Infant and Early Childhood Mental Health Task Force – Introductory Session

Rhode Island Executive Office of Health & Human Services
November 17, 2022

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Today's Agenda

- Welcome & Opening Remarks
- Charge: Planning Scope/Review of Legislation
- Overview of Infant/Early Childhood Mental Health
- Landscape Overview and Discussion: Preliminary Assessment of IECMH in RI
- Reflection on the Infant/Early Childhood Mental Health Experience
- Open Discussion
- Process & Next Steps

Charge: Planning Scope/Review of Legislation

In the 2022 Rhode Island legislative session, the General Assembly passed legislation directing the Executive Office of Health and Human Services to establish a task force to develop a plan to improve promotion of social and emotional well-being of young children as well as screening, assessment, diagnosis, and treatment of mental health challenges for children from birth through age five (5) with Medicaid coverage.

Please see the full legislation here:

http://webserver.rilin.state.ri.us/BillText22/HouseText22/H7801.pdf

Early Childhood Infant Mental Health Planning

Landscape Overview and Discussion:

Preliminary Assessment of IECMH in RI

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Preliminary Current State Assessment

- **Goal**: EOHHS asked our consultant to carry out a preliminary assessment of the current state and identify areas that need further discussion and consensus building.

- As a preliminary assessment, what you will hear today is robust – but there are gaps that we aim to continue to fill.

- However, we hope it is a good start and will provide an overall picture of the components of the early childhood system and serve as a foundation for discussion during the planning process about opportunities where we can strengthen our system of early childhood mental health.

- As we review and discuss these slides, please use the chat to point out gaps and ask questions.

Key Informants for Preliminary Interviews

- Susan Dickstein, Director, RI Association of Infant Mental Health
- Rebecca Silver, PhD, Staff Psychologist, Bradley Hospital
- Christine Low, PhD, Chief Psychologist, Bradley Hospital
- Cynthia Miller Loncar, PhD, Director of Clinical Services at the Center for Children and Families
- Margaret Howard, PhD, Division Director, Women's Behavioral Health, Women & Infants Hospital
- Dr. Pat Flanagan, Clinical Director and co-director of RI PCMH-Kids
- Dr. Beth Lange, Co-director of RI PCMH-Kids, Past President of the RI Medicaid Society
- Simmy Carter, Associate Director, Providence Center Early Childhood Institute, Director Imagine Preschool
- Jenn Kaufman, Part C Coordinator, EOHHS
- Ruth Gallucci, 619 Coordinator, RIDE
- Leanne Barrett, Senior Policy Analyst, RIKIDSCOUNT
- Kaitlyn Rabb, Policy Analyst, RIKIDSCOUNT

Outline of Components

- Screening
- Assessment/Evaluation
- Diagnosis
- Evidence-based Family-Child (Dyadic) Treatment
- Evidence-based Family-Child Group Interventions/Programs
- Workforce Development
- Workforce Registry
- Evidence Informed Family-Child Programs Supporting Social and Emotional Well-Being

Key Informant Feedback: Screening

	Pediatricians	Family Visiting	Child Outreach	Early Head Start/Head Start	Child Welfare
Current Related Practices	Use a standardized tool (SWYC, ASQ or PEDS) to screen for development. EPSDT screening schedule includes psycho-social BH assessments and routine maternal depression screening. Assessment of early relational health is often based on provider observations and parent responses. Well child visits not long enough to support in-depth assessment for BH.	Family visiting providers routinely screen for a variety of ACEs and social emotional health. First Connections uses the HOME Parent-Child Interaction tool to assess the quality of parent-child interactions	The goal of Child Outreach is to screen each child between the ages of 3-5 each year, prior to kindergarten. RI PreK and Head Start have goals to screen 100% of their children During the 21-22 school year, 23% of RI's 3-5-year-olds were screened.	Agencies are required to screen across five areas of development including social emotional. A specific tool is not prescribed. Many agencies choose to use the ASQ-SE.	FCCP does the Strengths, Needs, Cultural Discovery assessment which includes a consideration of development and education. If a developmental need is identified, children are referred to Early Intervention or First Connections for further screening. If there is a clearly identifiable BH need, young children are referred to Bradley PediPartial, the Providence Center Early Childhood Institute, or a private provider. There are often long wait lists.
Payment	Can bill for screening but not enough time allowed for the depth and breadth of required screening.	Screening is included as part of the family visit.	Child Outreach screening is paid for by LEAs using small amounts of IDEA funding distributed to school districts and local dollars.	Not applicable	Not applicable

- Approaches to screening for social emotional development vary depending on the setting.

*E.g. Infant Toddler Social Emotional Assessment or (Brief Infant Toddler Social Emotional Assessment.

Key Informant Feedback: Assessment/Evaluation

	Early Intervention	Early Childhood Special Education	Clinical Psychologists
Current Related Practices	Uses the Bayley Scales of Infant and Toddler Development or the Battelle Developmental Inventory to assess all areas of development including social emotional. Some agencies have other tools to further assess social emotional development.* But these are not commonly used.	LEAs use different assessment tools and assess all areas of development including social emotional development. For example, the BASC-3 | The Behavior Assessment System for Children and Devereux Early Childhood Assessment" (DECA) Special education is focused on the child so the relational health with the family is not a factor for eligibility. IEPs are developed for eligible children identifying the goals and services for that child. Primary focus are specific interventions and supports needed to support learning so the child can meet the standards set for all children.	Approach varies. Likely that most are using direct observation based on their training. The Early Childhood Institute at the Providence Center is using the Bruce Perry Neurosequential model for assessment.
Payment	Family training counseling covers ongoing assessment. Medicaid rates increased for Early Intervention providers.	Child Outreach screening is paid for by LEAs using small amounts of IDEA funding distributed to school districts and local dollars. Schools may also receive formula funding.	The diagnostic intake allows for in-depth assessment over multiple visits.

Note: this overview is pending input from a psychiatrists specializing in infant and early childhood..

*E.g. Infant Toddler Social Emotional Assessment or (Brief Infant Toddler Social Emotional Assessment.)

Key Informant Feedback: Diagnosis

	Pediatricians	Clinical Psychologists
Current Related Practices	Many seem to be using the DSM (built into billing system). Agree that the DC:0-5 is the gold standard and more appropriate for infants and young children. Feel the DC: 0-5 would help them by providing evidence based age-appropriate diagnostic criteria for young children and increase identification of children with mental health needs. With either tool, they are conceptualizing a diagnosis driven problem-intervention strategy. They would like the system to focus upstream on early relationships as a building block for life. Feel that adoption of the DC: 0-5 would take significant technology and training resources and should not be the first priority.	Many seem to be using the DSM (because it is connected to billing). Those that are currently using the DC: 0-5 are using it with families to help them understand what is happening with their children. Agree that the DC:0-5 is the gold standard and more appropriate for infants and young children. Did not think the use of the DC:0-5 would significantly change identification, access to treatment, or outcomes. Feel that adoption of the DC: 0-5 would take significant technology and training resources and should not be the first priority. Stressed that it is important to be clear about when it is helpful for kids to have a diagnosis.
Payment		Clinical psychologists have a billing mechanism that would allow for evaluation and diagnosis over multiple visits.

*Note: Children do not need a diagnosis to access Early Intervention or Special Education services and those programs do not use a diagnostic framework to determine eligibility (although a diagnosis could inform eligibility determination.) Mental Health Consultants are also not diagnosing.

Key Informant Feedback: Evidence-Based Family-Child (Dyadic) Treatment

- Evidence-based dyadic treatment includes evidence-based modalities such as:
  - Attachment and Biobehavioral Catch-Up (ABC)
  - Child-Parent Psychotherapy (CPP)
  - Infant-Parent Psychotherapy (IPP)
  - Parent-Child Interaction Therapy (PCIT)
  - Stanley Greenspan Floor Time

- There are a limited number of clinical psychologists trained to provide family-child interventions or dyadic therapies.
  - Note: FSRI is current pursuing funding to implement Parent-Child Interaction Therapy

- Rates of reimbursement for social-emotional health services are so low in Rhode Island, it is hard to retain clinicians (they leave to go work in CT or MA)

- Licensed clinicians can bill Medicaid for dyadic therapy under family therapy.

- Licensed Early Intervention social workers could bill dyadic interventions as a visit (if they were trained to provide them)

Key Informant Feedback: Evidence-Based Group Family-Child Interventions

- Evidence-based group family-child interventions include programs such as:
  - Circle of Security-Parenting (COS-P)
  - Incredible Years (IY)
  - Nurturing Family (NF)
  - Positive Parenting Program (Triple P)
  - Strong Roots programs

- Most early interventionists and family visitors are not currently trained to provide group-based family-child interventions with some exceptions.
  - FSRI and Looking Upwards uses Circle of Security as a component of their EI program
  - Looking Upwards implements Incredible Years
  - Children's Friend is training staff working with families enrolled in EHS in Strong Roots

Key Informant Feedback: Mental Health/Reflective Supervision Consultation

There are a limited number of MH Consultants in RI; consultants are grant-funded

	Early Care and Education	Family Visiting
Current Related Practices	SUCCESS provides mental health consultation to early learning programs (center-based and family child care). Implemented by the Early Childhood Collaborative at Bradley. SUCCESS child-focused consultation services in center-based settings include: ● Brief consultations of individual children using observations, questionnaires, and conversations with program staff and children's caregivers. ● Feedback, recommendations, and action planning. ● Follow-up supports to integrate consultation recommendations SUCCESS consultation for FFC Educators includes group-based IECMH series. RIDE and DHS are piloting Coordination of Care Teams within select ECE programs to promote reflective conversations about social, emotional, and behavioral supports at the classroom and program level (facilitated by SUCCESS). SUCCESS provides foundational trainings and monthly workshops on Reflective Practice and Supervision for ECE supervising professionals. RIDE Pre-K Staff and administrators have the opportunity to participate in the Conscious Discipline professional development series.	Early Childhood Collaborative at Bradley partners with RIDOH to: - provide foundational training to the RI Family Visiting programs on Reflective Practice and Supervision.* - facilitate year-long RP/S skill-building groups for supervising staff from Family Visiting programs*. - provides mental health consultation to RIDOH supported Family Visiting programs utilizing a Coordination of Care Team model (informed by RP/S principles; reflective conversations about social, emotional, and behavioral needs of children/caregivers). *Audience may include family visiting programs - broadly defined in RI) RIAIMH is also providing mental health and reflective supervision consultation to family visiting, early intervention, and early care and education programs.
Funding	DHS/RIDE	RIDOH

IECMH Provider Workforce Development

- Most interviewees identified workforce development/training as the most important priority.

- The Rhode Island Association for Infant Mental Health (RIAIMH) offers Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health® (RI-IMH-Endorsement®), a cross-sector and multidisciplinary endorsement that is recognized internationally. (Professionals from child and/or human development, education, nursing, pediatrics, psychiatry, psychology, and social work can obtain endorsement)

- RIAIMH sponsors many professional development opportunities (e.g. Community Conversations Series, etc.) every year to educate professionals about the latest infant mental health research and policy developments, and help professionals apply evidence-based principles in their practice.

- The Center for Evidence-Based Practice (CEBP) at the Bradley Learning Exchange provides:
  - Teacher Classroom Behavior Management Program for professionals working with children ages preschool through grade 3 in childcare and educational settings (for example, classroom teachers, teacher assistants, guidance counselors, mental health workers, social workers and others).

  - Incredible Beginnings™ Program for professionals working with children 1 to 5 years old in childcare and educational settings to provide an environment that supports children's optimal early development.

IECMH Provider Workforce Development, continued

- Brown's offers a five-year Triple Board Program, one of the original six in the country that includes: 2 years of pediatrics; 18 months of general psychiatry; and 18 months of child and adolescent psychiatry. It does not have a dedicated IMH track. Graduates of the Triple Board Program are board-eligible in all three disciplines. Most of them do not remain in RI.

- Brown Medical School has a Psychology Training Consortium which provides pre-doctoral and post-doctoral training for psychologists who want to specialize in early childhood.

- RIAIMH in partnership with the Sherlock Center at RIC, and EOHHS are facilitating a learning collaborative for EI supervisors on infant/early childhood mental health.

IECMH Provider Registry

- No registry of trained professionals currently exists in Rhode Island.

- Most interviewees agreed that a registry of trained professionals was a very important priority (second to training)

Evidence-based or Evidence Informed Family-Child Programs Supporting Social and Emotional Well-Being

There are a number of family-child programs supporting social emotional health in RI (access is program criteria dependent)

EVIDENCE-BASED

- Nurse Family Partnership
- Healthy Families America
- Parents as Teachers
- Early Head Start
- Family Care Community Partnership (FCCP)
- Early Intervention
- SafeCare
- Brazelton TouchPoints
- The Greatest Eight

EVIDENCE-INFORMED

- RI Children's Museum Visitation Program
- FSRI Visitation Program
- CCA Nurturing Early Connections Visitation Program
- “Family Music Time with the Phil”
- Literacy and language skills promotion
- The Autism Project programming
- Family coaching and other supports through the Dunamis Program
- Nurturing Family program

Planning Questions

- What is our vision for a IECMH system in Rhode Island?
  - What IECMH best practices do we want to prioritize for implementation in RI?
- How can Medicaid help facilitate the implementation of IECMH best practices in RI?
- In what areas do we need to clarify provider billing, referral, and treatment processes for IECMH services?
- Do new provider types or settings need to be recognized in RI Medicaid policy to strengthen access to IECMH services?
- What must we do to address and respond to the intergenerational effects of racism, economic insecurity, and toxic stress within the IECMH system?

EPSDT

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Key:
- • To be performed
- ★ Risk Assessment to be performed, with appropriate action to follow, if positive
- ←→ Perform within indicated time frame

		Infancy							Early Childhood						
	Prenatal	Newborn	3-5 days	By 1 Mo	2 Mo	4 Mo	6 Mo	9 Mo	12 Mo	15 Mo	18 Mo	24 Mo	30 Mo	3 Yrs	4 Yrs
History															
Initial/Interval (1)	• (2)	• (3)	• (4)	•	•	•	•	•	•	•	•	•	•	•	•
Measurements															
Length/Height and Weight		•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference		•	•	•	•	•	•	•	•	•	•	•			
Weight for Length		•	•	•	•	•	•	•	•	•	•				
Body Mass Index (5)												•	•	•	•
Blood Pressure (6)		★	★	★	★	★	★	★	★	★	★	★	★	•	•
Sensory Screening															
Vision (7)		★	★	★	★	★	★	★	★	★	★	★	★	•	•
Hearing		• (8)	• (9)	←	→	★	★	★	★	★	★	★	★	★	•
Developmental/Behavioral Health															
Developmental Screening (11)								•			•		•		
Autism Spectrum Disorder Screening (12)											•	•			
Developmental Surveillance		•	•	•	•	•	•		•	•		•		•	•
Psychosocial/Behavioral Assessment (13)		•	•	•	•	•	•	•	•	•	•	•	•	•	•
Tobacco, Alcohol and Drug Use Assessment (14)															
Depression Screening (15)															
Maternal Depression Screening (16)				•	•	•	•								

Open Discussion

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Process & Next Steps

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Process & Next Steps

Meeting cadence and structure

- 5-7 meetings between November and April
- Submit final report in May

Guiding questions for each meeting

- What training is happening right now? What is the current state analysis?
- What are the perspectives of providers on the registry?
  - *(We will collect these pre-meeting and share them before we gather together.) Is our pre-work correct?*
- Nationally, what are the best practices?
- What must we do to address and respond to the intergenerational effects of racism, economic insecurity, and toxic stress within these topics?

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