Action Area: Maternal & Infant/Early Childhood Mental Health
September 26, 2019

Infant Mental Health Definition: The developing capacity of the child from birth to five years of age to: form close and secure relationships, experience, manage and express a full range of emotions, and explore the environment and learn - all in the context of family, community and culture.

Statement of Need:

The first 1,000 days of life are a critical time when babies require positive, protective, and nurturing relationships with their parents (and/or primary caregivers) for healthy development. Across the U.S., infants and young children are among the most likely people to experience poverty and abuse or neglect. Babies and young children who are exposed to maternal depression and family other mental health challenges, parental substance use disorders, homelessness, family chaos, and/or disrupted relationships often experience "toxic stress" which causes suffering, pain, and fear which can have a long-term negative impact on the developing brain and body. Babies and young children may demonstrate serious behavior challenges, emotional and regulatory disorders, and/or insecure/disorganized attachment– all which place the child at heightened risk for developmental delays, health problems, cognitive impairment, and lowered rates of school success.

Babies and young children under age 6 years have a similar rate of mental illness as older children and youth (14% to 20%), although they are diagnosed and treated at significantly lower rates.

Maternal depression is highlighted as a significant risk for young children's healthy development given the critical connections between nurturing relationships and brain development. During the early years, maternal depression is common (approximately 20% of pregnant and postpartum women). This has an impact on both the mother and the child(ren) when left undetected and untreated.

Maternal depression and infant/early childhood mental health disorders are responsive to treatment. Effective treatments include reducing stressors, addressing individual mental health issues, and building a healthy and stable relationship between parents/caregivers and children through evidence-based dyadic therapies.

In Rhode Island in 2018, 1,972 (4%) of Medicaid covered children under age 3 and 4,901 (11%) of Medicaid covered children ages 3 through 5 received mental health services.

National Guidance:

- **Medicaid agencies are authorized to cover:** Maternal **depression screening as part of a well-child visit** under the Early Periodic Screening Diagnosis and Treatment provision (EPSDT).

- Medically necessary treatment for the child resulting from the impacts of maternal depression, including **parent-child psychotherapy**, can be billed through the child's Medicaid.

- The **American College of Obstetricians and Gynecologists (ACOG)** recommends that all pregnant women be screened for depression at least once using a valid and reliable tool.

- The **American Academy of Pediatrics (AAP)** recommends pediatric health care providers conduct universal, routine maternal/caregiver depression screening using a valid and reliable tool at recommended intervals and receive training and support to offer effective feedback to parents and refer to follow up services as needed.

- The American Academy of Pediatrics recommends that all infants and young children **receive regular, routine screenings for social-emotional health as part of developmental screening** with referral to Early Intervention and/or specialists for follow-up evaluation and treatment.

- **The US Preventative Services Task Force (USPSTF)** recommends that all pregnant and postpartum women be screened for depression and those with risk factors be referred for treatment.

- ZERO TO THREE and the Alliance of Infant Mental Health recommend that mental health providers use the **DC: 0-5 -- Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood**, a specially developed diagnostic tool to diagnose and treat mental health problems in the earliest years. The tool identifies and describes disorders in a developmentally appropriate way that is lacking in other classification systems, incorporates relational factors associated with early symptoms, and points the way to effective intervention approaches.

- Build awareness and **promote treatment through dyadic therapies** to improve parent-child interactions and strengthen relationships that are the building blocks for brain development. As of November 2018, 42 states cover dyadic treatment of young children and parents and 12 states require providers to use an evidence-based dyadic treatment model.

State Examples:

- As of November 2018, there were **32 states reporting Medicaid coverage** for **maternal depression screening** during pediatric or family medicine visits under the child's Medicaid insurance, up from 11 states in 2017.

- In Texas, in response to findings that **mental health disorders were causing a significant increase in maternal mortality**, a state law was passed requiring pediatric care providers serving Medicaid patients to provide maternal depression screening at well-baby visits, and develop a service referral plan with mothers who need follow-up evaluation and/or treatment.

- As of November 2018, there were **5 states (AZ, CO, MI, MN, and OR) that recommend and 1 state that requires (NV) the use of the DC: 0-5 diagnostic tool** to identify and understand mental health conditions that occur in children ages birth to five. Six states have issued guidance and a crosswalk linking DC: 0-5 codes to ICD codes and support provider training to facilitate the use of the tool.

- Minnesota's Medicaid office recommends the use of DC: 0 to 5 for children under age 5 in Medicaid and allows for up to three sessions for diagnosis. They have offered extensive trainings for clinicians and higher education faculty and support monthly consultation meetings.

- The Oregon Medicaid office has recently updated their DC: 0-5 crosswalk. They have developed and are implementing a communications plan to ensure providers know that young children can be accurately identified and diagnosed, and effective treatments are available for very young children.

Recommendations for Rhode Island Medicaid Office adopted by the Maternal, Infant, and Early Childhood Action Area Group:

Maternal Depression:

- Issue guidance and use incentives to ensure that pediatric providers follow the guidelines recommended by the AAP and **screen caregivers for depression at the 1, 2, 4, and 6 month well-child visits** using either the EPDS or PHQ 9 or PHQ2 tools.

- Issue guidance and use incentives to ensure that obstetric providers **screen pregnant women at least once (some recommend screening in each trimester) and at the 6 week postpartum visit** using the EPDS or PHQ 9 or PHQ2 tools.

- Ensure that all RI women have stable health insurance coverage throughout their pregnancy and 12 months following delivery. **Consider extending RIte Care coverage through 12 months post-partum** so women do not have to search for new coverage at 60 days postpartum when approximately 20% are experiencing depression and all are adjusting to having a new child.

Infant/Early Childhood Mental Health:

- Provide guidance, support, and incentives to pediatric providers to conduct psychosocial/behavioral health screenings for children under age 3 as part of the developmental screening in EPSDT.

- In policy, adapt (if needed) and adopt **the national DC: 0 -5 crosswalk** which links DC: 0 -5 diagnostic codes to DSM and ICD-10 codes for billing purposes. Disseminate crosswalk and guidance encouraging use of the developmentally-appropriate diagnostic tool to providers.

- Organize and support **DC: 0-5 trainings** for hospital and community-based clinicians, DCYF caseworkers and providers, preschool special educators, pediatric and primary care providers, and the Early Intervention system to promote the use of the DC: 0-5 tool. Consider collaboration with the RI Association for Infant Mental Health (and regional partners) to facilitate training efforts.

- Develop a **registry of infant/early childhood mental health care providers** and disseminate statewide. Ensure that pediatric health care providers know how to make appropriate referrals for mental health follow-up evaluation and services for infants and toddlers (and young children under age 6). Identify those who are trained to use the DC: 0-5, as well as those who offer dyadic therapies in the registry.

Both Maternal Mental Health and Infant/Early Childhood Mental Health:

- Train and use health navigators to help families with infants and toddlers connect with follow-up treatment needed as the result of a positive findings from caregiver screening for depression and/or positive social-emotional health screenings of children under age six.

Recommendations Beyond Medicaid:

- Support efforts to reduce "toxic stress" by improving family economic security and adult mental health.

- Promote the development of consistent, stable, positive relationships between parents/caregivers and very young children including expanding paid family leave, improving the qualify of infant/toddler child care, and ensuring access to evidence-based family home visiting.

Remaining Considerations/Questions:

1) Some providers are concerned about using DC: 0-5 work with various Electronic Health Records. Many practices do not have any other system (paper or electronic) to keep notes about the actual diagnosis. Other states have problems with this too and some are trying to get EHR systems to include the DC: 0-5 and integrate with a crosswalk to ICD-10 codes. Regardless, training is critical so that insurers are aware of the crosswalk and clinicians are documenting how they're coming to a diagnosis.

2) OHIC and private health insurance providers need to be involved in the decision and support the decision to adopt a state DC:0-5 crosswalk and promote the use of DC:0-5. Providers need the same system for public and private insurers.

3) The World Health Organization has approved the ICD-11 codes which will come into effect in January 2022. We anticipate that the DC: 0-5 national crosswalk would be adapted to map onto these codes.

4) Early Intervention (Part C of IDEA) and preschool special education (Part B, Section 619 of IDEA) are key systems that could provide supportive mental health treatment and services for young children in the context of their families and early childhood programs. Early childhood mental health consultation and KIDS CONNECT are also important services that can be expanded and improved to better support child care and early learning programs.

Action Group:
Leanne Barrett, Rhode Island KIDS COUNT, co-chair
Susan Dickstein, Ph.D., RI Association for Infant Mental Health, co-chair

Libby Bunzli, RI Executive Office of Health and Human Services Medicaid Office
Jennifer Kaufman, RI Early Intervention/IDEA Part C Program
Ruth Gallucci, RI Department of Education, Early Childhood IDEA Special Education
Ailis Clyne MD, Blythe Berger, Jim Beasley, Kristine Campagna, RI Department of Health
Susan Lindberg, Aimee Mitchell, Joe Carr, RI Department of Children, Youth, and Families
Marea Tumber, RI Office of the Health Insurance Commissioner

John Boekamp PhD, Bradley Hospital
Thamara Davis MD, Bradley Hospital
Pat Flanagan MD, Hasbro Children's Hospital/PCMH Kids
Pam High MD, Hasbro Children's Hospital

Margaret Howard PhD, Women & Infants Hospital
Beth Lange MD, Coastal Medical/PCMH Kids
Cynthia Loncar PhD, Women & Infants Hospital
Christine Low PhD, Bradley Hospital
Katherine Partridge PsyD, Bradley Hospital
Rebecca Silver PhD, Bradley Hospital

Leslie Bobrowski, Sherlock Center on Disabilities at Rhode Island College
Simmy Carter, The Providence Center
Carolyn Souza, Looking Upwards

Beth Marootian, Christopher Ottiano MD, Neighborhood Health Plan of Rhode Island
Mary Ricci, Juan Lopera, Tufts Health Plan
Sarah Coutu, Barry Fabius MD, United Health Care