Meeting the Social-Emotional Development Needs of Infants and Toddlers:

Guidance for Early Intervention Program Providers and Other Early Childhood Professionals

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Meeting the Social-Emotional Development Needs of Infants and Toddlers: Guidance for Early Intervention and Other Early Childhood Professionals

Preface

"Healthy social and emotional development refers to an infant's capacity to experience, manage, and express a full range of positive and negative emotions; develop close, satisfying relationships with others; and actively explore environments and learn. All this takes place in the context of family, community, and culture. The area of practice that focuses on social and emotional development in the early years is often referred to as 'infant mental health' or 'early childhood mental health'. The practice of infant mental health includes promoting healthy social and emotional development, preventing disorders, and intervening where infant mental health disorders exist (ZERO TO THREE, 2009)."

The quality of young children's relationships and environments has a profound influence on their brain architecture. Over the past decade, research has clearly shown that the brain architecture of children before the age of 5 has a phenomenal influence on their social, emotional, language, memory, physical, and cognitive development. We know that the lines of development are intimately and inextricably interlaced and social-emotional development is integral to mastery of all related areas (Foley and Hochman, 2006). As Jack Shonkoff, M.D. notes, "Healthy development depends on the quality and reliability of a young child's relationships with the important people in his or her life, both within and outside the family. The development of the brain's architecture depends on the establishment of these relationships (National Scientific Council on the Developing Child, 2004)."

Social-emotional development has by its very nature a strong relationship focus. The centrality of relationships in infant/toddler development makes addressing the social-emotional development needs of young children different from working with children in other domains of development that typically focus on either the child or the parent. In the social-emotional domain, the relationship is the focus and is not just limited to the parent-infant relationship, but also includes positive working relationships between caregivers and service providers (Zeanah et al, 2005).

This guidance was created to inform the wide range of adults who work with young children, from family child care providers to pediatric primary care providers to Early Intervention Program providers, of strategies they can build upon to strengthen positive relationships with children and their families, share empowering information, join with parents to promote and strengthen all areas of their child's development, including the social-emotional domain, and provide linkages to needed supports and services when indicated.

A. Purpose and Background
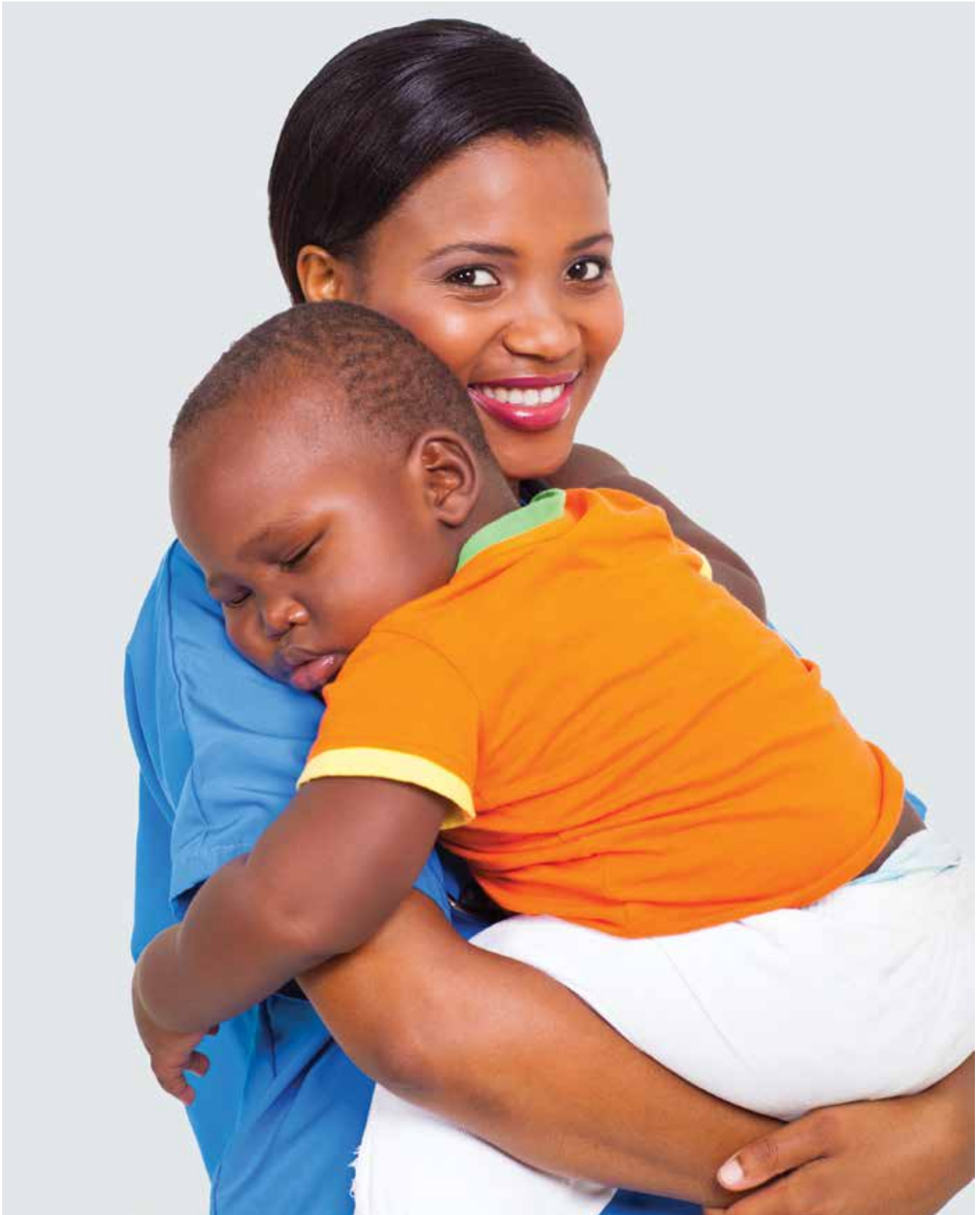
Purpose

The intent of this document on social-emotional development is to provide guidance to the wide variety of professionals who touch the lives of infants and toddlers and their families across the broad array of early childhood programs and services, including the Early Intervention Program for infants and toddlers with disabilities, early education, child welfare, health and mental health care, home visiting and other kinds of child and family supportive services provided to very young children and their families.

This guidance was written to achieve the following four objectives:

1. **Ensure that the general population of young children receive routine and ongoing screening of children's development, including social-emotional development.** Social-emotional development and positive social relationships are foundational for infants and toddlers and relate to all other areas of development – there is increasing emphasis on ensuring that primary care providers and other early childhood professionals understand the importance of social-emotional development and screen early and continuously for potential problems in this area, so that timely referrals can be made to the Early Intervention Program and other supports and services when needed.

2. **Identify children at-risk of experiencing a social-emotional development delay or disability and ensure that their families receive the assistance they need from the wide array of early childhood programs and services.** Infants and toddlers whose family and life circumstances make it more challenging to form stable and positive attachment relationships to caregivers, including children whose families are coping with poverty or lacking in social supports, who are exposed to trauma and violence, or experiencing other social and economic factors that impact health and development may be at higher risk for problems with social-emotional development and positive social relationships. Social-emotional development and positive social-emotional relationships can be promoted and supported, and problems potentially

avoided or ameliorated, when infants and toddlers are identified as early as possible and the family is linked to necessary services. These services should include ongoing screening and surveillance through primary health care providers and/or the Early Intervention Program to ensure a timely referral to the Early Intervention Program if a problem or delay in social-emotional development is identified or suspected.

3. **Improve the early identification of children who may already be experiencing developmental delays in social-emotional development.** It is important that professionals who work with infants and toddlers – primary health care providers, early childhood educators, home visitors - know how to identify clinical clues and potential delays and when and how to refer to the Early Intervention Program for evaluation and services. It is especially important that early childhood professionals understand that a delay in social-emotional development, or a diagnosed condition with a high probability for resulting in a developmental delay, is a sufficient reason to refer children to the Early Intervention Program for a multidisciplinary evaluation and assessment to determine program eligibility.

4. **Ensure that evaluations and assessments for all children in the Early Intervention Program adequately address the area of social-emotional development, and service coordinators, evaluators, and providers who are delivering Early Intervention services understand the importance of and pay attention to this area of development.** All children referred to the Early Intervention Program with a suspected developmental delay or disability must receive an evaluation and assessment of all five areas of development (communication, cognitive, physical, adaptive, and social-emotional development), regardless of the primary area of concern. It is very important that Early Intervention Program providers recognize the important role of social-emotional development and positive social relationships to an infant's and toddler's overall developmental progress. In addition, it

is very important for Early Intervention service providers to understand, recognize, and address the impact of diagnosed conditions and developmental delays in these other areas of development on children's social-emotional development and positive social relationships.

To achieve these objectives, this document provides information to increase the knowledge and expertise of the early childhood work force on the research supporting the importance of social-emotional development on the overall development of the child and the key factors that influence healthy development. It provides guidance to parents and professionals on strategies and best practices to support positive social-emotional development including suggestions on how to identify and intervene at the earliest possible point when concerns are noticed. Specific suggestions are made for how early childhood educators, home visitors, health care providers and early interventionists can address the social-emotional development needs of the children they serve. It includes information on the clinical clues that parents and professionals should look for that may indicate that a child and family is struggling and needs supports and services to promote healthy social-emotional development and positive social relationships. For those times when a problem seems to be indicated, guidance is provided to professionals on how to effectively talk to a parent about a concern regarding a child's developmental progress and how to make referrals to needed supports and services.

The document includes specific guidance to professionals working within New York State's Early Intervention Program, including primary referral sources, initial services coordinators, evaluators, Individualized Family Service Plan (IFSP) team members, ongoing service coordinators, and service providers. Information is provided throughout this section on specific factors that need to be considered at each point in the system and how to ensure that the right course of action is employed to best meet the needs of the child and his or her family. This includes children who have been referred to the Early Intervention Program with a suspected delay or disability in social-emotional development, as

well as information on how to address the social-emotional development needs of children in the program who have a delay or disability in another domain of development.

Guidance is provided on how to build mutually supportive relationships with parents, with particular attention given to supporting decision making regarding developmental concerns and, when a delay or disability is suspected, how to make a referral to appropriate services including the Early Intervention Program. To support making an appropriate referral, information is provided on the wide range of national and state resources that are designed to assist families with young children. Also included is guidance on planning for and helping children and families make effective transitions between programs. Finally, information is provided on professional development opportunities that are available to support them in developing the skills needed to effectively address the social-emotional development needs of young children and their families.

Background

This document is the culmination of the joint efforts of two New York Governor-appointed bodies – the Early Intervention Coordinating Council and the Early Childhood Advisory Council. The Early Intervention Coordinating Council is established in Public Health Law and is a 27-member, Governor-appointed body charged with advising and assisting the Department of Health as Lead Agency for the Early Intervention Program. Part C of the Individuals with Disabilities Education Act (IDEA) requires that states establish an advisory group which must include parents of children with disabilities, public and private providers of early intervention services, an individual engaged in personnel preparation, a Head Start representative, and state governmental agencies. The Early Intervention Coordinating Council assists the Department of Health with the administration of the Early Intervention Program and makes recommendations to the Department regarding appropriate services for infants and toddlers with disabilities and their families.

The Early Childhood Advisory Council was established in 2009, and is co-chaired and

administratively hosted by the New York State Council on Children and Families, to provide advice to the Governor and the Commissioners of the state health, education, and human service agencies on the development of a comprehensive system of supports and services for young children and their families. Early Childhood Advisory Council members include people with expertise in such issues as early childhood education, health and mental health care, child welfare services, home visiting, and parenting education. The Early Childhood Advisory Council supports the state by monitoring and guiding the implementation of a range of strategies to achieve its vision – "All young children are healthy, learning, and thriving in families that are supported by a full complement of services and resources essential for successful development."

The two Councils decided to work together on the development of this guidance due to the importance of the issue and the shared concerns for the large numbers of children and their families who are struggling with social-emotional development issues and the need to strengthen the current system of services to effectively meet these needs.

The Early Intervention Program is the statewide system for infants and toddlers birth to age three years with disabilities. The program is under Part C of the Individuals with Disabilities Education Act and Title II A of Article 25 of public health law. To be eligible for early intervention services, children must meet the State's criteria for developmental delay in one or more areas of development (cognitive, communication, physical, social-emotional, adaptive); or have a diagnosed physical or mental condition with a high probability of resulting in developmental delay (such as Down syndrome, autism spectrum disorder, cerebral palsy, etc.). Under State law, New York's Early Intervention Program also provides screening and tracking services for children at risk of developmental delays or disabilities (New York State Department of Health Early Intervention Program, n.d.). For children who meet the eligibility criteria for the Early Intervention Program, an Individualized Family Service Plan (IFSP) is developed, and services included in the plan are provided at no cost to families. The Early

Intervention Program is administered locally by the 57 counties and New York City (New York State Department of Health Municipal County Contacts, n.d.). Each municipality has an Early Intervention Official responsible for ensuring that children who are potentially eligible for Early Intervention Program services are identified, located, evaluated, and if found eligible, receive an IFSP and early intervention services. Early Intervention Officials are also responsible for ensuring at-risk children are periodically screened, tracked, and referred to the Early Intervention Program if a developmental delay or disability develops or is suspected.

Critical Concepts for Understanding Social-Emotional Development

The following are important concepts related to social and emotional development in young children as an introduction to this topic.

Social Development: Social development refers to a young child's ability to create and sustain social relationships with adults and other children. "Social Development means learning to form and value relationships with others. Intimate and caring relationships are the basic structure within which all meaningful development unfolds. Social development begins in infancy, when infants respond to the familiar voice, smell, and touch of the important people in their lives. When these first social experiences are rewarding, they support the next stage in social development. A toddler's excited exploration of new places is enabled by a secure relationship with a trusted adult who provides a base for the child's discoveries. Toddlers learn to share, cooperate, take turns, compromise, and negotiate through relationships (Michigan Department of Community Health, 2003, pg. 10)." As children grow older, their relationships with peers take on greater importance.

As children grow and face challenges, they have opportunities to learn skills such as cooperation, negotiation, appreciation for other people's needs and rights. This leads to the ability to sometimes put aside their own needs and desires to meet the needs of others. "The ability to relate with adults and other children and to learn from others influences the infant's development in all

of the other domains. As the child's interaction skills grow, the child learns from others through imitation and communication. Language learning, problem solving, fantasy play, and social games all depend on social development. With proper support, the infant eventually develops the ability to participate in a social group. Successful social development during the first three years prepares the child for preschool and school (Ohio Child Care Resource and Referral Association, 2006, pg.29)."

Emotional Development: "Emotional development is closely related to social development and refers to the young child's feelings about himself or herself, the people in his or her life, and the environments in which he or she plays and lives (Michigan Department of Community Health, 2003, pg. 11)." It includes the child's ability to recognize, express, and manage feelings and to understand and respond to the feeling of others. Healthy emotional development is the ability to handle a full range of emotions – from joy to sadness to frustration and anger - in appropriate ways. Learning to manage powerful emotions, and maintain focus and attention, also referred to as self-regulation, is a process that develops over time through reciprocal interactions with the adults in their lives.

The Center for the Developing Child at Harvard University calls these interactions, "serve and return" (Center for the Developing Child, 2015). These bi-directional interactions provide the child with cues that develop strong or weak emotional ties to caregivers. Emotions, such as delight, frustration, distress, color the child's experience and offer a window into their emotional development. An infant responds strongly to physical discomfort, including hunger and fatigue. An infant's emotional behavioral repertoire is basic, ranging from cooing to crying, and is shaped by temperament. Toddlers are developing a range of emotions. They may have tantrums, act out, or get easily frustrated. This is also a time when a child begins asserting independence by preferring to try to do things "myself" without help. Under most circumstances, these behaviors are typical for the child's age and development and are not a cause for concern.

Family Relationships: Relationships are key to young children's development and they matter as early as the first few days of infancy. For this reason, supports to address this domain in young children should always be relationship based - meaning services delivered to children and parents are family-centered, that children are served within the context of care giving relationships, joint child-parent therapy sessions are held, and as needed, parents and caregivers receive professional supports and services along with their children.

Attachment: "Attachment refers to the emotional relationship that develops between an infant and the primary caregiver, most often a parent, during the infant's first year of life. An infant's secure attachment to his or her parents is regarded as the 'seminal event' in a person's emotional development – the primary source of a child's security, self-esteem, self-control and social skills. Through this one incredibly intimate relationship, a baby learns how to identify his or her own feelings and how to read them in others (Eliot, 1999)." "It is a relationship that develops over time and is the result of many interactions and care giving experiences, particularly those in response to the infant's needs and bids for attention, comfort and protection" (Michigan Department of Community Health, 2003, pg. 11). "A child who experiences responsive, nurturing, consistent care giving is more likely to be securely attached and develops a positive self-image. Through predictable and responsive relationships with primary caregivers, babies and young children learn to trust that the world is a safe place to explore. From this secure foundation, children learn and master the skills they need to be successful in school and throughout their lives (Children's Behavioral Health Initiative, 2015, pg.7)."

Trauma and Resilience: Trauma occurs when a child experiences an intense event that threatens or causes harm to his or her emotional and physical well-being. "Young children who experience trauma are at particular risk because their rapidly developing brains are very vulnerable. Early childhood trauma has been associated with reduced size of the cerebral cortex. This area of the brain is responsible for many complex

functions, including memory, attention, perceptual awareness, thinking, language, and planning and organization. These changes may permanently affect intellectual ability, and the ability to regulate emotions, and the child may become more fearful and may feel less safe or protected (National Child Traumatic Stress Network, n.d.-a)." In addition to experiencing one or more traumatic events, experiencing multiple adverse childhood experiences (e.g., poverty, domestic violence, parental substance abuse, homelessness) can negatively affect young children's development and have cumulative power to undermine good outcomes. Numerous studies of children show that the accumulation of exposure to multiple adversities over time intensifies their harm and can overwhelm existing protective factors.

Although stressful or traumatic events in early childhood can contribute to developmental delays, there are a number of factors that promote adaptability, or resilience. Neural connections that are used more often become stronger, meaning that repeated, regular, positive communication between a caregiver and infant will likely lead to more secure attachment, even if the infant experiences occasional adverse experiences, or has previously experienced such events. This is one reason why consistency is important during infancy and early childhood. While there are some innate personality traits that promote positive coping in children, such as being "active, affectionate (and) cuddly," there are also resources for caregivers to use in promoting these traits. Caregivers of children who have experienced traumatic or ongoing adverse experiences can benefit from information about early interventions to address trauma and promote the development of resilience. Young children may be able to overcome the effects of adverse events through consistent, predictable, supportive interactions (Child Trends, 2015)."

ADDITIONAL RESOURCES

Brazelton, T. B. (1992). Touchpoints: *Your Child's Emotional and Behavioral Development.* Boston, MA: Addison-Wesley.

Brazelton, T. B. and Greenspan, S. (2001). The Irreducible Needs of Children: *What Every Child Must Have to Grow, Learn, and Flourish.* Cambridge, MA: Perseus Publishing.

Eliot, L. (1999). *What's Going on in There? How the brain and mind develop in the first five years of life.* New York, NY: Bantam Books.

National Education Association,(2015). *Brain Development Resources,* Retrieved from www.nea.org/tools/lessons/brain-development-resources.htm

New York City Early Childhood Strategic Workgroup, (2011). *Promoting the Mental Health and Healthy Development of New York's Infants, Toddlers and Preschoolers: Advancing the Agenda, Sustaining the Gains: A Call to Action.* June. Retrieved from www.nyccd.org/a-call-to-action.php

US Department of Health and Human Services, (n.d). Pathways to Prevention: Key Concepts. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/hs/resources/ECLKC_Bookstore/PDFs/27B 9EA2E8C611854D47E47984BF46274.pdf interventions to address trauma and promote the development of resilience. Young children may be able to overcome the effects of adverse events through consistent, predictable, supportive interactions," (Child Trends, 2015).

B. Importance of Social-Emotional Development for Infants and Toddlers

B. Importance of Social-Emotional Development for Infants and Toddlers[1]

Advances in neuroscience, developmental psychology and prevention science provide compelling evidence that the foundation for health is established in early childhood. More is known now than ever before about how very young children learn, think and grow. "All children are born eager to explore their world and master their development. From conception to 36 months, development proceeds at a pace exceeding that of any other stage of life. Infants and toddlers rapidly develop capabilities for self-regulation, relationships, learning, motor development, and language. These capabilities form the foundation from which all future development builds. Whether that foundation is sturdy or fragile depends to a great degree on the quality of the young child's early environments and relationships (Michigan Department of Community Health, 2003, pg. 11)."

Healthy social and emotional development begins at birth with attachment to a primary caregiver, typically a parent or other adult family member. According to John Bowlby's theory of attachment, a child is "attached" to someone when he or she is "strongly disposed (even 'genetically primed' as a survival strategy) to seek contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill" (Bowlby, 1969). "The young child's identity is shaped by the interactions they have with others who are significant in their lives – parents, childcare providers, and other family members (Michigan Department of Community Health, 2003, pg.5)." When the relationship is reliable and responsive, the child feels loved, important, and worthy (valued).

These early relationships are very important to children's healthy development across all developmental domains. "Relationships enable young children to care about people by establishing the human connection between self and others. As a consequence of early relationships, young children seek to understand the feelings, thoughts and expectations of others, as well as the importance of cooperation and sharing (Michigan Department of Community Health, 2003, pg.5). Children are able to gradually expand their relationships with other adults and children, building trust in the larger world as a place to explore and learn with confidence."

Research has opened the door to how a child grows and develops. We now know that infants and toddlers develop at a rapid pace building skills in social-emotional development, learning, motor development, and communication that will become the foundation for future growth. Their ability to form a strong foundation for development is influenced by many factors. The following four factors are especially important:

Connection: Infants thrive in close predictable relationships that support not only their basic needs but their emotional need for human connection. "At birth an infant's brain has about 100 billion nerve cells – nerve cells that have not yet formed the critical connections that determine a child's emotional, social and intellectual makeup. Research shows that these critical connections are primarily formed by attentive care and nurturing stimulation from the outside world. Since parents are a young child's first teachers, they can deeply affect the "wiring" of the brain through interaction with their infants, toddlers and preschoolers. Other primary caregivers, including child care providers, grandparents, and other family members, also deeply affect the young child's brain development through their interactions. Repetitive, positive experiences like singing, cooing, touching, holding, talking and reading..." (Michigan Department of Community Health, 2003, pg.6) are also known as "serve and return" interactions and shape brain architecture. When an infant or young child babbles, gestures, or cries, and an adult responds appropriately with eye contact, words, or a hug, neural connections are built and strengthened in the child's brain. This brain activity supports the development of communication and social skills (Center for the Developing Child, n.d.).

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[1] A portion of this section was drawn from "Social-Emotional Development in Young Children- a guide produced by the Michigan Department of Community Mental Health" (2003).

"Also essential to the young child is the experience of communicating a need or a want – for example, to be picked up or played with – and having that need or want promptly met. Simple interactions such as these help young children to learn that they can have a positive impact on their world. Young children are encouraged to communicate through these interactions and begin to learn the basics of "cause and effect" thinking. The foundation for understanding the consequences of choices and action in the preschool years begins with these simple interactions between the young child and his or her primary caregivers (Michigan Department of Community Health, 2003, pg.6) The quality of early relationships has a far more significant influence on early learning than has previously been understood."

It is also important to recognize that development for some children can be compromised due to exposure to a range of stresses early in life such as the circumstances into which they were born, their environment, genetic or congenital developmental impairments. Abusive or neglectful parenting/care giving in the earliest years can also compromise the young child's growth and development. "We now know that infants and toddlers who are exposed to trauma and violence are more likely to have developmental delays, exhibit aggressive behaviors and have learning problems into their school-age years when their caregivers are physically and/or emotionally unavailable to help them cope with that trauma," (Mendez, M., Simpson, T., Alter, A., Meyers,J., 2015).

Responsive and consistent care: The quality of a child's attachments impacts a child's development. Response and consistent caregiving by a primary caregiver, usually a parent, is strongly related to the quality of attachment. "Virtually all young children develop deep emotional attachments to those who care for them. Secure attachments arise from the warmth and sensitivity of the adult's care. Caregiving described as sensitive, consistently responsive, comforting and appropriate generally results in an attachment that is stable, enduring and secure. It is within the security of this relationship that an infant or toddler feels safe and confident, able to

explore the world with curiosity and enthusiasm. Caregiving described as unresponsive, rejecting, hostile, inconsistent or intrusive may lead to an attachment that is called insecure. An insecure attachment places the infant or toddler at risk of social, emotional or cognitive delays (Michigan Department of Community Health, 2003, pg.8)."

"The extent to which young children are able to rely on their parents and caregivers, especially in challenging or threatening circumstances, is based on the support they have received from these caregivers in the past (Michigan Department of Community Health, 2003, pg.8)." Responsive consistent care is an especially important consideration in early childhood settings where transitions in staffing and moving children to new rooms as they age are common.

Parental well-being: Parenting is both greatly rewarding and a daunting task for anyone. According to Bright Futures, a publication of the American Academy of Pediatrics, there are some attributes of parenting that can apply across children's developmental stages. There are also some general issues that can affect parenting regardless of a child's age. These include physical safety of the family's home and community, their cultural beliefs, parental education and attitudes toward parenting, parenting skills, family composition and emotional environment of the home (Hagan, J.F., Shaw, J.S., & Duncan, P., 2008).

Adapting to the role of parenting of infants is a stressful life event. In fact, becoming a parent may trigger long forgotten events that cause distress. In addition, there are other aspects of family life that can influence children's social-emotional development. Chronic family stress or significant life events, such separation or divorce, moving to a new home or community, the birth of a child with special needs, or a serious medical diagnosis can impact young children's well being. Regardless of a child's age, the most important goal after such life changes is to return to predictable and secure family life. Helping children to keep or reestablish close ties to parents and loved ones is also important (Hagan, J.F., Shaw, J.S., & Duncant, P., 2008).

Primary care providers can help parents manage these life challenges by being aware of family circumstances and how families and children adapt. By asking questions and offering suggestions, primary care providers can actively engage parents in discussions about child and family well-being and safety. Research has shown that most parents of young children find questions about family safety, and emotional health of the family to be appropriate questions for professionals to ask (Hagan, J.F., Shaw, J.S., and Duncan, P., 2008).

Family culture: The Family Involvement Center (VanDenBerg, 2008) states, "Family culture is the unique way that a family forms itself in terms of rules, roles, habits, activities, beliefs, and other areas." The racial or ethnic culture in which a family lives may strongly influence family culture (VanDenBerg, 2008). Cultural norms also greatly influence the type of child care arrangements that are acceptable. "Culture influences every aspect of human development. The influence of culture on the rearing of children is fundamental and encompasses values, aspirations, expectations, and practices. The culture of the family helps to determine the developmental characteristics of its children.

"A family's cultural norms prescribe how and when babies are fed, as well as where, and with whom they sleep...Culture affects the customary familial response to an infant's crying and a toddler's temper tantrums. It sets the rules for discipline, expectations for developmental achievements, how illness is treated, and how a disability is perceived. In short, culture provides a context for rearing children and role expectations for mothers, fathers, grandparents, older siblings, extended family members, and friends. Thus it affects what parents worry about, and at what point they become concerned about their child's development.

Practitioners who support the development and well-being of infants and toddlers must acknowledge and be respectful of each family's culture in order to be able to place the child's social-emotional development in a context that is meaningful to the family (Michigan Department of Community Health, 2003, pg.7)." Practitioners can combine well-honed interview skills with a willingness to learn from families to understand and build on the strengths of families. This is a process that takes time and openness to experiences different from the providers' own experiences and culture. To successfully address the parents' concerns and worries, professionals may offer guidance and resources from trusted websites such as the "Learn the Signs. Act Early." program sponsored by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities (Center for Disease Control Prevention, n.d.).

In addition to these four factors influencing social-emotional development, Zeanah and colleagues outline many of the risk factors for atypical social-emotional development (i.e., development that does not follow the normal developmental trajectory). They include:

1. "Environmental factors: poverty, teenage parent, parents having less than 12 years of education, social isolation, and unstable living situations.

2. Infant characteristics: prematurity or low birth-weight, chronic or significant health problems, difficult temperament, feeding and/or sleeping issues, or developmental delays and disabilities.

3. Parent/caregiver factors: unwanted pregnancy, history of unresolved losses, mental health issues, domestic violence, and substance abuse.

4. Caregiver/child relationship factors: a relationship characterized by a lack of warmth or nurturance. A parent/caregiver exhibiting harsh or rough handling/tone of voice, lack of comforting, consistent negative or critical remarks, inappropriate or unrealistic expectations. A child that does not seek comfort, is aggressive toward caregiver, is inhibited or has unusual interactions, is hyperactive or demonstrates disorganized activity or self-injurious behavior (Zeanah P, Stafford B., Nagle G., and Rice T., 2005, pg. 39)."

C. Promotion of Social Emotional Development

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Professionals who work with young children and their families have the unique opportunity to support both families in raising healthy children and in directly supporting the healthy development of the children they serve. Promoting healthy social-emotional development prepares a child for life and school and can help to avoid future developmental and emotional problems. Early childhood professionals report increasing numbers of children under stress from a variety of causes, including witnessing or experiencing violence, parental alcohol and substance abuse and other mental health problems, neglect, and the stress families encounter when living in poverty. Problem behaviors increase with the complexity of the difficulties that families and communities confront.

While challenging, early childhood professionals can mediate the impact of these stressors and support the healthy social-emotional development of all the children they serve using the following seven research-based, best practices to support infant and toddler social-emotional development. These practices can help early childhood professionals (e.g., early childhood educators, home visitors, family advocates or support workers, parenting educators, health and mental health practitioners) implement a family-centered practice approach while contributing to the social and emotional well-being of young children and their families[2].

- **"Listen to parents.** A parent's relationship with his or her child is the cornerstone for that child's development. Parents know their children best. A parent knows the young child's history, his or her developmental process, and the complexity of daily and weekly life (ZERO TO THREE, 2002, pg.22-23)." It is important to ask clarifying questions to ensure that you are hearing the parent fully and correctly. In instances where the family's preferred language is other than English, arrange for either a staff person who speaks the language to lead the conversation or arrange for an interpreter.

- **"Observe infant-toddler interactions in multiple settings to identify strengths and potential next steps.** Infants and toddlers tell us about their strengths and vulnerabilities through their behavior with others. The context or environment can influence behavior. Therefore, one needs to observe infants and toddlers in the home, and during socializations, in the classroom, and on the playground (ZERO TO THREE, 2002, pg.22-23)." The first three years of life are a period of rapid developmental change and progress. Monitoring the emergence of developmental milestones offers important opportunities to track children's progress and identify any potential concerns as early as possible.

- **Discuss developmental milestones with parents on a regular basis.** Incorporate the use of a developmental and behavioral screening tool as a first-line check of a child's development. A screening tool is a formal research-based instrument that asks questions about a child's development, including language, motor, cognitive, and social-emotional development. A screening does not provide a diagnosis; rather, it indicates whether a child is on track developmentally and whether a closer look by a specialist is needed (WestED, 2015). (See Appendices 2 and 3 for lists of recommended developmental screening instruments that include social-emotional development).

- **"Keep in mind the multiple, potentially interacting origins of an infant's or toddler's behavior.** Carefully consider the biology (including temperament), developmental stage, environment, family culture, expectations and interaction style, and the strength of the relationship between the baby, his or her family, and other people regularly in the child's life such as their child care provider or other children. Understanding a young child's behavior requires incorporating information about all domains of development (social, emotional, cognitive, and physical) and prior history. The meaning of behavior is not always obvious and cannot be assumed. For example,

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[2] A family-centered approach is best described as "family driven" which deepens the core value of family voice and choice in all service provision.

a 6-month-old who cries during transitions to and from child care at the beginning and the end of the day might be expressing a new understanding about separation or might be a child who generally has a hard time with transitions, prefers to take things slowly, and might be reacting to quick separations and reunions. Another 6-month-old who happily enters and leaves child care or other settings may feel supported by his or her parents spending time in the setting in the morning and evening and may also be a child who generally adapts easily to new situations and people (ZERO TO THREE, 2002, pg.22-23)."

- **"Identify and share observations of strengths in the infants' and toddlers' relationships with their parents and teachers.** Focusing on strengths increases parents' awareness of their own positive responses and provides a base from which to think about potential next steps. Building on strengths does not mean avoiding risks or ignoring them. Focusing on positive interactions promotes more positive interactions and is one successful way to decrease problematic exchanges (ZERO TO THREE, 2002, pg.22-23)."

- **"Listen to staff members.** Staff members' observations and experiences are valuable in helping to develop a full picture of the young child and his or her relationships (ZERO TO THREE 2002, pg.22-23)."

- **"When the social-emotional well-being of the parent or the young child appears compromised, seek immediate expert consultation and referral.** Practitioners can experience strong, difficult emotions of their own when working with families with young children. There naturally will be times when practitioners feel intensely frustrated, angry, sad or even hopeless working with families whose young children appear to be at great risk for social-emotional problems. It is important to have a supervisor or other supportive individual who can listen and help to sort these feelings out, so the feelings do not begin to undermine one's work or health (Michigan Department of Community Mental Health 2003, pg.22)." See "Clinical Clues of Social Emotional Development Delays and Disabilities" in Section D.

Signs of Positive Social-Emotional Development and Recommended Action to Support Development

Children do not develop at the same rate; as a result, not all children will reach the milestones listed below in the timeline provided. Some will reach these milestones earlier while others will need more time. In addition, for infants born prematurely, clinical judgment needs to be used in determining appropriate expectations for the chronological age at which these developmental milestones will emerge.

The following chart was developed by the Michigan Department of Community Health to provide examples of behaviors commonly found in typically developing infants and toddlers at each stage of development. This chart also contains general guidelines and suggestions for ways adult caregivers and others can encourage and respond to these behaviors. The chart is drawn from "Signs of social and emotional well-being for infants, toddlers, and preschoolers (Michigan Department of Community Health, 2003, pg.15)."

Infants/Toddlers	Recommended Actions
From birth to age 3 months	**Parent or Caregiver**
Looks at faces Listens to voices Quiets when picked up (the majority of the time) Cries, smiles and coos	Looks lovingly at baby Listens to baby Talks and sings to baby Picks up and soothes crying baby Offers a warm smile Touches baby gently Holds and cuddles baby Reads with baby
From 3 to 6 months	**Parent or Caregiver**
Gives warm smiles and laughs Cries when upset, and seeks comfort Can be comforted (the majority of the time) Shows excitement by waving arms and legs Likes to look at and be near special person(s)	Holds baby when feeding Shares baby's smiles and laughter Notices and pays attention to baby Responds to baby's cries and coos Holds and reads to baby Plays lovingly with baby
From 6 to 9 months	**Parent or Caregiver**
Plays games like "patty cake" Responds to own name Enjoys a daily routine and transitions from situation to situation with relative ease May get upset when separated from familiar person(s) Unsure of strangers to baby May comfort self by sucking thumb or holding special toy or blanket	Takes pleasure in games with baby Talks to baby in gentle voice Is predictable and consistent Watches and knows what baby wants and needs Reads with baby Sings songs and says nursery rhymes
From 9 to 12 months	**Parent or Caregiver**
Able to be happy, mad and sad Shows feelings by smiling, crying, pointing Has a special relationship with parents and caregivers Is curious about playthings Imitates others Enjoys books Trusts that needs will be met	Names feelings like happy, mad, sad Is available, responsive, gentle and protective of baby Encourages baby to explore Reads books with baby Talks, sings songs and says rhymes to baby
From 12 to 18 months	**Parent or Caregiver**
Safe and secure in loving relationships Curious about people Explores with enthusiasm Bold and confident Says "mama," "dada," and up to eight additional words (and some two-word sentences) by 18 months	Offers safe and trusting relationship Shows interest in toddler Is loving and patient toward toddler Talks, listens and responds to toddler Reads, sings songs and plays with toddler Uses words for feelings: happy, sad, mad Uses words to tell toddler "what comes next"

Infants/Toddlers **Responds to changes in daily routine**	Recommended Actions
From 18 to 24 months	**Parent or Caregiver**
Laughs out loud Loving toward others Curious and likes to explore people, places and things Plays beside other children Enthusiastic Protests and says "No!" Enjoys books, stories and songs	Shares in toddler's laughter Loving and patient toward toddler Encourages curiosity Celebrates what toddler does Sets limits that are firm, fair Responds evenly and respectfully Reads, talks, listens, plays and sings with toddler
From 24 to 30 months	**Parent or Caregiver**
Uses words to communicate Playful with others May be shy in unfamiliar place Likes people Uses pretend play Smiles and laughs Enjoys lots of different books and simple games	Talks to toddler and uses words for feelings Supports toddler's play Helps toddler feel comfortable Enjoys toddler and plays simple games Encourages imaginary play Praises and encourages toddler Reads to toddler every day
From 30 to 36 months	**Parent or Caregiver**
Able to play independently Easily separates from primary caregivers in familiar places Begins to share with others Shows feelings for others Expresses many feelings: sad, happy, frightened, angry Enjoys books and games	Encourages toddler to play independently Helps toddler to separate without difficulty Helps toddler to share with others Helps toddler to use words for feelings Listens and responds to toddler's feelings Disciplines positively and consistently Tells stories, reads and encourages pretend play

Capacities for Social-Emotional Functioning

There are six capacities of social and emotional functioning described in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0-3R) (ZERO TO THREE, 2005). It is important to note that, "In children who are developing typically, each of these six core capacities continues to develop as the child matures. Each fully mastered ability supports progress toward the next level of development within that capacity (e.g., competent gestural communication supports the development of spoken language). Some children, however, may show a constricted form of a higher-level capacity without having fully achieved more basic levels of emotional and social functioning (ZERO TO THREE, 2005)."

- **Attention and regulation** (typically observable beginning between birth and three months): the infant notices and attends to what is going on in the world through all the senses - for example by looking, listening, touching, and moving. The infant can stay sufficiently regulated to attend and interact, without over- or underreacting to external or internal stimuli. As the child achieves higher levels of functioning over time, her capacity to maintain

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a long, continuous flow of interactions provides evidence of her capacity for age-appropriate attention and regulation.

• **Forming relationships or mutual engagement** (typically observable beginning between three and six months): the infant develops a relationship with an emotionally available caregiver for soothing, security and pleasure. As development proceeds, with support from the care giving environment, the child becomes able to experience the full range of positive and negative emotions while remaining engaged in a relationship.

• **Intentional two-way communication** (typically observable beginning between 4 and 10 months): the infant gestures, including purposeful demonstrations of affect, to start reciprocal "conversations". Simple gestures, such as reaching to be picked up or pointing to an object of interest, become a more complex sequence of gestures during the second year. Two-way communication becomes actual conversation as the child develops verbal language.

• **Complex gestures and problem solving** (typically observable beginning between 10 and 18 months): the toddler learns how to use emerging motor skills and language to get what he needs or wants - that is, to solve problems. Single gestures are replaced by complex sequences of gestures and actions (e.g., leading a parent to a desired object). As the child develops language, words are used, as well as gestures for communication and problem solving.

• **Use of symbols to express thoughts and feelings** (typically observable beginning between 18 and 30 months): using imaginative play and language, the child begins to express thoughts, ideas, and feeling through symbols. A child can communicate what she imagines through role-play, dress-up, and play with dolls and actions figures. Imaginative play may represent experiences from real life, as well as themes the child has encountered in stories, books, videos, and television. In play scenarios, the child's feelings are projected onto the characters and actions.

• **Connecting symbols logically and abstract thinking** (typically observable beginning between 30 and 48 months): the child can connect and elaborate sequences of ideas logically. He uses logically interconnected ideas in conversations about daily events and imaginative stories. The narratives of children who function at this level typically have a beginning, middle and end. They include characters with clear motives and consequences of action that can be anticipated. The child is able to understand abstract concepts, reflect on feelings and articulate lessons that he has learned from an experience (ZERO TO THREE, 2005).

To expand upon the above listed capacities, the DC:O5 articulates the importance of using an integrative model for understanding the infant's/young child's developmental competencies across six different domains of development: emotional, social-relational, language-social communication, cognitive, movement and physical development (ZERO TO THREE, 2016a). Developmental competencies are examined and rated in Axis V of DC:0-5. It is acknowledged that social-emotional capacities are present at birth and serve as the foundation for all development. "Understanding the manner in which the infant/young child integrates competencies in and across different developmental domains is necessary for clinical formation that highlights the infant's/young child's demonstrated capacities within and across emotional, social and relational domains (ZERO TO THREE, 2016a, p.159)."

Specific Steps All Professionals Can Take to Promote Social-Emotional Development:

All professionals who work with infants and toddlers and their families can positively impact social-emotional well-being. This section includes general guidance that anyone providing services to infant and toddlers can use on a daily basis, as well as suggestions specific to professionals working in early childhood education, home visiting programs, and in primary health care practices. For anyone working with infants and toddlers and their families:

- **Use the following five questions for developing an understanding of the behavior of young children:** Children's behavior is an important way that they communicate. Understanding the reasons for their behavior will help adults be more reflective rather than reactive and will result in more positive outcomes for everyone. Begin with a conversation with the child's parents to determine if there are changes in the home environment which might be impacting their child's behavior. To better understand what may be motivating a child's behavior in your setting and how to respond most constructively, the following five questions can be considered (Reinsberg, 1999).

1.
"Is this a developmental stage?
Many problems that occur in infancy and early childhood appear at the onset of a new developmental stage. Each new phase of development brings challenges for the child and the child's caregivers. For example, body independence in the child's second year and an emerging sense of an independent self-elicit a period of negativism.

2.
Is this an individual or temperament difference?
Not all children of a certain age act the same way. These Individual differences may be rooted in a variety of causes. Biological factors such as visual impairments, tactile sensitivities, auditory and speech disorders, or motor disabilities may affect a child's behavior. Temperament qualities such as shyness, adaptability, moodiness, or inflexibility also may account for many of the differences in children's (and adults') behaviors.

3.
Is the environment causing the behavior?
Sometimes the setting provokes a behavior that may seem inappropriate. An overcrowded child care setting or the lack of an appropriate number or types of toys can increase aggression or spark jealousy. Look around your home or program setting and evaluate it in light of your child's behaviors. We need to get down on our knees and see the environment from a child's viewpoint.

4.
Is the infant/toddler in a new or unfamiliar situation or facing a new task or problem?

Perhaps this is the first time a two-year-old without siblings has been asked to share a toy or treasured object. Developmentally, he/she does not truly understand the concept of sharing, so it is up to us as parent and teacher to calmly explain to the child how the other children will react.

5.
Unmet emotional needs?
Emotional needs that are unmet are the most difficult cause of behavior to interpret. In these situations, the child's behavior has a particularly driven quality about it and occurs with regular frequency in all settings. The child who continually harms himself or other children should be stopped and may need an assessment by a trained professional. Careful observation, thoughtful reflection, and communication between parents and teachers who respond with quiet firmness and patience can be critical to the future emotional health of children (National Association for the Education of Young Children, 1999)."[3]

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[3] These 5 questions were adapted by the National Association for the Education of Young Children, retrieved February 2016 from https://oldweb.naeyc.org/ece/1999/11.asp.

- **Partner with parents in supporting each child's development:** Building collaborative partnerships with parents is an important strategy to promote healthy child development, especially social-emotional development and should include the value of parent-child bonding and breastfeeding. Through the daily routines of dropping children off and picking children up, early childhood educators have an opportunity to build trusting relationships with the child's parents or caregivers. This opportunity can lead to conversations such as sharing enjoyment of a child's achieving certain milestones, developing consistent strategies to address certain behaviors, and raising concerns as necessary.

- **Routinely screen the children in your program:** Screening is used to determine whether social and emotional, as well as all other developmental skills, are progressing as expected or whether cause for concern is warranted and further evaluation is necessary. The process is most helpful when both strengths and concerns are identified and the child's parents are involved. Using tools that take into consideration the wide variety of backgrounds, languages, and customs of participating families will ensure that the information is accurate and will build the vital connection between the program staff and the families. It is important that screening is systematic for all children and includes a method for documenting observations; a process for planning when, where, and how screenings will be accomplished; a process for discussing outcomes of screenings with parents; and a process for tracking change over time, including the need for a referral(s) and the outcomes of any referral (See Appendix 1 which includes a list of screening and assessment instruments provided by "Birth to Five Watch Me Thrive!").

Specific Steps Early Childhood Educators can take to Promote Social-Emotional Development

- **Use curricula materials that support healthy social-emotional development:** High-quality early childhood education programs and

providers develop or use curricula that support children's social-emotional development. They do this by organizing activities that promote relationship development, cooperative play, understanding of social interactions, and learning appropriate behavior in groups.

- **Use a "plan - do - review" instruction model when working with young children:** Skilled early childhood professionals observe children, plan and implement individualized approaches to encourage each child's optimal growth and development, and record and adapt their approaches as needed. With appropriate releases, this documentation can contribute to the evidence of need (especially if a referral is indicated), effectiveness of early intervention services or other support services, and plans for transitions useful to other early childhood specialists.

- **Use the New York Early Learning Standards Framework to improve the quality of your services.** Research has shown that children who participate in high-quality early childhood education programs are less likely to experience behavior problems and more likely to achieve social-emotional developmental competencies that will prepare them for success in school (Copple and Bredekamp, 2009). The NYS Early Childhood Advisory Council developed the *"New York Early Learning Standards Framework"* to support early childhood education programs in improving the quality of their services by providing specific standards to guide child development, implement professional development planning for staff, administrators, and home-based providers, as well as provide quality program standards for all early childhood education settings. Each set of standards is based on research that has shown to result in improved outcomes for children. These standards include:

  - **The *Early Learning Guidelines:*** the *Early Learning Guidelines* is both a professional development and reference tool that should be regularly used when working with young children. As a professional development tool, the *Guidelines* serve to help early childhood professionals deepen their knowledge of child development. As a reference tool,

the *Guidelines* can assist early childhood professionals gauge where children are developmentally and what they can do to promote child well-being across all five domains of development including social-emotional development (New York State Early Childhood Advisory Council, 2012b).

– **The *Core Body of Knowledge:*** The Core Body of Knowledge guides professional development by providing a comprehensive listing of the professional competencies that early childhood research has shown leads to positive child outcomes across all the domains of child development including social-emotional development. By seeking education, training, and in-classroom coaching, staff and providers develop the knowledge and skills they need to provide high-quality services (New York State Early Childhood Advisory Council, 2012a).

– **The *QUALITYstarsNY Program Standards:*** QUALITYstarsNY is a New York's early childhood education program quality rating and improvement system which is based on a set of program standards that guide program development. Whether a center or home-based provider is participating in QUALITYstarsNY or not, they can still use the standards to assess program quality and make changes to improve their services (New York State Early Childhood Advisory Council, n.d.).

Establish a Continuity of Care approach to support optimal social-emotional development for infants and toddlers in center-based early childhood education programs: Assigning each child a primary caregiver, ideally until the child is three, provides the stability children need for healthy emotional development. It promotes the security and trust that enable the child to explore the world with confidence, develop a positive sense of self, and flourish. Through the Continuity of Care model, adult caregivers develop a deeper attachment to the child and establish an on-going relationship with the other members of the child's family (Early Care and Learning Council, 2012).

Specific Steps Home Visiting Professionals can take to Promote Social-Emotional Development

In addition to implementing several of the steps listed above, home visiting providers have the unique opportunity to see parents and children in their natural environment and interact in the family's own home. Home visitors can support the social-emotional development of infants, toddlers and preschoolers by:

- **Providing affirmation to the parents in their role as the child's primary provider and teacher by:**

  – Reinforcing and encouraging or, if needed, introducing, positive parenting behaviors in the home environment, thus affecting parents' ability to support their children's overall development. Home visitors help parents improve their positive parenting skills by introducing authoritative parenting strategies in response to real life situations.

  – Whenever possible utilize materials found in the home. Provide suggestions on how to use these materials to support their child. If parents are receptive and interested in learning more, providers may introduce new materials such as books and toys.

  – Teaching and encouraging parents to engage children with developmentally appropriate activities such as storytelling, reading aloud, singing, and repeating nursery rhymes promotes early language and literacy. Asking parents about the stories, games, and songs they learned when they were children shows respect and interest in their culture and instills confidence in the parent.

- **Supporting and monitoring healthy development: Birth outcomes can be improved** beginning with the pregnant mom's prenatal care, by supporting her in attending to her health (addressing weight gain, smoking, alcohol and illicit drug use and other health risks). "Programs have been found to have a positive impact on breast feeding and immunization rates as well as lower depressive symptoms and stress (ZERO TO THREE, 2014)." These outcomes directly affect the environment and quality of the relationship parents are able

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to establish with their newborn and young child. Studies have found positive impacts on children's mental health as well including fewer behavior problems and increased mental development at age 6 (such as reading aloud, telling stories, saying nursery rhymes, and singing) (ZERO TO THREE, 2014).

- **Support the child's behavioral health:** Home visiting programs have demonstrated improved family economic self-sufficiency. One in four young children lives in poverty; this negatively impacts their physical, social, and emotional development, and can impede their ability to learn. "By helping parents enroll in educational and training programs and pursue employment, home visiting programs can help counteract the negative consequences of economic insecurity and encourage success not only at home but also in school and at work (ZERO TO THREE, 2014)." Studies have found that, compared with a control group, more parents in home visiting are working, participating in education or training, and have higher monthly incomes (ZERO TO THREE, 2014).

Specific Steps Pediatric Primary Care Providers Can Take to Promote Social-Emotional Development

Pediatric primary care providers including pediatricians, family practice physicians, nurse practitioners, and physician assistants are universally regarded as highly trustworthy early childhood experts. Because nearly every child is seen by a child health care provider, these professionals play a critical role in supporting families, promoting social-emotional development, and identifying, tracking, and, when needed, making referrals for intervention services as part of routine well-child health care. The following is a list of steps that primary care practices can take to strengthen how they support families in meeting their children's social-emotional development needs.

- **Routinely screen children for developmental delays and disabilities, including social-emotional development.** Early childhood screenings provide parents, health care and other early childhood professionals with a standardized way to assess child development

and identify concerns as early as possible. The American Academy of Pediatrics guidelines recommend developmental surveillance at every well-child visit and use of a standardized developmental screen at the 9-, 18-, and at either the 24- or 30-month well-child visits.Also, a screen for autism, like the MCHAT (Modified Checklist for Autism in Toddlers) should be administered at the 18- and 24-month visits. An additional standardized screening tool should be administered at any time when indicated by surveillance or parental concern. By sharing observations and hearing questions or concerns during the screening process, providers and parents have an opportunity to understand and support the child's optimal development. Screenings start during the first year of life when brain and body development occur at a rapid pace and continue at regular intervals during childhood (Hagan, et al., 2008). Appendix 1 includes a list of screening and assessment instruments provided by "Birth to Five Watch Me Thrive".

- **Talk with parents about their observations and concerns about the behavior and social-emotional development of their child.** Clearly, the child's parents are the experts on their child's behaviors and needs. Incorporating checks on child behavior, moods, parent's experience with discipline, and parent-child interaction into anticipatory guidance and ongoing developmental surveillance provides child health providers with many opportunities to have this important conversation with parents. In instances where the family's preferred language is other than English, arrange for either a staff person who speaks the language to lead the conversation or arrange for an interpreter.

- **Observe the relationship between the child and the parent and the child's behavior for indicators of social-emotional development issues and concerns.** It is important to routinely observe how the child and the parent are relating to each other. Solicit information from the nurses and office staff who have interacted with the family. They often have opportunities to observe interactions of the children and parents while they are waiting for the appointment. The exam room is a foreign

environment for child and parent, however observations on the following can be informative.

> – Are parents comfortable with routine care?
>
> – Are the parent and child interested in and responsive to each other (i.e., sharing vocalizations, smiles and facial expressions)?
>
> – Does the relationship seem warm and nurturing?
>
> – Does the child seek comfort?
>
> – How do they communicate? Is the tone comforting?
>
> – Are the parents' expectations realistic and appropriate for the age of the child?
>
> – Is the child aggressive, inhibited or hyperactive?

If observations raise concerns, follow-up questioning can give a full picture of the parent-child relationship when outside of the stressful circumstances of the primary health care provider's office.

- **Ensure that pregnant women and parents of infants are screened for maternal depression and mental health issues.** A critical factor influencing the healthy social-emotional development of children is the mental health of their parents or caregivers. Given the high incidence of maternal depression during pregnancy and the postpartum period, it is important that all pregnant women and mothers of newborns are screened for maternal depression, also known as perinatal mood and anxiety disorder. Primary care providers, by virtue of having a longitudinal relationship with families, have a unique opportunity to identify maternal depression and help prevent untoward developmental and mental health outcomes for the infant and family. There is good evidence that maternal depression can be accurately identified using brief standardized depression screening instruments, and that treatment improves the outcome for the woman and her family. As a result, screening can be integrated into the well-child care schedule and included in the prenatal visit.

- **Carefully follow any child for whom you have concerns, but as yet does not seem to be at risk of a delay or disability.** Because of the important role that the living environment plays in a child's social-emotional development, screening and assessing the child's home environment is an integral part of preventative care. A family history of reported suspected abuse/neglect, foster care placement, substance abuse (including fetal alcohol syndrome), domestic violence, family mental health issues, and other forms of traumatic exposure increase the risk of developmental delay and problems with social-emotional development. Screening families for Adverse Childhood Experiences (ACE) risk factors or use of another family risk assessment tool can be an effective way for identifying families and children needing careful ongoing follow-up.

- **Conduct a full clinical assessment.** If the child is identified with atypical social-emotional development, it is important for the primary care provider to rule out any significant medical/neurological abnormalities, evaluate general development, and screen for lead, anemia, hearing and vision abnormalities. Support, information, and counseling for families can continue but referral to Early Intervention for an evaluation and treatment of a delay or disability or surveillance if the child is at-risk of a delay or disability is required. For children at-risk of a delay or disability, referral to a mental health professional experienced in infant mental health issues, or to other services such as parenting education is advisable. Care coordination at this level includes collaboration if applicable with early childhood education professionals, mental health providers and the facilitation of referrals for diagnostic or specialty care.

- **Consider co-locating mental/behavioral health professionals in the pediatric/primary care practices.** Co-locating mental health services in a primary care setting is an increasingly popular and effective approach of care. These professionals can assist with screening, evaluation, assessment and treatment of young children and families who have atypical social-emotional development in a non-threatening and convenient manner. Some co-location

models also have successfully treated parental mental health issues in the primary care setting.

- **Develop a collaborative relationship with your local Early Intervention Program (EIP).** The American Academy of Pediatrics, recognizing the value of early intervention services for infants and toddlers with special needs and their families, points to the necessity of collaboration between the child's medical home and the Early Intervention Program. In New York State, the 57 counties and New York City are responsible for local administration of the EIP. Because of the important role of early intervention services in helping families address health and disability issues for infants and toddlers birth to three years of age, building a strong working relationship with the local Early Intervention Programs is important for ensuring that the child and his or her family receive the services and follow-up care they need. In particular, primary care providers can play an important role in supporting the efforts of local EIP to ensure children with possible developmental delays or disabilities, including those impacting social-emotional development, are referred to the program. Primary care providers can help IFSP teams determine appropriate services by providing information on what they have observed in serving the child and family. In addition, primary care providers often have important information about the child. It is critical that the health assessment form is filled out completely and documents any significant birth and medical history and referrals. A strong working relationship is crucial to maintaining communication during service delivery. The child's and family's EIP service coordinator can share progress reports with primary care providers if parents sign releases of medical information during the assessment period. It is then important for the service coordinator to provide the primary care practice with progress reports.

ADDITIONAL RESOURCES

Zeanah, C. H. (2009). *Handbook of Infant Mental Health (3rd ed.*). New York, London: Guildford Press.

Adas, R. and Tapia, C. (2013). Early Intervention, IDEA Part C Services and the Medical Home: Collaboration for Best Practice and Best Outcomes. *Pediatrics,* 132(4).

RESOURCES FOR PARENTS

These resources were developed by national organizations for parents to learn about infant/toddler social-emotional development and/or challenging behavior. These are tools early childhood professionals are encouraged to share with families during first contacts. Early Intervention Program Service Coordinators are encouraged to share this information with families prior to a child's multidisciplinary evaluation.

Child Mind Institute Resources for Educators and Families *(The Mind Institute)*
http://childmind.org/

Development of Social-Emotional Skills: Learn What You Can Do *(ZERO TO THREE)*
www.zerotothree.org/child-development/social-emotional-development/social-emotional-development.html?referrer=https://www.google.com/?referrer=http://www.zerotothree.org/child-development/social-emotional-development/social-emotional-development.html

Facts about Young Children with Challenging Behaviors *(Technical Assistance Center on Social-Emotional Intervention for Young Children (TACSEI)).*
http://challengingbehavior.fmhi.usf.edu/do/resources/documents/facts_about_sheet.pdf

RESOURCES FOR PARENTS (continued)

Family Routine Based Support Guide: Building Relationships with Infants *(Tennessee Pyramid Model Partnership).*
http://challengingbehavior.fmhi.usf.edu/do/resources/documents/tool_fam_routine_guide_infants.pdf

A GUIDE for Families with Children Birth to 8 Years
A simple guide for families highlighting what social and emotional health is, what it looks like, & simple strategies for promoting children's social and emotional skills
www.michigan.gov/documents/mdch/A_Guide_for_Families_with_Children_Birth-8_Years_420515_7.pdf#Top

Making Life Easier Tip Sheets *(Technical Assistance Center on Social-Emotional Intervention for Young Children (TACSEI)).*
http://challengingbehavior.fmhi.usf.edu/do/resources/making_life_easie_orgr.html

Milestone Moments - Learn the Signs. Act Early *(U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION)*
www.cdc.gov/ncbddd/actearly/pdf/parents_pdfs/milestonemomentseng508.pdf

Milestones Checklists *(in English and Spanish)*
www.cdc.gov/ncbddd/actearly/pdf/checklists/all_checklists.pdf

Parenting Concerns Web Resource *(Clay Center for Young Healthy Minds at Massachusetts General Hospital).*
www.mghclaycenter.org/parenting-concerns/infants-toddlers/

Questions About Kids Tip Sheets *(University of Minnesota Center for early Education and Development).*
www.cehd.umn.edu/CEED/publications/questionsaboutkids/default.html

Versions are available in Spanish, Somali, and Hmong.

Social-Emotional Development in Infancy (Birth to 12 Months): What to Expect and When to Seek Help: Bright Futures - A Bright Futures Developmental Tool for Families and Provider *(National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, in collaboration with the National Center for Education in Maternal and Child Health).*
English: http://brightfutures.org/tools/BFtoolsIN.pdf
Spanish: http://brightfutures.org/tools/BFtoolsIN_SP.pdf

Social & Emotional Development in Early Childhood (Ages 1 – 4): What to Expect and When to Seek Help- A Bright Futures Developmental Tool for Families and Providers *(Developed by National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, in collaboration with the National Center for Education in Maternal and Child Health).*
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Spanish: http://brightfutures.org/tools/BFtoolsEC_SP.pdf

D. Identifying and Addressing Concerns

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Each child is unique and will develop in his or her own way. Although skills generally develop in a specific sequence, it is difficult to know exactly when a certain skill will be developed, learned, or mastered. Developmental milestones give a general idea of the changes you can expect children to experience as they grow.

Science tells us that young children communicate through their relationships and behavior. For example, a toddler who is cranky in the morning might be telling you that she slept poorly the night before or that she is hungry. While a child's challenging behavior—e.g., tantrums, biting, hitting, or withdrawing—is usually communicating a temporary emotional distress, for some children this behavior might communicate more persistent needs.

Clinical Clues That an Infant or Toddler May Need Help

Recognizing and addressing behaviors that would benefit from professional support can be difficult. Parents and professionals who work with young children must look for signs that children are struggling. These clinical clues can be grouped into several areas of concern, including sleep, feeding, comfort, relating to people, mood, emotions and feelings, self-harm, behavior, possible exposure to excessive/toxic stress, and regression.

The "Clinical Clues of Social Emotional Development Delays and Disabilities" chart was gleaned from the research on factors that impact social-emotional development in infants and toddlers. Good judgment needs to be used in determining whether a child needs ongoing developmental screening and surveillance from his or her health care provider, or a referral for a comprehensive evaluation. Infants and toddlers may experience fussiness, trouble sleeping, or be difficult to comfort at times due to developmental stages or environmental circumstances that are temporary and will resolve in time. However, the persistence of one or more of these clinical

clues over a longer period of time, or an extreme behavior that is having a negative impact on the child and family, may be cause for concern and a referral to the Early Intervention Program for an evaluation.

For parents, any concern about a child's development is sufficient reason to talk with the child's health care provider to determine how best to investigate the concern. For professionals, such clinical clues need to be taken into account when conducting a screening, evaluation, or developing a diagnosis.

Clinical Clues of Social-Emotional Development Delays and Disabilities Chart

There are numerous behaviors that may be indicative of a clinically significant problem in the social-emotional domain itself or suggest social-emotional contributions to a presenting delay (s) in other domains of development. These items/behaviors have been culled from cross-referencing items/behaviors contained in a representative sample of social-emotional screening and assessment tools (see instrument reference list). This list is neither exhaustive nor intended to be diagnostic but rather to serve as a reference of clinical triggers to alert non-mental health and mental health professionals alike that a social-emotional/mental health factor(s) may be operative. The presence of these indicators strongly suggest that a social-emotional/mental health assessment may be indicated. These concerns can include:

Concerns about sleep

- Disrupted sleep
- Trouble falling asleep or staying asleep
- Refusal to sleep without an adult in the room
- Nightmares, night terrors
- Talks or cries out in sleep
- Hypersomnia- would sleep continually if not awakened by an adult

Concerns about eating

- Disrupted eating
- Significant growth deficiency
- Refuses to eat
- Distressed when eating
- Gags or chokes on food
- Eats or drinks things that are not edible (e.g. paper or paint)

Concerns about comfort

- Extreme fussiness
- Rarely seeks comfort in distress
- Does not seek comfort or help from familiar adults when hurt or distressed
- Seeks comfort from strangers when distressed
- Responds minimally to comfort offered to alleviate distress, hard to comfort, sooth or satisfy

- Cries excessively
- Easily dysregulated (upset, irritable, tantrums, "unmanageable")
- Difficulty settling or resettling after an upsetting experience
- Cries excessively
- Inconsolable in the presence of parent

Concerns about relating to people

- Reduced or absent social and emotional reciprocity - turn taking (visual, gestural, vocal, verbal)
- Overly familiar /indiscriminate/ reduced or absent reticence around unfamiliar adults (e.g. willingness to go off with an unfamiliar adult)
- Failure to reference familiar adult in an unfamiliar situation
- Does not orient or respond to familiar voices
- Ignores/avoids parent after separation
- Unusually avoidant or fearful (particularly of specific people /places/activities)
- Is clingy, doesn't want to be alone
- Lack of eye contact with parent
- Seems unresponsive to affection when extended
- Shows little affection toward people
- Shows little interest in things around him/her
- Unable to experience loving feelings

- Does not make or avoids eye contact with adults and peers
- Avoids initiating physical contact and or affection
- Limited exploration expected for age
- Has difficulty engaging and relating to peers

Concerns about mood, emotions and feelings

- Seems very unhappy, sad affect, worried, depressed, withdrawn, apathetic or listless
- Is easily frustrated
- Has frequent/excessively intense temper tantrums (duration, virulence, inconsolability) for developmental age
- Emotional withdrawal, lethargy, lack of interest in developmentally appropriate activities
- Increased irritability, angry outbursts (hits, bites, pushes)
- Seems fearful without reason obvious to observer
- Seems fearful of things (people, places, activities)
- Rapid/sudden shifts between sadness and excitement, moods, or feelings
- Has a restricted range in the variety of emotions or emotional expression (e.g. pleasure, anger, fear or anxiety, affection)
- Is unusually excessive in emotional intensity and reactivity and/or emotions inconsistent with the circumstance
- Is unusually muted in emotional intensity and reactivity/or emotions inconsistent with the circumstance

Concerns about self-harm

- Gets hurt so often that you cannot take your eyes off child
- Engages in head banging
- Engages in biting self
- Does not react when hurt
- Daring and reckless, risking accidents and injuries
- Runs away in public spaces

Concerns about behavior

- Is under or over reactive to touch, sounds or other environmental stimuli
- Is easily startled
- Is afraid to try new things
- Puts things in a special order over and over again, gets upset if interrupted or things are disrupted
- Repeats a particular movement over and over again (e.g. rocking, spinning)
- Repeats the same action or phrase over and over without enjoyment
- Tunes-out/spaces-out-seems totally unaware of what is going on around self
- "Nervous" movements or twitching
- Twirls or pulls hair
- Smears or plays with bowel movements
- Does not play or is constricted or immature in play compared to same age peers
- Play is disorganized, frantic, chaotic (e.g. moves rapidly from play thing to play thing; makes a shambles of materials; throws materials about)

- Is cruel to animals

- Is unusually destructive of toys

- Is overly combative, oppositional with parents/peers

Concerns about possible exposure to excessive/toxic stress

- Toxic stress is defined as the excessive or prolonged exposure to stress in the absence of the protection afforded by stable, responsive relationships.) (National Scientific Council on the Developing Child, 2005).

- Repetitive play theme (s) that may represent potentially traumatic event the child may have experienced

- Preoccupation with an upsetting event; distress not necessarily noticeable

- Difficulty concentrating

- Night terrors

- Hypervigilance

- Exaggerated startle response

- When upset, gets very still, freezes or doesn't move (freeze reaction-part of the primitive fright, flight, freeze response to danger)

- Nervous" movements or twitching

- Recurrent and intrusive recollections of the event outside of play

- Uncomfortable memories of events

- Is under- or overactive to people, places, things, activities (e.g. toileting, bathing), environmental stimuli (e.g. sirens, storms)

- Is unusually distractible

- Avoids/is fearful of things (people/places/ activities)

Concerns about regression

- Has a loss of recently acquired skills (loss of acquired words typically apart of the child's repertoire; bedwetting in a child who has been trained)

- Arrested development in terms of attainment of developmental milestones (developmental progress seems to come to a halt or significantly slows down following an average expectable attainment of developmental milestones)

- Loss of/reduced capacity to attune with caregiver

Vulnerable Children and Children with Adverse Childhood Experiences

There are some children whose life circumstances place them at risk of a developmental delay and disability. For this reason, they should be periodically monitored for clinical clues that may indicate a concern related to social-emotional development that needs further investigation.

Vulnerable children experience life circumstances that place them at very high risk of developing social-emotional issues or concerns in early childhood and later in life; these include infants and toddlers such as those involved in the child welfare system. Children living in families

experiencing poverty, homelessness, mental health conditions, substance abuse, and domestic violence may be particularly vulnerable (Smith, S., Stagman, S., Blank, S., Ong, C., and McDow, K, 2011).

In addition, children who have been born prematurely or have other biological risk factors or special health care needs may be more difficult to parent or experience challenges in social interactions that can affect their social-emotional development. Early childhood professionals working with vulnerable children must be especially attuned to their social-emotional development needs. Vulnerable children should be monitored closely by parents and professionals

for social-emotional development problems and receive routine screening.

"Sometimes a child's concerning behaviors may indicate that he or she is dealing with trauma, an emotional response to an extremely negative event. Young children's trauma response and recovery are particularly dependent on the context of the trauma experience. Some trauma is acute—a single event that lasts for a limited time, such as a response to a painful medical procedure. If the child's development has been typical and immediate family members were not also traumatized in the experience, then the family may be very capable of understanding the child's experience and response and providing sensitive support after the traumatic event. If the traumatic event triggers powerful memories for the adult, they may have limited emotional capacity to respond to the child's distress (Children's Behavioral Health Initiative, 2015, pg. 10."

In the most complicated circumstances, an immediate family member could be responsible for the child's trauma, as in cases of child maltreatment including abuse or neglect. "In such cases, the child's recovery process and resumption of normal developmental progress requires addressing both the needs of the individual child as well as repairing or rebuilding their relationships with significant others (Zindler, P., Hogan, A., and Graham, M., 2010)."

"Some kinds of trauma, such as child maltreatment or sexual abuse, can be chronic and last over a long period of time. Difficult family stressors, such as a parent suffering from depression (including postpartum depression) or other mental health issues, substance use, domestic violence, or poverty, can also have a negative impact on young children. A parent who experiences these stressors may have difficulty providing predictable, responsive, and consistent care that is essential for the child's healthy development, as well as for a nurturing parent-child relationship. These challenges can also affect how well a parent can protect the child from other life stressors, such as financial or housing instability (Children's Behavioral Health Initiative, 2015, pg. 10)."

Toxic stress occurs when a child experiences strong frequent and/or prolonged adversity without the buffering of adequate adult support. In 2012, the American Academy of Pediatrics called attention to the significance of children's early experiences and 'toxic stress' (Garner and Shonkoff, 2012). "Children are disproportionately at risk for social and emotional concerns when they are growing up in households confronted with environmental stressors such as: conditions of extreme poverty including homelessness; exposure to traumatic events that may include abuse, neglect, domestic or community violence; early separation from parents through parental incarceration or placement in foster care; and/or parent mental illness (Mendez, M., Simpson, T., Alter, A., Meyers, J., 2015)." The risks are especially high for infants and toddlers, who depend entirely on others for their care, have not developed the internal resources needed to understand or cope with trauma, and whose developmental trajectory is highly malleable.

"Even though they may not understand the meaning of what they see or hear, children absorb the images that surround them, and the emotions of the people they rely on for love and security can have a deep impact on them. Young children's behavior can be affected by trauma. It can leave them with a highly active startle response; confusion over what is dangerous and whom to go to for help; avoidance of contact; and difficulty self-soothing, among other symptoms (Children's Behavioral Health Initiative, 2015, pg. 10)." Trauma can leave children feeling frightened and powerless. It can affect how they learn, play, and relate to others. Just as with vulnerable children, children who have experienced trauma should be monitored closely for social-emotional development problems and receive routine screening.

The Adverse Childhood Experiences (ACE) Study is one of the largest investigations conducted to assess associations between childhood adversities and later-life health and well-being. More than 17,000 Health Maintenance Organization members undergoing a comprehensive physical examination chose to provide detailed information about their childhood experience of abuse, neglect, and family

dysfunction (Felitti, et al, 1998). As noted in the ACEs Survey Toolkit for Providers, "The ACE Study findings suggest that certain early experiences are major risk factors for the leading causes of chronic disease and death as well as poor quality of life in the United States. Specifically, the study finds that as the number of ACEs increase, there is a corresponding increase in the risk for health problems, including substance abuse, depression, intimate partner violence, heart disease, smoking, early sexual activity and adolescent pregnancy and even early death. The ACES survey has been administered to multiple populations, with similar findings. The results of the study are being used widely to inform efforts to create programmatic and policy solutions to address and prevent childhood trauma at the individual, community and systems levels (National Crittenton Foundation, 2015, pg. 8)."

The Centers for Disease Control and Prevention (CDC), Injury Prevention and Control, Division of Violence Prevention, identifies the promotion of safe, stable and nurturing relationships as a key strategy to preventing or ameliorating the impact of child maltreatment. When children are exposed to adverse environmental challenges, such a violence, poverty and substance abuse, it is the presence of safe, stable and nurturing relationships that can 'buffer' the brain in ways that mitigate the exposure. Professionals who work with infants and families are in a unique position to help families build these critical relationships and serve as a buffer to the effects of toxic stress.

Children with or at Risk for Developmental Delays or Disabilities

Although developmental skills generally emerge in a specific sequence, it is difficult to know exactly when a certain skill will be developed, learned, or mastered by a child. Developmental milestones give a general idea of the changes you can expect children to experience as they grow.

There are normal variations around the average ages at which developmental milestones are achieved. Children who have not achieved developmental milestones at the average age may be experiencing individual variations in

development and may not have a developmental delay that needs intervention.

The term *"developmental delay"* is used to describe the developmental status of children who are generally following a typical pattern of development, but develop at a slower rate than is average for a child of the same age. Developmental delays include mild to extreme variations in development and the failure of a child to reach developmental milestones in one or more areas of development.

Marked *regression or loss of developmental milestones* in any area of development, including social-emotional development, can be a sign of a serious underlying medical or neurological problem and may indicate the need for medical assessment by the child's health care provider(s).

A "disorder" or "impairment" is a condition that is expected to continue indefinitely and result in limitations in any area of development, including social-emotional development. Children who are experiencing *disorders or impairment in social-emotional development* may exhibit patterns such as inability to form attachment relationships with caregivers, failure to develop joint-attention skills, perseverative behaviors, and other qualitative differences in their social and emotional development. Examples of disorders in this area of development that can affect young children include; attachment disorders, autism spectrum disorders, attention deficit disorders, and emotional disturbances of early childhood. These conditions are characterized by qualitative and extreme problems and variations in child behavior and emotional development, in comparison with the "testing" or "trying" behaviors typical of most children in the two-to-three-year-old age group (New York State Department of Health Early Intervention Program, 2005, pg.27).

Talking with Parents about a Concern

It is very important that concerns about a child are expressed to the child's parents, but it is crucial to understand that how concerns are shared is as important as what is said. Some parents may already be concerned about their children, while others worry that their children's challenging behavior may reflect poorly on them. They may

interpret concerns as criticism of their parenting skills or their child. Establishing a positive and trusting relationship from the beginning will greatly aid communication about difficult subject matter. Principles to keep in mind when talking to parents include:

- All families have strengths.
- Parenting is a process built on trial and error.
- Parents are experts on their children—they love them, want to do their best by them, and want the best for them.
- Parents want you to like and appreciate their children.
- Parents have something critical to share at each developmental stage.
- Parents have ambivalent feelings.
- Parents want respect.
- Parents want to be heard (Brazelton and Sparrow, 2003).

The following steps are recommended to ensure that the conversation is positive and effective:

- **Plan ahead:** think carefully about what needs to be said and the desired result.
- **Make yourself available:** find a time with no distractions that works well for the parents. Depending on their availability, this can mean a face-to-face meeting or a phone call.
- **Start with the positive:** share something positive about the child such as enthusiasm for a particular song or interest in certain toys or activities, etc.
- Ask for help: let the parent know that the goal is to help the child be successful and that the professionals working with the child are doing everything they can to make that happen, but that help is needed from the parent. Provide descriptions of behaviors that are causing the concerns without attaching a meaning or judgment. Use this time to describe the kinds of solutions that are being tried. Here are some examples:

    "We're working with Abby to use her words to say 'my turn please' instead of hitting when she wants a toy."

    "We're working with Brian to stay settled in a particular area of the classroom instead of trying to run around a lot."

    "We're working with Keisha to rest by herself at naptime instead of having an adult by her side all the time."

    "We're trying to help Marie connect better with other children in small groups instead of staying on the sidelines a lot."

    "We're noticing that Joey seems very interested in what we're doing at circle time but he doesn't speak in the group discussion."

- **Share concerns:** ask the parent if he or she has similar concerns or has experienced similar situations and what solutions have worked at home. Parents often have ways of working with their children that can help in other early childhood settings. Asking parents about their own methods at home qualifies them as "experts" and invites them to be part of a team, rather than making them feel guilty or ashamed about what they've done or not done. This can be the opening they need to share their concerns.
- **Be ready with information and useful resources:** understand that a parent may not be ready to address a need immediately but they may appreciate being able to look into these resources later. Offer the parent a few options for moving forward and allow the parent to choose. You can always check in with the parent at a later time if he or she shows little interest at the moment.

- **Listen and be respectful:** it is very important to listen to the parent and be open to new information that might help gain a new understanding of the problem and how to solve it. As always, it is also important to be mindful and respectful of cultural differences and language issues. Be sure to check your tone, body language, and facial expression, because your nonverbal communication can speak just as loudly as your words.

- **Reflect on your interactions with families:** think about how your attitudes and perceptions about parents or caregivers influence your interactions with families. Consider whether your feelings and ideas are subjective or judgmental. Parents and caregivers can sense when someone does not agree with or understand their culture, parenting style or life choices.

In many cases, a worried parent will be the first to raise concerns. The same principles of good communication described above apply. Parents who approach early childhood professionals first are demonstrating trust in the professional and their expertise, so it is important to honor that trust. Parents who raise concerns are being proactive. It is important that they receive the time, attention and respect that they deserve. This can be an opportunity to share concerns or strategies used by program staff to address problem behavior. It can also be an opportunity to discuss next steps including describing their concerns to a pediatric primary care provider if they decide to seek a more in-depth evaluation.

ADDITIONAL RESOURCES

Oklahoma Department of Human Services, (2011). What is Early Childhood Mental Health? Retrieved from www.okdhs.org/NR/rdonlyres/E1C71983-237E-46D6-A2FD-E2D723EAFE3B/0/0656_WhatisInfantandEarlyChildhoodMentalHealth_occs_12012011.pdf

Child Health and Development Institute of Connecticut, (2015). Advancing Trauma Informed Systems for Children. Retrieved from http://www.chdi.org/files/7514/4405/4524/Trauma_IMPACT_-_FINAL.pdf

E. Specific Steps Primary Referral Sources and Early Intervention Providers Can Take to Address Social-Emotional Development Delays and Disabilities

"Early Intervention Steps" For Families and Professionals

Family Concern

1. Referral (Unless parent objects)
- Referral source or parent suspects child of having developmental delay or disability
- Family informed of benefits of Early Intervention Program (EIP)
- Child referred to Early Intervention Official (EIO) within two days of identification
- EIO assigns Initial Service Coordinator

2. Initial Service Coordinator
- Provides information about EIP
- Informs family of rights
- Reviews list of evaluators
- Obtains insurance/Medicaid information
- Obtains other relevant information

3. Evaluation*
- Determine eligibility
- Family assessment (optional)
- Gather information for Individualized Family Service Plan (IFSP)
- Summary and report submitted prior to IFSP

4. The IFSP Meeting*
(If child is eligible)
- Family identifies desired outcomes
- Early Intervention services specified
- Develop written plan
- Family and EIO agree to IFSP
- Identify Ongoing Service Coordinator (OSC)
- EIO obtains social security number(s)

Early Intervention Services*

- Assistive technology devices and services
- Audiology
- Family training, counseling, home visits, and parent support groups
- Medical services only for diagnostic or evaluation purposes
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Respite services
- Service coordination
- Social work services
- Special instruction
- Speech-language pathology
- Vision services
- Health services
- Transportation and related costs

AREAS OF DEVELOPMENT
- Cognitive
- Physical (including vision and hearing)
- Communication
- Social/emotional
- Adaptive development

5. IFSP Review Six Months, Evaluate Annually
- Decision is made to continue, add, modify or delete outcomes, strategies and/or services
- If parent requests, may review sooner (If parent requests an increase in services, EIO may ask for supplemental evaluation)

6. Transition
- Plan for transition included in IFSP
- Transition to:
  - Services under Section 4410 of Education Law (3-5 system)
    OR
  - Other early childhood services, as needed

*Parent/guardian may access due process procedures.

Parent/guardian consent is required for evaluation IFSP, provision of services in IFSP, and transition.
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E. Specific Steps Primary Referral Sources and Early Intervention Providers Can Take to Address Social-Emotional Development Delays and Disabilities

Primary referral sources and early intervention service providers have critical roles in ensuring that the needs of children and families in the area of social-emotional development are addressed in all aspects of the child's and family's participation in the program. Research has demonstrated that development in one domain affects development in others. Especially for very young children, social-emotional development is integrally related to a child's physical, cognitive, communication, and adaptive development. For this reason, it is very important that providers working in the Early Intervention Program fully take into account the social-emotional development of all the children they work with whether or not those children happen to be experiencing a social-emotional delay or disability. For guidance, please refer to the chart on "Signs of social and emotional well-being for infants, toddlers and preschoolers" and the chart on clinical clues of social emotional development delays and disabilities in this guidance document The following offers specific suggestions for primary referral sources, early intervention officials, service coordinators, evaluators, Individualized Family Services Plan (IFSP) team members, and early intervention service providers for addressing social-emotional development needs of children in the program.

Primary Referral Sources

Under Public Health Law, many early childhood professionals are responsible for referring children who are potentially eligible for the Early Intervention Program, or at risk of a developmental delay or disability, to the Early Intervention Official in the child's county of residence. These professionals are responsible for being aware of and understand the eligibility criteria for the Early Intervention Program, explaining the program and benefits of early intervention services to parents, and, when appropriate, referring the

child to the Early Intervention Program unless the parent objects and does not wish to proceed with the referral. Primary referral sources include all approved evaluators, service coordinators, and providers of early intervention services, and the following organizations and individuals who provide services to infants/toddlers and their families:

- hospitals;
- child health care providers;
- day care programs;
- local health units;
- local school districts;
- local social service districts;
- public health facilities;
- early childhood direction centers;
- operators of any clinic approved under Article 28 of Public Health Law, Article 16 of the Mental Hygiene Law, or Article 31 of the Mental Hygiene Law; and,
- all individuals who are qualified personnel as defined in PHL Section 2541(15) and Section 69-4.1 of program regulations.

Providers with trusting relationships with families can be valuable participants in the Child Find efforts of the local Early Intervention Program. Each local Early Intervention Program is required to have a comprehensive Child Find system which acts to identify and locate children who are eligible for the program and to provide for the identification, screening, and tracking of children at risk for developmental delay.

Whether through direct observation of an infant's or toddler's behavior and/or the concerns expressed by the child's parents or other caregivers regarding the child's social-emotional development and other areas of development, these professionals have an opportunity to explain the benefits of the Early Intervention Program to the family and recommend or make a referral to their local program. The flow chart at the beginning of this section describes the steps in the Early Intervention Referral Process.

Early Intervention Officials

As the public officials responsible for the implementation of the Early Intervention Program in communities across the state, Early Intervention Officials can play an important role in educating primary referral sources and the broader community about children's social-emotional development, as well as other areas of development that may mean a child is potentially eligible for the Early Intervention Program. Early Intervention Officials and their staff can ensure that Child Find materials and outreach activities specifically address social- emotional development, including the signs and clinical clues that may indicate a child is experiencing a delay in this area. Early Intervention Officials can work with the wide array of early childhood professionals who deliver services to young children and their families to be sure these professionals understand that a delay in social-emotional development, as well as many diagnosed conditions that impact on this area of development, requires a referral to the Early Intervention Program unless the parent objects and does not wish the referral to proceed. Finally, Early Intervention Officials, in their important oversight role, can ensure that children referred to the Early Intervention Program receive a comprehensive multidisciplinary evaluation that includes an evaluation and assessment of the child's social-emotional development. (See Appendix 4 for the criteria for initial and ongoing eligibility for the Early Intervention Program.)

In New York State, children who are at risk for developmental delays and disabilities who meet certain criteria must also be referred to the Early Intervention Official for screening and tracking of their development, unless the parent objects and does not wish to proceed with this referral. There are also some criteria which professionals can consider in making a referral to the Early Intervention Program. (For a list of the criteria for children at-risk of a delay or disability, go to Appendix 3). Early Intervention Officials can play an important role in ensuring early childhood professionals know about these screening and tracking services and how to refer families. This includes children who are typically developing but are at high risk for developmental problems due to medical/biological neonatal or medical/biological post-neonatal and early childhood risk factors (including parent or caregiver concern about the child's developmental status). Risk factors related to the child's family that may impact a child's social emotional development and may be considered by primary referral sources in a decision to refer a child to the Early Intervention Program include an indicated case of child maltreatment, or a parent's developmental disability, diagnosed serious and persistent mental illness, or substance abuse (including alcohol or illicit drug abuse).

Initial Service Coordinators

Initial Service Coordinators have a very important role in assisting families of children referred to the Early Intervention Program in completing all the necessary steps to determine if their child is eligible for Early Intervention Program services and supporting their participation in the process of developing an Individualized Family Service Plan.[4] Initial Service Coordinators can facilitate identification of parent concerns related to social-emotional development by:

- Encouraging parents to share information about their resources, priorities, and concerns about their child's social-emotional development (e.g., relationship to parents/other family members, challenging behaviors, child temperament, fussiness, and eating and sleeping routines).

- Reviewing all options for evaluation and screening with the parents from the list of approved evaluators including the most appropriate types of evaluations, settings for evaluations (e.g., home vs. evaluation agency), and qualified professionals who are specialists in the area of social-emotional development and who understand the culture and language (s) of the family.

- Encouraging parents to share concerns about their child's social-emotional development, social behaviors and relationships, and challenging behaviors with evaluators.

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[4]Initial Service Coordinators are responsible for informing the family about the Early Intervention Program and their rights and entitlement under the program. The primary responsibilities of the Initial Service Coordinator are outlined in regulation (10 NYCRR 69-4.7) and in guidance documents issued by the Department (www.health.ny.gov/community/infants_children/early_intervention).

Explaining the importance of and encouraging parents to provide consent for transmittal of medical and other records that may be useful to evaluators in determining children's eligibility and assessing children's social-emotional and other areas of development.

The outcomes of exemplary service coordination practices have been described by the Research and Training Center on Service Coordination, a five-year project that was funded by the Office of Special Education Programs, US Department of Education, that also support the social-emotional development for all children:

- Families make informed decisions about resources and supports in the community for their children.

- Families acquire or maintain a quality of life that enhances their well-being.

- Families have the tools, knowledge and support to access resources.

- Families are knowledgeable about their child's unique needs.

- Children's development is enhanced.

- Children are safe and healthy.

- Children have successful transitions.

- Children and families receive early intervention services that are individualized, coordinated, and effective (Dunst and Bruder, 2006).

Choosing an Evaluator

The Initial Service Coordinator is responsible to help families choose an evaluator and think about possible options for their child's evaluation. The following are some questions that the Initial Service Coordinator can ask parents to think about and discuss to help guide their choice of an evaluator:

- Do you think your child will do better during the evaluation at a certain time of day?

- Who else do you want to attend the evaluation with you? Would an appointment at a certain time of the day, or day of the week, make this possible?

- Is there a behavior that is a special concern that you are worried about? If yes, does this behavior occur at a certain time of day or during certain routines or activities?

- Is there anything else that occurs at these times that causes you concern about your child?

- Do you prefer the evaluation to be done in your home or in another location? How do you think the place will affect your child's performance?

The Initial Service Coordinator can also help parents to think about the information and outcomes they might want from the evaluation:

- The professionals who will/should be on the multidisciplinary evaluation team.

- The options for an appropriate evaluator to meet the needs of the child and family including the evaluator with expertise in the developmental domain where there is the greatest concern.

- An explanation of what the different professionals do.

- The amount of time it will take to do the evaluation.

- An explanation about the meaning of developmental age levels.

- What is expected for their child's age.

- What the evaluator is looking for in their child's response.

- Specific areas where their child needs help.

- What their child does well.

- Recommendations for service options.

- Suggestions on how to help their child's development.

Evaluators

Children referred to the Early Intervention Program with a suspected developmental delay or disability must receive a comprehensive, multidisciplinary evaluation, including an assessment of all five developmental domains (cognitive, communication, social-emotional, physical, and adaptive development). The multidisciplinary evaluation team has a very important role to play in ensuring that a child's evaluation includes an in-

depth assessment of the child's social-emotional development. In addition, parents can choose to participate in a voluntary, family-directed family assessment to identify their priorities, resources and concerns related to their child's development and the services and supports that the family needs to enhance their child's development.

Social-emotional development in the early childhood years provides the critical foundation for all future development and learning. In assessing the child's social-emotional development, it is important for evaluators to consider how the child relates to others, including their parents and caregivers, the quality of those relationships, the child's feelings about self and others, and the child's ability to regulate feelings. Evaluators have an important role to play in creating a comfortable and trusting environment for families, and working within confidentiality and parental consent requirements, should encourage parents to share their family history and information, child's medical history, and their concerns, priorities, and resources with the evaluation team so they can get a comprehensive picture of the child and family.

The following are some points for evaluators to consider at specific stages in the evaluation process:

Composition of the Multidisciplinary Evaluation Team

The evaluator is responsible for assembling an appropriate multidisciplinary evaluation team. In choosing evaluators for the team, the evaluator should consider the parent's resources, priorities, and concerns; any information provided by the referral source, if it is someone other than the parent (e.g., diagnostic information, medical/developmental history); and the family and child's language and culture. The multidisciplinary evaluation must include an assessment of the child's development in five areas of development, including social-emotional development. Other areas that must be assessed are communication, cognition, physical, and adaptive development. If the reason for referral is a social-emotional concern, there must be a specialist on the multidisciplinary evaluation team who will

Working With Families Whose Preferred Language is Other than English

If the family's first language is other than English:

- Provide materials in the family's preferred language whenever possible, and use as few written forms as possible.

- Use an interpreter when possible. Using a family member, friend, or neighbor is not recommended. It may be more difficult for the family to discuss concerns and problems with someone who is a part of their community or family.

- Take time to speak with the interpreter. Let him or her know that it is important to translate exactly what is being said. The interpreter must also understand that what is said is to be kept confidential.

- Learn a few words in the family's language. It will help to connect you with the family. (WestED, 2014)

complete an in-depth assessment of this area of development, such as a psychologist or a clinical social worker or other professionals with expertise in social-emotional development or infant mental health of children ages birth to three.

However, sometimes concerns about the child's social-emotional development arise during the course of the multidisciplinary assessment. When new concerns are identified during the initial evaluation process, the evaluation team should consider including an additional professional with specialized expertise who should conduct an in-depth assessment of the child's social-emotional development (referred to as a supplemental evaluation). It is important that all areas of a child's development, and especially those where a problem or concern has been identified, be fully

assessed as part of the initial multidisciplinary evaluation to determine eligibility. This is necessary to ensure that the IFSP includes the services and supports necessary to address all areas of developmental need.

Another important consideration when assembling the multidisciplinary evaluation team is the selection of evaluators who are fluent in the child and family's language and knowledgeable about the family's culture. Culture plays a strong role in social-emotional development. Understanding the parent's beliefs about child development, attachment bond, family dynamics and parenting is critical when assessing a child, since these directly impact how the child is raised, how family members interact, and how the child is socialized.

Components of the Multidisciplinary Evaluation

The multidisciplinary evaluation team must use many sources of information to assess the child's development and determine program eligibility, including observations of the child, interviews with the parent, standardized instruments, and, with parent consent, a review of medical and other records. Informed clinical opinion must be used by the evaluation team to synthesize all of these sources of information to help inform the child's eligibility and strengths and needs in each area of development. Children's behaviors can vary across people and settings. Obtaining information about a child's behavior in different contexts (e.g., at home versus child care, with adults versus children) helps evaluators not only understand the clinical significance of the behavior, but also identify those situations that improve or exacerbate it. With parent consent, evaluators can obtain information from other sources. When evaluating a child's social-emotional development, it is important to get a holistic view of the child; frequently, assessment of social-emotional development focuses solely on problematic behaviors, without consideration for the child's strengths and needs or the status of the child's social-emotional development. The evaluation team should also consider the impact of the assessment process on the child and family and take steps to ensure a shared understanding of findings and recommendations between the evaluation team and family.

Parent Interview

A parent interview is required as part of the multidisciplinary evaluation. During this interview, the evaluator asks the parent about the family's resources, priorities, and concerns related to the child's development. For all children referred to the program the parent interview represents a unique opportunity to gather information on child's social-emotional development and any concerns that the parents have with the child's behavior.

Voluntary Family Assessment

The voluntary family-directed family assessment is an important opportunity for evaluators to work with families to identify the formal and informal supports and services they need to enhance their child's social-emotional development, including promoting positive social-emotional development and addressing challenging behaviors and other concerns about their child's social skills, interaction with others, relationships, temperament, sleeping and eating routines, fussiness etc. Parents may also volunteer other issues with which they need help. As is true with other areas of development, social-emotional development is highly impacted by the responsiveness of the child's parents/caregivers. Asking families about their family background and stressors is critical to assessing factors which could be directly or indirectly contributing to difficulties that a child is experiencing in social-emotional development. For children in foster care, investigation of parental concerns can be particularly challenging.

Eliciting and Understanding Parent Concerns

"Because young children cannot report on their own internal experiences, clinicians must rely upon the reports of caregivers who know the children well (Zeanah, 2009)." It is important for evaluators to ask the parent and other caregivers about the child's skills and abilities during natural routines in familiar environments with parents and familiar caregivers. This should include as many people who see the child in as many different contexts as possible, because children's behaviors may be context-specific. When a parent reports

a social-emotional concern or the evaluator observes a behavior or concern, it is important for the evaluation team to work with the family to understand the nature, history and significance of the behavior. For example, if a parent or caregiver reported that a child has many temper tantrums, some of the questions that the evaluator could ask to get a full picture of the behavior and its context include:

- Has anything changed recently in the child's or family's life, and if so, could these changes be contributing to the behavior?
- What does "many" mean?
- How long does the temper tantrum last?
- How long has the behavior been going on?
- What things make the behavior worse or better (e.g., child hungry or tired)?
- In what settings or under what conditions does the behavior occur or not occur?
- Does it happen with all caregivers or specific ones?
- How has the parent addressed this behavior?
- How are other caregivers addressing this behavior?
- What strategies have worked or not worked?
- Why does the parent think the infant/toddler is demonstrating the behavior?

In exploring and documenting parental/caregiver observations and concerns, the multidisciplinary evaluation team gains a more comprehensive understanding of the behavior being observed. This enables them to apply their clinical opinion in determining whether the child's behavior is typical or atypical and indicative of a significant delay in social-emotional development consistent with eligibility criteria.

Eliciting and Gathering Information for Children in Foster Care

Depending upon how long the child has been in foster care and how well the foster parent knows the child, the foster parent may be unable to provide comprehensive information about the child's medical, social, family and developmental history, the reason for foster care placement, and prior foster care placements. Thus, it is critical for evaluators to explore alternative sources of information when evaluating children in foster care. A key source of information is the foster care caseworker or supervisor. The NYS Department of Health and the NYS Office of Children and Family Services have created a document called *Protocol for Children in Foster Care Who Participate in the Early Intervention Program* to guide the coordination of Early Intervention Program evaluations and services to children in the child welfare system (New York State Department of Health Early Intervention Program & New York State Office of Children and Family Services, n.d.). This document recommends that the Early Intervention Program evaluator have access to the foster care caseworker's contact information. It states that the foster care caseworker should share relevant information with the Early Intervention Program service coordinator and evaluator, including previous health/developmental evaluations and/or other information that will influence the Early Intervention Program evaluation [including] information regarding the foster placement that may impact on service delivery and feasibility of services.

It is critical to investigate the reason for the child's placement in foster care (e.g., abuse, neglect, trauma) as it may have a significant impact on the child's social-emotional development. Young children rely on their parents/caregivers to keep them safe physically and emotionally, and to help them regulate their emotions around stressful events. When children do not have this support, they often demonstrate challenging behaviors or symptoms which are indicative of atypical social-emotional development (National Child Trauma Stress Network, n.d.-b). Separation from the parent between 6 months and 3 years of age is particularly likely to result in social-emotional difficulties, because stranger anxiety is typical for all children in this age range, and because of the child's lack of language abilities to understand this disruption. These factors need to be considered when assessing children in foster care.

In addition, while removal of a child from their birth parent's home may provide physical

and emotional safety for the child, it also can undermine the child's ability to form attachment relationships with a primary caregiver, since the child experiences a loss and lack of permanency. Children who have multiple foster care placements are at even greater risk for oppositional behavior, crying and clinginess (Troutman, Ryan and Cardi, 2000). The absence of stable, responsive care giving can contribute to creating social-emotional difficulties in young children. It is for this reason that detailed inquiry about the foster care placement, the child's adjustment and attachment to a foster care parent, and reasons for placement are critical in assessing the child's social-emotional development.

Observations of the Child

Behavioral observations of the child throughout the evaluation process are critical to gathering information about the child's social-emotional functioning. Detailed descriptions of the child's behavior during the evaluation should be documented in the multidisciplinary evaluation and then integrated by the multidisciplinary evaluation team to determine the child's developmental functioning. Children can express different emotional experiences through play and how they play. Children's play can provide valuable information regarding the child's symbolic capacities, which is an important indicator of a child's developmental level and a window into their internal experience (Vig, 1998). For example, children who have witnessed domestic violence may demonstrate very aggressive play with objects. Observations of the child's play are important when gathering information about the child and determining the child's social-emotional developmental level.

Factors to consider include:

- Does the infant/toddler make eye contact? How does she or he interacts with evaluators?

- Does the infant/toddler initiate joint attention with the parent/caregiver or other adults? Engage in turn-taking behaviors?

- Does the infant/toddler recognize and respond to facial expressions?

- What does the infant/toddler do during unstructured periods?

- What is the infant/toddler's affect?

- How does the infant/toddler respond to limits?

- How does the infant/toddler transition from one activity to another?

- What is the infant/toddler's activity level?

- How is the infant/toddler's attention span?

- What is the infant/toddler's frustration tolerance? How does the child play with toys?

Observation of the Parent/Caregiver-Child Relationship

To adequately assess the social-emotional development of all children referred to the Early Intervention Program for services, it is critical that each evaluation include an observation of the child's relationship and attachment to parents and/or caregivers. The parent-child relationship provides a secure base from which the child is able to explore the social and physical environment, learn about the world and develop self-confidence and self-esteem. It is through the parent-child relationship that the child learns about regulation and management of emotions, a critical skill to learning and thriving.

Throughout the entire evaluation process, the evaluation team should observe how the child and caregiver interact with one another, share those findings with the families, and document the observations in the evaluation. Parents who are attuned to the needs of their children are able to attend to their physiologic needs. This provides the foundation for children to learn and grow during the early years, and fosters curiosity, self-direction, persistence, cooperation, caring, and conflict resolution (Lieberman, 1993). When parents are consistently or repeatedly unable to respond to their children's needs in a responsive and nurturing manner or are negative or controlling, children do not feel safe. As a result, they may develop difficulties trusting, connecting to others, and regulating their emotions.

In assessing the parent/caregiver-child relationship, some of the factors to consider are:

- How does the infant/toddler use the parent as a secure base to explore the environment?

- How does the infant/toddler use the parent for support in interacting with the evaluator and coping with the stress of the evaluation? (Ainsworth & Wittig, 1969).

- Does the infant/toddler engage in social referencing? Social referencing refers to how the infant/toddler child uses the facial expressions of the parent/caregiver to gain information about what to do.

Another important component to observe in the parent-child interaction is the parent's watchfulness of physical safety.

- Is the parent constantly monitoring the infant/toddler?

- Is the parent appropriately vigilant or is the parent overprotective, or, conversely, does the parent seem unaware or unconcerned with ensuring the infant/toddler's physical safety?

- How does the parent relate to the physiological needs of the infant/toddler?

- How does the parent monitor or help the child with the regulation of sleep, hunger, warmth, stimulation, stress, elimination and states?

- How does the parent help the infant/toddler mediate his/her arousal level?

- How does the parent respond to the distress of the infant/toddler?

The "Cues for Observing Parent-Child Interactions" chart provides additional tips for observing parent child interactions.

Cues for Observing Parent-Child Interactions
Cues reading: pleasure, distress and self-comfort

Parent: **Positive**	*Parent:* **Concerning:**
• Child's cues are recognized, and responded to – eliciting a pleasing response from the child (e.g. child cries, mother comforts, child quiets, mother feels competent) • Sensitive response to child cues • Physical and verbal attempts to comfort distressed child • Able to tolerate negative affect (crying, resisting cuddles) calmly • Able to prioritize the child's need for comfort and reassurance	• Misses or misunderstands cues • Responds to most distress cues by feeding baby • Caregiver believes child intentionally upsets them • Escalating rather than calming the child's distress • When child is distressed, parent becomes more distressed than child **Child: Concerning** • Failure to seek comfort for distress

Cues for Observing Parent-Child Interactions

Child: **Positive**

- Cues are clear and differentiated
- Comfort seeking when hurt, ill or emotionally upset
- Comfort seeking proportionate to distress precipitated by separation
- In absence of distress during separation, positive interaction or reconnection during reunion
- Balance between independent functioning and developmentally appropriate help-seeking

- Indiscriminate comfort seeking from relative strangers
- Frequent crying or distress, difficult to console, excessive demanding of attention
- Incongruence between separation behaviors and reunion responses
- Avoidance, resistance or disorganized responses
- Excessive dependence and unwillingness to tackle challenges
- Precocious competence in self-care
- Failure to use attachment figure for help with difficult challenges

Showing affection: empathy

Parent: **Positive**

- Warm and affectionate interchanges across a range of interactions
- Able to look at things from the point of view of the child (e.g. age appropriate expectations, activities)
- Being patient and trying to understand what the child wants
- Playtime follows the child's interests not the parent's, is at eye level with the child
- Showing an interest in what the child is doing or saying

Parent: **Concerning**

- Absence of warmth
- Promiscuous affection and sexualized affectionate interchanges
- Threatening to cry or send the child away
- Parent cannot divert from own needs or wants, repeated self-referencing
- Viewing child as a same aged peer
- Personalizing the child's behavior (e.g. "he hates me")
- Punitive discipline (numerous arbitrary rules, excessive time outs, harsh interpretations of ordinary behavior, "upping the ante" i.e. responding to problems with escalating threat)

Parent: **Positive**

- Eye contact & sustained gaze
- Look/ look away cycle
- Follows child's line of regard

Child: **Positive**

- Eye contact & sustained gaze
- Look/ look away cycle

Parent: **Concerning**

- Continues or increases stimulation when child looks away – calls child, pulls on arm or turn child's head
- Limited or poor eye contact

Child: **Concerning**

- Limited eye contact, parent says child does not look at him/ her

   Limited or no joint attention

Cues for Observing Parent-Child Interactions

Facial expression & level of arousal

Parent: **Positive**

- Smiles at child
- Affectionate mirroring
- Range of facial expression
- Tracks child's facial expression

Child: **Positive**

- Capable of "joy", smiles and positive expression sustained
- Range of facial expression
- Child tracks parent's facial expression

Parent: **Concerning**

- Non-responsive or withdrawn (i.e. flat, distant, disinterested, sleepy)
- Confused, disoriented
- Tense, angry, agitated, frightened, frightening or flat facial expression

Child: **Concerning**

- Predominately irritable, negative or angry mood
- Over aroused, excessive activity, limp, or inactive

Vocalizations

Parent: **Positive**

- Positive or sympathetic tone of voice
- Positive prattle
- Warm comments, finds family resemblance, boasts about baby
- Affectionate names
- Matches each other's rhythms

Child: **Positive**

- Presence of vocalizing
- Primarily positive or neutral vocalizations
- Matches parent's vocal rhythms

Parent: **Concerning**

- Frightening or frightened tone of voice, whispering or mumbling, tense or high pitched laugh or tone of voice
- Excessive or rambling talking
- Laughs, mocks or teases
- Angry tone, shouting
- Unhappy or scolding inflections
- Name calling, calls baby "it", finds resemblance to disliked person
- Many complaints about labor & delivery and/ or child's behavior

Child: **Concerning**

- Inhibition of all vocal distress
- Very quiet
- Primarily negative – fussy, angry

Physical connection: Touch/ holding

Parent: **Positive**

- Hugs, touches, kisses child
- Holds baby close and is protective of baby

Parent: **Concerning**

- Restraining instead of holding
- Demanding instead of seeking affection
- Continuous picking at child
- Poking, grabbing, pulling by wrist or clothes, rough handling, or pushes child away.
- Props baby when feeding

Cues for Observing Parent-Child Interactions	
Child: Positive	**Child:** Concerning
• Cuddle, touch and close physical contact is welcomed by the child	• Child arches back, looks away, fusses or frequently startles during interactions • Excessive hugging and kissing
Rhythmicity/ Reciprocity	
Parent: Positive	**Parent:** Concerning
• Interactions relaxed • Interactions are back and forth, not one way	• Tense, uncomfortable, fidgety interactions • Interactions are frequently disrupted or unpredictable – such as pulling away bottle from feeding child, waking a sleeping child or pulling away a toy the child is engaged with • Parent ignores invitation to play or other attempts to interact • Parent persists with unwanted stimulation
Child: Positive	**Child:** Concerning
• Demonstrates a willingness to comply with caregiver requests and redirections with minimal conflict • No pattern of attempting to control behavior of the caregiver	• Pattern of noncompliance • Hyper compliance, especially if accompanied by fearful affect • Punitive and bossy efforts to control attachment figure • Over solicitous, over concern with caregiver's well-being

Screening and Assessment Instruments

Evaluators are responsible for selecting appropriate instruments based on the unique characteristics of the child (age, language, culture, developmental concerns). In addition, evaluators must use instruments with adequate psychometric properties (tools must be reliable, valid, have good sensitivity and specificity). The Early Intervention Program has developed a list of approved instruments that must be used to assess the child's development. Comprehensive developmental assessments include items and components to assess social-emotional development. There are also screening and assessment instruments designed to be used to do an in-depth assessment of social-emotional development or child behaviors. A list of screening and assessment instruments approved by the NYS Early Intervention Program can be found in Appendix 2.

Assessment Process and Environmental Conditions

Many factors can influence how a child and family respond to the assessment process, including the setting for the evaluation (e.g., familiar versus novel) and the child's and family's physical and emotional state. A negative reaction to evaluation or environmental factors might make a child feel anxious, overwhelmed, or inhibited, resulting in behaviors ranging from refusal to participate to withdrawal or clinginess. These behaviors might be assessed as indicative of social-emotional delays if the cause is not thoroughly explored and identified as a function of the evaluation process. Some factors to consider in choosing the evaluation method and location include, but are not limited to:

- The child's usual reaction to novel environments.

- The child's usual reaction to strangers, and to having multiple adults present at once, including both the reaction to their physical presence and reaction to their interactions and requests.

- The child's physical or mental/emotional state, which might include being hungry, tired, irritable, just waking up from a nap, sick, over-stimulated.

- The parent's current physical or mental/emotional state can impact the child's sense of security and level of trust and anxiety.

- The parent's involvement in the evaluation process.

Efforts should be made by the evaluation team to minimize the impact of the assessment process and environmental conditions on the child's performance. When concerns about the impact of any of these factors are raised, it is important to consider whether there are other factors that might offset them, such as having a parent make requests rather than the evaluator, or whether an evaluation of this child in their natural environment with family and only one other evaluator present might be the most effective way to obtain an accurate portrayal of the child's abilities.

Regardless, evaluators must always consider and use informed clinical opinion to determine whether the assessment process and conditions impacted the child's performance. This includes whether the child's response is typical and if the multidisciplinary evaluation findings accurately portray the child's abilities.

Informed Clinical Opinion

Informed clinical opinion is the use of qualitative and quantitative information by professionals to assess a child's development. The use of informed clinical opinion and diagnostic procedures is particularly important when, due to the child's age, culture, language, and/or nature of the developmental problem or concern, standardized instruments are not available or appropriate. When using informed clinical opinion in the evaluation process, practitioners draw upon clinical training and experience, standardized instruments, as available and appropriate, recognized clinical assessment procedures (e.g., observation techniques, interviewing techniques, use of objective measurement techniques specific to the developmental problem or circumstances and concerns related to child and family, etc.), experience with children of different cultures and languages, and, their ability to gather and include family perceptions about children's development. Informed clinical opinion should be used to integrate, synthesize, and interpret all evaluation findings, including information provided by the parent about the child's development and the family's resources, priorities, and concerns about the child's development. The team is responsible for reviewing, interpreting, and synthesizing information among the evaluation team and including the parent's perspective in the evaluation report. When assessing social-emotional development, informed clinical opinion may be based on:

- A comprehensive biopsychosocial history of the child and the parents, when consented, with attention to trauma and toxic stress and sensitive to cultural, ethnic, language, immigration factors.

- Observation of the child in preferably more than one setting and engaged in more than one type of activity and always including play.

- Observation of a relational sample of behavior with the parents/primary caregivers with attention to attachment and the variables discussed above.

- Observation of a relational sample of behavior of the child with peers and other significant adults in the child's life.

- Data derived from objective parent report, rating scales and structured behavioral procedures, when possible, "norm referenced" instruments, including both screening and assessment tools.

The following are two case examples illustrating use of informed clinical opinion in determining eligibility for the Early Intervention Program.

Case Examples of Use of Informed Clinical Opinion in Determining Eligibility for the Early Intervention Program

Case Example 1

A young boy (30 months old) is referred to the Early Intervention Program because of concerns regarding his behavior. The multidisciplinary evaluation team is staffed by a psychologist and a special educator. The mother reports that since the death of her husband, her son hits people for no reason, is excessively clingy, wakes up in the middle of the night, does not like to take baths and screams when his mother tries to give him a bath (a ritual that he and his father previously enjoyed). The family history is significant for parental mental illness. The father, who was the primary caregiver, passed away seven months earlier from a heart attack. The mother reports that the child goes to the door, repeatedly asking for his father, and waits by the door for him to come home. The mother reports being frustrated with this behavior, and being unable to redirect or distract him. Since the father passed away, the child reportedly hits other children, pulls hair, gets upset by little things,

is difficult to soothe, yells, screams and bangs his head. In reviewing the DC: 0-5 diagnostic-classification system, it would appear that this child may be experiencing a clinical disorder based on the intensity of his symptoms and the impairment experienced by the child and his surviving parent.

A diagnosis of Complicated Grief Disorder of Infancy/Early Childhood may be warranted

based on the emergence of these symptoms after the death of the father. The description of this disorder explains that the loss of a significant caregiver is a serious stressor for a young child, and that most children do not have the emotional or cognitive resources to deal with such a loss and that those children who show significant and pervasive impairment following a death may be experiencing this clinical disorder. Based on the DC:0-5 criteria for this diagnosis, this child meets the criteria for Complicated Grief Disorder of Infancy/Early Childhood based on the following criteria:

- Young child persistently cries, call, or searches for the lost person.

- A strong emotional reaction to any theme connected with the loss for example his bath time ritual.

- The young child's reaction to the loss includes depressed affect, self-harming behaviors and significant sleep changes.

- Symptoms meet impairment criteria including distress to young child, interference in young child's relationships (especially with mother and peers), limitations of the young child's participation in developmentally expected activities or routines.

This child appears to have a 33% delay in social-emotional development based on the

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significance of the symptoms described and level of disruption in functioning and meets the criteria for Complicated Grief Disorder of Infancy/Early Childhood and possibly Depressive Disorder of Early Childhood. The use of this classification would be critical in guiding intervention, as the emotional and behavioral patterns that this child is demonstrating seem to be a reaction to a very significant loss in his life. Intervention should be geared towards helping create a safe and consistent caregiving environment, helping the child accept the physical reality of the parent's death and find alternative ways to

express his feelings of sadness and anger. In addition, it would seem that his mother would need guidance on how to talk to her son about the death of his father and help him grieve, and efforts to support the child's emotional connections with his surviving parent (mother) would be appropriate. The early intervention staff may consider referral for dyadic treatment such as Child Parent Psychotherapy (CPP). As a result, the Individualized Family Service Plan would include outcomes and goals tailored to this child's and family's situation, based on the findings of the multidisciplinary evaluation.

Case Example 2

Child is referred to Early Intervention because of emotional trauma. The multidisciplinary evaluation team consists of a psychologist and special educator. The child is 26 months of age. Parent reports that her daughter is scared of the bath and has nightmares. These behaviors began six months ago when her father had an acute psychiatric event. The father was exhibiting strange behaviors, some of which included rages and violent behavior and periods of isolating himself in the bathroom. The child had previously witnessed domestic violence between the parents. The mother reported that the father had been the child's primary caregiver while the mother worked full time. She describes her daughter as bright and verbal. However recently in the past six months, she has had significant temper tantrums which last 30-40 minutes. She bangs her head when she is upset, and she wakes up several times a week with nightmares. She is not able to articulate what happened but is visibly shaken and cries inconsolably for at least 10 minutes every day. In addition, she is highly resistant to going into the bathroom and her play reflects themes of adults fighting or losing control of their temper.

Based on the behaviors described above, it appears as if the child is experiencing Post Traumatic Stress Disorder. DC:0-5™ describes a specific constellation of symptoms in response to traumatic exposure (e.g., witnessing the psychiatric breakdown of father, witnessing domestic violence) in which the defining feature is a set of signs that appear following the exposure. This child's symptom picture is consistent with the criteria, including exposure to significant threat of or actual serious injury, significant loss or violence, evidence of re-experiencing the traumatic events through play or behavioral re-enactment, repeated nightmares, significant distress of reminders of the traumas, avoidance or attempts to avoid trauma related stimuli (e.g., bathroom), increased fearfulness and sadness, difficulty sleeping, and increased irritability and outbursts of anger and symptoms of impairment.

The diagnosis of Post- Traumatic Stress Disorder would be critical to understanding what is going on with the child and planning the intervention with the IFSP team. The emotional and behavioral patterns that this

child is demonstrating appear to be a reaction to the traumas that she may have experienced through witnessing domestic violence as well as interactions she has had with her father directly. Trauma informed care and treatment would be important means of intervening with this child and her mother. Referral for Child-Parent Psychotherapy would be beneficial. It would also seem important that the child's mother be referred for her own mental health counseling to address the issues of domestic violence.

Synthesizing Results and Deciding on Eligibility

A very important role of the multidisciplinary evaluation team is to review and synthesize all the information gathered in the assessment process to determine the child's functional abilities and developmental status in each domain. The evaluators or a designated team member are also responsible for informing and discussing the results of the evaluation with the parents, in a manner that is understandable. This discussion should include any concerns the parent has about the evaluation process and the extent to which the parent believes the evaluation accurately reflects the child's abilities and needs. The evaluator is responsible for helping parents understand the results and make certain the evaluation has addressed the parent's concerns and observations about the child.

When the primary concern to emerge from the child's evaluation and assessment is the child's social-emotional development, evaluators must consider whether the child is experiencing delays in developmental milestones for social and emotional development, or the the child's social and emotional development and behaviors are atypical (i.e., qualitatively different from typically developing children), or both. To be eligible for the Early Intervention Program, based on a developmental delay, the child's delay must be consistent with eligibility criteria. See Appendix 3 for Criteria for Determining if a Child is At-Risk of a Delay or Disability as well as Appendix 4 for Initial and Continuing Eligibility Criteria. To learn more about the eligibility criteria, go to: www.health.ny.gov/community/infants_children/early_intervention/memoranda/2005-02 (New York State Department of Health Early Intervention Program, 2005)

Another valuable resource to understanding social-emotional developmental disorders in young children is the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-5™) (ZERO TO THREE, 2016a). This classification system fills an important gap in describing mental health and behavioral disorders in children birth to five. The symptomatology of mental health and behavioral disorders in very young children look very different from how they would look in a school-aged child, adolescent or adult. Very young children can be clinically depressed and experience Post-Traumatic Stress Disorder (PTSD) and other mental health disorders, but they may manifest it differently than do older children who have higher-level cognitive and verbal skills. The two case examples presented earlier illustrate different behavioral diagnoses seen in young children.

Children with specific diagnosed physical and mental conditions with a high probability of resulting in developmental delay can be determined eligible for the Early Intervention Program based on this diagnosis (New York State Department of Health Early Intervention Program, 2005). Examples of diagnosed conditions that can affect young children's social-emotional development include Autism Spectrum Disorder (ASD), Post -Traumatic Stress Disorder , and Attention Deficit Hyperactivity Disorder (ADHD). Infants and toddlers who are diagnosed with these conditions may exhibit atypical emotional or behavioral conditions, such as delay or abnormality in achieving expected emotional milestones, such as pleasurable interest in adults and peers, ability to communicate emotional needs, and self-injurious and/or persistent stereotypical behaviors.

It is important for the evaluation team to be cognizant of the fact that some behaviors, though challenging, may be developmentally appropriate and occur as there are shifts in development. For example, between about seven and nine months, babies may develop anxiety around strangers and become fearful and upset when their parents leave them, even in a very familiar child care setting. Between 18 and 21 months, as the central nervous system is undergoing developmental changes, even the calmest of babies may suddenly, and frequently, tantrum.

During the second year, as toddlers have big ideas of what they can do and very few words to express those ideas, they may suddenly turn to biting as a strategy. These behaviors are challenging - but are part of normal development for that age. All infants and toddlers will have unhappy moments, but they usually have the capacity to calm down and enjoy being with their peers. The establishment of this emerging social and emotional control depends in part on the child's early relationships and may be influenced by the child's temperament. Thus, it is the responsibility of the evaluation team to put the behaviors in a developmental context and determine whether the behaviors are challenging but typical, or are atypical for the child's developmental age.

Assisting Children and Families Who Are Found Ineligible for the Early Intervention Program

If the multidisciplinary evaluation does not establish the child's eligibility for the Early Intervention Program, the child and family may still benefit from other services in their community that can promote the child's social-emotional development and support the family

in enhancing the child's social-emotional development, including positive social relationships. For example, services such as those provided by family resource centers, parenting education programs, libraries, and/or clinical services such as a mental health counseling or a medical consult for the child's parents may be

helpful. The child's and family's evaluation team and service coordinator can assist the family in providing information about and making referrals to other services that may be helpful to the child and family. In providing referrals, it is important to give the family information about types of services offered and any costs that may be associated with the service. In addition, if appropriate, a referral can be made to the Early Intervention Program's Child Find program for ongoing developmental surveillance. For information on making a referral for services and potential sources of supports and services for the child and family go to Section F: Making Referrals for Supports and Services.

Individualized Family Service Plan Team Members

If a child is found eligible for the Early Intervention Program, the Early Intervention Official is responsible for convening a meeting with the child's parent(s), the initial service coordinator, the evaluator, and anyone else the child's parent(s) wishes to invite. The purpose of this meeting is to develop an Individualized Family Service Plan (IFSP) that identifies the areas of child need, the resources, priorities, and concerns of the family in enhancing and supporting the child's development, and the measurable outcomes to be achieved for the child and family, and the services, strategies and supports to achieve those outcomes. Every member of the IFSP team, including the parent(s), has information to contribute to the creation of the IFSP to ensure that the appropriate IFSP outcomes and the strategies developed to support achieving these goals are discussed and documented. Once the plan is developed and agreed on, the plan must be reviewed every six months and evaluated annually to monitor the child's progress, and determine whether any changes are warranted to better serve the child and family.

An important part of a child's and family's IFSP planning process is to identify the measurable outcomes for the child and family, and the strategies and services needed to help the child achieve those outcomes. The U.S. Department of Education, Office of Special Education Programs,

has identified three child outcome indicators and three family outcome indicators for children and families participating in the program (The Early Childhood Technical Assistance Center, 2016a). One of the three child outcome indicators focuses on development of positive social-emotional skills. All states are required to measure and report annually to the Office of Special Education Programs on the percent of children who have made progress and the percent who have maintained or attained age-level on these three outcomes, which are defined as follows:

- ## Positive Social-Emotional Skills (Including Social Relationships)

  Making new friends and learning to get along with others is an important accomplishment of the early childhood years. Children develop a sense of who they are by having rich and rewarding experiences interacting with adults and peers. They also learn that different rules and norms apply to different everyday settings and that they need to adjust their behavior accordingly. This outcome involves relating to adults and relating to other children, and for older children following rules related to groups or interacting with others. The outcome includes concepts and behaviors such as attachment/separation/autonomy, expressing emotions and feelings, learning rules and expectations in social situations, and social interactions and social play.

- ## Acquisition and Use of Knowledge and Skills (Including Early Language/Communication and Early Literacy)

  Over the early childhood period, children display tremendous changes in what they know and can do. The knowledge and skills acquired in the early childhood years, such as those related to communication, pre-literacy and pre-numeracy, provide the foundation for success in kindergarten and the early school years. This outcome involves activities such as thinking, reasoning, remembering, problem solving, number concepts, counting, and understanding the physical and social worlds. It also includes a variety of skills related to language and literacy including vocabulary, phonemic awareness, and letter recognition.

- ## Use of Appropriate Behaviors to Meet Their Needs

  As children develop, they become increasingly more capable of acting on their world. With the help of supportive adults, young children learn to address their needs in more sophisticated ways and with increasing independence. They integrate their developing skills, such as fine motor skills and increasingly complex communication skills, to achieve goals that are of value to them. This outcome involves behaviors like taking care of basic needs, getting from place to place, using tools (such as forks, toothbrushes, and crayons), and, in older children, contributing to their own health, safety, and well-being. It also includes integrating motor skills to complete tasks; taking care of one's self in areas like dressing, feeding, grooming, and toileting; and acting on the world in socially appropriate ways to get what one wants.

All of these child outcomes must be considered in developing a child's and family's IFSP. The Department of Health's, Bureau of Early Intervention, has worked closely with stakeholders to identify additional child outcome indicators related to these three child outcomes. Each year, families whose children are exiting the program receive a survey that evaluates the extent to which early intervention services have been helpful to families and their children in achieving child and family outcomes. For children's positive social-emotional development, stakeholders identified the following as important outcomes for children in the Early Intervention Program:

- Learn to give and receive affection.
- Recognize the emotions of others.
- Adapt to new people.
- Engage in typical family activities.
- Improve joint attention skills (where two people share attention to the same object).
- Be included by his/her peers in playtime and activities.
- Take part in a group activity.
- Get along with other children.
- Seek positive interactions with peers.

These positive social-emotional outcomes are examples of the types of outcomes that should be considered by IFSP teams when identifying measurable child outcomes to include in IFSPs, along with strategies, services, and supports families need to enhance and promote their children's social-emotional development.

In developing the IFSP, it is important that IFSP team members carefully review the assessment of the child's social-emotional development and any concerns the family may have about the child, including social-emotional development and the child's relationship with the parent, siblings and other family members, and other individuals in the child's and family's social environment. If the family has participated in a voluntary family assessment, and wishes to use the results and information from this assessment in the discussion of outcomes, services, and strategies it may be helpful to include this information in the IFSP. If

the family is concerned or has challenges in the area of the child's behaviors at home and in the community, these should also be addressed in the context of social-emotional development and IFSP services to promote, and enhance and support the child's development and family's ability to care for and nurture their child.

A *family-centered* approach is a central tenant of the Early Intervention Program. A family-centered approach is best described as family-driven which deepens the core value of family voice and choice in all domains of early intervention. A family-driven approach implies that the family, along with the IFSP team determines the specific services as well as the combination, intensity, and duration of services that make the most sense for them. This includes the care and choices made in the interventions that would best address young children's social-emotional development.

In addition to the three child outcomes described above, the Office of Special Education Programs has also identified three family outcome indicators for families participating in the Early Intervention Program. These outcomes must also be measured and reported to the Office of Special Education Programs by states on an annual basis. Specifically, states must report on the percent of families reporting that early intervention services have helped the family:

- Know their rights.
- Effectively communicate their child's needs.
- Help their child develop and learn.

In working with stakeholders, the Early Intervention Program identified the following family outcomes that relate to promoting children's positive social-emotional development and parent-child relationships:

- Connect with parents of children with similar needs.
- Take part in typical activities for children and families in my community.
- Cope with stressful situations.
- Cope with the emotional impact of having a child with a disability.

- Find resources in the community to meet my child's needs.

- Be better at managing my child's behavior.

- Feel more confident in my skills as a parent.

- Help my child be more independent.

- Understand how to change what I'm doing to help my child as he/she grows.

These family outcomes are examples of the types of outcomes that should be considered by the IFSP team in identifying measurable family outcomes that can help families in promoting their children's positive social-emotional development and relationships.

Child and family outcomes included in the IFSP should be unique to the child and family, measurable, and specific enough to provide both the family and the early intervention service provider(s) working with the child and family information to guide intervention services and strategies. This will allow service providers to focus interventions and coach and inform families and caregivers in using natural learning opportunities to enhance children's positive social-emotional development and positive social relationships. By partnering with families and caregivers, service providers are enhancing the family's capacity to support their children's social-emotional development.

Achieving IFSP functional outcomes may also be attained by using resources external to the Early Intervention Program. The ongoing service coordinator and the therapeutic team may assist the family in accessing other community/medical/legal resources related to the parents' priorities and the IFSP functional outcomes. For example, parents might want to learn more about their child's diagnosis from other parents by joining a parent support group for children diagnosed with a similar problem or want their child to participate in various social activities with other children in the community (e.g., a play- or music-group for young children). In addition, the ongoing service coordinator may also assist the parents in accessing resources outside of the Early Intervention Program if the parents are seeking services so that they can meet the needs of

their family (e.g., English as a Second Language, depression, addiction, job training, couple counseling, stress reduction).

High quality functional IFSP child and family outcomes:

- Are developmentally appropriate for the infant/toddler's current age and address the progress that can be achieved within identified timeframes.

- Emphasize the positive strengths and assets of the child and family and how these can be enhanced.

- Describe a measurable and observable skill for which progress can be assessed and recognized by parents and interventionists.

- Promote skills and reflect the integrated nature of development across multiple domains (social-emotional, cognitive, communication, physical, adaptive development).

- Are clearly written and easily understood by the family and all members of the IFSP team and interventionists (they avoid clinical terms and jargon).

- Reflect family priorities for the child and family (Lucas et. al, 2014).

IFSP functional outcomes consist of the following elements:

- Who: the child or parent or family member/caregiver.

- What/Will do what: what the child or family will do.

- Measure for success: the criteria that will be used to determine when an outcome has been achieved and when new strategies and services may be needed because an outcome is not being realized. The IFSP should include how progress will be assessed including the measures that will be used and how often the child's progress will be reviewed.

- Routine activity: the events that occur typically during the child's day and are individual to the child's and family's culture and physical and social environment.

- Why: what the family would like to achieve for the child or family, and the reason the outcome is important.
- Specify: any adaptation or strategy that is reasonable to help the child achieve an outcome e.g., special spoon or verbal prompt.

Examples of functional IFSP outcome statements that address the social-emotional domain are:

- To support the family goal that everyone will sleep through the night, Ana will sleep in her own bed every day and will be guided by her parents to use self-calming activities during her bedtime routine.
- To support the family's goal that everyone in the family can start their day calmly and get to their respective jobs on time, parents will help Ty transition from home to his child care program each morning before work.
- Sam will sit in his chair and feed himself with helpful reminders from his mom or dad during dinner each day so that the whole family can enjoy mealtimes together.
- Shauna will share toys and take turns during each playtime with her sister and friends in the community to support the family goal that Shauna increase her social skills.

To learn more about creating family-driven functional outcomes, please go to the Early Childhood Technical Assistance (ECTA) Center website for technical assistance (Lucas, et al, 2012).

Once outcomes are identified by the IFSP team, the next step is to identify and agree on the strategies, supports and services needed for the child and family to make progress toward and achieve those outcomes. Useful considerations, articulated by the National Workgroup on Principles and Practices in Natural Environments, include:

- What is the family already doing to promote their child's positive social-emotional development?

- What are the child's and family's interests? Are there community routines and activities that could be used to promote social-emotional skills development and positive social relationships? What would they like to try to participate in, or having challenges in participating in with their child?
- What informal supports and services are needed to enhance participation and address challenges the family is experiencing or anticipating in having their child participate in experiences that will promote social-emotional development, positive social skills, and relationships with family members, caregivers and peers?
- Is there a need for assistive technology or other adaptations to enhance the child's participation in daily activities and social environment in ways that will enhance his/her social-emotional development and positive social relationships?
- What are the early intervention services that are needed to promote and enhance the child's social-emotional development and the family's ability to enhance and promote their child's social-emotional development and positive social relationships? (Workgroup on Principles and Practices in Natural Environments, 2008).

Ongoing Service Coordinator

The responsibilities of the ongoing service coordinator begin immediately after the initial IFSP meeting, upon being chosen by the parent to provide ongoing service coordination for their child. These include, but are not limited to:

- Arranging for providers to deliver Early Intervention Program services.
- Providing information to the rendering provider assigned to provide services to the child regarding insurance benefits available to the child under his or her insurance policy.
- Ensuring implementation of the child's and family's IFSP, in accordance with the IFSP, including ensuring the timely delivery of Early Intervention Program services within 30

calendar days from the projected dates for initiation of services as described in the plan.

- Monitoring the delivery of services to ensure they are being delivered in accordance with the IFSP.

- Coordinating the performance of additional evaluations and ongoing assessments to monitor the child's and family's progress in achieving outcomes in the IFSP. If new concerns about a child's social-emotional development are identified, the IFSP can be amended to include an in-depth assessment of this area by a qualified evaluator (known as a supplemental evaluation).

- Ensuring that the IFSP consistently reflects the family's current priorities, concerns, and resources.

- Facilitating any necessary collaboration between early intervention service providers, medical and health care providers providing services to the child and/or family.

- Ensuring families are aware of their rights and procedural safeguards as needed throughout their participation in the Early Intervention Program.

- All transition activities, including:
  – Facilitating the development of a transition plan.
  – Providing written notification to the Committee on Preschool Special Education (CPSE) in the child's school district if a child is potentially eligible for preschool special education programs and services, unless the parent opts out of this notification process.
  – Convening a transition conference with parental consent.
  – Assisting the parent with timely referral to the Committee on Preschool Special Education.
  – Obtaining parental consent and transferring evaluation, assessments, IFSPs, and other records to the Committee on Preschool Special Education and/or other programs.

- Continuously seeking the appropriate services and situations necessary to benefit the development of the child and/or family for the duration of the child's participation in the Early Intervention Program. In some families, regardless of whether there are family-based risk factors (e.g., poverty, incarcerations, maternal depression, homelessness, substance abuse, domestic and community-violence, etc.), significant emotional and physical stress may be present, and service coordinators should take an active approach in assisting these families.

- When a child and family requires services that cannot be met within the Early Intervention Program (for example, maternal depression), the ongoing service coordinator is expected to help the family access services that meet the mental health and social-emotional needs of both the child and the family.

Monitoring Progress

"For all children in the Early Intervention Program, it is important to ensure that parents, early intervention service providers, service coordinators, and Early Intervention Officials work together to evaluate the effectiveness of interventions and children's progress," (New York State Department of Health Early Intervention Program, 2005, pg.46). For all areas of the child's development, including social-emotional development and positive social relationships, the IFSP should include the criteria and procedures that will be used to determine whether progress is being made on the measurable outcomes included in the IFSP for the child and family.

A child's and family's IFSP must be reviewed every six months and evaluated annually. The six-month review and annual evaluation offer families, providers, service coordinators and Early Intervention Officials an important opportunity to assess the child's and family's progress and whether any amendments might be needed to the IFSP. IFSP reviews and annual evaluations can also help identify any new or emerging concerns about the child's development and the supports and services needed by the family to enhance their child's development, including social-emotional development and positive social-emotional relationships. An IFSP may also be reviewed more frequently, at the parent's request, or if circumstances suggest a review is needed

(such as an emerging new concern for the child and/or family, which might be a concern about social-emotional development).

If a concern emerges about an infant or toddler's social-emotional development and positive social relationships after the initial IFSP is developed which suggests the need for an in-depth assessment of the child's development in this area by a professional with specialized expertise, the IFSP can be amended to include an evaluation for this purpose. This type of evaluation is known as a supplemental evaluation. The IFSP team must agree that the supplemental evaluation is needed to amend the IFSP.

Early Intervention Service Providers

A central tenant of the Early Intervention Program is that early intervention services focus on active, involved caregiver-professional partnerships and family-centered practices to promote and enhance child and family development. Collaborative early intervention visits with the family focus on how to integrate intervention strategies into child and family routines and help families implement these strategies in everyday life.

Another key tenant of the Early Intervention Program is that early intervention services provided to infants and toddlers and their families are individualized to meet the unique needs of each child and family. This includes consideration for the variations in social and emotional functioning and interpersonal relationships unique to each child and his or her parents, family members, and community.

Social-emotional skills develop along with sensory-motor, cognitive, language, and adaptive skills. Therefore, in order to develop and implement effective individualized intervention approaches/strategies, it is important for providers who work with children who have a diagnosed physical or mental condition to understand how a disorder or impairments in physical, adaptive, cognitive, or communication development can affect children's social-emotional development.

Key components of effective strategies and interventions used by early intervention service providers to meet the unique strengths and needs of infants/toddlers in the social-emotional domain include:

- Using relationship-focused, family-centered intervention strategies regardless of professional discipline or the service being provided.
- Working with the infant/toddler and parent together throughout the early intervention session on developing positive social interactions skills.
- Sharing in the observation of the infant's/toddler's social-emotional growth and development.
- Offering anticipatory guidance to the parent that is specific to their child's social and emotional development such as the guidance provided by Bright Futures (American Academy of Pediatrics, n.d.).
- Alerting the parent to the infant's individual accomplishments and needs.
- Helping the parent to find pleasure in the relationship with the infant/toddler.
- Creating opportunities for interaction and exchange between parent(s) and the infant/toddler and/or between the parent(s) and the provider.
- Allowing the parent to take the lead in interacting with the infant/toddler or determining the agenda for the session or the topic for discussion.
- Identifying and enhancing the capacities that each parent brings to the care of the infant/toddler.
- Collaborating and consulting with other providers from different disciplines, as needed, in the provision of services to a child with social-emotional delays or disorders and/or behavioral challenges.
- Remaining open, curious, and elective about early social and emotional development (Weatherston, D.J. & Shrilla, J.J., 2002).

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Evidence-Based/Evidence-Informed Interventions and Curricula that can be used by providers and/or parents to promote positive social-emotional development and prevent social-emotional problems from developing include:

Evidence-Based/Evidence-Informed Interventions and Curricula	Website
Activity-Based Interventions: Social-Emotional (ABI:SE) Approach	https://vafamilysped.org/Resource/JWHaEa5BS76V9IVX5zqfTQ/Resource-an-activity-based-approach-to-developing-young-childrens-social-emotional-competence-book-j
Applied Behavioral Analysis (ABA)	www.appliedbehavioralstrategies.com/index.html
Circle of Security	http://circleofsecurity.net
Family-Guided Routines-Based Approach	http://fgrbi.fsu.edu/model.html
Incredible Years: Parent Training	http://incredibleyears.com
Playing and Learning Strategies (PALS)	www.childrenslearninginstitute.org
Positive Behavior Support (PBS)	www.pbis.org
Promoting First Relationships (PFR)	http://pfrprogram.org
Pyramid Model	www.pyramidmodel.org
Triple P – Stepping Stones	www.triplep.net/glo-en/home/

ADDITIONAL RESOURCES

Parlakian, R. & Seibel, N.(2002). *Building Strong Foundations: Practical Guidance for Promoting the Social-emotional Development of Infants and Toddlers.* Washington, D.C.: ZERO TO THREE Press.

ZERO TO THREE. (2003). Picture This: A Framework for Quality Care for Infants and Toddlers.

Early Childhood Advisory Council, (2012). *The Early Learning Guidelines.* Retreived from www.nysecac.org/files/1913/7711/9132/Early_Learning_Guidelines_Color.pdf

ZERO TO THREE - Early Head Start National Resource Center, (2006). *Strategies for Understanding and Managing Challenging Behavior in Young Children: What Is Developmentally Appropriate—and What Is a Concern? Working Paper Number 10.* U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth, and Families Head Start Bureau. Retrieved from http://eclkc.ohs.acf.hhs.gov/hslc/hs/resources/ECLKC_Bookstore/PDFs/TA10%5B1%5D.pdf

Devereux Early Childhood Assessment (DECA) Program - assessment and planning tools to promote social and emotional development, foster resilience and build skills for school and life success in children birth through school-age, as well as to promote the resilience of the adults who care for them. www.centerforresilientchildren.org/

The Preventing Child Abuse and Neglect: Parent/Provider Partnerships in Child Care (PCAN) Training of Trainers - concepts and information focused on helping infant/family professionals to recognize the importance of their relationships with very young children and their parents in reducing some of the risk factors associated with abuse and neglect. www.zerotothree.org/about-us/areas-of-expertise/training-and-professional-development/pcan.html?referrer=https://www.google.com/

Pyramid Model for Supporting Social-Emotional Competence in Infants and Young Children - user-friendly training materials, videos, and print resources to help early care, health and education providers implement this model promoting the social-emotional development and school readiness of young children birth to age five. http://csefel.vanderbilt.edu/

PEDALS - provides early childhood educators with resources they need to teach social-emotional skills and prepare kids for kindergarten. www.hfwcny.org/Tools/Broadcaster/frontend/itemlist.asp?reset=1&lngdisplay=7&phase=1

New York State Parenting Education Partnership — a resource for locating high-quality parenting education programs www.nyspep.org.

F. Making Referrals for Supports and Services

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New York State has a wealth of resources available to families and early childhood professionals to help promote and support healthy social-emotional development in infants and young children. While some services, such as the Early Intervention Program for infants and toddlers with disabilities and their families, preschool special education programs and services, and Child Protection and Prevention services, must be available in every community for children who meet eligibility criteria, the availability of other services, such as Early Head Start and Head Start, home visiting, etc., varies from community to community.

The New York State Education Department funds a statewide network of 14 Early Childhood Direction Centers that support parents of children under 5 years of age who have or are at-risk of developmental delay or disability including social-emotional development. Early Childhood Direction Center staff can support early childhood professionals to link families with appropriate services and link families directly with needed supports and services. They also can serve parents by:

- helping them obtain services for their child and family,
- matching the individual needs with services available in the community,
- making referrals to agencies that can provide direct services near the family,
- coordinating services between agencies and providers, and
- offering follow-up to ensure that the child and family are receiving all the services needed.

Referring for Services

Once the family is receptive to being referred for services, the early childhood professional making the referral has an opportunity to help families navigate what can sometimes be a confusing and overwhelming process. A family's difficulty following through with a referral can often be influenced by multiple issues, such as having to wait a long time for their appointment, meeting with a provider who isn't prepared, having expectations that don't match how the first meeting is handled, and/or the parent may be ambivalent or anxious about taking the next step. To avoid these pitfalls, early childhood professionals can take the following actions to help families have a smooth and successful experience:

- Come to an agreement with the family about the reason for referral. It is best not to assume everyone agrees why a referral is being made unless a clear conversation has occurred. Having a dialogue that includes the family's views and expectations before contacting the service provider will lessen any confusion and concerns as the referral progresses.
- Call the service provider ahead of time to let them know a referral is coming. Ensure the maintenance of confidentiality. Calling ahead allows the service provider to be prepared for a referral. Encourage parents to contact the service provider directly; if it is helpful, offer to support the parents in this process.
- Discuss with the family how the initial referral might flow. It is important professionals making a referral are aware of how service providers manage referrals so they can best prepare families.

Once a Referral Has Been Made

Early childhood professionals have an opportunity, and responsibility, to act on concerns regarding children's growth and development when they become apparent. Once the referral has been made, the primary referral source can continue to have a significant role in supporting the child and his or her family in obtaining the services they need. **The following table provides helpful information for early childhood professionals on the resources available to support young children and their families.**

National Parenting/Family Supports and Resources

Learn the Signs, Act Early	Information for a wide range of child care professionals, health care professionals, and parents. Interactive website offers toolkits, informational brochures, and multimedia tools.	www.cdc.gov/ncbddd/actearly/index.html
Birth to 5: Watch Me Thrive!	Website offers educational materials to a variety of child care professionals, health care workers, educators and families.	www.acf.hhs.gov/programs/ecd/child-health-development/watch-me-thrive

New York State Parenting/Family Supports and Resources

Early Childhood Direction Centers	The statewide network of Early Childhood Direction Centers supports parents of children under five years of age who have or are at-risk of developmental delay or disability including social-emotional development. Early Childhood Direction Center staff can assist families identify and link to appropriate services to address issues with social-emotional development and other concerns.	www.p12.nysed.gov/specialed/techassist/ecdc/locations.htm
Parent to Parent of New York State	Parent to Parent of New York State is an organization that builds a supportive network of families to reduce isolation and empower those who care for people with developmental disabilities or special healthcare needs to navigate and influence service systems and make informed decisions.	http://parenttoparentnys.org
NYS Parenting Education Partnership (NYSPEP)	Parenting education provides parents with helpful strategies for raising healthy children, addressing behavior problems, and providing their children with a good start in school and life. NYSPEP provides a statewide data base of parenting education programs and services.	http://nyspep.org

Family Resource Centers	The New York State Family Resource Center Network offers early and comprehensive support for parents/caregivers of young children.	http://ocfs.ny.gov/main/ publications/Pub5071.pdf
Families Together	Families Together in New York State provides support for families of children and youth with social, emotional and behavioral challenges.	www.ftnys.org/about-us
Child Care and Early Childhood Education	Child Care Resource and Referral programs are located in every region of the state and assist parents in identifying the most appropriate child care or other early childhood education opportunity for their children. They also are knowledgeable about other supports and services that families and young children need.	www.earlycareandlearning.org/ new-york-state-ccr-r-members. html
Choosing Child Care Services	Choosing child care is an important decision. You can learn about choices and payment support in the short Child Care Options video. Safe and positive child care sets the stage for healthy growth and development.	http://ocfs.ny.gov/main/ childcare/looking.asp
Head Start and Early Head Start	Head Start and Early Head Start are federally funded programs that promote the school readiness of children from birth to age five from low-income families by enhancing their cognitive, social, and emotional development. The link connects you to information on income eligibility and a locator to find a program in your community.	www.benefits.gov/benefits/ benefit-details/1928

Kinship Navigators	The NYS Kinship Navigator is an information, referral and advocacy program for kinship caregivers in New York State. A kinship caregiver is an individual (including grandparents, aunts and uncles) that is caring for a child that is not biologically their own. The Navigator seeks to assist these caregivers by providing information on financial assistance, legal information and referrals, and other types of issues that caregivers face when raising children in order to provide stability and permanency in the home.	www.nysnavigator.org
Library programs	Libraries provide a range of programs for children and families. Contact information for all public libraries in the state. Go to the website of the library in your community to see the services and programs they offer on topics including parenting, literacy, early childhood development, and health benefits system navigation.	www.nysl.nysed.gov/libdev/libs/publibs/1pls.htm

Family Health and Economic Resources, and Services

Health Home Case Management/ Care Coordination	Provides links to webinars and important information Children's Health Home for children in the Medicaid Program.	www.health.ny.gov/health_care/medicaid/

Early Intervention Services	NYS Early Intervention Program provides services for children from birth to age three who exhibit developmental delays or disabilities. Information on the Early Intervention Program, regulations, and service providers and *"Early Intervention Steps: A Parent's Basic Guide to Early Intervention"* is available at this site.	www.health.ny.gov/community/ infants_children/early_ intervention
	Each county in New York State and the City of New York have designated Early Intervention Officials who receive referrals for evaluation and services. Contact information for the Early Intervention Official in your community is available here.	www.health.ny.gov/community/ infants_children/early_ intervention/county_eip.htm
Growing Up Healthy Hotline	The New York State Department of Health operates the Growing Up Healthy Hotline, which provides information about health care, nutrition and other health and human services. The hotline provides confidential information and referral 24 hours/day, seven days a week in English and Spanish and other languages.	www.health.ny.gov/community/ pregnancy/health_care/ prenatal/guh.htm 1-800-522-5006 or through TTY access at 1-800-655-1789
Text for Baby	Text4baby offers a free mobile information service to anyone who needs it. They send you facts, information, and guidelines via your mobile phone timed to your pregnancy and baby's growth. All you have to do is text BABY to 511411 and specify how many months you are and the expected date of birth.	https://text4baby.org
My Benefits	myBenefits.org is website that provides an easy method for New York State individuals and families to determine if they are eligible for a number of financial, home energy and food assistance, health insurance, tax credits and other programs.	https://mybenefits.ny.gov/ mybenefits/begin

Respite Care Programs in New York State	Respite is planned or emergency care provided to a child or adult with special needs in order to provide temporary relief to family caregivers who are caring for that child or adult.	http://archrespite.org/ respite-locator-service-state-information/164-new-york-info
Employment Training	Career building, job training, and employment assistance programs and job centers.	https://labor.ny.gov/ careerservices/planyourcareer/ training.shtm https://otda.ny.gov/programs/ employment
Food Banks	There are eight regional food banks located across the state that support food banks in every community. To identify the food bank in your community, go to:	www.foodbankassocnys.org/ find-food-bank.cfm
SNAP	The Supplemental Nutrition Assistance Program (SNAP) provides benefits to low-income individuals and families and provides economic benefits to communities.	www.benefits.gov/benefits/ benefit-details/361
WIC	The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) offers nutrition education, breastfeeding support, referrals and a variety of nutritious foods to low-income pregnant, breastfeeding or postpartum women, infants and children up to age five to promote and support good health.	www.health.ny.gov/prevention/ nutrition/wic/

Hospice	Hospice provides appropriate skilled, compassionate care to patients and their families so that they receive the support, help and guidance they need to meet the challenges of serious illness. Call 1-800-860-9808 for information about hospice in your area.	www.hpcanys.org/about/hospice/
NY Connects	NY Connects resource directory provides links to long-term services and supports that can help you or a family member stay at home, stay in the community, or stay independent; provides aging and disability resources available in your community.	www.nyconnects.ny.gov/

Mental Health Resources, Services, and Links

The Office of Mental Health (OMH)	The Office of Mental Health (OMH) operates psychiatric centers across the state, and regulates, certifies and oversees more than 4,500 programs operated by local governments and nonprofit agencies. These programs include various inpatient and outpatient programs, emergency services, community support, and residential and family care programs. A directory of OMH-licensed providers by county is available through the OMH website.	http://bi.omh.ny.gov/bridges/index
Mental health services	Locate mental health services for adults; find programs for adolescents and children. The suicide prevention crisis line (National Suicide Prevention Lifeline) is: 1-800-273-TALK (8255). New York State Domestic Violence Hotline: 1-800-942-6906. Emergencies are handled through 911.	http://bi.omh.ny.gov/bridges/index

NYS Office of Alcoholism and Substance Abuse	Substance Abuse Services – Adult and Child. New York State HOPEline 1-877-8-HOPENY and Other Services. Find help and hope for alcoholism, drug abuse or problem gambling. Call or text 1-877-846-7369. Offering help and hope 24 hours a day, 365 days a year for alcoholism, drug abuse and problem gambling. All calls are toll-free, anonymous and confidential.	www.oasas.ny.gov/accesshelp/index.cfm

Other State Agency Resources

New York State Central Register of Child Abuse and Maltreatment (Child Abuse Hotline)	If you are aware of a child who has been abused or neglected call the New York State Central Register of Child Abuse and Maltreatment operated by the NYS Office of Children and Family Services.	1-800-342-3720; 1-800-638-5163 TDD/TTY; 1-800-342-3720 Video Relay System OR call 911 or the local police department if a child is in apparent immediate danger.
Child Advocacy Center	Child Advocacy Centers (CACs) are child friendly locations in which allegations of abuse are responded to collaboratively by a Multidisciplinary Team (MDT). These centers are community based and tailored to fit the needs of the community in which they are located.	http://nyschildrensalliance.org/about-cac/
Adoption Resources	New York State Adoption Service (NYSAS) encourages you to use their website to learn more about the process of adoption in New York State.	http://ocfs.ny.gov/adopt/
Bilingual Education Resources	NYS Education Department's Office of Bilingual Education and World Languages website provides resources for Bilingual Education, English as a New Language for both children and parents.	www.p12.nysed.gov/biling/bilinged/resources.html

G. Supporting Successful Transitions

G. Supporting Successful Transitions

Change is inevitable. Infants and toddlers grow and develop and they will eventually move on to other programs, services, and settings. When these changes can be anticipated, even planned, children and adults are able to adapt more easily and experience those changes with confidence. Below are a number of key strategies to support successful transitions:

- **Identify Transition Points Early**

  From the beginning of the relationship with the family, professionals can define the behaviors and benchmarks that will eventually be used to indicate when a child is ready to transition. Just as children become accustomed to small transitions such as moving from playtime, to clean up, and circle time through practice and routine, they can prepare for larger transitions such as moving from one classroom to another, leaving friends and teachers to join an older group of children. Well before a transition occurs, the professionals working with a child and family should be preparing them for the next step.

- **Ensure That Parents are an Integral Part of the Process**

  Professionals can identify appropriate options that the family can use to determine the best choice for their child. The culture, linguistic skills, and learning styles of the child and the family members will influence this choice. Providing information on programs and services that reflect these characteristics will help the family make a decision that best meets their child's needs.

- **Talk About the Future**

  Providing guidance on next steps helps children and their parents learn what to expect, creates confidence in their ability to handle what will come next, and relieve their anxiety and fear. Professionals should provide the information and support that the family needs to anticipate impending changes, make thoughtful decisions, and prepare for the next developmental stage, meeting, activity, and/or program and service.

- **Individualize for the Best Fit Moving Forward**

  To the extent possible, changes and transitions should be flexible to address the specific developmental needs of the individual child and his family. Programs that recognize, and plan to meet these needs can help sustain gains children have made in their current setting.

- **Create Opportunities to Develop New Relationships Before the Transition Occurs**

  It is not enough to simply provide someone with a referral and trust that they will be successful in navigating their way to the appointment or new program. Effective transitions require the staff in the current program to provide whatever supports the family needs to make the transition to the new program including going with the family to an initial appointment. A successful transition requires time to build trusting relationships with a new set of partners. The process may include multiple meetings or contacts so that the parents and the professionals can discuss eligibility, the enrollment process, and the goals for the new services.

- **Closure and Moving Forward**

  When a family is ending one program or supportive service, even when starting another level of care, this transition signals the loss of a relationship and a known support. Celebrations for the progress, the met goals, the successful outcomes that occurred during the previous period of work is a step in providing healthy closure and clear steps toward the next phase of development. Recognition of the progress provides a platform upon which to build during the new phase of work.

- **Begin Transition Planning Again**

  With each major transition, the process of preparing for the next transition should begin. Use the new plan as a blueprint for that next phase and expect to modify it as the child grows and develops and/or the family situation changes.

ADDITIONAL RESOURCES

Administration for Children and Families, (n.d.). *Family Engagement in Transitions: Transitions to Kindergarten.* Retrieved May 12, 2016 from http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/family/docs/transitions-kindergarten.pdf

Pennsylvania Office of Child Development and Early Learning (2013). *Early Intervention Infant, Toddler, and Preschool. Guidelines to Support the Early Intervention Process: Transition.* Retrieved May 12, 2016 from http://pattan.net-website.s3.amazonaws.com/images/

2013/05/29/EI_Trans_Guidelns_050713.pdf

H. Developing the Knowledge and Skills to Effectively Address the Social-Emotional Development Needs of Young Children

H. Developing the Knowledge and Skills to Effectively Address the Social-Emotional Development Needs of Young Children

The professional development of the infant-toddler workforce is critical to promoting healthy development and later school success. All those who work with very young children need education and ongoing professional development on relationships with families, cultural competence, infant-toddler development, and inclusion of children with special needs, including infants and toddlers whose development is at risk because of socio-economic and environmental conditions.

Strengthening systems that support infant early childhood professionals meet the social-emotional development needs of young children is a critical task for the early childhood field. While all states are in the process of designing and implementing these systems, 23 states have formed The Alliance for the Advancement of Infant Mental Health, and have created associations for infant mental health, with the goal of implementing a coordinated, cross-sector system of professional development for practitioners who work with children from birth to age five. In a recent paper addressing Infant and Early Childhood Mental Health Policy, ZERO TO THREE, a national organization that works to ensure that babies and toddlers benefit from the early connections that are critical to their well-being and development, noted the importance of building a workforce that understands infant and early childhood mental health and stressed that states should "embed infant and early childhood mental health education and competency standards in mental health, social work, health care and early childhood education professionals' training, coursework, and on-going professional development (ZERO TO THREE, 2016b)."

In the report "Transforming the Workforce for Children Birth Through Age Eight: A Unifying Foundation" the National Academy of Sciences (2015) addressed concerns that workforce knowledge and skills do not reflect the significant gains in science regarding social, emotional, and cognitive development in young children. "Science has converged on the importance of early childhood, but that understanding is not yet reflected in recognition of the critical role of the professionals who work with young children from infancy through the early elementary years. There is a growing base of knowledge about how children learn and develop, what children need from their interactions and relationships with adults, and what adults should be doing to support children from the beginning of their lives. Yet that knowledge is not consistently channeled to adults who are responsible for supporting the development and early learning of children and those adults are not consistently implementing that knowledge in their professional practice and interactions with young children (Allen L. & Kelly, B.B., 2015)."

Regardless of professional disciplines, levels of education or settings in which one works, the early childhood workforce needs to be highly skilled or trained in a core set of topics that include the following:

- The primary importance of responsive and stable caregiving relationships (attachment, separation, loss, trauma and grief).

- The science of early childhood development with special attention to neurological implications.

- The practical as well as the emotional needs of culturally diverse families.

- How to identify and access resources to address the complex needs of challenged families.

- The power of reflective practices and parallel process.

- The interdisciplinary nature of the work and the need for collaboration (Child Health and Development Institute of Connecticut, INC., 2015).

Currently, in New York State, there are two important efforts that advance professional competencies and training of the early childhood workforce to support children's social and emotional development. The New York State Pyramid Model Partnership, a statewide leadership team, formed to support the rollout of training to promote social and emotional competence strategies in child-serving settings, and the New York State Association for Infant Mental Health, a newly incorporated organization focused on implementing an interdisciplinary system of competencies and standards for the infant and early childhood workforce.

Promoting Social & Emotional Competence in New York's Young Children

The New York State Pyramid Model Partnership supports social-emotional competence and works collaboratively to:

- Increase the number of early childhood trainers and coaches providing professional development to the early childhood workforce to meet the social and emotional development needs of young children.

- Support partnerships between practitioners and parents.

- Support the implementation and sustainability of the Pyramid Model in early childhood settings.

- Evaluate the effectiveness of implementing the Pyramid Model in New York State. (New York State Pyramid Model Partnership, n.d.).

With its emphasis on strong relationships, support for cultural competence, and preventing and addressing challenging behaviors in infants, toddlers, and young children, the Pyramid Model is congruent with other New York State early childhood efforts to set the foundation for development and lifelong learning and aligns with the NYS Association for Infant Mental Health core competencies. These existing efforts include:

- The strategic plan of the New York State Early Childhood Advisory Council. www.nysecac.org/

- Promoting positive school climates through the implementation of Positive Behavioral Interventions and Supports (PBIS). New York State Education Department. www.nyspbis.org/.

- Establishing guidance on evidence-based practices for addressing the social-emotional development of very young children (Early

Childhood Advisory Council/Early Intervention Coordinating Council Joint Task Force on Social-Emotional Development). www.nysecac. org/files/6714/1080/7660/EICC-ECAC_Update_ rev.pdf.

- Creating a formal mental health endorsement/ credential for professionals working with infants www.nysaimh.org/.

- Supporting the provision of evidence-based services for children experiencing social-emotional development and mental health issues through the redesign of New York's Medicaid Program.

The Pyramid Model, formerly called the Center on the Social and Emotional Foundations for Early Learning (CSEFEL), is a national resource center for disseminating research and evidence-based practices to early childhood programs across the country. To support this goal, they have developed a conceptual model of evidence-based practices for promoting young children's social-emotional competence and preventing and addressing challenging behavior. This conceptual model includes a wealth of training materials for early childhood professionals to promote the social-emotional development and school readiness of young children birth to age 5. The Teaching Pyramid developed by CSEFEL organizes these practices into a "Teaching Pyramid" that includes four levels of a tertiary or intervention strategies to provide treatment to young children with 'mental health needs or serious and persistent problem behavior' and a fourth level includes 'individualized interventions that provide treatment to children with persistent challenges' (Cimino, J., Forrest, L.L., Smith, B.J., & Tracy-Stainback, K., 2007).

The New York State Association for Infant Mental Health (NYS-AIMH) incorporated in May 2015 is an interdisciplinary, professional organization established to promote and support the optimal development of infants, very young children and their families through relationship-focused professional training and development. The NYS-AIMH promotes uniform and nationally recognized competencies and standards to ensure that all individuals engaged in the multidisciplinary fields supporting young children are trained in up to date science of child development, Infant Mental

Health principles and relationship-based practices. NYS-AIMH is responsible for implementing a statewide competency system known as the NYS-AIMH Endorsement® (developed by the Michigan Association for Infant Mental Health) and for providing professional development through training and continuing education programs designed to build a more skillful infant and early childhood workforce.

NYS-AIMH is in the process of introducing the New York State Association for Infant Mental Health Endorsement® which recognizes and documents the development of infant and family professionals within an organized system of culturally sensitive, relationship-based infant mental health learning and work experiences. Endorsement by NYS-AIMH verifies that a professional has attained a specified level of education, participated in specialized in-service trainings, worked with guidance from mentors or supervisors and acquired knowledge to promote the delivery of high quality, culturally sensitive, relationship-focused services to infants, toddlers, parents and other caregivers, and families.

The Endorsement is based on attaining levels of knowledge in eight core competency areas that professionals across disciplines must meet to promote social and emotional well-being or treat mental health concerns in infancy and early childhood (Weatherston, D. J., Kaplan-Estrin, M., & Goldberg, S, 2009). The core competencies include: theoretical foundations, law, regulation and agency policy, systems expertise, direct service skills, working with others, communicating, thinking and reflecting. The NYS AIMH offers individuals in the infant and family field a professional development plan that focuses on principles, best practice skills and reflective work experiences. Nationally, the Endorsement has resulted in improvements in workforce competence; more targeted services to children and families; improved professional opportunities, job satisfaction and advancement potential; uniform and consistent delivery of services; an established standard of care for practitioners; an integrated cross disciplinary system focusing on prevention, early identification of social-emotional issues and evidence-based treatment; and improved outcomes for young children and their families.

The Endorsement includes four levels:

I. **Infant Family Associate:** focus is on promotion and prevention, mainly in early care and education settings including Early Head Start teachers and Child Development Associates.

II. **Infant Family Specialist:** focus is on early intervention with a Bachelor's or Master's degree. Many endorsed at this level include Nurse Family Partnership, Early Head Start and Healthy Families New York home visitors, and Early Intervention specialists.

III. **Infant Mental Health Specialist:** focus is on clinical intervention with a very specialized work requirement. Most Level III candidates have a mental health background such as clinical psychology, social work or counseling. Many come from child development backgrounds and have pursued specialized in-service training and reflective supervision.

IV. **Infant Mental Health Mentor:** focus is on clinical, policy and academic concentrations. This level provides reflective supervision to Levels II, and III.

Information about the Endorsement system and about the NYS-AIMH is available on the website www.nysaimh.org/ (New York State Association for Infant Mental Health, n.d.)

ADDITIONAL RESOURCE

National Center for Cultural Competence - www.georgetown.edu/research/gucdc/nccc/

Appendices

Name of Screening or Assessment Instrument	Developmental Domains Covered (As listed by publisher)	Age Range	Languages of Screening or Assessment Instrument	Training Available Through Publisher or Developer	Must Be Administered by Someone with Technical Background	Scoring Options (Manual Electronic)	Instrument Includes Parent and Family Input	Instrument Includes Guidance on Follow-Up Steps
Early Screening Profiles	Cognitive, Language, Motor, Self-Help/Social, Articulation, Home, Health Histories, Behavior	2 years 0 Months through 6 years 11 months	English	No	No	Manual	Yes	Yes
First STEP	Cognitive, Language, Motor, Social-emotional skills, Adaptive functioning	2-60 months	English	No	No	Manual	Yes	Yes
Infant Development Inventory	Cognitive, Language, Motor, Social-emotional skills, Adaptive functioning	Birth to 18 months	English	No	No	Manual	Yes	Yes
Learning Accomplishment Profile-Diagnostic Screens	Social Development, Self-Help, Gross Motor, Fine Motor, Language	3 years to 6 years	English Spanish	Yes	No	Manual	Yes	No

Name of Screening or Assessment Instrument	Developmental Domains Covered (As listed by publisher)	Age Range	Languages of Screening or Assessment Instrument	Training Available Through Publisher or Developer	Must Be Administered by Someone with Technical Background	Scoring Options (Manual Electronic)	Instrument Includes Parent and Family Input	Instrument Includes Guidance on Follow-Up Steps
Parents' Evaluation of Developmental Status	Global/Cognitive; Expressive Language and Articulation; Receptive Language; Fine Motor; Gross Motor; Behavior; Social-Emotional; Self-Help; School	Birth through 7 years 11 months	English (Forms also translated into 14 other languages)	Yes	No	Manual Electronic	Yes	Yes
Parents'Evaluation of Developmental Status- Developmental Milestones	Expressive Language; Receptive Language; Fine Motor; Gross Motor; Social-Emotional; Self-Help; Academic: Pre-Reading, Pre-Math, and Written Language	Birth through 7 years 11 months	English Spanish	Yes	No	Manual Electronic	Yes	Yes
Survey of Well-being of Young Children	Cognitive; Motor; Language; Social-Emotional; Behavioral Functioning; Autism; Family Factors	2 – 60 months	English Spanish	No	No	Manual	Yes	No

All of the screening tools have demonstrated both reliability and validity as demonstrated by Birth to 5. For more information, see www.acf.hhs.gov/sites/default/files/ecd/screening_compendium_march2014.pdf pages 13 to 14.

Appendix 2: Subset of Screening and Assessment Tools Approved by the NYS Early Intervention Program Included in Birth to Five-Watch Me Thrive

Name of Screening or Assessment Instrument	Developmental Domains Covered (As listed by publisher)	Age Range	Languages of Screening or Assessment Instrument	Training Available Through Publisher or Developer	Must Be Administered by Someone with Technical Background	Scoring Options (Manual Electronic)	Instrument Includes Parent and Family Input	Instrument Includes Guidance on Follow-Up Steps
Parents' Evaluation of Developmental Status	Global/Cognitive Expressive Language and Articulation Receptive Language Fine Motor Gross Motor Behavior Social-Emotional Self-Help School	Birth through 7 years 11 months	English (Forms also translated into 14 other languages)	Yes	No	Manual Electronic	Yes	Yes
Parents'Evaluation of Developmental Status- Developmental Milestones	Expressive Language Receptive Language Fine Motor Gross Motor Social-Emotional Self-Help Academic: Pre-Reading, Pre-Math, and Written Language	Birth through 7 years 11 months	English Spanish	Yes	No	Manual Electronic	Yes	Yes
Survey of Well-being of Young Children	Cognitive Motor Language Social-Emotional Behavioral Functioning Autism Family Factors	2 – 60 months	English Spanish	No	No	Manual	Yes	No

Name of Screening or Assessment Instrument	Developmental Domains Covered (As listed by publisher)	Age Range	Languages of Screening or Assessment Instrument	Training Available Through Publisher or Developer	Must Be Administered by Someone with Technical Background	Scoring Options (Manual Electronic)	Instrument Includes Parent and Family Input	Instrument Includes Guidance on Follow-Up Steps
Ages and Stages Questionnaire	Communication Gross Motor Fine Motor Problem Solving Personal-Social	1 – 66 months	English Spanish French	Yes	No	Manual Electronic	Yes	Yes
Ages and Stages Questionnaire: Social-Emotional	Self-regulation Compliance Communication Adaptive functioning Autonomy Affect Interaction with people	6 – 60 months	English Spanish	Yes	No	Manual Electronic	Yes	Yes
Brigance Screens	Expressive language Receptive language Gross Motor Fine Motor Academics/pre-academics Self-help Social-emotional skills	Birth through end of 1st grade	English	Yes	No	Manual Electronic	Yes	Yes

Name of Screening or Assessment Instrument	Developmental Domains Covered (As listed by publisher)	Age Range	Languages of Screening or Assessment Instrument	Training Available Through Publisher or Developer	Must Be Administered by Someone with Technical Background	Scoring Options (Manual Electronic)	Instrument Includes Parent and Family Input	Instrument Includes Guidance on Follow-Up Steps
Developmental Assessment of Young Children, 2nd Edition	Cognition Communication Social-emotional Physical Development Adaptive Behavior	Birth through 5 years	English	No	Yes	Manual Electronic (Available Fall 2013)	Yes	No
Learning Accomplishment Profile-Diagnostic Screens	Social Development Self-Help Gross Motor Fine Motor Language	3 years to 6 years	English Spanish	Yes	No	Manual	Yes	No

Appendix 3: Early Intervention Program – 10 NYCRR Section 69-4.3(f) Criteria for Determining if a Child is At-Risk of a Delay or Disability

Referrals of children at risk of having a disability shall be made based on the following:

Medical/biological risk factors:

(1) Medical/biological neonatal risk criteria, including:

   (i)   birth weight less than 1501 grams

   (ii)   gestational age less than 33 weeks

   (iii) central nervous system insult or abnormality (including neonatal seizures, intracranial hemorrhage, need for ventilator support for more than 48 hours, birth trauma)

   (iv)   congenital malformations

   (v)   asphyxia (Apgar score of three or less at five minutes)

   (vi)   abnormalities in muscle tone, such as hyper- or hypotonicity

   (vii) hyperbilirubinemia (> 20mg/dl)

   (viii) hypoglycemia (serum glucose under 20 mg/dl)

   (ix)   growth deficiency/nutritional problems (e.g., small for gestational age; significant feeding problem)

   (x)   presence of Inborn Metabolic Disorder (IMD)

   (xi)   perinatally- or congenitally-transmitted infection (e.g., HIV, hepatitis B, syphilis)

   (xii) 10 or more days hospitalization in a Neonatal Intensive Care Unit (NICU)

   (xiii) maternal prenatal alcohol abuse

   (xiv) maternal prenatal abuse of illicit substances

   (xv)   prenatal exposure to therapeutic drugs with known potential developmental implications (e.g., psychotropic medications, anticonvulsant, antineoplastic)

   (xvi) maternal PKU

   (xvii) suspected hearing impairment (e.g., familial history of hearing impairment or loss; suspicion based on gross screening measures)

   (xviii) suspected vision impairment (suspicion based on gross screening measures)

(2) Medical/biological post-neonatal and early childhood risk criteria, including:

   (i)   parental or caregiver concern about developmental status

   (ii)   serious illness or traumatic injury with implications for central nervous system development and requiring hospitalization in a pediatric intensive care unit for ten or more days

   (iii) elevated venous blood lead levels (above 19 mcg/dl)

   (iv)   growth deficiency/nutritional problems (e.g., significant organic or inorganic failure-to-thrive, significant iron-deficiency anemia)

   (v)   chronicity of serous otitis media (continuous for a minimum of three months)

   (vi)   HIV infection

   (g)   The following risk criteria may be considered by the primary referral source in the decision to make a referral:

      (1) no prenatal care

      (2) parental developmental disability or diagnosed serious and persistent mental illness

      (3) parental substance abuse, including alcohol or illicit drug abuse

      (4) no well-child care by 6 months of age or significant delay in immunizations; and/or

      (5) other risk criteria as identified by the primary referral source

Appendix 4: Early Intervention Program Regulations – 10 NYCRR Section 69-4.23 Initial and Continuing Eligibility Criteria

(a) Initial eligibility for the early intervention program shall be established by a multidisciplinary evaluation conducted in accordance with section 69-4.8 of this subpart and shall be based on the following criteria:

  (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay; or,

  (2) the presence of a developmental delay which affects functioning in one or more of the following domains of development: cognition, physical (including vision, hearing and oral motor feeding and swallowing disorders), communication, social-emotional, or adaptive development; and, as measured by qualified personnel using informed clinical opinion, appropriate diagnostic procedures, and/or instruments and documented as:

    (i)   a twelve-month delay in one domain; or

    (ii)   a 33 percent delay in one domain or a 25 percent delay in each of two domains; or

    (iii) if appropriate standardized instruments are individually administered in the evaluation process, a score of at least 2.0 standard deviations below the mean in one domain or a score of at least 1.5 standard deviation below the mean in each of two domains; or

    (iv) notwithstanding subdivisions (i)-(iii) for children who have been found to have a delay only in the communication domain, delay shall be defined as a score of 2.0 standard deviations below the mean in the area of communication; or, if no standardized test is available or appropriate for the child, or the tests are inadequate to accurately represent the child's developmental level in the informed clinical opinion of the evaluator, a delay in the area of communication shall be a severe delay or marked regression in communication development as determined by specific qualitative evidence-based criteria articulated in clinical practice guidelines issued by the Department, including the following:

  a) for children 18 months of age or older;

    (i) a severe language delay as indicated by no single words by 18 months of age, a vocabulary of fewer than 30 words by 24 months of age, or no two-word combinations by 36 months of age; or

    (ii) the documented presence of a clinically significant number of known predictors of continued language delay at 18-36 months of age, in each of the following areas of speech language and non-speech development:

      (1) Language production;

      (2) Language comprehension;

      (3) Phonology;

      (4) Imitation;

      (5) Play;

      (6) Gestures;

      (7) Social Skills; and,

      (8) Health and family history of language problems; or,

  b) for children younger than 18 months of age, documentation that the child has attained none of the normal language milestones expected for children in the next younger age range, and none for the upper limit of the child's current chronological age range, and the presence of a preponderance of established prognostic indicators of communication delay that will not resolve without intervention, as specified in clinical practice guidelines issued by the Department.

(b) If there is an observable change in the child's developmental status that indicates a potential change in eligibility, the early intervention official may require a determination to be made of whether the child continues to be eligible for early intervention program services. The early intervention official shall not, however, require that such a determination be made sooner than six months after a child and family's initial IFSP in the program.

   (1) Continuing eligibility for the early intervention program shall be established by a multidisciplinary evaluation conducted in accordance with section 69-4.8 of this subpart which includes the right for the parent to select an approved evaluator, and shall be based on the following criteria:

      (i) a delay consistent with the criteria established for initial eligibility as set forth above; or,

      (ii) a delay in one or more domains, such that the child's development is not within the normal range expected for his or her chronological age, as documented using clinical procedures, observations, assessments, and informed clinical opinion; or,

      (iii) a score of 1.0 standard deviation or greater below the mean in one or more developmental domains; or,

      (iii) the continuing presence of a diagnosed physical or mental condition with a high probability of resulting in a developmental delay.

Appendix 5: References

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