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Policies and Systems Support for Infant Mental Health in the Care of Fragile Infants and Their Families

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ABSTRACT

Successful mental health support in the neonatal intensive care unit and post-hospitalization relies on policies and systems that are aligned with infant mental health principles and practice. This article explores important considerations essential to promoting effective and competent care including a focus on building trauma-informed settings, the training of nursing and ancillary staff, and the reflective support necessary to help cope with the experience and stress of caring for very ill infants and their families. The types of evidence-based infant mental health treatments and interventions are discussed and the ways in which these treatments are financed are highlighted.

While there is a growing recognition of the importance of mental health support in infant intensive care settings and beyond into home settings post-hospitalization, attention is not always paid to the policies and infrastructure conditions necessary to create and sustain this support. These conditions cover the gamut from creating trauma-informed organizations and approaches within hospital settings and among nursing and other medical personnel to understanding and maximizing available financing for mental health support that is inclusive of both the infant and their caregiver. Within that frame, significant consideration can be paid to the specialized training required to understand and respond effectively to the unfolding and intertwined developmental and social emotional needs of the relationship partners. Medical care systems that attend to these issues take care to infuse their education and training programs with reflective supervision as a means of ensuring optimal care, and mitigating secondary trauma and burnout and to use treatment interventions identified with facilitating best outcomes for this population.

Trauma-Informed Systems

In recent years, health care organizations have begun to consider the importance of emotionally traumatic events in the lives of families impacted by infant medical illness, and to integrate the concept of trauma-informed interventions into the delivery of health care.[1,2] This shift in the medical field began with a large-scale study of adverse childhood experiences (ACEs) sponsored by the Centers for Disease Control (CDC). The initial study of over 17,000 working adults revealed that two-thirds had experienced stressful events in their childhood (such as their parents' divorce, substance abuse, mental illness, or domestic violence, or personal experience of abuse or neglect), and 13% had experienced four or more such adverse events.[3,4,47] Further research on ACEs showed that the number of traumatic events in childhood predicted later adverse health, mental health, and health risk behaviors.[3,5] Given the prevalence of adverse childhood events, we can assume that most of the parents, and indeed, most of the health care providers in a neonatal intensive care unit have experienced ACEs that may be impacting their reactions to the added stress of the hospital environment.

When considering the impact of stress on young children, the Center on the Developing Child at Harvard University outlined three levels of stress response.[6] *Positive stress response* occurs as a normal part of healthy development, such as when an infant receives an injected immunization and responds with a brief increase in heart rate and vocal distress or crying. *Tolerable stress response* involves activation of the body's alert system in response to more severe stresses, such as a young child being separated from his mother for several days while she gives birth to a sibling. Finally, the *toxic stress response* occurs when a child is exposed to frequent or prolonged adversity, without adequate adult support to provide a buffer from the effects of the stress.

Infants spending their first weeks or months of life in the NICU may demonstrate a toxic stress response. Exposed to painful, repeated, and unpredictable medical procedures, and possibly to physical pain or discomfort related to illness, these infants may not have consistent support from a parent or professional caregiver to help them stay regulated and recover from these stresses. The supportive buffering of the parent may

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be constrained by the medical procedures or risks themselves, preventing the parent from holding their child. In addition, parents may be unable to be present in the intensive care unit regularly due to barriers such as distance from their home and limited transportation, the need to work to avoid losing their job and their family's health insurance, and/or other children to care for at home. Toxic stress has been linked to changes in the developing brain, negatively impacting the creation of neural connections,[7] and this impact is likely to be particularly pronounced in younger infants and those without a supportive caregiver present.

Growing out of this developing understanding of the prevalence of adverse events in childhood and the impact of toxic stress on the developing brain, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a model of trauma-informed care to support organizations in ameliorating the negative effects of emotional trauma.[8] According to SAMHSA's model, a trauma-informed program, organization, or system (1): realizes the widespread impact of traumatic experiences (2); recognizes the signs and symptoms of trauma in children and families (3); responds by integrating knowledge about trauma into policies, procedures and practices; and (4) actively resists re-traumatizing children and families.

This model of trauma-informed care is helpful in developing procedures, protocols, staffing, and training that support families and staff in the infant intensive care units. Realizing that traumatic experiences are prevalent in the general population, we know that many parents we encounter in intensive care units have experienced adverse childhood events themselves, in addition to experiencing acute emotional trauma related to their infant's hospitalization. Thus it is not surprising that parents who have an infant in the NICU experience high rates of depression and anxiety,[9] and may experience difficulty regulating their emotions in response to stressful health care encounters.[10] When encountering family members showing distress through anger, withdrawal, or other challenging responses, a trauma-informed provider asks not "What is wrong with this family?" but instead "What has happened to this family?".[11] Understanding the impact of trauma on parents' coping responses then leads to the development of interventions that support the parent and infant in reducing traumatic responses, and promoting a parental bond to buffer the effects of stress on the infant. Family-centered care[12] and parent support interventions[13] overlap with a trauma-informed care model. However, a trauma-informed NICU setting also considers the impact of trauma triggers in the intensive care environment, examines policies and procedures that may re-traumatize parents, provides training for staff on the impact of pediatric medical traumatic stress and ways to reduce its impact, and recognizes the impact of trauma on health care providers and their own need for support and self-care.

Imagine a mother of an infant in the NICU arrives to visit her baby after a long day of work and a stressful commute. When she walks down the hall toward the room where she was with her baby the day before, she sees an empty crib. The mother's stress response system kicks into high gear as she feels with certainty that her baby has died. It takes only a few minutes for a nurse to realize her distress and show her to the new room where her baby was moved. Yet those few minutes were an eternity for this mother. How could a trauma-informed nursery prevent this mother's stress?

Training

Questions abound about how one builds competency in the infant mental health (IMH) principles described earlier in this issue.[14] What is known is that it is critically important to equip those who interact directly with infants and families with the knowledge and skills necessary to promote social emotional competence and mental wellbeing. Unlike other disciplines that rely on tertiary treatments for effective healing, IMH support at the prevention and promotion levels can propel meaningful change in attachment relationships, resiliency, and building parental competence.[15–17] Nursing staff and early intervention therapists play pivotal roles in the lives of vulnerable infants and their families as they facilitate care, growth and development and thus are in the unique position to incorporate IMH principles into their routine interactions and protocols. Examples of these interventions include the Newborn Individualized Care and Assessment Program[18] which provides relationship based individualized developmental care, and Family Nurture Intervention (Welch, et al., 2015), which is provided on a short term basis during an NICU stay and is designed to promote attachment between parents and the hospitalized infant, or home visiting interventions (e.g., Nurse Family Partnership in O'Brian, 2005) once the infant has been discharged.

There is, however, a lack of systematic, consistent and comprehensive training, academic preparation and pre-service opportunities across disciplines that would ensure a workforce that is ready to address this need. While recognizing that some training is provided to nurses on infant mental health or related topics, universal and consistent structured training is not the norm. Given the fundamental emphasis on the relationship between the infant and the parent in IMH, trainees need supervised experiences in addition to their coursework in order to build competency and really understand how to observe, interpret, and maximize this relationship. There are challenges and complexities related to IMH that need to be specifically addressed in training programs. Examples of the complex, interrelated nature of this specialized training include the emphasis on prevention approaches which require the ability to address the wellbeing of the family in the absence of social emotional disturbance. Professionals need sufficient knowledge of normative and atypical early childhood development in order to adequately observe and interpret behavior, particularly under conditions of stress and adversity. Additionally, IMH interventions and treatment are designed with the dyad in mind and practice. This means that parents' wellbeing, capacities and competencies are considered alongside those of the fragile infant, and that support is provided to foster the sturdiness of the relationship as the vehicle for health and development.

While opportunities for such training continue to evolve and expand, the IMH field is still new enough that only recently has even certificate or individual courses been offered through institutions of higher education. These programs have a variety of offerings related to infant mental health principles and practices, infant and family development, infant family assessment, and clinical interventions and treatment which can be considered as core courses across programs. Programs vary according to the teaching method, spanning online to intensive in-person contact that may involve actual clinical practice. Further, some programs require substantial pre-course experience, while others are geared for the entry level, usually post-baccalaureate student. Other training and preparation efforts are commonly organized by individual organizations or consortiums and are developed to meet needs of a local workforce. While workforce capacity continues to be an issue[19,20] in terms of both the number of professionals with sufficient training in IMH as well as the quality of that training, there are clear examples of the depth and breadth of topics and related supervised experiences needed to provide competent IMH care.[21]

Competency-based systems for the IMH workforce have emerged as a means of ensuring best practice service delivery by professionals with sufficient knowledge, skills and experiences in this field. Korfmacher[22] describes four main reasons why competency systems are necessary in the infant and early childhood mental health field. Competencies help guide the creation and implementation of training for early childhood professionals. Competencies enhance one's professional credibility both with organizations where one's expertise can be recognized and