**CORE PREVENTION & INTERVENTION FOR THE EARLY YEARS**

**Increasing research** and clinical evidence is demonstrating that:

- the early years of life have a unique and formative impact on development, relationships and functioning throughout life
- many adverse outcomes can be prevented when parents are provided with support and information that enables them to be optimally responsive to their infants and young children
- when there are identified risks and disorders in young children or in family functioning well-planned early intervention can promote optimal outcomes.

Practitioners in the field of infant mental health come from diverse educational backgrounds (e.g. nursing, social work, psychology, early childhood education, occupational therapy, speech-language therapy, on-the-job training). They provide care in different settings (e.g. the family home, clinics, centres in the community) through services offered by diverse organizations (e.g. public health, hospitals, children’s mental health, child welfare, infant development programs, childcare, family resource centres).

Frequently practitioners and organizations question what kinds of interventions and supports should be made available for young children and their families. **This document was developed by Infant Mental Health Promotion to provide a framework for the different types of interventions needed by individual children and families and the training needed by practitioners**¹ **to provide different levels of intervention.**

It is important to recognize that a variety of theoretical models and approaches are necessary to address the multiple needs of families. A broad integrated approach is needed with understanding of theoretical underpinnings of any intervention used. Practitioners from different disciplines may use similar approaches and techniques or more specialized interventions in providing care to young children and their families. However, all practitioners need to recognize the scope and boundaries of their skill and training. When necessary, referrals must be made to appropriate settings for intervention to meet the particular needs of young children and their families. Therefore it is necessary to be aware of available community resources and ways to find this information. As well, advocacy may be needed for appropriate public resources when these are lacking. When appropriate resources are not immediately available, it may be necessary to continue to work with a family within a practitioner’s area of competence.

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1. Also see Competencies for Practice in the Field of Infant Mental Health, IMP December 2002, and Organizational Policies & Practices to Support High Quality Services in the Field of Infant and Young Child Mental Health, IMP March 2004.
**Focus of Intervention Based on Identified Risk or Problem**

The focus of intervention will differ depending on the risks or problems identified by screening or assessment. For example, intervention might be needed for risks or problems identified in the following areas:

**Child** — difficult temperament, prematurity, developmental delay, failure-to-thrive, extreme sensitivity to sensory experiences, suspected abuse or neglect, loss of a significant caregiver, withdrawal, extreme activity level, aggressive behaviour and emotional disregulation/reactivity

**Parent** — limited parenting knowledge and skills, negative attributions of the child, failure to protect child, mental illness, chronic health problem, substance abuse, unresolved loss & trauma, developmental delay, low educational level, history of parenting difficulties, high stress, developmental stage of parent (e.g. adolescence, mid-career)

**Parent-child interaction** — insensitive and/or rejecting parental responses to child, angry & harsh discipline, frightened or frightening behaviour towards child, failure to protect child, disorganized parent-child attachment, child avoids eye contact with parent and/or seems afraid of parent, child is controlling with parent

**Home/family environment** — family dysfunction (e.g. disorganization, conflict, transience), partner violence, inadequate family supports, poverty/inadequate financial resources for food, housing and other basic needs, social isolation, lack of toys/play materials/recreational activities

**Community** — violence, poverty, lack of safety and supports, inadequate housing

**Society** — inadequate health & social resources, lack of employment opportunities, ethnocultural bias

In order to achieve optimal outcomes, the focus of intervention should cross all areas of risk (see Diagram 1). Therefore, a variety of interventions and practitioners may be needed with expertise in a particular area.

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**Diagram 1**

![Diagram](image)
Examples of intervention in the different areas include:

Child — direct therapies (e.g. play, speech and language, sensory motor, social interaction, emotion regulation, developmentally modified cognitive behavioural, intensive behavioural skill development), childcare, child protection

Parent — information (e.g. on child development, parenting, problem solving strategies), individual and group therapy (e.g. for unresolved loss/trauma, mental health issues, substance abuse, violence, building insight, brief solution focused), parent training for specific parenting skills, support groups (e.g information exchange, mutual support)

Parent-child interaction — dyadic interventions (e.g. psychodynamic parent-infant psychotherapy, infant-led psychotherapy, interactional guidance, modified interaction guidance), changing parental attributions of child, behavioural parent coaching, parent-child social interaction groups

Home/family environment — assistance with basic needs (food, clothing, shelter, safety), suggesting appropriate play materials, crisis intervention, supporting family self-sufficiency, family therapy

Community — connecting families to community supports, resources and recreational activities, providing parent-child play groups and quality childcare, case conferences, case management and service co-ordination, violence prevention, advocacy, community development

Society — general public information (e.g., radio, TV) and materials (e.g. pamphlets, videos), advocacy for appropriate services and resources

Focus of Intervention Based on Developmental Stage

At different child developmental stages the focus of intervention will differ. For example:

Prenatally — emphasis on the health and nutrition of the mother, the family’s preparation for labour and their new child, parental attributions of the unborn child and expectations for the child and parenthood, early risk identification and building supports to minimize their impact, concrete assistance for low income families

Postnatal period — emphasis on breastfeeding, the mother’s and baby’s health, baby safety and care, the role of the father

1-3 months — emphasis on supporting the parent in helping baby to soothe and begin to engage with people and the world around, in getting to know the baby and responding to temperamental characteristics of the baby

4-12 months — emphasis on promoting a selective, secure attachment to primary caregivers, exploration of the world around, gross & fine motor, communication and cognitive skill development, building a base of parenting support

Toddlerhood — emphasis on supporting the child’s growing autonomy (self-feeding, toilet training) and sense of self, emotion regulation (coping with temper tantrums), limit setting

Preschool — emphasis on helping child cope with negative emotions (fears, sadness, anger, jealousy), promoting ability to express thoughts and feelings in words and to inhibit aggression and resolve conflict prosocially, encouraging pretend play, cooperation, empathy, learning and complying with rules, and positive self-esteem
Level of Prevention and/or Intervention

A hierarchy of prevention and intervention approaches can be conceptualized to meet the diverse needs of individual young children and their families. (See pyramid of interventions in Diagram 2.) At the base of the pyramid are universal, preventive interventions that should be available to all families. Higher up in the pyramid more complex and sophisticated interventions are needed to address more complex child and family situations. The number of risks present can be an important indicator of the intensity and sophistication of intervention needed. The borders between levels are fluid as different risks are often recognized during the process of intervention. Families in need of interventions at a higher level in the pyramid will often need complementary interventions at a lower level. The key is to find the most suitable set of interventions and supports for each child and family, and to do so such supports must be both available and accessible.

Diagram 2

Broad expertise in working with particular disorders (e.g. mental health, speech & language, sensory integration, failure-to-thrive, substance use, violence, trauma counseling, child protection)

Specialized training to engage high-risk families and in interventions to address specific risks (e.g. attachment-based dyadic interventions, crisis interventions)

Specific training (e.g. running groups, individual and group parenting psycho-education, promoting development in specific areas)

Training in early development, parenting, health promotion & teaching, nutrition, safety, community development etc.

Diagnosed disorder or problem

High risk — more than 8 identified indicators of predisposition for disorder

At moderate risk for developing a problem — 4-8 risk factors

Whole population group — fewer than 4 identified risks

INTERVENOR COMPETENCE

LEVEL OF INTERVENTION

POPULATION SERVED
1. Universal Prevention

Population served:
- All expectant parents and families with young children in a community (population-based)
- Fewer than 4 identified individual risk factors & several protective factors, for example:
  ✔ Child developing well, responsive, content and well cared for
  ✔ Parent-child interaction warm, sensitive and responsive
  ✔ Parent(s) have realistic confidence about parenting, good emotion regulation, positive attributions of child, and are open to new information about parenting and child development
  ✔ Good family and/or community support

Tools/techniques:
1. Screening to identify children and parents who need more in-depth assessment
2. Engaging and motivating families
3. Referral for further investigation
4. Brief telephone interventions (e.g. parent help lines, parent information lines)
5. Support for accessing resources to meet basic needs (food, clothing, shelter, safety)
6. Communicating information about child development and parenting
7. Supporting and teaching problem solving strategies
8. Connecting families to community supports and resources
9. Providing parent-child play groups
10. Providing quality childcare
11. General public information (e.g. radio, TV) and materials (e.g. pamphlets, videos)

2. Early Intervention

Population served:
- Expectant parents and families with young children at moderate risk for developing a problem
- Between 4–8 risk factors and few protective factors, for example:
  ✔ Child shows some developmental difficulties, is sometimes responsive/content, and sometimes seems to have to demand care
  ✔ Parent-child interaction sometimes sensitive and responsive but can be rejecting
  ✔ Parent(s) anxious about parenting, have difficulty with emotion regulation, distorted attributions of child, and are ambivalent about intervention
  ✔ Inadequate family and/or community support

Tools/techniques:
1. Comprehensive assessments of child and family in the home or clinic to identify risk and protective factors
2. Engaging and motivating families
3. Providing home visiting with direct instruction, feedback, modeling
4. Monitoring developmental progress and referring children with health, cognitive, language, and social-emotional difficulties to appropriate resources
5. Providing parent groups (e.g. attachment focused, positive parenting focused, speech & language)
6. Supporting family self-sufficiency, competency and empowerment
7. Connecting families to community supports and resources
3. Indicated Intervention

Target population:
- High risk expectant parents and families with young children who have identified symptoms or biological indicators for a disorder
- More than 8 risk factors and few protective factors, for example:
  ✔ Child often unresponsive, withdrawn and unhappy, does not approach parents or acts out for attention
  ✔ Parent-child interaction insensitive, child’s cues ignored, no monitoring of child’s activities
  ✔ Parent(s) often lose control, seem depressed or anxious, have low or unrealistically high confidence about parenting, negative attributions of child
  ✔ Parent(s) are suspicious of intervention
  ✔ Isolated, socio-economic difficulties
  ✔ Family violence

Tools/techniques:
1. Comprehensive assessments of child, parents and family in the home or clinic
2. Engaging and motivating families
3. Referral for specialized assessments by appropriately trained professionals
4. Developing and monitoring individual goals and home-based or clinic-based treatment plans
5. Clearly set boundaries and expectations for intervention
6. Dyadic parent-child interventions to enhance reciprocity, sensitivity, responsiveness, attachment (e.g. psychodynamic parent-infant psychotherapy, infant-led psychotherapy, interactional guidance or modified interaction guidance)
7. Support and problem solving to help parents gain insight into personal issues and access appropriate services
8. Supporting family self-sufficiency, competency and empowerment
9. Sensitivity to the safety of child and parent and referral for child protection if not already involved
10. Crisis intervention as needed
11. Quality childcare with resources to address special needs, therapeutic childcare, and respite care
12. Case conferences, case management and service co-ordination

4. Treatment

Population served:
- Young child with a diagnosed disorder e.g. Post-traumatic Stress Disorder (PTSD), failure-to-thrive, autistic spectrum disorder, developmental delay, visual or auditory impairment
- Parent-child interaction abusive or neglectful, hostile attributions of child
- Parent(s) have a severe mental illness (e.g. psychosis), a significant loss or trauma, substance use problems, cognitive limitations, impulsivity
- Parent(s) are rejecting of intervention
- Conflictual family relationships and no strategies for solving problems
- Partner physical, verbal and sexual abuse

Tools/techniques:
1. Formal diagnostic assessments by professionals trained in using state-of-the-art standardized tools
2. Formulation, goals and a treatment plan developed by an appropriately skilled professional team
3. Reassessment at regular intervals to adjust treatment as necessary
4. Clearly set boundaries and expectations for intervention
5. Direct therapy for child to enhance communication, cognition/learning, social interaction, self regulation (e.g. play therapy, intensive behavioural intervention, sensory-motor integration, speech and language therapy)
6. Dyadic or family interventions guidance to enhance reciprocity, sensitivity, responsiveness, attachment and reduce atypical interactions e.g. psychodynamic parent-infant psychotherapy, infant-led psychotherapy, interaction guidance or modified interaction guidance, behavioural interventions
7. Individual or group therapy for parents (e.g. for unresolved loss/trauma, mental health issues, substance abuse, violence)
8. Quality childcare with resources to address special needs, therapeutic childcare, and respite care
9. Supporting family self-sufficiency, competency and empowerment
10. Awareness of the signs of child maltreatment, violence in the home, trauma and substance use and referral for child protection if not already involved
11. Crisis intervention as needed
12. Case conference, case management and service co-ordination

**Best Practices**

**Findings on what works** in prevention and early intervention have tended to be inconclusive and may not give clear directions for evidence-based best practices. Program evaluations differ in whether the intervention is home-based or centre-based, what is done and what is measured (e.g. attachment, cognition, parental self-esteem, incidence of child abuse, attendance). Some programs have shown positive effects on certain outcomes while others have not and few studies have met the criteria for scientific rigour. Some studies comparing two types of intervention have found each intervention to be effective for different outcomes (e.g. intervention focused on child development showing improved child social competence and adaptation, and relationship-focused intervention showing greater emotional security of the child). However, intervention groups generally show improved development over untreated control groups and although short-term gains are sometimes not sustained, major improvements are often seen with subsequent children and over the long term when the infants themselves became parents. It is important for practitioners to have reasonable expectations about improvement, to appreciate small gains made, and sometimes to continue working with a family when little progress may be seen.

Despite uncertainty about what works, some general principles can be drawn about optimal practice.

**General Principles of Prevention & Early Intervention**

1. Universal prevention strategies provide the foundation needed to identify families at risk and for other interventions to be effective. It is critical to build on the basics for intervention at higher levels to work.
2. The earlier the intervention the more positive outcomes are likely to be, in part because there is less likelihood for secondary complications.
3. For families with multiple risks, no single intervention can be effective and multiple components of treatment are needed from different services.
4. Case management and service integration models are important to ensure a seamless system of care.
5. At various stages, families may move up or down the pyramid (Diagram 2) to different levels of intervention in order to address the hierarchy of needs of a family and the well-being of both parent and child.

6. Higher up in the pyramid, longer and more intensive interventions will be needed and it is likely that some form of intervention will be needed throughout the life span.

7. Higher up in the pyramid, more intensive training is needed for intervention and specific training is needed to address specific risk factors (e.g. substance abuse).

8. Clinical consultation and supervision by more highly trained professionals is needed to support the work of those who work on the front-line.

9. a) A universal screening process is needed to identify children who might be at risk.
   b) Comprehensive assessment of the child, parents, parent-child interactions and environment is necessary to determine the appropriate level of intervention for those at risk.
   c) In-depth diagnostic assessment by trained discipline-specific professionals is needed for more complex situations.
   d) Ongoing monitoring and assessment will be necessary as changes occur or new needs arise.

10. Where there is an established child disorder or extreme psychosocial risk, direct work with the child may be needed.

11. Brief focused interventions have been found to be effective in changing specific aspects of functioning (e.g. parent-child interactions, attachment, language).

12. A focus on the parent-child interactions and parental attributions of the child may be necessary for optimum socio-emotional outcomes for the child.

13. In order to maintain gains, it is important to explore the needs of the whole family situation rather than focusing on only specific behaviours related to specific risks.

14. The therapeutic parent-intervener relationship is key, particularly when parents have a history of trauma or loss.

15. A first step often involves efforts to reach out and engage families (e.g. through information provision, home visiting, assistance with transportation/food/childcare, persistence, culturally-sensitive outreach practices).

16. A family-centred approach that makes the parents partners in the intervention avoids feelings of parental helplessness and anger and improves chances for positive outcomes.

17. Individual services should be available both for parent and child as well as appropriate community support resources such as respite care, childcare, housing etc.

18. Advocacy can be helpful in ensuring appropriate resources to meet individual family needs.

19. Interventions should be attuned to differences in family structure and patterns of relating including cultural, racial and socio-economic differences.

20. Practitioners need to keep abreast of and incorporate into their work new developments and research in this rapidly-developing field.

21. Regular reflective supervision, individually and/or in peer groups, provides the support needed by interveners for effective practice in this challenging field.