Recommendations
of the Pennsylvania
Early Childhood Mental Health Advisory Committee

Presented to Estelle Richman
Secretary, Department of Public Welfare

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Table of Contents

Early Childhood Mental Health Advisory Committee

History:

In February 2006, The BUILD Infant-Toddler Task Force issued its report with recommendations to promote "Infant and Toddler Development." One of three recommended focus areas was to improve social-emotional outcomes for young children by developing leadership in the Department of Public Welfare, coordinating increased communication regarding the importance of social-emotional health in state programs, and establishing training programs in infant mental health. As part of the department's leadership efforts, an Infant-Toddler Mental Health Symposium was held in December 2007, gathering stakeholders in early childhood mental health including representatives from DPW program offices, private foundations, health care providers, mental health providers, the Pennsylvania Key, family members and advocates, county human service programs, managed care organizations, and leaders from other states. The goal of the symposium was to foster relationships and connections as Pennsylvania builds its policy leadership agenda for young children.

One tangible outcome of the symposium was the creation of a statewide Early Childhood Mental Health Advisory Committee, composed of the same categories of stakeholders. The first meeting was held in May 2008, where three workgroups were established. The three workgroups—communication and collaboration, prevention and intervention, and professional workforce development—began immediately to name their priorities for the advisory committee. These priorities have been developed as recommendations to present to the Department of Public Welfare.

Framework

The committee has chosen the [Pyramid Model for Promoting Social and Emotional Competence in Infants and Young Children](#) as the framework for its three workgroups (communication and collaboration, prevention and intervention, professional workforce development). The pyramid emphasizes the importance of establishing strong foundations for young children (communication, prevention) as well as developing targeted supports and more intensive treatment programs (intervention) for those who need them. Undergirding early childhood mental health are skilled professionals (workforce development) and well-coordinated systems (collaboration).

Vision
Because every child is Pennsylvania's future, we envision that all young children will have a strong social and emotional foundation on which to grow.

Mission
Ensuring that coordinated and effective mental health services are available for all young children across the commonwealth.

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Selected Accomplishments in Early Childhood Mental Health in Pennsylvania:

- The establishment of a statewide advisory committee to build on the momentum and enthusiasm generated by the December 2007 symposium

- The joint announcement on January 15, 2009 from the Office of Mental Health and Substance Abuse Services and the Office of Child Development and Early Learning on "Behavior Supports for Young Children," which describes and calls for coordination of the county early intervention and mental health systems

- Expansion of the Early Childhood Mental Health Consultation Project statewide in all six Regional Keys

- Provision of funding for up to 30 early childhood practitioners from across the state (physical and occupational therapists, early childhood mental health consultants, developmentalists, counselors, psychologists) to attend the Infant Mental Health Certificate Program at Chatham University during the 2008-2009 academic year

- Expansion across DPW program offices of use of the Ages and Stages Questionnaire—Social/Emotional (ASQ-SE) screening instruments and increase in Medical Assistance rate for pediatric screening

- Launching of publication of "periodic update on early childhood mental health initiatives in Pennsylvania"

- Increase in number of university programs providing specialized attention to early childhood mental health (Chatham, Widener, Arcadia, Penn State)

- Early childhood mental health on agenda of State Interagency Coordinating Council and OMHSAS Children's Advisory Committee meetings

- Sustained early childhood mental health focus in Southeast region by Pennsylvania Council for Children and Youth and in the Western region by the Office of Child Development at the University of Pittsburgh

- SAMHSA grant awarded for evidence-based screening for Fetal Alcohol Syndrome Disorder for ages 0-5

- Increased awareness at many levels of the importance of attention to the social and emotional health of our youngest citizens

- Conference and training events, including the First Annual Infant Mental Health Conference, the Early Childhood Behavior Institute, and intensive training and coaching on Positive Behavior Supports in early intervention and early childhood education programs

For more information about state and national initiatives in early childhood mental health see **Appendix A**.

Introduction to and Brief Overview of the Committee's Recommendations

Introduction:

The social-emotional needs of young children are best served through an integrated approach to the delivery of all services. Such coordinated approaches support the healthy development of children and improve access to needed services. The system must partner with families to deliver the supports and care that are needed. This system must be strengths-based and child and family-centered and include all involved child and family serving processes and entities.

In providing effective supports and services to families with young children it is imperative that family-centered practices be highlighted. These include recognizing and validating that the family/caregivers are the constant and most important teachers to the child, facilitating collaboration between the family and professionals, sharing with the family complete and unbiased information and designing accessible individualized services and supports that include cultural sensitivity and flexibility. Families who have children with mental health or behavioral challenges already struggle— we need to ensure the services and supports we deliver do not add to those challenges.

Approximately 12-16 percent of American children are estimated to have developmental and behavioral problems (Boyle C, Decoufle P, Yeargin-Allsopp M., 1994). These problems are often associated with parental depression and other parent risk factors and may result in poor educational and functional outcomes for affected children (American Academy of Pediatrics, 1999). Identifying these problems and instituting early intervention services in a timely fashion is of critical importance to ameliorating the poor outcomes associated with these issues (Shonkoff JP, Phillips D, eds., 2000; Guralnick MJ , 1998). Under-detection of developmental and/or behavioral issues may be a particular problem in racial and ethnic minority communities. For example, Mandell and colleagues studied Medicaid files from a large metropolitan area and found that African-American children were diagnosed with autism on average a year and a half later than white children (Mandell D, Listerud J, Levy S, Pinto-Martin J., 2002).

In addition to identifying more children with developmental and/or behavioral issues in minority communities, diagnostic tools that are age-appropriate must be used more broadly.

The DSM- IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) is often used to diagnose behavioral health problems in children, but it is an adult tool super-imposed onto children. The DC: 0-3R is more developmentally-focused, and a crosswalk exists from it to the DSM IV, which would make it easier for clinicians to utilize the DC: 0-3R with their younger clients from birth through 5 years of age.

Brief Overview of Recommendations

The Early Childhood Mental Health Advisory Committee respectfully presents the following recommendations as important steps for sustaining and advancing the momentum that has begun for promoting and improving the social and emotional health and development of young children in Pennsylvania. The recommendations are presented in four categories under the three focus areas of Prevention and Intervention, Professional Workforce Development, and Communication and Collaboration:

- **Immediate:** to be completed within six months
- **Short-term:** to be completed within 12 months
- **Intermediate:** to be completed with 12-24 months
- **Long-term:** to be substantially completed and ongoing implementation established within 36 months

The advisory committee will establish specific milestones and completion goal dates in collaboration with lead stakeholders (for example, Department of Public Welfare program offices and other relevant advisory committees, counties, universities, professional provider and guild organizations, behavioral health managed care organizations, etc.). The committee will also develop a tracking document that will be reviewed every six months with the secretary of the Department of Public Welfare, program office deputy secretaries and key staff.

Focus Area 1: Prevention and Intervention:

Immediate Recommendation: Include language related to early childhood mental health in the guidelines for county integrated children's services plan.

Short-term Recommendations
- Improve access to and coordination of mental health services for young children
- Support and promote the use of existing screening instruments throughout programs serving young children (early care and learning facilities, pediatric and family practice offices, child welfare programs, etc.).

Intermediate Recommendations:
- Expand early childhood mental health consultation to all early childhood serving systems
- Identify and promote evidence based, best practice emotional coaching programs to better support the social-emotional foundation for all young children.
- Ensure the availability of well-coordinated and age-appropriate interventions for those young children and caretakers who need more intensive supports

Long-term Recommendations:
- None: the workgroup believes it is not appropriate to have long-term goals for serving young children.

Focus Area 2: Professional Workforce Development:

Immediate Recommendation: Adopt and promote a set of early childhood mental health competencies for all professionals and across all levels of service provision for families with children from conception through age five.

Short-term Recommendations:
- Develop a plan to systematically implement the core competencies
- Promote the concept that children must be understood and served within the context of their families.
- Assist and support universities and training institutes in promoting early childhood mental health specialty programs at the graduate level.

Intermediate Recommendations:
- Work with higher education institutions to develop the consistent inclusion of social and emotional curriculum in early childhood education programs.
- Implement the core competencies throughout all Department of Public Welfare programs.
- Include the core competencies in the professional development plans of all professionals working with young children.

Long-term Recommendation:
- Develop a system that supports comprehensive and effective clinical supervision (reflective practice consultation) to ensure better rates of retention for early childhood mental health professionals and better outcomes for children.

Focus Area 3: Communication and Collaboration:

Immediate Recommendations:
- Develop an implementation plan for the OMHSAS/OCDEL joint announcement on "Behavior Supports for Young Children," providing specific guidelines for how to ensure access to and coordination of services for young children.
- Include information about early childhood mental health in the Early Learning Council's communications plan.
- Develop an ongoing structure for the Early Childhood Advisory Committee that is modeled after Community Engagement Groups, statewide in scope and focused on early childhood mental health.

Short-term Recommendations:
- Develop a culturally competent social marketing campaign on the importance of early social and emotional development (partially in collaboration with Pennsylvania's Promise for Children)
- Host an internet discussion group and use existing organizational and agency newsletters and web sites to promote collaboration and share information about evidence-based and promising practices in ECMH with all early childhood providers and professionals.

Intermediate Recommendations:
- Develop a branded social marketing campaign promoting social and emotional development.
- Embed early childhood mental health information in all early childhood communications plans and programs.
- Create a dedicated early childhood mental health web site with resources for: 1) families and early learning practitioners on social and emotional development, and 2) agencies and professionals on identifying and serving young children at risk for problems.
- Develop a brochure/booklet containing information about early childhood mental health competencies and how and where to obtain training to meet those competencies.

Long-term Recommendations:
- Engage local communities in promoting healthy social and emotional development in young children.

The following pages provide
further background and details for these recommendations.

Prevention and Intervention Recommendations

Focus Area 1:
Prevention and Intervention Recommendations

Recommendations

1. **Improve access to, and coordination of, services for children--** All aspects of the service delivery and planning should occur through an integrated system that includes the direct representation of families, early childhood programs (Head Start, Early Head Start, child care, daycare, preschools and pre-kindergarten), primary care, mental health, child welfare, mental retardation, early intervention, drug and alcohol programs, education, and others identified by the family or planning team.

At the local level the ICSP (Integrated Children's Services Plan) asks counties to do cross- system planning to improve service access and coordination for children. We encourage the state to continue to support this process, adding an emphasis on early childhood programs.

Each community should also develop individualized approaches to achieving integration taking into consideration local organizational, administrative and other relevant factors. The key focus should be to have families at the table with all the relevant service providers and case coordinators. Such planning meetings should be held at times convenient for all those involved to assure broad participation that will result in efficiency, shared goals, and improved outcomes for the child and family.

Programs need to be held accountable in order for services to truly be coordinated. Early childhood programs are already monitored to ensure they meet certain requirements, and service coordination and related items should be included in these checklists. If coordination is not happening, programs should be asked to address the issue in a corrective action/follow up plan. The state should use funding incentives to encourage early childhood programs to improve access and coordination— for competitive funding, applicants could receive high scores for service coordination efforts, thereby qualifying them for more funds.

> *"If all programs are able to speak and collaborate together for the benefit of the child and family it will create a more conducive environment for those families to get the services that are needed and to be more successful in those programs. It also avoids duplication or the need for the family to continually retell their story and start over each time they get additional support."—Parent's comment*

For more detailed information on what an integrated service system should include, see **Appendix B.**

2. **Expand early childhood mental health consultation to all early childhood serving systems**- Evaluation results from several Early Childhood Mental Health Consultation (ECMH) programs— California, Florida, North Carolina, Illinois, Colorado, NY, and Ohio— indicate children showed a decrease in problem behaviors and an increase in social skills after being a part of an ECMH Consultation program (Bleeker, T., Sherwood, D., & Chan-Sew, S., 2005). This type of support helps to lessen the damage that family difficulties and environmental stressors can have in terms of children's needs being met. ECMH Consultation also allows parents, children and teachers to interact informally with the consultant, promotes optimal early childhood development and fosters children's school readiness (Lewit & Baker, 1995).

Currently in Pennsylvania, Early Childhood Mental Health Consultants have been provided through Keystone Stars, the state's voluntary child care improvement program. Unfortunately, this valuable resource is in short supply. In one part of the state, for example, one ECMH Consultant serves about 17 counties. Optimally each consultant is capable of maintaining 10+ active cases. We suggest, as in San Francisco's very successful, well researched model (Bleeker, 2005) each consultant serves 4 child care centers with approximately 10 cases. Consultants would spend 8-10 hours per week at each child care center. Their services can include case consultation, direct psychotherapeutic interventions with children and families, program consultation, therapeutic play groups, referrals for specialized services (i.e. developmental and learning assessments, occupational therapy and help with IEPs), parent education and support groups, advocacy for families and training and support for child care providers. Consultants can thus affect children's mental health and behavioral issues through direct or through indirect means (U.S. Dept. of HHS, 2005).

Early Childhood Mental Health Consultants must be appropriately trained (master's level) to assess children, caregivers, and caregiver-child interactions from birth to five in various settings (i.e. clinic, home and childcare/preschool) (Zeanah et al, 2000). Consultants can be counselors, psychologists, or social workers, but all must be able to work in the family systems model.

A survey of California's ECMH Consultation projects (Bleeker, 2005) suggests that parents were very pleased with the services they received from the consultant. In an evaluation of eight of these programs, there was a statistically significant relationship between the extent to which teachers felt helped by the consultant and the self-rated quality of their relationship with parents. Teachers reported they improved their skills and felt an overall satisfaction in their position as a child care teacher. For more information on ECMH Consultation, **see Appendix C.**

3. **Support and expand existing screening practices** to identify young children at risk of developing, or presenting with, social-emotional and/or behavioral challenges and ensure simultaneous parent/guardian depression screening

Pediatric primary care clinicians and early childhood educators have frequent contact with young children and are well positioned to screen for and identify developmental and behavioral

problems in young children. A number of well validated screening instruments exist to assist child health professionals or early childhood educators with conducting developmental and behavioral screening.

Depression is highly prevalent among adult caregivers of young children and is known to have a significant impact on caregiver's ability to nurture their children. Children of depressed caregivers are more likely to incur unintentional injuries and experience emotional and behavioral disorders. Under-detection of depression of caregiver and poor access to treatment is common. A strong step in the support of social-emotional development of children and the prevention and treatment of behavior challenges is to include screening for depression for parents and linking caregiver treatment with parent-child intervention.

Traumatic exposure is a common experience for children, including young children. An estimated one quarter of all girls and one-sixth of all boys experience sexual abuse; and one-third of the reported episodes of child sexual abuse occur in children under the age of six years (National Incidence Study, 1996). Thus it is important to train pediatric providers to screen for trauma exposure and impact, and include trauma screening in routine pediatric evaluation and well child care appointments when feasible. A 6-item empirically-informed parent instrument is available to screen preschool children for trauma symptoms (Pynoos, Steinberg & Scheeringa, 2008, reproduced in Cohen et al, 2008).

Universal screening of young children and their parents at established intervals would ensure proper identification of social-emotional problems. However, a number of barriers/issues to screening would need to be addressed before implementation of such a program. These barriers include establishing an age of child for screening (e.g. the American Academy of Pediatrics recommends autism-specific screening at 18 and/or 24 months of age), no cost or low cost access to screening materials, time to conduct screening, sufficient reimbursement of child health professionals for screening, education of these professionals on use of screening tools and their interpretation, community providers trained in early childhood mental health to accept referrals from these professionals and collaborative relationships between those doing the screening and those providing intervention for caregivers and young children.

For information regarding specific screening tools for both children and adults, please see **Appendix D.**

4. **Identify and promote evidence based, best practice emotional coaching programs to better support the social-emotional foundation for all young children.** These need to be provided in a variety of natural settings and blended with activities in which parents already engage.

Preschool children who fail to understand and regulate their emotions are at risk for mental health and antisocial behavior problems throughout their lives. Parents play a central role in helping children develop these abilities. Emotional competencies are skills in understanding and

regulating emotions – which are fundamental skills for healthy child development (Denham, 1998; Saarni, 1999) and central for relationships and behaving pro-socially (Eisenberg et al, 1995).

Previous research has shown that children's emotional competence, if developed early, acts protectively and preventatively, reducing the risk that under stress a child will become antisocial, have mental health problems/social difficulties (Cicchetti & Cohen, 1995; Eisenberg, Cumberland et al., 2001; Greenberg, Kuswche, & Speltz 1991), or have problems during adolescence with substance abuse and other risk-taking behaviors (Silk, Steinberg, & Sheffield Morris, 2003; Yap, Allen, & Sheeber, 2007).

Because these problems are often difficult to halt once developed, significant attention is being given by practitioners, researchers, and policy makers to early intervention and prevention, targeting risks (such as child behavior problems and anxiety) and intervening with factors known to alter these risks (such as parenting) (Greenberg, Domitrovich, & Bumbarger, 2000). Research has found that parental emotion coaching (i.e. supportive responses, verbally labeling emotions, using empathy, and teaching children to understand and regulate their emotions), is related to children's emotional competence (Eisenberg, Losoya et al., 2001; Gottman, Fainsil erf-Katz, & Hooven, 1996; Thompson, 2000). Thus, intervention needs to target emotion-focused aspects of parenting if children's emotional competence is to be improved (Cole & Dodge, 1998; Gottman, Katz, & Hooven, 1997; Thompson, 1994; Webster-Stratton & Reid, 2004).

For some details about specific emotional coaching programs, please refer to **Appendix E**.

5. **Ensure the availability of well-coordinated and age-appropriate interventions for those young children and caretakers who need more intensive supports**

Though it is the expectation that most children will respond to social-emotional/behavioral prevention and intervention services such as mental health consultation in child care, referrals to Early Intervention, or quality improvements in the child care classroom to, some children require more intensive behavioral health treatments. It is imperative that these therapies be age-appropriate, as young children will not respond to the same methods as older children. Parent Child Interaction Therapy (PCIT) is one example of a behavioral therapy that can be used with young children, as young as age three, through age 8. This therapy occurs with parent-child dyads, and can be effective in as few as 12 sessions of parent-child therapy geared toward improving the quality of the relationship between the parent and child. For more details about PCIT, please see **Appendix E**.

Behavioral health treatment not only needs to be age-appropriate, but just as importantly, family-centered. Staff who provide services to young children need to take the time to engage families meaningfully and facilitate their sense of self-efficacy.

Some children exposed to acute or chronic stress will have reactions that do not get better or get worse over time. Some children will develop PTSD and complex trauma. These children need further assessment after screening and may likely need treatment to recover. This service is often referred to as trauma-focused or trauma-specific treatment.

The proper identification and treatment of children suffering from mental illness as a consequence of neglect or abuse in infancy or early childhood is becoming an especially urgent matter. The committee working on publication of the 5th edition of the Diagnostic and Statistical Manual of Psychiatry (DSM-V) is studying research on the validity and reliability of the diagnosis of Developmental Trauma Disorder in children, which would lend greater clarity to the complex clinical presentations of these children and facilitate more effective treatment approaches.

Currently, two problems are all too common in treatment of children variously diagnosed with Post-Traumatic Stress Disorder or Reactive Attachment Disorder: 1) the impact of the trauma of neglect and/or abuse is not considered diagnostically and therefore not addressed with specific treatment approaches, and 2) the possibility of other disorders—for example, Attention Deficit Hyperactivity Disorder or Pervasive Developmental Disorder—coexisting with or instead of the aforementioned disorders is not considered. Therefore, competent early childhood mental health practitioners must be empowered to understand the struggling child as existing within the confluence of innate biological, social and developmental as well as traumatic influences, and take them all into consideration in treatment planning.

There is no one treatment intervention appropriate for all children who have experienced trauma. However, there are evidence-supported treatments and promising practices that share core principles of "culturally competent trauma-informed therapy" and that are appropriate for many children and families from diverse cultural groups. One such treatment is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT). TF-CBT is an evidence-based resiliency-focused model program developed by Drs. Cohen and Mannarino at Allegheny General Hospital in Pittsburgh and Dr. Esther Deblinger at UMDNJ in New Jersey. This treatment provides skills to parents and children ages 3-18 years who have experienced traumatic events. TF-CBT also addresses child behavior problems, parenting skills and successfully resolves children's trauma-related problems including Posttraumatic Stress Disorder (PTSD) symptoms. TF-CBT can be provided at home, school settings, or in clinics (Cohen et al, 1996a, b, 2006). For more information about trauma treatment considerations, please see **Appendix F**.
Special thanks to Dr. Judith Cohen, Professor of Psychiatry, Drexel University College of Medicine; Medical Director, Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital (www.pittsburghchildtrauma.org; www.musc.edu/tfcbt), and Leslie Lieberman, Director, Multiplying Connections Initiative, Health Federation of Philadelphia (www.multiplyingconnections.org).

Professional Workforce Development Recommendations

Focus Area 2:
Professional Workforce Development Recommendations

As Pennsylvania embarks on the task of ensuring that coordinated and effective mental health services are available for all young children across the commonwealth it is imperative to ensure that professionals are prepared to address the unique mental health needs of young children and their families. Professionals include all individuals who work with young children and/or their families in any professional capacity. Therefore, the following recommendations are intended for consideration in building a professional workforce across state programs designed to serve young children and their families so that all young children will have a strong social-emotional foundation on which to grow.

- Adopt and promote a system of early childhood mental health competencies for professionals across all levels of service provision for families with children from conception through age five.

- All levels of professional development emphasize the importance of understanding and providing services to children within the context of their families.

Working with young children requires a relational perspective and approach across the service continuum. Professional development includes an emphasis on parent-child relationships and interactions, the importance of the family's role in the child's development, and the family's involvement as a fully engaged partner in service provision. All training, interventions and decision making must be accomplished in accordance with CASSP, Youth and Family Institute, and Recovery and Resiliency Principles.

- All individuals who work with very young children have training exposure and the opportunity for reflective practice consultation consistent with their professional standards.

    o Reflective practice consultation training opportunities should be provided at each early childhood mental health level including early childhood educators, core providers, and mental health specialists.
    o Provision of reflective practice supervision by a trained and qualified facilitator (based on meeting minimum training requirements) may be made available within an ECMH training regimen, through consultation with a local ECMH provider, and/or through a centralized system of reflective practice support to be determined. Ultimately, the opportunity to obtain reflective practice consultation may be most optimal as provided within specified ECMH provider agencies (e.g. Early Intervention, CYF, etc.) wherein providers may require the highest levels of reflection and support.

The recommendations for reflective supervision are general in order to honor the current practices and models that are in place within ECMH provider agencies.

- Develop a system that supports comprehensive and effective clinical supervision (reflective practice consultation) to ensure better rates of retention for early childhood mental health professionals and better outcomes for children.

  o For core providers and mental health specialists who have not had the opportunity to experience reflective practice consultation, one consideration may be the establishment of an Infant Mental Health Association for the state of Pennsylvania, through which reflective practice consultation may be made available. Reflective practice consultation is offered through affiliate IMH Associations in MI, NM, and TX. A professional association such as this may be well-positioned to continue activities related to the development of a prepared infant and early childhood mental health workforce.

- Continue to assist with promotion and support of universities and training institutes which are offering specialty programs at the graduate level with particular emphasis on infant and early childhood mental health as well as specialization in psychology and psychiatry for working with children ages conception through five years.

- Work with higher educational institutions to develop the consistent inclusion of social and emotional curriculum for early childhood education programs.

The following pages detail specific early childhood mental health competencies across four levels/tiers. These competencies have been adapted from "California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health."

Recommended Competencies: The Structure

The competencies are organized into four tiers or levels based on professional roles and intensity of involvement in mental health services. The list of professions within a particular tier is not exhaustive. More time would be spent with each system to consider how best to embed these competencies within the existing training and professional structure. Tiers 1 and 2 are intended for core providers who work in promotion and prevention levels of early childhood mental health. Tier 3 is intended for infant and early childhood mental health specialists who, in addition to promotion and prevention may also provide intervention services to young children and their families. Finally, Tier 4 includes highly trained and experienced professionals who are in a position to facilitate reflective practice sessions with other professionals within a particular discipline.

Although the scope of the Early Childhood Mental Health Advisory Committee is from birth through five, the competencies include knowledge and skills related to prenatal development and health as this period of development is critical to later developmental outcomes for children and their parents.

Tier 1
- Child care and Early Head Start/Head Start providers, Children, Youth and Families staff, medical support staff, Maternal Child Health home visitors (Healthy Start, Nurse-Family Partnerships), Parent-Child Home program, Family Support workers **(see Appendix G).**

Tier 2
- Early Intervention teachers and therapists, Supervisory staff for child care or Early Head Start /Head Start, Therapeutic Support staff **(see Appendix G).**

Tier 3
Individuals from relevant professional practice disciplines who have a Masters Degree or higher and/or a license/certificate/credential and who have achieved mental health specialist competencies. Tier 3 practitioners will be expected to complete a moderate amount of supervised clinical work in order to meet this level of competence (**see Appendix H).**

- Early Childhood Mental Health Consultants, Child Development Workers, Diagnosticians, Early Intervention Specialists, Speech and Language Specialists, Occupational and Physical Therapists, Pediatricians, Child/Family therapists, Special Education Teachers, Service Coordinators (children and adult), Behavior Specialists, Mobile Therapists, Psychologists/Psychiatrists, Visiting Nurses, Early Intervention Specialists.

Tier 4
Individuals from relevant professional practice disciplines who have a master's degree or higher and a license/certificate/credential and training on conducting reflective practice consultation **(see Appendix I).**

- Reflective practice facilitators, clinical supervisors, and others who by designation and/or education are certified supervisors in a particular field

Additional work is necessary to identify mechanisms to monitor and measure progress toward each of the tiers. It will be important to embed the expectations within the existing system in a manner which is consistent and supportive of specific professional standards and continuing education requirements.

Communication and Collaboration Recommendations

Focus Area 3:
Communication and Collaboration Recommendations

Introduction:

The Communication and Collaboration Workgroup sees its role as supporting the Advisory Committee as a whole. The objectives and recommendations presented below were developed to outline the specific ways the workgroup intends to accomplish that and should be seen as complementing the recommendations from the prevention and intervention and professional workforce development focus areas. See the chart, "Communication and Collaboration Plan," **(Appendix J)** for more information.

OVERALL GOAL: Promote the healthy social and emotional development of young children

OVERALL RECOMMENDATION: Develop communication tools that will assist the commonwealth in supporting the healthy social and emotional development of young children.

OBJECTIVE 1: Promotion

Increase understanding of the importance of supportive environments and nurturing relationships for young children

> **Recommendation:** Develop a culturally competent social marketing campaign on the importance of early social and emotional development (partially in collaboration with Pennsylvania's Promise for Children)

OBJECTIVE   2: Prevention

Disseminate information on approaches to identifying and supporting young children at risk of developing emotional and behavioral problems

> **Recommendation:** Create a dedicated early childhood mental health web site with resources for: 1) families and early learning practitioners on social and emotional development, and 2) agencies and professionals on identifying and serving young children at risk for problems.

OBJECTIVE 3: Intervention

Promote the collaborative development of accessible, coordinated and effective interventions that will meet the needs of young children with emotional and behavioral needs and their families

> **Recommendation:** Host an internet discussion group and use existing organizational and agency newsletters and web sites to promote collaboration and share information about evidence-based and promising practices in ECMH with all early childhood providers and professionals.

OBJECTIVE 4: Professional Workforce Development

Disseminate information about competency standards and educational and training opportunities in early childhood mental health

> **Recommendation:** Develop a brochure/booklet containing information about early childhood mental health competencies and how and where to obtain training to meet those competencies.

OBJECTIVE 5: Collaboration

Foster effective collaboration and partnerships among agencies, creating an integrated service system and defining roles and promoting equitable access to early intervention and mental health services

> **Recommendation:** Develop a follow-up document to the OCDEL/OMHSAS announcement on "Behavior Supports for Young Children" that provides specific information about how to access and coordinate services for young children.

Conclusion

Since its creation in May 2008, the Early Childhood Mental Health Advisory Committee has worked hard to develop its vision and mission and the scope of its work. The vision and mission are focused on ensuring that all young children in Pennsylvania have the opportunity for healthy social and emotional development and have access to quality mental health services when they are needed.

Science shows that providing stable and responsive relationships in the earliest years of life can prevent or even reverse the damaging effects of early risk factors with lifelong benefits for learning, behavior, and health. The experts tell us that "From pregnancy through early childhood, all of the environments in which children live and learn, and the quality of their relationships with adults and caregivers have a significant impact on their cognitive, emotional, and social development. A wide range of policies, including those directed toward early care and education, child protective services, adult mental health, family economic supports, and many other areas, can promote the safe, supportive environments and stable, caring relationships that children need" (Center on the Developing Child, p. 1). The emotional, social and behavioral competence of young children is a strong predictor of academic performance in elementary school. The commitment of Pennsylvania's leaders to ensure that all children have access to quality early learning, healthcare, and family support services has enabled this committee to outline recommendations which build upon a substantial foundation and notable accomplishments. We are proud of what Pennsylvania has achieved in fulfilling its promise for young children; and we look forward to contributing to the assurance of a bright future through each young citizen.

The preceding recommendations in the three identified focus areas of prevention and intervention, professional workforce development, and communication and collaboration are presented as important steps for continuing to promote and improve the social and emotional health and development of young children in Pennsylvania. The committee believes that the Commonwealth's youngest citizens deserve nothing less than our best efforts. There are indications that early intervention can have a profound positive effect on the trajectory of emotional or behavioral problems as well as improve outcomes for children with serious disorders. Because every child is Pennsylvania's future, the Early Childhood Mental Health Advisory Committee is committed to establishing a positive trajectory for every young child and his/her caregivers.

Appendices

Appendix A

A Sampling of
State and National Initiatives in Early Childhood Mental Health

Pennsylvania:

Newsletters of various agencies regularly include section or article on topic related to social and emotional development of young children

Substance Abuse and Mental Health Services Administration grant to serve children birth to six who have a mental health diagnosis

Joint training on the DC 0-3R

Screening for maternal depression

Infant mental health promotion by Early Head Start

Learning modules on "Managing Challenging Behavior in Young Children" and "Managing Challenging Behavior in School-Age Children" (www.ecels-healthychildcarepa.org or 1-800-24-ECELS).

Child care health consultants in Regional Keys to assist early childhood education practitioners with medical and mental health issues

Year-long training program in Positive Behavior Supports from Early Intervention Technical Assistance

Early Childhood Intervention/Preschool Partial Hospitalization Program where children receive mental health treatment and individualized education plans in an integrated way; Intermediate Unit serves young children with mild to moderate behavior disorders

Mandated use of ASQ and ASQ-SE screening tools with children under the age of three who are victims of substantiated cases of abuse or neglect

Early childhood mental health and addressing challenging behaviors included in professional development; behavioral support teams conduct functional behavioral assessments and implement behavior intervention plans; training on positive behavior supports

Collaborative efforts to build system capacity for infant and early childhood mental health

Early Childhood Mental Health Work Group promoting quality community based mental health care prevention and intervention services for young children and their families; requesting Department of Public Welfare to implement a HealthChoices behavioral health medical necessity criteria that is more appropriate for young children; promoting and supporting training and implementation of evidence-based assessment for young children based on the 0-3R

Annual conference presentations on early childhood mental health efforts by the leadership of OCDEL and OMHSAS

Promoting early childhood mental health initiatives at meetings of the State Interagency Coordinating Council and the SICC Welcoming All Children Committee, and various other venues

National:

Arizona: Infant Toddler Mental Health Coalition of Arizona (www.itmhca.org); Institute on Infant Toddler Mental Health; chapter of World Association for Infant Mental Health (WAIMH)

California: First 5 Early Childhood Mental Health Project (http://www.f5ac.org/item.asp?id=537); California Early Childhood Comprehensive Systems Fact Sheet (http://ww2.cdph.ca.gov/HEALTHINFO/HEALTHYLIVING/CHILDFAMILY/Pages/SECCS.aspx)

Colorado: Child Care Intervention Team (ages 0-8)

Illinois: chapter of WAIMH

Indiana: Annual Conference on Infant Mental Health; chapter of WAIMH

Kansas: chapter of WAIMH

Maine: chapter of WAIMH

Maryland: The Maryland Early Childhood Mental Health Project (http://www.marylandpublicschools.org/NR/rdonlyres/38C2D261-0C1C-45B6-BD7C-F4C1C3347F0E/18705/ecmh_broch_1222.pdf): Early Childhood Mental Health Certificate Program (http://medschool.umaryland.edu/innovations/training.asp): Children's Mental Health Matters in Maryland (http://marylandtransformation.org/pdf/2.2Children'sMentalHealthMattersinMaryland.pdf)

Michigan: chapter of WAIMH; Michigan Association for Infant Mental Health (www.mi-aimh.org)

Missouri: Early Childhood Comprehensive Systems Action Plan; "Reforming Children's Mental Health Services in Missouri" (including early childhood) (http://www.dmh.mo.gov/diroffice/depdir/childsvcs/CCMHP.pdf)

Nebraska: Early Childhood Mental Health for Nebraska's Children: Supporting Social and Emotional Development (http://ectc.nde.ne.gov/partnerships/ecmh/pbs.htm); Early Childhood Mental Health Subcommittee for statewide infrastructure grant) (http://www.hhs.state.ne.us/med/sig/Early.htm)

New Jersey: New Jersey Association for Infant Mental Health (http://www.njaimh.org/); professional credentialing at Seton Hall University; Northern New Jersey Maternal/Child Health Consortium's ECMH "Play, Grow, Heal" (http://www.maternalchildhealth.org/content/index.php?pid=55)

Ohio: Early Childhood Mental Health Consultation Program; chapter of WAIMH

Oklahoma: chapter of WAIMH; Early Childhood Comprehensive Systems (http://www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/Child_and_Adolescent_Health/Early_Childhood_Comprehensive_Systems/index.html)

Rhode Island: chapter of WAIMH

Utah: chapter of WAIMH

Vermont: Children's Upstream Services (CUPs, ages 0-6)

Virginia: chapter of WAIMH

Washington: chapter of WAIMH; Center for Infant Mental Health and Development (http://cimhd.org); research, education and training; annual conference

Wisconsin: Wisconsin Alliance for Infant Mental Health (www.wiimh.org); conference in 2010; certificate program beginning in 2010; training in DC: 0-3R

Appendix B

What an Integrated Service System Should Look Like

An integrated service system for young children should include:
- Multiple points where families of young children can access centralized intake that includes a comprehensive assessment;
- A process where all service providers can meet with the family to develop a single service plan that is based on the comprehensive assessment and accesses resources from across systems to meet the needs of the child and family; and
- A process where all service providers can identify an integrated or lead case-manager to reduce duplication, effort and costs.

Those individuals and agencies involved in planning services for young children should consider the Department of Public Welfare's Integrated Children's Services Plan suggested Framework of Integration. The integration framework incorporates the following elements for children and adolescents, in every county, who need public "system" involvement:
- A continuum of care at every level of system involvement that provides for the healthy development, safety and well being of the child;
- A mechanism for all children entering the system to receive a comprehensive review of the child's needs;
- A service plan, based on the comprehensive review, that accesses resources from all appropriate sources to meet the needs of the child and family;
- A prevention strategy for children that encourages healthy development and stability;
- Integrated services where the child/family has needs and receives (or is eligible to receive) services from more than one categorical county program.

Appendix C

Additional Information on Early Childhood Mental Health Consultation

A working paper by the National Scientific Council on the Developing Child, Harvard University (2008), emphasizes the powerful influences of early relationships and illustrates how much the emotional well-being of young children is directly tied to the emotional functioning of their caregivers and the families in which they live. Caregivers who are regularly involved in the lives of infants, toddlers, and preschoolers often lack the knowledge and skills that would help them identify the early signs of mental health problems as well as fully understand the consequences of family difficulties and parent mental health problems for young children's development.

It may require a paradigm shift (NY ECMH Strategic Work Group, 2004) to recognize that mental health is the responsibility of no one discrete intervention system, but the responsibility of all child and family serving agencies and systems. Because young children's emotional well-being is tied so closely to the emotional status of their parents and non-family caregivers, the emotional and behavioral needs of infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships.

Appendix D

Screening Tools

- Ages and Stages Questionnaire-Social Emotional (ASQ-SE) is a 22 to 36-item parent self-report instrument that addresses behavioral functioning in 7 domains: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interactions with people (Ages & Stages Questionnaire: Social-Emotional, 2009)
- Brief Infant and Toddler Social-Emotional Scale (BITSEA) is a 23-item parent self-report instrument that address behavior problems and social competence in children 12 to 36 months(Sptizer, Kroenke, and Williams, 1999).
- Modified Checklist for Autism in Toddlers (M-CHAT) is a 23-item instrument that results in determination of risk status (e.g., pass or fail) for autism for children ages 18 to 30 months old (Robins DL, Fein D, Barton ML, Green JA., 2001; Dumont-Mathieu T, Fein D. , 2005; Robins DL, Dumont-Mathieu TM, 2006).
- Pediatric Symptom Checklist (PSC) is a 35-item parent self-report scale that assesses child psychosocial dysfunction in children ages 4-16 years old (Harris, M., & Fallot, R. , 2001).
- Another longer screening tool, the Child Behavior Checklist, for ages 1½-5 and 6-18 (CBCL/1.5-5 and CBCL/6-18) includes 4-page questionnaires for obtaining parents' reports of their child's competencies and problems (Strand, V., Sermiento, T., & Pasquale, L., 2005).The CBCL may not be appropriate for screening in pediatric offices and child care agencies due to the length of time needed for administration and scoring.
  - There are similar forms for obtaining reports from teachers (Teacher's Report Form; TRF), Caregivers (Caregiver-Teacher Report Form; C-TRF/1½-5), direct observers (Direct Observation Form; DOF), clinical interviewers (Semistructured Clinical Interview for Children & Adolescents; SCICA), and psychological examiners (Test Observation Form; TOF). Youth Self-Reports are also available for the Child Behavior Checklist.
  - The CBCL can also be used to measure a child's change in behavior over time or following a treatment. The first section of this questionnaire consists of 20 competence items and the second section consists of 120 items on behavior or emotional problems during the past 6 months.

For further details on these and other screening tools, please refer to The National Early Childhood Technical Assistance Center's **"Developmental Screening and Assessment Instruments with an Emphasis on Social and Emotional Development for Young Children Ages Birth through Five,"** which can be found at http://www.nectac.org/~pdfs/pubs/screening.pdf.

Screening instruments for parental depression exist and are typically very low cost. For example, The Physician Health Questionnaire-9 (PHQ-9) is a validated 9-item instrument that

screens for depressive symptoms in adults. Wethington, H., Hahn, R., Fuqua-Whitley, D., Sipe, T., Crosby, A., Johnson, R., et al., 2008). Some states (New Jersey, Illinois) have taken the lead in screening for depression in parents during their young child's well child visits by providing the ability for pediatrician to bill for this adult "service" through the child's insurance.

Screening for Trauma

Because we cannot always know if a child has been exposed to trauma, because trauma reactions are difficult to identify, because there is high exposure to traumatic events among children served in public systems such as child welfare, behavioral health, public health and education, and because, unrecognized and untreated trauma can have devastating life-long effects, we must adopt a philosophy of "universal precautions" and find ways to implement universal trauma screening for all children and families.

There are numerous quick, inexpensive and effective tools for screening. Strand et. al (2005) have identified 35 instruments for assessing and screening children for trauma. They range from self-report 5 minute screens to much longer in-depth interviews. Some only screen for exposure while others screen for exposure and symptoms. Screening tools are available for children of all ages. Additionally, since traumatic stress in young children is often expressed behaviorally, developmental screens, such as the Ages and Stages Questionnaire which often are part of routine pediatric care, can be clues to trauma exposure.

Appendix E

Emotional Coaching Programs

Tuning Into Kids: Emotionally Intelligent Parenting (TIK)
A targeted treatment for parents of preschoolers. Teaches parents skills that help children to learn about and regulate their emotions. TIK has been empirically tested and is a parenting program designed to improve children's emotional competence as a way of improving child behavior, and social-emotional functioning (Havighurst & Harley, 2007). A six session program for parents from the work of Dr. Sophie Havighurst and Ann Harley of The University of Melborne, Australia, and booster sessions, are available.

Incredible Years
Targets children two-eight years old, their parents and teachers with the use of three sets of developmentally appropriate curricula. It is designed to promote emotional and social competence and to prevent, reduce and treat behavioral and emotional problems in young children.

The Non-Compliant Child – ages 2-7
Helping the Noncompliant Child (HNC) is a training program that teaches parents to change maladaptive patterns of interaction with their children. The program is designed for parents of children ages 3 to 8 who have noncompliance or other conduct problems, but it also has been used with other high-risk populations of children and parents. The long-term goals of the parent-training program are 1) secondary prevention of serious conduct problems in preschool and early elementary school-age children and 2) the primary prevention of subsequent juvenile delinquency. Short-term and intermediate objectives include 1) disruption of coercive styles of parent–child interaction and establishment of positive, prosocial interaction patterns, 2) improved parenting skills, and 3) increased child prosocial behaviors and decreased conduct problem behaviors.

Parent-Child Interaction Training (PCIT)

This training model is for parents who desire to have greater skills in dealing with the behaviors of their young child. It is designed to assist parents and their children from 3-7 years of age. PCIT is an interactive, hands-on model that utilizes technology to enhance the skills of both parents and children. The interaction between a parent and their child is videotaped while a coach assists the parent behind a one-way mirror. The coaching provided to the parent is useful in developing positive parenting skills.

Parent-Child Interactive Therapy (PCIT)

A research based, best practice treatment for parents whose children, as a result of sexual, physical and/or emotional abuse, have serious behavior problems. PCIT provides structured, supportive education that focuses on improving the parent's communication, play and discipline skills. The goals of treatment are:

1. *improve and enhance the relationship between the parent and child*
2. *decrease the child's behavior problems through positive discipline*
3. *increase the skill levels and abilities of the parent*
4. *decrease the stress of the parent, which allows the parent to provide support and nurturing to the child.*

PCIT combines one-on-one "coaching" for parents by a trained PCIT provider using structured child-parent play activities. The coach uses a two-way mirror to observe and provide continual, real-time feedback, directions and encouragement through a discreet radio receiver that the parent wears behind her/his ear. The program is mastery-based; in 12 to 20 weekly sessions, parents practice specific play, communication, and discipline skills, with the help of the coach.

PATHS
A primary prevention program that helps children identify their emotions and think before acting on them. It includes a very standardized curriculum for use in preschool classrooms and extensive staff training and monitoring for fidelity of implementation (http://www.prevention.psu.edu/projects/PATHS.html).

Appendix F

Trauma Treatment

The word trauma can refer to a wide variety of negative events that children experience including motor vehicle injuries, natural disasters, painful medical procedures, terrorism, community and political violence, all forms of child abuse and neglect and sudden loss of a loved one. Additionally, the reactions children have to trauma are far ranging, complex, difficult to pinpoint and often misdiagnosed. They can include behavioral, psychological, physical and cognitive responses that impair their ability to learn, grow and thrive.

Over the last decade research has been conducted to identify effective models of trauma treatment for children. The National Childhood Traumatic Stress Network has identified numerous trauma treatment models considered to be evidence -based or promising practices for children and youth; these can be found at www.nctsn.org. Hahn et al. (2008) reviewed seven treatment modalities to determine effectiveness in reducing psychological harm to children who had PTSD as a result of trauma exposure. Group and individual cognitive behavioral therapy (CBT) were found to be effective at reducing psychological symptoms. There was insufficient evidence, however, to determine the effectiveness of play therapy, art therapy, pharmacologic therapy, psychodynamic therapy, or psychological debriefing in reducing psychological harm to children exposed to trauma.

Appendix G

Core Providers Competencies: Tiers 1 and 2

A. Parenting, Family Functioning and Parent Child Relationship		
Key Concepts	**Competencies: Tier 1**	**Competencies: Tier 2**
Pregnancy and Childbirth	Supports pregnant mothers and others in her life to seek out prenatal care, nutrition, etc. to foster optimal health during pregnancy	Supports pregnant mothers and her significant individuals to seek out prenatal care, nutrition, etc. to foster optimal health during pregnancy
Postpartum period	Communicates to families that the birth of a child is a significant event in a family's life and may bring surprises they did not expect such as: Post Part Depression Sleeplessness Change in behavior from other siblings	Supports families in understanding the birthing process and impacts on the family Understands the impact of mental health issues/perinatal mood disorders on parent-child relationships and can describe this impact to families to help transition them to appropriate intervention if needed.
Attachment	Introduces concept of attachment to new families. Promotes attachment with young children by providing interactive activities and opportunities for physical and emotional closeness.	Demonstrates an understanding of healthy attachment after birth and the importance of the postpartum period on the newborn. Demonstrates an understanding of different patterns of parent-infant interaction and attachment.
Family Dynamics	Recognizes and supports cultural beliefs and values of families	Demonstrates an understanding of family and parenting function as a lifelong developmental process beginning before conception
	Successfully initiates and sustains an effective working relationship with parents/caregivers that nurtures their strengths and emerging capacities	Successfully initiates and sustains an effective working relationship with parents/caregivers that nurtures their strengths and emerging capacities
	Supports family/caregivers to respond to child's cues and preferences including sensory processing needs.	Supports family/caregivers to respond to child's cues and preferences including sensory processing needs.

Key Concepts	Competencies: Tier 1	Competencies: Tier 2
Early Communication and Relationship Support	Can respond appropriately to a young child's non-verbal communication.	Is knowledgeable about the emergence of communicative intent and gestural communication between child and caregivers
	Accepts and communicates to families that interactions may be different at home than in group settings. Is willing to share and accept examples of successful interactions across settings.	Accepts and communicates to families that interactions may be different at home than in group settings. Is willing to share and accept examples of successful interactions across settings.
	Uses a variety of techniques to facilitate and reinforce positive caregiver-infant interaction and enhance families' capacity to be responsive and sensitive to their baby.	Uses a variety of techniques to facilitate and reinforce positive caregiver-infant interaction and enhance families' capacity to be responsive and sensitive to their baby.
	Is aware of the potential negative impact of multiple separations and/or multiple family placements on early development and behavior. Helps families to support young children to overcome any negative impacts.	Is aware of the potential negative impact of multiple separations and/or multiple family placements on early development and behavior. Provides families with specific interventions to support young children to overcome any negative impacts.
	Is aware and accepting of a wide range of family structures, family dynamics and cultural influences on family functioning	Is aware and accepting of a wide range of family structures, family dynamics and cultural influences on family functioning
B. Infant, Toddler and Preschool Development		
Key Concepts	Competencies: Tier 1	Competencies: Tier 2
Typical /Atypical development	Demonstrates knowledge of sequences of development and effects of risk factors such as genetics, medical complications, exposure to substances that can cause birth defects and the impact of familial, cultural, social, physical and economic factors on early development. Uses this knowledge to connect families to additional supports if needed.	Demonstrates knowledge of sequences of development and effects of risk factors such as genetics, medical complications, substance exposure and the impact of familial, cultural, social, physical and economic factors on early development. Uses this knowledge to connect families to additional supports if needed.

Key Concepts	Competencies: Tier 1	Competencies: Tier 2
Relationships with children and adults	Demonstrates knowledge of social and emotional development and resilience, including the development of attachment and trust. Is aware of and plans support to counteract the impact of stress and trauma.	Demonstrates knowledge of social and emotional development and resilience, including the development of attachment and trust. Is aware of and plans support to counteract the impact of stress and trauma.
	Supports social emotional development in young children. Actively involves families to implement strategies to facilitate emotional and social development	Supports social emotional development in young children. Actively involves families to implement strategies to facilitate emotional and social development
Cultural variations in development and family expectations	Collaborates with parents in implementing early intervention activities to promote development and identity, and to reduce risk of delay or disorder	Collaborates with parents in devising early intervention activities to promote development and identity, and to reduce risk of delay or disorder
	Actively involves parents to implement strategies to facilitate emotional and social development	Actively involves parents to implement strategies to facilitate emotional and social development
	Provides guidance and information in a manner timed and suited to the parent's strengths, concerns, priorities, and cultural values	Provides guidance and information in a manner timed and suited to the parent's strengths, concerns, priorities, and cultural values
C. Risk and Resilience		
- Foster care - Working with challenges such as family violence, teen parents, mental illness in parents, substance abuse - Chronic physical illness in child or parent	Considers the impact of stress and trauma on family and child development and learning	Considers the impact of stress and trauma on family and child development and learning
Protective Factors	Is able to describe developmental protective factors and implement practices that build resilience.	Is able to describe developmental protective factors and implement practices that build resilience.

D. Observation, Screening and Assessment		
Key Concepts	**Competencies: Tier 1**	**Competencies: Tier 2**
- Use of Screening Tools - Introduction to major assessment instruments and processes	Uses a variety of evidence-based screening and/or assessment tools and practices that are appropriate for infants, toddlers, preschoolers and their families	Selects and uses a variety of evidence-based evaluation and assessment tools and practices that are appropriate for infants, toddlers, preschoolers and their families
Development of observational skills with infants and young children	Conducts observation and other informal assessment procedures in a variety of settings natural to the family, as appropriate.	Conducts observation and other informal assessment procedures in a variety of settings natural to the family, as appropriate.
Use of observational information	Integrates assessment results with information from parents and other agencies/professionals Interprets and links assessment results with needed outcomes and services based on infant, toddler and family needs and perspectives	Integrates assessment results with information from parents and other agencies/professionals Interprets and links assessment results with needed outcomes and services based on infant, toddler and family needs and perspectives
When and how to make referrals	Recognizes when further assessment is warranted, collaboratively makes referrals and helps family to make initial contact with appropriate agency/professional	Recognizes when further assessment is warranted. Conducts assessment or collaboratively makes referrals and helps family to make initial contact with appropriate agency/professional.
E. Diagnosis and Intervention		
Diagnostic systems for infants, toddlers and young children	Demonstrates knowledge of typical child development as a basis from which to recognize delays or disorders.	Demonstrates knowledge of typical child development as a basis from which to recognize delays or disorders.
Linking assessment and diagnosis to intervention	Selects and implements evidence-supported intervention strategies that are appropriate to the infant or young child's strengths and needs	Selects and implements evidence-supported intervention strategies that are appropriate to the infant or young child's strengths and needs

Key Concepts	Competencies: Tier 1	Competencies: Tier 2
Effective formal and informal communication with caregivers and others	Attempts to participate in IFSP/IEP and/or behavior team meetings as appropriate. Provides regular feedback to families about child's progress.	Ensures that families are primary members of the IFSP/IEP and/or behavior team meetings as appropriate. Provides regular feedback to families about child's progress.
Developmental Guidance	In partnership with the family and other team members, develops, uses and analyzes ongoing observation to achieve child and family outcomes Provides guidance to family on how the child is developing	In partnership with the family and other team members, develops, uses and analyzes ongoing observation to achieve child and family outcomes Provides guidance to family on how the child is developing
F. Interdisciplinary/Multidisciplinary Collaboration		
Understanding the roles of other professionals in working with young children and families	Respects and incorporates information and feedback from the family and other team members,	Coordinates early intervention services across a variety of agencies
		Respects and incorporates information and feedback from the family and other team members
	Works cooperatively with the family, other team members and other agencies	Works cooperatively with the family, other team members and other agencies
Working together with other professionals to create an integrated plan	Facilitates relationships, communication and collaboration among family and all other team members	Facilitates relationships, communication and collaboration among family and all other team members
Respecting boundaries of practice	Demonstrates knowledge of the limits of one's own discipline's scope of practice and the need for referral for issues beyond one's own discipline's expertise	Demonstrates knowledge of the limits of one's own discipline's scope of practice and the need for referral for issues beyond one's own discipline's expertise

G. Professional Development and Ethics		
Key Concepts	Competencies: Tier 1	Competencies: Tier 2
Ethics of Scope of Practice Working ethically in family settings	Develops and implements a professional development plan recognizing a continuum of lifelong professional development.	Considers and reflects on the interpersonal nature of the family-specialist relationship
		Conducts early intervention practice in accordance with state and federal laws and regulations and in observance of discipline-specific requirements and principles
	Establishes effective supervision/mentoring relationships	Develops and implements a professional development plan recognizing a continuum of lifelong professional development.
		Establishes effective supervision/mentoring relationships

Appendix H

INFANT-FAMILY AND EARLY CHILDHOOD MENTAL HEALTH SPECIALIST
Competencies: Tier 3

To build upon the tremendous work that Pennsylvania has begun in many of these areas, the workgroup added competencies on trauma-informed care, and training in the utilization of the DC:0-3R when diagnosing and treating young children.

A: Parenting, Family Functioning and Child – Parent Relationships	
Key Concepts	**Competencies**
Range of family structure Pregnancy and childbirth Postpartum period Attachment issues Parenting as a developmental process Family dynamics Family expectation regarding child development Providing family sensitive services Cultural issues in parenting and family development Goodness of fit between parents and young children Importance of relationships to development Family systems	Demonstrates an understanding of: • optimal health during pregnancy; • the birthing process and impacts on the family; • healthy attachment after birth and the importance of the postpartum period on the newborn; • family and parenting function as a lifelong developmental process beginning before conception. • different patterns of parent-infant interaction and attachment and their impact on child outcomes. Is knowledgeable about the emergence of communicative intent and gestural communication in dyadic interaction during the first year of life. Understands the complexity of interrelationships between infant and caregivers within an environmental context and demonstrates a variety of appropriate strategies to support and promote family well-being. Uses a variety of techniques to facilitate and reinforce positive parent-infant interaction and enhances parents' capacity to be responsive and sensitive to their baby. Is aware of the potential negative impact of multiple separations and/or multiple family placements on early development.

	Is aware of and able to competently engage with a wide range of family structures, family dynamics and cultural influences on family functioning.
	Understands assessment of difficulties in parent-child relationships as outlined by Axis 2 and PIRGAS of DC:0-3R, and the implications for relationship-focused interventions.
	Understands strategies for facilitating change and growth processes in families with significant problems in relationships-at the representational, dyadic and systemic levels.
	Demonstrates reflective insight into personal relationship history and dynamics, and understands importance of one's own awareness in context o therapeutic relationships with families

B. Infant, Toddler and Preschool Development	
Key Concepts	**Competencies**
Typical development in infancy, toddler and/or preschool periods	Understands the developmental sequences and range of variation across multiple dimensions of child development, beginning prenatally and including sensory, motor, cognitive, communication, play, self-regulatory and social-emotional domains.
Milestones of development	
Peer relationships	Understands social-emotional development in a dyadic relationship context, as outlined by Axis 5 of the DC:0-3R and exemplified as social-emotional milestones, which may begin prenatally, and the implications for treatment of atypical dyadic emotional development.
Expectations of children in groups	
Cultural variations in development and family expectations	Accurately interprets information from direct and reported information, observations and assessments in a range of settings to identify capacities and strengths, as well as developmental delays and/or emotional disturbances in infants and young children served.
	Uses collaborative approaches to explore appropriate family expectations and provides developmental guidance in achieving strategies that support those expectations

	Suggests, demonstrates, and coaches families on strategies to nurture a child's development across all domains, including their strengths and emerging capacities
	Understands social-emotional development and the role of peer and group interactions and can utilize a range of strategies for promoting optimal interactions.

C. Biological and Psychosocial	
Key Concepts	**Competencies**
Temperament Regulatory issues Sensory issues Development of self-regulation Brain research Neuro-developmental issues Prematurity and low birth weight Nutrition Poverty Community issues School and community services Impact of such factors upon development and relationships	Accurately interprets the bi-directional nature of biological and psychosocial circumstances that influence infant brain development, parent-child relationships and the regulation of emotions and behavior, including genetics, low birth weight, under nutrition, and their role in child and family outcomes from preconception onward. Can identify and assess infant/child/adult states of arousal and how they are regulated and modulated. Understands the concept that prolonged unaddressed stress in the infant/child/parent or dyad affects all domains of development and that chronic stress may lead to subsequent interference with brain development and emotional regulation. Identifies and addresses prolonged stress as a focus of intervention. Comprehends that over-activity, under-reactivity or a combination of both to sensory information can disrupt typical development, and is able to provide appropriate intervention where there is a mismatch between the parent and the infant or child. Recognizes and works to combat the adverse effects of poverty and marginalization.

D: Risk and Resiliency	
Key Concepts	**Competencies**
Atypical development Teenage parenting "Ghosts" in the nursery Chronic physical illness in child or parent Chronic mental illness in parents Developmental disabilities Prematurity Communication and interaction problems Substance abuse in families Family violence Working with challenging caregivers Foster care Institutional care Factors that promote resiliency and help to insulate families from risk Promoting resiliency in young children and families, including principles and practices of trauma – informed care	Demonstrates a theoretical understanding of the cumulative risk factors that affect family well-being and parent-child relationships for infants and young children and their families and communities stemming from a variety of sources. Demonstrates a theoretical understanding of the resilience factors that allow infants, toddlers and preschoolers to positively adapt despite significant life adversities. Applies concepts of resilience to guide treatment planning assessment and interventions with children and families. Demonstrates the ability to: • modulate intervention style and strategies in response to specific strengths and vulnerabilities of each infant, child and family. • consider culture and context s well as risk factors in planning assessment and interventions. • identify and address parent-family difficulties that negatively impact the parent-child relationship and infant or child's social-emotional development.

E: Observation, Screening and Assessment	
Key Concepts	**Competencies**
Development of observational skills with infants and young children Use of observational information Use of screening tools When to make referrals for more comprehensive assessment	Demonstrates an understanding of: • assessment as intervention. • how to use observation, screening and assessment to determine necessary components for the individual child and family. Successfully uses a wide range of strategies in varied settings to reach and engage families.

How to make a referral, including following through or assisting family with initial contacts Introduction to major assessment instruments and processes	Incorporates observations of the child in multiple settings including play, child-parent interactions, child care settings and home into every multidimensional assessment of the child. Demonstrates an understanding of and ability to integrate a multidimensional assessment of an infant utilizing information from other providers and caregivers as appropriate, inclusive of health, physical, social, emotional, psychological and cultural aspects from a developmental and relational perspective. Understands how to select and use specific components of assessments for birth-5-year-olds and their caregivers within scope of practice and training. Uses components of assessment including observations, interviews, standardized and non-standardized tests and other professional reports, as appropriate, to provide multidimensional assessment with appropriate interpretation and application of findings in the design of interventions. Can, through observation and interview, recognize challenges to adults functioning as parents, including signs of substance abuse, developmental delay, mental illness, etc., and provide appropriate referrals and interventions. Demonstrates an ability to integrate multiple sources of information into a cohesive, family friendly report.
F: Diagnosis and Intervention	
Key Concepts	**Competencies**
Diagnostic systems for infants, toddlers and young children Linking assessment and diagnosis to intervention Effective communication with caregivers and others Concrete assistance Community resources Developmental guidance	Uses the DC:0-3R and DSM-IV to diagnose problems in very young children and provide the "cross walk" diagnosis between the two systems within their scope of practice. Recognizes intervention must be developed immediately following recognition of a child's developmental risk in order to minimize the likelihood of failure to progress.

Strategies to promote infant-family and early childhood mental health	Integrates information and formulates plans together with a family.
Strategies for preventive intervention addressing social-emotional-behavioral vulnerabilities	Understands and addresses the importance and need for concrete assistance, developmental guidance, crisis management and advocacy in therapeutic and developmental work with families of infants and toddlers.
Intervention strategies	
Therapeutic options, including current knowledge of evidence-based practice	Demonstrates an understanding of basic principles of a variety of individual, dyadic and family therapeutic approaches to promotion, prevention (parenting education) and intervention (treatment).
Developing reflective practice skills	Demonstrates knowledge of developmentally appropriate, evidence-based and best practice interventions and skills in delivering services.
Use of self in provision of services	
	Implements developmentally appropriate strategies for common problems in early childhood (tantrums, sleeping, eating, crying, and regulation).
	Is able to monitor progress and problems with intervention in writing, make adjustments as needed and maintain ongoing communication and collaboration with family and other agencies or providers regarding their perceptions and concerns.
	Demonstrates an understanding of basic principles of a variety of individual, dyadic and family therapeutic approaches to promotion, prevention (parenting education) and intervention (treatment).

| G. Interdisciplinary/Multidisciplinary Collaboration ||
Key Concepts	Competencies
Understanding the roles of other professionals in working with young children and families	Demonstrates an ability to assemble an interagency and interdisciplinary team in which team and family members exchange information and learn from one another.
Respecting boundaries of practice	Demonstrates awareness that relationships with other providers will have an effect on their relationships with the child and family.
Community resources	
Working together with other professionals to create an integrated plan	Demonstrates the importance of sensitive, respectful and effective communication with other providers of services to the child and family.
Collaborating to prioritize child and family needs	Demonstrates knowledge of the existence of a wide variety of resources and systems providing services to young children and families.
	Understands limits and boundaries of practice and makes appropriate referrals.
H. Ethics	
Key Concepts	Competencies
Ethics of scope and practice	Demonstrates self-awareness and the ability to reflect on one's impact on families and vice versa.
Working ethically in family settings	Demonstrates a clear understanding of scope of practice as defined by license, certification, and/or position/role, and seeks consultation when questions arise.
	Demonstrates a clear understanding of scope of areas of personal competency as determined by training and experience, and seeks consultation when questions arise.
	Keeps abreast of new scholarship and evolving notions of best practice in areas of competence through reading, continuing education, consultation, etc.
	Makes effective use of reflective practice facilitation and/or supervision.

Appendix I

Reflective Practice Facilitator/Supervisor Competencies: Tier 4

Shonkoff and Phillips (2000) stated that science has demonstrated that relationships support growth across all levels of development. Reflective supervision and practice has been defined as "a relationship for learning" (Shahmoon-Shanok, 2006). Weekly 45 to 60 minute individual or group (2 to 4 participants with a maximum size of 8 supervisees) reflective supervision meetings engage participants in the collegial, regular, and frequent act of thinking together and optimizing the work of helping young children and families. This supervision is differentiated from administrative and training supervisions as the goals do not include counting levels of service or necessarily meeting other administrative requirements, nor is the goal for one "expert" to impart their knowledge upon a less skilled or experienced mental health provider. Reflective supervision may be considered to be a "partnership formed for learning and for developing a deeper awareness about all aspects of a clinical case, especially the social, emotional, and overall interrelated complexity of developmental domains (Shahmoon-Shanok, 2006).

Reflective supervision requires several facets for successful implementation. These include; a trustworthy and responsive environment that is open to change, shared power, building of shared understanding of philosophy and practice, a focus on ethical practice, supports cross-cultural competence, amplifies calm and responsive care for clients, encourages trial action and critical thinking, and is considered to be essential for quality improvement and program accountability. Benefits of reflective practice include creating and honing a practitioner's self-knowledge, it begets initiative and effective and engaged practice, and the supervisory relationship models a "parallel process" in that providers receive support such that they can then offer support to others. Gilkerson and Shahmoon-Shanok (2000) found that reflective practice also contributes to professional identity and career development.

Given the evidence-base for reflective practice, the committee respectfully offered recommendations for development of a system for reflective practice consultation that would help to ensure the retention of competent early childhood professionals and improved outcomes for children. The following pages detail competencies for reflective practice facilitators.

I.   Clarity Regarding Roles and Ethics

- Demonstrates the ability to articulate and communicate directly and explain to the practitioner and any involved agencies or institutions his or her role as reflective facilitator, which may or may not include or overlap with additional roles in relation to the practitioner, such as clinical supervisor, administrative supervisor, consultant, mentor, tutor, proctor, etc.
- Evidences accomplishment within a particular Infant-Family and Early Childhood Mental Health orientation or conceptual framework as well as awareness of alternative Infant-Family and Early Childhood Mental Health orientations or conceptual frameworks with which she/he may be less familiar.
- Understands and can explain the legal and ethical issues pertinent to the role of the facilitator, such as when issues presented in reflective practice facilitation sessions must be referred back to program supervisors or discussed with program administrators. This entails specifically the ability to manage complex intra-and/or interagency issues around boundaries, confidentiality personnel matters and agency culture and politics in ways that promote practitioners' development, practice setting integrity and families' well-being.
- Understands that a variety of legal and ethical issues exist pertinent to a scope of practice and is able to support the practitioner in seeking clarity about these issues as needed.
- Is able to sensitively assist the practitioner in reflecting on his or her disciplinary scope of practice and the interdisciplinary nature of Infant-Family and Early Childhood Mental Health work, including, on the one hand, identifying times when additional referrals or consultation are needed for a child or family and, on the other hand, considering when there may be more professionals or agencies involved with a family than may be helpful or welcome.
- Is able to help the practitioner recognize and maintain professional boundaries in a variety of intervention/treatment settings such as home, child development center, social service system, healthy facility or other community setting.
- Is able to help the practitioner assess the strengths and limitations of their practice setting, and to consider best ways to provide services given family needs, relational and practical possibilities as well as limitations, and the need to consider interagency referral and/or collaboration.
- Can help the practitioner learn to listen closely to the family and discover the things that are important to them about their child and themselves and then collaborate with the family on behalf of the child. This means embracing the idea that intervention must be support the practitioner in seeking clarity about these issues as needed.
- Is able to sensitively assist the practitioner in reflecting on his or her disciplinary scope of practice and the interdisciplinary nature of Infant-Family and Early Childhood Mental Health work, including, on the one hand, identifying times when additional referrals or consultation are needed for a child or family and, on the other hand, considering when there may be more professionals or agencies involved with a family than may be helpful or welcome.

- Is able to help the practitioner recognize and maintain professional boundaries in a variety of intervention/treatment settings such as home, child development center, social service system, healthy facility or other community setting.
- Is able to help the practitioner assess the strengths and limitations of their practice setting, and to consider best ways to provide services given family needs, relational and practical possibilities as well as limitations, and the need to consider interagency referral and/or collaboration.
- Can help the practitioner learn to listen closely to the family and discover the things that are important to them about their child and themselves and then collaborate with the family on behalf of the child. This means embracing the idea that intervention must be rooted in a worry or a wish that a family has in relation to a child, rather than in some motivational system entirely external to the family.
- Possesses the ability to assist the practitioner to learn how to set the frame for the work as focused on parent-child relationships in spite of multiple needs and distractions.

II.   Understanding of Interpersonal Influence Issues

- Demonstrates an appreciation of the importance of relationships that is central to infant and early childhood development and mental health, as reflected in a strong commitment to consistent reflective practice facilitation meetings and attentiveness to the practitioner-reflective practice facilitator relationship.
- Possesses a basic set of skills that is both embodied by the reflective facilitator and promoted in the practitioner. These include a nonjudgmental, accepting stance; facility with interpersonal understanding and inquiry; and promotion of positive change.
- Has the ability to consider and address issues of culture, including the impact of racism, class, immigration-related issues, socioeconomic issues, etc., on families, practitioners and the practitioner-reflective practice facilitator relationship.
- Expands practitioner's understanding of how to create a feeling of reciprocity and comfort/friendliness with a family by allowing for normal everyday social interactions without losing a sense of purpose and safety about role and reason for involvement with the family (e.g., the ability to consider the costs and benefits of accepting offered tea and cookies on a home visit, ability to understand parents' worry that their children's developmentally inappropriate needs/behaviors will reflect badly upon them, etc.)
- Works with the practitioner to understand that personal characteristics, clinical context, culture, style, and professional role may unconsciously influence the interactive process with families.
- Helps the practitioner learn to observe and reflect on individual behavior and the interactive exchange with others, reflect on these processes and attribute relational meaning.
- Expands the practitioner's capacities to consider, observe and monitor impact of interactions on the family and talk with the family about this in a way that is potentially meaningful for them. In addition, facilitators should have the ability to help the practitioner expand these concepts to staff and collateral contacts and consultation relationships.

- Expands the practitioner's capacities to use self-knowledge and the ability to think about the client's experience to help formulate therapeutic responses and to act on the family's behalf in the context of collateral relationships.
- Expands the practitioner's capacity to understand and accept that each family is unique and will perceive the clinician and the intervention through the lens of their own experience and to extend this idea to work with staff and collateral contacts.
- Supports the practitioner to be able to tolerate strong affect and situations that are ambiguous realizing that these situations may involve not knowing or not understanding behaviors and motivation of the family.
- Helps the practitioner to recognize and think about experienced internal pressure that can "press" toward an emotional response and urges or wishes to act before adequate reflection or assessments are made. (As Clinical Professor in Psychiatry and Director of the Infant/Parent Program at the University of California-San Francisco Jeree Pawl has said, "Don't just do something, stand there!")

III. Facilitation Skills

- Has an ability to understand the developmental level of the practitioner and tailor reflective practice facilitation sessions to individual needs.
- Is able to set a tone, plan and sequence the use of time in the reflective practice facilitation sessions that helps the practitioner regulate his or her thoughts and emotions so they can think about and experience their work in new ways.
- Possesses basic group skills that support and develop practitioner abilities. Such skills include awareness of and the ability to address unconscious group dynamics, patterns of role assumption in groups, challenges of "airtime" sharing and other group resource sharing issues, group/infant family parallel process possibilities and the hearing/transformative potential of collaborative processes.
- Inspires confidence in Infant-Family and Early Childhood Mental Health principles and practice that lead to the practitioner's ability to be effective at outreach and relationship-building, successfully engaging families that might otherwise miss needed services.
- Helps practitioners working in nontraditional settings, such as shelters, medical facilities and early care and education and in developing ways to integrate Infant-Family and Early Childhood Mental Health principles into a variety of settings.

Appendix K

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