criteria a state sets for Part C, but can still be at risk of a worsening delay or condition. For this reason, Part C programs may have policies in place that promote the continued monitoring of these children's development. For the survey, states reported on whether there were any written policies to guide referrals or continued monitoring for infants and toddlers who do not meet Part C eligibility criteria. Over half of the states have policies inviting parents to contact the program again to request another screening if concerns about the child persist, while only a few require the Part C program to contact parents after a period of time to offer another social-emotional screening.

- 31 states have written policies stating the child and family should be referred to appropriate services, including home visiting and early care and education programs (AK, AL, AZ, CT, DC, HI, ID, IL, IN, KS, KY, LA, MA, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, RI, TN, VT, WA, WI, WV, WY)
- 29 states have written policies stating that parents should contact the program for another screening or evaluation if they have concerns in the future (AK, AR, CT, DC, DE, GA, HI, IA, ID, IL, KY, LA, MA, MD, MN, MS, MT, NC, ND, NE, NH, NM, NV, NY, OH, SC, VT, WA, WV)
- 5 states have written policies requiring the Part C program to contact parents within a specified period of time to offer another social-emotional screen, with follow-up ranging from three to six months (GA, ID, NY, PA, WV)
- 3 states offer regular monitoring of ineligible children's social-emotional and general development (AL, PA, UT). (See box on services for ineligible children.)
- 11 states have no written policies about supports for ineligible children (CA, CO, FL, ME, MI, OK, OR, SD, TX, UT, VA)

Services for Children Found Not Eligible for Part C in Alabama and Oklahoma

In Alabama, all children who are evaluated and found ineligible for Part C Early Intervention are referred to the statewide [Help Me Grow \(HMG\)](#) program. Children receive regular developmental and social-emotional screening through HMG, and can be referred again to Part C if screening indicates a need for another evaluation. HMG care coordinators also help link families to a wide range of services and programs, including home visiting programs and mental health providers, as well as local organizations that might be able to address basic family needs. HMG has contracts with local agencies statewide to ensure that connections between parents and providers can be made and to keep information about local resources up to date. HMG is funded by the Alabama Departments of Early Childhood Education (through a Preschool Development Grant), Human Resources (through the Child Care and Development Fund), and Mental Health (through a Project LAUNCH Grant). In addition, HMG is supported by an AmeriCorps State Grant.

See NCCP's [full PRISM profile](#) for more information on Help Me Grow in Alabama.

In Oklahoma, families with children who are not found eligible for Part C receive information on enrolling in the state's [Child Guidance](#) program. Child Guidance provides support and parent education to children ages birth to 13 and their parents in areas of behavioral health, child development, and speech-language pathology. Child Guidance works closely with Part C and other programs to provide a safety net to children and families who do not qualify for those services but who are at risk for behavioral, developmental, or communication delays. Child Guidance is available through 15 regional hubs located within local county health departments, and services are covered under Medicaid.

Source: Katie Prince, Help Me Grow Alabama Director, Alabama Partnership for Children; Gina Richardson, Assistant Director, SoonerStart Early Intervention, Oklahoma State Department of Health.

IECMH-RELATED SERVICES AND SUPPORTS FOR ENROLLED CHILDREN

Federal guidance does not specify the types of services that should be provided to children in Part C who have needs in the social-emotional domain.²⁴ This guidance calls for the provision of services that address needs in this domain and others and describes services that are relevant to social-emotional difficulties in fairly general terms (e.g., "... activities that promote the infant's or toddler's acquisition of skills in a variety of developmental domains, including ... social interaction.")

The survey asked Part C Coordinators about their programs' provision of four key services and supports used in other sectors (e.g., early care and education, home visiting programs, and mental health settings) to address children's social-emotional and mental health needs: 1) dyadic treatment, 2) parenting programs with a focus on promoting positive social-emotional outcomes for young children, 3) consultation with an infant-toddler mental health specialist for EI and other providers working with enrolled children, and 4) parent depression screening.²⁵

Dyadic Treatment

States reported on the Part C program's provision of dyadic treatment, a form of therapy in which the infant and parent are treated together by a clinician who supports the parent to engage in positive interactions with the child through

coaching. In this way, dyadic treatment helps strengthen the parent-child relationship and promote positive child behavior and development. Dyadic treatment is often used when very young children and parents have an impaired relationship or exhibit patterns of interaction that contribute to infant-toddler behavior difficulties or place a child at risk of a mental health condition.²⁶ There are currently several evidence-based models of dyadic therapy, including some forms designed for infants and toddlers who have experienced trauma.²⁷ While nearly half the states reported that their Part C programs provide dyadic treatment, the findings do not suggest wide use of evidence-based models.

- 24 states reported that their Part C program provides parent-child dyadic treatment (AK, AR, CO, HI, IL, ID, IL, KS, KY, LA, MA, MT, NH, NJ, NV, OH, OR, PA, RI, SC, TX, VA, WA, WV)
- Among the states that provide dyadic treatment, 6 states require (IA, KY, MA, MT, NV, WA) and 6 states recommend (AK, HI, IL, KS, PA, VA) the use of evidenced-based treatment models. See recommended and required dyadic treatment models in Table 1.
- 12 states allow the use of any dyadic treatment model (AR, CO, ID, LA, NH, NJ, OH, OR, RI, SC, TX, WV).

Table 1. Recommended/Required Evidence-Based Dyadic Treatment Models*

Evidence-based (EB) dyadic treatment models	States that require EB dyadic treatment model	States that recommend EB dyadic treatment model
Child Parent Psychotherapy/Infant Parent Psychotherapy/Toddler Parent Psychotherapy	KY, MT	AK
Parent-Child Interaction Therapy (PCIT)	KY	PA
Promoting First Relationships (PFR)	WA	AK
Attachment and Biobehavioral Catch-up (ABC)		KS
Watch, Wait and Wonder (WWW)		AK

*Not all states that report offering dyadic treatment identified specific models.

Other Approaches to Supporting Parent-Child Interaction

A few states identified other approaches used in their Part C programs, including [Family-Guided Routines Based Intervention \(FGRBI\)](#) and [Parents Interacting With Infants \(PIWI\)](#). FGRBI is a commonly used method of coaching family members to use targeted interventions in the course of daily routines to address developmental delays.²⁸ PIWI is a set of trainings and resources for EI providers that helps them support parents' sensitive, positive interactions with their infants and toddlers to promote a healthy parent-child relationship and social-emotional growth.²⁹ Developed by the Center on the Social-Emotional Foundations of Early Learning (which developed the Pyramid Model), PIWI strategies can be used in parent-child groups or with individual dyads during home visits. Although FGRBI and PIWI are not dyadic treatment models delivered by clinicians, both are models that can help EI providers support parent-child interactions that help build positive social-emotional competencies. As discussed later, several states are using PIWI or other Pyramid Model approaches for the training of EI providers.

Parenting Programs

Several evidence-based and research-informed group parenting models have been designed for parents of infants and young children and have a strong focus on parenting that contributes to a healthy parent-child relationship and positive social-emotional outcomes for children. Examples include Triple P Parenting, Incredible Years, and Circle of Security.³⁰ In the survey, Part C Coordinators reported on the provision of parenting programs that promote children's social-emotional well-being and address behavior concerns to families enrolled in EI.

Most states (34) reported their Part C programs offer this service (AK, AZ, CA, DC, DE, GA, HI, ID, IL, KS, LA, MA). Among the states that provide parenting programs, more than half (20) reported that any parenting program can be used (DC, GA, ID, IL, LA, MA, MD, ME, MO, ND, NE, NH, NM, NY, OH, RI, SC, TN, TX, WV), while 14 indicated that they recommend or require the use of evidence-based parenting programs (AK, AZ, CA, DE, HI, KS, MT, NV, OR, PA, SD, VA, WA, WY). The survey also asked for the name of these evidence-based models.

- 4 states recommend the Triple P (Positive Parenting Program) model (AK, AZ, KS, PA).
- 2 states recommend the Incredible Years model (PA, WY).

Evidence-Based Dyadic Treatment for Families Served by Part C Early Intervention: HopeSparks, Washington State

[HopeSparks](#) is a behavioral health and family services agency based in Washington state. It provides Early Intervention (EI) services, behavioral health, kinship care, home visiting, and parent education to thousands of families each year. The HopeSparks team of more than 50 professionals includes seven infant mental health therapists trained on [Child-Parent Psychotherapy \(CPP\)](#), an evidence-based dyadic treatment model for children from ages birth to 5 who have experienced trauma or who are at risk of insecure attachment or social-emotional problems. Children and parents in EI who need dyadic treatment have easy access to it since trained CPP clinicians are in the same agency with EI. All EI providers and staff at HopeSparks participate in monthly cross-disciplinary groups and one-on-one reflective supervision. Ongoing trainings cover motivational interviewing, as well as trauma and foundational training in [Promoting First Relationships](#), a relationship- and strengths-based home visiting program for families facing adversity. A number of service providers have [Infant Mental Health Endorsements](#).

EI-enrolled children receiving CPP at HopeSparks include infants and toddlers with a social-emotional delay or mental health condition, as well as children with conditions in other areas. For example, the team supports many children who have experienced medical trauma. Approximately 19 percent of children receiving EI services through HopeSparks receive CPP or other infant-toddler mental health services. Many children who receive CPP are initially referred to EI from a variety of systems. They are identified as candidates for CPP through an initial evaluation or in the course of receiving EI interventions, often in conversations with families and within a multidisciplinary team that considers the child's needs. For children receiving CPP through EI, CPP appears on the IFSP as "Family Training/Counseling." CPP and other mental health services for children in EI are billed to Medicaid.

Source: Lou Olson, Director of Children's Developmental Services, HopeSparks.

- 1 state recommends the Circle of Security-Parenting (COS-P) model (AK).
- Several states reported they recommend or require “other” evidence-based parenting programs; these were mostly evidence-based home visiting models such as Parents as Teachers and Nurse-Family Partnership

Maternal Depression Screening

Maternal depression screening identifies mothers who may be experiencing depression and need an evaluation. A positive maternal depression screen also suggests the need for enhanced monitoring of the child’s social-emotional growth and other areas of development since maternal depression increases the child’s risk for social-emotional difficulties and developmental delays.³¹ The survey asked about the Part C program’s provision of maternal depression screening or its referral for screening, evaluation, and/or treatment for maternal depression. Over half the states report that screening or referral for maternal depression-related services is not offered to parents of infants and toddlers enrolled in Part C, while a small number (five) offer maternal depression screening.

- 30 states do not provide screening or referrals for screening, evaluation, or treatment for maternal depression (AL, AR, AZ, CA, DC, DE, KS, KY, LA, MD, ME, MI, MN, MO, MS, MT, ND, NE, NH, NJ, NY, OK, OR, PA, SC, SD, TN, VA, WI, WY)
- 18 states provide referrals for evaluation and/or treatment of maternal depression (CO, CT, FL, HI, IA, ID, IL, IN, MA, NM, NV, OH, RI, TX, UT, VT, WA, WV)
- 16 states provide referrals for maternal depression screening (CO, CT, GA, HI, IA, IL, MA, NC, NM, NV, OH, RI, TX, UT, VT, WA)
- 5 states provide screening for maternal depression (ID, NC, RI, UT, WA)

Infant-Early Childhood Mental Health Consultation

Infant-early childhood mental health consultation (IECMHC), used most widely in early care and education programs, “aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age 6 and their families.”³² Increasingly, IECMHC is also being used in other child-serving sectors, including home visiting programs.³³ For the survey, Part C Coordinators reported on whether their state’s program provides consultation

Evidence-Based Parenting Programs to Promote Social-Emotional Development for Families in Early Intervention in Nebraska

Circle of Security-Parenting (COSP™) is an evidence-based, eight-week group parenting program for families with children under 6 years old. COSP™ aims to strengthen the parent-child relationship by helping parents serve as a source of security for their children. In Nebraska, COSPTM Programs are offered statewide in 50 communities.

Decisions to sponsor COSP™ Programs are made at the local level by a variety of early childhood stakeholder groups and organizations, including Early Childhood Planning Region Teams, which comprise local Part C Early Intervention (EI) stakeholders. Education agencies, including school districts which provide EI services in the state, sponsor 16 percent of COSP™ Programs. Local EI service coordinators share opportunities to participate in COSP™ with families who could benefit from this program, whether or not EI is sponsoring the program. When EI does sponsor a local COSP™ Program, the coordinator offers slots to EI families first, and then opens it up to the community if all spaces are not filled. To establish a cadre of certified COSP™ facilitators, Nebraska agencies partnered with Circle of Security International to offer training to two cohorts. The state Part C program covered half the training costs for 80 participants in the first cohort. Currently, there are approximately 240 certified COSP™ facilitators in the state.

See NCCP’s [full PRISM profile](#) for more information on COSP™ in Nebraska.

Source: Amy Bunnell, Early Childhood Special Education Supervisor, Nebraska Department of Education, and Sami Bradley, Assistant Vice President of Early Childhood Mental Health, and Lynne Brehm, Associate Vice President of Early Childhood Mental Health, Nebraska Children and Families Foundation.

by infant-toddler mental health specialists to other professionals within EI (e.g., a speech-language therapist, family coordinator) and/or to professionals outside EI who may be serving an EI-enrolled child (e.g., child care staff, pediatricians). Over half of the states reported that IECMHC is offered to professionals working with EI children.

- 29 states reported that consultation by infant mental health specialists is provided to other professionals (AK, AR, CA, CO, CT, DC, DE, GA, HI, ID, IL, IN, KS, LA, MA, MD, ME, MO, MT, NE, NH, OH, OK, RI, TX, VA, VT, WI, WY)
- Recipients of IECMH consultation identified by Part C Coordinators included early intervention specialists, child care and Head Start providers, nurses, child protection social workers, parents and foster parents, pediatricians and family practitioners.

Follow-up calls with states indicated that professionals providing IECMH consultation to EI providers are, in some cases, employees of the EI programs or agencies; in other cases, they are employees of outside organizations (such as mental health service agencies or universities) and provide IECMH consultation services for EI children through service agreements with EI programs and agencies.

Barriers That Limit Access to Services That Address SE Delays and Mental Health Conditions

Part C Coordinators reported on barriers that may limit families' access to services that address children's needs in the social-emotional domain. Most of these barriers are related to the limited workforce of IECMH specialists.

- 38 states cited the geographic distribution of qualified providers (i.e., having providers in some parts of the state, but not in others) (AK, AR, AZ, CO, DE, GA, HI, IA, ID, IN, KS, KY, LA, MA, ME, MN, MO, MS, MT, NC, NE, NH, NM, NV, OH, OK, OR, PA, RI, SC, SD, TN, UT, VT, WA, WI, WV, WY); some of these states specifically mentioned challenges related to serving families in rural communities
- 32 states indicated not having enough qualified providers (AL, AR, AZ, CO, CT, DE, HI, IA, ID, IN, KS, LA, MA, MN, MO, MS, MT, NC, NE, NH, NM, NY, OH, PA, RI, SD, UT, VA, VT, WA, WV, WY)
- 16 states reported inadequate reimbursement rates (AL, AZ, CO, HI, ID, IN, KS, KY, MA, MS, MT, NM, SD, TX, VA, WA); several states commented that low rates make it difficult to hire and retain qualified providers



Approaches to Mental Health Consultation in Part C Early Intervention

Infant-early childhood mental health consultation (IECMHC) pairs a mental health professional with early childhood providers and programs, including Early Intervention (EI), to build their capacity to support the healthy social-emotional development of children and address mental health challenges.

Louisiana has developed IECMHC for EI in the Lafayette area, with a focus on expanding the capacity of EI providers to identify children with mental health needs and to use interventions within the scope of their practice. The consultation team includes a master's-level IECMH specialist who provides in-home consultation, visiting families with the EI provider to help determine mental health needs and support the EI provider in offering ongoing supports for the child, parent, and family. EI providers also have access to consultation with the team's child psychiatrist, which can include phone and email communications. Additional consideration of family needs occurs in case discussions involving the IECMH consultant who serves EI, another consultant who serves families in pediatric settings, and the child psychiatrist. Annual EI provider surveys show improvements in provider perceptions of their ability to: identify and meet infants' and toddlers' mental health needs; access mental health services for young children, including dyadic treatment; and use strategies focused on parent-child and parent-professional relationships. Funding for the IECMHC services has come from the federal Maternal Block Grant through the Louisiana Office of Public Health, Bureau of Family Health.

See [NCCP's full PRiSM profile](#) for more information on consultation in Louisiana.

The Child & Family Connections (CFC) system in Illinois provides service coordination for families referred to the state's Part C program and offers supports for children's social-emotional (SE) growth and well-being through SE consultants, who are employees of local CFCs. As described in the state's [Child & Family Connections Procedure Manual](#), SE consultants provide: reflective consultation for the CFC program manager, which helps managers provide reflective supervision to service coordinators; integrated assessment and intervention planning in which the SE consultant works with service coordinators to interpret findings from interviews, screenings, and assessments to inform the development of an Individual Family Service Plan; and case consultation for service coordinators, parent liaison staff, and EI providers to help understand the child's SE development, the family's experiences and needs, and appropriate SE supports. A state appropriation funds CFCs' SE services.

Source: Sarah Hinshaw-Fuselier, Assistant Professor of Psychiatry, Tulane University School of Medicine; Mary Margaret Gleason, Children's Hospital of The King's Daughters; Ann Freiburg, Part C Coordinator, Bureau of Early Intervention, Illinois Department of Human Services.

MEDICAID AND PART C EARLY INTERVENTION

Early Intervention (EI) programs are financed by federal IDEA Part C funds and a variety of other federal, state, and local funding sources that vary across states.³⁴ Medicaid, along with the Children's Health Insurance Program (CHIP), serves as a primary or secondary source of health care coverage for 44 percent of the nation's infants and toddlers.³⁵ As such, the program can play a critical role in financing many EI services. A significant percentage of each state's Part C population is likely to also be enrolled in the state Medicaid program. Unlike federal Part C funding, which is a capped formula based on state population, federal Medicaid pays a percentage (or matching rate) for the cost of certain services for each Medicaid-enrolled beneficiary, ranging from 50 to 78 percent based on a state's income.³⁶ The use of Medicaid for certain EI services may free up the more limited federal Part C funds for other costs, including those related to services for children in Part C who do not qualify for Medicaid.

Medicaid's pediatric benefit, called Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT), guarantees a comprehensive array of services for all children under age 21.³⁷ Under federal Medicaid law, each enrolled child is entitled to receive recommended preventive screenings, follow-up diagnostic assessments, and any services a medical professional considers essential to prevent, treat, or improve a diagnosed condition.³⁸ EPSDT emphasizes prevention and early detection with its broad treatment mandate.³⁹ Statutory clarifications, federal guidance, and legal decisions against state Medicaid programs have reinforced the inclusion of mental health services under EPSDT.⁴⁰ In recent years, a growing number of states have taken steps to add, identify, or clarify reimbursement for infant-early childhood mental health services.⁴¹

While Medicaid's pediatric benefit requirements are comprehensive on paper, there is much work to be done to achieve EPSDT's potential to prevent and address conditions as early as possible.⁴² Like state Part C programs, state Medicaid agencies have flexibility in defining eligible beneficiaries, services, and providers, as well as the process for determining medical necessity for services.

Regular surveys of Part C agencies conducted every two years by the IDEA Infant and Toddler Coordinators Association (ITCA) suggest growth in the use of Medicaid

payment over time, as well as limitations and challenges related to billing Medicaid.⁴³ In 2018, at least half of all state Part C programs reported that their state used Medicaid to reimburse for family training/counseling and/or psychology services as interventions likely to align with the specific infant-early childhood mental health services that many Medicaid agencies cover, such as dyadic therapy or parenting programs designed to help parents support their child's social-emotional development.⁴⁴

In light of the potential role Medicaid can play in covering EI services in the social-emotional domain, the survey examined whether Part C programs are using administrative data to identify children dually enrolled in Part C and Medicaid and, if so, how they use the data. Sixteen states reported using administrative data to identify children who may be eligible for both Medicaid and Part C. Among these 16 states, the matching of Medicaid and Part C data was used for a variety of purposes related to promoting adequate supports and services for children in EI.

- 10 states use data to maximize federal matching dollars for services that may be covered by Medicaid (AZ, CO, IL, LA, MD, ND, NY, OR, PA, SC)
- 9 states use data to create reports for state legislators or others about Medicaid and other funding sources for the Part C program (AZ, CO, IA, IL, LA, ND, NY, PA, SC)
- 8 states use data to support quality improvement efforts within or across Part C and Medicaid (AK, AZ, CO, IN, LA, MD, PA, SC)
- 5 states identify Medicaid-enrolled children who have a diagnosis that typically results in a delay or condition that would make them eligible for Part C (IL, MA, MI, PA, SC)
- 4 states develop protected systems to aid information sharing between providers about individual cases (IA, IN, ND, SC)

States also set payment rates for Medicaid services. Part C Coordinators were asked whether the state reimbursement rates for EI services for social-emotional or mental health services are sufficient. Most of the states (33) reported that Medicaid reimbursement rates do not cover the full costs of EI services to address social-emotional or mental health conditions for Medicaid-eligible children.

The survey asked states to report whether they have taken steps in the past five years to improve Medicaid reimbursement and/or coverage of EI services to address social-emotional delays and mental health conditions. Part C Coordinators in 24 states reported that their state's programs have taken these steps. These states reported making the following changes:

- 10 states increased reimbursement rates for services (AZ, DC, DE, IL, IN, ME, MI, NM, SC, SD)
- 9 states expanded the number of EI services that can be reimbursed by Medicaid (CT, DC, IN, ME, MI, MS, NC, NE, SC)
- 6 states broadened or updated Medicaid provider requirements to help additional EI providers receive Medicaid reimbursement (CT, IN, KS, MI, OR, SC)
- 4 states expanded the range of allowable service settings for Medicaid reimbursement (CT, MI, OR, SC)

PROFESSIONAL DEVELOPMENT AND OTHER INITIATIVES TO ADDRESS NEEDS IN THE SOCIAL-EMOTIONAL DOMAIN

In response to open-ended questions about other efforts to strengthen supports and services related to infant-toddler needs in the social-emotional domain, states cited several types of initiatives.

A number of states reported expansion of professional development for the EI workforce focused on addressing

infant-toddler mental health needs. Some states (CO, CT, ID, UT, WA) are working with their state association for infant mental health to offer trainings and endorsement for service providers in EI. Other states are providing training for the EI workforce to build its capacity to identify and support children's social-emotional development using Pyramid-model approaches (MA, NC, NV, CT, MD, IA) and the BABES Toolkit (MT). As discussed earlier, the Pyramid Model's Parents Interacting With Infants (PIWI) helps EI providers promote positive, responsive parent-child interactions. The BABES Toolkit helps EI providers identify and understand specific parent concerns related to crying, sleep, feeding, and other infant behaviors and support parents in using relationship-based interventions.

To address regional disparities in access to IECMH services, several states (AR, HI, MA, ME, MT, NC) are exploring telehealth. The survey responses reflect efforts prior to COVID-19, which has spurred greater adoption of telehealth delivery of EI services across the country.

Part C programs in many states (AL, AR, GA, IA, IL, MN, NE, OH, PA, UT) are engaged in state-level collaborations, either within or across state departments and programs (e.g., home visiting, early care and education, Medicaid) or as members of formal workgroups and taskforces that focus on increasing access to infant-early childhood mental health supports. The range of efforts described in the survey responses is similar to findings reported in the recent ITCA report, *2020 Tipping Points Survey*:

Using Agency Data to Identify and Serve More Children in Part C Early Intervention

In 2016, South Carolina leaders placed the state's Part C Early Intervention (EI) program into the Medicaid agency in an effort to better serve children. Moving Part C EI into Medicaid allowed for the improved identification of children in Medicaid that may qualify for Part C and vice versa. Medicaid agency claims suggested that approximately 12,000 children between 2011 and 2016 had qualifying diagnoses for EI services but were not served in EI. Data also showed that nearly one-third of EI providers did not have a billing relationship with Medicaid, revealing opportunities to better align EI and Medicaid to maximize federal funding. The state moved to fully align provider networks across Medicaid and EI, required EI providers to enroll in Medicaid, and used Medicaid data to identify and enroll more children in EI. Since full integration of EI into the Medicaid data system in 2019, EI has experienced a more than 50 percent growth in enrolled children (from 4,500 at the end of 2016 to 6,819 in 2019). Integration also appears to have sped up referrals and access to Part C services because many providers now use the same data system to support families. State officials acknowledge that the focus of the past few years has been on integration and system alignment to maximize children served. Further challenges to ensure access to appropriate services, including infant and early childhood mental health, remain.

Source: Joshua Baker, Director, South Carolina Department of Health and Human Services; Jennifer Buster, Part C Coordinator, South Carolina Department of Health and Human Services.

Demographics and Challenges, which presented responses from 49 states to the question, “Is your Part C system involved in your state’s early childhood mental health initiatives?” In this report, 38 states reported being involved in special initiatives to support infant and toddler mental health.⁴⁵ These include Montana’s efforts to expand the use of social-emotional screening in local EI programs, Arizona’s design of procedures for early care and education programs to refer all children under age 3 with behavior concerns to EI, and New Mexico’s use of a team of clinicians to assess and treat infants and young children in foster care with mental health conditions.

Training and Support for Early Intervention Providers in Massachusetts

Massachusetts’ Part C Early Intervention (EI) program is using [Parents Interacting With Infants \(PIWI\)](#), a training component within the [Pyramid Model](#) designed to support positive parent-child relationships and infant-toddler social-emotional outcomes. The training is designed for EI providers who work with children experiencing any type of delay or disability and their parents. EI providers who receive PIWI training learn a wide range of strategies for working with parents to support children’s social-emotional development through mutual enjoyment in parent-child interactions and responsive parent-child relationships.

Implementation of PIWI began in 2016 with all of the states’ 60 local EI programs participating in one-day PIWI trainings led by the state’s master trainers. Following the one-day training, each EI program designated one or more staff as PIWI Champions to develop action plans, based on an analysis of the program’s strengths and challenges, and provide continuing supports to the PIWI-trained EI providers. The plans’ ongoing supports for EI providers included supervision, periodic training, and peer learning cohorts. The master trainers provided individualized coaching to the PIWI Champions to help them carry out the plans. New EI providers currently receive PIWI training from master trainers on the second day of their state-mandated early intervention orientation.

As of spring 2019, 2,020 early intervention providers had completed PIWI training. Evaluation of PIWI is ongoing in the state. Preliminary evaluation results show an increase in EI providers’ use of PIWI strategies. The state is also conducting a pilot project on reflective supervision to further strengthen PIWI implementation and outcomes. The state used federal Part C funds to pay for PIWI training and implementation.

See NCCP’s [full PRiSM profile](#) for more information on PIWI in Massachusetts.

Source: Patti Fougere, Director, Early Intervention, Massachusetts Bureau of Family Health & Nutrition; Emily Webb, Coordinator of General Supervision, Massachusetts Department of Public Health.



Summary

The results of this report suggest great variation in the capacity of state Part C programs to identify and meet the needs of infants and toddlers who have social-emotional delays, mental health conditions, or circumstances that put them at high risk of developing these difficulties. While significant gaps in state Part C programs are reflected in the results, most states are actively engaged in work to strengthen supports for infant-toddler social-emotional growth and mental health. In this section, a summary of key findings for each part of the survey is provided, followed by recommendations.

EARLY INTERVENTION PROMOTION, SCREENING, REFERRAL, AND EVALUATION

Most states (30) indicate that their Part C programs provide social-emotional (SE) screening and services to children with SE concerns in promotional materials and online information. Similarly, over half the states (30) report that they offer in-person training on SE screening and referral processes to providers who are primary sources of referral, such as early care and education teachers, pediatricians, and home visitors, while 24 states offer virtual training.

However, only a small number of states (8) require the use of a SE screener by EI providers and by providers outside of EI who conduct screening and refer children. This finding suggests that many children with SE concerns may miss out on the benefits of a referral to EI and a potential EI evaluation and services. While 30 states recommend the use of an SE tool (usually the Ages and Stages Questionnaires: Social-Emotional), the extent of providers' actual use of SE screeners could make a big difference in whether children with SE concerns are identified and referred to EI.

If children with SE delays or mental health conditions are missed in the screening process used in many states, survey results suggest that additional children with difficulties in the SE domain also may be missed in eligibility evaluations. Only 13 states require that a professional with expertise in infant-toddler mental health serve on the eligibility evaluation team. Although several states stated that this would occur in cases where there is "suspicion" of a SE delay or mental health condition, there appears to be no assurance that suspected difficulties in the SE domain will be found during screening since an SE screener is not required by most states.

Only three states require and five states recommend the use of a developmentally sensitive diagnostic system, the DC:0-5 or its predecessor, DC:0-3, for identifying infant-toddler mental health conditions. This finding suggests that the identification of infants and toddlers with mental health conditions is further limited in most states.

Most states (31) refer children with possible SE concerns who are found to be ineligible for Part C services to other programs that may help address delays or conditions in this domain. These include home visiting and early care and education programs. However, only five states have written policies that require Part C to offer another SE screening after a period of time—policies that may help identify children who become eligible for Part C due to persistent or worsening SE concerns.

SE-RELATED SERVICES AND SUPPORTS FOR EI-ENROLLED CHILDREN

For children with SE concerns who are found to be eligible for Part C, states vary in their provision of IECMH supports and services used in other sectors.

Almost half the states (24) reported that they offer dyadic (parent-child) treatment, while only six of these states require the use of an evidence-based model. The required or recommended evidence-based models that states reported using are Child-Parent Psychotherapy, Parent-Child Interaction Therapy, Promoting First Relationships, and Attachment and Biobehavioral Catch-up. Some of these states did not identify a specific evidence-based model. A few states reported the use of other approaches (Family-Guided Routines-Based Intervention and Parents Interacting With Infants) that can be used by non-clinicians and are not typically considered dyadic treatment models. Overall, the results suggest that some Part C Coordinators are not familiar with evidence-based dyadic treatment models and the conditions these treat.

Most states (34) report that they offer parenting programs that strongly promote positive SE outcomes, although only 14 require or recommend the use of an evidence-based model. Only a small number named an evidence-based model that is offered to EI families: four states recommend Triple P (Positive Parenting Program), two states recommend Incredible Years, and one state recommends Circle of Security. A few states cited

referrals to evidence-based home-visiting programs rather than group parenting programs. As with dyadic treatment, some Part C Coordinators may not be familiar with evidence-based group parenting programs that address infant-toddler mental health needs.

Maternal Depression and Risk Factor Screening and Referral

Over half of the states (30) do not provide maternal depression screening or referrals for screening, evaluation, or treatment, while five states do offer maternal depression screening. Other states either provide referrals for screening (16) or for evaluation or treatment (18). Maternal depression is often included in broader risk factor screening, including the Bright Futures Intake Form, which one state recommends. Most states (36) neither recommend nor require risk factor screening.

Infant-Early Childhood Mental Health Consultation

Over half the states (29) reported that they provide consultation by infant-toddler mental health specialists to EI providers and others, including child protection workers, parents and foster parents, and pediatricians. Follow-up calls with states indicate that consultants are employees of local EI programs in some states and, in others, work outside the EI program, providing consultation to EI through service agreements. In addition, IECMH consultation in EI does not appear to be as sustained or intensive as it might be in early care and education settings. For example, Part C Coordinators describe consultants as being available to an evaluation team trying to understand a child's mental health needs or to a provider who is trying to determine if a child or parent needs SE-related services.

Barriers to SE Supports and Services

Most states reported a shortage of available providers as a barrier to offering SE-related services. Thirty-eight states indicated that these providers were not available in all parts of the state and 30 reported an overall shortage of qualified providers. Other states (16) reported low reimbursement rates, which make it difficult to hire qualified providers, as a barrier.

MEDICAID AND PART C

Only a limited number of states appear to be maximizing the use of Medicaid, and Medicaid's pediatric benefit, Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) to reimburse for EI services, especially those related to mental health needs. Only 10 states reported that they use administrative data to maximize federal Medicaid matching dollars for EI services. Similarly, few states are using administrative data to help ensure EI benefits for children. Five states identify Medicaid eligible children with diagnoses that are likely to make a child eligible for Part C.

Several states have taken steps to improve Medicaid rates for EI services or adopt other policies that allow greater use of Medicaid for EI services, including those related to SE needs. Ten states have raised reimbursement rates for services; 9 states have expanded the types of EI services that can be covered by Medicaid; 6 states have changed provider requirements to allow Medicaid reimbursement for EI services, and 4 states have expanded allowable settings for these services.

PROFESSIONAL DEVELOPMENT AND RELATED INITIATIVES

Some states are working with their infant mental health associations to offer training and IECMH endorsement to EI providers, while many are expanding professional development and ongoing supports (e.g., coaching and reflective supervision) for EI providers using existing resources, including Parents Interacting With Infants (PIWI), which was developed as part of the Pyramid Model, and the BABES Toolkit. Several state Part C Coordinators also reported active engagement in cross-sector policy planning groups that are working to expand the availability of infant-toddler mental health services and supports, such as dyadic treatment and IECMH consultation in EI, early care and education, health care and community settings, and home-visiting.

Recommendations

The following recommendations suggest some ways to use the findings in this report. It is important to stress that these findings are based on reported policies and practices that may not fully reflect the actual and varied use of SE-related screening and evaluation practices and the delivery of services to Part C-enrolled infants and toddlers with SE needs in any given state. The survey results suggest broad trends (e.g., states appear to have EI evaluation policies that may result in missing children with SE-related needs). These results are best used as a springboard for discussion in each state among the Part C Coordinator, advocates, local EI agency directors, and other stakeholders about both policies and the actual implementation of screening, services, and other components in the state's Part C program that affect its capacity to address infant-toddler SE delays and mental health conditions.

1. **Part C Coordinators and others interested in strengthening the supports for infant-toddler mental health examined in this report should review results for their state and identify strengths and gaps in these supports.** Table 2 can be used to review features of Part C programs that are key to identifying and meeting the SE needs of infants and toddlers along with recommendations for making these features part of the state's Part C program. This review, in turn, can be used to inform potential policy goals (e.g., requiring the use of SE screening tools, guidance related to the use of evidence-based dyadic treatment) for strengthening the state's Part C program.
2. **Part C Coordinators, together with other stakeholders, should gather information about the scale and consistency of supports, such as screening and infant-toddler mental health services, that are reported to be part of the Part C program.** Each type of support can play an important role in efforts to identify and meet the needs of infants and toddlers with SE delays, mental health conditions, or risk factors that increase the chance of these difficulties. Information about the actual implementation of these supports might be found by examining available data (e.g., reviewing Individual Family Service Plans) and through discussions with local EI program staff and staff in other sectors (e.g., child care, home visiting, child welfare). It is possible that in states reporting a strong policy, such as a requirement that the evaluation team include a professional with infant-toddler mental health expertise, gaps will be found. Identifying gaps in implementation can be used to establish additional goals for strengthening the Part C program's support of infants and toddlers with SE needs. Conversations with providers in local EI systems might also identify the use of exemplary practices that are not yet embedded in Part C policy or used statewide, but could be scaled within the state through a funding or policy initiative.
3. **State Part C programs should collaborate with child welfare offices to closely examine policies and practices related to the screening and referral of infants and toddlers involved in substantiated cases of abuse and neglect to Part C.** States should require the use of tools and practices that help ensure that these children's SE needs are identified (e.g., use of SE-focused screening and assessment tools and participation of an IECMH specialist in the evaluation team) and addressed in EI.
4. **Planning and implementing new policies that strengthen the capacity of a state's Part C program for infants and toddlers with SE needs should involve collaboration among leaders across sectors and programs (e.g., mental health, early care and education, home visiting, and Medicaid).** Opportunities for collaboration include shared investment in training professionals on evidence-based dyadic treatment or parenting models or on the use of DC:0-5. Other opportunities may include collaborative efforts to increase Medicaid coverage of services and reimbursement rates and identifying other sources of funding for services that may span sectors (e.g., infant-early childhood mental health consultation).
5. **State Part C programs and stakeholders should assess and strengthen IECMH-focused professional development and ongoing support for EI providers.** Enhancements might include universal training to ensure foundational skills in promoting positive parent-child interactions that will benefit children with delays or conditions in any area of development, and in identifying children with a need for more specialized IECMH supports.

6. State Part C programs should use strategies for maximizing their use of Medicaid to cover essential services for infants and toddlers in EI with SE delays and mental health conditions. Use of administrative data to identify children dually enrolled in EI and Medicaid and collaboration to clarify covered services and providers should aim to ensure reimbursement for services such as evidence-based dyadic treatment and SE-focused parenting programs, adequate reimbursement rates, and the delivery of services by qualified professionals in range of appropriate settings.
7. State Part C Coordinators, advocates, and others should use available resources on IECMH screening and services to understand the full range of supports that could be built into EI programs. Several of these resources are listed below.

Table 2. Key Supports in Part C Systems That Address Infant-Toddler Social-Emotional Needs

System Support	Recommendation
Screening and Referral	<ul style="list-style-type: none"> Promote the use of a standardized social-emotional screening tool by providers who are primary sources of referral (e.g., child care providers, pediatricians, child welfare agency). Require a social-emotional screening in EI, especially for children referred without a recent SE screening, including for children referred from child welfare.
Eligibility Evaluation and Ongoing Assessment	<p>Require the following:</p> <ul style="list-style-type: none"> The use of a standardized assessment tool with strength in the social-emotional domain The participation of an infant-toddler mental health specialist in the multidisciplinary evaluation team and ongoing assessments The use of a standardized tool to identify risk factors in the family during the initial and ongoing family assessments The use of the DC:0-5 when determining eligibility and needed services on the basis of a mental health condition
Services for Ineligible Children	Establish a policy that requires EI programs (or a partner such as Help Me Grow) to monitor children who are at risk of delays and conditions in the social-emotional domain but who are not found eligible for EI services.
IECMH Supports and Services for Eligible Children and their families	<p>Ensure availability of key IECMH services and supports, including:</p> <ul style="list-style-type: none"> Evidence-based dyadic treatment Evidence-based group parenting programs that focus on the parent-child relationship and infant-toddler mental health Infant-early childhood mental health consultation Maternal depression screening and referral for depression evaluation and treatment
Professional Development	<ul style="list-style-type: none"> Provide universal training for EI service coordinators and providers on foundations of infant-toddler mental health (e.g., how to identify infants and toddler with mental health needs and how to promote positive parent-child interactions) Specialized training for EI providers working with children with mental health conditions or with providers who serve these children (e.g., to enable infant-toddler mental health specialists to provide IECMH consultation, dyadic treatment, and other supports)

RESOURCES FROM NCCP AND CCF

NCCP's online resource, [PRISM: Promoting Research-informed State IECMH Policies and Scaled Initiatives](#), features summaries of research evidence for IECMH supports (e.g., dyadic treatment, SE-focused screening) and state profiles of IECMH policies and scaled initiatives that incorporate social-emotional, risk factor, and maternal depression screening; effective assessment and diagnosis; dyadic treatment; SE-focused parenting programs; IECMH consultation, and other IECMH supports in different sectors, including Part C.

[Georgetown's Center for Children and Families](#) has several resources on [Medicaid](#) and its role in supporting child and parent screening and IECMH-related services.

ADDITIONAL RESOURCES

[Alliance for the Advancement of Infant Mental Health](#) is an organization that promotes young children's early relationships and represents state infant mental health associations that have licensed its system of competencies and professional endorsements.

[Center of Excellence for Infant and Early Childhood Mental Health Consultation](#) is a federally funded technical assistance center that supports the growth and advancement of the IECMH consultation profession, including in EI settings.

[DaSy: The Center for IDEA Early Childhood Data Systems](#) is a federally funded technical assistance center that supports high quality data systems and data use in Part C and Part B, Section 619 early childhood special education.

[ECTA \(Early Childhood Technical Assistance\) Center](#) is a federally funded technical assistance center that supports capacity-building and policy and practice improvements in Part C and Part B, Section 619 early childhood special education.

[IDEA Infant & Toddler Coordinators Association](#) is a professional organization representing state Part C Coordinators. ITCA surveys its members on Part C financing and challenges and produces position statements on topics, including mental health in Part C.

[National Center for Pyramid Model Innovations](#) is a federally funded technical assistance center that promotes the implementation of a multitiered system of supports to improve the social-emotional and behavioral outcomes of young children in early intervention and early care and education settings.

[Zero to Three](#) is a national professional, policy, and advocacy organization working in a wide range of areas to support infant and toddler well-being, including early intervention and IECMH.

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