Interprofessional Teams Supporting Early Childhood Mental Health

CONTENTS

INTRODUCTION

Best practice in early intervention includes coordinated intervention to support the family and child within that child's natural environment and to support the child's relationship with the family. Potential collaborators include the family, other healthcare providers, social workers, infant mental health specialists, physicians, caregivers, and preschool teachers. An early intervention service team often consists of an occupational therapist (OT), physical therapist (PT), and speech-language pathologist (SLP). Occupational therapists work in the development of occupations such as play, social participation, and activities of daily living. Physical therapy offers services to address the physical aspects of the child's development, including gross motor development and mobility. Speech-language pathologists focus on verbal and non-verbal communication. Speech pathologists often collaborate with occupational therapists to facilitate feeding and play, while occupational and physical therapists often collaborate to encourage the development of motor skills and positioning for play.[1] Recently, infant mental health specialists have been included on the teams to help support the child-parent relationship.

Family-centered and relationship-based care is all about relationships.[2] Supporting young children and their families through family-centered care requires the consistent collaboration of effective teams with the family. In order to benefit the child and family, team members must come together to share information and solve problems. Successful delivery of early intervention services depends on the team's ability to develop and maintain relationships. Collaboration is based on respectful and trusting relationships between all members of the team. This requires a shift from the clinician as the expert, director, or designer of an intervention plan, to the role of collaborator.

When working with families as part of this collaboration, parenting is more properly viewed from a relationship perspective rather than as a skill. Parental capacity is challenged under stress and having a child

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with a disability can be stressful. It is under stress that parents rely on their emotional resources as much as their knowledge and their parenting skills. The single most important factor in the child's emotional well-being is the well-being of the parent. In a family-centered and relationship-based intervention, all team members must be aware of and support the parent's well-being.[3]

Child Mental Health

The goals of general pediatric interventions are to assist the child to achieve function across the developmental domains: social, emotional, cognitive, and physical. The primary center and moderator of experiences in the child's life is the family, because young children achieve the foundation for later satisfactory functioning through interactions with their family unit. The period between birth and 3 years old is critical for facilitating the significant brain maturity and development progression that occurs during this period. Secure attachments to caregivers based on responsive and sensitive caregiving during early childhood have long-lasting effects on the mental health of a child.

Early intervention services can minimize developmental delay and enhance the capacity of parents to meet the needs of an infant or toddler, including their social and emotional needs. Whether receiving services in a home, educational or clinical setting, or community, children benefit from the combined perspectives of parents and professionals functioning as a team. Team assessment and planning ensure a comprehensive approach, expanding beyond a perspective limited by one discipline.[4] For example, when a physical therapist provides treatment to a child with low muscle tone and diminished motor planning, the practitioner will talk with the family about the nature of the intervention. When doing so, the physical therapist is not only delivering physical therapy but is simultaneously building an alliance with the family, offering developmental guidance and perhaps supporting the parents' positive responses to their child.[5]

TYPES OF APPROACHES

Family-centered Care

A key principle of successful early intervention approaches to infant mental health is family-centered care. The family is an active participant in all aspects of family-centered service delivery. An effective and collaborative team is able to see the child as a whole within the context of his or her family. Therefore, the family's needs and priorities lead the team as they provide appropriate services. The eventual outcomes are identified in terms of family functioning, the parent-child relationship, and the family's capacity to support the child's development. The composition and coordination of the team may change with the development of the child, service transitions, and needs of the family. As intervention outcomes (e.g., family capacity) are reached, the team also must adapt in approach and often in composition.

Relationship-based Care

As stated above, the relationship that a child has with his or her family and other caregivers is vital to emotional and social development and health. The relationship between young children with special needs and their parents is no different in this regard. This relationship may be more vulnerable to complications due to the child's delays or disabilities and the parent's response to the challenge of interpreting how the young child expresses his or her needs. The therapists' awareness of the parent's possible difficulties in these areas and others and their willingness to address the parent's feelings and response to the child are necessary to support the ongoing child-parent relationship.[6]

While a family-centered intervention defines who is the focus of intervention and provides guidelines regarding how to focus on the family, principles of relationship-based care provide specifics regarding the relationship inherent in family-centered care. The term "relationship-based approaches," refers to intervention approaches that rely on the context of relationships as central to the focus of intervention. An IMH relationship-based approach addresses the expected and unexpected stress, coping and adjustment reactions, and general well-being of families.[7]

Intervention that is relationship-based assumes a family-centered perspective, but expands the concept further by focusing on the social-emotional health of both

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the young child and the caregiver. The approach requires the creation of a safe and nurturing context in which a caregiver and practitioner may think deeply about the care of the infant, the emotional health of the caregiver, the multiple challenges of early parenthood, and possibilities for growth and change.[8] Questions that might be asked in a relationship-oriented way include, "How do the practitioner and caregiver see the same baby?" "Who is this infant or young child to this family?"[9] Individual team members who perceive emotional or behavioral health issues that are outside their scope of practice should consult with an infant mental health therapist and/or the other members of the team for an appropriate referral source.

Natural Environment

While the goal of intervention is to advance the individual child's developmental skills, the goals are achieved by addressing the child's needs through the family unit and the parent-child relationship. The Individuals with Disabilities Education Improvement Act of 2004 (IDEA) states that services for infants and toddlers are to be provided "to the maximum extent possible, in the natural environments including home and community settings in which children without disabilities participate" (20 U.S.C. §1432(I(4)(G) et seq.).

The natural environment of a young child may include the child's home or childcare setting. However, typically infants and toddlers learn and develop through early family experiences in the home. Therefore, a critical focus of early intervention is to enhance the family's capacity to support their child's development and be responsive to the child's changing needs. The primary ways a parent nurtures their child is through the caregiving activities embedded within family routines and play. These activities foster relationships and provide a safe base for the child to explore and learn. The reciprocal interactions between parent and child during these activities are essential to the child's social, emotional, cognitive, and physical development. Satisfying interactions reinforce parent's attachment to their child and foster joy and contentment in parenting. For these many reasons, working with the family in their home provides the best opportunity to embed intervention in these naturally occurring interactions. The child's everyday environment provides the natural learning opportunities of typical development.

Family-centered and Relationship-based Early Intervention Teams

Expanding on general pediatric models of intervention, providers of early intervention services recognize that the child and the family are recipients of services. Strategies in early intervention are based on the perspective that both the parent and the child have strengths that can be nurtured by the guidance of the team and the dyadic relationship can be a foundation for intervention. Strength-based approaches promote the family's capacity to care for and support the development of the child.

In early intervention, collaboration to problem-solve and monitor progress is ongoing. Therefore, communication among team members is vital for collaboration and logistical planning. Collaboration styles depend on the service model, the child and family's needs, and the team approach.

Team Models

In early intervention, a team can be defined as a small number of individuals with complementary skills committed to a common goal using common approaches.[10] Team membership requires a family and child and relationship focus rather than a discipline-specific perspective. Skills in interpersonal communication, relationship building, negotiation, and compromise are required. Table 1 on the next page depicts the three models.

The ***interdisciplinary team model*** is most often used in community and outpatient clinic-based programs. It requires professional team members to have a level of expertise in their own specialty as well as a general knowledge of the roles and functions of the other team members. Although evaluations may be conducted according to the individual members' expertise, identifying goals and planning are group processes that represent collaboration and parental input. Intervention is also delivered according to specialty roles. In this team model, team members agree to intentionally coordinate evaluations and intervention approaches to avoid duplication and to reinforce the intervention goals of the other specialties. Evaluation and intervention services are most often provided by each discipline separately. However, members of an interdisciplinary team consistently communicate both formally and informally in order to adapt and update their approaches.[11]

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Multidisciplinary teams are often the norm in medical model service delivery (e.g., acute care and hospital-based settings). Multidisciplinary teams evaluate the child and select interventions based on their findings and the expertise of their individual disciplines. Interdisciplinary or transdisciplinary models of service delivery are more often standard in early intervention settings. The hallmark of inter- or transdisciplinary teams is that roles are generally agreed upon and distributed among members to reduce duplication, establish lines of communication, and reduce stress on the family.[12] The key difference in the models is the amount and type of communication among team members and the amount of integration of intervention approaches. This requires that each team member has a basic understanding of the principles and practices of the other practitioners. For example, to strengthen social and emotional development or address potentially stressful environments, the various disciplines are knowledgeable about basic IMH practices and incorporate those into their work.

Common parent observations of both of these team models are that they require parents to take responsibility to coordinate multiple appointments with individual clinicians. Home or clinic visits with multiple professionals disrupt family routine, increasing stress levels. Communication with multiple individuals is often problematic, resulting in conflicting or inadequate information that can produce confusion and anxiety.

Transdisciplinary teams bypass traditional discipline boundaries. Team members exchange knowledge and skills across discipline borders, often "letting go" of specific roles. Evaluations are conducted across all areas of need by only one or two members of the team. After establishing intervention goals and approaches as a team, the team member (primary interventionist) whose expertise most closely matches the child and family's needs works with the child and family. The other members of the team provide consultation and share strategies that can be incorporated into intervention approaches. This model requires a great deal of communication. To be successful, team members must be willing to build on each other's skills and be comfortable sharing their expertise, skills, and knowledge.[13] This team model is most often employed in home or preschool settings. Multiple team members may provide direct services through co-treatment or co-visits to the family home or community setting.

This model encourages the primary interventionist to be the primary contact for the family and the other team members. One person is able to communicate and

Table 1

	Interdisciplinary	Multidisciplinary	Transdisciplinary
Team Interactions	Members commit to sharing intervention by reinforcing the goals of other disciplines.	Members recognize the contributions of other disciplines to successful outcomes.	Members commit to learning and teaching others across disciplines to provide integrated services.
Communication	Initial meeting supplemented by more informal communications.	Often written referral or informal conversations by phone; few if any face-to-face meetings.	Meet regularly to share information and consult; high level of member participation.
Evaluation	Conducted independently by each individual clinician according to discipline domain or role.	Conducted by individual clinician according to discipline domain or role.	Conducted by a limited number of team members across all domains of interest.
Intervention Planning	Independent discipline-specific goals and intervention approaches incorporated into a comprehensive plan (e.g., IFSP).	Parallel plans and goals developed according to discipline domain or role.	Collective planning by clinicians and family; one plan developed with unified goals.
Intervention Implementation	Implemented collaboratively with separate appointments by each discipline.	Implemented separately by each discipline with separate visits.	Team member whose expertise most matches family-centered needs works with the child and family.

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collaborate in regularly scheduled team meetings, discuss new information with the family, and implement additional strategies in the family's natural environment.[14] Though often logistically difficult to implement, the transdisciplinary model provides several distinct advantages for families. The child and family form a relationship and develop a rapport with one person. Building trust and consistent communication is easier. Communicating with one person decreases the chance of miscommunication, and coordination of appointments is less disruptive and intrusive.

EVIDENCE-BASED TEAM APPROACHES IN EARLY INTERVENTION

Research confirms that collaborative team approaches improve child outcomes. Transdisciplinary models have been recommended as best practice for early intervention services because they:

- Increase collaboration among the team members and with the family.
- Increase the efficiency and integration of actual service delivery.
- Reduce the fragmentation of services by discipline.
- Decrease the likelihood of miscommunication with the family by providing a key contact with a consistent message.
- Reduce the number of individuals with whom the family must interact, leading to less repetition and streamlined communication.
- Increase the potential for a strong relationship between the primary provider and the family.
- Decrease the number of appointments the family must work around, reducing the stress on family routine and intrusions on privacy.

Effective Team Collaboration

The interpersonal skills needed for team collaboration are different than those used to work with children and often those needed in everyday life.[15] Teamwork requires skills in negotiation and compromise. Empathy, self-awareness, self-reflection, and emotional control are just a few of the personal qualities required to be an effective team member. Effective listening and the ability to facilitate communication are crucial to collaboration. Self-confidence and a positive professional identity allow role-sharing and cooperation.[16]

In transdisciplinary teams, team members must be able to engage in "role release", sharing expertise and valuing the perspectives, knowledge, and skills of other disciplines. Role release also occurs with parents, as in coaching parents to apply appropriate approaches to daily routines.

Working effectively with families on transdisciplinary teams also requires a role change for clinicians. The goals of early intervention hinge on building the capacity of families. Rather than a therapist-client relationship, the clinician works side-by-side with the parent. They function as a team. The clinician has an expertise to share, but intervention priorities and implementation of the approach are accomplished by the parent. Engaging families in their natural environment requires the clinician to put aside their "expert role" and listen. Under this model, the traditional clinical therapy setting is replaced by the environment where the child spends a majority of their day: home, childcare, or preschool. Evaluating and working within the child's natural context can support the child's performance and assist parents to apply strategies to fit their life situation. However, a professional working in the family's home can be disruptive and uncomfortable. Initially, the early interventionist is a "visitor". Visits can be perceived as special occasions. Parents feel pressured to present their home as representative of their family and can feel anxious about the perception it creates. As time goes on and the relationship builds, the visit can become integrated into the family's routine. Keeping in mind a few key points can help to build an effective relationship when working with families in their natural environment.

- Respect the level of involvement that the family chooses to take. Your job is to build the family's capacity, and that takes time.
- Respect the family's dynamics, lifestyle, and commitments.
- Communicate in a family-friendly manner; reduce the professional jargon.
- Remember that changing the child's routine can impact the routine of the entire family.[17]
- "Home programs" should be incorporated into typical family interactions, rather than exercise-based programs that require the parent to perform therapy.

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INTERPROFESSIONAL APPROACHES TO INTERVENTION

Depending on the specific needs of the child and the goals of the family, the primary interventionist will provide services to enhance the family's capacity to support the development of the child; enhance parent-child interactions; improve the child's participation in everyday activities; promote the child's development of gross and fine skills, communication, learning, play, and social skills; and assist with transitions from home and day care to school.[18]

Hanft, Rush, and Shelden (2004)[19] suggested coaching as an intervention model to promote families' competencies through adult learning strategies. Coaching is defined as guided actions that the learner practices, refines, and independently employs in immediate and future situations.[20] Working side-by-side with the parent, the clinician may work through issues with the parent directly. In coaching, the parent is the adult learner, but the child directly benefits from the new strategies and skills that the parent learns to implement. As a team, the clinician and the parent can adapt routines and environments to enhance the child's experiences and facilitate the competency of the family.[21] In the natural environment, coaching helps the parent to learn new skills and new strategies that are specific to their family context.

CASE STUDY

Jane is a 15-month-old girl with reported language, motor, and social delays. She lives with her biological mother and father, and the only other family available is a maternal grandmother with multiple health problems.

Jane was born at 30 weeks gestation. At birth she was admitted to the NICU weighing less than 1000 grams (2.2 pounds) and requiring intubation. During her stay in the NICU, she had difficulty with feeding and temperature regulation, was slow to gain weight, and had poor state regulation. Jane's mother and father visits to the hospital were limited to weekends when they were not working. This lack of early interaction may have had an impact on the family's early bonding and attachment with the infant.

Jane was discharged at 4 months old or 6 weeks adjusted age. After discharge, Jane received limited services through Healthy Steps. Scheduled visits were often canceled by Jane's mother due to scheduling conflicts. The mother quit her job soon after Jane came home, raising concerns about potential social isolation.

Currently, Jane eats cereal mixed with breast milk and has limited experience with solid foods. She fatigues easily and has difficulty sleeping through the night. Jane does not like to be bathed.

Jane is crawling and cruising short distances. Mom reported that she discourages cruising as Jane has gotten several bruises due to falls. Upper extremity flexion posturing with bilateral thumbs adducted into her palms and bilateral UE flexion was more noticeable in the left than right extremity.

Jane is making sounds but has no recognizable words. She has limited play skills, preferring to listen to music or the TV or observe her mother as she cooks and cleans.

Mom reported that she is exhausted from constant worry about Jane and her own mother. The maternal grandmother does not drive and is dependent on the family for all transportation. Mom said she is having difficulty keeping up with taking care of Jane, her mother, and the house and being attentive to her husband, who is doing all he can to support the family.

Dad is concerned about their reduced income. He sleeps during the day and reported that he does not have time to play with the baby or help out with caregiving responsibilities. Mom must keep the noise down during the day in the house to avoid waking him. Mom and dad have little time for each other. These factors should be watched closely to ensure that the mother is receiving as much support as possible and is not experiencing any situational-related emotional difficulties.

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A transdisciplinary team has recommended that the occupational therapist assume the role of primary service provider for Jane. The team has identified the following intervention goals to strengthen parent-child interactions and address developmental delays in sleep and feeding patterns and in language, motor, and play skills: The physical therapist will consult the primary service provider (OT) concerning motor and play interventions. The speech-language pathologist will train the OT to incorporate language and communication in routine-based interventions. The SLP will co-visit in order to introduce any program-based language programs to Jane's parents. The PT will co-visit as needed. The infant mental health therapist will address the parent-child relationship as appropriate. Table 2 describes goals and strategies.

Table 2

Description of child	Evaluation	Intervention Plan
Jane is 15 mos. CA (12.5 adjusted age) referred due to possible developmental delay. Parent's primary concerns are Jane's play skills, sleep routines and physical health.	Referred to OT, PT and SLP for evaluation. Infant and toddler milestones in motor, self-care, language and play are delayed. Additional factors potentially influencing Jane's development should be explored: Cultural and family priorities, typical family routines, and risk factors known to be associated with utero/birth history. Visits in families natural environment will assist in a better understanding of family dynamics, family scheduling, and parenting philosophy.	Early intervention services provided in the home weekly. Coaching model of service delivery will be employed. OT will service as the Primary Service Provider (PSP). Goals are to strengthen parent-child interactions and address developmental delays in sleep and feeding patterns and in language, motor, and play skills. Physical therapist will consult with the PSP concerning motor and play interventions. The speech language pathologist will train the PSP to incorporate language and communication in routine-based interventions. The SLP will co-visit in order to introduce any program based language programs to Jane's parents. The PT will co-visit as needed.
Jane has limited experience with solid food; does not finger feed.	Jane consumes ½ cup of rice cereal with breast milk 4 times a day and has not begun to finger feed.	PSP will use coaching approaches to encourage oral play and oral motor skills, and address feeding development and food choices.
	Jane exhibits tactile and proprioceptive sensory issues.	Using modeling approach, PSP will introduce the use of massage and weight bearing activities (e.g. assisted wheel barrel, crawling and light bouncing on hands and knees).
Jane does not sleep through the night and wakes frequently. She fatigues easily.	Home visit revealed Jane sleeps with her mother. Both average 6 hours of sleep a night. Gather more detailed information regarding sleeping and feeding patterns during a 24 hour period to assist in problem-solving with mother as well as father if available.	Assist mother to identify consistent sleep routine; incorporate language rich sleep routine activities (e.g. storytelling, songs, reading). Introduce calming strategies for wakefulness.
Jane has limited play skills. Prefers listening to music or the TV or watching her mother.	Jane did not initiate play. She appeared attracted to objects and activities with auditory and visual interest.	Introduce play activities encouraging movement, language, and cognitive skills (e.g. books, blocks, colors and shapes that support the next level of Jane's development.) Using coaching and modeling help parents learn play strategies and activities and be able to interact with appropriate developmental expectations Help parents engage in nonintrusive play to support Jane's ability to take turns in a reciprocal interaction. Support parents to be emotionally available and an active participant in moment-to-moment interactions following Jane's lead and interests.

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Table 2 *(Continued from previous page)*

Description of child	Evaluation	Intervention Plan
Jane makes a limited number of sounds with no recognizable words. Does not use gestures (e.g., pointing).	SLP reports significant expressive and receptive language delays. During observation Jane's affect remained flat. She used limited sounds and had limited responses to interactive play (e.g. 'peek a boo'). Additional information through observation can include; use of eye contact, shared affect, shared attention, pacing of activities, movement, use of touch, and turn-taking skills of the dyad.	Instruct, coach, and model for family how to incorporate language stimulation during play and routine care. Assist parents to interpret the child's limited sounds as intentional communication and provide more functional verbal models. Instruct, coach, and model recognition of Jane's non-verbal cues; to pace interactions giving her a break when "I've had enough" is communicated and to pause to allow her to initiate and respond to social overtures. Assist parents with learning strategies to support and anticipate Jane's nonverbal engagement cues, subtle and potent, to match affect through prosody, tone of voice, facial expressions, eye contact, gestures, touch, and rhythmic movements. Help support parents to attach affective meanings to activities and situations related to Jane's specific emotional responses such as "You really like that music. Shall we dance?"
Jane is crawling and cruising short distances. Mother is concerned that Jane is not walking.	Gross motor skills are delayed, and Jane is functioning between 8-10 months. She does not pull to stand. When placed in standing is beginning to cruise. Mom reported Jane falls frequently from standing so she is reluctant to let her practice. Visually, Jane was unable to separate eye and head movements. She is able to sit independently with emerging balance reactions to correct her posture to midline. During subsequent visits, explore mother's fear of Jane falling, awareness of safety issues and what environmental modifications would allow her to feel more comfortable with her daughter's exploration and movement.	Coach and model short bouts of play activities with Jane to avoid fatigue. Coach reading a story to Jane encouraging her to visually attend and track the pictures. Coach mom to assist Jane to push up into sitting, and kneeling and standing at couch using toys and feedback. Play and assisted functional skills will be reinforced with weight bearing activities (e.g. assisted wheel barrel, crawling and light bouncing on hands and knees going after toys and over mom/dad's legs or pillows to build shoulder girdle stability. These activities will be modeled and coached. Include motor activities across multiple developmental domains during play such as: blowing bubbles; using objects/toys to encourage reaching across the midline; include games like pat-a-cake for rhythmic awareness, social interaction, imitation, and touch.
Jane shows gross palmer grasp bilaterally.	Upper extremity asymmetry with increased flexion tone in left elbow and hand; limited left thumb flexion and abduction. Jane showed gross palmer grasp bilaterally with no left hand active release.	Using coaching and modeling approaches, mother will offer activities to increase hand extension and thumb abduction (e.g. play dough, soft textured toys).

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Table 2 *(Continued from previous page)*

Description of child	Evaluation	Intervention Plan
Jane lives with mother and father; Jane's grandmother is dependent upon family for transportation. Father works nights.	Mother reports anxiety about balancing her responsibility for her mother and Jane, and potential marital strain due to financial and relationship issues. Home visit revealed unsafe conditions with limited toys or play objects.	Consult with case coordinator concerning: ▪ available support groups for families of premature babies in their area. ▪ community "play groups" for Jane and a "toy lending library" to access appropriate toys for Jane. ▪ availability of resources to purchase home safety devices (e.g. outlet covers). ▪ Monitor safety and the parent's ability to lower safety concerns in order to support Jane's developmental well-being and physical health. Consider a referral to an IMH therapist to further assist mother with her anxiety, relationship difficulties, family obligations, and financial burden in order to support Jane's development and to be emotionally available for her daughter. Include father in order to address the family dynamics.

Expected Outcomes:

- Increased parental engagement in play activities with Jane.
- Observations of spontaneous mother-child serve and return interactions will increase.
- Jane will demonstrate increased affect and increased animation.
- Mother makes an increased number of positive statements concerning parenting and Jane's strengths.
- Increased balance of wake and sleep time for mother and Jane.
- Jane will independently pull to stand and cruise the length of the couch with mother's encouragement.
- Jane will visually track and visually attend for 2 minutes while being read to.
- Mother will offer to report on techniques and strategies that were successful for at least one goal and request additional techniques for another goal.
- Successfully team with IMH and community supports involved with the parents to integrate services across developmental and psycho-social needs.

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