THE INFANT, PRESCHOOL, FAMILY, MENTAL HEALTH INITIATIVE

Mental Health Screening and Referral Capacity for Children 0-5

By Todd Sosna, Ph.D.
California Institute for Mental Health
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Table of Contents

EXECUTIVE SUMMARY ................................................................. 5

SCREENING AND REFERRAL PROCESS ............................................ 7

OUTREACH ..................................................................................... 7
  Barriers to Screening .................................................................... 7
    Resource Barriers ....................................................................... 7
    System Barriers ......................................................................... 7
    Social-Cultural Barriers ............................................................ 8
  Outreach Strategies ...................................................................... 8
    Integrated Settings ..................................................................... 8
    Flexibility in Time and Place .................................................... 8
    Public Education ....................................................................... 8
    Making the Screening Process Useful for Parents .................... 9
    Addressing Competing Needs .................................................. 10
    Well-Trained and Supported Practitioners ................................ 10

SCREENING AND RESULTS ............................................................ 11
  Social-Emotional Development and Risk Factors ....................... 11
  Screening Results ....................................................................... 12
  Limitations of the Screening Process ......................................... 12
  Screening Recommendations ..................................................... 13

MONITORING AND PERIODIC RE-SCREENING ............................... 13

REFERRAL AND LINKAGE TO SERVICES AND SUPPORTS ................ 14
  Referrals .................................................................................... 15
  Linkage ....................................................................................... 15
    Specific Referrals ..................................................................... 15
    Follow-up Support and Assistance ......................................... 16
    Brokering Agreements ............................................................ 16
    Prioritizing or Staging ............................................................. 17
    Coordinating Care .................................................................. 17
  Services and Supports ............................................................... 18
    Effective Treatment .................................................................. 19

ASSESSMENT .................................................................................. 21

PUTTING IT ALL TOGETHER .......................................................... 22

LESSONS FROM THE FIELD ........................................................ 23
  INTERAGENCY COLLABORATION ............................................... 23
  SCREENING AND REFERRAL MODELS ....................................... 23

APPENDIX A .................................................................................. 26
Mental health is critical for happiness and success throughout the lifespan and across all human endeavors. The development of social-emotional competence in early childhood is an important foundation for mental health throughout childhood and into adulthood. However, social-emotional disorders can develop in infancy and early childhood, and can result in significant and persistent distress and impairment for children and their families. Moreover, impairment resulting from social-emotional developmental delays and disorders can affect many areas of a child’s functioning, including readiness for and performance in school.

Prevention, early intervention and treatment of early childhood social-emotional delays and disorders are available and effective. However, many infants, toddlers, and preschool-age children with social-emotional developmental delays and disorders go unidentified or when identified do not receive needed services and supports. Early identification of social-emotional delays and disorders, and access to services is important for preventing distress and impairment, and improving outcomes for children and their families.

This is one of three guides designed to support early identification of social-emotional developmental delays and disorders, and access to prevention, early intervention and treatment services for children birth to 5 years of age. These guides are intended to support School Readiness sites, other state and county First 5 initiatives, and similar efforts on the part of schools, county behavioral health and social services programs. The other two guides are **Compendium of Screening Tools for Early Childhood Social-Emotional Development** and **Strategies for Financing Mental Health Screening, Assessments, and Services**.

This guide describes the screening and referral process and highlights important program design and staffing considerations. Screening tools have a number of uses including identifying children who show signs of a possible developmental delay or disorder, supporting care or curriculum planning, and tracking of outcomes. However, the use of screening tools for identification of children with a possible delay or disorder is the focus of this guide.

Moreover, the focus of this guide is restricted to screening and referral for services to promote social-emotional development; however, it is very important to approach early childhood development in a holistic manner. Therefore, screening of social-emotional development will ideally be part of a single comprehensive approach that also includes screening for physical health, sensory, motor, cognitive, and language development.

Screening to identify children with (or at-risk of) social-emotional delays or disorders is an important step in assisting children and families in obtaining services and supports to treat or remediate risk factors, delays, and disorders. Five sets of interdependent activities are important in ensuring that children with social-emotional developmental delays or disorders are identified and access needed services and supports. These five sets of activities are described at length in the guide and include:

1. **Outreach**—A process for promoting the broad use of early childhood screening.
2. **Screening**—An appraisal of a child’s development, and identification of signs that indicate a possible delay or disorder, or risk factors.
3. **Monitoring and Periodic Re-Screening**—A process of following children over time and periodically repeating developmental screenings.
4. **Referrals and Linkage to Assessments, Services and Supports**—A process to ensure that children and families have access to assessments, and needed and effective services and supports.
5. **Assessment**—An evaluation of a child’s level of development and identification of a delay or disorder.

Key considerations for providing screening, assessments and services to promote early childhood social-emotional development are summarized below:

- Early childhood development is dynamic. Very young children with social-emotional developmental delays and disorders can be identified with appropriate screening tools. Moreover, early childhood mental health services are effective in preventing and treating social-emotional delays and disorders. Therefore, easy access to screening and routine re-screening is important.

- A broad range of community-based services and supports are provided by formal and informal agencies to promote early childhood social-emotional development. All families can benefit from information about these opportunities.

- Some children are at greater risk for developing social-emotional delays or disorders. Risk factors need to be identified and addressed as early as possible.

- Families with unmet needs face barriers (resource, system and social-cultural) to accessing services and supports. Therefore, screening activities need to be highly accessible and relevant to parents. Moreover, efforts to refer and link families to services and supports may need to be individualized, prioritized, staged or coordinated.

- Monitoring needs to be available to verify that services are received and working, and to offer support and assistance when needed.

- Children identified through a screening process as showing a possible developmental delay or disorder need to have access to an assessment. An assessment may confirm a delay or disorder and lead to appropriate services and supports; however, the family may have other needs that require services and supports. Additional referral and linking activities may be needed.

- Families with multiple, severe or complicated needs, who experience corresponding resource, system and social-cultural barriers may need assistance with coordination of care that is achieved through an interagency collaborative.

- It is important that families have access to effective interventions. Therefore, practitioners need to be knowledgeable about the level of effectiveness of available services and share this information with families to help them make decisions about their child’s care. Moreover, it is important for communities to consider adopting effective or proven practices when given an opportunity to expand or improve their service delivery systems.

In addition, lessons learned from the Infant-Preschool Family Mental Health Initiative (IPFMHI) are highlighted at the end of the guide. IPFMHI is an effort piloted in eight counties to serve very young children (birth to 5 years of age) with (or at-risk of) social, emotional or behavioral delays or disorders, and their families. Funding to support this initiative was received by the California Department of Mental Health from First 5 California starting in 2001.

This joint effort between the California Department of Mental Health and the eight participating counties (Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus) resulted in protocols in the areas of screening and assessment, consultative modes, and improved provider preparedness. Lessons learned about the need for, and value of, interagency collaboration and coordination of care, along with examples of efforts to increase screening, identification, assessment and treatment of children with (or at-risk of) social-emotional delays or disorders from the eight IPFMHI counties are summarized.
Five sets of interdependent activities are important in ensuring that children with social-emotional developmental delays or disorders are identified and access needed services and supports. These five sets of activities are described at length in the guide and include:

1. Outreach—A process for promoting the broad use of early childhood screening.
2. Screening—An appraisal of a child's development, and identification of signs that indicate a possible delay or disorder, or risk factors.
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4. Referrals and Linkage to Assessments, Services and Supports—A process to ensure that children and families have access to assessments, and needed and effective services and supports.
5. Assessment—An evaluation of a child's level of development and identification of a delay or disorder.

The guide will describe each set of activities, along with important program and staffing considerations. However, collaboration with other service systems, such as schools, county agencies, Regional Centers, and civic and faith organizations will be important to success across all screening and referral activities. Children and their families may experience multiple, serious, and complicated needs that require access to a variety of services and supports. It is critical that these services are individualized, strength-based, effective, and provided in a manner that respects families and promotes autonomy. Moreover, it is undoubtedly the case that multiple agencies and School Readiness sites are involved in initiatives to identify and assist children with (and at-risk of) developmental delays and disorders. Coordination of these efforts is important to achieving optimal benefit community-wide. Therefore, it is incumbent upon School Readiness sites to develop strong collaborative relationships with other child and family serving agencies as part of their effort to develop screening and referral capacity.

**Outreach**

The goal of outreach efforts is the broad use of early childhood social-emotional development screening. Numerous children, birth to 5 years of age, have (or are at-risk of) social-emotional delays and disorders. However, many delays and disorders go unidentified, and children do not receive needed services or supports. Untreated, these disorders result in distress and impairment that adversely affect a child's functioning at home, with peers, and in childcare or preschool. Moreover, disorders can persist and worsen over time requiring more extensive and expensive treatment in the future. Social-emotional screening is an initial step in the process of identifying children with (or at-risk of) developmental delays or disorders. However, screening needs to be used broadly throughout the community to be of most benefit.

**Barriers to Screening**

Screening of social-emotional development is underutilized. Significant resource, system, and social-cultural barriers exist that are important to recognize when developing and implementing a screening program.

*Resource Barriers* refer to having the time and money to make use of services. These barriers include lack of transportation, appointment times that conflict with work or parenting responsibilities, and costs associated with services.
In many situations families recognize an area of need and want a particular service or support but, due to resource limitations, cannot make use of the opportunities that are available.

System Barriers refer to characteristics of the child and family service system. These barriers include restrictive eligibility criteria for services, inflexibility in available services (“one size fits all” programs), fragmentation across agencies, and “blaming” parents who are seeking assistance. For example, each agency has its own eligibility criteria and services are rarely individualized, comprehensive or coordinated. Parents may be blamed for the challenging circumstances in their lives (unemployment, mental illness, substance abuse or domestic violence) for which they seek assistance. System barriers tend to be more significant for families with multiple needs.

Social-Cultural Barriers refer to factors that influence the recognition of a need or the degree to which the service or support is valued, wanted, and provided in a respectful manner. These barriers include services unavailable in the family’s primary language, unfamiliarity with or insensitivity to cultural beliefs and values by providers, and stigma about emotional disorders.

Outreach Strategies
A variety of outreach strategies are available to overcome the resource, system and social-cultural barriers as well as increase interest in screenings. Prior to initiating any new outreach efforts, School Readiness sites will want to identify and build upon existing outreach efforts in their community.

A number of public and private agencies may be involved in early childhood developmental screenings, and include components for overcoming resource barriers, reducing service system fragmentation, countering stigma, and promoting cultural competence. It may be possible to build upon or integrate early childhood social-emotional screening into these efforts. For example, a campaign to access health screenings or immunizations could be expanded to include social-emotional screening.

Agencies that may be involved in outreach efforts include schools, Regional Centers, public health departments, maternal and child health programs, county mental health departments, child welfare services, Head Start and Early Head Start, preschool programs, and private community-based organizations.

In addition to building upon existing outreach efforts, School Readiness sites could use the following promising strategies.

Integrated Settings
Integrating services involves imbedding or offering developmental screenings at the sites in which families with young children routinely receive other services. This strategy makes obtaining a screening convenient and credible. Some notable examples include integrating screenings at:

- Childcare centers or preschools
- Doctor's offices or health clinics
- Social services programs such as CalWORKs, child welfare services, or probation departments.

Families routinely receive services and supports as part of these childcare, health, and social service programs. Often the services are provided at schools or county and private agency offices in which families spend considerable time in waiting rooms.

Offering early childhood developmental screenings at these settings is one way to reach families. Screenings can be offered by staff members associated with the host program. For example, a teacher, nurse, or CalWORKs social worker could administer the screening tool. Alternatively, School Readiness staff can be available at some of these locations on a full- or part-time basis to conduct screenings.

Flexibility in Time and Place
Flexibility in time and place involves making screenings available during hours of the day, and in locations in the community that are convenient for families. Offering screenings at School Readiness sites during non-traditional hours (evenings and weekends) and/or providing mobile screenings in
which practitioners travel to a family's home or an easily accessible neighborhood center is another strategy to overcome resource barriers. Moreover, home visits or use of valued neighborhood centers may help overcome social-cultural barriers as well.

**Public Education**

A public education campaign can be helpful in overcoming social-cultural barriers such as stigma. Campaigns may be designed to inform parents about the importance and value of early childhood screening. Moreover, information will ideally be available in multiple languages with the content tailored for different ethnic and cultural groups.

As a result of these campaigns, parents learn about the usefulness of early childhood screenings, and the availability of services and supports. This type of information can help normalize the identification of social-emotional disorders and overcome stigma about mental illness. Parents learn that screenings are easy to access, brief, and helpful for their children.

**Making the Screening Process Useful for Parents**

Providing comprehensive and useful screening is an outreach activity in itself. Actions speak loudly, and “word-of-mouth” communication is an effective outreach strategy. Parents who receive screenings for their children, and are pleased with the results, will tell their friends and neighbors, who in turn will seek screenings for their children, and then tell others.

Screenings that meet program requirements or other administrative needs, but are not helpful to parents will have limited value. With the goal of making the process useful for children and their parents, the ideal screening process will have the following characteristics:

- Brief to complete (less than 20 minutes).
- Easily administered, scored and interpreted so that parents can receive immediate results.
- Designed to be used by a broad range of practitioners so that it can be proficiently administered by practitioners with diverse educational backgrounds working in diverse settings.
- Comprehensive, appraising development across multiple domains (i.e. physical health, sensory, motor, cognitive, language, social-emotional).
- Multifaceted, appraising developmental level as well as risk factors that can contribute to social-emotional delays and disorders.
- Accurate, dependably and correctly identifying children who have (or are at elevated risk for) social-emotional delays or disorders.
- Appropriate for use with ethnically and culturally diverse children and families, and families who speak languages other than English.

Offering parents clear and concrete feedback about their child's development is critical to making their participation in screening valuable. The results must be explained clearly, and in the context of the limitations of the screening process. Screening tools are used to identify children who may have a disorder, but do not confirm the existence of a disorder or diagnosis. A clinical assessment is needed to make a diagnosis or confirm a disorder.

Typically the process of screening children yields one of two results: (1) positive for a possible disorder, meaning that there are signs of a social-emotional disorder and an assessment is indicated; or (2) negative for a possible disorder, meaning that there are not sufficient signs of a social-emotional disorder for an assessment to be indicated. However, because screening tools are not perfect predictors, errors in the identification are always present.

Two types of errors are associated with the screening process: (1) false-positive errors, meaning that the results of the screening suggest the possibility of a disorder, but an assessment fails to confirm a disorder; and (2) false-negative errors, meaning the results of the screening suggest that there is not a disorder, but a subsequent assessment confirms the presence of a disorder.
In the case of a false-positive error, a parent is led to believe that a disorder is possible, which later is not confirmed. The consequences of this error are worry on the part of parents and, if no assessment is forthcoming, the parent, child and others may operate under the false belief that the child has a disorder.

In the case of a false-negative error, a child’s disorder is not recognized early, and as a result may worsen over time adversely effecting the child’s development and requiring more intensive, intrusive and expensive intervention at a later date.

Regardless of the results of a screening, it is important for parents to benefit from their participation. When children show signs of typical development, parents can benefit from information about relevant milestones that have been accomplished, opportunities to ask questions, and encouragement to re-screen in the future.

When children show signs of a possible disorder or risk factors, the screeners need to be prepared to (1) describe the significance of the results to parents without creating undue anxiety, (2) explain the need for an assessment, (3) provide referrals to have an assessment completed, (4) explain the significance of risk factors, (5) provide referrals for appropriate services and supports to address areas of risk, (6) answer questions, and (7) offer support.

Addressing Competing Needs

It is important to have an appreciation of other competing needs experienced by families, for example, low-income families may have concerns about housing, health care, food and clothing, or employment. In addition, caregivers may have personal and interpersonal needs involving their own health, mental health, use of substances, and relationships with others.

The priority parents give to participating in an early childhood screening is influenced by competing needs. It is possible for parents to be overwhelmed by too many opportunities for assistance at one time. Parents may need help to prioritize competing needs, and develop a step-wise plan for obtaining assistance, in order to be prepared to participate in and benefit from an early childhood development screening for their child.

Well-Trained and Supported Practitioners

Regardless of the characteristics of the screening process or the time and place in which it is provided, well-trained and supported staff is critical to the success of the process. Moreover, practitioners responsible for completing screenings need be able to converse fluently in the parent’s primary language, and ideally share ethnic and cultural backgrounds or have developed cultural competence skills.

Important training domains include:

- Early childhood social-emotional development—An understanding of typical development as well as risk factors, and signs of social-emotional delays and disorders.
- Screening process—A thorough understanding of the purpose and limitations of the screening process.
- Scoring and interpretation—Detailed understanding of and all necessary skills for administering, scoring and interpreting the screening tools.
- Community services and supports—Knowledge about community providers, services and supports, and corresponding eligibility criteria and costs (if any).

Important agency support considerations include:

- Reasonable caseload expectations and sufficient time for practitioners to be thorough and respectful, which may include time for travel, documentation, sharing results with parents, and answering questions.
- Interagency agreements that support referral and linkage to important services and supports.
- Current information about the availability of services and supports, including eligibility information and costs.
Support and assistance from supervisors to help resolve unexpected, traumatic, or challenging situations that confront children and families.

Important interpersonal skills include:
- Ability to communicate in a clear and respectful manner.
- Strong planning and organizational abilities.
- Collaborates well with others.

**Screening and Results**

Numerous screening tools for measuring social-emotional development are available. Tools vary in format, administration characteristics, and psychometrics. Formats include caregiver or teacher report, observation of the child in a structured or unstructured situation, and evaluation of the child based on his or her completion of specific tasks. Administration characteristics include the length of the screening tool, and the level of training required of practitioners to administer, score and interpret. Psychometrics includes the reliability and validity of a tool. These considerations, along with a brief summary of screening tools, are presented in a separate guide, *Compendium of Screening Tools for Early Childhood Social-Emotional Development*.

This section is intended to provide important context for screening of social-emotional delays and disorders, and will focus on social-emotional development, risk factors, signs of delays and disorders, and screening results.

**Social-Emotional Development and Risk Factors**

Ideally screening processes will be comprehensive and multifaceted, appraising the child's current social-emotional development, in the context of other developmental domains (e.g. physical health, sensory, motor, cognitive, and language), as well as risk factors that can contribute to the development of social-emotional delays and disorders.

Optimal social-emotional development is associated with (1) children being physically healthy; (2) children showing typical sensory, motor, cognitive, and language development; (3) children having an “easy” temperament; (4) parents or primary caregivers showing parenting competence and having strong social support; (5) parents or primary caregivers providing emotional support, guidance, and love; and (6) children raised in safe, stable and calm homes and communities.

Alternatively, social-emotional developmental delays and disorders may result from biological or environmental factors, or an interaction of both sets of factors. Biological factors affect brain development and functioning, and may have numerous origins including exposure to substances in utero (e.g., fetal alcohol syndrome), genetic anomalies (e.g., fragile-X syndrome), or trauma during the birth process (e.g., asphyxia).

Environmental factors are also diverse. Many of the environmental risk factors distract parents from attending to the needs of their children, and as a result can adversely affect their children's development. A number of important environmental factors that put young children at increased risk of a social-emotional delay or disorder include:
- Parental mental illness or substance abuse
- Domestic violence
- Unstable or unsafe home
- Under- or unemployment (living at or near the poverty level)
Inadequate or absent supervision provided for the child
- Untreated physical illness or malnourishment
- Inadequate or poor parenting skills

These factors are discussed in an excerpt from Cathie Wright Technical Assistance Center (CWTAC) Updates: Series on Infant and Early Childhood/Family Mental Health Issue #1, (July/August 2002) by Marie Kanne Poulsen, Ph.D., in Appendix A.

**Screening Results**

A screening process needs to appraise the child’s current level of social-emotional development, along with factors, including those listed above, that put social-emotional development at risk.

Regardless of the screening method, three potential results occur:

- **No signs of developmental delays or risk factors.**
  In this situation, the child’s social-emotional behavior appears to be similar to that of other children of the same age, and there are no signs of any risk factors. These results indicate that the child’s behavior was not rated as being beyond the level that was set to identify children for further assessment.

- **No signs of developmental delays; however, risk factors are evident.**
  In this situation, the child’s social-emotional behavior appears to be similar to that of other children of the same age (the child’s behavior was not rated as being beyond the level that was set to identify children for further assessment); however, one or more risk factors are evident.

- **Signs of possible developmental delays.**
  Risk factors may or may not also be evident. In this situation, the child’s behavior appears to be similar to that of children with social-emotional delays or disorders (the child’s behavior was rated as being beyond the level that was set to identify children for further assessment). However, a screening process does not confirm a delay or disorder, but rather indicates that further dialogue with parents or primary caregivers and assessment of the child’s social-emotional development is appropriate.

**Limitations of the Screening Process**

Again, it is important to note that screening is not sufficient for confirming a developmental delay or disorder, but is designed to identify children who show signs suggestive of a delay or disorder and for whom a comprehensive assessment would be appropriate. As noted earlier, two types of prediction errors occur:

- Failure to identify a child who actually has a delay or disorder (false-negative).
- Identifying a child as having a possible delay or disorder in which none exists (false-positive).

The occurrence of these two types of errors is related. As one type of error increases, the other decreases. This relationship is influenced by how the score for identifying children (cut-off score) is set. As the score is set higher, behavior must be more extreme or atypical for the threshold to be reached, and fewer children will be identified. Increasing the cutoff score results in fewer false-positives and more false-negatives. A child who shows such extreme or atypical behavior is more likely to have a delay or disorder confirmed; however, children who actually have a less serious delay or disorder may be missed because the threshold is set so high.

Alternatively, as the score is set lower, relatively less extreme or atypical behavior is needed to reach the threshold, and more children will be identified. Reducing the cutoff score results in fewer false-negatives and more false-positives. It is less likely that a child with a delay or disorder will be missed, but more children without a delay or disorder will have results suggesting a delay or disorder because the threshold is set low.

When screening for social-emotional delays and disorders, the threshold is typically set so that children who actually have a delay or disorder are not missed. This is important in order to be able to offer early intervention services and supports.
and prevent increased distress, impairment and costs associated with untreated social-emotional disorders. However, this also means that when a screening process indicates signs of a delay or disorder, for some children no delay or disorder is actually present.

Therefore, it is important to ensure that screening practitioners fully understand the limitations of the screening process and are very clear with parents and primary caregivers about the significance of the results. In brief, a screening test is not infallible. If the results do not indicate a possible disorder, but parents or caregivers are concerned and want to seek an assessment, this preference needs to be supported. Alternatively, if the results do indicate a possible disorder, it is important for parents to understand that these results do not confirm a disorder, but rather mean that further assessment is indicated.

**Screening Recommendations**

In every situation, the parents or primary caregivers need to be involved in discussions concerning screening results. Moreover, any questions that parents have need to be addressed. Finally, each of the three categories of screening results, listed above, lead to recommendations for parents or caregivers as follows:

- Routine monitoring and re-screening is indicated when the results show no signs of developmental delays or risk factors.
- Referrals to services and supports to address risk factors, and heightened monitoring and re-screening is indicated when the results show risk factors but no signs of developmental delay.
- Referral for an assessment, concurrent referrals for services and supports to address any risk factors, and heightened monitoring and re-screening is indicated when the results show signs of possible developmental delay.

**Monitoring and Periodic Re-Screening**

Ongoing monitoring of social-emotional development and periodic re-screening is important to supporting and promoting optimal early childhood development. Development is dynamic throughout the lifespan. Individuals are affected by changing biology and their life experiences. Moreover, early childhood is a period of very rapid development. As a consequence, periodic re-screening will help ensure early identification.

The goal of monitoring and screening is to identify a delay or disorder (or risk factors that contribute to a delay or disorder) at the earliest possible point, and guide treatment services and supports. Outcomes for children are improved and development enhanced when interventions are provided early. Untreated, social-emotional delays and disorders can worsen, resulting in substantial distress and impairment adversely affecting success at home, in school, and with peers. Moreover, early interventions are cost effective.

Therefore, some schedule of re-screening is appropriate for all children, regardless of the results of the initial screening. The frequency of re-screening will vary according to the needs of the child and his or her family. Two levels, routine and heightened, are described below. Programs may adjust these schedules to better fit the needs of the children and families they serve.

- **Routine**—Annual re-screenings, at a minimum, is appropriate for children who show no signs of delay, and no risk factors are evident.
- **Heightened**—Twice yearly re-screenings and monthly or quarterly monitoring contacts, at
a minimum, are appropriate for children who show signs of a delay or in which risk factors are evident.

When the initial results of a screening show no signs of delay or risk factors, a parent's or caregiver's interest in re-screening may be low, particularly if they face barriers to participating in re-screening. Therefore, it is important to develop screening processes that engage and educate parents, reinforce the value of re-screening, and overcome potential barriers to re-screening.

A heightened re-screening schedule is important when the initial results indicate a possible delay or disorder, and/or when risk factors are evident. Ideally, these children receive an assessment to determine if a delay or disorder is present. Once possible delays and/or risk factors are identified, subsequent assessments, and services and supports need to be available to prevent any further impairment, restore social-emotional functioning, and promote optimal early childhood development.

After receiving screening results, parents may experience barriers to accessing assessments and services. Monitoring and support are important in helping parents overcome barriers. Monitoring and support involves checking in with parents or primary caregivers concerning their success in accessing an assessment and any needed services or supports. Important monitoring questions include the following:

- If an assessment is not completed in a timely way, what are the barriers? And how can these barriers be overcome?
- If an assessment was completed, was a delay or disorder confirmed? Are services and supports being provided to treat the delay or disorder, or address risk factors? If yes, are they effective? If no, what are the barriers, and how can they be overcome?

The full benefit of early identification that results from screening activities are not realized unless they lead to assessments and corresponding services and supports. Monitoring and heightened re-screenings are critical follow-up activities for supporting parents and caregivers in taking next steps to meet their children's needs.

**Referral and Linkage to Services and Supports**

Achieving broad access to and use of early childhood screenings is a means to an end, but only the first step in a larger effort to promote early childhood development. As noted in the previous section, the benefit of screening is the opportunity to intervene early, when further delays or disorders with corresponding distress and impairment can be prevented, and early childhood development can be enhanced. However, achieving the benefits of screening and early identification require that the screening leads to appropriate assessments and receipt of needed services and supports. Assessments are important for confirming a delay or disorder, clarifying the significance of risk factors, developing intervention or care plans, and determining eligibility for some service systems. The next section discusses the assessment process in more detail.

Services and supports are important for (1) preventing further delays or a worsening of any disorder, (2) reducing any risk factors and/or strengthening resiliency factors; (3) treating any delay or disorder; and (4) promoting optimal early childhood development and later success in home, at school and throughout life. Referral and linkage are distinct and important activities to help parents or primary caregivers gain access to and make full use of assessments, services and supports.

- **Referrals**—involves making recommendations and sharing information about accessing services or supports.
- **Linkage**—involves providing assistance to insure access to services or supports. Linkage includes activities that assist families overcome barriers to obtaining services and supports.
Referrals

Referrals typically take the form of advising a family of available services and supports and providing information about where to apply to receive services. Referrals are often informal, with verbal instructions and impromptu directions, or can be formal with a prepared form or detailed instructions. However, it is the parents’ or caregivers’ responsibility to pursue the referral by contacting and applying for services from the relevant agencies.

Many parents and caregivers make good use of referrals, and apply for and receive needed and effective services. However, for a variety of reasons, parents or caregivers may not pursue a referral, or may not gain access to services even when the referral is pursued. Again, resource, system and social-cultural barriers may prevent access to services.

In addition, many services provided by public and private agencies are available only to individuals who meet eligibility criteria. Often parents or caregivers need to first apply for the services for which they have been referred.

Depending on program-specific criteria, typically involving the nature and severity of the child’s need and the income of the parents or caregivers, the child and family may be eligible for services. If the child and family are not eligible for services, they may be offered additional referrals or be directed back to the program that originally referred them. In either situation, the process of seeking services and completing an application is time consuming and often redundant. This can strain a family’s limited resources, lead to frustration, and affect overall engagement with services and supports. Frustration and dissatisfaction on the part of parents and caregivers is obviously increased when they learn that they are not eligible for services and are referred elsewhere.

Few agencies to which parents or caregivers are referred are prepared to provide individualized and comprehensive services. As a consequence, children and families that have multiple needs or risk factors may receive multiple referrals, face multiple application processes, and may be offered varying types and levels of services. The services offered are often not coordinated. Moreover, families that have multiple needs and are receiving services from multiple agencies may be overwhelmed by the competing priorities and demands from each of their service providers.

Linkage

Linking families to services and supports involves a number of activities designed to overcome barriers to access. Linking strategies are diverse and include specific referrals, follow-up support and assistance, brokering agreements, prioritizing or staging, and coordinating care.

Specific Referrals

A specific referral, based on an accurate and current understanding of eligibility criteria, increases the likelihood that a family will apply for services for which they are eligible. The practitioner making the referral shares with parents or caregivers the eligibility criteria prior to making a referral so that the family is aware of their likelihood of being eligible.

To be successful, referring practitioners need to be well trained in the eligibility criteria used by other agencies. Eligibility criteria can be highly detailed and complicated, and often changes over time. Strong interagency collaboration is generally needed for referring agencies to be trained and to keep pace with changing criteria. It is critical that eligibility advice be current and accurate so that
families are not misled. For example, it would be a significant disservice if a family failed to follow-up on a referral because they were led to believe that they would not be eligible, when in fact they were.

**Follow-up Support and Assistance**

Completing applications or eligibility forms can be complicated, and at times require back-up documentation. Moreover, the application process may intimidate some families. Social-cultural and system barriers may also affect a family’s comfort level. To address these and related issues, referring practitioners may provide a continuum of support and assistance to help families obtain services and supports. For example, completing a follow-up call with a family to inquire about their application and compliment them for their efforts, assisting parents in completing applications or eligibility forms and gathering any needed documentation, or accompanying and assisting parents to complete each task from scheduling to attending appointments.

At the highest levels of support and assistance, the referring practitioner may be significantly involved in completing “case management” tasks. These activities require detailed knowledge of cross-system eligibility processes, and may be very time consuming. The benefits of these efforts can be substantial; however, it is also important that parents begin to learn the skills necessary to seek services independently and avoid becoming unnecessarily reliant on the referring practitioner. Therefore, it is important to assist parents and caregivers in developing their own skills in the context of providing support and assistance.

**Brokering Agreements**

It is often possible for collaborative or contractual agreements to be established between agencies that assure access to services for the families they refer. Collaborative and contractual agreements are designed to ensure that eligibility criteria are not a barrier to accessing services. Moreover, these arrangements tend to be mutually beneficial by assisting the referring agency and service provider to better meet the needs of children and families.

**Collaborative** agreements typically involve a service provider dedicating or “carving-out” services for families who will be identified by the referring agency. These agreements are often the result of interagency collaborative efforts and are documented in a memorandum of understanding (MOU). The collaborating agencies usually share similar priorities and overlapping areas of responsibility. Through the collaborative efforts in general, and brokering agreements in particular, both the referring and provider agencies are better able to meet the needs of children and families for which they are mutually responsible. Referring agencies identify and link families to service providers that have funding and expertise to address specific needs. The referring agency incurs no cost for the services provided to children and families through a collaborative agreement.

For example, an agreement could be established between a School Readiness site and a local housing authority for housing vouchers to be set-aside or prioritized for families with children under the age of 5 who are homeless. In this way, families who are referred by the School Readiness site receive priority for housing from the housing authority. This is a mutually beneficial agreement. The School Readiness site is assured that families that are referred will gain access to services (housing vouchers), and the housing authority benefits from the identification of high-need families with young children.

**Contractual** agreements typically involve a referring agency purchasing or contracting for services from a provider agency. These contracts are needed when a provider agency has established services without the funding resources to provide access to all families referred. As a result of a contract, a family will be guaranteed access to services whether or not they would otherwise be eligible. These contracts may be conditional, so that the provider agency will offer services at no cost to the referring agency when the family meets their eligibility criteria, but will draw on the contract when eligibility criteria is not met.

For example, a School Readiness site could establish a contract with a county mental health
department to provide treatment. This contract could specify that, when children are referred by the site, the county will provide services, at no cost to the School Readiness site for children who have Medi-Cal and who qualify for treatment (meet Medi-Cal specialty mental health medical necessity criteria), but will charge the School Readiness site for services provided to children who either do not have Medi-Cal benefits or who do not meet Medi-Cal specialty mental health medical necessity criteria. This contact is mutually beneficial. The School Readiness site is assured that all families referred will be offered services. Moreover, the School Readiness site only pays for services for which the family would not otherwise be eligible. The county mental health department benefits from the screening and early identification efforts completed by the School Readiness site, resulting in children accessing care earlier and preventing the need for more intensive, intrusive and expensive care that may be required when disorders are not treated early.

Prioritizing or Staging

Families with multiple, severe or complicated needs who experience corresponding resource, system and social-cultural barriers can be overwhelmed by the tasks required to obtain services. They may be offered too many services at one time, and struggle to keep appointments (which may compete for their limited available time), make plans, and complete tasks associated with each program. Moreover, the potential benefit of a service may be enhanced or diminished, depending on its relationship to other services. Too many services with too many demands that require too much of a person’s limited resources may be detrimental.

For example, a parent may be seeking employment, recovering from substance abuse, addressing child welfare issues, and dealing with an abusive relationship with a former spouse. This individual may be offered employment services through the county CalWORKs program, substance abuse treatment through a county alcohol and drug program, parenting classes as a requirement of child welfare, and a referral to the police to file a restraining order, in addition, to early childhood mental health services. Tasks associated with these services may include joining an employment “club,” attending Alcoholics Anonymous groups, participating in parenting classes, and completing police reports. Failure to complete these tasks may result in blame from providers, and in some situations, sanctions (e.g., loss of welfare benefits, loss of child custody).

In these circumstances, families may greatly benefit from assistance in developing plans that prioritize needs and services and that are staged or sequenced with some services being received first and others later. In this way, parents or caregivers are able to fully participate in services (without exhausting their limited resources), develop new skills, and resolve the most urgent or critical needs first. Then they can build on their new skills and recent successes as they participate in other services. Staging services allows parents to build success and meet needs in a stepwise manner so that achieving new goals builds on the success associated with accomplishment of prior goals.

When assisting families to prioritize and stage services it is critical that practitioners collaborate closely with other providers so that any plans or advice take into account legal requirements (e.g., child welfare or probation involvement) or possible sanctions (e.g., CalWORKs conditions).

Coordinating Care

When multiple needs are severe and complicated, resources very limited, service barriers very large, or legal consequences or service sanctions dire, the need to coordinate care across agencies will be essential to optimize access to and benefit from services. Under these circumstances, prioritizing and staging will require agreement from multiple service providers or agencies (e.g., child welfare, probation, courts, CalWORKs, mental health). Interagency coordination of care typically requires a collaborative agreement (memorandum of understanding) that describes concrete policies and procedures for coordinating care across agencies and making interagency decisions.
Coordination of care and corresponding agreements are common to the Children’s Systems of Care and Wraparound programs. It is noteworthy that both of these initiatives promote family partnership and family-driven care with the goals of building on family strengths, preventing blaming, and achieving sustainable child and family success.

Further information on Children’s Systems of Care is available from:

- California Department of Mental Health http://www.dmh.cahwnet.gov/CFPP/csoc_initiative.asp
- Federal Substance Abuse Mental Health Services Administration (SAMHSA) http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0013/default.asp

Further information on Wraparound programs is available from the National Wraparound Initiative at http://www.rtc.pdx.edu/nwi/.

**Services and Supports**

Families with young children may need or benefit from services and supports from a large variety of formal and informal, public and private entities. Practitioners affiliated with School Readiness sites and involved in early childhood screening will want to be knowledgeable about the resources in their community and of greatest need to the children and families they serve.

A variety of services for children identified with (or at-risk of) a developmental delay or disability are available through schools and/or Regional Centers, as part of and in addition to those required under the Individuals with Disabilities Education Act (IDEA) Parts B and C. Moreover, health screenings for children are available through the State’s Child Health and Disability Prevention (CHDP) program, and medical evaluations and treatment are available for low-income families to address some physical limitations and chronic health conditions from California Children Services (CCS).

In addition to the foundation of services available to children with (or at-risk of) a developmental delay or disability provided through these educational and health programs, a subset of services and supports are particularly relevant because they target the risk factors associated with early childhood emotional disorders (see “Social-Emotional Development Risk Factors and Services” table on page 19).

Considerable variation exists across counties in how these services are administered, the agencies involved, and the structure of specific programs. School Readiness sites and practitioners involved in screening will need to rely on local resource directories, and ideally develop collaborative relationships with these agencies to support strong referral and linkage activities for children and families.

Parenting skills and social support are uniquely important factors because of their importance in nurturing children and buffering or protecting children from external threats and stressors. The impact of stressful events on young children are influenced by the severity of the stressors, the developmental level of the child, and the capacity of their parents or caregivers to establish a protective environment. Parental or caregiver capacity to manage stress and meet their children’s needs for safety, security and comfort is in turn related to their parenting skills and social support networks.

Although a number of agencies, public and private, offer parenting classes, these may not be readily available or specific to the skills needed by parents with very young children. As a consequence, School Readiness sites may need to expand their capacity to provide parenting skills interventions. Moreover, a social support network of extended family, close friends, and other community or faith-based affiliations is important for supporting parents and caregivers to both celebrate accomplishments, and manage trauma, major stressors, and daily hassles. Therefore, School Readiness sites may need to develop the capacity to link families to local support and community- or faith-based groups, and assist families to develop social support networks.
### Social-Emotional Development Risk Factors and Services

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>SERVICE CATEGORY</th>
<th>PROVIDER AGENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental mental illness</td>
<td>Mental health treatment</td>
<td>County mental health and private providers</td>
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<tr>
<td>Parental substance abuse</td>
<td>Substance abuse treatment</td>
<td>County alcohol and drug program and private providers</td>
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<tr>
<td>Domestic violence</td>
<td>Shelter</td>
<td>Domestic violence shelters</td>
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<td></td>
<td>Legal protection</td>
<td>Law enforcement and probation</td>
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<td></td>
<td>Domestic violence intervention</td>
<td>Domestic violence treatment programs</td>
</tr>
<tr>
<td>Homeless</td>
<td>Shelter or subsidized housing</td>
<td>Housing authority</td>
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</tbody>
</table>
| Unsafe home                     | Family maintenance or reunification activities | Child welfare services
|                                 | Crime prevention activities                | Probation                                                                      |
| Under- or unemployed            | Employment training and support            | CalWORKS, Employment Development Department                                      |
| Inadequate or absent child supervision | Child care                  | Child Care Council                                                             |
|                                 | Parent skills training                     | CalWORKS and private providers                                                   |
| Untreated physical illness      | Health insurance                          | Department of Social Services                                                   |
|                                 | Medical home                               | Public health                                                                  |
| Malnourishment                  | Food stamps                                | Department of Social Services                                                   |
|                                 | Nutrition education                        | Women, Infants and Children (WIC)                                              |
| Inadequate or poor parenting    | Parent skills training                     | Schools                                                                        |
|                                 |                                            | County mental health and private providers                                     |
|                                 |                                            | Child welfare services and private providers                                   |
| Social isolation                | Support groups                             | Variety of community organizations                                              |
|                                 | Community or faith organizations           | Variety of community organizations                                              |

### Effective Treatment

Whereas screening leads to the identification of children who may have or are at-risk of a social-emotional delay or disorder, and referral and linking is important in helping families access services and supports, the achievement of optimal child and family outcomes also requires that the services and supports, when accessed by families, are effective. Although all services are intended to be helpful, an increasing body of research on the effectiveness of mental health treatments indicates that some treatment approaches are more effective than others. As a result of this research, a growing emphasis is being placed on identifying and linking families to proven practices that exist within the current service system, and in adopting proven practices when an opportunity exists to develop new programs or expand the capacity of the current service systems.

Evidence-based practice is a general term referring to practices with some level of research supporting their effectiveness. Effectiveness research is designed to investigate the degree to which a particular treatment results in, or is responsible for, the achievement of one or more specific outcomes (child and family goals). The relationship between mental health or social service interventions and the achievement of child and family goals is complicated. Research studies try to sort out the degree to which a particular...
outcome is the result of the intervention itself as opposed to other factors in the life of a child and his or her family.

A variety of research designs and methods are helpful in determining the impact of a particular treatment. Stronger or better controlled research studies support stronger conclusions about the benefit of the treatment. Treatment effectiveness research is developmental, with increasingly rigorous research progressing over time in the course of investigating a specific practice. Confidence in the effectiveness of a practice, the degree to which the practice is likely to achieve outcomes comparable to those in published studies when implemented in local communities, is increased when the research has been rigorous, conducted in real-world settings, and replicated by independent investigators (researchers other than the developer of the practice).

It is increasingly important for practitioners who make referrals and link families to services to be knowledgeable about the service’s level of effectiveness. Information about a practice’s level of effectiveness can be challenging to locate; however, a growing number of resources have been developed by federal and state agencies, and universities that help organize and make this information available. Although the terms used to describe levels of treatment effectiveness vary, the following general categories are helpful:

- **Effective and Efficacious**—refers to a practice that consistently achieves positive outcomes, based on a course of rigorous controlled research (random clinical trials) that has been independently replicated. When the research is conducted in real-world settings, it is referred to as effective, and when the research is conducted only in controlled settings, it is referred to as efficacious. Confidence in being able to implement a practice in a new community is higher when the course of research includes studies conducted in real-world settings.

- **Not Effective**—refers to a practice that consistently fails to achieve positive outcomes based on a course of rigorous controlled research.

- **Promising**—refers to a practice that has shown positive outcomes based on one or more “quasi-experimental” research studies. Quasi-experimental studies consist of a broad range of methods that are less rigorous than random clinical trials. This level of research is commonly a precursor to random clinical trials.

- **Emerging**—refers to a distinct practice, based on a clearly articulated theory that is grounded in the literature, or supported by expert-opinion and that is the focus of planned effectiveness research.

- **Not Researched**—refers to the large number of practices routinely used in real-world settings that have not been the focus of research. These practices may or may not be based on a clearly articulated theory, but in either case they have not been the focus of any outcome evaluation. The effectiveness of these “usual care” practices is not clear.
It is advisable to consider the effectiveness of a practice when making referrals or care plans with families, giving priority to practices that have demonstrated effectiveness. However, practices with lower levels of research supporting their effectiveness, including promising and emerging practices, may be strong options when no suitable alternative practice with a higher level of proven effectiveness is available, or when a deliberate decision is made to implement and evaluate a new or innovative, promising or emerging practice.

Early childhood mental health interventions are highly diverse, varying in terms of the treatment model, participants, and location. Numerous treatment models are available, for example, behavioral, supportive, and educational. Moreover, interventions may promote early childhood mental health by focusing on the child, caregivers or a combination of the two, and be provided in groups or to individuals and delivered in clinic, preschool, childcare, or family home settings, for example:

- Multi-component programs like *Incredible Years* include skill development curriculums for parents, teachers and children.


- The *Early Screening Project* or mental health consultation approaches focus on teachers or other caregivers.

- The *Nurse-Family Partnership Program* is a home visitation approach that supports and assists parents and children.

Given the large diversity of practices, additional effectiveness research is needed. However, numerous well-researched effective treatments, many of which have standardized materials and manuals for use across diverse communities, are appropriate for young children (birth to 5 years old) and their families. Included amongst the effective treatments are parenting, child skills development, parent-child interaction, preschool or childcare center-based, and home visitation programs.

The following resources provide well-organized and easy-to-use information about a large number of evidence-based practices:

- **SAMHSA Model Programs**—sponsored by the federal Substance Abuse Mental Health Services Administration at [www.modelprograms.samhsa.gov](http://www.modelprograms.samhsa.gov)


### Assessment

It is important that children who are identified by the screening process as showing signs of a possible delay receive an assessment. Assessments have multiple uses including:

- Verifying (diagnosing) a social, emotional or behavioral delay or disorder.
- Supporting treatment or care planning.
- Establishing program eligibility.
- Monitoring change over time.
- Evaluating program effectiveness.

Assessments are dynamic processes that typically involve review and synthesis of large amounts of information that may be gathered by multiple interdisciplinary practitioners using a variety of modalities. The breadth and complexity of the assessment will vary with the needs of the child and his or her family.

Assessments for social-emotional development would typically cover a broad range of information including areas of concern (presenting problems), developmental history, family and community characteristics, caregiving relationships, and physical health. Practitioners may include psychologists, social workers, nurses, physicians, developmental specialists, and others. Finally information may be gathered through interviews with parents and other caregivers, observations of the child in preschool/childcare and home settings, administration of questionnaires and/or structured tasks, and review of existing medical or preschool records.
Insuring access to assessments requires attention to all of the referral and linkage considerations described earlier in reference to helping families receive services and supports. School Readiness sites will ideally develop clear, dependable, and easy-to-use procedures for referring or linking children and their families to assessments. This will likely require strong collaboration with other agencies that have mutual interests and expertise in promoting early childhood development, for example county mental health programs, physical health care providers, Regional Centers, and schools.

**PUTTING IT ALL TOGETHER**

Numerous and interrelated administrative, programmatic and funding structures are needed to create an accessible and comprehensive service delivery system that can provide the screening, assessments, and services to promote optimal social-emotional development, and prevent and treat social-emotional disorders. Many of these structures and activities have been discussed in this guide. The following list summarizes the major considerations:

- Early childhood development is dynamic. Very young children with social-emotional developmental delays and disorders can be identified with appropriate screening tools. Moreover, early childhood mental health services are effective in preventing and treating social-emotional delays and disorders. Therefore, easy access to screening and routine re-screening is important.

- A broad range of community-based services and supports are provided by formal and informal agencies to promote early childhood social-emotional development. All families can benefit from information about these opportunities.

- Some children are at greater risk for developing social-emotional delays or disorders. Risk factors need to be identified and acted upon as early as possible.

- Families with unmet needs face barriers (resource, system and social-cultural) to accessing services and supports. Therefore, screening activities need to be highly accessible and relevant to parents. Moreover, efforts to refer and link families to services and supports may need to be individualized, prioritized, staged or coordinated.

- Follow-up monitoring needs to be available to verify that services are being received and are working, and to offer support and assistance when needed.

- Children identified through a screening process as showing a possible developmental delay or disorder need to have access to an assessment. An assessment may confirm a delay or disorder and lead to appropriate services and supports; however, the family may have other needs that require services and supports. Additional referral and linking activities may be needed.

- Families with multiple, severe or complicated needs who experience corresponding resource, system and social-cultural barriers may need assistance with coordination of care that is achieved through an interagency collaborative.

- It is important that families have access to effective interventions. Therefore, practitioners need to be knowledgeable about the level of effectiveness of available services and share this information with families to help them make decisions about their child’s care. Moreover, it is important for communities to consider adopting effective or proven practices when given an opportunity to expand or improve their service delivery systems.
Lessons From the Field

The Infant-Preschool Family Mental Health Initiative (IPFMHI) is an effort piloted in eight counties to serve very young children (birth to 5 years of age) with (or at-risk of) social, emotional or behavioral delays or disorders, and their families. Funding to support this initiative was received by the California Department of Mental Health from First 5 California beginning in 2001.

This joint effort between the Department of Mental Health and the eight participating counties (Alameda, Fresno, Humboldt, Los Angeles, Riverside, Sacramento, San Francisco, and Stanislaus) resulted in protocols in the areas of screening and assessment, consultative modes, and improved provider preparedness. Lessons learned about the need for, and value of interagency collaboration and coordination of care, along with examples of efforts to increase screening, identification, assessment and treatment of children with (or at-risk of) social-emotional delays or disorders from the eight IPFMHI counties are shared below.

**Interagency Collaboration**

Interagency collaboration is a natural and ongoing part of the development and success of mental health programs serving very young children and their families. A principal goal of IPFMHI was to extend collaboration between county mental health programs and other programs serving children birth to 5 years of age and their families. Counties have provided an informative list of key collaborating agencies, as follows:

- **Mental Health Providers** including county mental health and private contract agencies, private individual providers, and private community-based organizations for promotion, training and service delivery.
- **Interagency Service Providers**, including Early Start, Regional Centers, early childhood special education, childcare providers, preschools, social services, child welfare, public health and other agencies that serve very young children and their families for promotion, program development, training and service coordination.

- **Infant and Early Childhood Interagency Committees and Groups** which may include the service providers listed above as well as policy groups, institutions of higher education and funding agencies for the promotion and development of infant family and early mental health services, coordination, policies and training for the provision of services to very young children.

- **Institutions of Higher Education** to promote the infusion of concepts and values, and development of coursework and certificate programs in infant, family, and early childhood mental health.

- **Specially Funded Projects** included those funded by local First 5, The California Endowment, and other grants or special projects.

**Screening and Referral Models**

IPFMHI encouraged and supported development of individualized infant and early childhood mental health service delivery systems, based on the unique strengths and resources of each county. The models developed by the counties are informative. Noteworthy examples of collaborative program developed by counties to ensure effective screening and referral are presented below.

**Alameda County** makes a concerted effort through partnerships with Every Child Counts (First 5 Alameda County), Children’s Hospital Oakland, and Alameda Behavioral Health Care Services to train providers in promotion and preventive intervention services for young
children. Interagency providers attend annual interagency trainings and topical trainings provided by Every Child Counts. They learn about the importance of young children’s social-emotional development and the basics of relationship-based approaches to services. When an agency is identified and is interested in preventive intervention or is working with families at high risk for mental health problems, a team from mental health, Every Child Counts and possibly Children’s Hospital Oakland meet with the agency to develop a relationship. They begin planning and consultation to help the agency gain the awareness, knowledge, and skills necessary to be effective in promotion of preventive interventions and the identification of children and families in need of a referral to mental health treatment services.

Every Child Counts offers expert consultants to provide guidance and training. Alameda Behavioral Health Care Services coordinates with these efforts. Children’s Hospital Oakland may invite the agency to get intensive training by sending a representative to the Infant Mental Health Seminar. Most recently, representatives from Alameda County began meeting with staff from the perinatal substance abuse program. Programs that have already received training are the public health home visiting program, teen parenting programs, programs within Alameda County Social Services and childcare agencies involved in the extensive mental health consultation to childcare programs in the county.

Fresno County receives most of its referrals from the court system. The volume of referrals generated as a result of mandatory assessment of all children removed from their homes led to a collaborative with Fresno County’s Mental Health, Child Welfare, and Court Appointed Special Advocates (CASA) programs. Through the Baseline Assessment and Screening of Young Children program, funded by the California Endowment, Fresno County Mental Health provided training for Child Welfare and CASA practitioners to conduct screenings and assessments of very young children who have been removed from their families; thereby, identifying children in need of treatment services in a timely manner.

Humboldt County is geographically large and rural. With 26 percent of the children birth to 5 years of age living in poverty, a significant number of the county’s children are at high risk for social-emotional developmental delays or disorders. The county’s addition of mental health treatment services for children birth to 5 years and their families has significantly increased the county’s capacity to serve children and families, but with only one county clinician, collaboration with other service providers is essential to serving the needs of its families. Public health, social services, special education, child care council, Head Start/Early Head Start, United Indian Health Services and county and community mental health providers meet regularly and all work together to coordinate services, share training opportunities, and access additional funding through grants.

Riverside County has established the Social-Emotional Screening Project. In collaboration with the county’s Department of Health and funds from First 5 Riverside, countywide screening for emotional problems in children birth to 5 years of age is conducted in familiar settings, such as pediatrician’s offices and childcare centers. Screening, using the Devereux Early Childhood Assessment (DECA) is completed while families wait for related services. Screening items are submitted by internet or fax to a central location for scoring. Results are immediately provided back to the practitioner who conducted the screening so that they can be shared with the family during the same visit. When the results indicate a possible mental health concern, follow-up calls are made to families, who are then invited for further assessment. The ongoing collaboration between mental health, the pediatrician’s offices and childcare centers opens the doors to needed services for children and families in Riverside County.

San Francisco County enhanced the screening and referral of children and families in San Francisco General Hospital by having a mental
health provider from the Infant Parent Program provide consultation at joint screening and referral meetings and multi-disciplinary nursery rounds. The ongoing consultation, provided by a senior psychologist at San Francisco General Hospital, has focused on educating other mental health professionals, pediatricians, public health nurses, and social workers to assess the service needs of children birth to 5 years old and their families. The success of this consultation has been demonstrated by increased referrals.

Sacramento County Quality Childcare Collaborative participants include 10 major collaborating agencies with Child Action, the local childcare resource and referral agency, as the lead in this First 5 Sacramento funded project. Some of the collaborating agencies are Sacramento County Office of Special Education Infant Development Program (special needs), County Mental Health (mental health consultation), Public Health (health consultation), WestEd Program for Infant Toddler Caregivers (training for childcare providers), UC Davis (training on school readiness and leadership development), and California State University Sacramento (provides interns to childcare centers). The Collaborative provides four levels of activity as follows:

- **Level 1 Information Team**—Provides information about community and agency resources, training and education for parents and providers.
- **Level 2 Resource Team**—More in-depth discussion of a provider’s concerns about staff development, administration or behavior/inclusion about a particular child or group.
- **Level 3 Consultation Team**—At this level the childcare provider can access consultation services regarding children with special needs, health, mental health or administrative concerns.
- **Level 4 Outside Referral**—When more intensive services are needed referrals are made for specialized services including mental health treatment.
Appendix A

Infant and Early Childhood/Family Mental Health Issue #1

In this excerpt from Cathie Wright Technical Assistance Center (CWTAC) Updates: Series on Infant and Early Childhood/Family Mental Health Issue #1, (July/August 2002) by Marie Kanne Poulsen, Ph.D., Dr. Poulsen describes the interplay between child and parental emotional availability and the effects on early childhood social-emotional development.

Infant and early childhood/family mental health refers to the development of social and emotional well-being in infants and toddlers, including infant health and brain development, family functioning, and the “goodness of fit” in the infant/child-parent relationship. Typically infant mental health refers to children birth to three. Early childhood mental health is the more generic term referring to children birth to five. Child-parent relationships provide the emotional foundations of child development, and the biological underpinnings for the development of resilience that enables the child to better cope with the challenges of growing up. Mother-infant attachment provides the template from which the child learns what to expect from the world. These expectations will guide how the child learns to interpret, experience and respond to loving, challenging and distressing events.

The factors that support mother-child relationships and optimal developmental trajectories are multi-faceted. Either partner can facilitate or hinder the process. When young children are healthy, temperamentally easy and developmentally competent, when parents have a healthy history of being parented and current social supports, and when families can provide emotional attention, appropriate guidance, and low environmental stress, the stage is set for healthy brain development, rich attachments and emotional health.

The field of infant and early childhood/family mental health emphasizes a developmental approach. Infant developmental and neurobehavioral competencies, as well as the ability of the care giving environment to regulate the development of the child, are addressed in assessment and treatment processes.

The hallmarks of a positive developmental trajectory and early childhood mental health are evident in the young child’s capacity to:

- **Develop enduring relationships with primary caregiver.** Does Anna go to her caregivers to get her needs met when she is feeling scared, lonely, hungry, tired, bored, or wants something, or does she simply whimper?
- **Initiate, discover, play and learn.** Can Anna initiate and focus on playing with her blocks or does she randomly finger her toys?
- **Persist when discouraged and attend when distracted.** Does Anna keep trying to re-build or always throw the blocks in frustration whenever her tower falls?
- **Cope with disappointment and recover from disruption.** Does Anna get upset whenever it is time to stop and put the blocks away or is she able to tolerate change?
- **Develop self-regulation and a range of emotional responses that match the social-cultural developmental expectations of the situation.** Does Anna eagerly engage or avoid responding to caregivers’ overtures? Does she show pleasure or despondence in engagement? Does she refuse or respond when her mother says no? Has she learned that biting is not the way to relate to her peers?

All behaviors noted can be normal ways of responding. Behaviors are concerns only when they are intensive, extensive and pervasive and/or when parents feel overwhelmed to the extent that they are unable to cope with their child’s behavior. Infant mental health addresses infant’s and young children’s emotional and behavioral disturbances through the lens of parent-child relationships within the context of social and cultural expectation.

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The term mother will be used to designate primary caregivers.
and the child’s level of neuro-developmental functioning.

Quality mother-infant relationships are contingent upon the emotional availability of each partner. When there are child health, neurobehavioral, temperament or developmental vulnerabilities, or when parents are isolated, overwhelmed or dealing with debilitating life circumstance, child emotional well-being may be in jeopardy. When infant and parent are both struggling with significant biological or psychosocial circumstance, the parent-child relationships and quality of attachment may be in peril. Maternal characteristics and circumstances, infant characteristics and the transaction between them both are critical elements in understanding the attachment process.

**Child Emotional Availability**

Charles Zeanah (1997) emphasizes that in infancy and toddler periods, psychiatric disorders are less clearly differentiated and less well validated, and that “...much is to be gained by focusing instead on risk and protective factors for infant development.” Babies are born with certain temperamental/neurobehavioral characteristics that can influence how they initiate and respond to nurturing care. A child’s capacity to manage stress and regulate emotions stems from interactions among temperamental/neurobehavioral status, early experiences and the quality of attachments.

There is considerable new understanding relating to brain-behavior relationships. Behavior, such as impulsiveness, distractibility, aggression and a lack of responsiveness to ordinary disciplinary and socialization guidance, is thought to stem from insufficient inhibitory or over-reactive mechanisms in the brain and/or insufficient ability to process and organize information. This research has underscored the notion of neurobiological vulnerability that holds that biological factors can make one susceptible to developing emotional disturbance, but does not itself cause such an outcome.

When an infant’s neurobehavioral functioning is compromised, infant emotional availability and the attachment process can be in jeopardy. Abnormal sensory threshold, intensity of reaction, and poor self-regulation are neurobehavioral characteristics that can interfere with the development of a healthy stress management system, leading to increased tantrumming, aggression and oppositional responses to behavioral expectations.

A highly sensitive over-reactive nervous system sets the young child up for non-adaptive ways of dealing with the world if caregivers are not aware that protective caregiving strategies are needed to calm down an over-reactive nervous system. A neurobiological vulnerability may be mild enough to require severe environmental influences in order for dysfunction to arise. Conversely, an actual neurobiological deficit may be serious enough for behavioral disorders to occur, even in the presence of nurturing caregiving. In fact, children with neurological damage evidence a 2 to 3 times higher incidence of behavioral disorders than other children. The question remains how much of the behavioral disturbance is due to biological deficit and how much is due to biological vulnerability that has been compounded by negative environmental and/or ineffective caregiving influences. The task of the mental health professional is to sort out and address the differences.

Several biological and environmental circumstances can adversely impact neurobehavioral functioning making the child more susceptible to emotional disturbances. The emotional disturbance can be worsened if not addressed or can become compounded by multiple risk factors.

- **Low Birth Weight**—Tiffany Field’s (2002) research indicates that low birth weight babies (1600 grams) are at increased risk for a variety of behavioral difficulties at two and five years as measured by parental response to the Behavior Problem Checklist. Increased risk is due to neurobehavioral immaturities that may not be appropriately addressed. There are over 40,000 low birth weight babies born each year in California who are susceptible to regulatory vulnerabilities or disorders.

- **Developmental Delays, Disabilities and Chronic Illness**—Infants, toddlers and young children with delays, disabilities and chronic illness may be at increased
risk for social, emotional and behavioral disorders due to vulnerabilities related to reactivity, intensity of response and other neurobehavioral sensitivities that require special caregiving strategies. The mental health disorders are not due to the disability or illness directly. When the need for special caregiving strategies go unaddressed, the child can be set on a negative developmental trajectory that later requires mental health treatment in addition to developmental services. Regional Center and Mental Health programs need to work in partnership to triage Department of Developmental Services preventive intervention and mental health treatment needs. It is important to note that there are neurodevelopmental disabilities of such severity that dyadic/environmental regulation supports play only a small part of the total intervention plan.

Nutrition — Inadequate nutrition and iron deficiency anemia can seriously interfere with brain development leading to neurological and behavioral vulnerabilities. Maltreated children and iron deficient children may evidence more irritability, emotional unresponsiveness, fearfulness, lethargy, and mental apathy resulting in decreased sustained attention and a lack of persistence in task completion and interpersonal engagement. Nutrition/iron deficiency screening must be considered in the assessment process.

Drug and Lead Exposure — Prenatal drug, cigarettes and alcohol exposure and pre- and postnatal lead exposure can lead to low birth weight and central nervous system compromise that effect neurobehavioral functioning and child resilience. Hundreds of thousands of babies are born annually prenatally exposed to toxic substances. The impact on infant outcome will depend on the extent of maternal use, resiliency of the fetus, general health, nutrition and lifestyle of the mother, and, most importantly, postnatal care and special caregiving supports.

Exposure to Violence — Exposure to community violence is taking its toll. A study by Taylor and Zuckerman (1994) reported that 47% of the mothers using a community hospital recounted that their children heard gunshots in their neighborhoods, and one in ten of these young children had witnessed a knife or shooting before the age of six, half in the streets and half at home. With repeated exposures to violence, children are in danger of becoming accustomed to and emotionally dead to its impact, leaving them to feel hopeless or to identify with the aggressor.

Maltreatment — Maltreatment, including neglect, abuse, separation and loss, can result in central nervous system dysfunction. Annually, 140,000 children are seriously physically injured by caregivers, with the vast majority being under four years of age and 1,500 of that group being victims of “Shaken Baby” syndrome. One of three physical abuse reports is about a baby less than one year. Many times the inconsolable crying of a distressed infant unleashed the torrent of rage of the caregiver — described as distressed fathers, stepfathers and boyfriends. When any baby is described as an inconsolable crier, there needs to be assurance that the family is able to tolerate it and that the baby will be protected from harm via family support, caregiving strategies, respite care, and so forth.

Stress — Evidence suggests that high levels of stress can actually undermine brain development. Extremes of experience from trauma or neglect can result in prolonged elevated stress hormone (e.g., high cortisol levels) which increases activity in the brain structures involved in vigilance and arousal. Patterns of hyperarousal develop, including affective lability, behavioral impulsivity, and increased anxiety and sleep abnormalities. As a result, the brain becomes wired to be on ‘hair-trigger’ alert. Everyday events that do not initiate a stress response from a robust child may elicit an exaggerated one in the vulnerable child. Regions of the
brain that were activated by trauma are immediately reactivated when a potential threat is perceived. This unleashes a new surge of the stress hormone, leading to behavioral difficulties in intensity of reaction and self-regulation. This can set up the child to repeatedly experience events as catastrophic, leading to surge of stress hormones, patterns of arousal and lingering distress behaviors. And thus potentially begins a negative chain reaction. The rationale for early intervention for reactivity and self-regulation difficulties is to break the cycle before it becomes ‘hard wired’ and perpetuates the risk effects. Infants and young children at biological risk are more vulnerable to adverse environmental influences than are non-risk children. Thus, these young children are in double jeopardy.

Out of Home Placements—Out of home placement is always a traumatizing event and has escalated in the last decade. Multiple placements within the foster care system is leaving thousands of young children without rich attachments, and without a history of self, memory of family rituals, and persons to whom they really belong. In California, there are approximately 26,000 children under 5 who are living in out of home placement as a result of maltreatment. A University of California study indicated that 62% of toddlers in foster care lived in at least three different homes within six years of entering the system. A census at one California child protective services shelter listed 42 children under the age of four. Twenty-two had histories of multiple placements within the system. The 22 infants and toddlers had a mean age of 13 months and had been in 64 placements and still were in a temporary setting.

Maternal Emotional Availability

Central nervous system (CNS) vulnerability of an infant can be offset if the mother is emotionally available to read and respond to her baby’s emotional and social needs. However, parenting is not an inborn capacity. It is an apprenticeship process needing support in understanding, interpreting and responding to infant/toddler cues. Societal changes have left many young parents without the traditional supports needed to help them in the process of becoming parents. Many are isolated from their extended family, and concomitant guidance and support. Research has documented that the lack of social supports is deleterious to positive parenting and family well-being. There are several circumstances that can interfere with a mother’s capacity to be emotionally available for her child. If preventive intervention community supports are not accessible for these mothers, her child may later require mental health treatment.

Depression—Maternal depression has become a major focus in identifying mother/child dyads in need of preventive intervention or treatment programs. Mothers struggling with depression have more difficulty in establishing and maintaining nurturing relationships with their young children. According to research, depressed mothers tend to:

- Be sad, slow, understimulating and withdrawn.
- Show tenseness that can feel intrusive or rough to the infant.
- Demonstrate a lack contingent responding to the infant despite generally positive affect.

The latest infant-brain research reveals that brain activity in children of depressed mothers mimics the changes seen in their clinically depressed mothers. Consequently, infants of depressed mothers show less positive affect, more fussiness, more withdrawal, less focused attention, and lower activity levels. The positive side is that, in many cases, when mothers’ depression goes into remission with treatment, their infants’ brain activity and interactions return to normal.

Parenting Skills—Serious impact to rich mother-child relationships can come from women who were poorly parented themselves and who are naïve about how a child grows and develops. Poor parenting
history may lead to an inappropriate internal working model of relationships with a deleterious effect on parental expectations and attributions of infant behavior. Without effective understanding of child development and child rearing strategies, a parent can be over or under concerned with a behavior or have unrealistic expectations. Inappropriate expectations and inappropriate interpretation of infant, toddler and child behavior can have severe repercussions. Seventy percent of all cases of child abuse begin with inappropriate or overly severe discipline. Sometimes the discipline escalates because the toddler is seen as defiant and oppositional by saying “no,” the 24 month old will not stay his 15 minutes in time-out, or the three year old is evil because she “steals.” When appropriate caregiving needs goes unaddressed, social, emotional and behavioral disorders may develop. Maternal naiveté can also be benign and touching. One mother spent her welfare check on five pairs of tennis shoes (including Nikes, Reebok) for a five month old so he could have “good self-esteem;” another bundles her baby up in 98° weather because that is her understanding of what “good mothers do.” Parenting is an apprenticeship process and when there are no neighbors, no grandmothers, no community of moms, no relatives, basic child development and caregiving needs to be addressed.

Social Support—Unsupported single parenthood places the child at risk when the lack of emotional, financial, and social resources is so overwhelming that the mother is not able to attend to her infant’s emotional needs. One-third of babies born are to single women, many without benefit of a supportive mate, an extended family, a neighborhood or a community of moms to help them learn how to be mothers, let alone how to care for a child if there are biological vulnerabilities to begin with. When extreme social isolation, and/or a history of broken relationships accompany unsupported single parenthood, maternal emotional unavailability for her baby may be a significant consequence.

Poverty—Child biological vulnerability becomes compounded when circumstances such as poverty compromise the parent’s ability to provide nurturing, protective and enriching care. In our state, one in four of our children live in poverty. Jane Knitzer (2001) in her study of parents dealing with poverty reported that 47% of parents self-identified “poverty-related sadness, demoralization and other indices of despair.” Among this group are the homeless. And of the homeless, one in four is a young child. One study showed that 50% of the homeless women are clinically depressed which is an additional risk in an already high-risk situation.

Domestic Violence—Domestic discord and abuse has serious repercussions for children, even if they are not the targets of abuse. Many mothers think if they are the recipients of abuse, they are protecting their children from harm. It is estimated that 15 million women are abused by their spouses annually and that 3.3 million children are witnesses – most are preschoolers and younger because they have no means of avoidance or escape. There are also repercussions when pregnant women are recipients of spousal abuse. Battered women are four times more likely to have low birth weight babies with accompanying vulnerabilities than their non-abused counterparts.

Teen Parents—Several maternal circumstances can seriously interfere with a mother’s capacity to be emotionally available. This is exemplified by maternal adolescence and the concomitant social-emotional and economic needs of both mother and child that must be addressed.

Substance Abuse—Women struggling with drug recovery will need added support to be able to recognize and respond to their children’s emotional needs. Many professionals are aware of the 375,000 babies born each year to
drug using women. What many may not be aware of is the 12-15,000,000 children being raised in alcoholic homes that may appear stable from the outside, but may be wrought with discord and instability within. In one study of 12,000 households where the mothers were categorized as drinkers, the children sustained two times the risk of serious injury as children of abstainers, a marker of maternal neglect.

**Risk and Resilience**

Risk is not destiny. For the most part, single risk factors usually do not impact child outcome. However when a risk circumstance is compounded by family adversity (e.g., poverty, domestic violence) or maternal vulnerability (e.g., drug use, unsupported single parenthood, maternal depression, adolescent parenthood), the risk to positive outcome grows exponentially. The number, rather than the nature of the risk factors, appears to be most important for determining outcome. It is easy to see how quickly maternal, family and infant risks can accumulate for certain populations. The Kauai Longitudinal Study (Werner & Smith, 1982) followed at-risk children in at-risk families for thirty years. Significant risk factors included: infant perinatal stress, poverty, lack of maternal education, family discord, divorce, abandonment by parent, parental substance abuse and parental mental illness. Any four of these risk factors at the age of two placed the child at high risk. The presence of three critical variables almost assured child disturbance. Those were: low birth weight, poverty, and an unstable discordant family life. Other studies also yielded data to support the notion that multiple-risk status correlates with behavior problems in children. Risk factors that have been strongly implicated as potential markers of risk for psychological problems in children include: low income, lack of housing, parent without high school degree or equivalent, single parent household, permanent separation of parents, parent/sibling death, foster placement, abuse and violence exposure.

Rutter identified marital discord, low socio-economic status, large family size, parental criminality, maternal psychiatric disorder and child welfare involvement as the most significant risk factors. A child experiencing any two of these circumstances is four times more likely to have a psychiatric impairment, and those with four risk factors are ten times as likely to have a mental health disorder.

Rutter has also written extensively on the significance of protective factors in helping a child overcome adversity. The core components include emotional health and social competency, which he reports comes from a process of “adaptive transactions between mother and child.” Supportive environments improve the social, emotional and behavioral outcomes of young children through responsive emotional engagement, protection from over-stimulation, alleviation of distress, encouragement of persistence, and development of self-efficacy. Gabriano’s work cites parental self-esteem, parent-child attachment and physical necessities of shelter, food and health care as being the protective factors for children raised in communities that experience poverty and violence.

From an infant mental health perspective it is important to address developmental pathways to competence and family resilience, as well as developmental pathways to disorders. Treatment needs to address both positive and negative influences on child and family social, emotional and behavioral health.

Citation:

The entire newsletter can be found at [www.cimh.org](http://www.cimh.org).
The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting excellence in mental health. CIMH is dedicated to a vision of “a community and mental health service system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

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