UAIMH Newsletter

Utah Association for Infant Mental Health

(Issue 25, Fall 2016)

Editor: Ilse DeKoeyer-Laros
Technical Editor: Mary Ellen Heiner

http://www.uaimh.org

President's Corner

Dr. Kristina Hindert, UAIMH's first President, recently commented that we are entering a new era in Infant and Early Childhood Mental Health (IECMH) in Utah. I agree! In this Newsletter, you will learn more about the exciting developments that have been happening recently and some that are on the horizon. In order to look forward to our future, we have to know our history. Therefore, Susan Dickinson, Past President of UAIMH, has written a brief history of the IECMH movement in Utah.

Dr. Hindert made her remark at a meeting (held on October 11) that was focused on discussing a system of IECMH competencies and endorsements. Attendees included representatives of major organizations and professions working with infants, young children, and their families. These professionals from childcare, Head Start, Early Intervention, Home Visiting, pediatrics, mental health organizations, and other relevant organizations, frequently encounter situations in which parents are struggling with social-emotional concerns in their infants and young children; in which parents are dealing with trauma histories and have a hard time parenting their young children; or in which young children are at risk of being expelled from their preschools or daycare centers. Working with such families requires specialized knowledge (e.g., attachment theory, effects of trauma, and IECMH interventions), as well as specialized skills (e.g., observational skills, communication skills, skills in screening and assessment, and intervention skills). This Newsletter includes a brief overview of two major systems of IECMH competencies and endorsements that would support professional development and a recognition of the importance of IECMH in Utah.

Another exciting development in IECMH is the State Systemic Improvement Plan (SSIP) at the Baby Watch Early Intervention Program (BWEIP). Two pioneers in IECMH in Utah (Janet Wade and Susan Ord) were both at BWEIP in the early 2000s and recognized a need for improving practice and professional development related IECMH. Now, the SSIP project focuses on improving social-emotional outcomes in young children, thus supporting improved IECMH and better developmental outcomes. In this Newsletter, Catherine Hoelscher informs us of the current state of this SSIP project.

Increased interest in early social-emotional development, toxic stress, and IECMH is also coming from the medical professions. For example, Dr. Cosgrove, immediate Past President of the Utah Chapter of the American Academy of Pediatrics, is actively involved in the early childhood community in Utah to improve services and professional development that would support the social-emotional health of children and families. Also, in May of this year, I gave a Grand Rounds for the Family Medicine department at the University of Utah about IECMH. In this Newsletter, I summarize this presentation, which was well received. In September, I presented on prenatal anxiety and stress for about 100 nurses and other professionals at the Intermountain Healthcare Women & Newborns conference. My presentation was followed by a presentation by Amy-Rose White, LCSW, who leads the Utah Maternal Mental Health Collaborative (UMMHC), which provides training and advocacy related to perinatal mental health in mothers, and is an integral part of IECMH that needs to be addressed in order to support optimal development in infants.

This space is too short to list all the IECMH-related projects and efforts in Utah. Many individuals and organizations are involved in this movement and it is not possible to list all of them here. For instance, I have not mentioned that UAIMH members (and EC Utah members) were involved in panel discussions for a series on the Raising of America by the Utah Education Network (UEN), led by Lisa Cohne. This

(continued...)

Contents

series is now being broadcast by UEN. Currently, I am co-organizing an event around The Raising of America offered by the University of Utah Departments of Psychology and Family and Consumer Studies. In short, many things are happening all at once. We are part of a movement, and I hope you will join us!

Ilse DeKoeyer-Laros, Ph.D.
President, Utah Association for Infant Mental Health
Assistant Professor (Lecturer), University of Utah Psychology Department
Child Development Specialist, Help Me Grow Utah

Brief History of Utah Association for Infant Mental Health

In the late 1960s, Selma Fraiberg pioneered work in the critical importance of the infant-parent/caregiver relationship to all learning and development. With her Michigan colleagues she coined the term "infant mental health" (Fraiberg, 1959, 1977, 1980).

Infant mental health is reflected in the infant/child's functioning in appropriate cognitive, social, emotional and physical development. It develops and changes within the context of relationships between infants, parents, caregivers, families, communities, and cultures. In 2001, the Zero to Three Task Force on Infant Mental Health defined infant mental health as the developing capacity of the child from birth to three to: experience, regulate, and express emotions; form close and secure interpersonal relationships; and explore the environment and learn in the context of family, community and cultural expectations for young children.

In May of 2001, Janet Wade of the Baby Watch Early Intervention Project (BWEIP) took action under the leadership of Susan Ord, Director of the BWEIP at the Utah Department of Health. Together, they organized a two-day conference in Salt Lake City for a multidisciplinary group: *Expanding Options for Infant-Toddler Mental Health Interagency Committee*. The purpose was to address the lack of understanding and resources in the field of infant mental health in Utah. The high interest and building commitment following the meeting lead to writing and publishing an Infant Mental Resource Manual under the direction of Susan Ord and Janet Wade.

Infant Mental Health develops and changes within the context of relationships between infants, parents, caregivers, families, communities, and cultures.

The Utah Association for Infant Mental Health (UAIMH) was then established by Janet Wade in 2002-03 to bring awareness of infant mental health to the forefront in pediatric care, child care, and other service delivery. Founding Board members were: Adrienne Akers, M.S., R.P.T.; Glenna Cooper Boyce, Ph.D.; Ilse DeKoeyer-Laros, Ph.D.; Mark Innocenti, Ph.D.; Aziele Jenson, M.Ed.; Janice McCaffrey, M.S.W., Nick Tsandes, L.C.S.W., and Kristina Hindert, M.D., our founding President. A list of all past presidents will be included in extensive UAIMH history soon to be available on www.UAIMH.org

Janet Wade acted as Executive Secretary and assumed administrative duties. She connected with infant mental health specialists from around the country, including Mimi Graham from Florida, and worked with the World Association for Infant Mental Health (www.waimh.org) to seek WAIMH affiliation status which was awarded in 2004. Since then, UAIMH has been an affiliate of the World Association. Janet also spearheaded work on UAIMH's Bylaws. UAIMH worked with Brian Miller, Ph.D., of State Mental Health and the Utah Department of Health to establish Best Practices, after the mission, aims, and vision had been developed. UAIMH's founding Mission Statement was:

The Utah Association for Infant Mental Health (UAIMH) was then established by Janet Wade in 2002-03 to bring awareness of infant mental health to the forefront....

> *To promote a unified understanding of infant mental health across disciplines and programs and to develop a statewide system of resources in support of infant mental health for all families living in Utah.*

The original age range included in the definition of Infant Mental Health (originating in Michigan) was 0 to 3. However, UAIMH decided in the beginning that this age range needed to be expanded to 0 to 5, as knowledge, skills, and services were also lacking for preschool children aged 4 and 5 years old. Nationally, infant mental health is now referred to as Infant and Early Childhood Mental Health (IECMH) with age coverage from 0 to 5.

One of our main aims has always been "to disseminate research and to educate health care professionals who study and/or care for infants." In line with this, we have always disseminated research-based knowledge, in two main ways: (1) via our Newsletter and (2) via "mini-conferences" and

(continued...)

other trainings. The first Newsletter came out in 2003 and Ilse DeKoeyer-Laros was the main Editor until about 2007. During this time, Judith Ahrano, M.D., became involved with the Newsletter. Dr. Ahrano became the main Editor in 2009, making significant changes and bringing the Newsletter to a new level.

UAIMH has participated in four of the *Summer Institutes* that were organized by the University of Utah's School of Social Work, offering coursework in Infant Mental Health. The first course at the 21st Institute was *The Parent-Child Relationship: Developing an Advanced Skill Base in Working with Very Young Children and their Families* and was received by 31 participants from different agencies and groups, including Baby Watch Early Intervention, Head Start, Adoption, Home Care, DCFS, and Odyssey House.

Dr. Ahrano was a main presenter at these Summer Institutes, and UAIMH was extremely fortunate to have her involved in the important work of spreading knowledge and awareness about the field of Infant Mental Health. Dr. Ahrano, as a pediatrician, was able to connect UAIMH to the pediatric community and represent us at the yearly *Common Problems in Pediatrics* conference. She became UAIMH President in 2010 and has continued to advocate for IMH and to be the Newsletter Editor for many years since.

State and community education is not only provided by the UAIMH Newsletter, published twice a year, but also via the UAIMH website and Facebook. UAIMH is also actively engaged in the community, for instance by being an active part of the Early Childhood Utah Council and by engaging in community events. For example, we organized the first screening of the Signature Hour of *The Raising of America* in April 2015, prior to the PBS showing of this documentary.

UAIMH was extremely fortunate to have Dr. Ahrano involved in the important work of spreading knowledge and awareness about the field of Infant Mental Health.

A complete list of UAIMH's past conferences/workshops will be published on our website, but here are a few examples:

- A Mini Conference by Suzi Tortora, Ph.D., entitled: *Enhancing Physical, Cognitive, and Social/Emotional Development*. UAIMH will be sponsoring Dr. Tortora for a 2017 event!
- *Military Families and Mental Health: Raising Young Children in Face of Uncertainty and Separation* by Vonda Jump, Ph.D.
- A *Conscious Parenting* workshop by Shefali Tsabary, Ph.D.

UAIMH members have presented at regional conferences as well. For example, Susan Dickinson, Past President, has presented on *Reflective Supervision* at the Early Childhood Education Conference. And Ilse DeKoeyer-Laros, Ph.D., has presented at various events, including the annual *Critical Issues Facing Children and Adolescents* conference, the *Home Visiting Conference*, and the *Grand Rounds in Family Medicine*. UAIMH members also participated in Panel Discussions of *The Raising of America* series that were recorded for the *Early Childhood Critical Issues* series of the *Utah Education Network* (UEN). Vonda Jump, PhD, has even presented a TED Talk!

UAIMH has established working relationships with BWEIP, Intermountain Pediatrics, the Utah Maternal Mental Health Collaboration, and Early Childhood Utah (EC Utah). Ilse DeKoeyer-Laros, Ph.D., current UAIMH president, is co-chair with Alda Jones of the EC Utah Social Emotional Subcommittee.

UAIMH conducts annual meetings and regular meetings throughout the year to address current and long-term goals. All of you are welcome to these meetings and to join our efforts to increase awareness, knowledge, and acknowledgement of IECMH across the entire state of Utah. For membership information, see the bottom of this Newsletter. Please visit www.UAIMH.org to find documentation referred to in this article, and visit https://www.facebook.com/UtahIMH to follow us on Facebook!

Susan L. Dickinson, UAIMH Historian and Past President
Psychological Consultant to South East Early Intervention
Consultant on Doctorow Grant

Infant and Early Childhood Mental Health Competencies and Endorsements: Which System is Right for Utah?

Throughout the United States, various systems have been developed to outline a list of such competencies for professionals at different levels and in different settings. The oldest system is the one developed by the Michigan Association for Infant Mental Health (the first Association for Infant Mental Health in the U.S. and in the world).

The "Michigan system," operated by the Alliance for the Advancement of Infant Mental Health, offers a system of

(continued...)

IECMH competencies and endorsement options for four levels of professionals. At *Level I*, Infant-Family Associates work directly with infants, toddlers, and their caregivers. Their education is at the Associate's or CDA level or higher (two years of relevant work experience can count as well). This includes childcare teachers, for example. At *Level II*, Infant-Family Specialists have a Bachelor's or graduate degree as well as relevant work experience. These professionals can be in various fields, such as nursing, social work, or education. Infant Mental Health Specialists are professionals at *Level III* of the Michigan system and they are typically licensed mental health professionals with training and experience in IECMH. But medical doctors and others with advanced training and experience can also be in this category. Finally, *Level IV* professionals are Infant Mental Health Mentors who provide Reflective Supervision to professionals at Levels II-IV. Mentors can operate in three areas: Clinical, Policy, and/or Research/Faculty. Their educational background ranges from Bachelor's to MD level degrees and they also need relevant training, experience, and expertise. Clinical Mentors are also required to receive Reflective Supervision. Mentors are typically in leadership positions. The entire model is relationship-based, such that a basic assumption is that professionals need to provide support and mentorship to each other, so that every professional in this field feels comfortable and supported enough to be able to provide support and professional guidance (at different levels) to the families and young children they are serving. The Michigan system has now been adopted by 25 states and countries and several others are actively exploring this model. This model does require a fee to purchase access to the system, along with technical assistance to implement the system and use of their electronic submission system.

The "Michigan system"…offers a system of IECMH competencies and endorsement options for four levels of professionals.

Other systems have been developed by working groups in many states (e.g., Colorado, Florida, and …). In most cases, these working groups have found that it takes an extraordinary amount of time, effort, and organization to develop a system that can easily be implemented and maintained. The majority of these states eventually decided to choose the Michigan model, because it has been organized so well and comes "pre-packaged" with content, training, and tech support. Only one other system is considered for implementation in Utah, and this is the endorsement system that was developed in California. UAIMH learned about this system recently, during a meeting with Karen Moran Finello, Ph.D., who helped developed the California Endorsement system. This system was developed in parallel with the one in Michigan and in collaboration with IMH pioneers like Jeree Pawl. California chose to develop its own system due to the large cultural diversity in their state and a desire to serve children up to age 5 (59 months). Similar to the Michigan system, the California system offers competencies for professionals at different levels of employment and in varying professions, with reflective practice at the top levels. *Transdisciplinary Infant-Family Early Childhood Mental Health Practitioners* are the first category. This level includes professionals who provide direct services in their field to pregnant women, infants, toddlers, preschoolers and their families. *Advanced Transdisciplinary Infant-Family and Early Childhood Mental Health Practitioners* have a Master's degree or higher in a relevant field and a minimum of 8 years of direct experience with infants and young children. *Infant-Family and Early Childhood Mental Health Specialists* include providers with a Master's degree or higher who provide prenatal, infant-family, and early childhood mental health services within their scope of practice. They also have a professional license or relevant credential. Instead of reflective supervision, the California system uses the term *"Reflective Practice Facilitator."* There are two levels of these professionals, who must also qualify for one of the more basic endorsements and can provide reflective practice facilitation. At the highest level is the *Reflective Practice Mentor,* who must also qualify as Reflective Practice Facilitator and be able to train and support Reflective Practice Facilitators. These professionals operate in leadership positions and facilitate professional development and training of others. The California system focuses on a wider age range than the Michigan model. Professionals can choose to be endorsed in the prenatal through age 3 period, the 3-5 years' period, or the entire period between the prenatal period and 5 years (59 months) of age. The competencies are available at no cost online.

Only one other system is considered for implementation in Utah, and this is the endorsement system that was developed in California.

Adopting one of these systems will be a big step forward for IECMH in Utah. It will give us guidance for education and professional development of our workforce working with pregnant mothers, infants, toddlers, preschool-aged

(continued...)

Adopting one of these systems will be a big step forward for IECMH in Utah.

children, and their families. It will provide validation of the knowledge and skills already present in our state. And it will help to promote healthy social-emotional development of infants and young children in Utah and to provide skillful proactive intervention, as well as more specialized treatment of IECMH problems. Overall, such a system will raise more awareness in the general public and within the professional workforce of the importance of supporting optimal mental health in the earliest months and years of life (and of supporting the people who work in this field)!

Ilse DeKoeyer-Laros, Ph.D.
President, Utah Association for Infant Mental Health
Assistant Professor (Lecturer), University of Utah Psychology Department
Child Development Specialist, Help Me Grow Utah

Baby Watch Early Intervention Focuses on Social Emotional Outcomes

The Baby Watch Early Intervention Program (BWEIP) conducted a day long State Systemic Improvement Plan (SSIP) Stakeholder's meeting in June, 2016. The stakeholders included early intervention (EI) parents, Interagency Coordinating Council (ICC) members, early intervention administrators, and service providers. The SSIP 5-year child and family outcomes improvement plan is mandated by the Office of Special Education Programs (OSEP) to all states. The BWEIP improvement plan is focusing on improving social emotional outcomes for children from all backgrounds and who receive early intervention services. Evidence supports that social emotional development is the foundation for long-term life successes and positive outcomes.

The BWEIP improvement plan is focusing on improving social emotional outcomes for children from all backgrounds and who receive early intervention services.

Christina Kasprzak, Director of Early Childhood Technical Assistance (ECTA) Center; Ilse Dekoeyer-Laros, President of Utah Association of Infant Mental Health; Karen Moran Finello, Co-Lead NCSI Social Emotional Community of Practice; and Catherine Hoelscher, Baby Watch Program Coordinator, reviewed Phase I (selection of the Social Emotional Focus) and Phase II (details of the implementation and evaluation plans for the four strands-ssessment, professional development, family engagement and community collaboration) of the SSIP. The majority of the June SSIP Stakeholders meeting focused on aspects of social emotional referrals from families and health care providers, social emotional assessments and screeners, social emotional Individualized Family Service Plans (IFSP) outcomes, and weaving social emotional strategies into IFSPs.

The attendees determined that several new work teams should be formed in order to carry out implementation and evaluation plans.

The attendees determined that several new work teams should be formed in order to carry out implementation and evaluation plans. The identified Work Teams Include:

1. Social Emotional Child Find Referral Education (public/professional)
2. Social Emotional Assessments/Screeners
3. Writing Social Emotional IFSP Outcomes
4. Evidence Informed Relationship Based EI Practices
5. Diverse Communities Outreach and Resources
6. Quality Compliance (contracting site visits)

BWEIP would like to extend an invitation to UAIMH to join us in this work. Please contact Catherine Hoelscher choelsch@utah.gov 801-273-2886 or Lisa Davenport lisadavenport@utah.gov 801-273-2899 if you would like more information on the SSIP and the Social Emotional Work Teams.

Catherine Hoelscher
Baby Watch Program Coordinator

Infant and Early Childhood Mental Health Problems: Will They "Grow Out of It?"

"Developmental and behavioral health disorders are now the top five chronic pediatric conditions causing functional impairment," according to a recent article in *Pediatrics* (Weitzman et al., 2015). Weitzman and colleagues suggest that there is a 2- to 4-year window before a diagnosable disorder arises, in which symptoms begin to occur. Within this time

(continued...)

frame, we could offer proactive interventions that could reduce the number of children who develop diagnosable disorders. But how early can we see signs of mental health disorders?

"Developmental and behavioral health disorders are now the top five chronic pediatric conditions causing functional impairment..."

Challenges in Assessment, Diagnosis, Treatment, and Research

Young children develop so fast. Within the course of several weeks, even days, they can develop an entirely new skill or get much better at a skill they had already achieved. So when infants and young children show the beginnings of social-emotional problems, parents often wonder: "Is that normal for this age?" or "Will she grow out of it?"

Young children not only experience fast developmental changes, but also many moment-to-moment changes: happy one moment, obstinate the next; full of energy one moment, tired the next; or secure one moment, fearful the next. This changeability makes it challenging to do assessments with young children and to do research (Ozonoff, 2015). An additional barrier is a reluctance to apply diagnostic labels to young children. With so much future ahead, and possibilities of misdiagnosis and also of "growing out of it," many parents (and professionals) hesitate to have a young child assessed and possibly diagnosed. Lastly, there is still a lack of mental health professionals who are specialized in the assessment, diagnosis, and treatment of young children and their family.

...parents often wonder: "Is that normal for this age?" or "Will she grow out of it?"

Can Young Children Have Mental Health Disorders?

Can young children, including infants, have concerns that rise to the level of a diagnosable mental health disorder? From a developmental psychopathology perspective, all children encounter risk factors and protective factors in their development. The more risk factors a child encounters, the more likely that development will derail. Protective factors can protect against any ill effects of risk factors. In this view, abnormal development is just a deviance from normal development and it can get back on the rails by strengthening protective factors and reducing risk factors. This process may include support for the child and family, as well as more specialized interventions.

Within clinical practice, clinicians do encounter young children who show sufficient symptoms to meet criteria for a diagnosable disorder. However, diagnostic systems that are commonly utilized (the DSM-5 and the ICD-10) do not offer a lot of diagnoses that are specific to young children. Autism Spectrum Disorders is one exception. Attachment-related disorders are also diagnosable in young children. *Zero To Three* has a diagnostic manual called *Diagnostic Classification* 0-3™ or DC 0-3™ for short (1994). In December 2016, a revised version for the age range 0 to 5 is expected (DC: 0–5™). The DC 0-3™ was specifically developed for infants and toddlers and includes unique diagnoses, such as Relationship Disorders and Regulatory Disorders. However, this system has not been sufficiently researched to be found reliable and valid.

What is the Scope of IECMH Problems?

Studies of IECMH disorders have been conducted in the U.S. and internationally, often using traditional diagnostic classification systems, such as the DSM (sometimes in combination with the DC 0-3™). The prevalence of preschool psychiatric disorders has been estimated by these studies to vary between 7-27% of children age 5 and under. The lowest rate (7%) has been found in Norway in a large population-based study (n = 2,475; Skovgaard et al., 2007). The highest rate (27%) has been found in New York City (community sample; n = 362; Bufferd, Dougherty, Carlson, Rose, & Klein, 2012).

The prevalence of preschool psychiatric disorders has been estimated by these studies to vary between 7-27% of children age 5 and under.

Research with the youngest participants has found that diagnosable problems can even be present in infants and toddlers. One study looked at 306 infants, randomly selected from a Danish cohort (N = 2,155). The researchers used standardized measures and clinical assessments by psychologists and psychiatrists, using the DC:0-3™ or ICD-10. They found that about 17% of 1½-year-olds qualified for a Mental Health diagnosis (Skovgaard et al., 2007). Most common were emotional and behavioral disturbances, eating problems, and regulatory disorders. Eight percent of infants showed parent-child relationship problems (as assessed via

(continued...)

...about 17% of 1½-year-olds qualified for a Mental Health diagnosis...

the DC 0-3™. The risk for disorders was three times higher when the family faced high psychosocial risk (OR 3.1) and five times higher with disturbed parent-child relationships (OR 5.1). Psychosocial risk included low parent education level, crowded living circumstances, parental MH disorders, delinquency, broken home history, marital discord, lack of social support, chronic difficulties, poor coping skills, single parent, early parenthood, and having had an unwanted pregnancy.

A Dutch cohort study (*N* = 6,330) used parent reports of infants aged 14 to 15 months to learn about the prevalence of communication and behavior problems (Moericke, Lappenschaar, Swinkels, Rommelse, & Buitelaar, 2013, 2014). One third (33%) of infants showed some problems in their behavior or communication. These included severe communication and interaction problems (5.7%), moderate communication problems (16.4%), or severe negative and demanding behavior (10.8%). In a follow-up study at 36 months (*N* = 4,237), infants with severe problems at 14 to 15 months showed mild to severe problems at age 3. Negative and demanding behaviors improved more than communication and interaction problems did, probably because such behaviors are relatively normal at the toddler stage. Out of the infants with moderate communication problems, 85% showed near-normal behavior at age 3. This suggests that most infants caught on their communication skills by age 3. However, since communication and interaction problems were more stable, it is recommendable to screen children for such problems and to either monitor them or offer appropriate interventions.

Children who qualified for a diagnosis at age 3 were almost 5 times more likely to have a diagnosis at age 6....

A Canadian birth cohort (*N* = 2,045) showed stability of disruptive behaviors between ages 1½ and 5 (Carbonneau, Boivin, Brendgen, Nagin, & Tremblay, 2016). Home interviews with parents were done every year between ages 1½ and 5. This sample was mostly higher educated, White, middle to high socioeconomic status (SES), and two-parent families, so it is not representative for other groups. This study investigated three patterns of disruptive behaviors: hyperactivity-impulsivity, noncompliance, and physical aggression. Over 50% of children showed moderate trajectories for all three patterns, which indicates that moderate levels of these behaviors are normal for this age. However, there was also a group of 14-21% of children (mostly boys) who showed consistently high levels of these disruptive behaviors. In first grade, their teachers rated these children as highest on disruptive behaviors and lowest on language and cognitive skills. When children showed high hyperactivity/impulsivity *and* high physical aggression, this *always* went with high noncompliance. In other words, if both hyperactivity and physical aggression are present, interventions are called for. In the entire sample, 14% show high levels hyperactivity-impulsivity (17% of boys); 16% showed high for physical aggression (21% of boys); and 20.5% showed high levels of noncompliance (23% of boys). Although all of these behaviors are normal in the preschool years, high levels of these are likely to stay high as the child develops.

...there was also a group of 14-21% of children...who showed consistently high levels of these disruptive behaviors.

Psychiatric DSM-IV disorders were studied between ages 3 and 6 in a community sample of 362 children in New York (Bufferd et al., 2012). The parents were interviewed by trained graduate students or Master's level professionals in psychology. At each age (3 and 6), about 27% qualified for any disorder. There was significant continuity for anxiety, ADHD, and Oppositional Defiant Disorder (ODD); 14% of the sample met criteria for a diagnosis at both ages. Children who qualified for a diagnosis at age 3 were almost 5 times more likely to have a diagnosis at age 6 and half of those who received a diagnosis at age 6 also met criteria for a diagnosis at age 3. This study shows that, even though many children no longer qualified for a diagnosis 3 years later, a sizable number continued to show clinically significant symptoms. This underlines the importance of early identification and intervention.

IECMH in Practice

In practice, many young children go undiagnosed. Even when diagnosed, only a small minority receives appropriate services. In a study done in Norway, only about 10% of 4-year-olds (and 25% of 7-year-olds) with behavioral or emotional disorders received services. More services were used when the impairment was greater and when families were of low socioeconomic status. In the U.S., use of services

(continued...)

may be even lower (3% in one study of 4-year-olds). Besides the abovementioned issues around early identification and diagnosis, such as fear of stigma, it is clear that there is also a lack of services that are available and accessible to families.

IECMH does not only refer to diagnosable disorders. Young children can also show subclinical levels of problem behaviors, especially when they experience risk factors like low socioeconomic status of their family, toxic stress (e.g., from family conflict, community violence, or parental MH issues), parental characteristics (age, education, knowledge of child development, and "ghosts in the nursery"), and biological risk factors in the child. It is important to reduce these risk factors as much as possible, and also to build protective factors (as promoted by the Strengthening Families/Protective Factors Framework).

It is important to reduce these risk factors as much as possible, and also to build protective factors....

Promoting IECMH

Based on the research described above, it is essential to promote awareness of and education in IECMH for *all* families. Campaigns such as *Text 4 Baby* and *Vroom* are modern ways to bring research knowledge to parents. Online, *Zero to Three*, Infant Mental Health Associations, and other organizations are increasingly posting resources (such as videos, handouts, and the like) that can be used to educate parents and professionals.

In Utah, *Help Me Grow* offers universal support, information, and developmental screening for all families who are expecting a baby or who have a child between 0 and 8 years old. Developmental screening, especially with the Ages and Stages Social-Emotional, can indicate which children are more at risk in their social-emotional development and which of these children might need more intensive interventions that are offered by home visiting programs, early intervention, specialized mental health clinicians, and others. The Utah Association for Infant Mental Health will continue to spread awareness about and advocate for improved IECMH for all of young children and families, so that our children can have the best basis possible for their future mental health.

Developmental screening, especially with the Ages and Stages Social-Emotional, can indicate which children are more at risk in their social-emotional development and which of these children might need more intensive interventions....

References

Bufferd, S.J., Dougherty, L.R., Carlson, G.A., Rose, S., & Klein, D.N. (2012). Psychiatric disorders in preschoolers: Continuity from ages 3 to 6. *American Journal of Psychiatry, 169,* 1157-1164.

Carbonneau, R., Boivin, M., Brendgen, M., Nagin, D., & Tremblay, R.E. (2016). Comorbid development of disruptive behaviors from age 1½ to 5 years in a population birth-cohort and association with school adjustment in first grade. *Journal of Abnormal Child Psychology, 44,* 677-690.

Moericke, E., Lappenschaar, G.A.M., Swinkels, S.H.N., Rommelse, N.N.J., & Buitelaar, J.K. (2013). Latent class analysis reveals five homogeneous behavioural and developmental profiles in a large Dutch population sample of infants aged 14–15 months. *European Child & Adolescent Psychiatry, 22,* 103–115.

Moericke, E., Lappenschaar, G.A.M., Swinkels, S.H.N., Rommelse, N.N.J., & Buitelaar, J.K. (2014). Different stability of social-communication problems and negative demanding behaviour from infancy to toddlerhood in a large Dutch population sample. *Child and Adolescent Psychiatry and Mental Health, 8:* 19.

Ozonoff, S. (2015). Editorial: Early detection of mental health and neurodevelopmental disorders: the ethical challenges of a field in its infancy. *Journal of Child Psychology and Psychiatry, 56,* 933-935.

Skovgaard, A.M., et al. (2007). The prevalence of mental health problems in children 1½ years of age – the Copenhagen Child Cohort 2000. *Journal of Child Psychology and Psychiatry, 48,* 62-70.

Weitzman et al. (2015). Promoting optimal development: Screening for behavioral and emotional problems. *Pediatrics, 135,* 384-389.

Ilse DeKoeyer-Laros, Ph.D.
President, Utah Association for Infant Mental Health
Assistant Professor (Lecturer), University of Utah Psychology Department
Child Development Specialist, Help Me Grow Utah

Announcements/Upcoming Events

November 3-4, 2016, Hilton Salt Lake City Center: Critical Issues Facing Children and Adolescents Conference. Focus is on the critical behavioral health and addiction issues that are impacting children ages 0-18 years and their families. Special emphasis will be placed on helping professions, such as mental health, medicine, nursing, social work, psychology, psychiatry, pediatrics, and others, who are dealing with youth on a regular basis. Topics will include Aggression, DBT, Brain Development, Problem Behavior, Anxiety, Social Emotional Learning Skills, Mindfulness, as well as many others. UAIMH is presenting a poster about IECMH in Utah.

SAVE THE DATE: February 9-10, 2017, Bridging the Gap Annual Conference, Salt Lake Public Library, 200 E 400 S, Salt Lake City, UT. Please check The Children's Center website at: http://www.tccslc.org

SAVE THE DATE: February 25, 2017, 42nd Annual Utah Early Childhood Conference, Weber State University, Ogden, Utah. Please see www.utahearlychildhoodconference.com for registration information.

UAIMH on Facebook

You can find UAIMH on Facebook at https://www.facebook.com/UtahIMH or visit us on our website at http://www.uaimh.org

You can join UAIMH for only $10/year:

1. Click on the "Join UAIMH" link on the left side of your screen and complete the *Membership Application and Questionnaire Form* on the UAIMH website.

2. Print and mail your membership form with your check for $10 made payable to UAIMH to:

   Janet Wade, Treasurer
   c/o The Children's Center
   350 S. 400 E.
   Salt Lake City, UT 84111