Program Description:
Infant Early Childhood Mental Health Assessment

Infant and Early Childhood Mental Health Zero to Three Initiative

The Infant and Early Mental Health Zero to Three Initiative is designed to ensure that all babies and toddlers have a strong beginning in life. During the first three years of life, emotionally nourishing relationships lay the foundation for lifelong health and well-being. By supporting the infants, toddlers, and the adult caregivers, we hope to maximize our long-term impact in ensuring all infants and toddlers have a bright future.

Infant Mental Health (IMH) refers to the social-emotional well-being of children ages 0 through five years of age (72 months). Infant development cannot be separated from the caregiving environment. This environment primarily consists of attachment relationships, which cannot be separated from the culture in which these relationships develop. IMH includes:

- Capacity of the child to experience, regulate, and express emotions
- Ability to form close and secure relationships
- Ability to explore the environment and learn

Infants and young children develop within the context of one or more dyad-specific attachment relationship. The physical, cognitive, social, and emotional capacities of the infant are mediated by the quality of the caregiver-child relationships. Similarly, the relationships between the infant mental health practitioner, the infant, and caregiver are prized. Thus, prevention and intervention occur within the context of relationships (i.e., between caregiver and provider, family and organization, etc.).

Qualifications to Complete Assessment

Individual is independently licensed in a behavioral health discipline (PhD, LCSW, LPC-MHSP)
OR
Individual holds a Master's degree, works for a community mental health center, and is supervised by a licensed clinician (as described above). (TCA Title 63)

AND one (1) of the following in **Education**, **Endorsement** or **Evidence-Based Practice** domains:

1) **Education Domain**: **Verifiable education/training in the following areas:**
   Developmental screening of 0-5
   Trauma screening for 0-5 and adults
   Relationship-based assessment

OR

2) **Endorsement Domain**: **One (1) of the following, verifiable by AIMHiTN**
   a) Endorsement as Infant Family Specialist (Category 2) and receiving reflective supervision/consultation by, at minimum, an individual who is vetted to provide reflective supervision/consultation by AIMHiTN.

   b) Endorsement at Infant Mental Health Specialist or above (Category 3 or 4).

OR

3) **Evidence-Based Treatment Domain (1) of the following**:

a) Child Parent Psychotherapy (CPP) provider verified by CPP roster, certificate of completion, or verification by CPP trainer

OR

b) Current participant in CPP Learning Collaborative (LC) verified by CPP certified trainer of the LC

OR

c) Other Evidenced Based Treatment (EBT) for infants and toddlers with verification from a trainer certified by the developer or certified through the official training organization (Attachment Biobehavioral Catch-up, Parent Child Interaction Therapy, Parent Child Interaction Therapy-Toddler, Circle of Security, etc.)

OR

d) Participating in a Learning Collaborative for one of the identified EBTs

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

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

OR

2. Submit a certificate verifying that the person has completed one of the EBTs outlined in the document.

Key Core Concepts and Components of Infant Mental Health Assessment

Cultural Competence

Cultural Competence is the ability to interact effectively with people of different cultures. It means to be respectful and responsive to the health beliefs and practices of diverse groups (SAMSHA). The impact of socioeconomic or minority status, race, ethnicity, sexuality and culture on the caregiver, child, and relationship must be acknowledged and explored. Infant mental health is an ecologically-valid discipline, accounting for all factors impacting the infant and the caregiving dyad. Therefore, not only do IMH providers offer preventive support and evidence-based intervention to the child, dyad, and family, but they also advocate for services and/or social change, as necessary, for infants/families to thrive.

Trauma-informed/Evidence-based practices

Understanding trauma from a developmental perspective is a core competency of infant mental health. While young children do not have the words to describe traumatic events, they are impacted by trauma at a preverbal level (biological, cognitive, social, and emotional). Young children are especially impacted by interpersonal trauma because they experience the world through the lens of their primary caregivers. Early trauma may include exposure to domestic violence, community violence, parental addiction, or chronic maltreatment. Traumatized infants and dyads have a special need for trained providers who are sensitive to relational and developmental stages. For infants and young children, it is particularly important that evidence-based and evidence-informed interventions be implemented in the context of relationship based practice.

Assessment

The DC: 0-5 is the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. "DC: 0–5, the revised and updated DC: 0–3R, was created to provide developmentally specific diagnostic criteria and information about mental health disorders in infants and young children. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and World Health Organization's International Classification of Diseases (ICD) are comparable classification systems for older children and adults. The most recent edition of the DSM (DSM-5) has made some attempt to be more developmentally sensitive, but it still does not sufficiently capture the range of disorders typically seen in infancy and early childhood." (https://www.zerotothree.org/resources/2343-advancing-infant-and-early-childhood-mental-health-the-integration-of-dc-0-5-into-state-policy-and-systems)

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

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

Comprehensive Assessment Components

- Assessment will be guided by Tennessee Best Practice Guidelines (https://www.tn.gov/content/dam/tn/mentalhealth/documents/Pages_from_CY_BPGs_33-45.pdf)

The assessment process occurs over time and requires 3- 5 face to face sessions

  - Infant and young child assessment must include relationship-based assessment. Thus, the assessment becomes more complex when multiple caregivers are involved.
  - Assessment may need to occur in various settings
  - Caregiver only sessions are required (if there is more than one caregiver, the caregivers will need to be interviewed separately)
  - Caregiver child observation is required (if there is more than one caregiver, more than one relationship will need to be assessed)
  - Multidisciplinary input is often required; thus, multidisciplinary team meetings/consultations may be necessary
  - Reflective consultation is a part of the process
- A complete evaluation/assessment will typically involve the following:
  - Interviewing the parent(s)/caregivers about the infant's/young child developmental and medical history
  - Will include ACES screening and/or Trauma screening tool
  - Directly observing family functioning (e.g. family and parental dynamics, the caregiver-infant/young child relationship, and interaction patterns)
  - Gaining information through direct observation and report, about the infant's/young child's individual characteristics, language, cognition, social reciprocity, and affective and behavioral expression
  - Assessing sensory reactivity and processing, motor tone, and motor planning capacities
  - Incorporating a cultural perspective (pp. 10 – 12).

- In addition to consideration of clinical disorders, finding from a comprehensive evaluation should lead to preliminary notions of the following:
- The nature of the infant's/young child's pattern of strengths and difficulties, including the level of overall adaptive capacity and functioning in the major areas of development (emotional, social-relational, language-social communication, cognitive, and movement and physical) in comparison with age and culturally expected developmental patterns
- The relative contribution of the infant's/young child's competencies and difficulties of the different areas assessed (e.g. family relationships, interactive patterns, and constitutional-maturational patterns)
- A comprehensive treatment or preventative plan to deal with the first and second points above"

Diagnostics

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

Diagnostic classification systems available include:

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Area I: Clinical Disorders
Area II: Relational Context

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

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

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

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

Assessment Setting

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

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