

DBHS Practice Tool

Working with the Birth to Five Population



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
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TITLE

Working with the Birth to Five Population

GOAL/WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS TOOL?

To strengthen the capacity of Arizona's mental health system in responding to the unique needs of children age birth to five through strong clinical assessment, service planning and treatment that identifies and intervenes in situations that impede infants'/toddlers' ability to:

- form close parent/caregiver relationships,
- experience, regulate and express their emotions, and
- explore their environment.

TARGET AUDIENCE

This Tool is specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth to five and their families.

TARGET POPULATION(S)

All enrolled behavioral health recipients, birth to five years of age (up to age 5), in collaboration with their caregiver(s).

ATTACHMENTS

[Attachment 1: Child's Adjustment to Out of Home Placement](#)

[Attachment 2: Arizona Department of Health Services/Division of Behavioral Health Services Developmental Checklists for Children Age Birth to Five](#)

[Attachment 3: Initial Engagement Session](#)

[Attachment 4: Behavioral Analysis](#)

[Attachment 5: Arizona's Crosswalk for DC: 0-3R, DSM-IV-TR and ICD-10-CM¹](#)

[Attachment 6: Recommended Resources](#)

¹ *Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood: Revised Edition (DC: 0-3R); Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR); the International Classification of Diseases, Ninth Revision-Clinical Modification Manual (ICD-9-CM).*

DEFINITIONS

[Annual Update](#)

[Assessment](#)

[Behavioral Health Paraprofessional](#)

[Behavioral Health Professional](#)

[Behavioral Health Technician](#)

[Caregiver](#)

[Child and Family Team](#)

[Credentialing](#)

[Culturally Competent Care](#)

[Family](#)

[Infant and Early Childhood Mental Health](#)

[Natural Support](#)

[Serious Mental Illness](#)

[Service Plan](#)

BACKGROUND

The promotion of mental health in infants and toddlers is critical to the prevention and mitigation of mental disorders throughout the lifespan. The Policy Brief entitled, *Building a Comprehensive System to Address Infant and Early Childhood Mental Health Disorders*, November 2006 (Zero to Three Policy Center) emphasizes the importance of linking adult and children's mental health services, inclusion of parents in treatment planning and service delivery processes as part of a multidisciplinary team, and the need for community collaboration.

Early childhood experiences can build strong foundations or fragile ones and can affect the way children react and respond to the world around them for the rest of their lives. The early social and emotional development of infants and toddlers is vulnerable to such factors as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance exposure. Without intervention, these risk factors can result in mental health disorders including depression, attachment disorders, and traumatic stress disorders which can have an effect on later school performance and daily life functioning.

Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of trauma.² Children entering the child welfare system have higher rates of exposure to traumatic events with most victims of child abuse

² Cloitre, M., Cohen, L.R., & Koenen, K.C. (2006). *Treating survivors of childhood abuse: Psychotherapy for the interrupted life*. New York, NY: Guilford Press.

and neglect being under the age of five. Children who have been maltreated are at an increased risk for mental health concerns, poor psychological adaptation and lifelong health difficulties.³

An effective approach to promoting healthy social and emotional development must include equal attention to the full continuum of mental health services-promotion, prevention and treatment, as well as improving the capacity of the system in the delivery of services. Essential components of a comprehensive system include:

- supporting the use of evidence-based early childhood service delivery models,
- increasing the quality and capacity of trained infant and early childhood mental health professionals, and
- improving access to services.

Untreated mental health disorders can have disastrous effects on children's functioning and future outcomes. Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma. Mental health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth and constipation, as well as overall delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdrawal from social interaction.

Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) can predict subsequent aggressive behavior. Some early mental health disorders have lasting effects and may appear to be precursors of mental health problems later in life, including withdrawal, sleeplessness or lack of appetite due to depression, anxiety, and trauma stress reactions.⁴

Increasingly, young children are being expelled from child care and preschool for behavior problems, including biting, tantrums, hitting, throwing objects, or inconsolable crying.⁵ Even if they do remain in a program, young children with behavioral concerns are challenging to teach and quickly lose motivation for learning, withdraw from their peers or face social rejection.⁶

Healthy social-emotional development is strongly linked to success in elementary school. Children who are not secure in relating to others and do not trust adults are not motivated to learn. Furthermore, children who are unable to respond to calming influences initiated by themselves or others will not be responsive to teaching methods nor benefit from their early educational experiences and may lag behind their peers.

³ Cooper, J.L., Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. (2007). Section 1: Understanding Trauma and Its Effects. *Strengthening Policies to Support Children, Youth, and Families Who Experience Trauma*. National Center for Children in Poverty, 7-11.

⁴ Perry, B.D., Pollard, R.A., Blakely, T.L., Maker, W.L., et al. (1995). Childhood Trauma, the Neurobiology of Adaptation and "Use-dependent" Development of the Brain: How States become Traits. *Infant Mental Health Journal*, 16(4), 271-291.

⁵ Wheatley, E. (2001). *Child care Expulsion Survey*. Bow, NH: New Hampshire Association for Infant Mental Health.

⁶ McEvoy, A., & Welker, R. (2000). Antisocial Behavior, Academic Failure and School Climate: A Critical Review. *Journal of Emotional and Behavioral Disorders*, 8(3), 130-140.

Parent's mental health can affect young children. Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond as parents with an untreated mental disorder are less able to provide developmentally-appropriate stimulation and parent-child interactions.⁷ Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence and maltreatment.^{8,9} Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school.¹⁰ Although these sources cite maternal depression, these effects can also be attributed to relationships the young child has with other primary caregiver(s).

Increased training in early childhood mental health is necessary and essential. In-depth knowledge of child development systems and multi-disciplinary approaches, as well as possession of diagnostic and clinical skills are critical components for professionals who assess and treat young children.¹¹ Additionally, practitioners need to acquire and demonstrate a range of interpersonal skills in their work in order to build individualized, respectful, responsive and supportive relationships with families. These skills include:

- the ability to listen carefully;
- demonstrate concern and empathy;
- promote reflection;
- observe and highlight the child-parent/caregiver relationship;
- respond thoughtfully during emotionally intense interactions; and
- understand, regulate, and use one's own feelings.¹²

Scientific advances in neurobiology have provided birth to five practitioners with greater insight into the complex system of the brain. The development of the central nervous system begins with the formation of the neural tube, which nears completion by 3-4 weeks of gestation and is the basis for all further nervous system development.¹³ Genes determine when specific brain circuits are formed and each child's experiences then shape how that formation develops. Stable and responsive relationships along with proper sensory input through hearing and vision are what build healthy

⁷ Administration for Children and Families. (2000). *Summary of Current Literature – Maternal depression*.

⁸ Gurian, A. (2003). Mother Blues – Child Blues: How Maternal Depression Affects Children. *New York University Child Study Center Letter*, 7(3).

⁹ Embry, L., & Dawson, G. (2002). Disruptions in Parenting Behavior Related to Maternal Depression: Influences on Children's Behavioral and Psychobiological Development. *Parenting and the Child's World: Influences on Academic, Intellectual, and Social-emotional Development*. Mahwah, NJ: Erlbaum: Eds. Borkowski, J.G., Ramey, S.L., & Bristol-Powers, M., 203-214.

¹⁰ Knitzer, J. (1996). Meeting the Mental Health Needs of Young Children and Families: Service Needs, Challenges, and Opportunities. *Children's Mental Health: Systems of Care in a Changing Society*. Baltimore, MD: Brookes, P.H.: Ed. Stroul, B., 553-572.

¹¹ Bussye, V., Wesley, P.W., Bryant, D., & Gardner, D. (1999). Quality of Early Childhood Programs in Inclusive and Non-inclusive Settings. *Exceptional Children*, 65(3), 301-314.

¹² Gilkerson, L. & Taylor Ritzler, T. (January 2005). The role of reflective process in infusing relationship-based practice into an early intervention system. In Finello, K.M. (Editor). *The handbook of training and practice in infant and preschool mental health*. Jossey-Bass.

¹³ Giedd, J.N. & Lenroot, R.K. (2006). Brain Development in Children and Adolescents: Insights from Anatomical Magnetic Resonance Imaging. *Neuroscience & Biobehavioral Reviews*, 30(6), 718-29.

“brain architecture”. Thus, the most important relationships begin with the child’s family and extend outward to other adults important in that child’s life such as day care and educational providers.¹⁴

Empirical evidence has shown that young children are greatly impacted by their early development and experiences. By understanding how specific events impact a young child’s brain functions the mental health professional is able to formulate individualized interventions. Therefore, it is incumbent upon all practitioners to become educated about brain development, functions of the various parts of the brain and their role in the physical and emotional development of the child. Some additional resources in the area of brain development include:

- “Brain Facts, A Primer on the Brain and Nervous System” through the Society for Neuroscience;¹⁵
- “The Secret Life of the Brain”, a PBS series exploring brain development;¹⁶
- “Starting Smart—How Early Experiences Affect Brain Development”¹⁷; and
- “From Neurons to Neighborhoods: The Science of Early Childhood Development”.¹⁸

PROCEDURES

In an ongoing effort to improve the delivery of behavioral health services in an effective and recovery-oriented fashion, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) implemented the use of the Child and Family Team (CFT) practice model and the [12 Arizona Principles](#) which strongly support the critical components of mental health practice with children age birth to five and their families. Infant and Early Childhood Mental Health practice integrates all aspects of child development such as organic factors (genetics and health) with the child’s experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

The nature and pace of these changes, as well as the preverbal nature of this young population present the mental health professional with uniquely complex challenges. They must rely on the knowledge of the parents/caregivers and the expertise of a multidisciplinary team of professionals to provide them with information when conducting behavioral health evaluations, developing service plans, and implementing clinical interventions. Qualified professionals will have an understanding of the correct use and interpretation of screening, assessment and evaluation tools and processes, and how to use these results for service planning and implementing clinical interventions.

Assessment and treatment of children age birth to five is based on the philosophical orientation that work is done on behalf of the child predominantly through his/her parent or caregiver(s). Child development takes place within the context of the caregiving relationship which is strongly

¹⁴ National Scientific Council, Center on the Developing Child at Harvard University. (2007). *The Science of Early Childhood Development: Closing the Gap Between What We Know and What We Do* from:

http://www.developingchild.net/pubs/persp/pdf/Science_Early_Childhood_Development.pdf.

¹⁵ <http://www.sfn.org/skins/main/pdf/brainfacts/brainfacts.pdf>

¹⁶ <http://www.pbs.org/wnet/brain/index.html>

¹⁷ <http://www.zerotothree.org/site/DocServer/startingsmart.pdf?docID=2422>

¹⁸ National Research Council, Institute of Medicine. (2000). *From Neurons to Neighborhoods: The Science of Early Childhood Development*. National Academy Press.

influenced by child characteristics, parent/caregiver characteristics, and perhaps most importantly the unique match or “fit” between a child and his/her caregivers. It is important that trained personnel:

- have comprehensive knowledge of early childhood development;
- possess excellent observational and relationship-building skills with children and adults;
- be able to identify resources and needs within the family/caregiving environment; and
- communicate assessment results in a comprehensible manner to parents/primary caregivers and other professionals.

For children involved with Department of Child Safety (DCS) who are referred through the Urgent Response process, it is important for the behavioral health provider to consider a full range of services at the time of removal. Refer to [ADHS/DBHS Policy and Procedures Manual Section 102, Appointment Standards and Timeliness of Service](#) and the [ADHS/DBHS Covered Behavioral Health Services Guide](#) for additional information related to the Urgent Response process and the array of covered behavioral health services.

As part of the assessment process, ongoing evaluation of the child after the initial removal is needed to assess the child’s physical appearance, areas of functioning, his/her relationships, and adjustment to the new environment. If the child is placed with a different caregiver re-assess again to monitor the child’s adjustment to the new setting. When assessing children involved with DCS who are showing delays which can be due to the trauma of removal, neglect, or abuse, determine if a referral for additional services or any other type of assistance is needed. Refer to [Attachment 1: Child’s Adjustment to Out of Home Placement](#) for use with children living in a kinship placement, DCS resource parents (foster or adoptive), or congregate care (shelter or group home). Additional information outlining special considerations for providing services to infants, toddlers and pre-school aged children involved in the child welfare system can be accessed through the [ADHS/DBHS Practice Tool: The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS](#).

EVALUATION

Evaluation practices with respect to children age birth to five involve awareness on the part of the mental health practitioner that all children have their own individual developmental progression, affective, cognitive, language, motor, sensory and interactive patterns. All children age birth to five are participants in relationships, their most significant relationships being those with their primary caregiver(s). A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of his/her most significant relationships. This is best done over several and whenever possible with all significant caregivers, and in different settings (e.g., home, child care, clinic). In order to support a child in demonstrating his/her true capacities, screening and assessment processes are best done in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and reflect their daily life experiences. Identification of all significant caregivers and the child’s relationship with each person is a critical part of assessment practice.

Developmental Screening

Screening for sensory, behavioral and developmental concerns initially begins an ongoing process that organizes continuous observations regarding the needs, challenges, strengths and abilities of the child and parent/caregiver. Screening or testing instruments become part of comprehensive assessment practice, are intended to be used for the specified purpose they were designed for, must be reliable and valid, and are not to be used in isolation to render a diagnosis.

The use of **developmental checklists** provide assessors and caregivers with a set of dimensional milestones (e.g., movement, visual, hearing, smell, touch, speech, social and emotional, language, cognitive, hand and finger skills), as well as growth and developmental “red flags”. As part of the assessment process for infants and young children, developmental checklists establish a baseline to which subsequent screenings during the course of treatment can be compared to. Refer to [Attachment 2: Arizona Department of Health Services/Division of Behavioral Health Services Developmental Checklists for Children Age Birth to Five](#) as one example of a screening tool that may be used to determine if a child’s developmental skills are progressing as expected or if there is cause for concern requiring further evaluation by the child’s Primary Care Provider (PCP), the Arizona Early Intervention Program (AzEIP) for **children age birth to three**, by the public school system for **children age three to five**, or for any other type of assistance.

Assessment Considerations

It is essential that mental health practitioners continually evaluate their screening and assessment tools because the practice of infant and early childhood mental health is dynamic and continually changes due to improved technology and newly developed research techniques, strategies and results. While ADHS/DBHS does not require the use of a specific assessment tool, minimum elements have been established that must be included in any comprehensive behavioral health assessment as outlined in [Policy and Procedures Manual 105, Assessment and Service Planning](#). Refer to [Attachment 3: Initial Engagement Session](#) as one example of an assessment tool for children age birth to five.

There is no single tool that encompasses the full range of social, emotional and developmental skills and challenges that can occur in young children. The following tools and resources can provide additional information when assessing developmental milestones, behavioral, emotional and social concerns, trauma and attachment:

- [Attachment 4: Behavioral Analysis](#): descriptive analysis of behavior;
- [Ages and Stages Questionnaire \(ASQ\)](#): developmental and social-emotional screening for children age one month to 5 ½ years;
- [Hawaii Early Learning Profile \(HELP\)](#): curriculum-based assessment covering regulatory/sensory organization, cognitive, language, gross and fine motor, social and self-help areas for children birth to 3 years; separate profile available for 3-6 year olds;
- [Infant-Toddler Social-Emotional Assessment \(ITSEA\)](#): measures social-emotional and behavioral domains for children one to three years of age;
- [Connor’s Early Childhood Assessment](#): aids in the early identification of behavioral, social and emotional concerns and achievement of developmental milestones for children two to six years of age;

- [Parents' Evaluation of Developmental Status \(PEDS\)](#): evidence-based screening of developmental and behavioral concerns for children birth to 8 years; and
- [Trauma-Attachment Belief Scales \(TABS\)](#): measure cognitive beliefs about self and others for parents/caregivers age 17 and older to assist with identifying possible trauma history and its potential impact on the attachment relationship between the parent/caregiver and the child.

Refer to *Technical Assistance Paper No. 4, Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs* for further information on other resources and test reviews of screening and assessment instruments.¹⁹

Considerable skill is required in the administration of the assessment process, integration of the data obtained from the assessment, and development of initial clinical conceptualizations and intervention recommendations. Assessment with children age birth to five is a specialty area that requires specific competencies. Competent providers recognize the limitations of their knowledge and scope of practice. When necessary, they make use of the expertise of more experienced mental health practitioners, as well as the range of disciplines that address questions related to early development (e.g., pediatrics, speech/language therapy, occupational therapy, physical therapy, etc.) through collaboration, consultation, and referral practices.

Mental health practitioners must demonstrate competence for the services they provide. Reference [ADHS/DBHS Policy and Procedures Manual 405, Credentialing and Re-credentialing](#) for further information on requirements for validating that relevant training, experience, qualifications and ongoing competence has been demonstrated by practitioners who provide behavioral health services to infants, young children and their families. Refer to [ADHS/DBHS Policy and Procedures Manual 105, Assessment and Service Planning](#) for additional information on the types of behavioral health providers who may conduct assessments.

Assessment practice with children age birth to five typically involves:

- interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories;
- direct observation of family functioning;
- gaining information, through direct observation and report, about the child's individual characteristics, language, cognition and affective expression;
- assessment of sensory reactivity and processing, motor tone, and motor planning capacities;²⁰
- observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/learning, and to help regulate emotions;
- obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship; and

¹⁹ <http://www.zerotothree.org/site/DocServer/FinalTAP.pdf?docID=221>

²⁰ Zero to Three (2005). *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*. Zero to Three Press.

- interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, mental health, parenting, legal, educational, domestic violence, military, etc.).

Diagnostic Considerations

The diagnostic process consists of two aspects: the classification of disorders and the assessment of individuals. In classifying disorders practitioners are able to communicate with one another about descriptive syndromes using universal terms and language. The diagnostic process is ongoing rather than a onetime “snapshot” of symptoms. Mental health practitioners collect information over time in order to understand multiple aspects of the presenting concerns, as well as variations in adaptation and development that are revealed on different occasions within various contexts.²¹

It is suggested that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the *Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood: Revised Edition (DC: 0-3R)* which draws on empirical research and clinical practice that has occurred worldwide since the manual was first published in 1994. The *DC: 0-3R* is designed to help mental health and other professionals recognize mental health and developmental challenges in young children, understand how relationships and environmental factors contribute to mental health and developmental disorders, use diagnostic criteria effectively for classification and intervention, and work more effectively with parents and other professionals to develop effective service plans. The updated version provides clear and specific criteria for all diagnostic categories, explains criteria for identifying Autism Spectrum Disorders in children as young as 2, introduces new criteria for disorders of sleep, eating, relating and communicating, clarifies the Parent-Infant Relationship Global Assessment Scale (PIRGAS), and includes checklists for identifying relationship problems, psychosocial and environmental stressors. Copies of the *DC: 0-3R* manual are available through the Zero to Three Press.²²

An additional resource clinical personnel can utilize is the [ADHS/DBHS Crosswalk](#),²³ which cross-references the *DC: 0-3R*, the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR)*, and the *International Classification of Diseases, Ninth Revision-Clinical Modification Manual (ICD-9-CM)*. Arizona’s Crosswalk is strictly a tool to assist the behavioral health provider in assigning the correct diagnostic code when working with children in the first four years of life and is referenced as a sample document.

Maintenance of this document with up-to-date diagnostic codes is a T/RBHA responsibility.

Annual Assessment Update

While assessment is an ongoing process that offers new information throughout the continuum of service delivery, a formal assessment update must be completed on an annual basis, or sooner, if there has been a significant change in the child’s/family’s status. A child’s response to treatment might be affected by significant events or trauma that have occurred

²¹ Ibid.

²² <http://www.zerotothree.org>

²³ ADHS/DBHS Attachment 5: Arizona’s Crosswalk for DC: 0-3R, DSM-IV-TR and ICD-9-CM

since the last assessment/update, such as changes in the child's living environment, childcare arrangements, death of a primary caregiver, as well as medical/developmental conditions and hospitalizations. Input from the family/caregiver, as well as observation(s) of the child in conjunction with a review of the clinical record provides information necessary for summarizing their response to treatment and progress toward meeting goals over the past year.

A review of the child's current level of functioning would include updating information related to the child's emotional and behavioral regulation, quality of the parent-child interaction, relationships with caregivers/significant others, living environment, family stressors, safety concerns, and stability of home/relationships. Developmental screening as part of the annual update, as well as during the course of treatment, will assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral. The demographic data set is also updated when assessment updates are done whether it is an annual or changed status update.

SERVICE PLANNING CONSIDERATIONS

Use of CFT Practice

The early development of an engaged relationship with the child, parent/caregiver, and family as part of the CFT process is required practice when working with children age birth to five, as the work directly involves the entire family and the family guides the therapeutic process. Please refer to the [ADHS/DBHS Practice Tool Child and Family Team Practice](#) for additional information on the specific components and the required service expectations of this practice model.

Infants and young children benefit from planning processes that support the inclusion of the following components:

- ongoing and nurturing relationships to one or two deeply attached individuals;
- physical protection, safety and regulation at all times;
- experiences suited to individual differences to include regular one-to-one interaction between the caregiver and the child;
- developmentally appropriate experiences (e.g., one-to-one interaction that encourages an emotional dialogue that fosters a sense of self, problem solving, communication skills and a sense of purpose);
- limit setting, structure and expectations (e.g., clear messages and routines); and
- stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral concerns and/or developmental delays. An essential part of the therapeutic process is to help reduce this social isolation. Encouraging the exploration of natural supports can spur a family to begin thinking differently about their support system(s).

Whenever possible, the utilization of natural environments for clinical intervention is recommended. If the natural environment is not a conducive setting due to a lack of privacy,

site of traumatic event for the child/parent and/or safety concerns, alternative settings need to be considered with input from the family. In addition to location, natural environments also include the everyday routines, relationships, activities, people and places in the lives of the child and family (Edelman, L. 2002).

Community Collaboration

Starting with the assessment process, intervention strategies include information from all involved providers serving the child, parent, or caregiver, such as healthcare, childcare and early intervention providers, the parent's/caregiver's mental health provider(s), as well as friends and extended family who are important in the family's life. Examples of several early intervention providers include Head Start/Early Head Start, the Arizona Early Intervention Program, Early Childhood Education through the Arizona Department of Education, and the Division of Developmental Disabilities. These individuals, if the parent/caregiver wishes, then become part of the Child and Family Team who will develop an effective service plan that employs natural supports in conjunction with formalized services. The size, scope and intensity of involvement of the team members are determined by the objectives established for the child and the needs of the family in providing for the child.

In order to make informed referrals as part of the service planning process it is imperative that behavioral health personnel who work with children age birth to five and their families become familiar with community services and programs that serve young children, as well as the local school district programs for children 3-5 years of age. See [Attachment 6: Community Programs & Services](#) for a few examples of these resources.

If at any time throughout the assessment, treatment delivery, or service planning processes a mental health practitioner believes that a child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a **duty to report** your belief to a peace officer or Department of Child Safety per [A.R.S. § 13-3620](#). Behavioral health staff are to consult with their supervisor if they are unclear about their duty to report a situation.

In Arizona, the behavioral health program was developed as a carve-out from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI), a model in which eligible persons receive general medical services through health plans and covered behavioral health services through the T/RBHAs. Because of this separation in responsibilities, communication and coordination between behavioral health providers and AHCCCS Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of young children receiving services from both systems.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs must occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For T/RBHA enrolled children who are not Medicaid eligible, coordination and

communication should occur with any known health care provider.²⁴ Refer to the [ADHS/DBHS Practice Tool Psychiatric Best Practice for Children Birth to Five Years of Age](#) for additional information on the use and coordination of psychotherapeutic and psychopharmacological interventions.

Documentation in the clinical record is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health treatment. Refer to [ADHS/DBHS Policy and Procedures Manual 902, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#) for further information.

Service Plan Development

While a comprehensive and accurate assessment forms the foundation for effective service planning and is required before a service plan can be fully developed, needed services should not be delayed while the initial assessment process is being completed. In addition to consideration of clinical disorders, findings from a comprehensive assessment of children birth to five years of age should lead to preliminary ideas about:

- the nature of the child's pattern of strengths and difficulties, risk and protective factors;
- level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns;
- contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns, etc. to the child's competencies and difficulties; and
- how the service planning process will address these areas.²⁵

Service plans should be strength-based in addressing needs and whenever possible draw upon natural supports. For young children, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.²⁶

A comprehensive and intensive approach to service planning would include attention to those factors that place young children's healthy attachment and social-emotional development at risk. Critical planning includes interventions that address a parent's/caregiver's mental health concerns and how these may affect the ability of that parent/caregiver to interact and respond sensitively to his/her child's emotional and physical needs. Prematurity, low birth weight and conditions associated with prenatal substance exposure may require specific interventions when they affect the early social and emotional development of infants and toddlers.

²⁴ ADHS/DBHS Provider Manual Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers & Medicare Providers

²⁵ Zero to Three (2005). *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition*. Zero to Three Press.

²⁶ Berlin, L.J., O'Neil, C.R., & Brooks-Gunn, J. (1998). What makes early intervention programs work? The program, its participants and their interaction. *Zero to Three Journal*, 18(4), 4-15.

Service planning also needs to address a child's ability to form close parent/caregiver relationships which can be undermined by traumatic events such as repeated exposure to violence, abuse or neglect or when children experience multiple caregiver changes. When the child/family has multi-agency involvement, every effort is made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. Additionally, planning would address collaboration with early intervention service providers and early education programs especially for those children who are experiencing expulsion from childcare or preschool settings due to behavioral concerns.

The use of all service settings, the full array of covered services, and skilled and experienced providers are to be considered as indicated by the Child and Family Team during the service planning process. Service planning that includes the use of Support and Rehabilitative Services is often an essential part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community. Refer to the [ADHS/DBHS Practice Tool: Support and Rehabilitation Services for Children, Adolescents and Young Adults](#) for guidance on how to integrate these types of services with CFT practice to enhance behavioral health outcomes for birth to five children and their families.

All service plan development with children age birth to five is completed collaboratively with the child's parent or primary caregiver. Development and prioritization of service plan goals are not focused solely on the child, but include the parent, caregiver and the needs of the family as a whole. Due to the age of the birth to five population and the rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives. At the time of the Annual Update, the service plan is modified to align with the needs identified in the updated Assessment. Refer to [ADHS/DBHS Policy and Procedures Manual 105, Assessment and Service Planning](#) for further information on the minimum elements of a service plan and required timeframes for completion.

Clinical Practice

The guiding principle in the practice of infant and early childhood mental health is to "do no harm". Clinical intervention assumes a preventative, early intervention treatment focus, is based on sound clinical practice, delivered in a timely manner across all settings, and is implemented in accordance with the [Arizona Vision and 12 Principles](#). Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.

Infant and early childhood therapeutic approaches are supported by the following conceptual premises:²⁷

- the child's attachment relationships are the main organizer of his/her responses to danger and safety in the first five years of life;

²⁷ Community Partnership of Southern Arizona and Easter Seals Blake Foundation presentation, *Treatment and Intervention Strategies in Early Childhood Mental Health*.

- emotional and behavioral problems in early childhood are best addressed within the context of the child’s primary attachment relationships; and
- promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.

The following skills and strategies are fundamental to the work of infant and early childhood mental health:

1. “building relationships and using them as instruments of change;
2. meeting with the infant and parent/caregiver together throughout the period of intervention;
3. sharing in the observation of the infant’s growth and development;
4. offering anticipatory guidance to the parent/caregiver that is specific to the infant;
5. alerting the parent/caregiver to the infant’s individual accomplishments and needs;
6. helping the parent/caregiver to find pleasure in the relationship with the infant;
7. creating opportunities for interaction and exchange between parent/caregiver(s) and infant or parent/caregiver(s) and practitioner;
8. allowing the parent/caregiver to take the lead in interacting with the infant or determining the ‘agenda’ or ‘topic for discussion’;
9. identifying and enhancing the capacities that each parent/caregiver brings to the care of the infant;
10. wondering about the parent/caregiver’s thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood;
11. wondering about the infant’s experiences and feelings in interaction with and relationship to the caregiving parent;
12. listening for the past as it is expressed in the present, inquiring and talking;
13. allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing and talking about them as the parent is able;
14. attending and responding to parental histories of abandonment, separation and unresolved loss as they affect the care of the infant’s development, the parent/caregiver’s emotional health and the early developing relationship;
15. attending and responding to the infant’s history and early care within the developing parent/caregiver-infant relationship;
16. identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness and family dysfunction;
17. remaining open, curious and reflective.”²⁸

While all the skills and strategies noted above are pertinent in working with children and families, item numbers 10 through 16 are of unique importance to the practice of the infant and early childhood mental health practitioner. These seven strategies address the emotional health and development of both the parent/caregiver and the child. The practitioner focuses on past and present relationships and the complexities many parents/caregivers encounter when nurturing, protecting, and responding to the emotional needs of their children. Within this context, the practitioner and parent/caregiver may think

²⁸ Weatherston, D.J. (October/November 2000). *The Infant Mental Health Specialist. Zero to Three Journal*, 3-10.

deeply about the care of the young child, the emotional health of the parent/caregiver, the many challenges of early parenthood, and the possibilities for growth and change.²⁹

Clinical Approaches

Information obtained through the assessment process will guide infant and early childhood trained practitioners in determining which intervention(s) is most conducive in meeting the needs of the young child and his/her family. More than one approach may be utilized and integrated into the service plan.

Support is the most basic intervention, where behavioral health personnel function as a resource to assist primary caregivers in accessing community resources, such as housing, employment, child care, health services and food. Emotional support may also be provided to families when they are faced with a crisis related to the care of their child(ren). This support can be shown by the clinician's attention to the expressed concerns of the caregiver, acknowledgement of the caregiver's needs and strengths, and showing empathy in response to the situation. Support and Rehabilitation services can also assist with reducing the family's distress so that they are able to focus on the care requirements of their young child.

Advocacy can take the form of helping caregivers find their voice in expressing their needs and navigating systems of care. It can be challenging for clinicians to know when and how to speak effectively on behalf of young children and their families, especially those who may be involved with the child welfare system.

Developmental Guidance provides information to the primary caregiver(s) on a young child's abilities, developmental milestones and needs, as well as practical caretaking guidance that may be delivered individually or in a group format. The clinician can offer the caregiver opportunities to strengthen positive interaction and playful exchange with his/her child within a therapeutic environment. These exchanges reinforce what the caregiver is able to do with his/her child that promotes a mutually pleasurable experience and purposeful response.

Relational Guidance helps primary caregivers to increase their knowledge of and experience with their infant or young child through spontaneous interactions. Caregivers are taught how to attend to their child's distinctive cues with clinicians modeling parenting behavior. When using guided interaction strategies, clinicians can then provide feedback directly or can review videotapes with the caregiver.

The following two approaches to therapy focus on the relationship between the primary caregiver and the infant. Child-parent psychotherapy offers the opportunity for thoughtful exploration with the caregiver of his/her ideas about parenthood and the continuing needs of the infant or toddler. The clinician assists the primary caregiver in gaining access to repressed early experiences, re-experiencing the feelings

²⁹ Berlin, L.J., O'Neil, C.R., & Brooks-Gunn, J. (1998). What makes early intervention programs work? The program, its participants and their interaction. *Zero to Three Journal*, 18(4), 4-15.

associated with them and achieving insight into how these experiences may affect the caregiver's capacity to be responsive to his/her infant. Relational difficulties with his/her infant may take the form of a caregiver's inability to hold or feed his/her baby, set limits that are appropriate in keeping young children safe, or interacting in ways that will arouse the child's curiosity. The infant is included as a catalyst for change, with the clinician guiding the caregiver to interact in a different way with his/her infant. A second approach, child-parent dyadic therapy, reflects the perspective that infants contribute to relationships and holds that the infant is able to use the time therapeutically for him/herself, same as the caregiver.

Several approaches incorporate and utilize an internal working models construct. This concept of self in relation to others is set down throughout life and unconsciously guides and filters attention and processing of experiences with regard to attachment and can impact the course of future relationships. Interventions based on this construct are consistent with attachment theory if they include the following elements:

- provide emotional and physical access to the mother/caregiver;
- focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals;
- place the mother/caregiver in a non-intrusive stance;
- provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver; and
- provide a clinician who functions as a secure base for the dyad.

Developmental approaches to therapy offer an alternative to the traditional behavioral approach. Modalities under this approach can provide a framework for understanding and organizing assessment and intervention strategies when working with children with developmental delays and mental health concerns.

Refer to [Attachment 7: Recommended Resources](#) for additional reference material on infant and early childhood mental health practice. This resource list is not meant to be exhaustive as research and clinical practice in this area continues to evolve.

TRAINING AND SUPERVISION RECOMMENDATIONS

Infant and Early Childhood Mental Health has gained increased attention. The need to have providers with trained expertise in this area has risen dramatically and is well recognized nationally and in Arizona. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has focused its efforts in several areas to build workforce expertise and availability of services to children age birth to five and their families.

WORKFORCE DEVELOPMENT

The Infant and Toddler Mental Health Coalition of Arizona (ITMHCA) has adopted the *Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health*. Endorsement recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family field. This endorsement

model describes the areas of expertise, responsibilities, and behaviors that demonstrate competency and verifies that professionals have attained a specified level of understanding and functioning linked to the promotion of infant mental health. Of additional importance, endorsement provides an organized approach to workforce development that identifies competency-based trainings and reflective supervision experiences that enhance confidence and credibility among infant, toddler and family clinicians (Behavioral Health Professionals), as well as other professionals who work with this population (Behavioral Health Technicians/Behavioral Health Paraprofessionals). While competency-based training and reflective supervision supports mental health practitioners who work primarily with young children and their families, this expertise may also be applied to professionals working with adults with a serious mental illness or substance use concerns who are parenting their own infants/toddlers.

It is recommended that provider agencies have practitioners endorsed as appropriate to the mission of the agency. Endorsement through the ITMHCA includes four levels of competency:

- Level 1: Infant Family Associate- Individuals who possess a CDA or Associate's degree in an infant/child/family related field plus experience; recommended for childcare or respite workers;
- Level 2: Infant Family Specialist- Bachelor's or Master's degree and work related experience with infants/toddlers and families; recommended for mental health staff involved in service planning and delivery such as case management and peer/family support, support and rehabilitation service provider personnel, parent educators, childcare consultants, and Department of Child Safety workers;
- Level 3: Infant Mental Health Specialist- Masters or Post-Graduate degree with post-master's work and training in infant, early childhood and family fields; recommended for mental health clinicians and supervisors, infant mental health specialists, clinical nurse practitioners, psychologists, and early intervention specialists; and
- Level 4: Infant Mental Health Mentor (Clinical, Policy, or Research/Faculty)- Individuals at the mastery level (Master's, Post Graduate, Doctorate, Post Doctorate or MD) qualified to train other professionals; recommended for infant and early childhood program supervisors, administrators, policy specialists, and physicians/psychiatrists.³⁰

Endorsement information and application materials are available through the [Infant Toddler Mental Health Coalition of Arizona](#).

TRAINING

While this Practice Tool applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health staff who provide direct service delivery to children age birth to five and their families, mental health practitioners working with this population require specialized training. Professional development in the area of infant and early childhood mental health is necessary at all levels of the behavioral health system, as well as for the personnel of service systems that interface with behavioral health professionals such as Department of Child Safety, Division of Developmental Disabilities and other community early intervention programs.

³⁰ Michigan Association for Infant Mental Health at http://www.mi-aimh.org/endorsements_overview.php

Mental health practitioners seeking increased knowledge in this area are encouraged to attend infant and early childhood mental health trainings that include:

- a multidisciplinary approach that is strengths-based;
- effective interviewing and observational techniques;
- assessment of parent-infant relationships;
- screening and diagnostic measures for infants and toddlers;
- early childhood development;
- effects of early adverse experiences and trauma;
- understanding parent-child interactions and healthy attachment;
- cultural influences in parenting and family development;
- building a therapeutic alliance;
- treatment and intervention strategies/modalities endorsed by ADHS/DBHS;
- collaboration practices with other providers/caregivers; and
- a reflective practice focus.

It is the expectation of ADHS/DBHS that behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth to five and their families be well trained and clinically supervised in the application of this tool. Each T/RBHA shall establish their own process for ensuring that all agency clinical and support services staff working with this population understands the recommended processes and procedures contained in this tool. Whenever this Practice Tool is updated or revised, each T/RBHA ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

SUPERVISION

Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the T/RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with [A.A.C. R9-20-205 Clinical Supervision](#) requirements. Refer to [ADHS/DBHS Practice Tool: Clinical Supervision](#) for further information related to supervisory practices.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development that focuses attention on supporting the growth of relationships that are critical to effective infant and early childhood mental health practice. How each of these relationships interrelates and influences the others is explored through reflective supervision and is referred to as the “parallel process” (see Figure 1).

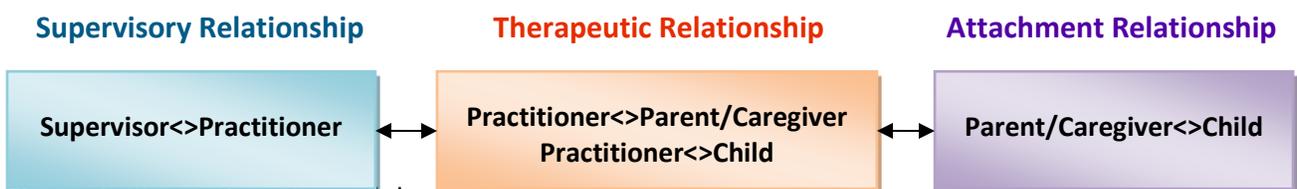


Figure 1. Illustration of parallel process

In each of these relationships there is an emphasis on learning, personal growth, and empathy. Through supervision, supervisors assist practitioners in professional skill development and ensure that practitioners are maintaining the agency's standards for clinical performance.³¹

Key elements of reflective supervision include reflection, collaboration, and consistency. With supervisory support, the practitioner reflects on the emotional content of the work and how one's reaction to this content affects his/her work. Supervisors support a practitioner's professional development through the acquisition of new knowledge by encouraging the supervisee to assess his/her own performance. The supervisor's ability to listen and wait allows the practitioner an opportunity to analyze his/her own work and its implications, and to discover solutions, concepts or perceptions on one's own without interruption. Collaborative supervision is characterized by the development of a trusting relationship between the supervisor and practitioner in which both parties can safely communicate ideas and share responsibility for decision-making without fear of judgment. Establishment of a consistent and predictable schedule of supervisory sessions supports the professional development of infant and early childhood mental health practitioners.

It is the recommendation of ADHS/DBHS that personnel who supervise staff that provide service delivery to children age birth to five and their families receive adequate training in the elements of Reflective Practice and Supervision before implementing this approach in their supervisory activities. Refer to [Attachment 7: Recommended Resources](#) for additional reference material on reflective supervision and consultative practices.

Training and supervision support the acquisition of specific knowledge, skills, and competencies critical to delivering effective relationship-based services to children age birth to five and their families. While training and other academic learning venues build the practitioner's understanding of core concepts, it is through supervision that practitioners can assess their level of competency when applying these concepts within their scope of practice. When evaluating a practitioner's level of competency as part of supervisory activities, supervisors can access the [ITMHCA's Endorsement Competency Guidelines and Requirements](#) to clarify the knowledge and skills needed for practitioners to provide effective infant and early childhood mental health services. An additional resource is the [Revised Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health](#) which identifies key areas of knowledge and related concepts for the development of professional competencies, as well as the desired competencies for facilitators of reflective practice.

ANTICIPATED OUTCOMES

- Increased community and professional awareness of infant and early childhood mental health;
- Improved use of effective screening, assessment and service planning practices specific to the needs of children age birth to five and their families;
- Increased knowledge and referrals to early intervention resources in the community; and
- Improved outcomes through the use of accepted approaches in working with children age birth to five and their caregivers.

³¹ Williams, Abi B. (Winter 1997). On Parallel Process in Social Work Supervision. *Clinical Social Work Journal*, 25(4), 425-435. Retrieved from <http://www.springerlink.com/content/r317n1382758h426/fulltext.pdf>.