



Infant & Toddler Mental Health

Service Delivery Guidelines

Intervention guidance for service providers and families of young children referred for mental health concerns



State of Alaska • Department of Health & Social Services • Office of Children's Services
Alaska Early Intervention • Infant Learning Program

ALASKA EARLY INTERVENTION / INFANT LEARNING PROGRAM

Service Delivery Guidelines

INFANT & TODDLER MENTAL HEALTH

EARLY INTERVENTION GUIDANCE FOR SERVICE PROVIDERS AND
FAMILIES OF YOUNG CHILDREN REFERRED FOR MENTAL HEALTH
CONCERNS

JUNE 2011



MISSION

To promote positive development and improved outcomes for Alaska's families by creating a culturally responsive, comprehensive and accessible service delivery system that links service providers, empowers families and engages communities

–Alaska Early Intervention/ Infant Learning Program

SERVICE DELIVERY GUIDELINES FOR ALASKA

INFANT TODDLER MENTAL HEALTH

Alaska Early Intervention/Infant Learning Program

June 2011

Erin Kinavey, Early Intervention Manager - Part C Coordinator
Lisa Balivet, Data Manager
Meghan Johnson, Training Coordinator
Linda Borghols, Program Specialist
Jane Atuk, Program Specialist
Kassi Hill, Office Administrator

Acknowledgments

The Alaska Early Intervention/Infant Learning Program would like to thank the following people for their personal and professional contributions to the completion of this guide.

Sue Armstrong, MSW, LCSW – RurAL CAP Head Start/Early Head Start
Dorothy Erickson – RurAL CAP Head Start
Amanda Faulkner – Frontier Community Services
Lisa Hodges – Center for Community, AK-AIMH
Jeanine Jeffers-Woolf, LMFT, AK-AIMH
Christy McMurren – Program for Infants & Children, Inc., AK-AIMH
Gail Trujillo – Center for Community, AK-AIMH
Jerry Welch – Juneau Youth Services, AK-AIMH

Prepared by

Information Insights, Inc.
212 Front Steet, Suite 100
Fairbanks, Alaska 99701
(907)450-2450
www.iiialaska.com

Additional Copies or Services

*These guidelines are available online at www.hss.state.ak.us/ocs/infantlearning
To request additional copies or auxiliary aids and services, please contact:*

Alaska Early Intervention/Infant Learning Program
P.O. Box 240249
323 East 4th Avenue
Anchorage, Alaska 99501

Toll-free (877) HSS-FMLY (477-3659)
Local (907) 269-8442
TT Relay (800) 770-TYPE (8973)

CONTENTS

Introduction.....	5
Understanding Mental Health in Young Children.....	9
Assessing Mental Health in Young Children.....	14
Approaches to Intervention	22
Planning for Transition	29
References.....	31
Appendices.....	33

INTRODUCTION

Mental health is an important aspect of a baby's ability to learn and grow. In the past, mental health was a term applied to teen and adult emotional and social conditions, rarely to children, and almost never to infants. However, we know now that a human being begins learning social and emotional behavior from birth, and that many of the behaviors learned early in life will persist into adulthood, thus, infant mental health is of the utmost importance.

Medical research has shown that the brain changes and grows significantly from birth into the toddler years, particularly when supported by nurturing parental and caregiver relationships. Research indicates that these early relationships help support brain architecture that enables children to explore and learn the world around them.

During the first few years of life, the brain undergoes extraordinary changes. Millions of synapses in the brain begin reaching out and connecting to each other. Connections made in these early years directly influence specific learning. For example, an infant's repeated exposure to language helps the brain build the neural connections needed to learn words. Nurturing, sensitive caregiving helps build the foundation for healthy social emotional development.

A child's ability to learn, feel confident and secure, regulate their emotions, and demonstrate both empathy and curiosity is highly dependent on a caregivers ability to develop awareness of a child's cues and have the ability to respond appropriately. It is these attributes that are most closely associated with success later in life (1). Without close, responsive relationships children are at extreme risk for developmental delays. However, early interventions and family supports can increase a family's protective strategies and reduce the risk of later mental health problems for vulnerable children.

When approaching infant mental health, it is important to address the needs of the whole family, because it is within these significant relationships that the best learning occurs. For this reason, Infant Mental Health is sometimes referred to as Infant Parent Mental Health (IPMH). We know that while all families face challenges when raising a child, not all children or parents have the same resources to respond positively to those challenges. The Alaska Early Intervention/Infant Learning Program (EI/ILP) strongly supports families and works with them to build positive, healthy relationships with their children.

PURPOSE OF THE GUIDELINES

The purpose of these guidelines is to provide parents and service providers with an overview of the best practices for early identification and intervention for young children referred for mental health concerns in Alaska. These approaches have been shown to result in the best outcomes for families and children from birth to three.

While most of the recommended practices in the guidelines do not carry the force of regulation, they are intended to guide parents and providers in making informed decisions about the most appropriate assessment practices and intervention strategies for promoting the emotional well being of children and families. They also provide information on transitioning to school- and community-based services designed for older children. A list of resources for obtaining more information and support is included at the end of these guidelines

Not all practices will be appropriate for all children. Therefore, a plan of care should be tailored to a child's particular needs and available resources with input from the family and the primary provider or early intervention team.

EARLY INTERVENTION SERVICES IN ALASKA

Early intervention services are federally mandated under Part C of the Individuals with Disabilities Education Act (IDEA), a federal law passed in 1986. IDEA requires states to ensure that young children who may have disabilities or developmental delays receive an evaluation to identify the potential need for early intervention.

Alaska's early intervention services are administered by the Department of Health and Social Services, Office of Children's Services, Early Intervention/Infant Learning Program (EI/ILP). They include a flexible array of services for children birth to three years of age who experience disabilities or developmental delays, or who are at risk for developmental delays.

EI/ILP partners with grantees to provide services directly to families at a local and regional level. In 2010, services were provided to children throughout the state by approximately 115 highly qualified staff employed within 17 regional grantee agencies. Programs vary widely by staff and region size. Service may include:

- Developmental screening and evaluation
- Individualized Family Service Plans to outline goals for the family and child
- Child development information
- Home visits
- Infant mental health services
- Physical, occupational or speech therapy
- Specialized equipment
- Referrals to other needed services

EI/ILP APPROACH TO SERVICE DELIVERY

Because no single professional can meet all the needs of a child with developmental delays, EI/ILP encourages the use of a *transdisciplinary* approach, with a primary service provider assigned to each child and a team of professionals from different disciplines who share their expertise with the parents and other team members as needed to support the child's progress and participation in daily activities in the family's home and community.

In addition to taking a team approach to service delivery, the core values of EI/ILP support services that are *evidence-based* and *family-centered*. By listening to the family throughout the process, intervention techniques can be modified on a continual basis to match the child's and family's unique needs and strengths.

MORE INFORMATION

More information and resources for early intervention services in Alaska are available at the EI/ILP website. The site includes a statewide directory of EI/ILP programs that cover all regions of the state.

 www.hss.state.ak.us/ocs/InfantLearning

UNDERSTANDING MENTAL HEALTH IN YOUNG CHILDREN

TYLER'S STORY: THE BEGINNING

Tyler was born full term and healthy to 17-year old Brittney while she was living in a juvenile detention center. His father, DeMarcus, age 37, was in prison. His parents' brief liaison occurred following DeMarcus' parole from prison after serving 15 years for armed robbery. Shortly after Tyler's parents met, they robbed a grocery store. The store clerk was shot and critically injured, but recovered. DeMarcus and Brittney were quickly caught and blamed each other for the shooting. DeMarcus was sent back to prison and Brittney to the juvenile center where it was soon discovered she was pregnant with Tyler. Brittney spent most of her pregnancy fighting with both the girls and the boys at "juvie." She often bragged about being the toughest girl there and "your worst nightmare."

Tyler spent his first few weeks with Brittney's aunt Nancy, who quickly decided Tyler was a "handful" and wasn't fitting in with her other children. Nancy passed him on to her cousin Jill. The plan was to eventually reunite Brittney and Tyler once she was released from the juvenile center. However by 3 months of age, Tyler had lived with three other relatives and one non-relative foster placement. He was not gaining weight, cried nearly constantly, and was impossible to console. It was decided that Brittney would be released from juvenile detention to her great-grandmother's custody, and that together, the two of them would care for Tyler.

By the time Tyler was two and a half, his mother described him as being "crazy" and "possessed by the devil." He seldom slept during the night and would roam the house, turning on the television and getting into the refrigerator. He was aggressive and assaultive with children his age and younger, but he had a near hero-like worship of older children. He was also bright, athletic, and spoke in complete sentences with a large vocabulary. However his mother complained that he never listened or complied with any directives from anyone. He had previously started a fire in a trailer they were living in, and the family, which now included 1-year-old brother Ryan, was living with Brittney's friend Lisa. Brittney described herself as tough and ready to fight anyone that "messed" with her or her children. But what she wanted most for Tyler was enough drugs to completely knock him out at night and keep him docile during the day. It was at this point that Tyler's pediatrician referred him to EI/ILP.

WHAT IS INFANT MENTAL HEALTH?

The term infant mental health has come to refer to both the social-emotional development of the young child and to the definition of a field of study.

Zero to Three: National Center for Infants, Toddlers and Families defines infant mental health as:

The developing capacity of the child from birth to age 3 to experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn, all in the context of family, community and cultural expectations for young children. Infant mental health is synonymous with healthy social and emotional development (2).

Infant mental health refers to “the mental wellness of the actual caregiving relationship between caregiver and child” (3). It is in this unfolding relationship that the optimal growth and social emotional, behavioral and cognitive development of the infant will take place. In a healthy, stable and loving environment most children will thrive.

The World Association of Infant Mental Health (WAIMH) describes infant mental health as “a field dedicated to understanding and treating children 0-3 years of age within the context of family, caregiving and community” (4).

Infant mental health is a growing field of interdisciplinary research and practice devoted to the promotion of healthy social-emotional development, prevention of mental health concerns, and treatment of the mental health concerns of very young children in the context of their families.

INFANT MENTAL HEALTH SERVICES

Infant mental health encompasses a continuum of approaches in working with young children and their families that include: the promotion of healthy social and emotional development; the preventive-intervention of mental health difficulties; and the treatment of mental health conditions among very young children in the context of their families.

A popular way to look at infant mental health services is to consider a pyramid in which the broad base represents the services **all** children need for healthy social and emotional development regardless of the presence or absence of developmental delay. The middle part of the pyramid represents those children and families with social-emotional concerns who can benefit from intervention, with the very top representing the relatively small number of children and families who will benefit from clinical mental health services.

Supporting the healthy social and emotional development of young children and their families is an important role of every EI/ILP provider. That support begins by establishing a caring, trusting relationship with the family.

A foundational strategy for all early interventionists is to be a reflective practitioner. Early intervention providers can engage in reflective practices by looking for family strengths, listening actively to family needs, and helping the family to identify stressors or concerns.

What does it mean to be reflective?

Reflective thinking is "A cognitive process that involves a deliberate pause to examine beliefs, experiences, responses, goals, and practices in order to gain new or deeper understandings resulting in actions that improve outcomes for those we work with. It involves talking with each other openly about what we do, what it touches in us, how we feel, how it works, and why we do it." (Shapiro & Reiff, 1993).

There are many models to consider when considering reflection and the reflective process. Please see the references section of this document for links to additional resources.

It is important for EI providers to develop healthy, professional relationships with family members while assisting the family in meeting the outcomes identified by the family and the early intervention team.

Early interventionists should understand the role of culture and diversity in the social and emotional development of children, and they should have a capacity for empathy and support when helping families that face multiple challenges.

Often a family facing multiple challenges is unable to focus on the early intervention goals or effectively use services until their other challenges have been addressed. Early interventionists should work with the family to address these challenges, as the family prioritizes them, in order for that family to utilize the early intervention service most effectively.

Maslow's hierarchy of needs is a simple and powerful tool for early interventionists to use when working with families facing multiple challenges. The fundamental premise of Maslow's hierarchy is that families struggling with basic physiological and safety needs are unable to address higher level needs. A homeless family will not be able to identify and satisfy their child's social or emotional needs until the unstable housing situation is resolved.

Early interventionists can promote healthy social and emotional development through a variety of activities, including but not limited to:

1. Creating a reflective relationship with families where parents feel valued, heard and supported.
2. Incorporating the concepts of infant parent mental health, including the importance of nurturing and responsive relationships and high-quality

environments, into trainings for personnel working with young children and their families

3. Providing information about social-emotional development in the context of caregiving relationships to all parents, health care providers, childcare providers and others who make up the constellation of a child's world (see Appendix 3 for a list of resources)
4. Distributing information about school readiness to parents of young children with disabilities, and talking to them about how emergent learning and school readiness apply to their children (for example, encouraging curiosity in a child who needs assistance in mobility or developing self-regulation in a premature infant).
5. Talking with families about social and emotional milestones as well as other age-appropriate developmental milestones (see Appendix 1 for a list of typical milestones in social-emotional development from birth to age 3)

CULTURE, CLASS AND DIVERSITY IN INFANT MENTAL HEALTH

Healthy social and emotional development reflects the context of the life of each child. Culture in infant mental health is more than customs; it is the way of being with each other, the way of expecting relationships to be. Culture defines the world of the child.

Culture teaches a child how to relate in social situations and what to expect of oneself. More importantly, culture teaches children what they can expect of others in their group or family. It is from this point that a child begins to form secure attachments. In this context, culture can be viewed as the “shaper of children” (5). It encompasses and surrounds a child providing rules of living that include language, ethnicity, religion and moral values.

Cultural differences exist in attachment and parenting styles. It is a challenge for the early interventionist and infant mental health programs to explore and promote healthy multicultural development in families and integrate this cultural knowledge into their work (6).

The child's world may look very different from the world of the early interventionist. Religion, sexuality, moral values and even hygiene standards may be completely unlike anything the early interventionist has experienced. Care must be taken to avoid critical or disapproving assumptions about the family. Observations and gentle inquiries surrounding culturally related activities should occur at every visit. Most families love to tell their stories. Giving families an opportunity to speak about their life and what is important to them while listening non-judgmentally is essential if an interventionist truly wants to understand what a family needs most.

The early interventionist will also be aware of the more subtle cultural experience of a family that typically operates outside of conscious awareness. The intimacy between mother and child that involves knowing and understanding the feelings and sensitivities of each other according to what feels right, is often referred to as the “goodness of fit” (7). The goodness of fit is especially important for children who are developmentally or emotionally vulnerable. Knowing there is one person who understands and accepts them exactly as they are provides children with a solid foundation from which to grow. The role of the early interventionist is to help parents become aware of the unique way they fit with their child.

Early interventionists must also be aware of the ways their own culture, “way of being” or professional agenda may influence a parent child dyadic relationship. There are three dyadic relationships to consider when thinking about early intervention work in general, but specifically with IPMH work.

- 1) Parent child dyad
- 2) Parent provider dyad
- 3) Provider child dyad

It is imperative that providers be conscious and reflective about their influence on these dyadic relationships. A provider’s own cultural and professional agendas can have a positive effect on the parent child dyad, but if the provider is not consciously aware of this influence, it may affect the parent child dyad in a negative way. A provider should also be aware of how the other two dyads may influence the parent child dyad.

ASSESSING MENTAL HEALTH IN YOUNG CHILDREN

TYLER'S STORY: ASSESSMENT

Tyler was found to be 2.0 standard deviations below average in the Personal-Social domain based on the Battelle Developmental Inventory. Tyler was determined eligible for early intervention services.

It was clear to Tyler's early intervention team that Tyler's mother felt her son needed treatment for what she considered to be a mental illness. She attributed much of his behaviors to him being "crazy" and "bipolar." Brittney saw no connection between the turmoil in the household and Tyler's attention seeking and extremely challenging behaviors. Brittney was very candid that the only reason she wanted early intervention services was to placate Tyler's pediatrician who she then felt would finally prescribe drugs.

The team, however, was much less sure whether Tyler had a mental health disorder. They were confident that a comprehensive assessment would allow the team and Tyler's family to decide the best approach to support the healthy emotional and social development of Tyler. The referral concerns for Tyler clearly indicated the possibility of the presence of relationship or behavioral disorders. For that reason the early intervention team that did the eligibility evaluation with Brittney and Tyler included a social worker.

Although it is difficult to identify all the strengths and needs at the initial visit the early intervention team noted the following strengths of this very needy family:

- *Brittney saw many positive skills of her little boy.*
- *Brittney was very protective of her children.*
- *Brittney had a friend willing to share her home.*
- *Brittney was determined to get what she needed for her child.*

The team also recognized immediately the many challenges to establishing a relationship with the family:

- *Unstable housing/homelessness*
- *Teen parent*

- *Criminal activity in the home*
- *Substance abuse issues*
- *Attachment disorders*
- *Sleep disorders*
- *Multiple partners/boyfriends of mother*

The EI/ILP team initially met resistance from Tyler’s mother, Brittney. She was certain Tyler was very bright; not delayed or disabled in any way. She also was very insistent that in order for Tyler’s doctor to prescribe medication for Tyler to control his behavior, he had to be found eligible.

The team struggled with understanding how much involvement Brittney’s new boyfriend of several weeks should have providing information that might be used in determining eligibility. During the course of the evaluation, the boyfriend tried to dominate by answering the questions. Understanding the family dynamics and developing an empathic and non- judgmental relationship with the family was critical for the team in order to make a fully informed eligibility determination.

THE ASSESSMENT PROCESS

Identification of social and emotional concerns is of significant importance and should be a part of every child’s assessment process including both initial and annual assessments. Depending on the specific training of the EI/ILP staff, the use of Infant Mental Health screening tools may be an important step in the assessment process to gather information about social-emotional concerns prior to referral to a qualified mental health professional.

Typically screening tools are designed for use by paraprofessionals and professionals who do not have extensive training or expertise in the mental health profession. The results of screening can be used to help determine which infants and toddlers have the need for more in depth assessments conducted by an Infant Mental Health professional. A variety of screening and assessment instruments that may be used in the process of identifying mental health concerns are listed and described in Appendix 2.

Early identification of social-emotional or parent child relationship challenges can lead to more successful interventions. An appropriate and thorough assessment provides information essential to determining what services and supports are needed, including the need for further social-emotional assessment or referral.

For all children who are eligible for EI/ILP services, an assessment indicating the child’s unique abilities in each area of development must be completed by a multidisciplinary team and must cover all areas of development (cognitive, social-emotional, speech-language, physical and adaptive).

In order to ensure a mental health perspective in early intervention, each of Alaska's EI/ILP providers should have access to a qualified mental health professional or someone with certification in Infant Parent Mental Health (IPMH) to work with children under age 3 for ongoing consultation for all staff.

Developmental evaluations address the multiple factors that affect a child's social-emotional development, including environmental strengths and risks, a child's physical health and development, parent or caregiver factors, and the relationship between the infant and the parent or other caregiver. When social and emotional concerns are significant, the assessment should delve deeper in the following areas:

- Infant and toddler feelings, relationships, behaviors, and temperament
- Parent/infant interactions
- "Goodness of fit"
- Infant and toddler brain functioning: regulatory, sensory, emotional (relevance) and executive aspects.
- Family concerns particularly regarding the feelings, relationships and behaviors of the child
- Family resources that include extended family and other natural supports
- Family issues (substance abuse, mental illness, domestic violence, poverty, economic constraints, job loss, homelessness)
- Environmental stressors (community violence, multiple foster home placements)

The most common strategies for assessment:

- Family interview
- Observation of caregiver-infant/toddler play and interactions
- Observation of family-child ways of relating
- Use of formal assessment instruments

FAMILY INTERVIEW

The initial visit with every family should be more than just a flurry of paper signing and evaluation questions. The early interventionist should be attentive to the surroundings, asking important questions about the child's prenatal history and first year of life, relationships and routines, and observing patterns of interactions and reactions. As the relationship between the early interventionist and the family unfolds the early interventionist should be prepared to observe and question the following areas that could signal a young child is at risk:

- Parent depression and health concerns
- Family history of mental health issues
- Risky parenting beliefs

- Parent substance abuse
- Domestic partner abuse and other trauma
- Poverty level
- History of homelessness
- Educational and age level of mother
- Child health concerns
- History of Office of Children’s Services (OCS) involvement
- Concerns due to military deployment or other matters related to families in the military.

The early interventionist should always allow parents to pass on answering any questions that might make them feel uncomfortable, but should note the emotion and not ignore it. Some suggested responses are:

- “That’s okay. We can talk about this another time.” (*Remember to follow up*)
- “That seems to be hard topic for you.” (*Pause*)

If a parent says, “I had a bad experience when I was young,” the interviewer should pause and wait for the parent to continue. It may take a little time before the person is ready to describe the experience. The interventionist’s role is to listen, to make no judgment statements, but to ask questions in order to better understand the meaning for the parent.

NOTE: Please see reference section for specific family assessment, history and child assessment tools that may be helpful at assessing qualities of caregiver-child relationships.

OBSERVATION

In using any measure with young children it is always important to take into account young children’s and the caregiver’s emotional states. This is particularly critical for children with social and emotional concerns. Typical evaluation practices rely on cooperation between the evaluator and the child and the caregiver’s ability to support a child in the evaluation process. Young children may resist participating in structured activities with an adult they have never met before. They may act shy, frightened or appear to lack understanding of what is being asked of them.

For this reason, the importance of evaluating a child in the context of his primary relationships with an integrated, developmental and collaborative approach cannot be emphasized enough. Two of the most common assessment techniques focus on observation of the child in his natural environment in the context of his primary relationships. Observations of the caregiver-infant/toddler interactions during play and of family interactions during daily routines can provide useful clues to a child’s social and emotional development. Observations of the caregiver-infant/ child dyadic relationship that take into account how the caregiver and child are co-

regulating each other can be extremely beneficial in identifying the appropriate goals and intervention/therapeutic supports.

Typical Developmental Milestones

As with other areas of development, babies go through typical stages of social-emotional development that evaluators can look for. While some babies progress faster or slower, what is important is that there is change over time from one step to the next. The milestones in social-emotional development in Table 1 were developed by Dr. Stanley Greenspan, author of the Greenspan Social-Emotional Growth Chart. See Appendix 1 for a list of typical behaviors of children at each stage of social-emotional development from birth to three.

Table 1: Greenspan Developmental Milestones, 0 to 42 months

0-3 months	Exhibits growing self-regulation and interest in the world
4-5 months	Engages in relationships
6-9 months	Uses emotions in an interactive, purposeful manner
10-14 months	Uses a series of interactive and emotional gestures to communicate
15-18 months	Uses a series of interactive and emotional gestures to solve problems
19-30 months	Uses ideas to convey feelings, wishes, or intentions
31-42 months	Creates logical bridges between emotions and ideas

Source: Greenspan Social-Emotional Growth Chart, 2004. <http://www.pearsonassessments.com>

Behaviors that May Signal Concern

As with other areas of development, there are also signs when a child's progress is not keeping up with developmental milestones, which may be a cause for concern. EI/ILP staff can help family members decide if the signs warrant specific assistance.

Depending on their intensity and frequency, the following signs may indicate the need for further assessment (8).

Infant (birth to 12 months)

- Unusually difficult to soothe or console
- Limited interest in things or exploring the environment
- Limited interest in interacting with people, difficult to engage
- Lack of joy in interaction with caregiver, somber
- Consistent strong reactions to touch, sounds, or movement
- Always fearful or on guard
- Reacts strongly for no reason

- Evidence of abuse or neglect
- Lack of use of gestures to communicate, like pointing
- Somatic dysregulation, sleep disturbance, prolonged screaming or crying at night, nightmares
- Feeding and eating abnormalities: rejecting bottle, spitting up formula, insatiable eating or hoarding or stuffing of food
- Concerns about emotional or behavioral functioning reported by caregiver

Toddler

- Displays very little emotion, sad, withdrawn, somber
- Unable to comfort or calm self, irritable beyond early infancy
- Difficulty self-regulating emotions, prolonged tantrums
- Hyper-vigilant, anxious, fearful
- Limited interest in things or exploring the environment
- Limited interest in interacting with people, difficult to engage
- Chaotic, unfocused activity, frequently hurt
- Does not turn to familiar adults for comfort, help, or shared pleasure
- Indiscriminant affection
- Has inconsistent sleep patterns
- Aggression directed to self or others
- Regression with loss of previous milestones

ASSESSMENT TOOLS

There are a variety of assessment instruments that can be used to identify delays in a young child's social-emotional development, to determine eligibility for early intervention services, and to perform initial and ongoing assessments of children in EI/ILP. The format may include observation, parent questionnaires, interviews, and direct assessment, or a mix of methodologies. All tools should be administered by a professional with training and credentials that meet the requirements specified by the particular test instrument.

If a general early childhood developmental inventory identifies a concern with a child's social-emotional competencies, then the evaluation team should follow up with an instrument specific to social-emotional assessment in young children. See Appendix 2 for a list of assessment tools for use with infants and toddlers.

Children with OCS History

The Child Abuse Prevention Treatment Act (CAPTA) includes a federal mandate to refer all children under the age of three who have experienced abuse or neglect to the state early intervention service system. When children referred to EI/ILP have had some involvement with the Alaska HSS Office of Children's Services (OCS), it is

especially important to review their history carefully. OCS-involved children have experienced some kind of family disturbance (substance abuse, trauma, family violence, etc.) and are at risk for delays in social and emotional development.

In Alaska, children under the age 3 who have a substantiated report of harm are automatically eligible for Part C services. A comprehensive developmental assessment, with an emphasis on social emotional development and parent child interaction should be completed to guide the development of goals and intervention strategies.

DIAGNOSING MENTAL HEALTH CONDITIONS IN YOUNG CHILDREN

A growing number of children who experience a delay in social-emotional development qualify for early intervention services. Many of these children have been exposed to domestic violence, experience trauma or been a victim of abuse or neglect. Some diagnosed conditions that may result in exposure to abuse, neglect or trauma include:

- Childhood Depression
- Childhood Disintegrative Disorder
- Reactive Attachment Disorder
- Regulatory Disorders of Sensory Processing
- Adjustment Disorder
- Relationship Disorder
- Deprivation/ Maltreatment Disorder

The above conditions are considered medical disorders and can be diagnosed by a licensed mental health professional based on criteria in the Diagnostic and Statistical Manual of Mental Disorder IV (DSM IV TR), the International Statistical Classification of Diseases and Related Health Problems 10 (ICD-10), or the DC: 0-3R Diagnostic Guidelines. The diagnoses should be determined by clinically trained and licensed professionals with specific expertise and training in infant mental health.

EARLY IDENTIFICATION WITH DC: 0-3R

The Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood Revised (DC: 0-3R) is designed to complement the DSM IV TR. It provides a developmental framework for understanding mental health and developmental problems in the earliest years.

DC: 0-3R identifies emotional and behavioral patterns that represent significant deviation from normal behaviors. Some of the categories in DC: 0- 3R are new categories reflecting mental health and developmental difficulties. Other categories mirror the DSM IV disorders of infancy. Still others describe the earliest signs of

mental health problems seen in older children and adults. However, in the latter categories the signs of mental health problems are not yet attributed to infants and toddlers.

In young children, mental health disorders may have very different characteristics from those diagnosed at a later age. DC: 0-3R allows for the earliest identification of mental health disorders so that effective intervention can occur. Crosswalks between DC: 0-3R and DSM IV TR are available for insurance reimbursement purposes (see the resource listing for Michigan Association for Infant Mental Health in Appendix 3). Like all early intervention, it is hoped that more optimistic prognoses will result from this earlier identification and treatment.

TYLER'S STORY: ONGOING ASSESSMENT

Building a relationship with Brittney and Tyler was never an easy process. Relating with Brittney required patience, perseverance, and lots of listening and clarification. Understanding Tyler's behaviors was not possible until the early intervention team spent time building the relationship. It was only then that Brittney began to feel comfortable talking about her life. The team quickly began to gain a better understanding of why Brittney and Tyler both responded to each other in the ways they did.

By providing a warm, non-judgmental and caring atmosphere, the team was able to watch, listen to, and observe the interactions between Brittney, Tyler and the rest of the family. They learned that Brittney had suffered severe physical, sexual, and emotional abuse as a child. She was also severely neglected. Brittney's mother had a series of boyfriends that moved into the house, took on the role of parent, and left just as quickly. These same boyfriends were often the perpetrators of Brittney's abuse.

Brittney also explained that as a child she had been diagnosed with hyper-activity attention deficit disorder. Her prescription drugs made a huge difference in her ability to concentrate at school. For a brief time she was able to do well in school and be accepted by her peers—two things that she desperately wanted for her own children. But substance abuse was all around her, and by the time she was 11 she was drinking and using drugs with her mother and her mother's friends.

Brittney also talked about being terrified as a child of being out in the streets and homeless. She worried that Tyler's tantrums and behaviors would cause her already precarious living situation to unravel and leave her and her children out in the cold. For Brittney, having her doctor write a prescription for drugs that would quiet Tyler was really more about being able to stay in a safe and stable place.

APPROACHES TO INTERVENTION

Nationally, evidence-based practices recommend an early childhood mental health *system of care* be developed to effectively coordinate the medical, mental health, educational and community-based services and supports needed by young children with serious social-emotional deficits and their families (10). While Alaska, with its small population spread over great distances, does not have an integrated system of care for early childhood mental health, the same principles that apply in a system of care approach to service delivery can inform an EI/ILP approach to infant and toddler mental health services and supports.

PRINCIPLES OF INTERVENTION

The following principles of intervention are based on developing systems of care with the most positive outcomes for very young children with significant emotional disturbances (11).

- Children should have access to a comprehensive and integrated array of services that address each child's unique physical, emotional, social and educational needs.
- Services should be guided by a family-driven Individualized Family Service Plan (IFSP) and set in a child's natural environment.
- Families and caregivers should be full participants in all aspects of planning and delivery of services. Multiple services should be coordinated in such a way so that all providers can deliver comprehensive coordinated care as the child's needs change.
- Early identification and intervention for children with social/emotional concerns should occur in order to enhance the likelihood of positive outcomes.

Research-based best practices (12) further suggest that mental health services and supports for young children are most effective when they are:

- **Grounded in developmental knowledge.** Early childhood systems of care must be deeply grounded in the developmental knowledge of what are typical and atypical behaviors for infants, toddlers and preschoolers.
- **Relationship-based.** The system of care design should reflect the philosophy that healthy relationships among parents, children and caregivers are essential for the child's healthy emotional development.
- **Family supportive.** In almost all instances, the best way to help young children

is to enhance and strengthen the families' abilities to meet their emotional needs. This includes supporting families as they struggle with economic, physical and mental health issues.

- **Infused into the existing early childhood networks and services.** All children and families connect with a constellation of people who play integral roles in their lives. These people may be relatives, caregivers, pre-school and Early Head Start and Head Start programs, pediatric and well child clinics, social service programs and EI/ILP programs.
- **Responsive to the community and cultural context.** When designing a system of care one size does not fit all. Responding to families' ethnic and cultural strengths and customs is essential to facilitate understanding among all families and the people who are part of their system of care.
- **Attentive to outcomes.** Developing mechanisms to assess the impact of an early childhood mental health system of care shows both public and private funders the impact the investment of dollars has on school readiness, early learning and more costly interventions for children with social-emotional disturbances.
-

STRATEGIES FOR INTERVENTION

TARGETED SOCIAL EMOTIONAL SUPPORTS

All early intervention work is grounded in supporting caregiver-child relationships, regardless of specific area of developmental need of a child. There is a continuum of IPMH supports available through early intervention and partnering agencies. Trauma and stress are relative terms that are individually dependent. Trauma and stress are not always related to abuse and neglect situations. Having a child, even with a mild developmental delay, can be a stress for a family. Hence early intervention services that promote supports for all families are part of a continuum of IPMH practices.

The results of a social-emotional assessment will suggest specific areas of intervention and support needed by a particular child and family. The following strategies can be used to design an effective system of services and supports to target specific goals (13):

Enhance the emotional and behavioral well-being of infants and toddlers, particularly those whose emotional development is compromised by poverty or other risk factors.

- Use screening and assessment of social and emotional development as a part of the early identification process
- Carefully listen to families to help them identify, clarify, and address issues that

may be affecting the developing relationship with their child (14)

- Coordinate services with community mental health and public health providers when there is concern about maternal depression, parental substance abuse and other family mental health disorders

Help parents become more effective nurturers.

- Assist parents in understanding and responding sensitively to the cues of their child
- Use relationship-based practice with families in order to model and promote the parent-child relationship
- Provide parents with support as they increase their coping skills and build resilience in their children (14)

Expand the competencies of non-familial caregivers to prevent and address problems.

- Develop relationships with childcare providers and other non-familial caregivers
- See specific suggestions below for working on social-emotional issues in childcare settings

Ensure more seriously troubled young children get appropriate help.

- Services for children with serious social-emotional disturbances should be provided by qualified mental health provider or Infant Parent Mental Health specialist certified to work with children under age 3.

INTENSIVE INTERVENTION

For the very small percentage of young children with diagnosable mental health conditions, the goal is to design a program to alleviate the symptoms and support the return to healthy development and behavior. In addition the intervention team should develop strategies to improve the quality of family life and child development. These should be considered Part C services and should be listed on the IFSP. These services should be provided by a qualified mental health provider or certified IPMH specialist. Often the provision of infant mental health supports and services will include a cross-agency approach, involving linkages across early intervention programs and public mental health services at the state and local levels.

The approach to intervention should be broad and interdisciplinary, embracing professionals from many disciplines, including social work, child welfare, education, speech and language, occupational and physical therapy, child and family development, psychology, nursing, pediatrics, and psychiatry. The qualified mental health provider (e.g., social worker, psychologist, counselor, IPMH specialist) may serve as primary service provider and in this role would assist families in the

following ways:

- Building relationships and using them as instruments of change
- Meeting with the infant and parent together throughout the period of intervention
- Sharing in the observation of the infant's growth and development
- Offering anticipatory guidance to the parent that is specific to the infant
- Alerting the parent to the infant's individual accomplishments and needs
- Helping the parent to find pleasure in the relationship with the infant
- Allowing the parent to take the lead in interacting with the infant or determining the "agenda" or "topic for discussion"
- Identifying and enhancing the capacities that each parent brings to the care of the infant
- Wondering about the parent's thoughts and feelings changing responsibilities of parenthood
- Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent
- Listening for the past as it is expressed in the present, inquiring and talking
- Allowing core relational conflicts and emotions to be expressed by the parent holding, containing and talking about them as the parent is able
- Attending and responding to parental histories of abandonment, separation and unresolved loss as they affect the care of the infant, the infant's development, the parent's emotional health and the early developing relationship
- Attending and responding to the infant's history of early care within the developing parent-infant relationship
- Identifying, treating and/or collaborating with others if needed, in the treatment of disorders of infancy, delays and disabilities, parental mental illness and family dysfunction
- Remaining open, curious and reflective

In addition to the skills and clinical strategies of infant mental health practices, the IPMH specialist needs:

- An ability to observe and listen carefully
- A willingness to work hard at establishing and strengthening strong and meaningful relationships with individuals and consulting groups
- A respect for continuity and predictability, sensitivity and responsiveness as integral to effective consultation with early intervention practitioners/groups
- An ability to invite another person to tell you what they saw, heard, felt or experienced when caring for an infant or toddler, talking with a parent, going

on a home visit, working with a parent and infant together, determining eligibility for services, running a teen parent infant group, etc.

- An ability to provide a context in which people feel safe and secure, able to think about their work with families and to reflect on their own emotional responses as appropriate.

There is a wide range of individual skills, experience, and areas of specialization among health care professionals and other service providers working in Alaska. Licensed practitioners who work with Alaska's children should follow the high-quality, evidence-based standards of their professions as determined by their state and national credentialing and professional associations. All providers who work with Alaska's young children should engage only in those aspects of their profession that are within the scope of their competence, considering their level of education, training, and experience.

WORKING ON SOCIAL-EMOTIONAL ISSUES IN CHILDCARE SETTINGS

Early interventionists frequently provide services for children in a childcare setting. Young children with social-emotional disturbances often present particular challenges to childcare staff. Childcare providers are a resource for both the family and the interventionist in determining plans for the child. Children with social-emotional disturbances can provide particular challenges to childcare staff.

When discussing behavior issues with a childcare provider:

- Discuss with the director opportunities for staff training in the areas of social-emotional development in order to promote infant mental health well being
- Discuss with the childcare center using a screening instrument routinely with families, such as the Ages and Stages Social Emotional Questionnaire (ASQ:SE)
- Discuss using a specific social-emotional curriculum such as: Creative Curriculum used by Head Start programs, Promoting First Relationships, DECCA and Bright Futures (see Appendix 3 for more early education resources.)
- Suggest contacting an early childhood mental health consultant if the classroom environment seems to be impacting the child's behavior and/or the child's behavior is impacting other children's activities

If your community has access to early childhood mental health consultants, it may be useful to engage one to help address the concerns about a young child who exhibits challenging behaviors in a childcare setting.

In addition to improving the social-emotional development of an individual child or the climate of a classroom, early childhood mental health consultants can improve the quality of early childhood programs and reduce the likelihood of suspensions and expulsions.

TYLER'S STORY: PROVIDING SUPPORTS

Now that Tyler had been found eligible for EI/ILP services, the early intervention team, including Brittney, needed to consider what kinds of services best fit his family. The IFSP that Brittney and her team developed reflected an assessment process that revealed both issues readily identifiable from the beginning and others that were not.

Tyler's sensory integration issues were often misunderstood even by those closest to him as simply bad behaviors. Through this process both Brittney and her team agreed that while Tyler's behaviors were very challenging, he really did not need medication. Tyler did not need treatment for a mental health disorder but rather targeted social emotional supports. For Tyler, the initial strategies addressing his development included:

- *Completing the Sensory Profile*
- *Finding community mental health resources for Brittney*
- *Finding a preschool with mental health consultation services*
- *Identifying activities that Brittney and Tyler could enjoy together (physical activities since Tyler excels in that area)*

The early intervention team was able to connect Brittney, Tyler, and their family with a series of supportive community programs. These programs included mental health counseling for Brittney to deal with addiction and her own past history of abuse, and subsidized housing and respite care. They found a preschool program for Tyler with a staff that was highly experienced in working with children with social and emotional concerns.

The early intervention staff helped Brittney understand the sensory issues Tyler experienced and how to help Tyler manage those issues. They also were able to support Brittney and build her confidence in herself as a mother and as a person. They repeatedly found ways to praise Brittney and acknowledge her successes as a mother. By the time Tyler was ready to turn three, Brittney and her EI/ILP team were confident that despite a rocky and turbulent beginning, Tyler was on his way to becoming a healthy, happy little boy ready to relate and learn in his next school environment.

TYLER'S STORY REVISITED: OTHER APPROACHES

SCENARIO I: NOT ELIGIBLE

Let's revisit Tyler when he was an infant and alter his story just a little. Tyler at 3 months was referred to EI/ILP by his OCS worker while his mother was still in the juvenile detention center. He was living with a cousin of his great aunt. The cousin contacted Tyler's mother who agreed to an eligibility evaluation.

On the day of the evaluation Tyler was alert, responsive, and no developmental delays were observed. Because of the risk factors noted the team completed the

Ages and Stages Social Emotional Questionnaire with the caregiver. Overall, the screening suggested no current developmental concerns.

What is the responsibility of the EI/ILP staff at this point? Here are some suggestions:

- Encourage the caregiver or OCS case worker to enroll Tyler in Early Head Start or other early childhood program available in the family's community
- Provide family information about Alaska mental health agencies and other community-based programs supporting child development and families that can offer services to the family given Tyler's risk factors (see list of resources in Appendix 3)
- Support the caregiver in her role with Tyler
- Provide developmental information for the caregiver, stressing the risks that Tyler has already experienced
- Recommend community activities for Tyler and his caregiver such as library story time for infants, "Mommy and me" activities at hospitals and family and youth services programs
- Suggest to the primary care provider, the OCS case worker, and the relative caregiver a re-referral in 3 to 6 months

SCENARIO II: ELIGIBLE BUT NOT FOR SOCIAL/EMOTIONAL CONCERNS

In this second scenario, Tyler was evaluated by the EI/ILP team at 3 months of age and was found eligible based on his adaptive scores: his eating and sleeping were of concern to the cousin, his caregiver, and he was not gaining weight. These issues should alert the EI/ILP team to relationship, emotional, and sensory issues.

Because the promotion of social and emotional well-being of all infants and toddlers is part of EI/ILP services, the following supports should be considered:

- Parent and caregiver guidance to social, emotional, and behavioral development issues
- Assistance to parents and caregivers in reading infant and toddler cues
- Development of individual and care giving strategies to use with infants and toddlers that address specific delays as well as social and emotional development
- Assistance to parents to obtain services to reduce financial and other stressors
- Assistance to parents in accessing and using other support systems
- Screening for social-emotional wellness whenever families have concerns about social-emotional and behavioral issues

Regardless of the reason for eligibility, EI/ILP mission and core values require that staff take a holistic and comprehensive approach to development. For all children the approach is to promote and foster nurturing and responsive relationships.

PLANNING FOR TRANSITION

As a child approaches 3 years of age, the family's service coordinator and IFSP team, including parents, will work together to plan for a smooth transition from early intervention services to services designed for preschoolers. For most children and families with identified mental health concerns, it will be important to have continued mental health supports after the child turns three.

If the team believes the child will continue to benefit from intervention but may not qualify for special education preschool programs, the service coordinator will help the family locate age-appropriate community-based mental health services and supports. This may require creative effort and state level participation in the development and coordination of services that meet individual needs at the community level in many areas of the state.

Whatever their child's particular case, families need to plan for this transition. Starting at the initial IFSP meeting, the service coordinator will talk with the family about what will happen when the child turns three or no longer needs services. At least 6 months prior to the child's third birthday, the team will develop a detailed transition plan that will outline the steps, services, and supports for the child's transition to the appropriate setting. Parents participate in all meetings to ensure a smooth transition for their child.

Transition Planning Tools

EI/ILP Transition Planning Handbook

A detailed, step-by-step guide for parents going through the transition process with a timeline of steps as a child gets older and an overview of the process to create an Individual Education Plan (IEP). Available at:

www.hss.state.ak.us/ocs/InfantLearning/afterage3/ilp_StepAhead.pdf

Alaska Transition Training Initiative

A consortium of early childhood programs and providers in Alaska, ATTI helps address transition issues for special needs children moving from Part C to Part B at age 3. Learn more at:

www.alaskaearlytransitions.org/trainers.html

Stone Soup Group: Transitions

Information and resources for parents and caregivers transitioning someone with special needs from one phase of care to the next, including medical and legal issues, guardianship, Medicaid, and transitions into postsecondary programs. Links to parent groups, behavioral supports and assistance programs specifically for kids transitioning from an early intervention to early education can be found at:

www.stonesoupgroup.org/transitions.html

The Paper Trail Notebook

An organizational tool available from the Stone Soup Group, the Paper Trail Notebook can assist the family in identifying and organizing information that will be needed for transition, including records of medical history, appointments and providers. Available at no charge to families of children with special health care needs through EI/ILP providers or directly from the

REFERENCES

1. **Oser, C. and Cohen, J.** *Improving Part C early intervention: Using what we know about infants and toddlers with disabilities to reauthorize Part C of IDEA.* Washington, DC : Zero to Three Policy Center, 2003.
2. **Zero to Three.** *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition.* Washington, DC. : Zero to Three Press, 2005.
3. **Onunaku, N.** Improving Maternal and Infant Mental Health: Focus on Maternal Depression. [Online] 2005.
www.healthychild.ucla.edu/PUBLICATIONS/Maternal%20Depression%20Report%20FINAL.pdf.
4. *World Association of Infant Mental Health.* [Online] [Cited: January 18, 2005.]
www.waimh.org.
5. **Lieberman, A. F.** An Infant Mental Health Perspective. 1998, December/January, pp. 3-5.
6. **Huang, L. N. and Isaacs, M. R.** Early Childhood Mental Health: A Focus on Culture and Context. [ed.] D. F. Perry, R.K. Kaufmann and J. Knitzer. *Social & Emotional Health in Early Childhood.* Baltimore, MD : J.Brooks Publishing Co, 2007.
7. **Christenson, M., Emde, R. and Fleming, C.** Cultural perspectives for assessing infants and young children. [ed.] R. Del-Carmen-Wiggins and A. S. Carter. *The Handbook of Infant Toddler and Preschool Mental Health Assessment.* New York : Oxford University Press, 2004, pp. 7-23.
8. **Connecticut Birth to Three System.** *Service Guideline 4: Infant Mental Health.* September 2009.
9. *Children's Mental Health FACTS.* s.l. : U.S. Department of Health and Human Services, 2006. SMA-4125/2006.
10. **Stroul, Friedman and.** *A system of care for children and youth with severe emotional disturbance (Rev. Ed).* Washington, DC : Georgetown University Child Development Center, 1986.
11. **Knitzer, J. and Cooper, J.** Beyond integration: Challenges for children's mental health. 2006, Vol. 25, 3, pp. 67-680.

12. **Knitzer, J.** *Building services and systems to support the healthy emotional development of young children—An action for policy makers.*: Mailman School of Public Health, Columbia University. s.l. : National Center for Children in Poverty, 2002. Policy paper no. 1.
13. **Heffron, M. C.** Clarifying Concepts of Infant Mental Health: Promotion, Relationship-Based Preventive Intervention and Treatment. *Infants and Young Children*. 2000, Vol. 20, 4.

APPENDICES

1. Milestones in Social-Emotional Development
2. Screening, Evaluation & Assessment Tools
3. Resources

MILESTONES IN SOCIAL-EMOTIONAL DEVELOPMENT

The progression in social emotional development as a baby grows and matures occurs at different rates for different individuals. The milestones listed below describe typical behaviors from birth to three. For some babies the growth will be slower or faster. What is important is that there is change over time from one step to the next.

FROM BIRTH TO 6 MONTHS

Babies are learning ways to be soothed and are establishing regulation and predictable cycles of eating and sleeping. Young infants need to know that a familiar caregiver will respond promptly when they feel distressed. Learning that they can count on being cared for helps infants build a sense of security. Specifically an infant at this time:

- Is alert to voices and faces
- Follows caregiver with eager eyes
- Show enormous joyful smiles to interesting facial expressions
- Vocalizes happily
- Spends lots of time getting to know own body: sucks hands, look at hands, pulls feet to mouth
- Moves arms and legs to the rhythm of caregivers' voices
- Interacts best when in an alert state or inactive and attentive state
- Will engage, disengage, then reengage with caregiver for short periods of time; and is learning to trust, love, and feel emotionally close to caregivers

FROM 6 TO 18 MONTHS

Exploration takes center stage as infants become more mobile. It is important for caregivers to remember that at this stage infants practice independence but very much need trusted adults as a secure base of support. A baby at this time:

- Responds to caregiver gestures with gestures in return: hands toys back and forth, plays peek a boo
- Initiates interactions and looks expectantly for caregiver response, shares pleasure
- Expresses desires and wants by pointing to food or toy or caregiver
- Initiates comforting and closeness by pulling on caregivers' legs and eventually runs to give hugs
- May express feelings of anger by banging or throwing and later with gestures

and sounds

- May show anxiety when separated from primary caregiver
- Recognizes self in pictures or mirror

FROM 18 TO 36 MONTHS

Through dramatic play, increasing facility with language, and negotiation of conflicts with peers and adults, toddlers build a sense of themselves as social beings—competent, cooperative, and emotionally connected. A toddler at this time:

- Engages in pretend play with others: puts doll to sleep, races cars/trucks
- Uses words or combines gestures to express feelings: “me mad” or “no bed”
- Communicates desire for closeness by saying “hug” or gesturing to sit on lap
- Can recover from anger and be cooperative
- Watches others
- Defends possessions

SCREENING, EVALUATION & ASSESSMENT TOOLS

Ages & Stages Questionnaires: Social- Emotional (ASQ: SE)

Authors: Squires, J. Bricker, D. and Tomboy, E. (2002)

Publisher: Brookes Publishing Co., Baltimore, MD.

Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T).

The Devereux Early Childhood Assessment for Infants and Toddlers (DECA-I/T) is a standardized, norm-referenced, strength-based assessment that assesses protective factors and screens for social and emotional risks in very young children. It meets Early Head Start performance standards. e-DECA is a web-based computer version of the DECA. (2007)

Publisher: Devereux Early Childhood Initiative

www.devereux.org/site/PageServer?pagename=deci_it

Infant Toddler Developmental Assessment (IDA)

IDA provides guidance for a collaborative, team-based and family-centered approach to developmental assessment of children who are developmentally at risk. It includes a health component where medical professionals can obtain and organize information vital to a child's development. (1995)

Administration: Time varies

Ages: Birth to 3 years

Authors: Provence, S., Erikson, J., Vater, S. and Palmeri, S.

Publisher: Riverside Publishing, Rolling Meadows, IL

www.riverpub.com

Infant Toddler Sensory Profile

The Infant/Toddler Sensory Profile was developed to evaluate sensory processing patterns in the very young. The results provide you with the understanding of how sensory processing affects the child's daily functioning performance. (2002)

Administration: 15 minutes

Qualification level: B,Q1,Q2-Level

Ages: Birth to 36 months

Author: Dunn, W.

Publisher: Pearson Assessments. San Antonio, TX

www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=076-1649-549

Infant Toddler Social Assessment (ITSEA). Brief Infant Toddler Social Emotional Assessment (BITSEA)

The ITSEA/BITSEA focuses on competencies, as well as deficits, and relies on input from the parent and childcare provider. Use the BITSEA to quickly identify possible developmental delays, followed by the ITSEA to provide in-depth analysis and intervention guidance. Spanish-language parent and childcare provider forms are available. (2006)

Administration: ITSEA: 25 to 30 minutes; BITSEA: 7 to 10 minutes

Qualification level: ITSEA: C,Q2-Level; BITSEA: B,Q1,Q2-Level

Ages: ITSEA: 12 to 36 months; BITSEA: 12 to 35 months

Norms: National sample of 600 children. Clinical groups included language delayed, premature, and other diagnosed disorders.

Authors: Briggs-Gowan, M. and Carter, A.S.

Publisher: Pearson Assessments. San Antonio, TX

www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-387

NCAST Feeding Scale

This is a tool for observing parent-child relationships. In particular, the Neuro-relational Framework Assessment of Load Conditions and Current Brain Capacities for Child and Parents, and Neuro-sequential Model of Therapeutics (brain map) are good resources for evaluation.

Neonatal Behavioral Assessment Scale (NBAS)

Developed in 1973 by Dr. T. Berry Brazelton and his colleagues, the NBAS represents a guide that helps parents, health care providers and researchers understand a newborn's language. "The Scale gives us the chance to see what the baby's behavior will tell us. It gives us a window into what it will take to nurture the baby," according to Dr. Brazelton, professor emeritus, Harvard Medical School.

Publisher: Brazelton Institute

www.brazelton-institute.com

Parent-Child Interaction Feeding and Teaching Scales (PCI Scales)

PCI Scales are widely used in both clinical practice and research with families and young children for measuring parent-child interaction. They are a reliable and valid means of observing and rating caregiver-child interaction for the purpose of assessing a dyad's strengths and areas needing improvement. The scales may be used as pre and post-test measures. They contain a well-developed set of observable behaviors that describe the caregiver-child communication and interaction during either a feeding situation, or teaching situation, birth.

Administration: Feeding: same time as a feeding; Teaching: 1-6 minutes

Ages: Feeding: Birth to 12 months; Teaching: Birth to 3 years

Publisher: NCAST Programs, University of Washington

www.ncast.org

Parent Stress Index (PSI), 3rd Edition

Author: Abidin, R.

Publisher: Western Psychological Services, Los Angeles, CA.

Social Emotional Assessment Measure (SEAM)

SEAM is an activity-based approach to screening, assessment, goal development, intervention and evaluation developed for non-mental health professionals from the creators of the Ages & Stages Questionnaires: Social-Emotional (ASQ: SE). It provides a linked system for identifying concerns and improving young children's social-emotional competence based on a five-step intervention process called Activity-Based Intervention: Social Emotional (ABI:SE). (2007)

Ages: Infant: 3 to 18 mos.; Toddler: 18 to 36 mos.

Authors: Squires, J., Bricker, D.

Publisher: Brookes Publishing Co., Baltimore, MD.

eip.uoregon.edu/seam

Stanley Greenspan Social-Emotional Growth Chart

A questionnaire completed by the child's parent, educator, or other caregiver, the growth chart is useful as a preliminary step in childcare screenings, early identification screenings, and pediatric screenings to determine mastery of early capacities of social-emotional growth and detect deficits or problems. It should be used to determine whether further assessment/referral is warranted and can assist in establishing goals for early intervention planning and monitoring progress. (2004)

Administration: 10 minutes

Qualification level: A-Level

Ages: 0-42 months

Author: Greenspan, S.

Publisher: Pearson Assessments. San Antonio, TX

www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8280-229

Temperament and Atypical Behavior Scales (TABS)

Authors: Bagnato, S.J., Neisworth, J.T., Salvia, J.J., and Hunt, F.M..

Publisher: Brookes Publishing, Baltimore, MD

Mental Health Assessment of Infants in Foster Care

Author: Silver, J. and Dicker, S. (2007)

Publisher: Child Welfare League of America #050735-55

Vineland Social Emotional Early Childhood Scale (Vineland SEEC)

Three scales (Interpersonal Relationships, Play and Leisure Time, and Coping Skills) and the Social-Emotional Composite assess usual social-emotional functioning in children from birth through 5:11. Data is collected through an interview with the parent or caregiver. The tool assesses strengths and weaknesses in specific areas of social-emotional development that can be used to plan targeted activities and supports, monitor progress, or evaluate success after completion of a program. It can be used alone or in conjunction with the Mullen Scales of Early Learning for a more complete assessment of a young child's development.

Administration: 15-25 minutes

Qualification level: B,Q2-Level

Ages: Birth to 5 years 11 months

Authors: Sparrow, S.S., Balla, D.A., and Cicchetti, D.V.

Publisher: Pearson Assessments. San Antonio, TX

www.pearsonassessments.com/haiweb/cultures/en-us/productdetail.htm?pid=paa3600

ASSESSMENT INSTRUMENT	SCREENING	ELIGIBILITY	ASSESSMENT
Ages & Stages Questionnaires: Socio-Emotional (ASQ:SE)	X		
Brief Infant Toddler Social Emotional Assessment (BITSEA)	X		X
Devereux Early Childhood Assessment for Infants/Toddlers (DECA-I/T)		X	X
Infant Toddler Developmental Assessment			X
Infant Toddler Sensory Profile			X
Infant Toddler Social Emotional Assessment (ITSEA)		X	X
Mental Health Assessment of Infants in Foster Care			X
Neonatal Behavioral Assessment Scale (NBAS)	X		
Parent Stress Index (PSI)			X
Parent-Child Interaction (PCI)Scales	X		X
Social Emotional Assessment Measure (SEAM)			X
Stanley Greenspan Social-Emotional Growth Chart	X		
Temperament and Atypical Behavior Scales	X		X
Vineland Social Emotional Early Childhood Scale		X	

(1) A care coordination planning guide

Source: Adapted from Connecticut Birth to Three System, 2009 (1)

APPENDIX 2

RESOURCES

ALASKA RESOURCES

Alaska Early Intervention/Infant Learning Program (EI/ILP) is a division of the Alaska Department of Health and Social Services, Office of Child Services that partners with grantees around the state to provide services directly to children with special needs and their families at a local level.

P.O. Box 240249, 323 East 4th Avenue, Anchorage, AK 99501

Toll-free (877) HSS-FMLY (477-3659). Local (907) 269-8442

Fax (907) 269-3497

www.hss.state.ak.us/ocs/InfantLearning

Find a complete list of EI/ILP providers in Alaska at:

www.hss.state.ak.us/ocs/InfantLearning/program/program_dir.htm

Alaska Governor’s Council on Disabilities and Special Education (GCDSE) is one of four governor-appointed advisory boards to the Alaska Mental Health Trust. The Council plans, evaluates, and promotes programs for people with disabilities in the state of Alaska.

3601 C Street, Suite 740, P.O. Box 240249, Anchorage, AK 99524-0249

Toll-free (888) 269-8990. Local (907) 269-8990, Fax (907) 269-8995

www.hss.state.ak.us/gcdse

Alaska Infant mental Health Association (AK-AIMH) AK-AIMH is an interdisciplinary infant and early childhood mental health organization that facilitates, supports and encourages cooperation, coordination and collaboration among those concerned with promoting the optimal development of children birth through five and families and caregivers.

Alaska Mental Health Board (AMHB). As part of its mission of planning and coordinating behavioral health services funded by the State of Alaska, AMHB supports the development of a comprehensive system of care for children and families. Its website includes links to mental health resources in Alaska.

www.hss.state.ak.us/amhb

Alaska Mental Health Trust Authority (AMHTA) funds projects and activities that promote long-term system change, including capacity building, demonstration projects, funding partnerships, rural technical assistance, and other activities to improve the lives and circumstances of Trust beneficiaries, which include Alaskans with development disabilities and with mental illness.

3745 Community Park Loop Suite 200, Anchorage AK 99508

Phone (907) 269-7960. Fax (907) 269-7966. Email info@mhtrust.org

www.mhtrust.org

APPENDIX 3

Alaska Youth and Family Network (AYFN) is a peer-run, peer-delivered service to create a more effective and inclusive behavioral health treatment system for Alaska's children, youth & families.

40 Communications Avenue, Anchorage, AK

Toll-free (888) 770-4979. Local (907) 770-4979. Fax (907) 770-4997

Email admin@ayfn.org

www.ayfn.org

thread provides professional development and support to individual early educators and early care and education programs, including training in positive ways to support children's social and emotional development.

Anchorage Office: 3350 Commercial Dr, Suite 203, Anchorage, AK 99501

Toll-free (800) 278-3723. Local (907) 563-1966. Fax (907) 563-1959

Toll-free fax (877) 563-1959. Email info@threadalaska.org

www.threadalaska.org

NATIONAL AND ONLINE RESOURCES

Brazelton Touchpoints Center promotes the healthy development of children through professional development, research and policy. We support families to ensure that all children have the best start in life and optimal opportunities to succeed.

www.brazeltontouchpoints.org

Center on the Social and Emotional Foundations for Early Learning is designed to promote social emotional outcomes and enhance school readiness of low-income children birth to age 5, and to serve as a national resource center for disseminating research and evidence-based practices to Head Start and childcare programs across the country.

www.vanderbilt.edu/csefel

Child & Adolescent Bipolar Foundation has extensive information on pediatric bipolar disorder and resources.

www.bpkids.org

Child Trauma Academy seeks to help maltreated and traumatized children. It is a nonprofit organization, based in Houston, Texas, that works to improve the lives of high-risk children through direct service, research and education..

www.childtrauma.org

Early Childhood Behavior Project provides strategies, useful materials and interventions, case studies, presentations, and publications promoting positive behavioral supports for young children who engage in challenging behaviors. Designed to help services providers and families. Also Link to Positive Behavior Support and Technical Assistance Center on Social Emotional Intervention

www.slhslinux.cla.umn.edu

Fussy Baby Network at Erickson Institute can help parents who have questions about their infant's development, including crying, sleeping and feeding issues. Parents can talk with an infant specialist if they are exhausted or overwhelmed and would like to talk with someone. Infant specialists are available for private, in-home consultations, or to talk with on the phone. Services are available in English and Spanish. The Erickson Institute has a graduate school program for students interested in working to improve the care and education of children from birth to 8 years of age.
www.erikson.edu/fbn.aspx

Infant and Early Childhood Mental Health: the DIR Model provides a comprehensive developmental approach that takes into account all aspects of an infant's life, such as individual "processing" differences, developmental abilities, interactive patterns, and caregiver, family, cultural and community dynamics. www.icdl.org

Mental Health Family Tree Program is designed for families who may have concerns about the existence of mental health disorders in their family; provides an online tool to assist families in learning about their family's mental health history.
www.familyaware.org/familytree

Michigan Association of Infant Mental Health. Crosswalk between Diagnostic Classifications 0-3, ICD 9 CM and DSM IVR+ developed by the Michigan Department of Community Health Division of Children's Mental Health Services in collaboration with representatives from the Michigan Association for Infant Mental Health.
www.mi-aimh.org

National Early Childhood Technical Assistance Center provides extensive information on early childhood mental health and social emotional development and challenging behaviors.
www.nectac.org/topics/menhealth/menhealth.asp

National Technical Assistance Center for Children's Mental Health has information on policy, research, and clinical practice to improve the lives of families and their children with special needs including: developmental disabilities and special health care needs, mental health needs, young children and those in the child welfare system.
www.gucchd.georgetown.edu/67211.html

NCAS Programs offers training programs and products for promoting nurturing environments in young children, including the Parent-Child Interaction Scales, Promoting First Relationships, Baby Cues, Keys to Caregiving and other programs.
www.ncast.org

APPENDIX 3

The Neurorelationship Framework for Interdisciplinary Practice offers training, resources and a framework working with caregivers and young children. A Neurorelational Framework for Interdisciplinary Practice is a groundbreaking neuroscientific understanding of infant and child development. <http://the-nrf.com>.

PBS Parents provides information to help parents and caregivers of children with disabilities improve the overall quality of life for their children and family. Includes section on challenging behaviors. www.pbs.org/parents/inclusivecommunities

Portland State U: Family Support & Children's Mental Health has information on research, training, access to resources and publications on effective community-based, culturally competent, family centered services for families and their children who are, or may be affected by mental, emotional, or behavioral disorders. www.rtc.pdx.edu

National Technical Assistance Center on Positive Behavioral Intervention & Supports is funded by OSEP to address the behavioral systems needed for successful learning and social development of children. www.pbis.org

Skillstreaming provides instructional materials designed to show how to teach prosocial skills to preschool and kindergarten children.

Tourette Syndrome "Plus" has an extensive collection of articles, materials, and practical resources for parents and professionals pertaining to a variety of behavioral/mental health disorders www.tourettesyndrome.net

Young Children with Challenging Behavior provides resources, practical materials, training opportunities, and publications to promote the use of evidence-based practice to meet the needs of young children who have, or are at risk for, problem behavior. www.challengingbehavior.org

Zero to Three addresses common issues (biting, aggression, self control, etc.) that interventionists and childcare providers encounter with young children. Click on "Key Issues" on the home page. www.zerotothree.org

EARLY EDUCATION RESOURCES

The following early education curricula may be useful for childcare providers and parents in supporting the development of healthy relationships and social-emotional development.

Bright Futures health promotion initiative at Georgetown University provides a set of best practices guidelines, which examine early childhood mental health in a developmental context, present information on early recognition and intervention for specific mental health problems and mental disorders, and provide a tool kit with hands on tools for health professionals and families for use in screening, care management, and health education.

www.brightfutures.org/mentalhealth

Bingham Early Childhood Prosocial Behavior Program is an evidence-based program for educators that encourages positive social skills in preschool and kindergarten children. Available in *A Blueprint for the Promotion of Pro-Social Behavior in Early Childhood* (Vol. 4 in the series “Issues in Children's and Families' Lives”), edited by Elda Chesebrough, Patricia King, Thomas P. Gullotta, and Martin Bloom. New York: Springer, 2005.

Creative Curriculum for Preschool is a comprehensive, research-based curriculum and resource system for all early childhood educators, with built-in support for children with disabilities, English language learners and dual-language learners.

www.teachingstrategies.com

Partners in Parent Education (PIPE) is a Colorado-based program that offers specialised curricula to train service providers in promoting parent-child relationships, particularly in working on the emotional connectedness of parents and caregivers.

www.HowtoReadYourBaby.org

Promoting First Relationships trains service providers in the use of practical, effective strategies for promoting secure, responsive, nurturing and healthy relationships between caregivers and young children (birth to 3 years) through a series of training workshops.

www.pfrprogram.org

Alaska Infant Learning Program

This report, historical data and other publications available at www.earlyintervention.alaska.gov

Call toll free in Alaska: 1 (877) HSS-FMLY (477-3659); In Anchorage 269-8442

INFANT LEARNING PROGRAMS THROUGHOUT ALASKA



The Alaska Infant Learning Program offers developmental services to families of children birth to 3. If you have concerns about your child's development make a referral to your local Infant Learning Program. Our Mission is to promote positive development and improved outcomes for Alaska's children birth to 3 by creating a culturally responsive, comprehensive and accessible service delivery system that links service providers, empowers families and engages communities.