

# Planting Seeds in Fertile Ground: Actions Every Policymaker Should Take to Advance Infant and Early Childhood Mental Health



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## Executive Summary

Children’s earliest experiences—both positive and negative—impact their brain formation and in turn, their social and emotional, physical, cognitive, communication, and sensory and motor skills development. Promoting an optimal environment for brain growth is paramount to influencing healthy development. Conversely, certain negative early experiences (often referred to as adverse childhood experiences (ACEs)) have long-lasting and consequential impacts on health outcomes (chronic illness, substance abuse), educational performance (absenteeism, dropout rates), and even criminal justice involvement (juvenile arrests, felony charges) throughout children’s lives. Recognizing the tremendous opportunities – and risks – associated with this critical time, policymakers are increasingly investing in what experts call “infant and early childhood mental health” (I-ECMH), defined as the capacity of a child from birth to age five to 1) experience, express and regulate emotions; 2) form close, secure interpersonal relationships; and 3) explore his/her environment and learn, within the context of family and cultural expectations.

To strengthen I-ECMH policies and support the healthy development of young children statewide, policymakers should take the following actions:

1. **Establish cross-agency I-ECMH leadership** to drive the strategic direction of statewide I-ECMH efforts.
2. **Ensure Medicaid payment for I-ECMH services** to support prevention and treatment for children and their families.
3. **Invest in prevention through mental health consultation** embedded in early childhood settings to promote positive social and emotional development and identify and address mental health issues among at-risk children.
4. **Train workforce on I-ECMH** to ensure all professionals working with infants, young children and their families are equipped to identify early warning signs and connect families to support.
5. **Raise public awareness of I-ECMH**, including why it is important for all infants, young children and their families and what can be done to support children’s healthy development.

## Introduction

Children’s earliest experiences matter. In the first three years of life, a child’s brain grows faster than any other time, charting the course for all major areas of human development—physical, cognitive, social and emotional, communication, and sensory and motor skills. Providing optimal relationships and environments for brain formation are paramount during this time, as is preventing and intervening when children are at-risk of or are facing challenges that threaten healthy development. Negative early experiences have long-lasting and consequential impacts, leaving children more susceptible to poor health, poor educational performance and even criminal justice involvement over the course of their lives. Recognizing the tremendous opportunities – and risks – associated with this critical period of brain development, policymakers are increasingly investing in what experts call “infant and early childhood mental health” (I-ECMH). The purpose of this brief is to 1) explain what I-ECMH is; 2) document why investments in I-ECMH matter; and 3) identify specific actions that state policymakers should deploy to support the healthy development of young children.

## What is I-ECMH?

Across the fields of neurobiology, child development, psychology, and early childhood education, researchers have documented how infants’ and toddlers’ early experiences—both positive and negative— influence brain development and, in turn, impact children’s social, emotional, and physical health, as well as broader societal outcomes. Experts regard I-ECMH as a cornerstone to healthy, lifelong development. Because infants and young children learn and develop within a family context, parents and other caregivers are vital influencers of a child’s healthy development.

I-ECMH is defined as the capacity of a child from birth to age five to:

- 1) experience, express and regulate emotions;
- 2) form close, secure interpersonal relationships; and
- 3) explore his/her environment and learn, within the context of family and cultural expectations.

Just as positive childhood experiences promote favorable I-ECMH development, negative experiences – often referred to as adverse childhood experiences (ACEs)<sup>1</sup> – can adversely impact brain development, with serious, lasting ramifications. ACEs include, for example, physical abuse, mental illness, substance use, or unrelenting stress in the household, or the loss of a parent or family member. A child’s exposure to one or more ACEs has been strongly linked to evidence that a child will experience poor physical growth; aggressive, impulsive behavior; and over time, even serious mental health diagnoses.<sup>i</sup>

Fortunately, I-ECMH may be positively impacted through a continuum of targeted strategies focused on promotion, prevention, and treatment:<sup>ii</sup>

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<sup>1</sup> In this paper, we use ACEs to refer to certain negative childhood experiences generally, rather than the specific set of ACEs identified in the original ACEs study (Felitti, V. J., Anda, R. F., Nordenberg, D., et al. (1998)).

1. **Promotion:** Strategies that aim to encourage positive I-ECMH development may include public awareness campaigns that encourage parents to speak to their preverbal children and “help lines” for parents to seek advice on child development.
2. **Prevention:** Prevention services, delivered in diverse settings, seek to identify risk factors, mitigate the impacts of ACEs, and intervene in child/caregiver dynamics that threaten healthy development; they may include parenting education, home visiting services, and referrals to community and social services.
3. **Treatment:** Effective, evidence-informed treatment provides services and supports intended to directly address mental health disorders. Children’s parents or primary caregivers are typically involved in treatment, which may include [Child Parent Psychotherapy](#),<sup>iii</sup> [Parent-Child Interaction Therapy](#),<sup>iv</sup> and [Attachment and Biobehavioral Catch-Up](#).<sup>v</sup>

Strategies along this continuum should be “trauma-informed,” incorporating recognition of trauma symptoms and acknowledgement of the role that histories of trauma play in the lives of children, families, and providers.

## Why is I-ECMH Important?

I-ECMH is directly linked to the formation of a child’s brain architecture, shaping neural connections and pathways through repeated experiences and early relationships. Left untreated, I-ECMH disorders can impact every facet of a child’s development—physical, cognitive, communication, sensory and motor skills, emotional resiliency, and social—and in turn, a child’s ability to succeed. If not addressed in early childhood, I-ECMH disorders have implications for all facets of adulthood.

### *Prevalence and Early Manifestation of I-ECMH Disorders*

Approximately 9.5%-14.2% of children birth to five years old experience emotional, relational or behavioral disturbance.<sup>vi</sup> Children living in families coping with parental loss, substance abuse, mental illness (such as maternal depression and bipolar disorder), or exposure to trauma are at heightened risk of developing I-ECMH disorders,<sup>vii</sup> often linked to early ACEs and the quality of attachment between infants and caregivers. The stressors of poverty can compound these risks. Young children, even infants, can show early warning signs of mental health disorders, presenting as developmental delays, inconsolable crying, failure to seek comfort from caregivers, and a lack of curiosity, among others.<sup>viii,ix</sup> Without intervention, serious mental health problems can manifest, including depression, anxiety, post-traumatic stress disorder, attention deficit hyperactivity disorder, and obsessive compulsive disorder.<sup>x</sup>

### *Impacts over Time*

Research has documented the impacts of ACEs and mental health problems in childhood across multiple dimensions.

#### *Physical and Behavioral Health*

Children’s exposure to ACEs has been shown to impact long term physical and mental health outcomes and substance use. For example, children with two or more ACEs are more likely to qualify as children with special health care needs,<sup>xi</sup> and researchers have documented a direct relationship between the number of ACEs and likelihood of having heart disease, cancer, chronic

bronchitis or emphysema, hepatitis or jaundice, and skeletal fractures in adulthood, even in the absence of health compromising behaviors, like smoking.<sup>xii</sup> Adults who experienced four or more ACEs are at significantly increased risk of depression, attempting suicide,<sup>xiii</sup> alcoholism, and illegal drug use.<sup>xiv</sup> Additionally, children with mental health disorders face increased risk of experiencing abuse and neglect.<sup>xv</sup>

### ***School Readiness and Educational Attainment***

Success in school is strongly linked to healthy social and emotional development,<sup>xvi</sup> and for children who experience ACEs, school readiness<sup>xvii</sup> and educational attainment are often negatively impacted.<sup>xviii,xix</sup> Children who experience ACEs and/or mental health problems are: 1) at heightened risk of pre-school expulsion due to “disciplinary” or “behavior” concerns;<sup>xx</sup> 2) more likely to experience absenteeism (18 – 22 days on average per school year);<sup>xxi</sup> 3) more than twice as likely to repeat a grade in school;<sup>xxii</sup> and 4) significantly less likely to graduate from high school.<sup>xxiii</sup>

### ***Juvenile Justice Involvement***

ACEs also contribute to juvenile delinquency, increasing children’s risk of juvenile arrests and felony charges.<sup>xxiv</sup> Of the 2 million youth involved in the juvenile justice system each year, approximately 70% have at least one diagnosable mental health need<sup>xxv</sup> (vs. 20% of youth in the general population<sup>xxvi</sup>) and 20-25% have a serious emotional disturbance (SED).<sup>xxvii</sup> Nearly all youth with SEDs have lifelong involvement with the criminal justice system.<sup>xxviii</sup>

### ***State Spending***

I-ECMH disorders not only impact individual children and families but also state spending on health care, education, child welfare, and criminal justice, as well as economic productivity. The Centers for Disease Control and Prevention estimates that childhood abuse and neglect results in a lifetime cost of more than \$200,000 per child, amounting to approximately \$124 billion in total lifetime costs as a result of new child maltreatment cases in the U.S. each year.<sup>xxix</sup>

Failing to address I-ECMH disorders in early childhood increases the need for intervention across multiple state programs over the life of a child and into adulthood.

## **What Can Policymakers Do to Advance I-ECMH?**

While there is no magic bullet to prevent or treat I-ECMH disorders, state policymakers can implement evidence-based strategies to improve outcomes for children and families. For instance, teachers’ access to mental health consultants is associated with reduced rates of expulsion for pre-kindergarteners,<sup>xxx</sup> and some treatment approaches that include both children and primary caregivers have demonstrably improved attachment and children’s abilities to regulate their emotions, even within 6 months of treatment.<sup>xxxi,xxxii</sup> The following actions are examples of how all policymakers can advance I-ECMH.

## 1. Establish cross-agency I-ECMH leadership.

Improving I-ECMH outcomes requires leadership. To ensure coordination and accountability and to drive a statewide I-ECMH strategy, the State should designate an accountable person (or team) to develop I-ECMH policies, make programmatic and funding recommendations, manage implementation, and monitor the State's progress. Cross-agency collaboration is critical to integrate and prioritize I-ECMH policies across otherwise siloed State entities and funding streams.

Specifically, states should:

Colorado established the [Office of Early Childhood](#) and designated a Director of Early Childhood Mental Health to drive the State's I-ECMH policy agenda.

- a. Fund an I-ECMH Division or full-time Director responsible for developing and driving implementation of the State's I-ECMH strategic plan.
- b. Form an inter-agency I-ECMH Task Force (or committee) to ensure I-ECMH priorities and metrics are integrated into all relevant agencies' agendas.
- c. Map the continuum of early childhood care and services across State agencies to identify opportunities to leverage funding and build cross-agency initiatives targeted at I-ECMH.
- d. Perform an annual assessment of I-ECMH services, service utilization, and outcomes, including disparities across these measures, to inform policy and funding decisions, monitor progress against I-ECMH goals, and identify opportunities for continued improvement.

## 2. Ensure Medicaid payment for I-ECMH services.

Nearly 50% of children under six years old receive health care coverage through Medicaid or CHIP.<sup>xxxiii</sup> States should leverage Medicaid payment to support I-ECMH prevention and treatment services for children and their families. In many states, contracts with Medicaid Managed Care Organizations (MCO) or accountable provider-led organizations can serve as a lever.

Specifically, states should:

A child's pediatrician typically is a new mother's main contact with the health care system during the postpartum period, an isolating time for many women. Many women lose Medicaid coverage 60 days post-partum when pregnancy-related coverage expires. Use of a child's Medicaid number to bill for mother's services provides necessary access to and continuity of care and coverage.

- a. Mandate that Medicaid providers follow [Bright Futures](#) pediatric guidelines to screen for, and if indicated, further evaluate, a child for I-ECMH disorders.
- b. Require use of an age-appropriate diagnostic classification system (e.g., Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised [[DC:0-3R](#)]) for diagnosis of infants and young children for payment and utilization review purposes.
- c. Crosswalk DC:0-3R to adult diagnostic codes (i.e., [DSM-5](#) and [ICD-10](#)) to facilitate billing through Medicaid, if billing system cannot accommodate DC:0-3R.

The State of Minnesota's [outpatient rule](#) indicates that the DC:0-3R should be used when assessing children under the age of five.

- d. Update outpatient rules for diagnostic assessment and treatment to permit clinicians three or more visits, as necessary, with a child before making a diagnosis for all children under five years of age.
- e. Permit Medicaid payment for:
  - i. I-ECMH prevention and treatment in diverse settings (e.g., pediatric primary care, home visiting, early education);
  - ii. Mental health services to prevent or treat I-ECMH disorders provided to families and children both together and separately (two-generational treatment) under the child’s Medicaid number; and
  - iii. Multiple screenings for parent and child (e.g., depression and developmental screens, respectively) in the same setting and/or on the same day.

[Washington D.C.](#) pays for Child-Parent Psychotherapy and Trauma-Focused Cognitive Behavioral Therapy in diverse settings under a child’s Medicaid number. In Minnesota, maternal depression screening is covered as a [“Child and Teen Checkup”](#) (EPSDT) service or at other pediatric visits within the child’s first year of life, billed separately but on the same claim as the child visit; child developmental and socio-emotional screening can also be billed for the same visit.

In Colorado, post-partum visits is a [key performance indicator](#) used to measure and reward providers through Regional Care Collaborative Organization contracts.

- f. Incentivize I-ECMH quality initiatives through MCO contracts and Value-Based Payment arrangements.
- g. Educate local I-ECMH providers about becoming administratively equipped to bill Medicaid.

### 3. Invest in prevention through mental health consultation.

An early childhood mental health consultation system—in which a consultant with mental health expertise works collaboratively with programs, their staff, and families to improve their ability to prevent and identify mental health issues among children in their care—helps reduce problem behaviors in young children and, more broadly, promotes positive social and emotional development.<sup>xxxiv</sup> Specifically, states should:

- a. Fund a statewide system of mental health consultants who are integrated, on-site or by on-call consult, into all Early Intervention (EI) programs, home visiting, primary care and early care and education settings, as well as non-traditional settings, such as WIC offices and domestic violence shelters.
- b. Embed mental health consultation as a prevention strategy in existing state plans related to early childhood (e.g., Child Care Development Block Grant, EI, Home Visiting).

In Cuyahoga County, Ohio, 89% of children at high risk of preschool expulsion remained in their child care setting for at least six months following mental health consultation as part of the [Invest in Children](#) partnership.

#### 4. Train workforce on I-ECMH.

Embedding I-ECMH education and competency standards in mental health, social work, health care, and early childhood education professionals' training, coursework, and on-going professional development provide opportunities to build a workforce that understands I-ECMH and is prepared to identify situations that threaten children's healthy development. Specifically, states should:

- a. Implement competency standards and endorsement for mental health professionals serving infants, young children, and their families at-risk of or with I-ECMH disorders.
- b. Embed [I-ECMH education](#) into state child care licensing training requirements and within state core knowledge and competency statements for the early childhood workforce.
- c. Embed I-ECMH education in Managed Care credentialing requirements for pediatricians.

The [Michigan Association for Infant Mental Health](#) (MI-AIMH) created a 4-level workforce development process, the MI-AIMH Endorsement®, to recognize all infant and family professionals within the diverse and rapidly expanding infant mental health field. Endorsement® verifies an individual's attainment of a specific level of education, service provision to infants and families, participation in specialized in-service trainings, receipt of guidance and reflective supervision or consultation, and the ability to deliver high quality, culturally-sensitive I-ECMH services. To date, more than 20 states have adopted the MI-AIMH Endorsement® through their infant mental health associations.

#### 5. Raise public awareness of I-ECMH.

Developing public health campaigns, educational materials, and other efforts can help build public awareness of the importance of I-ECMH. Specifically, states should:

- a. Conduct public awareness campaigns to promote infants' and young children's positive social and emotional development and educate families at-risk about available supports.
- b. Develop parent educational materials for distribution by health care providers (e.g., obstetricians, pediatricians, nurse practitioners, psychiatrists) highlighting ways parents can promote child well-being through everyday moments, care for their own mental health, recognize signs of maternal depression, and identify community resources for help.
- c. Distribute parent education materials through public benefit programs (e.g., WIC).
- d. Encourage public-private partnerships with local foundations to support I-ECMH efforts.
- e. Host learning collaboratives for stakeholders (including providers and payors) to share best practices and address barriers in advancing the State's I-ECMH goals.

["LAUNCH Together"](#) is a privately-funded initiative that supports Colorado's communities to expand evidence-based prevention and promotion strategies and build public/private capacity around infant and young children's social and emotional development.

In April 2015, New York City launched the ["Talk to Your Baby"](#) initiative to teach parents and caregivers about the impact of communicating with preverbal infants on their brain development.

## Conclusion

Implementing the actions outlined above will position states to have a meaningful impact on the lives of young children, their families and communities. For more information about how to put these strategies into action, visit [ZERO TO THREE](#).

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## About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based resource for federal and state policymakers and advocates on the unique developmental needs of infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at [www.zerotothree.org/policy-and-advocacy](http://www.zerotothree.org/policy-and-advocacy)

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