Serving Families Where They Live

Supporting Multigenerational Health During Infancy and Early Childhood Through Community-centered Approaches

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KEYWORDS

• Multigenerational • Early childhood • Mental health • Community-centered
• Perinatal • Cultural considerations • Social determinants of health • Intervention

KEY POINTS

- Importance of early childhood mental health: Early childhood, including the perinatal period, is a critical time for addressing mental health, as environmental factors during this time can have lasting effects on children's and their families' mental health.
- Multigenerational approach: Mental health in infancy and early childhood is inherently multigenerational, as the child's development is closely linked to caregiver's well-being. Recognizing and addressing mental health in both children and caregivers is essential, starting during the prenatal period.
- Community-centered strategies: Community-oriented approaches are effective in addressing mental health issues in young children and their families. Collaborative efforts within communities can help eliminate barriers to care and address social determinants of health contributing to mental health burdens.
- Cultural considerations: Cultural humility and awareness are crucial when working with families during sensitive periods like pregnancy and early childhood. Mental health providers should be flexible in delivery of interventions to meet the diverse needs of families and involve them in cocreating solutions. Addressing systemic issues like racism is also essential in improving outcomes for historically marginalized communities.

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INTRODUCTION

To address the children's mental health crisis, it is critical to focus on and invest in perinatal, infant, and early childhood mental health.[1] Scientific evidence suggests that this period is particularly salient and sensitive to environmental perturbations that have lasting effects on the health and mental health of children and their families.[2] Even as the American Academy of Child and Adolescent Psychiatry (AACAP) and other organizations declared a National Emergency in children's mental health in October 2021, there has been limited consideration of infant and early childhood mental health and the role it plays in the current mental health crisis.[2,3]

This study aims to provide evidence as to (1) why addressing the children's mental health crisis needs to involve a developmental perspective and focus on early childhood, by providing an introduction to infant and early childhood mental health, (2) the importance in expanding clinical considerations beyond the index patient and include multigenerational mental health as well as social determinants of health (SDOH), and (3) provide clinical examples of multigenerational interventions that have demonstrated promising results within communities. We aim to underscore the effectiveness of community-oriented strategies in mitigating the mental health crisis from its earliest underpinnings and simultaneously demonstrate the importance of including community members in the cocreation of mental health solutions in order best serve those we hope to engage in healing.

BACKGROUND

Mental health challenges begin early. Epidemiologic studies demonstrate that 9% to 12% of children aged 2 to 5 years have a mental health disorder.[4] Early onset of mental health problems impair functioning across multiple domains and are often predictive of psychopathology and impairment later in childhood and in adulthood.[4,5] Much less is known about mental health disturbances in children aged younger than 2 years. However, evidence suggests that the perinatal period (from pregnancy up to 1–2 years postpartum) is a time of increased biological and psychological vulnerability to psychopathology for parents and offspring due to increased biological, psychological, and social demands of pregnancy and the postpartum period.[2] In fact, studies suggests that maternal depression and other caregiver mental health conditions and trauma can impact the social-emotional development of infants and the parent–infant relationship, with mental health disturbances potentially starting before the age of 2 years.[6]

Supporting the emotional development of infants and young children mandates a consideration of their broader environment. Children develop in the context of relationships and primary caregivers are inextricably linked to infant mental health.[7] In other words, infant mental health is by its very nature multigenerational mental health. Not only because multiple facets of early caregiving influence a child's development but so too does the infant and young child influence the parent and their environment.[8] Working with infants and young children provides unique opportunities to support adult and child mental health together by holding the caregiver and child both in mind with respect to assessment and treatment.

Clinician treating children need to be equipped with strategies to recognize and treat mental health problems in young children and consider the context of their families and broader ecological contexts. Recognizing psychopathology or risk for psychopathology in young children, including the relationships between children and their caregivers, can lead to interventions that are best suited for a child and family's needs. By implementing preventive practices for young children as a part of treatment

and care, young children at risk for mental health problems can follow a different trajectory. Ideally, the current strain on our mental health system will be relieved by reducing the prevalence of mental health disorders in older children and adolescents.

Expanding infant and early childhood mental health practices beyond the confines of clinical offices is imperative in meeting the needs of the community. Even before a mental health crisis was declared, many communities, particularly historically marginalized communities, were experiencing overwhelming challenges in accessing mental health support.[9] Psychiatrists working with children and adults need to build an awareness of what supports are available to families with young children and strive to work in partnership with other disciplines working with families in the community to truly support a continuum of care. By working within communities, not only can we eliminate or mitigate barriers to care but also more accurately assess the SDOH that contribute to mental health burdens.

In alignment with this edition of child and adolescent psychiatry (CAP) clinics, this article strives to encourage a paradigm shift in the field of CAP, advocating for the integration of multigenerational infant mental health interventions within communities that can also extend the critical work of psychiatrists and mental health clinicians. We also highlight ways to support caregivers and community members to participate in the delivery of interventions typically safeguarded for use by clinicians. Through collective efforts that empower families and promote community resilience, we can envision a future where every child has a nurturing start to life, paving the way for healthy social, emotional, and developmental trajectories.

DEFINING MULTIGENERATIONAL PERINATAL AND INFANT AND EARLY CHILDHOOD MENTAL HEALTH

Perinatal mental health typically focuses on mental health in pregnancy and postpartum (up to 1 year) but tends to be more caregiver focused. On the other hand, Infant and Early Childhood Mental Health (IECMH) focuses on integrating both clinical and research activities that are devoted to helping children aged 0 to 5 years. A common definition of infant mental health is "the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional wellbeing."[10] "Infant" as it relates to IECMH often refers to a child during the first 3 years. However, focusing on birth to 3 years of age "starts too late and ends too soon."[8] Therefore, prenatal experiences also need to be considered as a part of IECMH. Thus, the Perinatal mental health and IECMH fields need to work synergistically to support infant–caregiver mental health. Intrinsic in the definition is the consideration of the caregiving environment, including the caregivers. Therefore, IECMH is by definition multigenerational mental health and parental mental health during these early years.

Because of its emphasis on environmental influences, IECMH provides a portal to address disparities and SDOH as a way to promote positive developmental outcomes. Families regularly encounter stressors that are compounded by the effects of poverty and systemic racism, as well as the presence of adverse childhood experiences (ACEs).[11] For children, these experiences can continue to have an effect into adolescence and adulthood. Some children who experience "toxic stress,"[12] meaning stress that overwhelms their capacity to cope, have been shown to undergo changes to their brain that affect their executive functioning and their ability to regulate their emotions

and behaviors.[13] Adults with a history of ACEs are more likely to experience poor physical and mental health.[12] As they have children of their own, the cycle of toxic stress can continue resulting in intergenerational transmission of mental health risk. Not all communities are affected by ACEs equally. While 45% of children in the United States have experienced at least 1 ACE, that number rises to 61% and 51% for Black and Latinx children, respectively.[14] This is not surprising given the disproportionate impact of systemic racism, which is a root cause of multigenerational poverty and historically divested neighborhoods.[9] Moreover, ACEs and poverty have a cyclical relationship. People living in poverty are more likely to experience ACEs, and ACEs have a strong correlation with poverty.[15,16]

IECMH interventions—and their multigenerational approach—are a critical part of the solution in ameliorating the impact of ACEs on families, dismantling intergenerational transmission of mental illness and supporting healthy social emotional development. At their core, these interventions aim to foster healthy relationships between caregivers and their children—a protective factor for those at risk for mental health disorders.

CULTURAL CONSIDERATIONS IN INFANT AND EARLY CHILDHOOD MENTAL HEALTH

Infants and young children are particularly dependent on their caregivers and their environment to provide security, nurturance, and the critical early caregiver–child interactions that form the building blocks for healthy brain development. Not only are caregiving practices intricately linked to a family's cultural beliefs but also social forces operating in the broader environmental context—including racism, discrimination, disparate access to treatment, and systemic bias—impact young children vicariously through their caregivers.[17]

Racism has been widely documented as a factor affecting outcomes during pregnancy, postpartum and the first years of life. Research indicates that maternal mortality rates are elevated among Black women, with similar disparities observed among American Indian/Alaska Native women when contrasted with their White counterparts.[9] Additionally, studies have revealed that Black and Latinx infants are more likely to be delivered in hospitals with heightened rates of neonatal morbidity and mortality, marked by factors such as increased infection rates, inadequate staffing, higher patient–nursing ratios, and inferior quality neonatal intensive care units.[9]

Furthermore, research has demonstrated the negative impact of racism and discrimination on the well-being of caregivers and children during the toddler and preschool period. For example, Black children are more likely to experience higher rates of suspensions and expulsions in preschools leading to disruptions in education and childcare as well as negative psychological consequences for children and their caregivers.[18]

There is a clear need for clinicians working with children and families during this sensitive period to be particularly attuned to the effects of racism at the systemic and individual level. Part of that requires cultural humility and consistent reflective practices (described in a later section). Working with perinatal individuals and families with young children can create a particular vulnerability to cultural blind spots that can impact care. Some assessments and interventions are provided in the home, adding intensity to interactions and layers of complexity to the balance of power dynamics. The presence of a baby can evoke strong emotions and trigger our own unconscious memories and internal representations formed from our early caregiving experiences. Clinicians' knowledge of the rapid brain development of infants and young children can create a sense of urgency, which may impair our ability to maintain a reflective

stance—meaning the ability to reflect and "put oneself in the other's shoes" while also being attuned to one's reactions. Clinicians working with young children and their caregivers must then be particularly intentional about cultural humility—and particularly conscious of the ways in which our own cultural stories and biases impact the families we serve—in order to avoid reproducing patterns of historical and current oppression.[19]

A work group of the Irving Harris Foundation developed The Diversity-Informed Tenets for Work With Infants, Children and Families,[20] a set of aspirational principles grounded in diversity, equity, and inclusion, and designed to promote awareness of the social justice issues and forces of oppression that impact our work with infants and families. The Tenets are rooted in the principle that self-awareness and intentional action are critical for individuals, agencies, and systems of care who work with or on behalf of young children and families,[20] and are foundational to applying a cultural lens.

A cultural framework begins with creating the opportunity, space, and safety for caregivers to share their stories, beliefs, and concerns. Thoughtful consideration of the physical space—including the availability of culturally and linguistically diverse books, toys, art, and handouts—as well as the family's preferences and feelings about the location, structure, and participants should help guide assessment planning.[21] Explicitly asking caregivers about their cultural background and upbringing, their views on parenting practices, their beliefs about the problem and possible causes/solutions, and their feelings about the meaning of play can inform a better understanding of the broader cultural context; exploring the cultural expectations and beliefs of family and community members regarding diagnosis and treatment (both prior to beginning treatment and in an ongoing manner as treatment progresses) can support caregiver engagement in interventions.[21] Taking the time to create safe spaces and therapeutic relationships to discuss cultural aspects of care will help navigate any potential issues that may arise during the treatment course.

When clinically working with families, it is crucial to utilize interventions that have been developed with families of diverse backgrounds. However, many existing interventions have been developed within academic settings and with limited input from families or diverse voices. There is an overall dearth of interventions developed, adapted, or evaluated in families of diverse cultural backgrounds.[22,23] Additionally, many interventions are structured to be used in psychiatric care settings, which is problematic because families tend to engage in their communities and not necessarily in psychiatric centers. Finally, the lack of community input limits the generalizability of interventions, and the ability for them to be sensitive and responsive to the needs of diverse families and contexts. In a later section, we discuss some promising interventions and community settings that are important to consider when supporting IECMH.

MULTIGENERATIONAL MENTAL HEALTH IN EARLY CHILDHOOD EDUCATION CENTERS

Mental Health Consultation in Early Childhood Education Centers

Programs providing mental health consultation within childcare centers strive to support the workforce to maximize social emotional development and have demonstrated success in reducing teacher-rated behavior problems and preschool expulsions.[18] However, parents are not always involved in this work. Yet, parents are central to the healthy development of their children in the early years, particularly for children who spend a large percentage of time in childcare.[24] At the same time, providing mental health supports within childcare can help to overcome multiple barriers,

particularly for families that experience perceived racism in health care and live in areas where there is a lack of mental health services and where there is a perceived stigma in receiving mental health support in the community.

Place-based Mental Health in Early Learning Environments

Offering mental health services within early childhood education centers, specifically centers that service children experiencing poverty, provides a unique portal to overcome barriers to care. Embedding multigenerational mental health supports within early learning sites, also referred to as place-based care, offers a solutions-focused approach that both circumvents traditional barriers and offers new opportunities to strengthen relationships with families and community organizations. More specifically, offering parenting interventions in childcare settings can mitigate significant financial barriers (ie, transportation costs), which is cited as one of the primary reasons for dropping out of treatment.[25] Place-based care also leverages the naturally occurring community relationships (ie, between childcare staff and caregivers) that can scaffold entry into services and reinforce treatment-seeking behaviors. Furthermore, early childcare centers represent a population of very young children where interventions can have a big impact in preventing the development of firmly entrenched mental health problems.[26] This population is typically a group of children and caregivers with a common geographic location and a resulting shared microculture leading to opportunities to adapt programs to the needs of the environment through caregiver input. Parenting interventions, adult individual and group therapy supports, and developmental evaluations are all well positioned for dissemination in this type of setting.

Feasibility for this approach was demonstrated through a collaboration between an academic university hospital and a community Early Headstart/Headstart program in the Mid-Atlantic region.[27] The Family Wellbeing Program (FWP) was developed to support families with children attending early childhood education centers in underresourced communities in the mid-Atlantic region. The FWP aimed to promote emotional and behavioral well-being in families, prevent the development of mental health problems, and treat clinically significant impairment when necessary. As a multigenerational program (providing services to both caregivers and children), it provides evidence-based practices designed to meet the varying levels of families' needs including mindful parenting classes, individual therapy for parents, dyadic (ie, parent–child) therapy, and peer-led parenting groups.

Peer-to-peer Mental Health Support in Early Education Settings

In addition to the benefits of traditional mental health clinical offerings, initial data from the Coates and colleagues study[27] demonstrated positive results for families that engaged in this program. Notably, the most well-attended aspect of the program was the peer-led parenting group. These groups also had the highest level of parent satisfaction based on a survey evaluation. Prior evidence demonstrates that group therapy attendance is associated with decreased levels of self-stigma related to seeking help. Programs that include a group component, particularly those led by peers, indicate that they play an important role in mitigating barriers for families in need of mental health support.[27]

These results also highlight the key role peer-professionals or peers with lived experience can play in leveraging the expertise of the community and expanding the peer workforce to support family mental health during this period.[28] Given the feasibility and acceptability of this program, particularly the peer-to-peer support, further research is needed to examine its impact on IECMH outcomes. Overall, this study shows promise in programs that provide a continuum of multigenerational services collocated within

an early childhood education setting. Given its promise in meeting the needs of communities, it is a starting point for this burgeoning approach to mental health care that goes beyond traditional practice models in traditional practice spaces.

With an expansion of these types of programs, additional evaluations will be necessary to determine how they directly impact changes in behavioral and mental health symptoms in both caregivers and their young children. Furthermore, evidence-based interventions offered in these programs need to be tailored to meet the needs of the community. More work needs to be done to include community members in cocreating adaptation of evidence-based interventions and to train nonlicensed caregivers to take part in the delivery of interventions when possible, given its demonstrated effectiveness in prior studies.[27,29] Supporting teachers and staff through mental health consultation and broader systemic policies (ie, early childhood caregiver pay equity) is also a critical component in addressing the mental health needs of young children and the individuals who care for them.

PEDIATRIC MEDICAL SETTINGS: COLLABORATIVE CARE APPROACHES

Workforce shortages in child psychiatry are particularly severe for young children, even though rates of mental health problems in young children are similar to rates in older children.[30] Furthermore, significant disparities exist in access to evidence-informed treatment and best practices for young children. Children insured by Medicaid are more likely than commercially insured children to be prescribed psychiatric medications and are 2 to 3 times as likely to be prescribed antipsychotics.[31] Disparities likewise exist in access to treatment of perinatal depression—although rates of postpartum and maternal depression are higher among underserved racial and ethnic minority groups, they are less likely to initiate care and less likely to continue treatment.[30,32,33]

One method for increasing accessibility and mitigating disparities is providing support and interventions in the places families already visit. Pediatric primary care (PPC) settings are trusted environments, and pediatricians have longitudinal relationships with children and families.[34] Evidence-informed program models range from provider-level training (including Project ECHO) to telephonic mental health consultation for PPC clinicians, to embedded on-site mental health specialists, and even to brief interventions in the PPC setting.

Healthy Steps is a population-based model for children aged 0 to 3 years and their families that embeds a licensed child development specialist in the PPC setting to comanage care along with the medical provider. The model includes universal screening for child developmental/social-emotional/behavioral needs and family needs, short-term consultation and care coordination for families with mild concerns, and well-child visits with the developmental specialist for families most at risk. Family needs screening includes maternal depression, food insecurity, housing instability, transportation needs, and interpersonal safety, along with referrals for caregivers if needs are identified. The model has demonstrated improved parent-related outcomes including increased sensitivity in interactions, safe sleep practices, and avoidance of harsh discipline techniques, as well as child-related outcomes including increased likelihood of secure attachment, increased timely well-child care, and decreased parent report of behavior problems.[35]

Child psychiatry access programs (CPAPs) help pediatricians enhance their capacity to manage mental health concerns by providing point-of-care child psychiatry expertise via telephone. The first such program, the Massachusetts Child Psychiatry Access Program (MCPAP), has demonstrated clinician satisfaction, clinician self-reported improvement in their ability to meet the mental health needs of their

patients,[36] and parent satisfaction with their primary care physician (PCP's) handling of their child's mental health concerns after the PCP consulted with MCPAP.[37] There are now 46 existing or developing CPAPs across as many states, with most programs offering resource/referral support and provider trainings in addition to telephonic consultation. One statewide tele-mental health consultation program—which included televideo consults and medication reviews in addition to telephone consultation for providers—resulted in a 42% decrease in statewide use of psychopharmacologic prescriptions for children aged under 5 years and a decreased need for residential treatment/hospitalization for high-need children in the foster care system.[38]

Building on the success of the MCPAP model, MCPAP for Moms was launched in 2014 to support obstetrician-gynecologists and other frontline health care clinicians with identifying and managing perinatal mental health and substance use concerns via provider-to-provider psychiatric consultation, face-to-face evaluation with the patient when needed, and resource and referral support. The program has demonstrated high utilization and increased rates of frontline health care provider willingness to address perinatal mood disorders.[39] There are currently 19 active perinatal psychiatry access programs, with more in development. These programs are currently implementing measures to ensure there is increased focus and adaptations to serve individuals from diverse backgrounds.

In addition to the CPAP model, there are a handful of ECHO (Extension for Community Health) addressing IECMH (Oklahoma's Infant Mental Health ECHO and Maryland's KKI-Network for Early Childhood Tele-education), which have been effectively training and improving clinician confidence in identifying and treating mental health, emotional, developmental and behavioral and problems (MEDB), specifically in early childhood.[40] Maryland recently received a federal grant, Transforming Pediatrics for Early Childhood, which will include an ECHO training Healthy Steps consultants alongside pediatric providers in MEDB disorders. These programs highlight the need to further train the workforce in IECMH topics in order to leverage the expertise concentrated in disparate geographic locations.

A next frontier in psychiatric consultative programs will be to center work on the family needs across the perinatal and early childhood period and have the 2 models (pediatric and perinatal consultation) work synergistically. An example of leading work in this area is Michigan's MC3 program, which incorporates a relational lens in working with pregnant, postpartum, and families with infants and young children.

By "going where the families are"—providing support in the medical home and helping clinicians meet their families' mental health and social needs—collaborative care approaches hold promise for reducing disparities in access to quality treatment and culturally responsive community-based supports. However, there is a critical need to engage families and communities in intervention development (cocreation) and evaluation to ensure family voice/community needs are at the center of these efforts.

INTENSIVE PSYCHIATRIC CARE: DYADIC APPROACHES

Although a lot of mental health care can be conducted in settings where families live and visit, some families require more intensive psychiatric support. It is critical for psychiatrists to know about resources availble for pregnant, postpartum, and families with young children who require more intensive psychiatric support. Currently, much of the psychiatric care for parents is "adult" focus, as opposed to having a focus on dyadic/relational aspects of the parent and parental role. However, particularly during this early period of parenthood, the dyadic approach is essential. Despite the fact that approximately 15% to 20% of perinatal individuals experience psychiatric symptoms

and conditions that can have significant effects on the dyad, few options for treatment of individuals with moderate-to-severe symptoms exist.[41] Even fewer take into account a dyadic approach. Incorporating infants is key to engaging women/caregivers in more intensive treatment. Often the lack of integration of infant and dyadic services is a barrier for perinatal individuals who may not have the support, resources, or ability to otherwise engage in more intensive treatment.[42]

A burgeoning group of interventions for parents during this period is beginning to emerge to support parents in the continuum of care they may require. In the United States, there are currently a few psychiatric inpatient units for pregnant and postpartum individuals that allow infants in order to prevent separation and work on dyadic components; evaluations of these show promising results.[43] Additionally, the Perinatal Intensive Outpatient Programs (IOPs) and Partial Hospital Programs (PHP) have been developed in the United States, many that allow infants and others that specifically work with dyads. These programs have programming that incorporates group psychotherapy, as well as individualized treatment. Some programs also include dyadic work and welcome infants into the programs by providing nursery support for mothers to engage in their own individual treatment. Nursery care can provide a place for infant observation, dyadic observation and support, as well as supporting mother–baby separations that may be particularly difficult for mothers who have anxiety or depression or other symptoms. Some programs also offer infant massage as a way to support the dyadic relationship.

To date, unfortunately, there are only approximately 23 perinatal IOPs in the United States, and only a handful of PHP and mother–baby inpatient units. Studies to date show high utilization of IOPs, PHP and mother–baby inpatient units, as well as high acceptability, and positive pre–post effects on maternal psychiatric symptoms and dyadic outcomes.[44]

CHALLENGES AND FUTURE DIRECTIONS

Supporting dyads and families during pregnancy, postpartum, and the first 5 years after birth are crucial. The burgeoning innovative programs we describe are beginning to meet the needs of communities and families with young children. And much research still needs to be done to increase services for families that take into consideration SDOH, the voices of those with lived experiences, cultural and multigenerational aspects of mental health.[45] Even more research is needed to systematically examine how incorporating these aspects has immediate and lasting effects on the mental health of caregivers, children, and their relationship. Even though families often interact with the health care and educational settings during this period, these systems often work in silos, are complex to navigate, and create barriers for accessing services that could improve the health of caregivers and children. Clinicians can lend their voices to alert stakeholders and policymakers to the importance of IECMH. By doing so, we can also center the lives and needs of caregivers and children who are crucial partners in improving these systems, and dismantling longstanding systems of oppression undergirding our current mental health crisis.

CLINICS CARE POINTS

- Focus on multigenerational approaches: Emphasize the significance of considering both caregiver and child mental health in your care approach. Recognize that addressing the mental well-being of caregivers alongside that of children is essential for comprehensive and

effective care delivery. Treating only the caregiver or only the child can limit optimal mental health outcomes for both.

- Prioritize cultural humility: Prioritize the development of culturally responsive care in your practice. Understand that cultural awareness and sensitivity are vital for tailoring interventions to diverse families effectively. Failing to do so may lead to misunderstandings, miscommunication, and reduced engagement with families from different cultural backgrounds.
- Center community voices: Building programs and providing interventions that involve peer support modalities can enhance community engagement and promote mental health among caregivers and their families.

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The authors have nothing to disclose.

REFERENCES

1. Harrison J, Aron E, Chesher T. The crisis in children's mental health: what about the babies? J Am Acad Child Adolesc Psychiatry 2023;62(3):285–7.
2. Londono Tobon A, Stransky AD, Ross DA, et al. Effects of maternal prenatal stress: mechanisms, implications, and novel therapeutic interventions. Biol Psychiatr 2016;80(11):e85–7.
3. American Academy of Child and Adolescent Psychiatry. Pediatricians, CAPs, children's hospitals declare national emergency: children's mental health. Available at: https://www.aacap.org/AACAP/zLatest_News/Pediatricians_CAPs_Childrens_Hospitals_Declare_National_Emergency_Childrens_Mental_Health.aspx. [Accessed 14 August 2023].
4. Egger HL, Angold A. Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. J Child Psychol Psychiatry 2006;47(3–4):313–37.
5. Lavigne JV, Gibbons RD, Christoffel KK, et al. Prevalence rates and correlates of psychiatric disorders among preschool children. J Am Acad Child Adolesc Psychiatry 1996;35(2):204–14.
6. Schechter DS, Willheim E. Disturbances of attachment and parental psychopathology in early childhood. Child Adolesc Psychiatr Clin N Am 2009;18(3):665–86.
7. National Scientific Council on the Developing Child. Young children develop in an environment ofrelationships. Working Paper No. 1. 2004. Available at: http://www.developingchild.net.
8. National Research Council and Institute of Medicine. From neurons to neighborhoods: the science of early childhood development. committee on integrating the science of early childhood development. In: Shonkoff Jack P, Phillips Deborah A, editors. Board on children, youth, and families, commission on behavioral and social sciences and education. Washington, D.C.: National Academy Press; 2000.
9. Berry OO, Londoño Tobón A, Njoroge WFM. Social determinants of health: the impact of racism on early childhood mental health. Curr Psychiatr Rep 2021;23(5):23.
10. Zero to three infant mental health task force steering committee. Definition of infant mental health. Washington, DC: National Center for Clinical Infant Programs; 2001.
11. Centers for Disease Control and Prevention. Adverse childhood experiences (ACEs) prevention resource for action: a compilation of the best available evidence.

Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention; 2019.
12. Shonkoff JP, Garner AS, Dobbins MI, et al. The lifelong effects of early childhood adversity and toxic stress. Pediatrics 2012;129:e232–46.
13. Johnson SB, Riley AW, Granger DA, et al. The science of early life toxic stress for pediatric practice and advocacy. Pediatrics 2013;131:319–27.
14. Sacks V, Murphey D. The prevalence of adverse childhood experiences, nationally, by state, and by race or ethnicity. Child Trends 2019.
15. Steele H, Bate J, Steele M, et al. Adverse childhood experiences, poverty, and parenting stress. Can J Behav Sci 2016;48(1):32–8.
16. Liao H, Yan C, Ma Y, et al. Impact of adverse childhood experiences on older adult poverty: mediating role of depression. Front Public Health 2021;9:749640.
17. Heard-Garris NJ, Cale M, Camaj L, et al. Transmitting trauma: a systematic review of vicarious racism and child health. Soc Sci Med 2018 Feb;199:230–40.
18. Gilliam WS, Maupin AN, Reyes CR. Early childhood mental health consultation: results of a statewide random-controlled evaluation. J Am Acad Child Adolesc Psychiatry 2016;55(9):754–61.
19. Ghosh Ippen C. Wounds from the past: integrating historical trauma into a multicultural infant mental health framework. In: Zeanah C, editor. The handbook of infant mental health. 4th Edition. New York: Guilford Press; 2018. p. 134–53.
20. Irving Harris Foundation Professional Development Network Tenets Working Group. Diversity-informed tenets for work with infants, children and families. 2018. Available at: https://diversityinformedtenets.org/. [Accessed 1 September 2023].
21. Njoroge WFM, Londoño Tobón A. Infant psychiatry: culture and early childhood. In: Parekh R, Al-Mateen CS, Lisotto MJ, et al, editors. Cultural psychiatry with children, adolescents and families. Washington, DC: American Psychiatric Association Publishing; 2021.
22. González MJ. Evidence-based practice with ethnically diverse clients. In: Congress EP, González MJ, editors. Multicultural perspectives in social work practice with families. New York, NY: Springer Publishing Company; 2013. p. 31–40.
23. Martinez CR, Eddy JM. Effects of culturally adapted parent management training on Latino youth behavioral health outcomes. J Consult Clin Psychol 2005;73:841–51.
24. NICHD Early Child Care Research Network. The effects of infant child care on infant-mother attachment security: results of the NICHD study of early child care. Child Dev 1997;68(5):860–79.
25. Edlund MJ, Wang PS, Berglund PA, et al. Dropping out of mental health treatment: patterns and predictors among epidemiological survey respondents in the United States and Ontario. Am J Psychiatry 2002;159(5):845–51.
26. Kessler RC, McLaughlin KA, Green JG, et al. Childhood adversities and adult psychopathology in the WHO world mental health surveys. Br J Psychiatry 2010;197(5):378–85.
27. Coates EE, Hayes KR, de Heer R, et al. "It was just good to have an outlet for other parents to talk to": feasibility and acceptability of integrating mental health and wellness services into predominantly black early childhood education centers during the Covid-19 pandemic [published online ahead of print, 2023 Jul 3]. Child Psychiatr Hum Dev 2023. https://doi.org/10.1007/s10578-023-01563-4.
28. Robertson HA, Biel MG, Hayes KR, et al. Leveraging the expertise of the community: a case for expansion of a peer workforce in child, adolescent, and family mental health. Int J Environ Res Publ Health 2023;20(11):5921.

29. Acevedo-Polakovich ID, Niec LN, Barnett ML, et al. Incorporating natural helpers to address service disparitiesfor young children with conduct problems. Childrenand Youth Services Review 2013;35:1463–7.
30. Gleason MM. Partnering with child-serving professional organizations: the example of early childhood mental health policy. J Am Acad Child Adolesc Psychiatry 2017;56(12):1012–4.
31. Howie LD, Pastor PN, Lukacs SL. Use of medication prescribed for emotional or behavioral difficulties among children aged 6-17 years in the United States, 2011-2012. NCHS Data Brief 2014;148:1–8.
32. U.S. Government. Accounting Office. Children's mental health, concerns remain about appropriate services for children in Medicaid and foster care. GAO Publications 2012;13(15).
33. Declercq E, Feinberg E, Belanoff C. Racial inequities in the course of treating perinatal mental health challenges: results from listening to mothers in California. Birth 2022;49(1):132–40.
34. Piotrowski CC, Talavera GA, Mayer JA. Healthy steps: a systematic review of a preventive practice-based model of pediatric care. J Dev Behav Pediatr 2009; 30(1):91–103.
35. Sarvet B, Gold J, Bostic JQ, et al. Improving access to mental health care for children: the Massachusetts child psychiatry access project. Pediatrics 2010;126(6): 1191–200.
36. Cama S, Knee A, Sarvet B. Impact of child psychiatry access programs on mental health care in pediatric primary care: measuring the parent experience. Psychiatr Serv 2020;71(1):43–8.
37. Hilt RJ, Barclay RP, Bush J, et al. A statewide child telepsychiatry consult system yields desired health system changes and savings. TelemedJEHealth 2015;21: 533–7.
38. Masters GA, Yuan Y, Li NC, et al. Improving front-line clinician capacity to address depression and bipolar disorder among perinatal individuals: a longitudinal analysis of the Massachusetts Child Psychiatry Access Program (MCPAP) for Moms. Arch Womens Ment Health 2023;26:401–10.
39. Harrison J, Steinberg J, Wilms Floet AM, et al. Addressing pediatric developmental and mental health in primary care using tele-education. Clin Pediatr 2022;61(1):46–55.
40. Fisher J, Cabral de Mello M, Patel V, et al. Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review. Bull World Health Organ 2012;90(2):139G–49G.
41. Muzik M, Borovska S. Perinatal depression: implications for child mental health. Ment Health Fam Med 2010;7(4):239–47.
42. Meltzer-Brody S, Brandon AR, Pearson B, et al. Evaluating the clinical effectiveness of a specialized perinatal psychiatry inpatient unit. Arch Wom Ment Health 2014;17:107–13.
43. DiSanza CB, Geller PA, Bonacquisti A, et al. A stepped care model of patient navigation to enhance engagement with perinatal mental health care. Health Equity 2020;4(1):484–8.
44. Stephenson LA, Macdonald AJ, Seneviratne G, et al. Mother and baby units matter: improved outcomes for both. BJPsych Open 2018;4(3):119–25.
45. Lane A Jr, Gavins A, Watson A, et al. Advancing antiracism in community-based research practices in early childhood and family mental health. J Am Acad Child Adolesc Psychiatry 2022;61(1):15–22.