
Opportunities in Public Policy to Support Infant and Early Childhood Mental Health

The Role of Psychologists and Policymakers

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Infant and early childhood mental health practices can be supported by policies and professional standards of care that foster the healthy development of young children. Policies that support infants and toddlers include those that strengthen their families to provide a family environment that promotes mental wellness. Policy issues for infants, toddlers, and young children have come to the forefront of thinking as children need a “voice” to advocate for their support and care. This article (a) highlights several important policy areas that support the social–emotional development of very young children and (b) gives examples of current policy accomplishments and challenges. The article offers a policy agenda to promote the mental health of infants and young children and suggests ways that psychologists can engage with policymakers to promote policies that foster infant mental health, including contributing to the knowledge base that informs policy decisions, educating the public and policymakers about early childhood development and mental wellness, forming community partnerships to identify and address infant mental health risks, and participating in the development of policy recommendations that improve access to evidence-based practices in infant mental health.

Keywords: infant mental health policy, infants and toddlers, policies supporting early childhood mental health, early childhood

P sychologists and mental health professionals have a role to play in furthering the development of sound public policies that support social–emotional health and wellness in the very young. It has been well documented that early experiences matter (Center on the Developing Child at Harvard University, 2007; Shonkoff & Phillips, 2000). Public policies that promote social–emotional wellness in the early years can help to establish the foundation needed for successful relationships with teachers, peers, and others once children enter school, furthering their success in school and in life. Mental health professionals can inform policymakers on the conditions that promote social–emotional wellness and those conditions that present threats to mental health. They can propose effective interventions and develop the evidence base that guides how

investments are made in programs that support the healthy social–emotional development of young children (Zigler & Gilliam, 2009).

It has been difficult to engage policymakers in discussions about how to best support the social and emotional development and mental health needs of infants and toddlers. There is a need to educate policymakers and opinion leaders on the nature of mental health and wellness among infants and toddlers and the root causes of mental health problems. The infant and toddler years are far from being a period of transitory challenges and reversible effects, and conditions in those years can lay the groundwork for lifetime mental wellness. Even within the field of mental health the infant years are not a priority. The field of early childhood mental health has a limited number of training programs and qualified practitioners, making it difficult for parents and child-serving programs to access experienced professionals when they believe such help is needed. When they find such assistance, the cost of preventive services or treatments for children under the age of three years may not be covered by insurance or other resources.

As the field of infant and early childhood mental health continues to mature, many specialties within psychology (e.g., developmental, clinical, psychometric) can collaborate and advance a policy agenda that meets the social and emotional needs of very young children. This article provides a brief overview of the definition of infant and early childhood mental health and presents examples that support a coherent infant and early childhood mental health policy agenda. We close with the role that psychologists can play to ensure that children and families have access to the support they need, when they need it.

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Defining Infant and Early Childhood Mental Health

In 2001, ZERO TO THREE convened a task force that created the following definition:

“infant mental health” refers to the capacity of children from birth to age three to experience, regulate, and express emotions; form close, secure interpersonal relationships; and explore the environment and learn—all in the context of family, community, and cultural expectations for young children. Infant mental health is synonymous with healthy social–emotional development. (ZERO TO THREE, Infant Mental Health Task Force, 2002, p. 1)

Thus, the primary aim of providing infant mental health services is to support and promote social–emotional well-being. Although our focus is on infants and toddlers to age three, many early childhood mental health efforts across the states include children up to five years of age or school entry. Program and policy examples shared in this article include both birth-to-three and birth-to-five efforts.

Early experiences are instrumental in shaping the skills and capabilities that young children bring to their interactions with family, peers, and the broader community. By the time young children reach kindergarten, most have learned to regulate and express emotions in typical situations. They have developed complex social behaviors, motivations, and attention skills that support their later successful participation in school activities. These skills grow out of the early relationships that are the building blocks of secure social–emotional development (American Psychological Association [APA], Task Force on Early Mental Health Intervention, 2003; Brazelton & Greenspan, 2000; Center on the Developing Child at Harvard University, 2007; Cohen, Onunaku, Clothier, & Poppe, 2005; Sameroff & Fiese, 2000; Shonkoff & Phillips, 2000; Thompson, 2009).

The early years present opportunities to identify developmental risks and address them before serious problems are entrenched (APA Task Force on Early Mental Health Intervention, 2003). Unfortunately, mental health policies and funding have focused primarily on providing mental health treatment for older children and adults—often ignoring or minimizing important opportunities to promote, prevent, and treat the mental health needs of infants and toddlers (Huang et al., 2005; Society for Research in Child Development, 2009). An emerging public health approach to infant mental health recognizes that strengthening social–emotional health in the early years can support life-long mental wellness (Cooper, Masi, & Vick, 2009; Miles, Espiritu, Horen, Sebian, & Waetzig, 2010).

A public health approach to mental health seeks to optimize the well-being of all children. The desired outcome is lifetime overall health, competence, and successful function in life tasks. In this view mental health promotion carries benefits to individual productivity as well as supporting society’s needs for social capital and competitive success in the global economy (Miles et al., 2010). Expanding the policy frame to include infants and toddlers in

this way could have significant payoffs, both personal and economic (Heckman, 2006; Heckman, Grunewald, & Reynolds, 2006; Karoly, Kilburn, & Cannon, 2005).

A public health approach to infant mental health would increase efforts at health promotion. *Promotion* refers to efforts to optimize mental wellness by ensuring that the factors that support mental health are present in the environments and interactions of infants and toddlers (Miles et al., 2010). Promotion strategies support the social–emotional well-being of infants and toddlers by ensuring that parents and other adults who care for them provide a safe, nurturing, and responsive environment (Mann, Powers, Boss, & Fraga, 2007). Infant mental health cannot be separated from physical health or healthy development. Parents and family members, caregivers, and communities all contribute to the early development of mental wellness (Society for Research in Child Development, 2009). Social–emotional health can be promoted in the many environments that infants and toddlers and their parents encounter in their daily lives—in child care and early education programs, in well-child visits with physicians, in parent–child activities such as play groups and library story hours, in home-visiting programs, or in prenatal obstetric visits.

In short, promotion strategies capitalize on using the daily responsive interactions between infants and toddlers and the adults who care for them to help foster social–emotional development and behavioral regulation. This approach recognizes that mental health professionals must join forces with other professions to ensure that parents and other caregivers understand the importance of early experiences and can provide nurturing and responsive home and care environments (Miles et al., 2010).

Prevention strategies identify and reduce conditions that lead to mental health problems, thereby reducing the likelihood that a problem will emerge (Miles et al., 2010). In the case of early childhood mental health, prevention activities ensure that all children live in situations that promote mental wellness. When necessary, prevention strategies ensure that children and families have access to screening services that identify problems early and that concerns are addressed before the child develops more significant mental health disturbances (Mann et al., 2007). Prevention strategies may provide extra support to targeted groups of infants and their families to establish and sustain secure, responsive relationships. For example, hospital newborn intensive care nurseries have long provided added support to parents to ensure they are able to bond and forge a nurturing relationship with their baby even as they cope with the separation imposed by the intensive medical interventions required for a newborn with special health-care needs (Talmi & Harmon, 2003).

Children’s social–emotional development is embedded in family dynamics and social environment and is affected by parental mental health and stress (Lieberman & Osofsky, 2009). For this reason early childhood mental health prevention services also encompass a broad range of activities aimed at improving parents’ health and family circumstances, such as reducing drug and alcohol use dur-

ing pregnancy, addressing perinatal depression, or reducing violence in the community and domestic violence.

The concept of mental health intervention has traditionally been associated with treatment efforts to reduce the effects of an individual's mental health problem. Increasingly, mental health professionals acknowledge that infants and toddlers can suffer from significant mental health disorders and that these difficulties can have a lasting impact on their development. Unfortunately many pediatricians, psychologists, and other professionals still take a "wait and see" attitude toward behaviors and symptoms of concern in very young children (Sices, 2007). Parents may not seek services for their baby because they lack understanding of warning signs or because of the stigma associated with acknowledging that their child has a "mental health problem." To support policy development, more work is needed to understand these phenomena and to identify appropriate, evidence-based interventions (Egger & Angold, 2006).

The notion of intervention in infant mental health has broad reach when a public health approach to infant mental health is applied, having a community- or population-level focus. Miles et al. (2010) defined *intervention* as "efforts that create positive change in children's mental health" (p. 25). All infants and toddlers could benefit from public health efforts to create health-promoting communities. Children at risk (especially those children affected by prenatal health challenges, family trauma or disruption, parental depression or mental illness, poverty, abuse, or exposure to violence) need a safety net of infant mental health services (Center on the Developing Child at Harvard University, 2007). Reducing exposure to adverse early experiences may reduce the likelihood of behavioral health and physical health concerns later in life. The cumulative impact of multiple risks may have more significant implications for development than exposure to a single severe incident of short duration. Research findings suggest a link between repeated trauma during early childhood and outcomes later in life (APA Task Force on Early Mental Health Intervention, 2003; Felitti et al., 1998; Sameroff & Fiese, 2000; Shonkoff, 2010; Shonkoff & Phillips, 2000). Although the precise mechanisms creating the link between adverse experiences and poor later outcomes are only beginning to be understood, it appears that the impact of early exposure to severe stress and trauma can be life-long. Community and population-based approaches to reducing or eliminating exposure to these significant life risks is a form of intervention that could create positive changes in the current and long-term mental health status of many infants and toddlers.

There are a number of current policy developments that promise to improve the delivery of infant mental health services, increase access to services, and influence positive developmental outcomes. In the next section we outline a policy agenda to promote infant mental health and discuss some promising examples.

Building a Coherent Infant and Early Childhood Mental Health Policy Agenda

Advances in neuroscience over the last decade have placed a spotlight on the importance of early development and its implications for the child's developmental trajectory (Center on the Developing Child at Harvard University, 2007; Shonkoff, 2010). The science has been persuasive, and yet policy directions do not reflect scientific findings that indicate the importance of supporting the social-emotional development of infants and toddlers (Knitzer & Cohen, 2007). There are several reasons for this state of affairs: (a) With scarce resources, it is difficult to swing the pendulum from the intervention/treatment end of the spectrum to more health-promoting models that would reach children at younger ages. (b) Multiple factors contribute to emotional health and resilience; the choice of solutions is broad and sometimes daunting. (c) Policymakers rarely have the background to interpret scientific findings or translate these findings into practical policies. (d) Policy solutions tied to a single funding "silo" (e.g., social services, health services, or mental health services) do not support comprehensive, integrated strategies that address parents, their children, and the family situation together.

Coordinated attention to children's social-emotional development across a broad set of policies affecting health, mental health, social services, and family support is required to achieve positive mental health outcomes (Huang et al., 2005; Lally, Lurie-Hurvitz, & Cohen, 2006). The policy recommendations below recognize that all children need support to develop optimally and that children whose parents' or family's condition (e.g., substance abuse, mental illness, poverty) puts their children at risk of poor developmental outcomes should be of high priority. These policies create linkages among mental health practitioners and practitioners in other child-serving settings, improving our ability to recognize and respond to risks or early signs of compromised social-emotional development and mental health disorders (Cohen et al., 2005; Lally et al., 2006; Mann et al., 2007). Policy initiatives designed to improve the delivery of infant mental health services are listed here, followed by specific examples of implementation.

1. Expand screening and early identification activities to detect social-emotional problems in infants and toddlers, such as relationship disorders, depression, and self-regulation problems. Include screening for family risk factors that might affect children's social-emotional development—for example, poverty, pre- and postnatal parental depression, family isolation, parental mental illness, or parental substance abuse. Incorporate infant and family screening procedures into routine standards of care in mental health practice as well as in pediatric care and other child-serving settings.
2. Address workforce capacity issues by (a) strengthening the capacity of professionals in mental health, pediatric health, early childhood education,

child welfare, and related professions to recognize the risk factors and early signs of social–emotional problems and mental illness in infants and toddlers; and (b) ensuring that undergraduate, graduate, and continuing professional education programs include content on infant mental health.

3. Integrate supports for infant mental health consultation into the contexts where infants and toddlers are found, for instance, in parent education programs, child care and early education programs, well-child health services, and home-based services.
4. Improve access to early childhood mental health services by addressing insurance and Medicaid payment policies to provide coverage for developmental screening, including screening for social–emotional health, payment for preventive services, and payment for appropriate treatments for infants and toddlers.

Examples of Current Infant Mental Health Policy Initiatives

Policies to Improve Early Screening and Identification

Early screening for developmental delays and disrupted social–emotional development has received increasing attention as a way of preventing later problems or reducing the severity of developmental problems (American Academy of Pediatrics, 2006; Sices, 2007). One system of screening for developmental delays is delivered through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program under Medicaid. States are required to provide screening for physical, cognitive, and emotional issues for eligible children and to provide treatment, including mental health treatment, if problems are identified. EPSDT providers have traditionally focused on physical health; greater attention is needed to appropriate screening and treatment for cognitive and emotional concerns. Psychologists can help improve the delivery of Medicaid-approved infant mental health services by advocating for appropriate screening, assessment, and treatment procedures; by ensuring that early childhood mental health professionals can become approved Medicaid providers; and by participating in care coordination efforts between state departments of health and behavioral health. Changes anticipated with implementation of health reform may improve payment for both mental health screening and mental health treatments mandated under EPSDT (see Insurance and Medicaid Reimbursement Policies section).

The Individuals with Disabilities Education Improvement Act of 2004 (IDEA; Pub. L. 108-446, originally enacted as Pub. L. 99-457 in 1986) is another resource for identifying children in need of developmental services. Part C, also known as the program for infants and toddlers with disabilities, is the portion of IDEA that addresses services for eligible children under the age of three years. Federal dollars to each state and territory fund a system of services for infants and toddlers who experience developmental

delays and/or disabilities. States must establish “Child Find” activities and work with community representatives such as pediatricians and infant mental health professionals to identify eligible children and refer them to Part C services in a timely manner. Nationally, Part C serves 2.5% of the population of children under the age of three (U.S. Department of Education, Office of Special Education Programs, 2009). One recent survey found that the number of eligible children may be as high as 13% (Cooper & Vick, 2009).

Each state develops eligibility guidelines for its Part C program on the basis of criteria established in the federal enabling legislation, Sec. 632 (5) (A): The child is “experiencing developmental delays . . . in one or more of the areas of cognitive development, physical development, communication development, *social or emotional development* [emphasis added], and adaptive development” (IDEA, 2004). A state also may choose to provide services to infants and toddlers “who would be at risk of experiencing a substantial developmental delay if early intervention services were not provided” (IDEA, 2004, Sec. 632[1]). Risk categories include concerns such as severe relationship disorders and disruptions to the development of the nervous system, and environmental risks such as parental drug abuse, child abuse, poverty, or homelessness. Currently only seven states include developmental risk factors in their definition of eligibility (Shackelford, 2006). California discontinued eligibility for Part C services for children at high risk of disability as a cost-cutting measure in 2009, and other states have considered similar reductions in service.

Despite the existing regulatory language requiring that Part C screening and assessment include social–emotional development, it is often overlooked in developing individual treatment plans (Perry, 2007). The 2004 Congressional reauthorization of IDEA strengthened requirements for intervention with children experiencing social–emotional delays. States must now report social–emotional outcomes, including the percentage of infants and toddlers receiving Part C services who demonstrate improved social–emotional skills and the percentage of children who achieve functioning comparable with same-aged peers (U.S. Department of Education, Special Education and Rehabilitative Services, 2007). States have struggled both to identify appropriate assessments of social–emotional skills and to train early interventionists in appropriate treatment strategies. Multidisciplinary assessment approaches are needed to bring the infant and early childhood mental health perspective to early intervention. A 50-state survey of practices found that only 16 states required the multidisciplinary assessment team to include a professional with social–emotional expertise (Cooper & Vick, 2009).

IDEA also sets in place requirements to improve outreach to groups that are at high risk for social–emotional disorders, such as children in the child welfare system and homeless children. One innovation was the so-called “CAPTA” requirement, written into both the 2004 IDEA reauthorization and the reauthorization of the Child Abuse Prevention and Treatment Act of 2003 (CAPTA; reauthorized in 2003 by the Keeping Children and Families Safe

Act of 2003; Pub. L. 108-36). Recognizing that one third of the children entering foster care are under the age of three years (Hudson, Klain, Smariga, & Youcha, 2007) and that these children often have short-term emotional issues related to separation from their families and/or long-term problems related to exposure to violence or abuse (Derrington & Lippitt, 2008), the CAPTA provision requires states to have policies ensuring referral for screening of children under the age of three years who are involved in a substantiated case of abuse or neglect or are affected by illegal substance abuse or prenatal drug exposure. This provision encourages child welfare departments and Part C screening systems to better coordinate efforts to ensure that infants and toddlers entering the child welfare system receive timely and appropriate screening for Part C services. As of 2009, 22 states reported having formal processes in place for referral. Another gap is in identifying and referring to services when children in the child welfare system are at risk but are not eligible for Part C (Cooper & Vick, 2009).

Policies to Increase Workforce Capacity

There is a shortage of psychologists and other practitioners qualified to provide intervention and treatment with infants, toddlers, and their families, let alone to provide the training programs needed to increase capacity. Several provisions of the recent health reform legislation (Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148, passed March 23, 2010) create opportunities to build the workforce, including a loan repayment program for pediatric health care specialists (including mental health) and a psychology workforce development program. The legislation also establishes a National Health Care Workforce Commission to track the workforce (American Psychological Association, Public Interest Government Relations Office, 2010). Among the challenges to professional associations and licensing authorities will be the task of ensuring that psychologists working with infants, toddlers, and their families have appropriate knowledge of early childhood development and child mental health promotion strategies, and an understanding of screening and diagnostic techniques for this age group. Adequate access to training in appropriate treatment strategies is needed, including dyadic and family approaches, as is an expanding evidence-base of appropriate interventions for infants and toddlers. Innovations such as the new CAPTA requirement have increased demand for training of mental health specialists and professionals from other fields on how to support the social-emotional health of infants and toddlers. These innovations also demand increased collaboration between mental health providers and the health, education, and child welfare systems to promote mental wellness in young children (Rosenberg & Robinson, 2003). Tolan and Dodge (2005) called for "a new breed of public health psychologist" (p. 612) and recommended that professional preparation programs add skills in epidemiology, wellness promotion strategies, and evaluation to those of traditional psychology.

The State of Illinois addressed this need with a plan for mental health consultation and mentoring of Part C

providers. A statewide survey found that 70% of early intervention providers felt unprepared to identify and intervene to meet social-emotional needs or to respond to parental concerns (Onunaku, Gilkerson, & Ahlers, 2006). To address this issue, the Illinois Department of Human Services initiated training on a relationship-based approach to services. They introduced a standardized screening tool, offered reflective consultation and supervision to early intervention program managers and case coordinators, and provided parent-to-parent support (Onunaku et al., 2006). Other states, such as New Mexico, Florida, Utah, and Michigan, have developed strategic plans to link infant mental health services across Part C, health, mental health, child welfare, and other service sectors (Perry, 2007).

Many states are addressing the need to build capacity in infant mental health services by defining professional competencies and infusing the competencies into training programs. In 2007, representatives of 16 states attending a national summit on infant mental health called for a national effort to define a core set of professional competencies for infant mental health (ZERO TO THREE, 2008). Several state affiliates of the World Association for Infant Mental Health have taken the lead in this effort in their own states. The Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health is an example of this work. The Michigan Competencies are being used as a model by several other states in integrating competencies to their workforce requirements (Weatherston, Moss, & Harris, 2006). Community mental health centers in Michigan are beginning to include this credential in their staff requirements, and their conferences base content on the credential competencies (Weatherston et al., 2006).

Florida's state infant mental health plan includes workforce development goals that build capacity in infant mental health at three different levels (Meyers, 2007). At the first level are practitioners who come into contact with families, infants, and toddlers in places where children spend their time—for example, child care and home visitation programs. These venues provide the opportunity to promote healthy social-emotional development of all children. The second level includes professionals outside the field of mental health who can help to identify children in need of evaluation and/or intervention. This might include physicians, nurses, child welfare staff, or parent educators. Level 3 of the Florida system addresses the shortage of infant mental health clinicians by encouraging the development of postgraduate specialist programs and continuing education opportunities that build the competency of infant mental health specialists. More work is needed to develop the evidence base showing that the competencies and credentialing systems being defined for infant mental health specialists indeed promote positive developmental and social-emotional outcomes for young children (Meyers, 2007).

Policies to Infuse Mental Health Supports Into Child- and Family-Serving Programs

A public health approach to infant mental health would infuse mental health supports into all services touching

children to support social–emotional development. Head Start/Early Head Start is the only broad-based federally funded effort that requires early childhood programs to engage the services of mental health professionals. Early Head Start is the component of Head Start that serves the nation’s most impoverished pregnant women, infants, and toddlers—a population in which a high level of mental health issues might be anticipated (Center on the Developing Child at Harvard University, 2007). Congress increased the allocated funding for Early Head Start services in the 2007 reauthorization of Head Start and with funds from the American Recovery and Reinvestment Act of 2009, and yet the program currently serves fewer than 4% of eligible infants and toddlers nationally.

Early Head Start provides a model for building mental health services into child development programs. All Early Head Start programs are required to screen children for developmental/behavioral concerns. Programs must employ or contract with mental health professionals to consult with program staff and to provide family-centered mental health services (U.S. Department of Health and Human Services, Administration for Children & Families, 2006). A national evaluation of Early Head Start had positive findings with implications for social–emotional development. At three years of age, Early Head Start children had more positive interactions with their parents than control group children and displayed less aggressive behavior (Love et al., 2005).

Reports from Early Head Start programs suggest that mental health services are an important part of the program’s comprehensive two-generation approach to child development. The Early Head Start Research and Evaluation Project found high rates of depression among participating mothers and fathers (Hoffman & Ewen, 2007). Depressed parents may not engage in positive interactions with their infants or toddlers, but Early Head Start parents were observed to be more emotionally supportive and less detached with their three-year-olds than control group parents were. Two years after the end of the program, former Early Head Start parents reported fewer symptoms of depression. Although Early Head Start participation did not have an immediate impact on the parents’ depressive symptoms, the program did have positive impacts on the parent–child interactions of depressed parents. It is unclear whether the reduction of parental depression symptoms was associated with improved life circumstances or because parents accessed mental health services provided by Early Head Start (U.S. Department of Health and Human Services, Administration for Children & Families, 2006). However, increasing numbers of Early Head Start parents use the provided mental health services, including treatment for depression, crisis intervention, child abuse and neglect services, substance abuse prevention and treatment, and domestic violence services, suggesting that these services are an important resource (Hoffman & Ewen, 2007).

Mental health consultation in early care and education programs is a promising strategy to increase infant mental health resources in Early Head Start and other early care and education programs (Gilliam, 2008; Perry, Allen,

Brennan, & Bradley, in press). Early childhood mental health consultation refers to mental health professionals collaborating with professionals in other fields to prevent or address early childhood mental health problems (Johnston & Brinamen, 2006; Perry et al., in press). Early childhood mental health consultants have knowledge of child development and parenting and understand the dynamics of early childhood settings. Consultation is generally focused on program staff, not on children or families, with the intent to strengthen the capacity of programs to recognize and address social–emotional issues (Brennan, Bradley, Allen, & Perry, 2008). Gilliam (2008) identified a growing need for mental health consultation in early care and education settings when he found a high rate of expulsion from preschool programs for behavior issues among three- and four-year-olds. Programs participating in his study that had access to early childhood mental health consultation were less likely to exclude children for behavior issues. Some studies have found that offering mental health consultation can reduce child care staff turnover and increase staff confidence in addressing behavioral issues (Brennan et al., 2008). More controlled studies of mental health consultation are needed to determine the most effective models (Brennan et al., 2008; Perry et al., in press).

Infant mental health consultation has been supported on a statewide basis through policies in several states. For instance, Pennsylvania is using federal child care development funds to pilot an infant and toddler mental health project within three regions in the state (ZERO TO THREE, 2009). The program is staffed by regionally based infant mental health specialists who provide child-specific on-site consultation to early care and education programs. The governor of Vermont initiated a state funding stream to support mental health services, professional development, and child care consultation for children birth to age 5 who are at risk of serious emotional disturbances, through the Vermont Children’s Upstream Services Program (Cohen et al., 2005).

Another effort to increase capacity to address social–emotional development and wellness is a multistate effort led by the Center on the Social and Emotional Foundations for Early Learning (CSEFEL; <http://csefel.vanderbilt.edu/index.html>). CSEFEL, funded by the U.S. Department of Health and Human Services, Administration for Children & Families, is a national resource center that disseminates research and evidence-based practices for promoting social–emotional development and effectively addressing challenging behaviors of children birth to 5 years of age. CSEFEL teams in 11 states are developing plans to build a professional development infrastructure that supports adoption of effective practices to promote early childhood social–emotional development in child-serving settings. The project uses tools such as training, mentoring, evaluation, and sharing lessons learned.

The state teams include a variety of state-level decision makers in areas including, but not limited to, child mental health, child welfare, early care and education, and Head Start. The teams work to identify gaps in services and identify resources to address system improvements. It is

hoped that engaging representatives of state agencies will lead to statewide adoption of promising practices in supporting infants' and toddlers' positive social-emotional development (Center on the Social and Emotional Foundations of Early Learning, 2010). The project provides a faculty institute to help college faculty think about how to incorporate knowledge of social-emotional development and infant mental health into coursework. Higher education faculty in several CSEFEL participant states are working on developing course syllabi reflecting this content, which will be incorporated into the coursework for early childhood educators (R. Corso, personal communication, June 30, 2010).

Insurance and Medicaid Reimbursement Policies

The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148) has laid the groundwork for better reimbursement for early childhood mental health services. There is much work to be done, however, to ensure that our youngest children benefit from the innovations of the health reform act. The requirements are quite complex and do not apply to all health plans or take effect in the same time period. The health reform measure includes the following:

1. Coverage for mental health and substance use disorder services is provided, including behavioral health treatments, in basic insurance benefit packages offered through the new state insurance exchanges that will come online in 2014.
2. Mental health parity protections are extended to all health plans participating in the insurance purchase exchanges. These mental health parity protections already apply to many commercial plans under existing law. This means that financial requirements (such as co-pays and deductibles) and treatment visit limits applicable to mental health or substance abuse disorder benefits cannot be more restrictive than the requirements applied to most medical/surgical benefits (U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2010).
3. Children who need mental health services and who are covered by plans subject to current mental health parity requirements will benefit fairly soon from changes to medical coverage in the reform bill. For instance, the prohibition on considering pre-existing conditions in determining coverage for children began in September 2010.
4. Lifetime benefit caps have been ended by the legislation, and annual payment caps will be ended by 2014.
5. For children, new insurance plans starting in September 2010 must include coverage of "evidence-informed preventive care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration" (Patient Protection and Affordable Care Act of 2010, Sec. 1001). This means that

preventive care prescribed in the Bright Futures guidelines published by the American Academy of Pediatrics (Hagan, Shaw, & Duncan, 2008) must now be covered with no deductible or co-pay. One of the themes of the guidelines is mental health, with guidance to pediatricians on identifying signals and screening for social-emotional and mental health issues, including for infants and toddlers.

6. Medicaid reimbursement rates for preventive services will be increased to the Medicare rate for the years 2013 and 2014.
7. The State Child Health Insurance Program (CHIP) will be extended until 2019 (with funding through 2015), with states required to maintain current eligibility criteria. This extension will provide time to assess whether plans offered through the insurance exchanges will be adequate to cover CHIP-eligible children.
8. Grant programs are proposed to address postpartum depression and to support recruitment, training, and field placements for students in mental and behavioral health, including child and adolescent mental health. Funding is dependent on Congress appropriating funds for these programs.

Children's mental health advocates will have to work at the national and state levels to ensure that these opportunities are converted into guidance and regulations that improve the payment system for infant mental health services. Strengthened definitions of "preventive services" and a catalog of "evidence-informed preventive care and screenings" appropriate to infants and toddlers are much needed. Current child mental health payment practices are generally based on individually based treatment models responding to diagnoses appropriate to older children. The payment system often does not support preventive or health-promoting interventions, nor does it fit the mental health service needs of infants, toddlers, and their families through dyadic or two-generation treatment.

Although increased investment in health promotion and prevention services supports the long-range vision to promote mental wellness and reduce the need for mental health services, individual children do develop mental health challenges that require attention and perhaps treatment. Payment for preventive and health-promoting services has been one challenge to the funding of infant mental health. Other payment barriers reflect the status of mental health diagnosis and treatment in the early years: (a) requirement of a diagnosis to provide payment; (b) lack of appropriate infant-toddler diagnostic criteria; (c) lack of diagnostic and treatment codes that qualify for insurance reimbursement; (d) lack of a range of approved treatments suitable to the age group, especially dyadic and family treatments; and (e) barriers to infant mental health service providers in being approved to receive insurance or Medicaid payments. In addition, resources are needed to support parents and strengthen parenting so that if parents are worried, fearful, or distressed about their child's behavior they can receive support.

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood—Revised Edition (DC:0-3R; ZERO TO THREE, 2005)* has been used in some states to address payment barriers. The *DC:0-3R* provides a framework for understanding mental health disorders in children three years of age and younger (Mann et al., 2007). The *DC:0-3R* was created to complement other diagnostic and classification systems by describing symptom patterns and associated events and developmental features during the first four years of life. The *DC:0-3R* has been used by advocates to improve reimbursement for infant mental health services. Three states (Iowa, Minnesota, and Utah) have created crosswalks between *DC:0-3* and the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) diagnostic codes so that Medicaid could be billed for treatment (Kaye, May, & Abrams, 2006; Rosenthal & Kaye, 2005).

Medicaid is currently the major payer for early childhood health services. Through the EPSDT benefit, Medicaid mandates that treatment be provided for any physical, cognitive, or emotional issues that are detected. Only 10 states meet the federal benchmark that 80% of children are screened annually (Cooper et al., 2009). Half the states pay for treatment if a diagnosis is assigned, and half the states pay for treatment without a diagnosis. Other barriers include the types of service providers who are approved to receive Medicaid payments, the types of services that can receive payment (including providing dyadic therapy and addressing conditions of the family to benefit the child), and whether payment extends to activities such as follow-up on referrals and activities to coordinate services (Kaye et al., 2006). Psychologists have a role in ensuring that appropriate screening and assessment tools are incorporated into state guidance to EPSDT providers along with identifying developmentally appropriate, evidence-based treatment strategies. Advocacy efforts can also be undertaken to ensure that appropriately credentialed early childhood mental health providers are approved service providers under Medicaid and other insurance systems (see discussion of Project ABCD that follows).

The Assuring Better Child Health and Development Project (Project ABCD), funded by the Commonwealth Fund, supported eight states to develop strategies to improve the delivery of child development services (Kaye et al., 2006). Although the focus of this project was on improving developmental screening in pediatric practices, important lessons from the efforts identify opportunities for stronger collaborations between physical health and behavioral health services to provide developmental screening, referrals, and needed services. Some of the innovations accomplished by ABCD states have included (a) revising provider manuals, contracts, and other regulatory documents to clarify procedures and identify appropriate services that support cognitive and emotional development, including dyadic and family therapy; (b) expanding the types of approved service providers (North Carolina, for instance, allows independently enrolled mental health providers); (c) allowing screening for parental perinatal de-

pression as an approved service supporting child health and development; and (d) facilitating follow-up coordination and exchange of information between pediatricians and other health providers, including mental health providers. Participation by state behavioral health agencies and mental health professional groups in the ABCD collaboratives informed the policy improvements. Mental health professionals need to be proactively involved in state efforts to strengthen public and private insurance rules to ensure that mental health services are available and accessible. Psychologists can communicate to policymakers about payment challenges by, for instance, serving on regulatory revision task forces, offering testimony at public hearings, or responding to proposed regulations.

What Can Psychologists Do to Get Involved?

Psychologists help to shape new policies that support infant mental health in four ways: (a) by conducting research and contributing to the knowledge base that informs policy decisions, (b) by educating the public and policymakers about early childhood development and mental wellness, (c) by forming community partnerships to identify and address infant mental health risks, and (d) by participating in the development of policy recommendations that improve access to evidence-based practices in infant mental health (APA Task Force on Early Mental Health Intervention, 2003; Miles et al., 2010).

Build a Knowledge Base for Policy Decisions

Improved understanding of brain science and the impact of early experiences over the last decade have begun to enter public awareness and influence policymakers, but much more work is needed to motivate policy decisions based on this science (Shonkoff, 2010). Psychologists can contribute to increasing public understanding by conducting research that addresses key policy questions. Some of these questions include the following (Shonkoff, 2010): What conditions promote the mental wellness of infants and toddlers? What are the best indicators to use in monitoring the mental wellness of infants and toddlers? What is the prevalence of infant mental health problems? How are these problems distributed across different child characteristics, settings, and experiences? What are the evidence-based interventions that support infant mental health? Are there cultural or social factors that influence the success of an intervention? Are there individual differences among children that affect the outcomes?

The expertise found in the field of psychology in individual assessment is very much needed today to support infant mental health. For instance, mental health professionals have an important role in improving developmental screening and expanding mental health services for infants and toddlers. Psychologists can promote the use of efficient, reliable, and developmentally appropriate measures of social-emotional outcomes; work with state health, Medicaid, behavioral health, and Part C lead agencies to develop lists of evidence-based screening and as-

assessment tools and to incorporate such guidance into regulation; and collaborate with pediatricians, Part C agencies, and child welfare agencies to develop early childhood mental health prevention and intervention services grounded in effective practice. Program evaluation expertise is also needed to assist community programs to design and report on solid evaluations that build the evidence base on infant mental health best practices and share results with policymakers.

Build Public Awareness

Psychologists are credible experts who can be a voice for babies in public policy discussions and in raising public awareness about infant mental health and social–emotional wellness. Testimony and letters of support from professionals justifying a policy action with scientifically sound information can make a difference in developing policies that actually have a positive impact on children and families. For instance, testimony to Congress by child development experts about the importance of reliable methods of tracking and assessing children’s development led to language in the most recent Head Start re-authorization requiring that programs use “standardized developmental assessment tools” to monitor children’s development. Psychologists can play an important role in educating policymakers and opinion leaders, individually and through their professional organizations. The Children, Youth, and Families Committee provides leadership on these issues within the American Psychological Association.

Raising public awareness is also important in garnering public support for investment in early childhood mental health and in overcoming the stigma of seeking mental health services. Letters to the editor of the local newspaper and participation in community forums on health issues are just two ways that mental health professionals can be a voice for babies and encourage mental wellness in the community.

Contribute Mental Health Expertise to Community Partnerships

Cross-disciplinary efforts to promote community health need the expertise and perspective of mental health professionals who understand the conditions that promote early childhood development and mental wellness. The public health approach to infant mental health suggests infusing mental health supports throughout the community in the places that infants, toddlers, and their families have contact with child and family services—in early education and child care settings, in health services, and in child welfare services among others. Population-based public health approaches address a broad spectrum of issues that ultimately affect developmental outcomes for infants and toddlers—from community violence, to substance abuse, to adult education and job training. Cross-disciplinary collaborations working to advance infant mental health may encounter many barriers, from differences in professional culture and approach, to payment barriers for collaboration or for new treatment strategies. The hard work of identifying these barriers, developing practical and evidence-based so-

lutions, and crafting these solutions in policy language needs the input of professionals who understand the realities of practice. Psychologists who get involved can be a voice for babies in community planning and decision making.

Support Efforts to Improve Access to Mental Health Services

The last area of influence has to do with improving access to evidence-based practices in infant mental health. Two strategies are offered in this article: building a qualified infant mental health workforce and addressing payment policies. To grow the field, psychologists can encourage their professional organizations to support policies that expand access to infant mental health education. Mental health professionals can strengthen professional education curricula for early childhood mental health practitioners through their professional organizations. They can speak out for the need to increase funding for higher education programs that equip psychologists with knowledge of early childhood development and skills in working in multidisciplinary collaborations and become involved in designing and offering training in these areas. Their advocacy can ensure that specialized opportunities to focus on infant and toddler development and mental health are included in training programs in order to expand service capacity.

Reimbursement and payment policies are shaped by commitment of resources and through the development of regulations. Mental health professionals who are active in building public awareness of the need for infant mental health services can help create policy wins that direct increased resources to promote mental wellness and support early childhood mental health services. This advocacy needs to go hand in hand with efforts to shape payment and reimbursement policies and regulations so that infant mental health providers are adequately compensated for their services and access is not denied to children and families because of inability to pay. Psychologists can be effective advocates by sharing their own experiences with the payment system and the experiences of their clients in securing services.

Getting Started

For those who need a starting place, resources for becoming informed are available through a number of policy centers and projects. The American Psychological Association has a website dedicated to children’s mental health policy issues (<http://www.apa.org/pi/families/children-mental-health.aspx>). Other resources include the National Center for Children in Poverty (www.nccp.org), Georgetown University Center for Child and Human Development—National Technical Assistance Center for Children’s Mental Health (<http://gucchd.georgetown.edu>), National Scientific Council on the Developing Child (<http://developingchild.harvard.edu>), and ZERO TO THREE (www.zerotothree.org/policy).

Policymakers need input and welcome it from professionals to help them make the best decisions for infants, toddlers, and their families. Public policies can reflect our

knowledge of best practice if psychologists are engaged in the policy process at the federal, state, and local levels. Now is the time to capitalize on the growing public awareness that an investment in the health and mental wellness of our youngest children can have lasting benefits to society. We have made important strides but still have much to do as we work to support the social-emotional health of infants and their families today and into the future.

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