

MAKING IT HAPPEN

Overcoming Barriers to Providing Infant-Early Childhood Mental Health



Introduction

Public policy has been slow to catch up with neuroscience. For decades, the science of child development has demonstrated the impact of positive and negative early experiences on brain development, school success, and adult physical and mental health. Meanwhile, advances in neuroscience have progressed at a rapid pace, setting the stage for public policy initiatives that would support the healthy development of very young children. Yet we are only now beginning to see federal and state policies that incorporate the social and emotional aspects of child development into early learning and development systems.

In the terminology of the child development field, social and emotional development is also referred to as *infant-early childhood mental health (I-ECMH)*. We now know from studies of the long-term outcomes of child development programs that efforts to improve the health and education of young children or the financial stability of their families will not be effective unless they also address social and emotional health. Social and emotional development is inextricably linked to other domains and, along with

What Is Infant-Early Childhood Mental Health?

Infant-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.

It should be noted that there is a shift toward using the term *behavioral health* instead of mental health. However, the field of I-ECMH has been deliberately growing its identity, so we use the prevailing term.



cognitive development, forms the foundation—the bricks and mortar—of development.

The science is clear: Public policies and programs intended to support the development of infants and young children must address I-ECMH. Although challenges continue to exist in the delivery and financing of infant mental health promotion, prevention, and treatment, we know what needs to be done.

To catch up to and keep pace with the science of child development, we must ensure that our state and federal policies create a continuum of strategies to prevent mental health problems, to promote social and emotional well-being, and to treat mental health disorders beginning in pregnancy and continuing on throughout the early years of life and beyond. Successful early learning and development systems must include a strong and well-financed I-ECMH component.

This article is intended to illuminate the scientific evidence for I-ECMH policies; examine issues faced by national, state, and local program directors and mental health practitioners in providing I-ECMH services; and propose a set of recommendations for policy improvements at the federal level. Additionally, we seek to provide a context for the issues and barriers states face when financing services for those most in need and during a time when those services would have the highest rate of return. These significant issues faced by states include the lack of a service delivery system for provision and reimbursement of I-ECMH services, underutilization of Medicaid financing for

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I-ECMH services, insufficient numbers of adequately trained mental health specialists, and a lack of intentional focus on promoting the social-emotional development of young children in state policy.

The bottom line is that states and communities don't have the I-ECMH services that infants and young children need, don't have the people to provide them, and don't have a system that will pay for them. These issues need to be taken up by federal and state decision-makers so that the early foundational development of all infants and young children will enable them to realize their full potential.

The Science of I-ECMH

Early experiences matter. The early experiences of infants and toddlers influence the physical architecture of their brain, literally shaping neural connections and pathways. These experiences determine the course of children's social-emotional development, which in turn affects early learning, behavior, relationships, and the ways in which children react and respond to the world around them throughout their lives. Social-emotional development is the cornerstone of healthy development; it provides a foundation upon which all future development rests: physical growth and health, cognitive skills, and communication.

Strategies to improve I-ECMH fall along a promotion, prevention, and treatment continuum. Promotion strategies, such as a public awareness campaign on the importance of I-ECMH and tips for caregivers on what they can do to support it, focus on promoting well-being among all children. Prevention strategies are aimed at children who are at risk for mental health problems and may include screening for I-ECMH or home visiting for at-risk families. Treatment involves specialized services for infants, toddlers, and families who are already exhibiting symptoms of mental health disturbances.

Infants, toddlers, and parents can have serious mental health problems that affect development. Contrary to common belief, mental health problems can occur in children under the age of 5 years. Infants and toddlers have the capacity to experience peaks of joy and elation as well as depths of grief, sadness, hopelessness, intense anger, and rage.¹ Mental health problems for infants and toddlers might be reflected in physical symptoms (poor weight gain or slow growth), delayed development, inconsolable crying, sleep



problems, aggressive or impulsive behavior, and paralyzing fears. Over time, untreated symptoms of mental health problems can “take root” in young children and accumulate to seriously affect their ability to learn and function. Because infants and young children develop in the context of close, consistent relationships, their own emotional well-being is directly tied to the emotional functioning of their caregivers and families.² Untreated parental depression, substance abuse,

domestic violence, and trauma disrupt parenting and can affect the mental health of children.

It is estimated that between 9.5% and 14.2% of children age birth to 5 experience emotional or behavioral disturbance.³ Symptoms of depression and anxiety, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, and other mental health issues can begin to manifest in infancy and toddlerhood.⁴ Also of concern is the prevalence of maternal depression, which can lead to mental health issues not only in the parent but in the child as well.⁵ However, mental health issues identified in young children and their parents are treatable (and sometimes preventable), and there is a growing body of evidence on the effectiveness of I-ECMH services.^{6,7,8,9,10}

Untreated mental health disorders affect multiple domains of development and have detrimental effects on future health and developmental outcomes.

Undiagnosed or untreated mental health disorders can have serious consequences for early learning, social competence, and lifelong health.¹¹ That is why early identification and treatment is so important.

The encouraging news is that when early experiences lead to poor social-emotional development, I-ECMH problems can be identified and treated. Research demonstrates that early prevention and treatment strategies are more beneficial and cost-effective than attempting to treat emotional difficulties and their effects on learning and health after they become more serious.¹² However, despite evidence that earlier intervention is effective, the availability of appropriate treatment for infants and toddlers is scarce.

What is 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.

Both early development and effective I-ECMH treatment occur through relationships.

Infants and young children learn and develop in the context of interactions and engagement with the significant adults—parents and other consistent caregivers—in their lives. In the earliest years, therefore, mental health disorders often result from problems in the child's primary attachment relationship. In order to address this underlying principle, promoting, preventing, or treating the mental health of a child under the age of 5 must involve the child's caregiver. Dyadic therapy is one effective treatment approach.¹³ And as an evidence-based treatment, parent-child psychotherapy, a form of dyadic therapy, presents an opportunity for encouraging Medicaid reimbursement.

Identifying Barriers to the Provision of I-ECMH Services and Supports

To get a sense of the significant issues facing states in providing I-ECMH services, the ZERO TO THREE Policy Center identified key informants at the state and national level and then interviewed each one to learn about barriers, successful strategies, and possible recommendations for federal policy action. Efforts were made to select participants who were well-versed in I-ECMH practices and policies and who had either implemented various system elements (e.g., credentialing systems, Medicaid, and other financing strategies) or had integrated I-ECMH into home visiting or early care and education. Telephone interviews were conducted with 23 leaders in 10 states: California, Florida, Illinois, Louisiana, Michigan, New Mexico, Ohio, Pennsylvania, Washington, and Wisconsin. National experts and organizations were invited to participate as well, and various materials on the topic (e.g., published research, reports, presentations, and state reports) were reviewed. Once the interviews were completed, the information was synthesized for sharing with

key informants. A conference call was convened to seek additional input and consensus on the federal recommendations.

Initially, this project was intended to identify the issues that arise when using Medicaid to finance I-ECMH interventions unique to infants and young children (such as dyadic therapy) as well as those provided in nonclinical settings. However, as key informant interviews were carried out, it became obvious that financing was not the only barrier to the provision of I-ECMH. The issues raised by those interviewed related to virtually all aspects of providing and receiving reimbursement for I-ECMH across the promotion, prevention, and treatment continuum.

These state and national experts initially identified 10 sets of barriers to the provision of I-ECMH, which we have consolidated into five categories. Although the following summary is not necessarily comprehensive or representative of the barriers faced by all states and providers, the five barriers listed present an important sampling of the issues that hinder the provision of appropriate I-ECMH services.



Barriers to Provision of I-ECMH Services

Barriers in Brief

- A. The evidence base for I-ECMH is not reflected in public policy for mental health, early learning and development, or health care reform (including Medicaid and managed care).
- B. Systemic reimbursement issues hinder the ability to pay for I-ECMH.
- C. Eligibility determination and diagnosis impede appropriate I-ECMH services.
- D. There are not enough providers with training in I-ECMH.
- E. The broader system that serves young children does not adequately incorporate I-ECMH services.

A. The evidence base for I-ECMH is not reflected in public policy for mental health, early learning and development, or health care reform (including Medicaid and managed care).

There is a distinct lack of I-ECMH focus in federal policy regarding mental health, early education, child welfare, health care, and related fields. The isolated cases in which federal policy touches on I-ECMH fall far short of what is needed to reorient public policy to the needs of infants and young children. For example, there has been some attention paid to I-ECMH in Part C of the Individuals

with Disabilities Education Act (IDEA) and in early education programs concerned with challenging behaviors in young children. However, these are only glimmers of progress and are not necessarily part of an overall public policy strategy to improve I-ECMH.

Each of the state experts interviewed for this project identified gaps between research evidence and state policy. For example, mental health systems are designed around adult needs and prioritize the deep end (serious emotional disturbance) of the spectrum. New mothers are not routinely screened for postpartum depression in pediatricians' offices. And parents and young children suffering from exposure to trauma have trouble accessing dyadic therapy.

What would a system with an I-ECMH orientation look like? A system informed by the science of I-ECMH would invest much earlier in the prevention of adverse childhood experiences by meeting basic health needs and offering high-quality early care and education programs. Such a system would actively promote I-ECMH through practices such as routine social-emotional development screening for infants, depression screening for pregnant women and new parents, and home visiting for families of infants and young children. And the I-ECMH informed system would use all available resources (and increase funding where necessary) to train an I-ECMH workforce and assure access to I-ECMH services.

The evidence base for an early childhood-oriented approach is robust. The impacts of early development on later physical and mental health—and even economic outcomes—are well established. The Adverse Childhood Experiences (ACEs) study has identified important links between adverse childhood experiences and later adult health outcomes.¹⁴ Indeed, untreated mental health

disorders can have serious consequences for early learning, social competence, and lifelong health.¹⁵ Nobel Prize-winning economist James Heckman demonstrated the economic impact of investing in early childhood development: Early intervention yields huge cost savings—with estimated returns of \$7 to \$9 for every \$1 invested—but those returns diminish the later the intervention is administered.¹⁶ According to Heckman, there is a steep decline in economic returns even by the end of the first 3 years of life. In other words, the later the intervention, the more costly the remediation. Heckman's economic analysis and the ACEs study illustrate the critical role that social-emotional development plays in driving both individual and societal health. They also present a strong case for early intervention and investment in the continuum of promotion, prevention, and treatment with young children.

Research has also shown that, because of the key role caregivers play in the lives of infants and toddlers, treatment of the child must include the adult.¹⁷ In the earliest years, mental health disorders often result from problems in the child's primary attachment relationship. For example, maternal depression or stress can affect parenting and manifest behaviorally, emotionally, or even physically in the child. In the general population, it is estimated that between 5% and 25% of new mothers experience depression; in poor mothers, the rate rises to 40%–60%.¹⁸ Yet less than 15% of state Medicaid programs permit reimbursement for maternal depression screening at pediatric visits.¹⁹ In cases like these, only treatment that responds to the needs of mother, child, and the relationship will comprehensively and successfully address the underlying issue and possibly prevent further harm.

B. Systemic reimbursement issues hinder the ability to pay for I-ECMH. A second set of barriers to the provision of I-ECMH services relates to financing the services through Medicaid and other mechanisms. Problems include (a) not reimbursing services appropriate for infants and young children in the settings where they are most effective; (b) limitations imposed by the mental health services system and/or Medicaid in times of scarce resources, sending infants and young children to the back of the line; (c) limitations that arise because services to infants and young children don't fit into the categories of care for adults; and (d) transitions in delivery systems for health care and mental health care. Throughout, barriers result from an unfamiliarity with issues related to the identification and treatment of I-ECMH issues. In this section, we discuss these problems as they relate to financing, managed care, and state Medicaid limitations.

Medicaid should be a primary payment source for adequate mental health care for infants and toddlers who are most at risk for social and emotional developmental problems, but it falls short. In the United States, 35 million children living in low-income and poor families receive their health coverage through Medicaid, the federal health insurance program for low-income individuals.²⁰ In 2008, 40% of all infants in the United States were receiving health coverage through Medicaid or the Children's Health Insurance Program (CHIP).²¹ Infants and toddlers who are covered by Medicaid— young children who are living in families facing unemployment or poverty, chronic health and mental health problems, and multiple other stressors—have disproportionate needs for mental health services.

Infants and toddlers in the child welfare system also rely on the Medicaid system to cover their health care and mental health costs. However, Medicaid's mental

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health coverage isn't designed to fit the needs of infants and young children.²² With so many young children depending on Medicaid for their health care, it is critical that the program respond to their unique health and developmental needs. In addition to Medicaid's provision for Early Periodic Screening, Diagnosis, and Treatment (EPSDT), mental health workers across the country rely on the program to provide reimbursement for dyadic therapy and other appropriate I-ECMH services received in nonclinical settings (e.g., during maternal child home visits or at child care centers). However, the lack of Medicaid reimbursement continues to pose a major obstacle to early and effective intervention, and while some states are successfully navigating it, the majority struggle to consistently and effectively use Medicaid and other health insurance to cover I-ECMH services.

It is important to note that there is nothing in federal Medicaid policy that specifically prohibits reimbursement for I-ECMH services for eligible children. Some states and individual providers successfully bill Medicaid for I-ECMH; however, these are exceptions. The variability in states' use of Medicaid funds for I-ECMH services results from a variety of circumstances, including barriers related to financing,

managed care, coding, and specific limitations on treatment imposed by Medicaid at the state level. Success or failure in using Medicaid as a funding source depends, among other things, on interdepartmental relationships; billing pathways; availability of funding and matching funds for Medicaid; the state's Medicaid plan; and each party's familiarity with I-ECMH issues. (Golden and Fortuny²³ provide detailed information on how Medicaid can enhance the delivery of necessary mental health services to parents and families.) This section explores some of these barriers.

Financing

The use of Medicaid for I-ECMH services varies by state, region, locality, program, and managed care provider, and depends heavily on relationships between agencies and individuals. Within these jurisdictions, billing pathways for mental health services vary; the billing might go through a state department of mental health, the Medicaid agency, or a managed care organization (MCO).

Access to federal Medicaid funding is bounded by issues including capacity (understanding how to seek reimbursement and availability of matching funds) and a state's willingness to modify its reimbursement policies to meet the needs of infants and young children (e.g., changing its state Medicaid plan, or submitting a federal waiver request or state plan amendment). Furthermore, mental health systems have incurred large budget cuts, and in some states, services for young children have received disproportionate cuts (including cuts to child welfare and Part C of IDEA).

When budgets are tight, mental health systems (including those that are carved out of Medicaid as well as the systems that Medicaid purchases services from) impose restrictions such as limiting the provider pool, lowering the number or length of services



allowed, reducing or freezing reimbursement rates, denying any new eligible populations or services, or prioritizing service populations—and infants and young children rarely make the priority list. Part C early intervention systems in all but a very few states have completely eliminated the at-risk population from their eligibility definitions. Even within states, mental health funding can shift between agencies, into behavioral health managed care contracts where few infants and toddlers benefit, or to community health centers for the public safety net.

Another barrier to financing and especially to obtaining reimbursement from Medicaid and other insurers results from some local providers not having the administrative capacity to do their own billing. Providers in private practice may have very few resources to dedicate to navigating the world of Medicaid reimbursement, which may hinder their ability

to be reimbursed. On the other side of the equation—within Medicaid agencies—authorizations for Medicaid reimbursement are made by prior authorization from medical reviewers who may not understand I-ECMH. As a result, these reviewers routinely reject prior authorizations for I-ECMH services.

Managed Care

The states we included in our study have multiple health maintenance organizations (HMOs) and MCOs whose representatives, like those in the state Medicaid agency, may lack expertise in I-ECMH as it pertains to Medicaid reimbursement. Because training in this area is difficult to facilitate and is often left undone, those making decisions about reimbursement within HMOs and MCOs often do not have the requisite knowledge about appropriate I-ECMH services. This results in inappropriate

reimbursement decisions and reduces access to care.

States are undergoing several transitions. Some state mental health and Medicaid systems are transitioning to managed care contracts, others to capitated rates, while others are preparing to meet the Affordable Care Act^a provisions or carving behavioral health out of Medicaid. The impacts of these changes on I-ECMH remain to be seen. In addition, states are moving to performance-based contracting, and the performance expectations for I-ECMH are unclear. Finally, there may be carve-outs, separate behavioral health managed care or other insurance contracts for children in out-of-home care (e.g., foster care). Therefore, while the child's point of entry should not determine the I-ECMH services the child receives, our interviews reveal that it often does.

State Medicaid Limitations

State officials we interviewed reported that their Medicaid policy placed a variety of constraints on reimbursable services, which interfered with the provision of I-ECMH treatment. Time, frequency, age, and other restrictions on treatment curb providers' ability to meet families' needs. For example, although the most effective services for infants and toddlers are relationship-based and offered in the home, child care centers, or other venues familiar to the child, some state Medicaid agencies will not reimburse for treatment in nonclinical settings. (We discuss this issue further as it relates to broader early childhood system issues

^a The Affordable Care Act consolidates the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119) and the amendments made by Title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029).

below in Section E.) They also may not reimburse for important services like observation. If the child is not present or is sleeping, the therapist might be able to bill the session as consultation instead of assessment or treatment, but the number of allowable consultation sessions is limited. If a state has defined I-ECMH as a "rehab option," all treatment must be rehabilitative in nature: The provider must demonstrate that the child has had a problem for a certain period of time, prior to which he or she did not have the problem, and that the treatment can rehabilitate him or her. Proving all of these elements when dealing with an infant or toddler is challenging because often the child is too young to have the requisite health history for the rehabilitative designation.

C. Eligibility determination and diagnosis hinder appropriate I-ECMH services.

A third set of barriers raised in our sample relates to eligibility determination and diagnostic processes. Medicaid eligibility restrictions, together with the underutilization and lack of recognition of age-appropriate diagnostic tools for very young children, prevent these children and their parents from receiving the I-ECMH services they need. Despite the fact that efforts to improve the health and development of young children will not be effective unless they appropriately address mental health, other challenges contribute to the eligibility and diagnostic barriers that stand in the way. These include instances when one member of the dyad is eligible for Medicaid while the other is not, or when both the parent and the child are affected and yet the relationship cannot be designated as the client; excessively stringent or inappropriate criteria for children to be eligible for Medicaid reimbursement for I-ECMH

services; and use of adult diagnostic codes rather than codes from an infant diagnostic classification system.

Eligibility

Several problems emerged that relate to eligibility, including the following:

1. Eligibility allows only one “patient,” prohibiting dyadic therapy (which focuses on the parent and the child together);
2. If there is a mechanism to pay for dyadic therapy, often either the parent or the child isn’t eligible for Medicaid;
3. I-ECMH providers are reluctant or unable to accurately diagnose an infant or young child because the financing mechanism (Medicaid or other insurance provider) doesn’t allow an age-appropriate instrument;
4. Infants and young children can slip between Medicaid and state CHIP coverage.

These problems are explored in more detail below.

One of the most common barriers to receiving dyadic therapy occurs when one member of the dyad (either parent or child) is eligible for Medicaid and the other is not. Although parents who are not eligible for Medicaid may receive some parenting education through their child’s health care coverage, these services do not constitute sufficient treatment when a mental health disorder has been identified. As a result, many of the most vulnerable children and parents find themselves unable to access dyadic therapy. For example, children born of immigrant parents in the United States are U.S. citizens and, as such, are eligible for Medicaid. Their parents, however—whether legal or illegal—often are not.

Unauthorized immigrants cannot receive Medicaid benefits, and legal immigrants face a 5-year waiting period before becoming eligible. This issue is compounded by the fact that many of these families are at extreme risk for health and mental health disorders due to poverty, substance abuse, violence, and other trauma experienced in their home country or after arrival in the United States.

The issue of mismatched eligibility has also been magnified by increased perinatal screening for disorders such as maternal depression. Although heightened screening identifies and diagnoses more mothers with clinical depression,

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this early identification does little to support mothers and children if it is not followed with quality treatment. In many of these cases, dyadic therapy would be an appropriate companion intervention to medication, but this course of treatment proves inaccessible because only one member of the dyad is eligible for Medicaid.

In most states, current Medicaid policies do

not allow intervention and reimbursement to be directed at the parent–child relationship even though the science of I-ECMH points to the relationship as the “client.” Instead, Medicaid reimbursement requires a single identified patient. Some states have defined I-ECMH in a way that allows a parent and child to be treated together, but there is no consistency in this strategy across the states.

I-ECMH providers are reluctant to make the child the patient due to concerns over stigmatization and inappropriate diagnostic requirements, but appropriate treatment often relies on this designation because Medicaid requires an eligible client to be identified. However, if the parent is the identified patient, treatment may need to be delivered by a provider who does not specialize in I-ECMH. Eligibility requirements for reimbursement will be higher, and it is likely that fewer sessions will be covered than would have been available under EPSDT. Finally, eligibility for Medicaid is elusive for children whose family’s income fluctuates between meeting eligibility for Medicaid and qualifying for state CHIP coverage.

Diagnostic Barriers

Some state mental health eligibility and diagnostic definitions require children to meet stringent criteria—a diagnosis of “severe emotional disturbance,” imminent risk of out-of-home placement, or “involvement with two or more systems”—in order to be eligible for Medicaid services. Infants usually do not meet these criteria. Furthermore, Medicaid requires a qualification of medical necessity before making an appropriate diagnosis, carrying out treatment planning, and

securing reimbursement despite the fact that appropriate application of current medical necessity guidelines to this age group is unclear.

More specifically, some states require infants and toddlers to be diagnosed with a major mental health disorder^b to qualify for Medicaid mental health reimbursement. These diagnostic criteria are too

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stringent—and simply inappropriate—for infants and toddlers. For example, the requirement to “show disruption across multiple venues” is unattainable for infants who are not living, working, or attending school in multiple venues. This makes it difficult for infants and toddlers to meet the access to care standards. It further demonstrates a lack of

^b Some states require the use of Axis I diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to qualify for mental health services under Medicaid. Common Axis I diagnoses from the current *DSM, Fourth Edition, Text Revision (DSM-IV-TR)* manual include depression, bipolar disorder, attention-deficit/hyperactivity disorder, autism spectrum disorders, anorexia nervosa, bulimia nervosa, and schizophrenia.

understanding of how mental health problems manifest in infants and toddlers.

Although adult diagnostic codes are inappropriate for young children, most insurers—including Medicaid, HMOs, and MCOs—do not recognize codes from an infant diagnostic classification system such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised Edition (DC:0-3R). In 2005, it was reported that only five states (Maine, Minnesota, Tennessee, Texas, and Washington) use codes from the DC:0-3R, a classification of mental health and related disorders in children age birth to 3, to bill through Medicaid.^{24,25} Other states have adopted the DC:0-3R, actively promoted its use, and provided training on it, but have not adopted it as a billing code.

When I-ECMH providers use the DC:0-3R for clinical assessment of infants and young children, they may need to create a “crosswalk” between that and adult diagnostic codes for billing purposes. There is no universal crosswalk between the DC:0-3R and adult diagnostic codes. States including Arizona, California, Florida, Indiana, Maine, Maryland, Michigan, Minnesota, Missouri, New Mexico, Ohio, and Tennessee have adopted their own crosswalk between developmentally appropriate diagnostic coding for very young children and reimbursable adult mental health coding (DSM–IV–TR) or medical and health care billing codes (*International Statistical Classification of Diseases and Related Health Problems, 10th Revision*).

Finally, despite research that confirms the importance of screening, there is an underutilization of age-appropriate screening tools for very young children. A 2005 study reported that 40% of state Medicaid agencies did not permit reimbursement

for the use of standardized screening tools to identify emotional problems in very young children.²⁶ Diagnostic barriers to the provision of I-ECMH services underscore the need for mental health and financing systems to reorient to the developmental needs of infants and young children.

D. There are not enough providers with training in I-ECMH. Despite the need for a trained, skilled workforce to deliver mental health services to young children and their families, the states in our study reported a dearth of qualified providers in the field. Barriers include a lack of specialized training opportunities, the time-intensive nature of providing treatment services, a shortage of jobs in the field due to reimbursement challenges, and a lack of credentialing opportunities. Most states do not require special I-ECMH certification or credentials to provide I-ECMH services.²⁷

Filling the gap in I-ECMH services means interrupting a vicious cycle: Without a way to recover costs and receive reimbursement for these services, programs are reluctant to hire specially trained I-ECMH providers. There are few jobs in the field, and budget cuts and subsequent layoffs have exacerbated this problem. Because there is little incentive to invest in training and credentialing in a field where there are few jobs, this leads to a lack of training and credentialing opportunities. This lack of systemic professional development pathways to I-ECMH competence, together with the lack of training suited to the full range of individuals who work with infants and toddlers, prevents the professionals who work with young children from receiving the mental health training they need. This includes early care and education professionals, home visitors, social workers, nurses, marriage and family therapists,

psychologists, and psychiatrists. This, in turn, results in a workforce that is insufficient to meet the demand for services. Compounding the deficit of providers is the fact that I-ECMH services are time-consuming, so a single I-ECMH professional has time for fewer cases than providers in other health and mental health fields. Although beyond the scope of this article, it is important to note that some states and communities are expanding capacity to meet the mental health needs of very young children by creating new networks of I-ECMH consultants.

Furthermore, most states do not adequately credential I-ECMH professionals—only 17 states have a credentialing mechanism or competency system for their I-ECMH providers.^{c, 28} In addition, I-ECMH credentials are not widely acknowledged, valued, or required by states in order to provide services or be reimbursed. Some trained I-ECMH specialists do not meet state Medicaid provider guidelines if they are not child psychologists; and in some states, only providers on the approved provider panel can administer services and be reimbursed, further limiting the pool of I-ECMH providers. Also, I-ECMH providers may not be familiar with all of the HMOs and MCOs working in their states and may be denied as providers or not included on MCO panels.

E. The broader system that serves young children does not adequately incorporate I-ECMH services. Failure to sufficiently infuse early learning and development systems with I-ECMH workers and services is a missed opportunity

^c As of July 2011, 13 states (Alaska, Arizona, Colorado, Connecticut, Idaho, Indiana, Kansas, Minnesota, New Mexico, Oklahoma, Texas, Wisconsin, and Virginia) have been licensed for the Michigan Infant Mental Health Association credentialing materials, and California, Florida, Indiana, and Vermont have created their own competency systems.

for the field and a barrier to reaching children who need care. I-ECMH and promotion of social-emotional development are not just mental health system issues. I-ECMH is an essential building block to promoting greater success for high-needs children when they reach school. Child care, child welfare, health, family strengthening, Part C early intervention, home visiting, and early education all need to be involved and considered when planning

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and administering policies and programs that support social-emotional development. However, existing systems of care lack the financing mechanisms, workforce, and access to services necessary to prevent the lifelong effects of untreated infant mental health problems. None of the public systems that care for the health and well-being of infants and young children currently have adequate capacity to deliver the continuum of I-ECMH promotion, prevention, and treatment services and supports.

There needs to be discussion at the federal and state level about integrating I-ECMH into personnel preparation and workforce development initiatives across child development, early education, special education and early intervention, and mental health. Professionals who work with infants, young children, or



parents in any system should be prepared to promote and support healthy social and emotional development. These professionals should be able to identify issues that require consultation with a mental health professional. Systems should then be prepared (with reimbursement mechanisms and practice approaches) to bring appropriately trained mental health professionals into early childhood and family programs.

To be effective, mental health services must be available for families and be coordinated across service providers. As described in a previous section, in many states, current policy dictates that, to receive Medicaid reimbursement for mental health treatment of an infant, some providers must deliver their services in a clinical setting. This is not always appropriate for infants, who might be best served in their home or child care center, for example. This approach affords the provider the opportunity to witness normal feeding, sleep, and playtime routines that would be altered in a clinical setting and—in the case of home-based treatment—allows the provider to observe the natural dynamic between child and caregiver in a comfortable setting. In some states, reflective supervision and consultation in child care settings is further restricted by the lack of appropriate

billing codes for these services in state Medicaid plans. To maximize the efficacy of I-ECMH services, health care systems must give practitioners permission to provide and bill for I-ECMH services in a variety of settings such as primary health care, families' homes, child care, Early Head Start, Part C early intervention, and other settings where families and very young children spend time.

Although there are many possible points of entry for access to I-ECMH services (including pediatric primary health care, community services such as newborn home visiting and family resource centers, child care and other early care and education programs, and the child welfare system), the point of entry should not determine the diagnosis (or trigger for eligibility) or type of treatment that the child requires. Furthermore, there may be a lack of communication and collaboration between programs and systems, which hinders the delivery of comprehensive I-ECMH services. For example, Part C early intervention and child welfare systems have yet to fully address the intent of the referral requirements in the Child Abuse Prevention and Treatment Act,^d and some states report that community mental health centers are difficult to engage on this issue. There also remains a broader lack of consistency, continuity, and alignment between assessment, diagnosis, and treatment approaches to emotional health in adult and child mental and behavioral health systems, the child welfare system, the health care system, and other systems such as child care.

^d The Child Abuse Prevention and Treatment Act Reauthorization Act of 2010 (CAPTA; Pub. L. No. 111-320) was signed into law on December 20, 2010. Since 2003, CAPTA has required states that receive CAPTA funds to develop provisions and procedures for the referral of a child under the age of 3 who is involved in a substantiated case of abuse or neglect to early intervention services funded under Part C of IDEA.

Federal Recommendations in Brief

1. **Centers for Medicaid and Medicare Services (CMS) should:**
 - a. Issue guidance to state Medicaid agencies expressing the CMS's intent to include infants and young children in mental health treatment;
 - b. Urge consistency across states and regions in I-ECMH screening, diagnosis, and treatment;
 - c. Encourage the development of state policies to support reimbursement of I-ECMH.

2. **Substance Abuse and Mental Health Services Agency (SAMHSA) should:**
 - a. Develop and adopt federal policies, and encourage development of state policies that support I-ECMH concepts and interventions;
 - b. Address the needs of infants and young children who are affected by adult domestic violence, substance abuse, trauma, and mental health issues;
 - c. Increase the focus on I-ECMH throughout all SAMHSA initiatives.

3. **Department of Education's Early Learning Initiative team and the Office of Special Education Programs should:**
 - a. Develop and adopt federal policies, and encourage development of state policies that support I-ECMH concepts and interventions;
 - b. Provide resource materials to states to highlight the connections between I-ECMH and early learning, including supports for children with special needs and their families;
 - c. Support the development of comprehensive state early learning and development systems, especially financing strategies that are inclusive of I-ECMH promotion, prevention, and treatment.

Recommendations for Federal Policy Action



Identifying barriers and challenges is just a first step in improving the provision of I-ECMH. The following recommendations emerged from interviews with state leaders, national experts, and organizations about their struggles and successes in providing I-ECMH services in general, and specifically in obtaining Medicaid reimbursement for I-ECMH services. Although there are other federal agencies whose work is closely related to I-ECMH, the recommendations addressed here are the ones that would immediately assist states in providing I-ECMH. To close the gaps between research, policy, and practice, the recommendations should be given priority attention by the appropriate federal agency.

Federal Recommendations

I. The Centers for Medicaid and Medicare Services (CMS) should:

- a. Issue a guidance letter/memo/directive to state Medicaid agencies clarifying current policy and expressing the CMS's intent to include infants/young children as a population in state Medicaid and related managed care and mental health plans.
- b. Urge consistency across regions and states regarding Medicaid policies for I-ECMH screening, diagnosis, and treatment.

- c. Support and encourage the development of state policies that would:
 - i. Allow for defining “medical necessity” to better address the unique needs of infants and young children;
 - ii. Allow reimbursement of dyadic therapy if either individual in the dyad meets medical necessity;
 - iii. Accept the relationship (the parent–child dyad) as the identified client for reimbursement of dyadic therapy.



2. The Substance Abuse and Mental Health Services Agency (SAMHSA) should:

- a. Develop and adopt federal policies and encourage the development of state policies and program guidelines that support I-ECMH concepts and interventions.
- b. Publish educational materials, papers, and other resources for state and community agencies on topics such as use of federal prevention funds for I-ECMH services, the connections between I-ECMH and adult mental health and substance abuse, children who are in the child welfare system due to parental mental health and substance abuse, intergenerational evidence-based practices such as residential drug treatment programs for mothers/babies, and the relationships between domestic violence, substance abuse, trauma, and mental health in children and adults.
- c. Increase the focus on infants and young children throughout SAMHSA initiatives, including dissemination of evidence-based and promising I-ECMH practices, partnering on the National Children’s Mental Health Awareness Day, and promoting evidence-based I-ECMH approaches through financial and other support.

3. The U.S. Department of Education’s Early Learning Initiative team and the Office of Special Education Programs should:

- a. Develop and adopt federal policies and encourage the development of state policies and program guidelines that support I-EMCH concepts and interventions.
- b. Publish educational materials/papers for states on topics such as the connections between early childhood mental health, early learning, and support for young children with special needs and their families.
- c. Support the development of comprehensive state early learning and development systems, especially financing strategies, so that financing opportunities work in concert to maximize Medicaid utilization and improve access to I-ECMH.

Conclusion

Across the country, as states plan early learning and development systems to include social-emotional development, they struggle to provide and finance I-ECMH services. Financing continues to be one of the several barriers to young children and families receiving needed services across the promotion, prevention, and treatment continuum. This project has added to the evidence base on financing issues and other barriers to service provision for I-ECMH services, but there is still more work to be done. Further examination of these issues is needed, and the next phase of work will be to highlight successful state and local strategies. With this information, it is expected that early learning and development systems will capitalize on the scientific evidence and reduce barriers to infants, young children, and their families getting access to the quality I-ECMH supports and services they need.

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April 2012

Acknowledgments:

We are extremely grateful to the many individuals who contributed to this paper. First we would like to thank our colleagues at ZERO TO THREE for their thoughtful comments and assistance: Patty Cole, Barbara Gebhard, Linda Gillespie, Amy Hunter, Dia Jackson, and Debbie Rappaport. We would also like to thank our colleagues in the states who shared critical insight and provided invaluable information.

This paper was made possible by a generous grant from the A.L. Mailman Family Foundation.

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Design: Metze Publication Design

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