Program Description:
Intensive Infant and Early Childhood Mental Health (IECMH) Services

Infant and Early Childhood Mental Health

Infant and Early Childhood Mental Health services focus on the need to ensure that all babies and young children have a strong beginning in life. During the first five years of life, emotionally nourishing relationships support children's well-being and lay the foundation for lifelong health and well-being. By supporting the infants, young children, and the adult caregivers, we hope to maximize our long-term impact in ensuring all young children have a bright future.

Infant and Early Childhood Mental Health (IECMH) refers to the social-emotional well-being of children ages 0 through five years of age (72 months). A central tenet is that infant development cannot be separated from the caregiving environment, nor can infant development be separated from the culture in which the relationships develop. IECMH includes:

- The ability to form close and secure relationships;
- The developing capacity of the child to experience, regulate, and express emotions; and
- The ability to explore the environment and learn.

The physical, cognitive, social, and emotional capacities of the child are mediated by the quality of the caregiver-child relationships. Similarly, the relationships between the mental health practitioner, the child, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.). The need for IECMH assessment and intervention could be identified/referred by any community provider.

Qualifications to Complete Assessment and Provide Treatment:

License: The provider's counseling professional must be independently licensed to provide counseling services. Independently licensed professionals must hold, at least, a master's degree in the mental/behavioral health discipline and if the counseling professional is not independently licensed they must hold, at least, a master's degree in the mental/behavioral health discipline and, if not independently licensed to provide counseling services, be under the direct supervision of a licensed mental health provider practicing within their scope of licensure as outlined in Tennessee Code 33-1-101.[1] The entity must be contracted with the member's TennCare MCO to provide supervision under these guidelines. In order for an unlicensed master's level therapist to deliver therapy services in a TennCare contracted mental health agency, the following criteria must currently be met as outlined in the current policy:

- The facility in which the therapist is practicing must be licensed as a Mental Health Outpatient Facility by the Tennessee Department of Mental Health and Substance Abuse Services.
- The facility in which the therapist is practicing contracts with one or more TennCare managed care organizations (MCOs) in a manner that allows for the unlicensed therapist to render behavioral health services while under the supervision of a licensed professional.

https://www.tn.gov/content/dam/tn/tenncare/documents2/pro-22-002.pdf

AND

1. **<u>Education:</u>** Verifiable education/training in the following areas:
    a. Assessment, developmental screening of 0-5,
    b. Trauma screening of children ages 0-5 and caregiver?
    c. Relationship-based assessment

AND one or more of the following:

2. **<u>Endorsement and/or Evidence-Based Practice:</u>** Fulfilling the criteria of at least one of the following categories- Endorsement and/or Evidenced-Based Practice:

Endorsement:

- Infant Mental Health (IMH) Endorsement® for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E®) with endorsement as an Infant Family Specialist or above (categories 2, 3, or 4).

Evidence-Based Practice (EBP):

- Certified/rostered or current participant in and evidence-based treatment (EBT) for infants and young children with verification from a trainer certified by the developer or certified through the official training organization (Child-Parent Psychotherapy, Attachment Biobehavioral Catch-up; Parent Child Interaction Therapy; Parent Child Interaction Therapy-Toddler, Circle of Security, etc.).

OR

- The therapist could attest the evidenced-based practice domain by doing one of the following:

    a. Submit a letter from the EBP trainer that the person is participating in one of the EBT learning collaboratives or trainings.

OR

    b. Submit a certificate that the person has completed one of the EBTs for infants and young children.

Clinical Indications for Procedure

Assessment is for children 0 to 72 months of age,

AND for one or more of the following conditions:

- Child has experienced acute trauma or chronic stressors including but not limited to separation from primary caregiver, chaotic household, constantly changing caregiving environments, inappropriate caregiver expectations or role reversal, abusive/neglectful or inconsistent caregiving, occurrence of traumatic events, or lack of safety in home and community.
- Child is exhibiting symptoms including but not limited to inconsolable crying, aggression, feeding and elimination difficulties, sleep problems, flat or depressed affect, withdrawal, inflexibility, emotional dysregulation, developmental delays (cognitive, social, adaptive, communication, physiological control), regression, attachment issues, anxiety, separation anxiety, the absence of developmentally expectable affect, sensory or sensory motor processing difficulties.
- There are concerns about the child-caregiver relationship due to caregiver's inflexibility and other behaviors including but not limited to those that:
    - interfere with the child's needs, goals, and desires,
    - dominate the child through over-control,
    - do not reciprocate through serve and return, and/or
    - whose anger, depression, anxiety or other mental health issues or social determinants of health result in inconsistent caregiving.
- Child or family member has experienced medical difficulties that have interrupted consistent, nurturing family relationships. Difficulties include but are not limited to
    - Child was born premature.
    - Child has experienced drug-exposure (both in utero and/or after birth)
    - Serious physical and/or mental health illness

Key Core Concepts and Components of Infant Mental Health Assessment and Treatment

Cultural Competence/Cultural Humility

Cultural Competence is the ability to interact effectively with people of different cultures. It means to be respectful and responsive to the health beliefs and practices of diverse groups (SAMHSA). 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 IECMH 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.

Diversity-informed

The field of IECMH recognizes that infants develop in the contexts of their families, communities, and cultures, that society can actively hurt or harm young children, and that the level of risk/benefit children receive from society is based on systems of oppression. The field values diversity, equity, inclusion, and social and racial justice and uses the Diversity-Informed Infant Mental Health Tenets (St. John, Thomas, Noroña, and Irving Harris Foundation Professional Development Network Tenets Working Group, 2012) to guide all IECMH work including assessment

and intervention. The Tenets have been defined as "a response to the persistent and urgent need to expand our professional capacity and deepen our work with families by increasing awareness and developing intentional action for individual, organizational, and systemic change" (Thomas, Noroña, St. John, 2019). The ten Tenets focus on issues including self-awareness, recognizing non-dominant bodies of knowledge, honoring diverse family structures, supporting families in their preferred language, and understanding that language can hurt or heal.

Trauma-informed/Evidence-based practices

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. For infants and young children, it is particularly important that evidence-based and evidence-informed interventions be implemented in the context of relationship-based practice.

Assessment

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5™) was created to provide developmentally specific diagnostic criteria and information about mental health disorders in infants and young children. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and World Health Organization's International Classification of Diseases (ICD) are comparable classification systems for older children and adults. The most recent edition of the DSM (DSM-5) has made some attempt to be more developmentally sensitive, but, unlike the DC: 0-5™, it does not capture the full range of symptoms and disorders typically seen in infancy and early childhood.

Caregiver interview and caregiver-child observation are always necessary. A full evaluation may include the following:

- Structured/semi-structured caregiver interview
- Obtaining information about the caregiver, child, and caregiving environment
- Structured/semi-structured observation of caregiver-child relationship (with each primary caregiver)
- Standardized caregiver report from multiple sources including parent(s), childcare provider(s)/teacher(s), and other primary caregivers.
- measures of caregiver's symptoms to assess for the child's caregiving environment.
- Standardized developmental assessment (e.g. Bayley; WPPSI)
- Other assessments as necessary (e.g. ADOS)

Comprehensive Assessment Components

- Assessment will be guided by Tennessee Best Practice Guidelines (https://www.tn.gov/content/dam/tn/mentalhealth/documents/Pages_from_CY_BPGs_33-45.pdf)
- The assessment process occurs over time and requires 3- 5 face to face sessions.

  - Infant and young child assessment must include relationship-based assessment. Thus, the assessment becomes more complex when multiple caregivers are involved.
  - Assessment may need to occur in various settings.
  - Caregiver only sessions are required (if there is more than one caregiver, the caregivers will need to be interviewed separately)
  - Caregiver-child observation is required (if there is more than one caregiver, more than one relationship will need to be assessed)
  - Multidisciplinary input is often required; thus, multidisciplinary team meetings/consultations may be necessary.
- Reflective consultation is a part of the process.
- A complete evaluation/assessment will typically involve the following:
  - Interviewing the parent(s)/caregiver(s) about the infant's/young child developmental and medical history
  - A trauma screening tool
  - Directly observing family functioning (e.g. family and parental dynamics, the caregiver-infant/young child relationship, and interaction patterns)
  - Gaining information through direct observation and report, about the infant's/young child's individual characteristics, language, cognition, social reciprocity, and affective and behavioral expression
  - Assessing sensory reactivity and processing, motor tone, and motor planning capacities
  - Incorporating a cultural perspective (DC: 0-5™, pp. 10 – 12).
  - In addition to consideration of clinical disorders, finding from a comprehensive evaluation should lead to preliminary notions of the following:
    - The nature of the infant's/young child's pattern of strengths and difficulties, including the level of overall adaptive capacity and functioning in the major areas of development (emotional, social-relational, language-social communication, cognitive, and movement and physical) in comparison with age and culturally expected developmental patterns.
    - The relative contribution of the infant's/young child's competencies and difficulties of the different areas assessed (e.g. family relationships, interactive patterns, and constitutional-maturational patterns)
    - A comprehensive treatment or preventative plan to deal with the first and second points above."

Diagnostics

The assessment will lead to the ability to diagnose the child in five clinically significant areas (DC: 0-5™ five axes). To assess each axis, the evaluation will require meetings with caregiver(s) alone as well as with the caregiver and child.

Diagnostic classification systems available include:

1. The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC: 0-5™)
2. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)
3. World Health Organization's International Classification of Diseases (ICD) are comparable classification systems for older children and adults.

Area I: Clinical Disorders
Area II: Relational Context

- "More than one primary relationship may be the focus of clinical assessment, and separate (assessment and) ratings should be obtained for each primary caregiving relationship assessed."
- "The assessment of the parent-infant/young child relationship should, whenever feasible, include observations of parent-infant/young child interactions as well as noting parents' attitudes and attributions about the infant/young child."
- Relational context includes:
  - Caregiver-infant/young child relationship adaptation
- Dimensions of caregiving (DC:0-5™ Table 1, p. 142)
- Infant's/young child's contributions to the relationship (DC:0-5™ Table 2, p. 143)
  - Caregiving environment and infant/young child adaptation
- Dimensions of the caregiving environment (DC:0-5™ Table 3, p. 146)

Area III: Physical Health Conditions and Considerations
Area IV: Psychosocial Stressors
Area V: Developmental Competence

Given the needs of the assessment, development may be measured by:

- Observation
- Caregiver report
- Developmental screening tools
- Formal developmental testing

Assessment Setting

- Any approved CMS place code
- To get a full understanding of the child, it is often necessary to see the child in multiple settings. Assessment sessions may occur in office, home, school, and community and include other components in this list (concrete assistance, emotional support, advocacy, developmental guidance, and reflective consultation). A typical assessment involves office-based interviews and observation of the child with multiple caregivers in natural environments (whenever possible). (TN Best Practice Guidelines) https://www.tn.gov/content/dam/tn/mentalhealth/documents/Pages_from_CY_BPGs_33-45.pdf

Treatment

- Conducted by the approved provider who conducted the assessment.
- Based on assessment findings that reflect the needs of the child and family
- Therapy is problem-specific and goal-oriented.
- Uses a therapeutic approach that is consistent with evidence-based practices for a particular concern.
- Emphasizes social/interpersonal competence.
- Considers the family's strengths, needs and cultural values.
- Restores and strengthens the family's unique social and/or inter-familial relationships.
- Treatment follows the child regardless of placement or caregivers.

Contact duration will vary depending on clinical need but should, at a minimum, last at least 15 minutes. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service. Variation in required intensity of services for families must be documented.

Discharge Criteria

Infant and Early Childhood Mental Health Services are no longer necessary due to adequate child/family stabilization or improvement as indicated by **ALL** of the following:

- The child and parent/child dyad have reached stability and there are no safety concerns
- The child and family's support system has been substantially strengthened
- The majority of goals in the child/family plan have been met and a discharge plan with follow-up appointments/referrals/resources is in place

Infant and Early Childhood Mental Health Services are no longer necessary due to **1 or more** of the following:

- The family refuses to participate in treatment and there is no court order for treatment
- The frequency of services required or delivered do not meet the intensity of service description for this level of care
- The family has not made progress despite participation and is not likely to improve with ongoing services at this time
- Inadequate participation in treatment by member and/or supports

***Please note that family needs vary. A child with a single caregiver will not need as much face-to- face assessment time as a child with multiple caregivers (i.e. a mother, grandfather and foster parents). Likewise, a young child who is having significant difficulty in the childcare setting may need more ancillary meetings that include observation and consultation in the childcare/preschool setting than a young child who does not have the same difficulty in the childcare setting**.