

TDMHSAS BEST PRACTICE GUIDELINES

Infant and Early Childhood Mental Health

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Note: The use herein of the term “infant mental health” or “IMH” will include “early childhood mental health,” just as most references to infants, toddlers, and young children can be interchangeable. Additionally, IMH “providers” and “specialists” are used without referring to a specific state’s competency endorsement system.

1. Definition: What is infant mental health?

Infant mental health (IMH) refers to the social-emotional well-being of children ages 0 to 5 years. A central tenet is that infant development cannot be separated from the caregiving environment, primarily the attachment relationships, as well as the culture in which the relationships develop.

Currently there are multiple programs across the United States that train infant mental health practitioners. Training is generally intensive, requiring at least one year of study plus ongoing supervision, and includes the following core concepts:

- **Relationship-Based Assessment and Intervention:** Infants and young children develop within the context of one or more dyad-specific attachment relationships. The physical, cognitive, social, and emotional capacities of the infant are mediated by the quality of the caregiver-child relationships.

Similarly, the relationships between the infant mental health practitioner, the infant, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.).

- **Cultural Competence:** Just as infants cannot be understood outside of the context of their primary relationships, relationships cannot be understood outside of the culture in which they grow. The impact of socioeconomic or minority status, race, ethnicity, sexuality, and culture on the caregiver, child, and relationship must be acknowledged and explored. Infant mental health is an ecologically-valid discipline, accounting for all factors impacting the infant and the caregiving dyad. Therefore, not only do IMH providers offer preventive support and evidence-based intervention to the child, dyad, and family, but they also advocate for services and/or social change, as necessary, for infants/families to thrive.
- **Reflective Practice:** A large core knowledge base that includes child development, adult development, ability to observe behavior, ability to translate between caregiver and child, ability to work across service systems, etc. is required of an IMH specialist. This knowledge base is necessary but not sufficient; an IMH specialist must also have the ability to engage with a caregiver-child dyad while holding each in mind and being aware of what each member, including the specialist, brings to the relationships. Reflection is a necessary skill and responsibility involving the specialist's acknowledging and examining his/her own responses to the dyad and regularly accessing appropriate supervisory or consultative relationships.
- **Collaborative Systems:** The practice of IMH rarely occurs solely within a therapist's office; rather it is community based. Infants and young children are uniquely dependent upon their caregivers at all times. It is crucial that an IMH specialist be able to assess and coordinate intervention as part of a team of significant figures who interact with a child. This may include health and allied health professionals, educators, extended family members, etc. and is especially important where there are developmental concerns. Some of the most successful prevention and intervention programs have been developed in collaboration with child welfare/courts, education, and primary care practices (e.g., Zero to Three Safe Babies Court Teams, mental health consultation in Early Head Start, embedded mental health professionals in pediatric settings).
- **Trauma-Informed/Empirically-Based Assessment and Intervention:** Understanding trauma from a developmental perspective is a core competency of infant mental health. While young children do not have the words to describe traumatic events, they are impacted by trauma at a preverbal level (biological, cognitive, social, and emotional). Young children are especially impacted by interpersonal trauma because they experience the world through the lens of their primary caregivers. Early trauma may include exposure to domestic violence, community violence, parental addiction, or chronic maltreatment. Traumatized infants and dyads have a special need for trained providers who are sensitive to relational and developmental stages. An IMH specialist whose practice implements all of the core concepts previously stated will need additional training and supervision in working with trauma-exposed infants and their caregivers. For infants and young children, it is particularly important that evidence-based interventions be implemented in the context of relationship-based practice.

Why focus on infant and early childhood mental health?

- **Early development and vulnerability:** Advances in neuropsychology have led to an understanding of the “experience-dependent brain.” The pace of brain growth and organization in the first three years is unmatched at any other time during the lifespan, with fully 83 percent of dendritic growth occurring after birth, mostly during the first three years of life. Given this early growth and later neuronal pruning, the “use it or lose it” principle may best describe how experience shapes the brain. Because early trauma and deprivation can derail lifelong functioning, positive relationships and stimulation are crucial in the early years. When children are exposed to trauma and/or neglect, developmental priorities shift from learning to vigilance. Violence exposure leads to smaller brain mass and less brain tissue connecting the hemispheres, difficulty with emotion regulation, motor coordination, language and learning (De Bellis et al., 1999). Young children exposed to trauma have a heightened “fight or flight” response due to increased hypothalamic-pituitary-adrenal reactivity (Perry et al., 1995; van der Kolk, 2003).
- **Early development and recovery:** While infants and young children may be particularly susceptible to adverse experiences (e.g. poverty, lack of resources, absence of an emotionally nurturing caregiver) and trauma (e.g. abuse/neglect, interpersonal violence, medical trauma, terrorism, natural disaster), the good news is that they are also more able to repair, learn, and grow from positive experiences than older children and adults. Early and appropriate intervention can improve lifelong functioning (Tronick et al., 1998). Recent research has shown that the first two years of brain development are especially sensitive to corrective psychological environments (Sheridan et al., 2012).

III. What is healthy infant and early childhood social-emotional development? How do we promote it?

- Infants are fully dependent on their primary caregiver(s) not only for instrumental care (feeding, clothing, etc.) but also for psychological nourishment. Without consistently responsive, nurturing attention, infants can be psychologically malnourished which in turn can stunt growth in all developmental domains (physical, cognitive, social, etc.). The healthy reciprocity of the primary attachment relationship is the essential psychological nutrient. Support for child well-being begins with communities where adults have what they need physically and psychologically in order to thrive and care for their children.
- Healthy social-emotional development and attachment are associated with (Anda et al., 2006):
 - Emotional Regulation
 - Optimal Cognitive Development
 - Academic Achievement
 - Physical Health
 - Mental Health

- Relational Capacity (the ability to form positive parental, peer, and romantic relationships)
- Developing optimal autonomous functioning
- According to the Infant Mental Health (IMH) Task Force at Zero to Three, IMH is:
 - The developing capacity of the child, birth to 3 years, to experience, regulate, and express emotions;
 - The ability to form close and secure relationships; and
 - The ability to explore the environment and learn.
- IMH specialists can recognize and advocate for environments where young children learn socially appropriate coping strategies to express and regulate emotions and where they can form secure relationships, explore and learn. IMH specialists can support parents in learning developmentally appropriate expectations and discipline techniques and guide parents in identifying family needs and resources, such as high-quality early childhood programs, timely medical and/or developmental screening, nutrition choices and sources, health-promoting activities, and age-appropriate cognitive stimulation.

IV. Screening and Assessment

- Universal screening of infants, generally in a primary care setting, has been mandated given the benefits of identifying problems early. With early screening (e.g. EPSD&T), successful prevention can occur. The American Academy of Pediatrics disseminated a policy on developmental surveillance and screening (AAP, 2006) and issued a reaffirmation of the policy in 2010 (AAP, 2010). TENNderCARE is a full program of check-ups and health care services for children who have TennCare and includes developmental/behavioral screening (<http://www.tn.gov/tenncare/tenndercare/visits.shtml#2>).
- Assessing social-emotional wellness in infants and young children can be more challenging than with older children because of the rapidity of growth, the small window of elapsed time between age-appropriate and delayed development, and the overarching impact of the primary attachment relationship. Close and frequent contact and evaluation is necessary for an IMH provider's assessment and recommendations to remain current.
- Methodology:
 - Interviews with caregivers
 - Standardized/Objective Measures
 - Caregiver-report measures regarding infant symptomatology, infant exposure to trauma and stressful life events, and parenting stress. The following is a non-exclusive list of some available measures.
 - Ages and Stages Questionnaire: Social-Emotional (<http://www.pbrookes.com/tools/asqse/index.htm>)

- Parenting Stress Index
(<http://www4.parinc.com/Products/Product.aspx?ProductID=PSI>)
 - Child Behavior Checklist
(<http://www4.parinc.com/Products/Product.aspx?ProductID=CBCL-PS>)
 - Infant-Toddler Social and Emotional Assessment and Brief Infant-Toddler Social and Emotional Assessment
(<http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=015-8007-387>)
 - Observation
 - Given that children communicate primarily through behavior, careful observation of the child and caregiver is of utmost importance and is an essential part of all training protocols.
- A typical assessment involves office-based interviews and observation of the child with multiple caregivers in natural environments (whenever possible).
 - Background
 - IMH provider meets with primary caregiver and/or custodial caregiver to obtain history.
 - Child history includes prenatal, medical, temperament/sensory issues, behavioral issues, family composition and functioning, social relationships, school/daycare, trauma exposure, loss, etc.
 - Child Functioning
 - IMH provider first observes the child with caregivers in natural and/or clinical environments, then directly interacts with the child.
 - Observations and assessments help determine functioning in all developmental and social-emotional domains including motor, language, cognition, sensory processing, affective expression, emotional regulation, and social interaction with peers and adults.
 - Caregiver Functioning
 - IMH provider meets and evaluates caregiver(s) strengths and needs.
 - Caregiver history includes health, psychiatric, intellectual, adaptive functioning.
 - Caregiver's Perceptions of the Child
 - IMH provider meets with caregiver(s).
 - IMH provider administers a semi-structured clinical interview developed to elicit caregiver perceptions. This type of semi-structured interview requires advanced training.
 - Observation of family functioning, specifically, the child's interactions with each caregiver.
 - IMH provider facilitates interactions between the infant or young child and each significant caregiver.
 - These observational methods require advanced training.
 - Psychiatric Evaluation
 - IMH provider may refer to an IMH-trained physician or nurse practitioner who meets with the family to assess for the suitability

of psychopharmacological intervention. See **Appendix I, Pharmacotherapy in infant and early childhood mental health**; see also Gleason, et al. 2007, *Psychopharmacological Treatment for Very Young Children: Context and Guidelines*; for older references, see AACAP Practice Parameters for the Psychiatric Assessment of Infants and Toddlers (Thomas, 1998). The AACAP parameters are undergoing revision.

V. *Diagnosis*

- Diagnosis is an ongoing process requiring multiple sessions or contacts (as outlined in the assessment section).
- Diagnoses may change more rapidly in early childhood than for older children and adults.
- Diagnosis often requires a multidisciplinary team that can assess medical as well as developmental and psychological issues.
- The standard diagnostic manual is the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R)* (Zero to Three, 2005). IMH clinicians are trained to use this system as well as the DSM-IV (for older youth, caregivers and other adults who may be the focus of clinical intervention).
- The DC:0-3R is developmentally appropriate for infants and toddlers and focuses on caregiving relationships as a primary factor in children’s emotional health.
- Many young children are referred for assessment for being “oppositional” or “hyperactive.” IMH clinicians are trained to differentiate between developmentally appropriate stages during which children are expected to display certain behaviors, such as separation anxiety and bids for independence, and when those same behaviors might signal a problem. Likewise the IMH clinician can evaluate situational or timely expressions of grief, depression, trauma, etc. and identify behaviors that may be an early manifestation of a more pervasive diagnosis. The DC:0-3R recognizes the occurrence of disruptive behavior as a symptom of a multiple diagnoses.
- The quality of an attachment is relationship-specific. The DC:0-3R contains descriptors for the quality of an attachment relationship in the context of each relationship. It does not offer diagnostic classifications for attachment problems separate and apart from a relational context.
- To facilitate reimbursement, crosswalks have been developed for DC:0-3R and DSM-IV TR. (For example, see a crosswalk developed by the state of Florida at http://gucchdtacenter.georgetown.edu/Activities/TrainingInstitutes/2012/Resources/Inst_16_R2_FL%20Crosswalk%20June%202010%20PDF.pdf.)

Comparison of Five-Axis Categories in DSM-IV TR and DC:0-3R

	<i>DSM-IV TR</i>	<i>DC:0-3R</i>
Axis I	Clinical Disorders	Clinical Disorders
Axis II	Personality Disorders Mental Retardation	Parent-Infant Relationship Global Assessment Scale (PIRGAS) Relationship Disorders
Axis III	Medical Disorders	Medical & Developmental Disorders
Axis IV	Psychosocial & Environmental Problems	Psychosocial & Environmental Problems
Axis V	Global Assessment of Functioning	Functional Emotional Developmental Level (includes attention, mutual engagement, communication, problem solving, and symbolic thinking)

Source: Egger & Emde, 2011.

VI. *Intervention*

- There are many evidence-based primary, secondary, and tertiary interventions for infants and toddlers that address a wide range of presenting issues (e.g. developmental delays, feeding/sleeping issues, disruptive behavior disorders, symptoms associated with trauma exposure).
- Treatments may be as practical as case management and parent support or as intensive as dyadic psychotherapy.
- Multiple settings for intervention include home-based, school-based, agency-based, or a more traditional clinic.
- The following is a non-exhaustive list of empirically-based interventions for infants and young children. Web links for each intervention are included. These interventions are not generally available in Tennessee at this time, primarily due to the shortage of infant mental health specialists. Tennessee has, however, brought parent-led, professionally coordinated training and support programs for families with young children to communities statewide through the Regional Intervention Program (<http://www.ripnetwork.org>).

- Attachment and Biobehavioral Catch-up (ABC) (Dozier)
 - For caregivers and children (ages 0-5) who have experienced early maltreatment and/or disruptions in care: <http://abcintervention.com>
- Child-Parent Psychotherapy (Lieberman & Van Horn)
 - Home or clinic-based treatment for traumatized children (ages 0-5) and their caregivers: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194>
- Circle of Security (Cooper, Hoffman, Marvin, Powell)
 - An intervention program for caregivers and children designed to prevent insecure attachment and child emotional disorders (ages 0-5): www.circleofsecurity.org
- Nurse-Family Partnership (Olds)
 - Nurse home visitation program for low-income, first-time parents and their children (prenatal–infancy): <http://www.nursefamilypartnership.org/>
- Nurturing Parenting Programs (Bavolek)
 - Focused on prevention and treatment of child abuse and neglect for caregivers and children (ages 0-5): <http://www.nurturingparenting.com/>
- Parent Child Interaction Therapy (Eyberg)
 - An intervention for children (ages 2-7) with externalizing behavioral problems that focuses on improving the caregiver-child relationship: <http://www.pcit.org/>
- Key components of collaborative IMH intervention:
 - Concrete service support/case management
 - Emotional support/therapeutic engagement
 - Advocacy
 - Developmental guidance/parent education
 - Dyadic psychotherapy
 - Reflective supervision and consultation

Appendix I: Pharmacotherapy in Infant and Early Childhood Mental Health

M.M. Gleason, MD, Assistant Professor of Psychiatry and Behavioral Sciences,
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There is limited scientific evidence that supports or guides the use of psychopharmacologic treatment in preschoolers (3 -5 years old) and none in the infant and toddler ages. Challenges for physicians considering psychopharmacological intervention include:

- Complexity of diagnosing clinical disorders in very young children and the specialized skills such diagnosis requires.
- Relative limitations in the empirical base examining the validity of diagnostic criteria for some common disorders (including all anxiety disorders other than post traumatic stress disorder).
- Evidence that there is both continuity and discontinuity of preschool presentations of disorders with school age disorders.
 - Known and unknown risks because of metabolic and developmental differences, including the possible risk of disruption of central nervous system development.

- Extreme limitations in pharmacokinetic data about psychopharmacologic agents in preschoolers
- Lack of FDA indications for most medications in this age group (even those with empirical support)
- The sensitivity to context (especially caregiving) of young children's emotional and behavioral development.

Because the evidence base supporting dyadic and family psychotherapy exceeds the evidence supporting psychopharmacologic interventions for every disorder studied, psychotherapeutic treatment is the first-line intervention. All systems should make every effort to ensure that children with significant mental health disorders have access to quality psychotherapy. Unfortunately, in most parts of the United States, access to therapists trained in infant and early childhood mental health is extremely limited either by number of providers, their training, third-party payer barriers, or family schedules. In addition, as with all evidence-based treatments, a sizable minority does not complete or does not respond to the treatment.

The disorder with the most substantial evidence base for pharmacologic treatment is ADHD, for which two large randomized controlled trials have reported similar findings for different medications. In rigorous studies of methylphenidate (Greenhill et al., 2006) and of atomoxetine (Kratovich et al., 2011), the medications were found to be more effective than placebo, but less effective with higher rates of adverse effects compared to older children. These findings reinforce the recommendations that the first-line treatment of ADHD in preschoolers is parent management training (Gleason et al., 2007, Charach et al., 2012) and that psychopharmacologic agents may be considered as second- or third-line interventions, used only with close monitoring of both effectiveness and potential adverse effects.

For other disorders, psychopharmacologic information is based on case reports, case series, and open trials, but not on randomized controlled trials. The use of non-pharmacologic treatment of disruptive behavior disorders as well as of ADHD is strongly supported by an extensive and rigorous empirical literature (Charach et al., 2012 and overview in these Guidelines). There is also evidence that children as young as four can participate effectively in modified cognitive behavioral therapy (Scheeringa et al., 2011) and that a modified version of parent management training is effective in treating preschool depression (Luby et al., 2012).

After a failure of an adequate trial of non-pharmacologic treatment (whether rigorously evidence-based, supportive or symptom-focused interventions), parents and clinicians must weigh the risks of an untreated disorder with the known and unknown risks of medication treatment. In such situations, use of pharmacotherapy is not contraindicated, but should be one part of a more comprehensive treatment plan and must be monitored closely. Medications that cause unacceptable adverse effects or those that are ineffective should not be continued. Polypharmacy should be used with caution and with caregiver understanding of the extent of the data supporting such treatments.

Systems of care may be able to improve the quality of care by using claims data to develop organized monitoring and reviewing of specific treatment approaches. Review of practices with limited support might include all use of psychotropic medications in children under three, specific treatment approaches in preschoolers, use of medications which are not supported by

randomized controlled trials, failure to order recommended metabolic labs with such medications, or numbers of concomitant psychopharmacologic medications. It should be noted that review of such practices would ideally be a productive and collaborative process. These practices must be evaluated in the clinical context before a judgment about the level of appropriateness can be made. When lack of access to evidence-based treatments is cited as a reason for the use of pharmacologic agents, focused efforts to increase access should be a priority.

As with other providers of IMH intervention, physicians who prescribe psychoactive medications form part of a multidisciplinary supportive team. Systems that encourage and reimburse frequent communication between non-prescribing and prescribing mental health providers may develop the greatest flexibility and most enduring safety net for well-being in all domains.

Note: Dr. Gleason wrote the foregoing paragraphs at the request of the IMH workgroup, which recognizes her expertise and experience and is especially appreciative of this generous contribution to Tennessee's Best Practice Guidelines.

VII. Selected Resources/References

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