

Best Practices in Early Childhood Mental Health Services

Creating Continuity in Early Childhood Mental Health Services between Medicaid and Other Funding Sources



[//www.arthursclipart.org/children/togetherbw1.htm](http://www.arthursclipart.org/children/togetherbw1.htm)



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Note

This manual is offered as a guide to best practice with some, but not all tools and therapy models appropriate for young children and their families. It is not meant to replace training or ongoing supervision. Inclusion in this document does not infer an endorsement of the particular model or tools highlighted. These are offered as examples of what early childhood specialists are currently using. The Medicaid codes listed in this manual are accurate at the time of publication. However, due to the changing nature of the health care field, clinicians are encouraged to check the codes provided. They are offered as examples of how early childhood work can fit within our current coding system. Any questions regarding the information contained in this guide should be addressed to Claudia Zundel at Colorado Department of Human Services, Division of Behavioral Health, 3824 West Princeton Avenue, Denver, CO 80236 Claudia.zundel@state.co.us.

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Ten Standards for Best Practices in Early Childhood Mental Health

1. Relationships rather than individual children are a focus of intervention as young children's psychological functioning unfolds within the context of their relationships.
2. Initial assessment should take place over 3-5 sessions as the meaning of the child's behavior must be uncovered. Young children do not have the language to describe what they are thinking and feeling. Assessments need to be multi-faceted and include all caretakers and settings in the child's life.
3. Assessment should be part of every session as the child's development is emerging rapidly.
4. Mental health assessment should include information from a full developmental evaluation since development in various domains is related.
5. Location, length and time of sessions provided by early childhood specialists will vary; therefore clinicians need flexibility and small caseloads at any one time. Services and interventions should be provided in the most appropriate environment including in real time and natural settings such as childcare, pediatric clinics and homes.
6. Parents and children function within the context of cultural, socioeconomic, familial and psychological conditions. These must be understood to develop a successful intervention plan.
7. Early Childhood Clinicians need to be specifically trained in early childhood mental health and supported with ongoing reflective supervision.
8. The array of services and supports offered to children and their families should be individualized and not driven by funding source restrictions. Some interventions may be environmental and consultative rather than direct therapy such as a recommendation to child welfare for a change in foster care home.
9. The DC: 0-3R should be used for diagnosis for all children birth through age four and up to five if appropriate.
10. Exposure to violence and chronic stress should be considered as a core area of early childhood mental health. Children may develop reactions that linger and affect their daily lives long after the stress or traumatic event(s) has ended.

Standard One

Relationships rather than individual children are a focus of intervention as young children's psychological functioning unfolds within the context of their relationships.

How is this unique to early childhood?

Relationships are important for all children but to a greater extent for young rather than older children. Viewing the infant or young child alone as the client or the source of the problem can lead to ineffective practice. The infant and young child's psychological health is strongly influenced by their environment of relationships and support or risk these relationships offer.

What does science tell us?

The emotional well-being of infants and toddlers is directly tied to the emotional functioning of their caregivers and the families in which they live. A core premise of infant mental health is that babies' emotional, social, and cognitive development unfolds within relationships. Additionally, the impact of larger influences of cultural values, poverty, and social conditions are filtered through the ability of parents and caregivers to protect, buffer, and socialize the infant (Osofsky & Leiberman, 2011).

Stable, nurturing relationships early in life are associated with better physical and mental health, fewer behavior problems, higher educational achievement, more productive employment, and less involvement in the criminal justice system (Center on the Developing Child at Harvard University, 2010).

Children with insecurely attached relationships are more likely than those in secure relationships to show elevations in cortisol (stress reactions) when encountering even mildly threatening events (Fisher et al, 2006).

When these relationships are abusive, threatening or chronically neglectful they are a potential risk factor for the development of early mental health problems. Several Colorado studies illustrate the fact that a large majority of children (60-80%) identified with serious emotional difficulties come from homes with a history of mental illness, substance abuse, domestic violence or child abuse (Project BLOOM, 2008, Kubicek, 2010).

Standard Two

Initial assessment should take place over 3-5 sessions as the meaning of the child's behavior must be uncovered. Young children do not have the language to describe what they are thinking and feeling. Assessments need to be multi-faceted and include all caretakers and settings in the child's life.

How is this unique to early childhood?

Young children do not have sufficiently developed social and emotional language to describe what they are feeling. They do not respond to emotional experiences and traumatic events in the same way as adults. Because there is a broad range of developmental difference in young children, it is important to tease out what behavior might be a developmental difference and what behavior indicates an emotional difficulty. Seeing children in different settings allows the clinician to determine whether behavior is a specific response or generalized across settings.

What does science tell us?

The recommendations of the developers and trainers of the DC: 0-3R system is for the initial assessment to take place over a 3-5 session period. The DC: 0-3R was developed by leading experts in the field. Since the DC: 0-3R system is multi-axial, a comprehensive assessment must attempt to understand the child's functioning across all axes (Emde & Egger, 2011).

Because young children's symptoms may vary across settings, it is imperative for clinicians to assess multiple contexts and relationships and include multiple sessions, multiple informants, multidisciplinary and multicultural perspectives and multiple modes of assessment (Zeanah, 2000).

Standard Three

Assessment should be part of every session as the child's development is emerging rapidly.

How is this unique to early childhood?

Although ongoing assessment is an important part of all treatment, it is especially important for young children as their development is moving quickly. Some distress may indeed be transient as the children develop more sophisticated means of dealing with stress. In addition, every child reaches developmental milestones at different times and these natural differences must be weighed when determining the extent of a child's distress. The goal of treatment is to promote and support positive movement towards increased child-care giving reciprocity as well as a more adaptive child developmental course. Only an open-ended approach to diagnosis can be flexibly responsive to this dynamic developmental and interactional picture.

What does science tell us?

Early childhood is an exciting time of rapid development. Young children are growing physically, cognitively, socially, and emotionally. Often, development in one area is strongly tied to development in another area. Assessment needs to be an ongoing process because children change, parents change and circumstances change.

New research on the developing brain suggests the importance of early experience not just for cognitive development, but for emotional development as well. During this period, brain development occurs at a rapid pace and is shaped by the infants' experiences and early relationships. Early childhood is the most intensive period of brain development during the lifespan. It is during these years that a child's brain is most sensitive to the influences of the external environment. Rapid brain development affects cognitive, social and emotional growth (World Health Organization, 2009).

Standard Four

Mental health assessment should include information from a full developmental evaluation since development in various domains is related.

How is this unique to early childhood?

For young children, an issue in one developmental domain may affect another. For example, if a child has limited language ability this may affect his or her ability to regulate emotionally without signifying an emotional issue. Because early childhood is a time of rapid growth that is not necessarily sequential, all of the child's development must be examined when addressing social and emotional concerns.

What does science tell us?

Emerging brain research has demonstrated the clear connection between developmental domains. The brain is a highly interrelated organ, and its multiple functions are richly coordinated. Cognitive, emotional and social capacities are inextricably intertwined (INBRIEF, Center on the Developing Child at Harvard University, 2010).

The circuits that are involved in the regulation of emotion are highly interactive with those associated with "executive functions." Emotions support executive functioning when they are well regulated, but interfere with attention and decision-making when they are poorly regulated (National Scientific Council on the Developing Child, Working Paper #4, 2004).

Rather than a straightforward path of development, research is illustrating more complex pathways of interesting development within various domains. The examples of the alternate developmental pathways for shy, autistic, and maltreated children highlight the importance of examining the intersections of domains from a developmental perspective. Assumptions about the child's cognitive, language or social development, made in the absence of context and without attention to domain intersections, can lead to the erroneous belief that the child, for example, has a cognitive delay rather than an adaptive difference. The practical result is often that the assumed cognitive delay is addressed without acknowledgement of the child's actions as adaptive and developmentally maturing responses to an adversarial condition or environment (Ayoub, 2006).

Because young children are eligible for Part C services for early intervention, the child's current functioning must be understood across the various developmental domains (cognitive, language, motor, and social-emotional) and include assessment of any developmental delays and/or medical/genetic conditions. The complete mental health assessment of a young child will include collaborations with professionals who can provide these evaluations (Emde & Egger, 2011).

"Emotional growth, patterns of attachment and increasing competency in the ability to form relationships, and the emergence of self-confidence are as crucial to overall development as are physical growth, cognitive or motor skills. The physical, mental and emotional health of the very

young child provides the foundation for further development” (Jane Knitzer, National Center for Children in Poverty, Columbia School of Public Health, 1998).

The care that infants and young children receive by caregivers lays the groundwork for the development of a wide range of basic biological processes necessary to support emotion regulation, sleep wake patterns, attention, and ultimately all psychosocial functioning (Center on the Developing Child at Harvard University, 2010).

Standard Five

Location, length and time of sessions provided by early childhood specialists will vary; therefore clinicians need flexibility and small caseloads at any one time. Services and interventions should be provided in the most appropriate environment including in real time and natural settings such as childcare, pediatric clinics and homes.

How is this unique to early childhood?

Early Childhood mental health interventions are largely targeted at those who interact with the child. It is important to observe the meaning of behavior within different settings and with different caregivers. Because the focus of intervention may be changing an adult's reaction to a child's behavior it is important to observe in real time and make relevant suggestions. The parent or caregiver is often the primary agent for change.

What does science tell us?

The evidence based or best practice strategies are designed for implementation either with parents or childcare providers. This means early childhood clinicians are often on-site in different settings, delivering services. The amount of time for each service does not neatly fit into a 50-minute session. Travel time and the ability to adjust intensity of services to the needs of the families must be factored in when considering appropriate caseloads. Often parents have their own mental health or substance abuse issues, which also impacts the complexity of interventions.

Services should be delivered within a cross disciplinary approach that focuses on the family as the agent of change (Osofsky & Leiberan, 2011).

“Despite longstanding calls for an explicitly community-focused, primary care strategy, a recent national study of pediatric practices identified the persistent inability to achieve better linkages with community-based resources as a major challenge” (Center on the Developing Child at Harvard University, 2010).

Standard Six

Parents and children function in the context of cultural, socioeconomic, familial and psychological conditions. These must be appreciated and fully explored to develop a successful intervention plan.

How is this unique to early childhood?

The family as the child's main environment is not unique to early childhood, but holds special importance. The families' childrearing practices and beliefs must be a part of the assessment and resulting intervention. The foundations of relationships and the fundamentals of socialization are culturally embedded and established during the early childhood years.

What does science tell us?

The following excerpt from Neurons to Neighborhoods summarizes the science and explains its relevance to early childhood. In the realm of early childhood development, symbolic inheritances include (but are not limited to) parents' expectations, goals, and aspirations for their children; the values that govern differential approaches to discipline; gender roles; religious or spiritual values; and ideas and beliefs about health, illness, and disability. Behavioral inheritances, in turn, are embodied in the "scripts" that characterize everyday routines for such common activities as sleeping, feeding, and playing, among others, and the distinctive contexts that shape cognitive, linguistic, and social-emotional development and thereby influence the acquisition of specific skills or behaviors.

Central to the process of intergenerational culture transmission during the early childhood years is the translation of cultural belief systems ("parental ethno theories") into parenting practices (Goodnow and Collins, 1990; Harkness and Super, 1992; Sigel et al., 1992). Whiting and Child (1953) noted both similarities and differences in approaches to childrearing in different cultures, and identified distinctive parenting practices as important reasons for the variations in child outcomes found across diverse populations. LeVine (1977:20) proposed a hierarchy of three universal goals that all parents have for their children: (1) physical survival and health, (2) development of the capacity for economic self-maintenance, and (3) development of the "behavioral capacities for maximizing other cultural values—e.g., morality, prestige, wealth, religious piety, intellectual achievement, personal satisfaction, self-realization—as formulated and symbolically elaborated in culturally distinctive beliefs, norms, and ideologies." In a society in which threats to physical survival are significant, care giving is focused primarily on protection. When survival is assumed, childrearing practices reveal a process of socialization that reflects the values of the culture and the aspirations of parents for their children (Neurons to Neighborhoods, 2000).

One in five children who live in poverty have a diagnosable mental health disorder (Masi & Cooper, 2006 cited in Osofsky & Lieberman, 2011).

Socioeconomically patterned differences in children's emotional, cognitive and social experiences have been linked to brain development, especially in areas of the brain tied to the regulation of emotion and social behavior, reasoning and stress reactivity (Center on the Developing Child at Harvard University, 2010).

Standard Seven

Early Childhood Clinicians need to be specifically trained in early childhood mental health and supported with ongoing reflective supervision.

How is this unique to early childhood?

It is important that early childhood clinicians understand the areas listed on page 17 in this document. Early Childhood Mental Health is more than “just playing” or modifying techniques used with older children. The clinician must understand early childhood development and the interplay of various developmental domains. The clinician must also be skilled at understanding adult psychology as the mental health needs of caregivers will impact young children. This work will take the clinician out of the office and into the home and childcare settings. The clinician must be able to creatively take advantage of everyday moments to teach important new skills to caregivers. Reflective supervision relates to professional and personal development within one’s discipline by focusing on the emotional content of the work and how reactions to the content affect the work with families (Michigan Association of Infant Mental Health website).

What does science tell us?

The science on the benefits of reflection supervision is very young. However, the leading experts in the early childhood mental health field agree that reflective supervision is a critical part of providing effective services. Studies in other fields such as education demonstrate the benefit of coaching or reflective supervision as a means to change behavior. The Michigan Endorsement, the most widely used infant mental health competency system in the country, documents the best practice associated with reflective supervision. Interviews with experienced IMH consultants, supervisors and practitioners in Michigan confirm the importance of reflective practice to infant mental health work (Weatherston, 2000).

In most communities, mental health services for young children are limited, of uneven quality, and difficult to access. There are few well-trained professionals with expertise in infant mental health (National Scientific Council on the Developing Child, Working Paper #6, 2008).

When mental health specialists are not well trained they may succumb to the widely held belief that young children are not affected by trauma. In these instances, intervention plans often address the wrong problem; in some cases very young children are even placed on psychotropic medications (Chinitz et al, 2010).

Research has shown the extent to which higher levels of staff training and expertise predict effectiveness in services targeting developmental progress and child abuse prevention (Center on the Developing Child at Harvard University, 2010). There is considerable new knowledge related to evidence-based services for young children and the ways in which these services can support parents and professional caregivers to intervene with children exhibiting excessive fears, withdrawal, aggressive behavior, or difficulty with inattention, hyperactivity and impulsivity, but access to these services remains markedly limited (Center on the Developing Child at Harvard University, 2010).

Standard Eight

The array of services and supports offered to children and their families should be individualized and not driven by funding source restrictions. Some interventions may be environmental and consultative rather than direct therapy such as a recommendation to child welfare to change a foster care home.

How is this unique to early childhood?

Early childhood is a time of rapid growth and development. Children's development is linked to the quality of their relationships with adult caregivers. Each situation may be carefully evaluated and interventions designed specifically for the child and family. Even evidence-based practices such as Parent Child Interaction Therapy are individualized for the specific issues of the family. Interventions are more environmental than individual change driven. The young child does not have the capacity to adjust; therefore, the environment and relationships need to adjust to address the child's distress.

What does science tell us?

New science is constantly emerging that documents the important brain development happening in early childhood. The World Health Organization states:

- Early childhood is the **most** important phase in overall development throughout the lifespan.
- Brain and biological development during the first years of life is highly influenced by an infant's environment.
- Early experiences determine health, education and economic participation for the rest of life (World Health Organization, Fact Sheet N332, August 2009).

It is clear that relationships and the child's exposure to stress may influence the actual brain architecture. What we know is that because every individual's experiences are different, their brain is unique. Every brain is wired differently (Medina, 2010). We know that children are affected by experiences emotionally much earlier than we had previously understood. Children as young as four months old can experience depression (Zerotothree). But children lack the cognitive ability to make changes in their thought patterns. Therefore, the necessary environmental and relationship changes need to be carried out by adults.

Standard Nine

The DC: 0-3R should be used for diagnosis for all children birth through age four and up to five if appropriate.

How is this unique to early childhood?

Although we know that children suffer with emotional distress, current diagnostic systems do not fully appreciate the developmental issues of early childhood (Emde & Egger, 2011). The creation of the DC: 0-3 represented a useful scheme that would complement but not replace existing medical and developmental frameworks such as The Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association and the International Classification of Diseases of the World Health Organization. The DC: 0-3 helps clinicians: a) recognize individual differences in ways infants and young children process sensation, organize experience and implement action, b) observe and understand the child's interaction with key caregivers, c) explore the impact of family, cultural and community patterns on the child's development, and d) capture the quality of the child's adaptive processes as well as developmental challenges the child faces (DC: 0-3 Casebook, 1997).

What does science tell us?

The DC: 0-3 published in 1994 was the first developmentally based system for diagnosing mental health and developmental disorders in infants and toddlers. Its diagnostic categories reflect the consensus of a multi-disciplinary group of experts in early childhood development and mental health. The Diagnostic Classification and Developmental Disorders of Infancy and Early Childhood, Revised (DC: 0-3R) draws on empirical research and clinical practice that has occurred worldwide since 1994. Because the DC: 0-3R examines relationships and environmental factors it points to way to effective intervention approaches (DC: 0-3R, 2005).

The DSM system was developed with little or no attention to the developmental differences in the presentation of psychiatric disorders (Emde & Eggers, 2011).

“Despite the age range implied in its title, the DC: 0-3 has been widely adopted in clinical and service settings for the assessment of children from birth to age five years” (Emde & Egger, 2011).

Standard Ten

Exposure to violence and chronic stress should be considered as a core area of early childhood mental health. Children may develop reactions that linger and affect their daily lives long after the stress or traumatic event(s) has ended.

How is this unique to early childhood?

While a trauma screening should be part of every assessment, we know that many young children experience some type of trauma. The Adverse Childhood Study revealed that 2/3rds of a general population experienced at least one adverse childhood experience. Over half of the child welfare open cases are children under the age of seven. The exploration of trauma in early childhood situations means that support can be offered closer to the time of experience. It should also be noted that children may experience events in their lives differently than adults.

What does science tell us?

“Science clearly demonstrates that, in situations where toxic stress is likely, intervening as early as possible is critical to achieving the best outcomes. For children experiencing toxic stress, specialized early interventions are needed to target the cause of the stress and protect the child from its consequences (*INBRIEF, Center on the Developing Child at Harvard University, 2010*).

There is extensive evidence that very young children can experience debilitating anxiety and trauma from parental abuse or neglect or witnessing violence, as well as data illustrating the early interventions can moderate these effects (National Scientific Council on the Developing Child, Working Paper #2, 2004).

Often due to the passage of time and other intervening variable the connection to these early experiences can become muddled and perhaps forgotten, making effective intervention more time consuming and costly later in life (Adverse Childhood Study).

Skills/Competencies/Knowledge Needed to be an Effective Early Childhood Mental Health Clinician

Clinicians working in early childhood mental health should have all basic skills expected of a professional in psychology or counseling in the areas of adult and child assessment, diagnosis, treatment, ethical and culturally competent practice.

In addition, the clinician in early childhood mental health needs the following:

*Knowledge of:

- Pregnancy, early parenthood and family development.
- Infant & young child development and behavior including early brain development and implications for parenting.
- Screening and assessment instruments for identification of developmental progress, concerns and delays.
- Family relationships & dynamics including characteristics and needs of chronically stressed or dysfunctional families.
- Attachment theory, early relationship development and the impact of separation, loss and pathogenic care.
- Disorders of infancy/early childhood and DC: 0-3R as a diagnostic system.
- Infant/young child & family-centered, relationship based therapeutic practice.
- Specific strategies and interventions targeting developmental and therapeutic needs of young children and their families.
- Special issues related to emotional health (e.g., prematurity, failure to thrive, adolescent parenthood, maternal depression, violence and its impact on families, grief and loss, substance use).

Understanding of:

- Service delivery systems for infants and young children.
- Childcare practices in families, childcare homes and childcare centers.
- Community resources for young children and their families.
- Consultation and collaboration.

Reflective Practice Skills:

- Contemplation.
- Self-awareness.
- Curiosity.
- Emotional Responsivity.

*Adapted from the Michigan Department of Community Health Website and the Michigan IMH-E Competencies.

Resources for Professional Development

Clinicians working with young children need to have specialized skills and knowledge. There are few formalized programs across the country providing these trainings. Most clinicians obtain the necessary skills and training on the job. For this reason, early childhood mental health clinicians must receive regular clinical and reflective supervision from an experienced early childhood mental health clinician.

In addition, there are several resources for acquiring knowledge and skills in Early Childhood Mental Health:

Colorado offers the Harris Fellowship Program as a means for psychology fellows and other mid-career professionals from a variety of disciplines to receive a year of intensive training and supervision while maintaining employment. More information at:

www.medschool.ucdenver.edu/psychiatry/harrisprogram

The Colorado Association of Infant Mental Health (COAIMH) is working across the state to implement the full Michigan Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health (IMH-E), known also as the Infant Mental Health Endorsement. This would allow early childhood clinicians to receive an endorsement after demonstrating a set of competencies. More information can be obtained from:

<http://www.coaimh.org/endorsements.php>.

Information on early childhood development as well as tip sheets for parents can be found at <http://www.zerotothree.org/>

What does an Early Childhood Mental Health Clinician Do?

What follows are various activities that early childhood clinicians may be implementing. Information about coding and billing is in bold ink. A general statement of best practice is included with a limited number of resources. This is not meant to be inclusive but merely a starting point. This document is not meant to replace training.

Screening

Early Childhood Mental Health Specialists may be called up to conduct or interpret social/emotional screenings in a number of settings. It is important that all involved understand the nature of screening. Screening looks at the whole population to identify those at risk. It flags those who need further assessment. Screening instruments differ from information obtained in an assessment/full evaluation in that they indicate, "risk" for negative outcome or a possibility that a problem or challenge exists. Screening should not be a one-time activity. Rather, best practice says that children should be screened in regular intervals (every 4-6 months – especially in the first 3 years). Screening instruments do not diagnose or identify delays in order to qualify for services. Feedback and interpretation to parents, caregivers and professionals should reflect this distinction. Screening instruments are not intended to be used as pre/post measures in studies or as "outcome" measures to prove that your intervention was working.

Guidance for *some* appropriate tools can be found

<http://jfkpartners.org/documents/Social-Emotional%20Screening%20Report.pdf>

Or

<http://www.nectac.org/~pdfs/pubs/screening.pdf>

Not all screening tools are equally effective. Tools chosen should be empirically validated instruments. In addition, it is important to determine if the instrument has been validated with the particular population that is being screened.

Screening tools used commonly in Colorado include:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire – Social and Emotional (ASQ-SE)
Further information can be found at www.coloradoabcd.org
There is an entire section for Child Care providers that include many resources. Assuring Better Child Health and Development (ABCD) offers trainings on the ASQ-3 and the ASQ: SE, 3-4 times a year. Please contact Eileen Auer-Bennett about these trainings; her contact information is on the ABCD website.
- Parents Evaluation of Developmental Status (PEDS)
- Devereux Early Childhood Assessment (DECA)
- Devereux Early Childhood Assessment – Clinical Form (DECA-C)
- Brief Infant Toddler Social-Emotional Assessment (BITSEA)
- Temperament and Atypical Behavior Rating Scale (TABS)

Billing for Screening:

Behavioral Health Screening (H0002)

Observation

Observation often occurs in the context of consultation. Early Childhood Mental Health Clinicians often consult in childcare or primary care settings or consult with providers in other infant and child serving systems such as Early Intervention or Nurse Home Visiting. When in a consulting role, the ECMH Clinician often relies on observation as a primary tool.

During any assessment process, skilled and on-going observation plays a key role. Mental health professionals must regularly identify a child's emerging competencies, evaluate parent-child relationships, note typical and atypical development and assess delays and/or emotional disturbance. This is an important skill that needs to be finely tuned. Children cannot give us significant information through conversation and interviewing. The child's key communication tool is their behavior, if we know what to look for. It is easy to develop incorrect or damaging theories so clinicians should proceed carefully on the basis of what is observed. Some observation tools are available to help guide the clinician and focus attention. Tools often focus on recording behavior including antecedents and consequences. Some tools are directly related to a particular curriculum such as High Scope or the Pyramid Model Some examples are:

- Behavior Observation Form @ Jason Wallin
- Functional Assessment Direct Observation Tool adapted from O'Neill and Colleagues (1997)
- Social Attributes Checklist McClellan and Kaz (2001, March)
- Behavioral Observation Checklist (Early Childhood Directions Center, 2006)

Billing for Child-Specific Consultation/Observation

- **Individual Behavioral Healthcare Counseling (H0004)**
- **Behavioral Health Outreach (H0023)**
- **Behavioral Health Screening (H0002)**

Assessment

Assessment should take place over 3-5 sessions in settings in which the child resides and with the various caregivers caring for the child. At least the following areas should be addressed in the assessment:

- Presenting symptoms and behaviors.
- Development history—past and current affective, language, cognitive, motor, sensory, family and interactive functions.
- History of pregnancy and delivery.
- Family functioning and cultural and community patterns.
- Parents as individuals.
- Caregiver-infant (child) relationship and interactive patterns.
- The infant's constitutional maturational characteristics.
- Affective, language, cognitive, motor and sensory patterns (recommend short sensory profile form).
- Family's current environmental conditions and stressors (DC: 0-3 Casebook, 1997).

Methods for completing an assessment include clinical interviewing, observation, use of standardized assessment tools and interactive assessments that are usually recorded and shared with the parent/caregivers as part of the assessment process. Specifically:

- Clinical interview with a full social and symptom history.
- Review of previous assessments and developmental screenings or evaluations.
- Review of health records from primary health provider.
- Direct observation in multiple settings with significant caregivers, focusing on:
 - Child's developmental functioning in all areas.
 - Child-parent/caregiver and family relationships and dynamics.
 - Child-parent/caregiver interaction patterns.

Standardized assessment tools answer specific questions and develop a baseline of more objective measures. The following is a list of useful tools, from which to choose depending on the assessment questions. This list is not exhaustive nor should it be interpreted as an endorsement for the tools listed:

- Parenting Stress Index.
- PIR-GAS from DC: 0-3R at the 1st and 6th session.
- Child Behavior Checklist.
- DECA-C.
- Marschek Intervention Method (interactive and recorded).
- Parent Child Structured Play Interview (Crowell) (interactive and recorded).
- Early Relational Assessment (interactive and recorded).
- Trauma Symptom Checklist for Young Children.
- Trauma Exposure Screening Inventory – Parent Report Revised.
- Colorado Clinical Assessment Record (CCAR).

Early childhood specialists at the public mental health centers are required to complete a CCAR and Parenting Stress Index short form (PSI) at the beginning of treatment and at the conclusion.

Billing for Assessment:

- Behavioral Health Outreach (H0023) - for children who are not open to the mental health system and assessment is in a community setting.
- Intake Assessment – Licensed (90801) – use only for initial intake session.
- Intake Assessment – Non-licensed (H0031).
- Family Assessment (H1011) – can be used more than one time under Medicaid.
- Assessment (H0031) – can be used more than one time under Medicaid.
- Individual and/or Family Therapy Codes: Assessment is not separate from therapy and trial interventions are often part of the assessment process.

Perspective from one early childhood clinician

I am often asked how we can assess a child less than two years of age for mental health concerns. I explain to our partners that for a child of this age we are looking for mental health concerns rather than mental illnesses. We are really looking to see if the child is experiencing stress and how they respond to attempts by adults to support them in times of stress.

What we use is a variety of assessment modalities, including reports from caregivers and others involved with the child who have information about overall functioning, including developmental milestones and overall ability to function in expected daily routines (i.e.: sleeping, eating, transitioning to/from activities, ability to respond to caregivers...) as well as history of trauma and life experiences. We ask adults if any of these have changed (e.g.: child used to sleep through the night and now is up 3 times a night). Often young children demonstrate their stress through a dysregulation in their ability to sleep, eat, accept adult support, stay engaged in activities, etc.... We also take into consideration the child's overall temperamental style as this can impact the way in which a child responds to stress or trauma.

In addition to seeking good information from adults, we do some assessment of the child in their natural setting (i.e.: home or child care setting). We are looking both at the child as an individual as well as the child within the context of the adult relationship (both with primary caregivers and with the therapist).

Diagnosis

The DC: 0-3R should be the primary diagnostic manual used with children under the age of 5. Other diagnostic manuals such as the DSM-IV-TR and the ICD-9 are based on research and symptom patterns of adults or older children and do not take into account the developmental variables of young children. The DC: 0-3R not only provides age-appropriate symptom patterns for young children, it also provides guidance for thinking through the diagnostic process with young children. The DC: 0-3R diagnosis targets children birth through age four but can be used up to age five, at which age the child should receive a new assessment.

The use of the DC: 0-3R does not exclude the use of the DSM-IV-TR diagnoses, which are included as part of the DC: 0-3R and DSM diagnoses should be used when they are the best explanation for the child's symptoms and coded on DC0-3R Axis I under 800.00 disorders.

Many times a key issue impacting a child's symptoms is the nature of the parent-child relationship. It should be noted that a score PIR-GAS score of 60 or below can be cross-walked to the ICD-9 diagnosis of Relationship Disorder (313.3), which is a covered diagnosis under capitation.

The Division of Behavioral Health has the crosswalk between DC: 0-3R and ICD-9 posted at: http://www.cdhs.state.co.us/dmh/PDFs/DC_0_3_Crosswalkpdf.pdf

Use of the DC: 0-3R requires specific training. Training is provided annually in late August or early September at the University of Colorado Denver. In addition, there is a list of approved Colorado trainers in the appendix. Training information can be found at: <http://jfkpartners.org/WorkshopsItem.asp?NUMBER=169>

Co-Occurring Disorders: It should also be noted that if a child has co-occurring disorders such as traumatic brain injury, autism or a developmental disability under Medicaid, they should receive a thorough mental health assessment and can receive treatment for their mental health diagnosis through their Medicaid Behavioral Health Organization.

EPSDT: If a child has a diagnosis that is not covered under Medicaid Capitation, they may be served under EPSDT through a fee for service process.

Autism: Colorado has an autism waiver, which provides services for children birth through age five.

Information about other referral sources for children under the age of 3 is located at: <http://www.eicolorado.org/index.cfm?fuseaction=Referral.referral&CFID=8251731&CFTOKEN=78744953> and at: http://www.medicalhomecolorado.org/referrals_35.htm for ages 3-5.

Treatment

Interventions in Early Childhood Mental Health are founded in an overall approach that is relationship-based. While children may contribute vulnerabilities and difficult behavioral symptoms, intervention often target changes in primary relationships or adult care giving strategies rather than individual change strategies for the child. This is because the context of relationships is a powerful force in early childhood. The focus on caregivers and relationship can feel uncomfortable or blaming to the adults who bring a child to therapy, and this issue must be addressed sensitively in order to fully engage the family.

In addition, interventions occur in the context of the rapid developmental changes of early childhood. We cannot “wait” with young children, or we will lose key windows of opportunity to impact the developmental process. For this reason, interventions may not lend themselves to 50-minute sessions, to bimonthly appointments or to office-based services. It is important that Early Childhood Mental Health Clinicians have a caseload size that allows for frequent sessions, longer sessions and sessions that may occur in the home or childcare center, based on the individual needs of the child and family.

The following is a description of best practice interventions in early childhood mental health and possible service codes. Because the descriptions of early childhood interventions are different from the standard mental health interventions, they may need to be cross-walked to available service codes for payment.

Play therapy is often a primary intervention or an intervention that is integrated into therapy. Play therapy incorporates children’s natural means of communication and allows for physical movement, which can be helpful in accessing the body’s memory of traumatic events or stress. Play therapy allows for a corrective experience to occur in a manner that the child can understand and integrate. Play therapy is one of the modalities that can be used with children who have experienced trauma or are having difficulties managing stress. It can also be useful during assessment, as the child developmentally communicates directly through play.

Service Codes:

Play therapy is billed through individual or family therapy codes.

Relationship-based treatment: Young children function within the relationships with their primary caregivers. Building a secure attachment that promotes security and safety is critical for young children to heal and grow. This treatment is indicated for young children whose relationship with a primary caregiver is disrupted and/or stressed due to the mental health needs of the child or the parent. If the mental health needs of the parent are of concern, individual treatment for the parent is also indicated. However, relationship-based treatment is also indicated to help the caregiver understand and change their ability to have a positive relationship with the child despite their own mental health challenges.

Service Codes: Family Therapy codes. Remember that the child may be diagnosed with a relationship disorder under the ICD9 code of 313.3 if PIR-GAS is 60 or below.

Mental Health Consultation:

Colorado information on Mental Health Consultation can be found at

<http://jfkpartners.org/documents/MHC%20Toolkit%20Merged%20smaller%20size.pdf> and
<http://www.pffac.org/index.php?s=80&cat=33>

National resources for Early Childhood Mental Health Consultation can be found at

<http://www.ecmhc.org/>

Service Codes:

Consultation often requires a contract with the provider and some agencies or grants are able to fund this service. Within the context of the community mental health center and Medicaid, service codes appropriate for consultation include:

- **Individual Behavioral Health Counseling (H0004).**
- **Behavioral Health Outreach (H0023).**
- While not an infant mental health consultation program, many childcare centers are implementing the Pyramid Model in order to increase staff competence in promoting social and emotional development. For more information on this approach and for free materials please see <http://www.pyramidplus.org/>
- Challenges include if a child is not an open-consumer but could benefit from support prior to determining the need for more direct mental health intervention if the child has Medicaid and the family is willing to give basic information (name, date of birth and Medicaid number) **this can be billed under Behavioral Health Outreach H0023.**

Parenting Education/Groups/Classes:

Young children need adults in their daily life to support their healing, growth, and learning through their relationships and their care giving strategies. This can require parents and caregivers to examine their current style and practices and to learn new ways to care for and discipline their children. In addition, the care of young children with mental health needs can be very stressful for parents and caregivers. Support and education for caregivers is a key strategy in addressing early childhood mental health issues. This may include peer-led support groups, clinician-led support groups and a variety of parenting and psycho educational classes and groups. In addition, clinicians may work with caregivers one-to-one to address barriers to the implementation of suggested interventions in the home or other newly learned skills. Parents and caregivers are not always open consumers with their own diagnosis and therefore services are sometimes billed under the child for the benefit of the child.

Service Codes:

- **Psycho educational Service (H2027).**
- **Multi-Family Group Therapy (90849).**
- **Wellness Group (H0025).**
- **Family Therapy Client Not Present (90846).**
- **Individual Behavioral Health Counseling (H0004) – can be used for contact with parents and caregivers over the phone as well as in a session without the child.**

Care Coordination:

To help young children receive consistent interventions and to help their caregivers receive consistent and aligned messages, care coordination is critical for young children in need of mental health support/services. Often young children are involved in a variety of services and supports and have multiple caregivers. Care coordination can help involved providers support the child and the family in a consistent manner. This is especially true when children are struggling in a variety of settings and need the support of adults. In addition, when children have multiple needs that present in their mental health treatment (speech, OT) care coordination is critical to help ensure the successes of all treatments/interventions.

One model of care coordination especially useful for families when children are involved in a complex array of services is Fidelity Wraparound Facilitation. For more information go to:

<http://www.nwi.pdx.edu/>

Service Codes:

- **Case Management (T1016) Case management identifies assessment, treatment planning, referral; monitoring and follow-up activities that help a mental health consumer access needed non-mental health services.** (Note: as of the publication of this manual targeted case management was not yet an approved code for Medicaid although it has been proposed.)
- **Community Based Wraparound Services (H2021)**

Selected Evidence based Treatment/Prevention Practices

Each of the areas in which an Early Childhood Mental Health Clinician works has specific best practices and evidence-based models of treatment. The field of evidence-based practice is complex and the ways in which interventions are assessed can be more or less rigorous. It is important that we do not overshadow good practice in the pursuit of evidence-based models. It is equally important that we learn and incorporate these models into our practice. In addition to specific models, clinicians can think in a framework of evidence-based practice by being careful in their assessment and diagnosis process, choosing interventions thoughtfully, deliberately and assessing their impact regularly within the limits of the system in which we work.

For information on Evidence-Based Practices, two resources are:

<http://www.ojjdp.gov/mpg/ratings.aspx> and www.nctsn.org

Specific Evidence-Based Treatment Models and Best Practice frameworks used widely in Early Childhood Mental Health include: (This list is not complete and is not meant to be an endorsement of any particular model).

Evidence-Based Models and Promising Practices

- **Parent Child Interaction Therapy (PCIT)**: An empirically supported treatment for young children with oppositional, defiant and other externalizing behaviors. PCIT is a highly specified, step-by-step teaching and coaching model that places emphasis on improving the quality of the parent-child relationship and changing parent-child interaction patterns. It is best implemented with a “bug-in-the-ear” transmitter and microphone in a setting that has an observation room so that the therapist and the parent-child dyad are separated. Also requires periodic sessions with parents only, for which childcare may be necessary. PCIT’s role in trauma treatment is to address deregulation by providing the parent with a safe way to connect with the child and address difficult behaviors safely. Developed by Sheila Eyberg and modified for children with trauma histories by Cheryl McNeil.
- **Trauma Focused –Cognitive Behavioral Therapy**: A phased treatment protocol that involves family psycho education and individualized child therapy sessions focused on emotional skills training which are later used to confront the experiences which initialized trauma (PTSD) symptoms. Requires childcare and for parent/caregiver psycho education sessions. Web-based initial training available at <http://tfcbt.musc.edu> Certification requires two-day training with six months of coaching via a group or conference call format. Developed by Judith Cohen and Anthony Mannarino.
- **Child-Parent Psychotherapy**: A multi-theoretical, relationship-based approach to help young children and families who have experienced trauma. Promotes developmental progress through play, physical contact and language through unstructured and reflective developmental guidance, modeling of protective behaviors, interpretation of the links between past and present, emotional support and concrete assistance. A full-year training is available through the NCTSN Learning Collaborative process. Developed by Alicia Lieberman and Patricia Van Horn.
- **Psycho-Education for Parents and Children**: This can occur with individual children, caregivers, and families or in-group settings. For children this includes use of bibliotherapy and teaching/practicing coping skills. For caregivers this includes information sharing with a parent to help them understand their child’s issues, supporting parents in choosing parenting strategies and/or teaching of parenting strategies. For families this includes teaching and practicing of skills and strategies with direct support of the therapist.

- Circle of Security:
This is an attachment-focused model that helps caregivers and child create a trusting “secure base” in a developmentally based manner. This model helps caregivers and children to engage in a reciprocal manner through observation of child’s cues, reflective functioning and responses, empathy, and support for emotional regulation. Materials are available for free on the Circle of Security website. The original model with empirical data is a group model for young mothers and their babies and includes recording of a “Strange Situation” session and review of the sessions with the group. The model has been modified for home visitation. Training is available from the developers in Spokane, WA and includes a two-day overview and a two-week full training to develop skills in analyzing the Strange Situation sessions. Developed by Glen Cooper, Kent Hoffman and Bert Powell.
- Nurturing Parenting Programs:
All Nurturing Parenting Programs are based on five constructs developed through research on the differences in parenting attitudes between parents with founded abuse charges and the general public. NPP includes an evaluation tool, the Adult-Adolescent Parenting Inventory, which has been used widely for many years. NPP was chosen by the Colorado Children’s Trust Fund as an evidence-based child abuse prevention program and is widely implemented across Colorado. NPP training is a two-day overview that teaches the philosophy of NPP, the use of the AAPI and strategies for teaching and program development. The specific NPP formats each have a detailed teaching manual. NPP can be implemented in community groups, during home visitation and in community mental health center offices. NPP formats include specific curricula for parents of infants, toddlers and preschoolers as well as an associated Nurturing Father’s Program. Developed by Stephen Bavolek.
- Incredible Years:
This is a parenting training curriculum that helps increase parent competencies and increase involvement in child’s school experiences to increase academic, social and emotional competencies. This curriculum is divided according to child’s age and in early childhood includes a birth-three series, a 3-6 series and a 6-12 series. This curriculum is often offered in conjunction with classroom-based curriculum for children. Training, certification and implementation processes along with the full curriculum are outlined on the Incredible Years website. Developed by Carolyn Webster-Stratton.
- Theraplay:
Short-term, therapist-guided dyadic psychotherapy that focuses on parent-child relationship and uses directive activities (in the domains of structure, nurture, engagement and challenge) to enhance attachment, self-esteem and trust in others though joyful engagement. Initial four-day training includes use of the Marschak Interaction Method as an assessment tool. See the Theraplay Training Institute for more information. Developed by Ann M. Jernberg and Phyllis Booth.

Autism Guidelines for Infants and Toddlers

In July 2009, the Colorado Department of Human Services, Division for Developmental Disabilities began collaborating with the University of Colorado, School of Education and Human

Development to develop the Early Intervention Colorado Autism Guidelines for Infants and Toddlers. The purpose of the Guidelines is to ensure infants and toddlers, birth through two years of age, who have a diagnosis of or characteristics of Autism Spectrum Disorders (ASD) receive early intervention services based on their individualized identified need. The document is intended to assist local early intervention programs in providing early intervention services derived from evidence-based practices, published research and early childhood clinical judgment that will increase the awareness and knowledge of families, providers, and early intervention administrators. The content is compiled from a review of research-based programs and models, state-of-the-art information from experts in the field of Autism Spectrum Disorders, and work with family members who have infants and toddlers with ASD. The early intervention services within the Guidelines are consistent with the Individuals with Disabilities Education Act of 2004 (IDEA).

Early Intervention Colorado Autism Guidelines for Infants and Toddlers can be found at:
http://www.eicolorado.org/Files/EIColorado%20Autism%20Guidelines%2010-21-10_FINAL.pdf

Essentials for Providing Mental Health Services to Young Children and their Families

NEEDS: Toys, sand, sturdy child-size furniture appropriate to a range of children from babies to preschoolers and kindergarteners.

Time to therapeutically manage transitions, set up and clean up playrooms, and clean toys to keep a sanitary environment.

WHY? Play therapy requires toys, office space and time. The ECMH Clinician cannot see clients “back to back” as they have to set up, clean up and often deal time consuming transition difficulties with young children. These processes cannot be hurried and are part of the treatment. While the ECMH Clinician is responsible for managing the schedule so that there is time for prep, clean up, dealing therapeutically with transitions as part of treatment. Therefore, they cannot be expected to see the same number of clients as an adult outpatient clinician in the same amount of time. In addition, ECMH Clinicians need funding for toys, snacks and sturdy, safe child-sized furniture. These items are not expensive and can be creatively found at yard sales and second-hand stores, with the purchase of a few key clinical items on the more expensive end.

NEEDS: Small and healthy snacks, extra clothes and diapers for children, a “clean-up” kit with gloves, mask and disinfectant for dealing with childhood accidents involving bodily fluids.

WHY? Young children cannot delay their hunger, bowel and bladder responses and are still prone to small accidents involving scrapes, cuts and bruises. The ECMH Clinician has to have time and materials to respond therapeutically to these early childhood disasters. While parents are expected to manage most of these situations, the Clinician has to be able to support the unprepared parent in a way that is therapeutic and not blaming or shaming.

NEEDS: Childcare for extra siblings and for the child client when parents or caregivers need to talk about trauma or other sensitive, adult issues related to the child and family functioning.

WHY? Some caregivers do not have resources of trustworthy family and friends or financial ability to pay for childcare. In addition, sensitive issues that should not be discussed in front of young children may arise during therapy and need to be addressed, especially when a caregiver has had a crisis in the family. A third reason for this is that some evidence-based models of therapy, such as PCIT and TF-CBT, require individual sessions with the caregiver for psycho-education and training. While full-time childcare is not feasible for programs, a combination of volunteers and paid childcare staff can provide enough hours of supportive childcare to meet this need. The childcare does not have to be licensed, as the caregiver is always on the premises when the child is in care. However, it is important that the care is of good quality, both in terms of the childcare room itself and the capabilities of the provider who cares for the children.

NEEDS: A variety of therapy rooms.

- Play therapy room with lots of appropriate toys.
- Art room (may be integrated into play therapy room).
- Sand tray room (may be integrated into play therapy room).
- An “empty” room with basic furniture but no toys. This room is used for children who are over stimulated and for family work when the therapist wants to select toys or activities to direct the therapy for a clinical purpose.
- Observation room with a sound and recording system for models of treatment that require recording and observation.

WHY? Their environment to a greater degree than older children and adults influences young children, because they do not have the cognitive or self-regulation skills to analyze and adjust to different environments. Therefore they respond emotionally and behaviorally. With the exception of individual play therapy, most treatment for young children involves parents, caregivers and siblings in the sessions. ECMH Clinicians need larger and more flexible office space than is typically needed for adult outpatient services, including rooms that can be used for family therapy, recording sessions and working through a one-way mirror or video system. Recording and reviewing sessions is part of many evidence-based and best practice models of assessment and treatment in early childhood mental health. They promote a reflective process with parents and caregivers, which have been shown to lead to changes in behavior and responsiveness to children’s needs. The ECMH Clinician needs a variety of environments to meet the needs of young children and families in a constructive and therapeutic way.

NEEDS: Equipment to support services provided in home and community settings and travel time for work in home and community settings, including consultation and direct services.

- Recording equipment (flip cameras are great and inexpensive) for recording during visits in home or community settings and tech support for this equipment.
- A travel play therapy kit with a variety of appropriate toys to use in home and community settings.

WHY? The ECMH Clinician often meets the family and client in their home, childcare or school setting.

Special Considerations

Early Childhood Mental Health Clinicians may observe questionable discipline practices in either the home or childcare setting. The document in this link sets out a clear description of what is developmentally appropriate regarding seclusion and restraint.

http://challengingbehavior.org/do/resources/documents/brief_preventing.pdf

Additionally here is a link to a Colorado handbook on child abuse reporting and etc.

<http://www.cdphe.state.co.us/ps/cctf/canmanual/index.html>

The CCAR and Early Childhood Considerations

**Remember to complete the Domain and Recovery areas based on the child's age: so how are they functioning compared to most children their age.

**Consideration of when do behaviors occur and why? i.e.: During transitions and if so, is this really about anxiety or lack of structure (family)? If the child has impulsive behaviors, what area is impacted by this (role performance, interpersonal, family??).

Self-Care and Basic Needs

For really young children, this will generally be rated a "1" because they are not responsible for their own self-care or basic needs. For children 4-6, you might consider developmentally what they should be able to do (i.e.: dress themselves, use the toilet, feed themselves...).

Security and Supervision

For really young children, they need to be supervised and this should not be taken into account when rating this. This should only be rated higher if the child needs additional supervision based on behavior—i.e.: can't be out of parent's sight without getting into trouble.

Aggression and Danger to Others

It is typical for young children to hit or kick others (ages 2-3), so rate this based on the intensity and frequency of this behavior for this age group. For children 4-6, some aggression is still expected, so again base your rating on if this behavior is occurring often or has become more severe. Some young children can show extremes of aggression compared to their age-mates. For example, a 3 year old expelled from several childcare settings for hitting, biting and throwing chairs which injure others could be rated high on this scale.

Suicide/Danger to Self

Self-harming behaviors (head banging...). Are these related to another area (i.e.: anxiety and the child is attempting to self-soothe) or impulsivity? Rate this higher when there is concern of child actually hurting him/herself.

Interpersonal

Does the child demonstrate an attachment to caregivers? Does the child respond to caregiver's directions? Is the child soothed by caregivers when needed? Does the child interact with siblings or close friends? Do they acknowledge others who are playing next to them—talk to them, imitate their play, show interest in them/their play, show others what they are playing.

Socialization

Most 2-3 year olds are not developmentally "social" beings. In general they engage in parallel play with others versus cooperative play. Rate this according to if they are able to generally maintain safe behaviors in relationships with others close in age.

Role Performance

What are the child's main roles (classmate)? In general, does the child function age-appropriately in these roles? If the child is not in a formal role, but only in relationships with families, rate this as a 1, and indicate their relationship roles in either "Family" or "Interpersonal."

Attention

Try to get specifics about the child's attention span verses just hearing the parent say s/he has a short attention span, as the parent may or may not understand a developmentally appropriate attention span. Also, during the intake, did the child engage in play for an age-appropriate amount of time (considering your room may be full of new toys)?

Mania

Similar to older children: difficulty sleeping; rapid talking; inability to slow down & making dangerous decisions (not related to ADHD); This is a very difficult area to rate for young children. It may be helpful to remember that the incidence of mania in children under 5 is extremely low.

Depression

Similar to older children: flat affect, irritability; loss of interest in activities; sleep or eating difficulties; loss of energy; play themes around guilt/worthlessness; poor attention or ability to respond.

Anxiety

Similar to older children: restless; difficulty concentrating; irritable; difficulty sleeping; persistent worrying; excessive fears; excessive self-soothing activities; hyper vigilant; avoidance; distress when routine changes;

Family

Here is where our numbers are usually higher, but not always, because the young child functions within the relationship with their caregivers.

Symptom Severity

While a "5" indicates the need for mental health services, a "4" can also be indicated for children who need services on a more minimal level (i.e.: weekly).

**Most of the recovery measures can also be considered in terms of the family, as the family often greatly impacts the child's ability to move forward.

Hope

Does the child look forward to events that will happen in the future? This area can be assessed through play-based assessments as children often indicate their level of hope for their life through play. Do they demonstrate a sense that things may get or could be better?

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