

NURTURING CHANGE

State Strategies for Improving Infant and Early Childhood Mental Health



Introduction

Infant and Early Childhood Mental Health (I-ECMH) remains a critical but often overlooked policy challenge. Compared to other issues affecting infant-toddler well-being, I-ECMH stands out in many states as lacking a comprehensive approach to prevention, let alone a system to ensure access to treatment after diagnosis. At its core, I-ECMH suffers from a fundamental lack of understanding by policymakers best positioned to nurture change.

In 2011, the ZERO TO THREE Policy Center identified and interviewed key informants at the state and national levels to learn about barriers, successful strategies, and possible recommendations for federal policy action in the field of I-ECMH. Telephone interviews were conducted with 23 leaders in 10 states: California, Florida, Illinois, Louisiana, Michigan, New Mexico, Ohio, Pennsylvania, Washington, and Wisconsin.

As a result of these interviews, in May 2012, the ZERO TO THREE Policy Center released *Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health*.¹ This report reviewed the scientific evidence behind I-ECMH policies; examined issues faced by national, state, and local program directors and mental health practitioners in providing I-ECMH services;

STATE POLICY RECOMMENDATIONS IN BRIEF

- 1. Promote the Cross-Cutting Nature of I-ECMH:** Create a state strategic plan to infuse I-ECMH into behavioral health, maternal-child health, child welfare, home visiting (including the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program), and Individuals with Disabilities Education Act Part C early intervention initiatives.
- 2. Encourage Greater Attention to Early Identification and Response:** Require a social-emotional component to screening, referral, and intervention requirements in home visiting (including the MIECHV program), child welfare, and other early learning and development programs, as well as pediatric and prenatal health care.
- 3. Increase Access to I-ECMH Services and Financing:** Advocate for language in state Medicaid and behavioral health plans to cover I-ECMH screening, assessment, and treatment.
- 4. Build Capacity and Competence in I-ECMH Practice:** Expand professional development in I-ECMH.
- 5. Promote Public Awareness of the Impact of Early Experiences on Success in School and Life:** Emphasize the importance of social-emotional development for children to succeed in school, be healthy, and enjoy financial stability in adulthood.

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and proposed a set of recommendations for policy improvements at the federal level. A variety of barriers were identified: lack of a service delivery system for provision and reimbursement of I-ECMH services, underutilization of Medicaid financing for I-ECMH services, insufficient numbers of adequately trained mental health clinicians, and a lack of intentional focus on promoting the social-emotional development of young children.

This follow-up policy paper provides a more in-depth look at some of the promising strategies that states have employed to address I-ECMH access, delivery, financing, evidence

base, and systems-level issues across the promotion, prevention, and treatment continuum. The paper also provides recommendations for nurturing change in state I-ECMH supports and services, as well as strategic questions for states to consider in planning for I-ECMH. A Glossary at the end of the paper explains state- and field-specific terms found in the profiles.

The six states profiled in this paper—Wisconsin, California, Michigan, Florida, Ohio, and Louisiana—offer compelling and varied examples of successful work in I-ECMH. Though each state is unique in geography, budget, leadership, and political landscape, they all share a commitment to:

- identifying and breaking down barriers to I-ECMH services;

- making the necessary policy improvements and investments to ensure that infants and young children receive the I-ECMH services they need;
- ensuring that there are qualified and trained professionals to provide I-ECMH services; and
- identifying funding sources and procedures to pay for the services.

State Profiles

Wisconsin, California, Michigan, Florida, Ohio, and Louisiana have all developed strategies to address some of the barriers to providing I-ECMH. The strategies described in the profiles do not represent everything that each state is doing. Rather, they provide examples of what can be done to nurture change. Table 1 summarizes the barriers that states face and the strategies they have used to surmount them.

As the state profiles illustrate, both incremental changes and changes that are larger and more systemic in nature can advance the objective of providing I-ECMH services and supports. For example, Florida developed and adopted a user-friendly crosswalk that matches codes from *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0–3R)* to *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* and *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)*, which aids Medicaid reimbursement for I-ECMH services. In contrast, Michigan developed competencies and an endorsement system for I-ECMH workers. The Michigan competencies and endorsement system was copyrighted, and 14 states have purchased the license to use either the competency guidelines or endorsement system or both.

Together, the six state profiles make it clear that change in the field of I-ECMH can be achieved. This paper is intended to raise questions for policymakers and provide actionable models for addressing common barriers, opening the door for healthy social-emotional development.

* States may use different terms for infant mental health. When referring to a specific state program, this paper uses the state's own nomenclature; otherwise, the terms "infant-early childhood mental health" or "I-ECMH" are used.

Table 1. State Strategies In Brief

BARRIER	STRATEGY	STATE
<p>Systems-Level: None of the public systems that care for the health and well-being of infants and young children have adequate capacity to deliver the continuum of I-ECMH promotion, prevention, and treatment services and supports. Child care, child welfare, health and mental health, family strengthening, Part C early intervention, home visiting, and early education all need to be involved and considered when planning and administering policies and programs that support social-emotional development.</p>	<ul style="list-style-type: none"> Develop a proactive and comprehensive approach to building an I-ECMH system. 	<p>WISCONSIN</p>
<p>Access: Too often, eligibility determination or diagnosis has become a barrier to access. Problems include definitional issues, inadequate screening and response, reluctance to diagnose young children, diagnostic systems that are not appropriate for infants and toddlers, and lack of recognition for DC:0-3R diagnostic classifications.</p>	<ul style="list-style-type: none"> Enable providers to treat and receive Medicaid reimbursement for dyadic therapy by adding definitions such as “Individual and Family Therapy.” Use Medicaid funding to reimburse for dyadic therapies for infants, toddlers, and their families. 	<p>FLORIDA</p> <p>CALIFORNIA</p>
<p>Delivery: Building competence both within I-ECMH professions and in related disciplines (child welfare, social work, nursing, etc.) is important. However, across the country, there are not enough providers with training in I-ECMH to meet the need.</p>	<ul style="list-style-type: none"> Create competency guidelines and endorsement to build capacity for I-ECMH service delivery. Develop a state I-ECMH workforce system. Build I-ECMH into the infrastructure of the early childhood system so that a broad band of providers understand and are able to implement I-ECMH principles and practices. 	<p>MICHIGAN</p> <p>WISCONSIN</p> <p>LOUISIANA</p>
<p>Financing: Systemic reimbursement issues hinder the ability to pay for I-ECMH services through Medicaid and other mechanisms. Problems range from not reimbursing services appropriate for infants and young children in the settings where they are most effective and accessible (e.g., in homes, early learning and pediatric care settings) to limitations that arise because services to infants and young children do not fit into the categories of care for adults.</p>	<ul style="list-style-type: none"> Develop and adopt a crosswalk from DC:0-3R to ICD-9-CM and DSM-IV to aid Medicaid reimbursement for I-ECMH services. Recognize DC:0-3R for reimbursing I-ECMH services, including in-home services. Create an infant mental health endorsement to enable Medicaid to recognize and reimburse for I-ECMH. Ensure that the Medicaid waiver covers I-ECMH home-based services. Ensure Medicaid and EPSDT reimbursement for I-ECMH services. Secure TANF funds for I-ECMH direct services. 	<p>FLORIDA</p> <p>WISCONSIN</p> <p>MICHIGAN</p> <p>CALIFORNIA</p> <p>LOUISIANA</p>
<p>Incorporating Evidence of I-ECMH Into Practice and Policy: The evidence base for I-ECMH is not reflected in public policy; significant gaps between research evidence and policy still exist. For example, pregnant women and new parents are not routinely screened for depression.</p>	<ul style="list-style-type: none"> Develop a Maternal Depression Screening and Response Program to ensure that maternal depression screening and response is embedded in the statewide home visiting system. 	<p>OHIO</p>

A Proactive and Comprehensive Approach to Building an I-ECMH System

With leadership from the Wisconsin Alliance for Infant Mental Health (WI-AIMH) and informed practitioners in the fields of early intervention, child welfare, home visiting, and early learning and development, Wisconsin carried out a proactive and comprehensive set of strategies that address multiple barriers and build an I-ECMH system. The state focused on raising public awareness, securing funding for and initiating small projects, developing a state I-ECMH workforce system, and recognizing DC:0–3R codes for Medicaid payment.

Raise Public Awareness About the Importance of I-ECMH

Wisconsin focused on raising awareness among policymakers, administrators, providers, and private citizens about the importance of I-ECMH. Through presentations at meetings and contributions to newsletters targeting early childhood providers across disciplines, I-ECMH advocates and experts spread simple messages about the importance of early emotional development in setting the stage for more formal learning. Like many other states, Wisconsin had a children’s mental health system focused on older children with severe emotional disturbances. The promotion-prevention-treatment continuum was at the forefront of all discussions. Emphasizing the full continuum was

critical in order to highlight the need for promoting emotional well-being in infants and young children and preventing more serious mental health challenges.

As a result of increased awareness, policymakers and providers came together for a state infant mental health summit in October 2002 to share information about policy, funding, and public awareness. The summit discussions shaped the development of a state plan that was vetted by high-ranking officials in state government and a team of parents, thus ensuring that the plan was politically achievable and realistic for meeting the needs of parents and their very young children. Eventually, the plan was woven into then-Governor Jim Doyle’s KidsFirst Agenda, giving advocates a powerful new tool for making the case for services and financial support. Administrators began looking for ways they could remove the existing child mental health system’s eligibility requirement for a “serious emotional disturbance” in the case of infants and toddlers. And they looked for ways that Medicaid could pay for home-based services.

Small-Scale Projects Pave the Way for Future I-ECMH Investments in Child Care

Funding was secured from private foundations (including the Greater Milwaukee Foundation and NoVo Foundation) and state contracts (including the Children’s Trust Fund, Mental Health Block Grant, and Early Childhood Comprehensive Systems grant) to launch a series of small-scale projects to demonstrate the efficacy of I-ECMH services. Funded projects focused on mental health consultation and reflective practice within child care settings. Because the public awareness activities discussed above had increased their understanding of the importance of I-ECMH, decisionmakers overseeing public health, mental health, and the Wisconsin Children’s Trust Fund were ready and willing to consider and endorse funding requests for needed services.

A System to Bolster the I-ECMH Workforce

Wisconsin has done several things to bolster the I-ECMH workforce. First, WI-AIMH purchased a license for the Michigan Association for Infant Mental Health (MI-AIMH)

“The early years are a critical time of brain development. It is essential that all who touch the lives of young children and their families have the knowledge, skills, and experiences to best support the social and emotional well being of infants and young children. That’s why we need a comprehensive approach to ensure that our policies, professional development, and funding are based on the science of early childhood development.”

Therese Ahlers, M.S., M.P.A., Executive Director,
Wisconsin Alliance for Infant Mental Health

competency and endorsement system, with support from the Children's Trust Fund and Mental Health Block Grant (more specific information about the MI-AIMH competency and endorsement system is included in the Michigan profile that follows). Training programs, colleges, and universities are now intentionally working to incorporate these competencies and prepare members of the workforce for infant mental health endorsement. For example, the University of Wisconsin and the Waisman Center, in partnership with WI-AIMH, have developed a 13-month certificate program that meets 2 days a month and offers a foundational pathway with a focus on early interventionists and home visitors (aligned with MI-AIMH's Level II competencies) and a clinical course of study for those providing intervention or treatment (aligned with Level III competencies). When the third cohort graduates in 2013, the program will have trained over 130 providers.

Second, state-funded home visiting programs are partnering with Project LAUNCH Milwaukee to promote reflective practice by pairing senior I-ECMH practitioners and consultants with home visitors. Project LAUNCH, funded by the federal Substance Abuse and Mental Health Services Administration, focuses on testing evidence-based practices, improving collaboration, and integrating mental health and other prevention strategies into systems for young children and families. As a result of this pairing and focus on reflective practice, the home visitors' capacity to effectively integrate infant mental health in their work with families is strengthened.

Third, state leaders are working to infuse I-ECMH principles into child care and early learning. The state is implementing the Center on Social and Emotional Foundations of Early Learning (CSEFEL) Pyramid Model in several child care centers each year.

Medicaid Recognizes DC:0–3R for Payment of In-Home Services

After years of meetings with the WI-AIMH staff and other I-ECMH champions in the state, the Wisconsin Medicaid agency released a statement in 2007 that DC:0–3R diagnostic codes would be recognized for billing in-home mental health services and preferred

STRATEGIC TIPS: WISCONSIN

- Seek opportunities to bring about changes that are tied to practice. Tying changes to policy can be effective but can be slow and dependent on the political climate.
- Craft a clear, consistent message about I-ECMH that will resonate with policymakers, administrators, and others in the field.
- Build relationships with policymakers and administrators so that they understand the importance of I-ECMH and are willing to seek opportunities to embed I-ECMH principles into practice, funding streams, and policy.
- Gather data on the cost savings realized by providing I-ECMH services. These can be a powerful tool for education and advocacy, especially when working with Medicaid to secure payments.
- Seek public and private funding for strategic initiatives, and leverage federally funded projects that have an I-ECMH component, such as Project LAUNCH and Early Childhood Comprehensive Systems. Small amounts of funding can result in meaningful changes in practice and policy.

for outpatient clinical services. Medicaid administrators continue to work on communicating this change to staff in charge of issuing prior approvals so that claims are processed smoothly and I-ECMH services become increasingly available to those who need them.

Resources

For information about the Wisconsin Alliance for Infant Mental Health: www.wiimh.org/

For the Department of Health Prior Authorization form that specifies the DC:0–3 codes: www.dhs.wisconsin.gov/forms/F0/F00212.pdf

For information about the Wisconsin Infant, Early Childhood and Family Mental Health Certificate Program: <http://continuingstudies.wisc.edu/pda/mental-health/infant/>

CALIFORNIA

Class Action Lawsuits Open the Door for Medicaid and EPSDT Reimbursement for IFECMH Services

Advocates in California used the legal system to address barriers to reimbursement and eligibility determination for infant-family and early childhood mental health (IFECMH) services. In *Smith v. Belshe*, a group of California-based attorneys argued that the California Department of Health Services was out of compliance with federal law relating to diagnostic and treatment services under Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT). In fact, before the 1993 lawsuit, the state provided almost no mental health services to children under age 4. This changed when the court ruled in favor of the plaintiffs. The ruling led to implementation of the EPSDT mental health benefit and increased the availability of state general funds for financing specialty mental health services for children ages birth to 21. The expansion of services was implemented through an interagency agreement between the state departments of health services and mental health.

In *Katy A v. Bonta*, filed in July of 2002, the state was challenged for not providing necessary mental health treatment services to children in foster care or to those who were at imminent risk of placement in foster care. Several counties settled the class action lawsuit early and took steps to prioritize referrals between child welfare and mental health. The state settled in 2011 and, as part of the settlement, developed a guide that describes practice standards and activities that are to be used by child welfare and mental health. This lawsuit led to increased attention to IFECMH services because the majority of cases in the child welfare system are children under age 5.

Following the lawsuits, the cost of mental health services was covered by a combination of federal funds (50%), state funds (40%), and county funds (about 10%). In 2012–13, Governor Edmund G. Brown's budget eliminated the California Department of Mental Health. As a result, mental health services became the fiscal responsibility of each county. Counties now receive a capped match allocation. Once the match is spent, counties are responsible for the entire 50% nonfederal share of EPSDT-funded services.

Dyadic Therapies Can Be Reimbursed by Medicaid

California's ability to use Medicaid to pay for dyadic therapies for infants, toddlers, and their families came without a specific amendment to the state's Medicaid definition of "client." While Medicaid still requires that the child be the designated client and primary beneficiary of services, the EPSDT ruling specifies that parents may be involved in treatment as proximal to the child's well-being. This means that dyadic therapy can be covered as long as the child meets the eligibility requirement of medical necessity and the written goals address the infant-toddler's needs. Nevertheless, because decisions are made at the county level, the use of Medicaid for infant-early childhood-family dyadic therapy varies from county to county.

Advocates and providers knew they needed to take things a step further to make sure that the court's ruling in the class action lawsuits and a flexible definition of "client" would indeed mean more appropriate IFECMH services for eligible children in every county. Providers used case vignettes to help state Medicaid and mental health staff and administrators understand infant mental health issues, effective treatment approaches,

"Children under four were not receiving mental health services through public funding prior to the class action lawsuit. Now these children are served. We have seen an enormous increase in [mental health] services to young children and their families. Agency contracts often quadrupled in size as EPSDT services grew to cover early childhood mental health services."

Karen Moran Finello, Ph.D., WestEd Center for Prevention & Early Intervention

and the importance of serving the dyad. Further, policy groups met with Medicaid staff to detail what services might look like and how agencies could get contracts with county departments of mental and behavioral health. In response, Medicaid now provides training for practitioners on how to bill for birth-to-5 services through EPSDT, and some counties have designated special contracts for agencies to ensure that birth-to-5 services are provided. Policy groups are working within counties to ensure that claims and billing forms fit the birth-to-5 population and are not just generic Medicaid forms designed for adolescents and adults. The state received more requests for IFECMH training as agencies saw the need for mental health providers who are qualified to meet the mental health needs of infants and young children.

Citizens Vote in Support of State Proposition 63 to Fund Prevention and Early Intervention

In November 2004, California voters approved Proposition 63, also known as the Mental Health Services Act (MHSA). The MHSA provides state funding for new or expanded mental health programs through a personal income tax surcharge of 1% on the portion of a taxpayer's taxable income in excess of \$1 million. The MHSA provides county mental health departments with funds to expand services and train the workforce in evidence-based practices.

Like all mental health rules and services in California, the MHSA is administered at the county level; therefore, the types of therapies and services provided vary across the state. Some counties require that MHSA dollars be used only for evidence-based practices. MHSA dollars may also fund training for clinicians in approved evidence-based practices, such as Child-Parent Psychotherapy, that use dyadic treatment.

STRATEGIC TIPS: CALIFORNIA

- Leverage class-action lawsuits for policy change.
- Mobilize IFECMH providers and families of infants and toddlers who have benefited from services to press for policy change.
- Build a formal partnership between health and mental health agencies.
- Provide information to state Medicaid staff about IFECMH symptoms and effective treatments so that they recognize eligibility and pay for services.
- Anticipate increased demand for services and train sufficient numbers of providers to meet the expanded demand.

Resources

For information about the California Center for Infant-Family and Early Childhood Mental Health: www.cacenter-ecmh.org

For a copy of California's EPSDT Fact Sheet: www.cacfs.org/files/advocacy/FINAL3EPSDTFactSheet.pdf

For additional information on *Katy A v. Bonta*: www.lacdcfs.org/katieA/index.html

For additional information on Proposition 63: www.dmh.ca.gov/Prop_63/mhsa/

To learn more about challenges of implementing evidence-based mental health for infants, young children, and their families: www.tapartnership.org/docs/ThinkTankbriefFINAL.pdf



MICHIGAN

Competency Guidelines and Endorsement Builds Capacity for Infant Mental Health

The seeds of Michigan's competency guidelines and endorsement system were sown in 1977 with the incorporation of the Michigan Association for Infant Mental Health (MI-AIMH). Between 1983 and 1986, MI-AIMH approved and published *Training Guidelines*, which laid out infant mental health principles that would grow into the competency guidelines. With the passage of the Individuals with Disabilities Education Act Part H (now Part C) in 1986, the need for a set of core competencies for professionals working with infants, toddlers, and families became increasingly relevant. By 1996, the Michigan Department of Education (MDE), the lead agency for Part C early intervention in Michigan, recognized five areas of competency for early interventionists across many disciplines that work with children from birth to 3 years and their families. These areas included theoretical foundations, legal and ethical foundations, interpersonal and team skills, direct service skills, and advocacy skills. MI-AIMH added systems expertise, thinking, and reflection to these competencies.

Convinced of the necessity of an official endorsement for infant mental health providers in Michigan, MI-AIMH formed a work group to expand on the MDE's 1996 competencies. A grant from the W. K. Kellogg Foundation in 2000 provided funding to build a framework for the endorsement, create the endorsement examination, and hire an executive director. The MI-AIMH endorsement was designed with four levels:

- **Level I:** Infant Family Associate
- **Level II:** Infant Family Specialist
- **Level III:** Infant Mental Health Specialist
- **Level IV:** Infant Mental Health Mentor (Clinical, Policy, or Research/Faculty)

The endorsement verifies that an applicant has attained a specified level of education (e.g., a Child Development Associate credential, Associate degree, or 2 years of paid work in early childhood for Level I; a Bachelors or Masters degree for Level II; a Masters degree or doctorate for Levels III and IV), participated in specialized trainings, received mentorship and reflective supervision and consultation, and is able to deliver or work on behalf of high-quality, culturally sensitive, relationship-focused services to infants, toddlers, parents, and other caregivers.

By 2002, MI-AIMH had copyrighted the initial Michigan endorsement system. To date, 14 states have purchased the license to use either the MI-AIMH Competency Guidelines® or Endorsement® system or both (Alaska, Arizona, Colorado, Connecticut, Idaho, Indiana, Kansas, Minnesota, New Mexico, New Jersey, Oklahoma, Texas, Wisconsin, and Virginia). Two additional states are in the process of licensing (West Virginia and Rhode Island). Together, these states are known as the League of States. MI-AIMH nurtures the League of States by:

- providing mentorship and technical assistance for the first years;
- coordinating monthly conference calls for the states to discuss challenges and opportunities, such as creating practitioner interest in the endorsement system;
- sharing content for competency-based trainings;
- discussing cross-systems policy changes; and
- building capacity to provide reflective supervision and consultation.

Further, leaders from each state within the League of States plan an annual retreat to share information, develop strategies for reflective practice, review policies and procedures, explore strategies for growth, and strengthen collegial relationships – all for the purpose of building a knowledgeable and skilled infant mental health workforce.

"It is surprising how long it takes and how much persuasion is needed to create an interdisciplinary work force development system for IMH [infant mental health]. We started with folks in the IMH field who were hands-on but learned that we needed policymakers at the table, too. It was only with the leadership and support of policymakers that we could bring about real systems change in building capacity within the IMH service community. The relationship between clinical folks and policymakers is essential."

Deborah Weatherston, Ph.D., Executive Director,
Michigan Association for Infant Mental Health

Infant Mental Health Competencies Guide Higher Education and Professional Development

To expedite the endorsement for the next generation of infant mental health workers, several universities in Michigan are using MI-AIMH's Competency Guidelines® to develop their curricula. Wayne State University in Detroit has created a dual degree program in infant mental health that is rooted in the competencies. The dual degree program is available for students working toward advanced degrees in social work, nursing, and education. At Michigan State, students graduating from the School Psychology Program are prepared to earn Level I endorsement, and the school's interdisciplinary doctoral program in infancy has been revised to align with the competencies. Professors at the University of Michigan who have earned endorsement are beginning to offer courses that reflect the competencies and prepare students to acquire necessary skills and knowledge for working with infants, toddlers, and parents. Across the state, universities are crosswalking the competencies with existing curricula in order to streamline application for endorsement after graduation.

MI-AIMH has offered intensive trainings and workshops, using the Competency Guidelines® as standards, in partnership with other community partners (e.g., Early Head Start/Head Start, Part C early intervention, Great Start Collaboratives), private foundations, and agencies to help practitioners across disciplines and systems meet criteria for endorsement at each of the four levels. In addition, through the Division of Mental Health Services for Children and Families, the Michigan Department of Community Health provides funding for competency-based training for providers of infant mental health services and practitioners in related systems. The training includes topics such as DC:0–3R, reflective supervision, and the use of screening and assessment tools. The Division, along with MI-AIMH and infant mental health practitioners, provides forums for professionals in infant mental health and related systems.

By the end of 2012, 530 professionals across all levels, systems, and programs had earned endorsement in Michigan, and 287 are working toward endorsement.

STRATEGIC TIPS: MICHIGAN

- Work in partnership with your state infant mental health association to build capacity and improve quality in infant mental health services.
- Seize opportunities to strengthen infant mental health across systems (e.g., Part C early intervention, early learning and development, Medicaid, community health, mental health).
- Create a learning community with other states who are working on similar issues to share information, avoid duplication of effort, and enhance peer support.
- Build momentum through incremental change. Stay focused on the goal of a fully competent field of infant mental health providers.
- Encourage individuals seeking endorsement. Keep them motivated and make sure they have the resources they need to be successful (e.g., access to trainings that meet the standards, time to participate in trainings, access to reflective supervision and consultation, scholarship support).
- Motivate colleges, universities, and other educational institutions to link their training curricula to the competency guidelines and endorsement system.

Infant Mental Health Endorsement Required in Medicaid Policy in Michigan

The Michigan Department of Community Health recognized the value of the infant mental health endorsement in building a quality workforce. Because of this, the requirement for the infant mental health endorsement was incorporated into the Department's 2007 Medicaid Provider Qualifications. The policy states that mental health staff who work with infants and toddlers (birth to age 47 months) and their families be endorsed by MI-AIMH at Level II, and preferably at Level III. In addition, the *Medicaid Provider Manual* states that, "for home-based services programs serving infant/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions and, effective October 1, 2009, must minimally have Endorsement Level II by MI-AIMH; Level III preferred."

Resources

For information about the Michigan Association for Infant Mental Health: www.mi-aimh.org

For information about the Michigan Association for Infant Mental Health Competency Guidelines® and Endorsement®: www.mi-aimh.org/endorsement

For a copy of the language in the *Medicaid Provider Manual* requiring a Level II or Level III MI-AIMH endorsement (see the chapters on "Maternal Infant Health Program" and "Mental Health/Substance Abuse"): www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf

FLORIDA

A Crosswalk from DC:0–3R to ICD-9-CM Aids Medicaid Coverage for I-ECMH Services

Building upon the recommendations of the Florida Strategic Plan for Infant Mental Health, the Florida Agency for Health Care Administration took steps beginning in 2000 to support providers in using diagnostic classification systems to seek payment from Medicaid for I-ECMH services to children ages birth to 5. First, the state revised its *Community Behavioral Health Services Coverage and Limitations Handbook*, Section 5, “Services for Children Ages 0 Through 5 Years.” The revision encouraged the use of DC:0–3 for assistance in determining the infant or child’s ICD-9-CM diagnosis. The revised handbook states:

For children 0 through 3 years of age, Medicaid encourages use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC:0–3) for assistance in determining the infant or child’s ICD-9-CM diagnosis. (page 2-5-1)

Second, the state developed, adopted, and has since updated (in 2006 and 2010) a user-friendly crosswalk that matches codes from DC:0–3R to DSM-IV and ICD-9-CM. Finally, with support from the Florida State University Center for Prevention and Early Intervention Policy, Harris Institute for Infant Mental Health Training, the state provided professional development to more than 240 infant mental health specialists so that they are able to use the crosswalk for translating a diagnosis into Medicaid language and thus bill for services.

This work was the result of a partnership between the Florida Medicaid and mental health directors, early childhood providers, early interventionists, pediatricians, and parents. With leadership provided by the Florida Association for Infant Mental Health, these partners committed to resolving barriers for reimbursement. In order to make a strong case for the need to develop a crosswalk, the partners drew on the Surgeon General’s 1999 report on mental health and The President’s New Freedom Commission on Mental Health recommendations.² These reports emphasized the following points about early intervention:

- Untreated I-ECMH issues impact later physical and mental health.
- There is a link between I-ECMH issues and later substance abuse.
- There are effective responses across the promotion, prevention, and treatment continuum to address I-ECMH.

No additional funding was needed to develop the crosswalk, only a commitment of the partners and careful analysis for aligning each DC:0–3 diagnosis to an ICD-9-CM code that most clinically matched the description of the diagnosis. The crosswalk was updated following the release of DC:0–3R and will continue to be updated as diagnostic manuals are revised. The 2010 update compared crosswalks in 10 states and was crafted to gain consistency across the Axis 1 diagnostic codes. Some in Florida believe the 2010 update could be a model for a universal crosswalk.

“Not enough Medicaid folks in states know DC:0–3R is a legitimate diagnostic tool. It is lack of knowledge – not resistance – that is standing in the way. We hope states can see that Florida found ways to get Medicaid reimbursement for I-ECMH, so they can too.”

Kathryn Shea, LCSW, President & Chief Executive Officer,
The Florida Center for Early Childhood, Inc.

Addition of “Individual and Family Therapy” Enables Providers to Treat and Receive Medicaid Reimbursement for Dyadic Therapy

In 1999, influenced by the Center for Prevention and Early Intervention Policy, the Florida Agency for Health Care Administration changed the service description for “individual therapy,” renaming it “individual and family therapy.” This simple change in the way the service description is written allowed parent–child dyadic therapy, as well as therapy with the parents alone without the child present or therapy with the child alone. If the child is the Medicaid recipient, therapy with the parent must be focused on the relationship with the child, and the child’s benefit must be documented. As a result, the service can be used for many different therapeutic approaches and the establishment of a specific service code for dyadic therapy is unnecessary.

Leadership in the Florida Agency for Health Care Administration has long recognized the benefits of I-ECMH and worked with the I-ECMH community to promote a vision and set of policies to support appropriate services. The science behind dyadic therapy and favorable cost-benefit analysis means that managed care plans also support this change as they recognize the link between untreated I-ECMH issues and long-term costs associated with adult mental health challenges and substance abuse.

Resources

For information about the Florida Association for Infant Mental Health: <http://faimh.org/>

For a copy of *Florida’s Strategic Plan for Infant Mental Health*: www.cpeip.fsu.edu/faimh/2008IMHPlan.pdf

For a copy of the *Community Behavioral Health Services Coverage and Limitations Handbook* (see Section 5, “Services for Children Ages 0 Through 5 Years,” page 2-5-1): www.djj.state.fl.us/docs/bhos-medicare/cbh_draft_rule_development-050411_zip.pdf?sfvrsn=2

For a copy of Florida’s DC:0–3R crosswalk: www.thefloridacenter.org/pdfs/FL_Crosswalk_June_2010.pdf

For a copy of the Medicaid individual and family therapy language: www.adapt-fl.com/files/B.Medicare%20Codes.10-07.doc

STRATEGIC TIPS: FLORIDA

- Ensure that all decisionmakers and other partners are at the table from the beginning with a commitment to resolving barriers to reimbursement.
- Provide relevant information to the state Medicaid staff to improve knowledge of DC:0–3R and other pertinent I-ECMH topics.
- Encourage Medicaid staff to formally support use of DC:0–3R in policy guidance, provider manuals, and informational memoranda to providers.
- Ensure that I-ECMH providers are well versed in Medicaid’s requirements for documentation, coding, and billing in each phase of the process – assessment, diagnosis, and treatment – to minimize the risk of audits.



Maternal Depression Screening and Response Embedded in the Ohio Help Me Grow Home Visiting Program

Ohio's effort to identify and respond to maternal depression began in earnest in 2004 when maternal depression was included as an objective in the Ohio Early Childhood Mental Health Plan. The objective called for depression screening for parents of children receiving services from any child-serving agency. As a result, the Ohio Department of Mental Health and the Ohio Department of Health reached out to pediatricians, mental health providers, and home visitors to improve awareness and screening for maternal depression. The departments worked with the Ohio Pediatric Research Consortium to train primary care pediatricians and pediatric residents to screen and refer mothers with or at risk of depression. A systematic identification, referral, and data system was developed. As part of the Access to Better Care Initiative in 2006, the Ohio Department of Mental Health and the Ohio Department of Health collaborated to develop the Help Me Grow Maternal Depression Screening and Response Program (MDSR). Seven counties were selected to participate in a pilot MDSR project.

During the pilot phase, participating counties were provided with nominal incentive funds from the Ohio Department of Mental Health using state general revenue. Federal Transformation State Incentive Grant funds supported the development of the Web-based data collection system and the pilot process. In 2010, the Ohio Department of Health also began contributing funds to support expansion and sustainability of MDSR.

Beginning in 2010, MDSR became a required component of the Ohio Help Me Grow home visiting program in all 88 Ohio counties. Every first-time mother enrolled in Help Me Grow is offered screening through the Edinburgh Postnatal Depression Scale. In 2012, the screening became mandatory to participate in the home visiting program. Positive screens, with parental consent, are referred to participating community mental health therapists for services.

For those mothers referred for services, trained mental health therapists provide a treatment program, In-Home Cognitive-Behavioral Therapy (IH-CBT), which is delivered concurrently with home visiting. There is regular contact between mental health providers and Help Me Grow home visitors, with cross-system training and monthly conference calls to support mutual problem solving, resolve issues, and motivate ongoing participation. Further, home visitors attend one of the final sessions in the IH-CBT series to review treatment impact and facilitate support following termination of the mental health intervention.

Evaluation of the Help Me Grow MDSR model is ongoing, and preliminary results indicate that the approach of embedding mental health services in home visiting is effective. In a study conducted in southwestern Ohio and northeastern Kentucky, there was a significantly greater reduction in depressive symptoms in a group of mothers who received IH-CBT compared to their counterparts who did not receive the treatment. Treated mothers had decreased diagnosis of major depression, lower reported stress, increased coping and social support,

and increased positive views of motherhood at post-treatment. Discussions are underway at the Ohio Department of Health to expand the state's home visiting infrastructure, with increased attention to continuous quality improvement.

"Ohio's experience demonstrates a synergy between home visiting and mental health. A mental health practitioner embedded in home visiting will help achieve child outcomes as well as maternal outcomes and responses, and the home visitor can help the mother persevere with mental health treatment."

Frank Putnam, M.D., Professor of Psychiatry,
University of North Carolina at Chapel Hill and evaluator, Ohio MDSR Program

Partnership Builds Capacity Within Child Welfare to Address Early Childhood Mental Health

In 2010, Ohio launched a collaborative effort between child welfare and mental health to ensure that children birth to age 6 in the child welfare system receive social-emotional assessments and related services. With \$2 million in funding made available to states as a result of increased federal reimbursement for Medicaid, 14 of Ohio's 88 counties participated in the partnership.

A dozen trainings for child welfare workers and mental health providers were held across the state. During these trainings, a half-day was devoted to education on trauma, a half-day on social-emotional development, and one day on using the Devereaux Early Childhood Assessment for Infants and Toddlers (DECA-IT). A follow-up training was provided to instruct practitioners on use of the DC:0–3R. The goal is for child welfare workers to regularly use the DECA-IT and to share the data with a mental health consultant when children's scores are concerning. Consultants then observe the child in the home and determine an appropriate plan for services.

The early childhood mental health and child welfare partnership demonstrated positive impacts on providing services to very young children involved in the child welfare system. Positive impacts included:

- increased access to mental health providers specializing in early childhood and family issues;
- improved access to in-home, one-on-one coaching and mentoring for parents;
- earlier identification and intervention with children affected by trauma;
- better coordination between early childhood mental health and child welfare;
- greater stability for children (i.e., prevention of placement disruption);
- greater consistency and less confusion for families via collaborative services; and
- an increase in caseworkers' knowledge of social-emotional development.³

STRATEGIC TIPS: OHIO

- Build upon the synergy between home visiting and mental health. Doing so advances well-being for both the child and the mother.
- Embed early childhood mental health in other systems, including home visiting and child welfare. Create specific roles, responsibilities, and supportive resources, such as consultation between these providers and mental health clinicians, to ensure follow-up services when a need is identified.
- Provide training to child welfare staff on social-emotional development and on the impact of trauma on very young children and parents.
- Train child welfare workers to conduct screenings to identify social-emotional concerns and then report such concerns to mental health consultants.
- Partner with researchers and other states piloting similar approaches to create evidence and guide systemwide effective implementation.

Resources

For information about the Ohio Association for Infant Mental Health: www.oaimh.org/

For information on the Ohio Help Me Grow program: www.ohiohelpmegrow.org/

For specific information about maternal screening and response: www.ohiocando4kids.org/Maternal_Depression



LOUISIANA

I-ECMH Is Built Into the Infrastructure of Louisiana's Early Childhood System

Infant mental health clinicians, academics, and researchers in Louisiana intentionally worked to incorporate the principles and perspectives of I-ECMH into the state's early childhood system. BrightStart, serving as Louisiana's Early Childhood Advisory Council, is charged with building, maintaining, and strengthening a comprehensive and integrated early childhood system, including opportunities for mental health and social-emotional development. For example, the BrightStart strategic plan includes goals and strategies for Quality Start, a quality rating system for child care centers that includes a strong grounding in social-emotional development. Through a collaboration with the Nurse-Family Partnership home visiting program, infant mental health specialists work alongside home visitors. I-ECMH principles are infused into the child welfare system as well. Similar attempts have been made with Part C early intervention, but budget cuts too often stall action.

To further embed I-ECMH into systems and practice, Louisiana provides 30 hours of I-ECMH training to every public health nurse in the state and makes that same

training available to child welfare, early intervention, and other frontline government workers. These trainings are funded by the Maternal and Child Health (MCH) Block Grant and are provided twice a year by faculty at Tulane University.

TANF Funds I-ECMH Direct Services

In 2002, Louisiana's Assistant Secretary of Mental Health, alongside clinicians from Tulane and Louisiana State University, secured funding through Temporary Assistance to Needy Families (TANF), plus some state general funds, to create the Early Childhood Supports and Services (ECSS) program. ECSS was a direct-service program that brought together practitioners from across early childhood to provide comprehensive services (including but not limited to mental health services) to TANF-eligible children. The program was a public health intervention that combined intensive multisystem case management and I-ECMH services using clinical assessment and evidence-based interventions. I-ECMH provided the framework for all evaluation and service provision.

"We know that the earlier we handle I-ECMH issues, the more successful we will be. But the Early Childhood Supports and Services (ECSS) program can only handle so many clients, and there is more need than we can provide for. That's why we need to work across early childhood systems. And we need a major push to fund I-ECMH at the program level rather than the procedure level. We're doing it with adolescents; we need to do it with younger kids, too."

Richard Dalton, M.D., Former Professor and Training Director,
Child/Adolescent Psychiatry, Tulane University School of Medicine

ECSS was an example of an effective public-private partnership. State teams provided direct services and administered the program in all but two of Louisiana's regions. They were supported by Tulane psychiatrists, psychologists, and social workers who provided intensive training, clinical consultation, leadership, and some direct service as well. Louisiana State University faculty members also provided consultation.

In late 2012, funding for ECSS was eliminated by Governor Bobby Jindal; the program ended in early 2013. An agreement was made to keep one program site active through September 2013, provided that a local foundation would cover the prior state contribution. With the elimination of ECSS funding, Louisiana lost a \$6.3 million investment (\$753,001 in state general funds and \$5,550,000 in TANF dollars) for I-ECMH. To continue the gains made through the ECSS effort, work is already underway to make sure that I-ECMH is addressed in new mental health managed care delivery systems in Louisiana.

Resources

For background on Louisiana BrightStart:
www.brightstartla.org

STRATEGIC TIPS: LOUISIANA

- Apply an I-ECMH frame to the larger early childhood system by embedding the principles of I-ECMH into existing child-serving programs and agencies (e.g., child welfare, Part C early intervention, home visiting, child care quality).
- Enlist an expert in I-ECMH to educate mental health, Medicaid, and other relevant state-level directors about early brain development and infant mental health.
- Gather data for proving the success of interventions on a large scale. When Louisiana did this for an evidence-based treatment program for adolescents, Medicaid agreed to reimburse for the program rather than for individual procedures.
- Diversify funding sources to guard against the effect of harsh budget cuts on individual programs.



Strategic Questions to Consider in Planning for I-ECMH

Systems-Level Issues

- Do I-ECMH issues have traction in your state? Can you link I-ECMH to other early childhood issues that are high on the policy agenda?
- Does your state have an Infant Mental Health Association? What are the strategic priorities?
- Who are your I-ECMH champions?
- Does your state have political leaders who are likely to oppose I-ECMH services?
- What kind of advocacy messages can you use that will make the case for I-ECMH services? Are there hot-button issues that could be linked with I-ECMH arguments?
- Does your state have a strategic plan for I-ECMH that sets forth long-term goals and strategies related to policy; financing; professional development, training, credentialing, and endorsement; data collection and use; and evaluation?
- Does your state have a formal training program for I-ECMH providers?
- Does your state have a mechanism for collecting and analyzing I-ECMH data? Can you use the data to make the case for scaling up I-ECMH services?
- How is social-emotional development reflected in state early learning guidelines and program guidelines? Is I-ECMH integrated into your state's tiered Quality Rating and Improvement System?
- How is I-ECMH embedded in your state's home visiting/MIECHV program?
- How is your state using the resources and approaches of initiatives such as Project LAUNCH or the Center for Social and Emotional Foundations of Early Learning?

Access

- What are the existing I-ECMH services and supports for expectant parents, infants, young children, and families in your state?
- Are there waiting lists for I-ECMH services and supports?
- Do the existing I-ECMH programs work in partnership with other programs in the state that serve infants and toddlers (home visiting including MIECHV, child welfare, child care, pre-K, Head Start/Early Head Start, and Part C early intervention)?
- What gaps in I-ECMH services currently exist?
- What are the diagnostic barriers that stand in the way of access? Are providers in your state encouraged to use DC:0–3R?
- What are the eligibility barriers that limit access?
- What work has been done to address gaps in services and barriers to access?
- What more work needs to be done, and who can provide leadership to get it done?



Delivery

- Does your state have a plan for delivering I-ECMH services?
- Does your state have a plan for embedding I-ECMH services in related children’s programs (early learning and development, Part C early intervention, child welfare, home visiting including MIECHV, pre-K, and Head Start/Early Head Start)?
- To what extent is there a formal training program for I-ECMH providers?
- What is the plan for growing the numbers of professionals who have specialized training, certification, or endorsement in I-ECMH?
- Does your state provide I-ECMH training or consultation to individuals who work with children being served by other systems (child welfare, Part C early intervention, home visiting including MIECHV, Head Start/Early Head Start, pre-K, and child care)?
- Does your state have a mechanism for reviewing the I-ECMH services that are provided and for reporting on the progress made?

Financing

- How are the I-ECMH services and supports funded? Is the funding diverse enough to mitigate the impacts of budget cuts?
- Does Medicaid or other third-party payers pay for I-ECMH services? Are the appropriate coding and documentation procedures well known to providers and third-party payers?
- Has your state examined current spending to determine where resources can be shifted to better support evidence-based I-ECMH services and supports across the promotion, prevention, and treatment continuum?
- What are the billing and payment barriers?
- Can your state garner additional funding for I-ECMH services (e.g., new state funding, federal waivers, foundation support, leveraging)?
- Does your state have a DC:0–3R to DSM or ICD-10 crosswalk to ensure appropriate I-ECMH diagnoses within current Medicaid billing codes?

Incorporating Evidence of I-ECMH into Practice and Policy

- Is the use of evidence-based I-ECMH approaches required by your state mental health, early learning and development, Part C early intervention, education, or Medicaid agencies?
- Does your state have an approved list or definition of evidence-based approaches for I-ECMH?
- How are evidence-based practices reflected in state public policy? For example, is parental depression screening a routine part of postpartum care?
- How are I-ECMH initiatives being evaluated? What benchmarks for continuous improvement have been established?

Recommendations for Nurturing Change in I-ECMH Supports and Services

The profiles highlighted in this paper represent some of the strategies employed by states to overcome barriers to the provision of I-ECMH services and supports. Although each state may be unique in the way that it organizes its behavioral health, health, and child development services, some overarching recommendations for making I-ECMH a higher priority emerged from successful state efforts. States are urged to take advantage of current federal and state policy opportunities, such as health care reform, mental health parity, a renewed focus on violence prevention and trauma, and school readiness initiatives, to advance I-ECMH. The list of strategic questions on pages 16–17 can be used to begin or continue conversations about strengthening I-ECMH in states and communities.

Recommendations for States

1. Promote the Cross-Cutting Nature of I-ECMH: Create a state strategic plan to infuse I-ECMH into behavioral health, primary and public health, early learning and development, child welfare, home visiting including MIECHV, and Part C early intervention initiatives.

Healthy social and emotional development is essential to some of the most timely state policy issues, including promoting school readiness and success, preventing violence, reducing the impact of trauma, identifying and responding to maternal depression, assuring early identification and intervention for children with disabilities, and improving health outcomes. Some federal programs already have requirements for mental health services. For example, Head Start and Early Head Start have standards and guidance for programs regarding engagement with parents, screening and identification of concerns, use of a mental health consultant, and follow-up. These standards might serve as a starting point for states looking to enhance their I-ECMH requirements.

Existing groups, such as state infant mental health associations, Early Childhood Advisory Councils,

Project LAUNCH advisory groups, Early Childhood Comprehensive Systems grants, or American Academy of Pediatrics state chapters, might provide appropriate vehicles for strengthening and infusing I-ECMH. A report by the National Center for Children in Poverty, *Building Strong Systems of Support for Young Children's Mental Health*, includes a useful tool for state planning.⁴ Involving a diverse group of champions and working collaboratively across disciplines to develop and implement a state strategic plan is an important step for states to take. An I-ECMH state plan should address the promotion, prevention, and treatment continuum and include several core components:

- leadership;
- financing;
- systems integration;
- improvement strategies;
- professional development; and
- public awareness.

Until a state plan is in place, identify leaders in the field who are part of other state early childhood systems-building efforts to monitor and advocate for I-ECMH. Also, if there is no infant mental health association, convene a small group of I-ECMH professionals and get one started. A state I-ECMH association can help drive change and assist in carrying out the strategic plan.

2. Encourage Greater Attention to Early Identification and Response: Require a social-emotional component to screening, referral, and intervention requirements in home visiting (including MIECHV), child welfare, and other early learning and development programs, as well as primary pediatric and prenatal health care.

Early identification, partnered with a system of intervention and other supports, can prevent early challenges from compromising a child's long-term development. All infants and toddlers should receive ongoing developmental screening, and states should require the use of standardized tools, including tools that

identify concerns in social-emotional development. States should develop an integrated approach to developmental screening, including mental health, across settings to avoid duplication and increase coordination of responses to identified needs.

In addition to early identification and response to children's development, the emotional wellness of parents plays a significant role in the physical and mental health of their children. States should offer screening for maternal depression as part of prenatal and postpartum care and home visiting. Adult mental health issues, such as depression or substance abuse, can disrupt parenting and interfere with the parent's ability and availability to nurture a child's development, but treatment can be very effective. States should improve screening for parental depression and improve access to services and supports for substance abuse and addiction, family violence, depression, and other adult mental health disorders.

3. Increase Access to I-ECMH Services and Financing: Advocate for language in state Medicaid and behavioral health plans to cover I-ECMH screening, assessment, and treatment.

Right now, states are in the process of creating basic benefit packages for health and behavioral health services. These efforts are being driven by health care reform, mental health parity, and Medicaid expansion. Benefit packages for behavioral health should include:

- language to make it clear that infants and toddlers (e.g., “children from birth on ...”) are included in definitions of “serious emotional disturbance”;
- language to support the use of developmentally sensitive, evidence-informed diagnostic criteria such as DC:0–3R and crosswalks between DC:0–3R and ICD or DSM codes for billing purposes;
- a definition of “medically necessary services” to include prevention, diagnosis, and treatment of I-ECMH impairments; and
- a requirement for evidence-based approaches appropriate for infants, toddlers, and their families,

such as treating parents and young children together and delivering I-ECMH services in primary care settings and via home visits.

4. Build Capacity and Competence in I-ECMH Practice: Expand professional development in I-ECMH.

States can improve their efforts to develop core knowledge and skills across prevention, promotion, and treatment of I-ECMH, and across multiple sectors dealing with early learning and development. Some states are creating I-ECMH competencies to provide a framework for core knowledge and skills, and others have created endorsement systems to acknowledge various levels of I-ECMH expertise. States can also review and align professional standards across sectors and make sure that I-ECMH is adequately addressed in training for child welfare, maternal-child health, MIECHV and other home visiting efforts, Part C early intervention, mental health, and early learning and development so that all of these professionals understand how to promote social-emotional development and when a concern should be referred for appropriate follow-up. Specialized training in the use of developmentally appropriate tools such as DC:0–3R should be offered to those who work intensively on I-ECMH. State policymakers can incorporate I-ECMH knowledge and competencies into higher education, personnel preparation, and workforce development initiatives across child development, early childhood special education, early intervention, social work, pediatrics, and related disciplines.⁵

5. Promote Public Awareness of the Impact of Early Experiences on Success in School and in Life: Emphasize the importance of social-emotional development for children to succeed in school, be healthy, and enjoy financial stability in adulthood.

Foundations for essential skills, such as confidence, curiosity, problem-solving, and empathy, are built in the early years of life. Infants and toddlers who develop strong and secure attachments with their parents and other significant adults can go on to form friendships with other children and meaningful relationships as adults. We know that early experiences

have a tremendous impact on later physical and mental health as well as employment, social connections, and educational achievement. Messages about positive early experiences, and resources to foster these experiences, should be readily available to the general public, and especially to parents and those who work with young children. With the increasing attention to school readiness at the federal level, state I-ECMH efforts can play an important part in assuring that all children acquire the social and emotional skills, knowledge, and attitudes required for success in learning and in life.⁶

Conclusion

Early experiences matter. For infants and toddlers or their parents who are struggling with mental health issues, well-trained professionals can provide needed supports and services, and policymakers can help ensure that needed programs and policies are in place

to support a continuum of I-ECMH services. Despite challenging economic times, many states are forging ahead to tackle some of the significant barriers they face in providing I-ECMH. They are working hard, not only to address barriers, but also to be planful in looking at how to bring a strong and well-financed I-ECMH component to early learning and development systems.

Wisconsin, California, Michigan, Florida, Ohio, and Louisiana have each taken impressive steps to address barriers and invest in I-ECMH programs and policies. Although some are still in the early stages of implementation, they provide important lessons for other states in how to nurture and finance policy change, how to engage a diverse group of I-ECMH champions, how to ensure that there are qualified and trained professionals who can provide I-ECMH services, and how to be creative in infusing comprehensive I-ECMH supports into a variety of early childhood settings.

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April 2013



ACKNOWLEDGMENTS

We are extremely grateful to the many individuals who made this policy paper possible. First, we would like to thank our colleagues who shared examples of the impressive work they are doing in states to improve and expand access to I-ECMH. For their invaluable input and feedback, we thank Therese Ahlers, Richard Dalton, Sheri Falvay, Karen Finello, Mimi Graham, Wendy Groves, Mary Ludtke, Geoffrey Nagle, Marie Poulsen, Celeste Putnam, Frank Putnam, Kathryn Shea, and Deborah Weatherston. We also thank our colleagues at ZERO TO THREE for their thoughtful comments and assistance.

This paper was made possible by a generous grant from the A.L. Mailman Family Foundation, the William Penn Foundation, and an anonymous donor.

ABOUT US

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GLOSSARY

Center for Social and Emotional Foundations of Early Learning (CSEFEL)	CSEFEL is a national resource center funded by the Office of Head Start and the Child Care Bureau. The primary goal of CSEFEL is to enhance the capacity of Head Start and child care professionals to support the social-emotional development and school readiness of low-income children birth to age 5.
Children’s Trust and Prevention Fund	Each state has a Children’s Trust and Prevention Fund that supports a system of services, laws, and practices that strengthen families’ capacity to provide their children with safe, healthy, and nurturing childhoods and thus prevent child abuse and neglect.
Devereaux Early Childhood Assessment for Infants and Toddlers (DECA-IT)	DECA-IT is a standardized assessment tool designed for use with children from ages 1 month through 36 months to assess and support emotional health and resilience. DECA-IT uses a comprehensive approach that focuses on the child, the caregivers, and the environment.
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–3)	DC:0–3, published in 1994 by ZERO TO THREE, was the first developmentally based system for diagnosing mental health and development disorders in infants and toddlers. It was developed by a group of experts in early childhood and mental health.
Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC: 0–3R)	DC:0–3R was published in 2005 by ZERO TO THREE and extends DC:0–3 by incorporating empirical research and clinical practice. It supports the clinician in preventing, diagnosing, and treating mental health problems in the earliest years.
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)	DSM-IV, published in 1994 by the American Psychiatric Association, provides guidance to mental health professionals on diagnosing and treating mental health disorders in children and adults. It is used by third-party payers to make decisions about reimbursement. The codes in DSM-IV are designed to match the codes in the International Classification of Diseases and Related Health Problems (ICD), which is the most widely used classification system in the world. DSM-IV is soon to be updated to DSM-V.
Dyadic Therapy	Dyadic therapy is an intervention approach provided to infants and young children with symptoms of emotional disorders. Therapy includes the child and the parent and focuses on rebuilding a healthy and secure relationship between them. Research suggests that these types of therapy are useful in helping the parent and child to regain trust and to work through trauma and fears.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	EPSDT has been a requirement of the Medicaid program since its inception in 1966. The benefit serves children and adolescents from birth through age 21 who meet Medicaid income eligibility requirements. Benefits were expanded in the 1989 Omnibus Budget Reconciliation Act to inform individuals of the availability of screening and treatment, provide screening services to identify health and mental health needs, and provide diagnostic and treatment services to correct or ameliorate mental illness conditions.
Edinburgh Postnatal Depression Scale	The Edinburgh Postnatal Depression Scale is a validated 10-question screener for identifying women who may be at risk for perinatal depression.
In-Home Cognitive-Behavioral Therapy (IH-CBT)	IH-CBT is an evidence-based mental health treatment that is delivered in the home, focuses on the needs of depressed pregnant or postpartum mothers, and coordinates with ongoing home visiting efforts to optimize outcomes.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	ICD-9-CM is the standard diagnostic tool for epidemiology, health management, and clinical purposes. It is used to monitor the incidence and prevalence of disease and is the official system for assigning codes to diagnoses and procedures that are then used for reimbursement decisionmaking. It will be updated to ICD-10-CM in 2013.
Infant-Early Childhood Mental Health (I-ECMH)	Infant and early childhood mental health (I-ECMH), sometimes referred to as social and emotional development, is the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn – all in the context of family, community, and culture. The practice of I-ECMH includes promoting healthy social and emotional development, preventing disorders, and intervening where infant mental health disorders exist.
Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)	MIECHV is a federal program designed to facilitate partnership at the federal, state, and community levels aimed at improving the health and development of young children through evidence-based home visiting programs.
Maternal and Child Health (MCH) Block Grant	MCH (or Title V) Block Grant is a federal program aimed at improving the health of mothers and children. Designed to be a federal-state partnership, the MCH Block Grant is to be used to develop systems that will reduce infant mortality; ensure comprehensive services for women before, during, and after pregnancy and childbirth; reduce adolescent pregnancy; prevent injury and violence; and other such issues.
Medicaid	Medicaid is a jointly funded, federal-state health insurance program for lower-income people, families and children, the elderly, and people with disabilities. Each state designs its own Medicaid program with guidance from the federal government.
Medical Necessity or Medically Necessary Covered Services	“Medical necessity” or “medically necessary covered services” are terms used by third-party payers to indicate criteria they require for reimbursement. Criteria might include such factors as appropriate eligibility (e.g., a DSM diagnosis and resulting impairment, age, enrolled in the health plan), services provided by qualified providers, and within the scope of services (e.g., habilitative, preventive, rehabilitative).
Part C Early Intervention	Part C early intervention refers to the section of the federal Individuals with Disabilities Education Act (IDEA, 2004) that addresses services for infants and toddlers with disabilities. Part C provides grants to states “to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families” Sec. 631(b)(1)].
Reflective Practice	Reflective practice is a term used to describe what programs do to establish and maintain an organizational culture that facilitates mental health, such as developing strong working relationships with parents served by the program, paying attention to the physical and emotional quality of the work environment, and addressing the intellectual and emotional demands of I-ECMH work.
Temporary Assistance for Needy Families (TANF)	TANF is a federal block grant program designed to turn welfare into a program of temporary assistance for needy families with children. TANF emphasizes self-sufficiency through work participation, benefit time limits, and support for two-parent families.

Endnotes

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