Screening Tools and Evidence Tested Practice

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Prevalence of mental disorders in children 0-5

- Difficult to estimate (ranges from 1% to 24%, depending on methodology, sample etc),
- Diagnostic criteria are in rapid evolution
- Infants and pre-school children are seen in pediatric, preschool, and social service settings, where DSM diagnoses are not typically conferred.
- There are multiple risk factors for young children in our society.
RANGE OF REACTION FOR EXPERIENCE-DRIVEN NEURODEVELOPMENT

Zone of Preventive Modifiability (range of reaction)

Developmental Epochs
- Conception
- Birth
- Kindergarten
- High School
- Adulthood

Developmentally Delayed Trajectory
- neurodevelopmental genetic limitations
- degree of biosocial risk
- lack of resources

Typical Life Course

Intervention Impact Determinants:
- Developmental relevance
- Timing
- Intensity

adapted from Ramey & Ramey, American Psychologist, 1998
The Impact of Early Environments on Children’s Developmental Competence
Georgetown University Center
PREVENTION:
UNIVERSAL:  - e.g. Screening, Case management, Parenting Education, Promotion

SELECTIVE:  e.g. Risk-specific assessment, preventive intervention

SELECTIVE:  e.g. Diagnostic Assessment, Direct Infant or early childhood services
Locating the problem- where does screening fit?

- Universal (Primary)
- Selective (Secondary)
- Indicated (Tertiary)

- Health & development screening
- Parenting education
- Risk-specific assessment
- Diagnostic assessment
Screening in California: Medicaid program strategy 1

- To identify and promote use of appropriate mental health screening and assessment tools.

- To increase primary care providers’ ability to provide more comprehensive care e.g. through use of formal screening tools.

(Only 30% of pediatricians employ formal developmental screening, yet parents’ concerns are highly predictive of true problems.)
Screening in California: Medicaid program strategy 2

- Quality improvement learning in collaboration – e.g. improve identification of at-risk children

- Mental health screening of parents

- Establish separate billing mechanism for childhood mental health screenings.
Common problems presenting to the pediatrician

- Excessive crying
- Feeding problems
- Poorly regulated sleep
- Un-Goodness of Fit
- Difficult behavior
Current State of Affairs: Providers are Ill-prepared

- 17% children have developmental or behavioral disorders
- But 70% of children with developmental disabilities, & 80% of children with mental health problems are NOT identified until school entry
- Most parents want guidance from their health care provider about their child’s development
- Surveys by AAP show that 2/3 of pediatricians feel inadequately trained in assessing children’s developmental status
- Less than 20% of pediatricians use validated screening tools on a routine basis
Barriers to early identification and referrals/treatment

- No reimbursement in most managed care plans
- Too many mandates / no time to do screenings
- Capacity issues- Community may not have capacity for treating these children
- Transfer and flow of information is difficult, given HIPPA, FERPA, and other institutional privacy rules…..
Use of Screening Tools

- Identifying children for assessment
- Identifying areas of need
- Developing individualized interventions or services
- Evaluating progress
Selecting a Tool

- Fits constructs of interest
- Psychometrics are acceptable
- Fits children and families in program
- Administration and scoring requirements fit program staff and resources
 Constructs of Interest
 
o Early childhood social and emotional health
o Factors that can adversely affect emotional health
  o Parental mental illness or substance abuse
  o Domestic violence
  o Unstable, unsafe or absent home
  o Inadequate or absent supervision
  o Inadequate or poor parenting skills
Psychometrics Acceptable

- Reliability is acceptable
  - Test-retest
  - Inter-rater (for observation tools)

- Validity is acceptable
  - Concurrent or predictive

- Identifies children in need of further assessment
  - Specificity and Sensitivity
Fits Children and Families

- Children and families in the program were represented in the normative sample; or criterion is appropriate
  - Ethnicity
  - Language
  - Special needs
Administration and Scoring

- Staff are available and have necessary training to administer, score and interpret
- Sufficient funding for costs of materials and administration
- Burden of children and families is acceptable
- Results will be useful to children, families and program staff
What screening tools?

• Development - ASQ, PEDS
• Symptoms of possible social-emotional problems - MHST, ASQ -SE
• Maternal Depression - Edinburgh
• Parent Stress - Parent Stress Index (Short form) (PSI-SF)
• Autism - M-CHAT
Resources for screening tools

- Administration for Children and Families
  

- Compendium of Screening Tools for Early Childhood Social-Emotional Development
  

- AAP early mental health policy statement and toolkit coming

- ASQ 3rd edition will be out Spring 2009. 2 and 9 mos added, plus online capabilities and other upgrades
Three General Developmental Tools Stood Out from the Rest

• ASQ (Ages and Stages Questionnaire) http://www.agesandstages.com
• PEDS (Parent’s Evaluation of Developmental Status) http://pedstest.com
• PEDS-DM (PEDS: Developmental Milestones) http://pedstest.com/dm
Why? They cover all developmental domains &:

- Are accurate—at least 70% of infants, toddlers & preschoolers with & without disabilities, delays or developmental problems—backed by solid research
- Are short, low cost, easy to use and score
- Rely on parents, so appropriate across many cultures
- Can be completed in many settings—health, child care, home visit, pre-school, online…
Why?

- Great way to communicate with parents, make most of well-child visits, and complies with state and federal requirements (high quality)- IDEA, Head Start, CAPTA…
- Billable under CPT Code #96110 for fee-for-service medical settings (over $50 for each screening)
- Compatible with electronic medical records (EMR)
- Either already available online or will be shortly
Differences-

- Ages they cover
- Amount of time to administer and score
- Available languages and reading level
- The questions they ask and their “feel”
- Costs
IPFMHI screening
(Infant Preschool Family Mental Health Initiative)

- Developed a **compendium** of early childhood (0-5) emotional health screening and assessment tools
- To support selection and use of screening tools by preschools, child development and daycare centers, and School Readiness programs
Compendium

- Use of screening tools
- Understanding psychometrics
- Selecting a tool
- Description of tools

*Intended to be easy to use and concise with references to more detailed information*
Descriptions of Tools

- Title, developer and ordering
- Construct(s) measured
- Psychometrics
- Administration and scoring
Use of Screening Tools

- A process for identifying individuals at a greater likelihood of having an area of need or problematic development.
- Typically, administration and scoring are brief (less than 20 minutes) and easy, requiring little training.
Use of Screening Tools

- Identifying children for assessment
- Identifying areas of need
- Developing individualized interventions or services
- Evaluating progress
ASQ-SE

• Age-specific questionnaires completed by caregivers, scored automatically or by paraprofessional
• Forms for 6, 12, 18, 24, 30, 36, 48, 60 months; each form covers +/- 3-6 months of target age
• 7 areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people
ASQ-SE, continued

• Properties:
  – Norms: 3,014 preschool children, representing 2000 census for family income, education and ethnicity
  – Reliability: test-retest = .94
  – Validity: average sensitivity = .78; average specificity = .95

• Low cost proprietary instrument: $125/kit, with unlimited reproduction of forms

• www.pbrooks.com or 800.638.3775
What do you do after you screen?

- Assessment
- Referral
- Provide parental support
Assessment 1 - What?

What is being “assessed?”

“....the strange behavior of children in strange situations with strange adults for the briefest possible periods of time.” (Bronfenbrenner 1979).

OR

The adaptations of a developing child in his developing interpersonal context.
Assessment 2 - For Whom?

The person requesting the assessment wants the answer to a question. e.g.:
1. Should the child be removed from his home?
2. Can the child attend regular school/preschool?
3. Why does the child have X behavior?
4. Can/should parent behavior change?
5. Does the child need medication?

The Assessment may answer the wrong question.
Use of Assessment Tools

- A procedure for identifying individuals who have specific areas of need or problematic development.
- Administration and scoring may be lengthy (more than 20 minutes) and complex, requiring specialized training.
Use of Assessment Tools

- Document a developmental delay or disorder, resulting in a diagnosis and/or eligibility for special services
- Identifying areas of need
- Developing individualized interventions or services
- Evaluating progress
Psychometrics

- Methods
- Reference
- Reliability
- Validity
- Scoring
Methods

- Interaction with a child or caregiver
- Observation
- Self- or other-report
Reference

- **Norm referenced**
  - Compares individuals performance to that of other individuals on the same measure
  - Applicability varies depending on similarity to the normative sample

- **Criterion referenced**
  - Compares an individuals performance to an established standard
Reliability

- Describes the dependability of the measure
  - Test-retest (across administrations)
  - Inter-rater (across administrators)
  - Internal consistency (across items)
Reliability

- **Test-retest**: Receives a similar score across repeated administrations that occur close in time.

- **Inter-rater**: For observation measures, receive a similar score across 2 or more observers.

- **Internal consistency**: The tools individual items contribute to measuring the same construct.
Validity

Describes the authenticity of the measure
- Content (items appear to represent the area of interest based)
- Criterion (how well the results compare to a criterion or independent measure)
  - Concurrent
  - Predictive
Validity

- **Content:** Based on professional judgment
- **Concurrent:** Relationship to an established measure of the same construct administered close in time
- **Predictive:** Relationship to functioning level at a later point in time
  - Sensitivity
  - Specificity
Validity

- **Sensitivity**: Correctly identify individuals with the need/disorder as having the need/disorder
- **Specificity**: Correctly identify individuals without the need/disorder as not having the need/disorder
Scoring

Understanding an individual’s performance in comparison to the performance of others

- Percentile rank
- Age equivalent
- Standardized score
Percentile Rank

- Indicates the relative ranking of the individual’s score to that of the normative sample
- Ranges from 0-100
- A 50% score indicates that the individual’s score is higher than 50% of the normative sample
- Percentile scores are not easily compared to each other due to variation in raw scores across the percentile range
Age Equivalent

- The average raw score of children at that age in the normative sample
- Indicates the performance level of children at different ages
- Does not provide an indication of the expected variance in performance for different ages
Standardized Scores

- The relationship between the individual’s score and the mean score for the normative sample
- Fixed mean and standard deviation
- Facilitates comparison between scores
Evaluating early child distress (an example)

• Context
• Relationship
• Temperament
• Symptoms
Importance of identification and Diagnosis

• Children 0-5 do develop emotional disorders
• Children 0-5 are at risk of emotional disorders: Either internal to child or external to child (internal to caregiver or external to caregiver)
• Social/emotional development needs for 0-5 rarely identified & targeted for Tx: because children 0-5 spend their time at home, daycare and preschools, where mental health services are not commonplace.
Identification and Diagnosis

- **Why is this age typically not a focus**
  - Minimized (No normative comparison OR “They will grow out of it”)
  - Not taken seriously (low behavioral intensity)
  - Attributed to developmental disorders

- **Why is it important to focus on this age**
  - Children are in need
  - Untreated disorders/risk factors will adversely effect critical development in other domains
  - Untreated disorders can become more severe resulting in need for treatment when they are older that is more intensive and expensive
Can we diagnose mental disorders in children 0-3?

The Diagnostic Classification for Children Zero to Three.  www.zerotothree.org

A 5-Axis diagnostic system, parallel to the DSM-IV except for Axis 2

AXIS 1 - Psychiatric disorder
Axis 2 - Relationships
Axis 3 - Medical
Axis 4 - Psychosocial stress,
Axis 5 - PIR-GAS

DSM IV-V: A DSM-V team examining criteria for diagnosis in 0-5.
Regulatory Disorders (on Axis 1 - DC 0-3)

Dx requires both a distinct behavioral pattern and a sensory, sensory-motor, or organizational processing difficulty.

Type 1    Hypersensitive
Type II   Under reactive
Type III  Motorically Disorganized, Impulsive
Type IV   Other

Regulatory disorders underlie many or most psychiatric diagnoses in children
Risk: Children in the Child Welfare System (California)

Substantiated abuse/neglect for children 0-3 - about 27,000

Children in out of home placement: aged 0-3:
as of 12/06:
11,673 in-home,
15,764 – foster care (more than half of substantiated cases)
What does this mean for the young child?

Attachment disrupted
Neglect or trauma early in life
Loss of safe context
Developmental risk
Risk of social-emotional disorders
What are the stakes - for the child?

If something goes off-course as the baby develops to a child, what are the off-course pathways?

A Sudden
  Example: Post-traumatic stress disorder

B Continuous
  Example: Developmental Disorders - Mental retardation, Autism

C Cumulative:
  Example: Regulatory disorders (DC 0-3)
Trauma

Child is overwhelmed and may:

- Dissociate
- Be hypervigilant (+/or “hyperactive”)
- Have disturbed sleep, appetite, concentration

DC 0-3 diagnostic criteria
Screening questions for trauma

INFANTS & YOUNG CHILDREN

- Disturbance of sleep & eating
- Inability to be soothed
- Constant crying
- Generalized fears
- Avoidance of situations that may/may not be related to the trauma.

PRESCHOOL CHILDREN

- Disrupted expectations of protective figures (attachment difficulties)
- Agitated motor behavior or extreme passivity
- Eating or sleeping disturbances
- Inconsolable crying
Maternal depression

• The highest risk for first episode of major depression is during childbearing years
• Prevalence: 10-15%.
• If left untreated, 30-70% experience depression for a year or longer.
Maternal depression: 1

27% of women w. clinically significant scores on EPDS in first postpartum year

• Previous history --> 6x increased likelihood of recurrent depression

• Universal screening in postnatal care --> three-fold recognition of maternal depression

• Screening in pediatric well-child visits --> five-fold recognition.
27% of women w. clinically significant scores on EPDS in first postpartum year

- 33% of women have persisting symptoms, 26% develop high symptoms after the first 3 months; 44% (less than half) improve after the first 3 months.
- child(ren) have a higher risk of behavioral (3x) or other (8x) social-emotional problems
Postpartum Blues

• @85% of mothers experience postpartum blues from 2-4 days after delivery, peaking at 5-7 days, ending at 2nd week.
• Risk factors PMDD and depression + FH of depression
• The condition resolves and does not require aggressive management, but early discharge mores indicate that parents and partners should be educated about this.
Multidisciplinary assessment of Maternal Mood

- **KEY COMPONENT**
  - Maternal mood state
  - Perception of fetus/baby
  - Marital/partner supports
  - Next steps

- **HOW TO ASK**
  - “How are your spirits?”
  - “What has baby been telling you about him/herself?”
  - “How has (partner) been handling all this?”
  - “You notice a lot. Things sound difficult. Let’s help you find someone to talk to”

www.zerotothree.org
Postpartum Depression

- MDD reported to be 3x higher in first 5 weeks postpartum.

- Risk for negative parenting behavior → child at risk for behavioral and cognitive impact.

- History of MDD increases risk of PPD to 24%.

- Depression during pregnancy MDD increases risk of PPD to 35%.
Maternal depression - impact on the child

Children of depressed mothers have

• Behavioral problems,
• Emotional problems,
• Problems with their own relationships later in life.
Effects of treatment - STAR*D

- Depression remitted in 33% within 3 months
- Rates of DSM-IV diagnoses in children decreased from 35% to 24%
- (In untreated controls, rates increased to 43%)
Effects of treatment - STAR*D

- Duration of the mother’s depression correlated with the child’s baseline symptoms, and magnitude of improvement in the mother correlated with the child’s improvement.

Maternal substance abuse - impact on the child

- Child with FAS. Short palpebral fissures, a smooth philtrum, and a thin upper lip are evident
- Neuropsychological & behavioral problems
- Impact on developing fine and gross motor skills and adaptive and social skills
4 P’s Plus screen

PARENTS  Did either of your parents ever have a problem with alcohol or drugs?

PARTNER  Does your partner have a problem with alcohol or drugs?

PAST  Have you ever drunk beer, wine or liquor?

PREGNANCY  In the month before you knew you were pregnant:

• How many cigarettes did you smoke?
• How many beers/much wine/liquor did you drink?
• How much marijuana did you smoke?
Where are Mental Health services?

• EPSDT Medi-Cal (Medicaid)
• Healthy Families insurance (SCHIP)
• Realignment $
• AB 2726 (3632) SB 1895 & SB 90 unfunded mandate
• Proposition 63 (MHSA)

RESOURCE: Mental Health Screening and Referral Capacity for Children 0 - 5
http://www.cimh.org/Services/Child-Family/Free-Publications.aspx
Child Welfare & Cal-WORKs

• Child welfare Redesign (AB 636)

• Title IV-E (foster care, administration, training)

• Mental health substance abuse allocation
Current changing trends 1

• 2006 AAP policy statement requires 3 screenings w. standardized screening tool at ages 9, 18, and 24 or 30 months.

• AAP Task Force on Mental Health developing parallel algorithms for mental health at infant/pre-school, school-age & adolescent levels.
Current changing trends 2


- **Head Start** (reauthorized 2008) requires high-quality developmental screening
Current State of Affairs: IDEA Part B & C

- IDEA Part B- Individuals With Disabilities Education Act (IDEA) Part B addresses the educational needs of children with disabilities from birth to the age of 21.

- IDEA Part C- requires a statewide, comprehensive, coordinated, multidisciplinary, interagency system to provide early intervention services for infants and toddlers with disabilities and their families (Early Start).
Current State of Affairs: CAPTA

- Child Abuse Prevention and Treatment Act (2003) requires that a child under the age of 3 involved in a substantiated case of child abuse or neglect be referred to early intervention services.
- A foster care child is 4x’s more likely to have a disability, serious behavioral or emotional problem than a child living with one or both parents.
- 21% of children in foster care have learning problems, compared to 4% of children living with a parent.
- 22,000 children under 3 in Early Start, with 13% from Child Welfare= UNDER identification.
Current state of affairs: California Children’s Mental Health

- DMH serves MediCal beneficiaries meeting medical necessity criteria - conferred by a DSM-IV diagnosis & severe functional impairment.
- Children under 5 have historically been infrequently diagnosed with DSM-IV, excepting Autism. (During 2000-2001, of children < 18 served, 4.5% were < 5 years old).
- Nonetheless, many/most children served by Mental Health can be identified as having problems that originated before school age.
Integration across systems

• Service for children, particularly age 0-5, requires finding a way to incorporate information, strengths and outcomes across several systems.
Coordinating Services - the Screen Door

Current: Screening used to define eligibility; tools selected to identify a particular problem (e.g. developmental delay)

Goal: Screening used to identify the child’s strengths and needs in order to plan for him.

This requires communication among agencies
Developmental and Mental Health Screening Code -- 96110

- DHS pays for the 96110 code when an objective developmental or mental health screening occurs
- Both may be performed and billed on the same day
- Bill 96110 for developmental screening, 96110 w/UC modifier for mental health screening
Developmental and Mental Health Screening Code -- 96110

• Other payers in MN also cover objective developmental & mental health screening

• Managed care contracts for 2008 include:
  – $20 incentive for each developmental screening in encounter data (96110 code) above the percentage last year
  – $25 incentive for each mental health screening in encounter data (96110 code w/UC modifier)
Treatment Planning:

• Identification and diagnosis  
  (includes Dx appraisal of parent)
• Knowing when to intervene  
• Knowing how to intervene  (knowing resources)
• Treatment planning  
  (knowing which practices to support)
Interventions

- Universal (Primary)
  - Well child visits (primary care)
  - Bright Futures model

- Selective (secondary)
  - Early intervention
  - Connection to community resources

- Indicated (Tertiary)
  - Referral for specialized infant mental health services
  - Treatment, parent & child
Evidence-Based Practices for children 0-5

MTFC - Multidimensional Treatment Foster Care

IY - Incredible Years

PCIT - Parent-Child Interaction Therapy

Olds Nurse Home Visiting

Triple-P Parenting

Trauma-focused Cognitive-behavioral Therapy (valid 3-18 yrs)
Bringing Services together

- Family support
- Medical home
- Early childhood education
- Mental Health
- Developmental services
- Social Services
BEST-PCP

Behavioral, Emotional-Social & Developmental Screening and Treatment in Pediatric Primary Care
Funded by Commonwealth Fund, administered by NASHP

Goals:
• 1- Pilot screening in 2 managed care MediCal Plans
• 2- Matrix of responsibilities for service
• 3- Inform policy change
BEST-PCP Lessons Learned

1- Standardized screening well received by parents and providers: increased efficiency and identified children in need of services

2- Matrix demonstrated that:
   • Real information and implementation is local
   • Gaps are greater for services than for assessment

3- Policy change very difficult in large State
Resources & reports

• *For more information on: ABCD Initiative, go to:
  http://www.nashp.org/_catdisp_page.cfm?LID=2A78988D-5310-11D6-BCF000A0CC558925

• **ABCD II project, BEST-PCP, go to:
SECCS: State Early Childhood Comprehensive systems

Phase 1: 2004-5
MCAH Maternal and Child & Adolescence Health Bureau convened multidisciplinary group to identify service needs/gaps

Phase 2: 2006-8
Scope of work focused on developing mental health screening pilots: Lead: Janet Hill (CA DPH)
ABCD Screening Academy

• Third in ABCD series, funded by CW, admin by NASHP.
• Focus on screening for developmental and mental health problems in 2 pilot counties (LA, Orange)
• Opportunity to move toward long term plan to make screening a standard activity
• Lead (CA DPH) Janet Hill
ABCD Screening Academy

2 Pilots –Los Angeles and Orange Counties- to identify where policies are needed and to spread the practice. Physicians listen to other physicians…

- Los Angeles- Early Developmental Screening and Intervention Initiative (EDSI) which has over 15 provider sites (F5LA-UCLA)

- Orange County- Piloting various models of implementing developmental and S/E tools:
  - CalOptima: Healthy Families managed care plan
  - CHDP- county clinics
  - AAP – provider offices
  - Help Me Grow- works with parents to test and score, then sends results to MD
Statewide Screening Collaborative

Objectives:

1. Improve synergies among state programs involved in recognition and response (screening) activities

2. Adopt common language, standard tools and screening protocol (for families and children that affect health childhood development)
Accomplishments: Statewide Screening Collaborative

• Created Statewide Screening Collaborative-more than 15 state departments and outside programs to implement the logic model= create “common language, tools, etc.”

– Enhance state capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings throughout CA
Statewide Screening Website

Developing website for the Statewide Screening Collaborative partners to use

– Click on counties to find resources (@First 5 Association)
– 0-36 months and 3-5 years of age portals
– Links for providers across many sectors, e.g. health, early childhood education, child care, schools, social services (foster care), etc.
– To begin 2009
Early Intervention Communication Toolkit

• Developing Community Communication Toolkit with AAP, IDA, ARCA, UCLA, First 5 CA & Association, etc.
  – Foster communication amongst providers when there are developmental concerns about a child
  – Forms and resources to facilitate flow of information across sectors, e.g. health, ECE, schools, foster care, and parents
  – 0-36 months and 3-5 years orientation
  – To be housed on the Screening website
Accomplishment: helping families

• Negotiating state discount for ASQ, ASQ-SE, PEDS and PEDS-DM. Other tools may follow

• Identified model communities that have Regional Centers working together with other providers and with families
How Programs and Communities can help families…

• Know and use high quality screening tools
• Use results to move child to assessment and diagnosis, if indicated
• Share results with others
• Accept results of others (including parents) if high quality screening tools, e.g. ASQ, PEDS, etc. were used
• Don’t make parents go through duplicate efforts to screen the child
Step by Step – Developmental Checkups for California Kids

Infants and Toddlers – Birth to 36 Months Old

Parent or family has concerns

Staff or provider has concerns

Child seems OK

Parent Completes Developmental Screening Tool

**PEDS:DM, PEDS or ASQ** – 6, 10 or 30 questions

Score and Discuss Results with Parents

RED FLAGS

Concerns in One or More Developmental Areas

- Behavior
- Language
- Movement
- Problem-Solving
- School Readiness
- Self-Help
- Social-Emotional

No Red Flags, BUT Concerns About Risk Factors

Screen for Other Risk Factors.

Follow Up on Flagged Issues.

- Social-Emotional
- Maternal Depression
- Parental Stress
- Family Violence
- Poverty

No Red Flags

No Developmental Concerns Right Now

Partner with and Support Child, Parents and Families.

Get regular feedback.

- Does the child have:
  - a diagnosed disability, delay or risk factor?
  - a formal plan – an IFSP (Individualized Family Service Plan) – for services?

Do Annual Developmental Screens

Until Child Turns Age 8.

Follow Up on Any Red Flags and Screens with “Concerns.”

Involve Community Partners for Every Child at Every Step!

- California Regional Center Lanterman Act services for people with autism, cerebral palsy, epilepsy or mental retardation
- Dial 211 for information and referrals 24/7
- Early childhood educators and child care workers
- Early Head Start – Developmental screening required
- Early Start/Early Intervention programs (IDEA Part C), run by California Regional Centers and school districts (LEAs)
- Family Support Agencies and Family Resource Centers
- First 5 Commission
- Food and nutrition programs, including WIC
- Health care and “medical homes” – medical workups such as hearing, vision and neurological
- Health programs for high-risk children and families – California Children’s Services, Child Health and Disability Prevention, Nurse-Family Partnership, Black Infant Health, other programs
- Mental health services for mother, child or family
- Reading and literacy initiatives
- Schools and local education agency (LEA) services
- Social Services and Child Welfare – Developmental screening required
- Special screenings – autism, social-emotional, other
- Substance abuse programs – alcohol and drug abuse prevention and services

Involve a Child’s Health Insurance at Every Step!

- Health Plans, Private Health Insurance, Medi-Cal (Medicaid), Healthy Kids (SCHIP, State Child Health Insurance Program)
Step-by-Step – Developmental Checkups for California Kids

Preschoolers – Children Ages 3 to 5

Parent or family has concerns

Parent Completes Developmental Screening Tool

PEDS:DM, PEDS or ASQ – 8, 10 or 30 questions
Score and Discuss Results with Parents

Parent or family has concerns

Staff or provider has concerns

Child seems OK

RED FLAGS
Concerns in One or More Developmental Areas
Behavior, Language, Movement, Problem-Solving, School Readiness, Self-Help, Social-Emotional

No Red Flags, BUT
Concerns About Risk Factors

Screen for Other Risk Factors.
Follow Up on Flagged Issues.
Social-Emotional, Maternal Depression, Parental Stress, Family Violence, Poverty

No Red Flags
No Developmental Concerns Right Now

Involve Community Partners for Every Child at Every Step!

- California Regional Center Lanterman Act services for people with autism, cerebral palsy, epilepsy or mental retardation
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- Food and nutrition programs
- Head Start – Developmental screening required
- Health care and “medical homes” – medical workups such as hearing, vision and neurological
- Health programs for high-risk children and families – California Children’s Services, Child Health and Disability Prevention, other programs
- Mental health services for mother, child or family
- Reading and literacy initiatives
- Schools and local education agency (LEA) services, including Preschool Special Education (IDEA)
- Social Services and Child Welfare
- Special screenings – autism, social-emotional, other
- Substance abuse programs – alcohol and drug abuse prevention and services

Involve a Child’s Health Insurance at Every Step!

- Health Plans, Private Health Insurance, Medi-Cal (Medicaid), Healthy Kids (SCHIP, State Child Health Insurance Program)

Refer for Assessment and, if Needed, Diagnosis and Treatment.
Determine if the child qualifies for Preschool Special Education because of a disability and a need for services.

Partner with and Support Child, Parents and Families.
Get regular feedback.

Does the child have:
• a diagnosed disability
• a formal plan – an IEP (Individualized Education Program) – for services?

Do Annual Developmental Screens
Until Child Turns Age 8.
Follow Up on Any Red Flags and Screens with “Concerns.”

By Margaret Dunkle
10/31/08
Conclusion

Prevention and early intervention for mental health disorders in early childhood:

• Pay off
• Are evidence based
• Are possible within existing and potential funding sources
Capitalizing on Resilience

• We cannot (and perhaps should not) protect young children from stress, but we can support their capacity to master it.