



**UNLOCKING POTENTIAL: THE NJ PRITZKER LEADERSHIP TEAM  
INFANT MENTAL HEALTH CONSENSUS DOCUMENT  
SEPTEMBER 20, 2019**

This consensus document is intended to document key information and decisions made during the planning meeting held on September 20, 2019. This information will be reviewed by meeting participants for edits and additions and then finalized. The finalized consensus document will serve two purposes: to document the outcomes of the planning meeting and to inform the development of a community-wide Infant and Toddler Strategic Plan supported by the Pritzker Children's Initiative.

The purpose of this meeting was to learn of current activities related to Infant Mental Health and to explore key issues related to infant and early childhood mental health. This meeting sought to gather data and insight related to future needs assessment activities to inform the strategic plan for the Pritzker effort. The discussion focused on three key issues related to infant and early childhood mental health including: social and emotional screening; clinical services; and the workforce that supports these functions.

**Landscape background:**

DCF's Children's System of Care (CSOC) serves children and adolescents with emotional and behavioral health care challenges and their families; children with developmental and intellectual disabilities and their families; and, children with substance use challenges and their families. CSOC is committed to providing services based on the needs of the child and family in a family-centered, community-based environment. Available services include community-based services, in-home services, out-of-home residential services, and family support services, which can be accessed through PerformCare, CSOC's contracted services administrator. In 2018, PerformCare received 8,000 calls for services for children ages 0-4 for issues related to developmental delay or disability (22.8% of calls) and behavioral health services (63.5% of calls). Services were authorized for 1,669 children aged 0-4, or 2.9% of children served by PerformCare in 2018. In September 2019 are currently 245 children ages 0-5 were receiving Care Management services through CSOC (1.8% of children and youth receiving Care Management).<sup>1</sup>

There are limited services for infant mental health in New Jersey. Currently, there are two known infant mental health clinics in the state dedicated to serving this population: Youth Consultation Services (YCS) Institute for Infant and Preschool Mental Health and Montclair State University (MSU) Center for Autism and Early Childhood Mental Health (CAECMH). These are both located in the northern part of the state.

It is unknown how many other mental health professionals around the state will treat infants. Currently, the only data available to assess the number of professionals that provided infant mental health services is the NJ-AIMH Endorsement.<sup>®</sup> In 2014, the New Jersey Association for Infant Mental Health (NJ-AIMH)

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<sup>1</sup> DCF CIACC Dashboard Data



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began offering an Infant Mental Health Competencies and Endorsement system grounded in the best practices developed by the Michigan Association for Infant Mental Health. As of January 2019, 161 people have received the Endorsement® in the following categories:

- Category I: Infant Family Associate: 59
- Category II: Infant Family Specialist: 67
- Category III: Infant Mental Health Specialist: 8
- Category IV: Infant Mental Health Mentor (Clinical): 17
- Category IV: Infant Mental Health Mentor (Policy): 7
- Category IV: Infant Mental Health Mentor (Research/Faculty): 3

New Jersey also has a small early education mental health consultation system operated by Montclair State University Center for Autism and Early Childhood Mental Health called the Social Emotional Formation Initiative (SEFI). Three of the SEFI staff (2.25 FTEs) are designated as Infant and Early Childhood Mental Health Consultants to support children with infant mental health needs and their families and the center staff that work with them. This program is funded through the Child Care Development Block Grant and run through the NJ Department of Human Services, Division of Family Development.

As a result of increased child care funding, the state recently added an Infant and Toddler Specialists to every Central Intake agency in the state.

There are not enough clinical providers trained with a prenatal to 5-year-old focus as a result of an undergraduate and graduate training deficit. There are only two higher education programs with this focus in the state and both are located in Northern New Jersey.

New Jersey has the training capacity to support use of the DC:0-5, a diagnostic tool for children under age 5 developed by Zero to Three. New Jersey has 2 expert trainers and 6 certified trainers to the deliver DC:0-5 content; this is an opportunity to ensure full use of this important tool.

According to a 2018 NCCP 50-state survey of Medicaid coverage for key mental health services for children birth to age 6, NJ is one of only 8 states that does not cover social-emotional learning and one of 10 states that does not cover dyadic (parent-child) mental health treatment. Medicaid mandates health and developmental screenings and services through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit to help ensure that children's healthy development is on track. However, even though these infant mental health services are allowable under EPSDT, they are not written into New Jersey's state Medicaid plan.



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Child Welfare system is a key partner in assessing and referring for mental health recognizing that young children in these families may be exposed to trauma and toxic stress and maltreatment. Per the presentation provided during the meeting, 8,712 children ages 0-2 and 8,087 children ages 3-5 are served in this system annually. The vast majority of children ages 0-5 are served in their homes (14,282 in home versus 2,512 out of home). Much of the supports are focused on treating adults however there are important connections via the case management system for assessing and serving very young children.

**Needs Assessment Planning: Social and Emotional Screening**

Screening for social and emotional concerns has two critical roles: for children and families, it assures that issues are identified to facilitate referrals for assessment and treatment; social and emotional screening and analysis of screening data can also inform systems of needs and development of support rationale for building capacity and increasing services.

There are opportunities to conduct social and emotional screening in many settings if there are trained professionals, including: child care and early learning programs (centers and homes); pediatric primary care; Early Intervention; child welfare; homes where doula and home visitors encounter children and parents (Central Intake).

General Issues:

- Measures and tools for social and emotional screening are adequate (ASQ, SWYK), but there is a severe lack of training for those administering these tools, and there is lack of knowledge and availability of services to refer when concerns are identified to ensure fidelity of implementation.
- All screening tools and training around them needed to focus on culturally competent tools and practices.
- There are concerns about ensuring the most at-risk children are screened and included. How to reach those hard to reach? Children who are not in child care (or regulated care), undocumented immigrants, and others.
- Gathering and analyzing social and emotional screening data can support documentation of service needs and gaps.
- There is a need to create incentives and system expectations to promote social and emotional screening across the various settings.

Early Learning/Child Care:

- A pilot in the child care resource and referral (CCRR) will start in October 2019 where each CCRR will be required to screen 100 kids and support them with referrals that they may need. It is unclear if this screening will include social and emotional screening. There is an opportunity to support this initiative to



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ensure social and emotional screening is included, = to determine what data to collect regarding this pilot, and how its successes and challenges can be used to inform policy.

- Grow NJ Kids Technical Assistance (TA) introduced Ages and Stages 3<sup>rd</sup> edition (ASQ-3) training statewide and now there is TA support for implementation. The roll out of ASQ social and emotional screener has not begun. The penetration of the TA is unknown. There is no policy agenda to require the use of social and emotional screening or to require referrals. There are worries about whether there are resources to maintain this initiative within GNJK. And as noted above, when screening occurs there are concerns about where to refer children.
- Policy Need: Ensure that social and emotional screening and referral is required as a part of a supported process that occurs when a child is at risk of being expelled.
- Medicaid does not currently reimburse for behavioral health services for delivered at the early learning/child care setting. Other states have seen success in billing Medicaid for infant mental health consultation and could be a model for New Jersey.

Early Intervention:

- Early Intervention system does not conduct screening. Only full evaluations of referred children occur who are referred when concerns are suspected. The protocol includes the use of the Battelle assessment tool (which has social and emotional sections).
- EI does provide services to children who have demonstrated delays in social emotional development, it is an eligibility category. These services are recorded as EI services and not specifically IMH services. There was some disagreement in the group regarding this point.
- It is unclear how NJ manages its infant and toddler at-risk tracking population; there are 6 federally defined categories of child risk that entitle children to tracking in the early intervention system including homeless, active child maltreatment, born substance dependent, and premature births.
- Early Intervention does receive Medicaid reimbursement for children that are eligible for the program.

Home Visiting/Central Intake:

- The Help Me Grow within the Central Intake supports children with developmental delay and can facilitate social and emotional screening.
- There are opportunities to enhance the role of home visitors and Central Intake to conduct social and emotional screening as these entities already have a role in assessing child and family needs and connecting families to services. Can this be expanded across various systems?



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- The early childhood specialists at the Central Intake agencies are tasked to ensure that families get linked to services, ideally these staff have training in IMH and how to use the screening tools.

Child Welfare:

- The Child Welfare system conducts assessment of each child in the system (these are focused on physical wellbeing), our group was not aware if social and emotional screening was being conducted. All children entering OOH placement receive a comprehensive medical exam. Children in OOH placement receive EPSTD services and are referred for EIS as indicated. Children 0-3 for whom there is a substantiation of child abuse or neglect are referred for EIS.

Pediatric Primary Care:

- There are some pediatric federally qualified health centers (FQHC) in the state and some are supported by American Academy of Pediatrics (AAP) to include social and emotional wellness.
- The Pediatric Psychiatry Collaborative offers child and adolescent case consultation for primary care providers, as well as care coordination for children and families with identified behavioral health needs. Providers who enroll in the Hub are trained to integrate universal behavioral health care screening into their practices.
- Questions were raised about how to ensure that social and emotional screening happening in the pediatric health care setting and being billed for appropriately as a part of EPSTD. Is additional training and support needed?
- Currently there is a restriction on billing for Medicaid for depression screening for mom in pediatric setting.

Other Settings:

- Quick Peek- Parents in New Jersey with questions about their young children's development can get a free screening for their children. Through funding by Kohl's Cares\*, Children's Specialized Hospital created the Quick Peek Early Developmental Screening Program to make it easy for parents to bring their young children into their local library or Kohl's store for a screening with the ASQ®-3 developmental screener.

Opportunities to collect data across these settings – how do we know there is a problem? How do we collect the data to make the case for services?



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**Needs Assessment Planning: Clinical Services**

- There are gaps in the supply of mental health services for infants and toddlers.
  - There are very few providers and most are located in the northern part of the state.
  - Some providers are treating babies and toddlers with inappropriate therapies.
  - When calls come in to the Mobile Crisis line for children under age 2 they do not progress (there are no services to request or provide).
  - Many referrals are not processed because there are no service providers to refer to.
- There are gaps in the mental health providers who are prepared to treat babies and toddlers.
  - The focus on child development within the behavioral health degree programs is not sufficient.
  - Training on specific evidence-based interventions for children ages 0-5 is insufficient.
  - There are very few institutions offering programs for endorsement or additional education for MH practitioners focused on infant mental health.
  - There is geographic disparity in terms of access to the few programs that do exist; they are located in the northern part of the state.
- Lack of workforce training in IMH, across early childhood teachers, pediatricians, MH clinicians. The emphasis on social and emotional screening needs to be coupled with expanding the network for referrals to ensure families get connected to needed services. Zero to Three Program for Infant Toddler Care (PITC) could be a model training for this cross-sector of professionals.
- There is cross-systems recognition of the harmful impacts of adverse childhood experiences (ACEs) but more needs to be done to embed screening and treatment in systems such as the family court system.
- There is strong support for a universal system for child care-based mental health consultation where all centers and family homes can access services.
  - It is unclear where this system should be based – CCR&Rs, EI, Grow NJ Kids, Pediatricians, expanded Central Intake
- Models of early childhood mental health consultation to consider:
  - Minnesota has a good model for EC mental health consultants in infant and toddler centers, uses Medicaid funding for consultants without needing clinical diagnoses
  - Georgetown has an effective model
  - There is support for an idea that mental health consultation could be embedded universally within 3 systems: early childhood education; primary health care; and judicial system.
- NJ could consider embedding infant and toddler mental health specialists at child care programs, like integrated medical/behavioral health homes (Nicholson model in other settings).



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- NJ could develop a system level pyramid concept showing that the IECMH consultation should be universally available to pediatricians in the pediatric setting and to child care in the child care setting, as a primary prevention strategy as well as an early intervention strategy.
- Early Intervention services are offered in the inclusive child care environment (and are prohibited from pulling children out) however more can be done to integrate EI services in to child care.
- There is a need to gather data and conduct studies on the effectiveness of the I-T credentials and certifications and endorsements to expand both philanthropic and public funding for these programs.
- Is there a role for Medicaid Managed Care Organizations in integrating behavioral health at pediatric health setting? These agencies are often able to develop an fund innovation and pilots.
- Policy Need: Medicaid policies that allow for off-site provision of clinical services in community locations such as child care (currently can only be delivered on-site in the licensed location). Currently, services can only be billed at the clinic space and therefore can't bill for home or school based services. This significantly limits the families in need that can be served and prevents integration with other services (pediatric care, child care, etc).

**Moving to Action: Advancing the workforce to support infant and toddler mental health.**

Recognizing that the needs around the workforce are better understood, the group focused time on developing action steps to progress the workforce that is qualified and able to meet the needs of very young children.

**FINANCING**

Goal: Identify a sustainable public funding source for the professional development of early learning providers surrounding IMH and endorsement of the MH workforce that provides behavioral health services to very young children in early learning settings.

Indicators:

- 1) Improved teacher competence and confidence
- 2) Number of early learning programs and other target programs accessing IMH support services
- 3) Number of MH professionals who are able to deliver Medicaid-approved therapies for children 0-3 and number of MH professionals who can do so outside of Medicaid
- 4) Parent child relationships: parents ability and perception of the availability of infant mental health services and supports
- 5) Need to develop a child level measure such as chronic absenteeism



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6) Modify the Medicaid plan to reflect the need for social emotional screening and service delivery

Financing mechanisms:

- Workforce Development Fund (state funding)
  - Dept of Labor, could be used for continuing education and initial endorsement/training (apprenticeship is a possible model)
  - There is additional data that needs to be collected to make this request, including: What is supply gap in clinical I/T MH workforce? How many more are needed? Do we know scope of problem and then the workforce needed us to bridge this gap?
- Policy Goal: Universal MH consultant system for all early learning facilities
  - Should this be internal to the program or external?
  - If external, can GNJK develop this capacity?
  - Of internal, where will the training and support for the internal resource come from?
  - Supervision (coaching) key to the success of either of these approached. Could NJ create a new position in Grow NJ kids for a Master Teacher/ Program Director that would take on the role of supervision and direction for Infant Toddler work?
- Medicaid
  - Opportunity to investigate how Medicaid funding can support: clinical services; social emotional screenings; and training on the screening or clinical service category
  - Look at models from other states where ECMH is supported with Medicaid funding
- Children's System of Care (CSOC) expansion
  - Needs to expand to include services for children 0-3; additional resources required to build capacity
- Early Intervention
  - Concerns about enrollment were raised and that there is currently income based co-pay.
- Central Intake & CCR&Rs
- Require new early childhood specialists to be endorsed? Serve supervision role?





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## **CAPACITY**

### Goals:

- Use needs assessment data to drive capacity building strategy.
- Build capacity of the early learning and mental health workforce to meet the behavioral health needs of very young children.
- Expand (and finance) the early childhood mental health consultant workforce.

### Indicators:

- 1) Number of MH professionals with credentials (by role and level)
- 2) Number of early childhood teachers who participate in coursework focused on IMH
- 3) Cross training on IMH offered to ECE and MH workforce

The group identified a vision that at the prevention/promotion/universal level, all adults (parents, teachers, caregivers, all child-serving professionals): have basic knowledge of infant and toddler social emotional development; can effectively screen young children or support their parents in screening; and can make referrals to additional services and liaise and coordinate with professionals supporting children and families.

### Action steps:

- Identify institutions of higher education to offer coursework and credentials for various professionals (focus on ensuring geographic parity).
- Develop cross system training to bring together child-serving professionals for learning and networking.
- Embed parent supports and training on social emotional development via the Family Engagement Collaborative Improvement and Innovation Network
- Investigate and deploy cost-effective methods for training to large number of people. Online and web-based modalities with follow-up in-person experiences are recommended.
- Develop processes to conduct ongoing data collection to study effectiveness of coursework and credentialing.



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## MESSAGING

Goal: Recommendation to develop a core message that can then be enhanced depending on the audience; this message should focus on social emotional development because many people do not understand infant mental health. Relationships are central to social and emotion health and development and this needs to be reinforced throughout the messaging strategy.

There is a critical need to determine how best to talk about this issue, what are the key messages, and who are the best messengers. There is discomfort in discussing mental health for babies and many important messengers are not prepared to describe IMH to varied audiences. The group recommends developing a single, clear definition that can be adapted for various audiences.

Additional data collection and analysis is needed to ensure that all messages are based on evidence and data drives the strategic goals of the messaging approach.

- Core message: *Social-emotional development is the cornerstone of all future success.*
  - Families – focus on academic achievement, employment, and relationships.
  - Child care providers – focus on school readiness, learning cannot occur until a child is socially and emotionally ready.
  - Policymakers – focus on the future workforce creating a return on investment.
  - Behavioral Health system – supporting healthy social-emotional development helps to create a better society.
  - Other stakeholders:
    - Business – a happy baby is your best employee.
    - Judges – supporting healthy relationships for babies can disrupt the preschool to prison pipeline.
  - Other messages:
    - New Jersey needs the right kind of help, from the right kind of people, at the right time. For every child.
    - The social-emotional start to life beings with loving, supportive relationships.
- Messaging images, graphics and videos need to be created.
  - Social-emotional development is the foundation of the house.
    - You cannot build on a weak foundation.
    - If there is a crack in the foundation, you would not wait years before fixing it.
    - One house on the block that is crumbling is fine, but what if all the houses on the block were crumbling?



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- Videos can show what IMH looks like in action.
- Future workforce
  - Image of babies turning into future workers

Action steps:

- Use social media to promote these messages.
- Town hall meetings are needed to engage consumers and stakeholder with the research on social and emotional development.
- Identify and hire communication experts to develop messages, formats, products.
- Use storytelling and testimonials to illustrate how we all need infant mental health and how its helped consumers.
- Engage the business community to understand the value of investing (tie to executive function and brain science).
- Find champions to promote these messages.