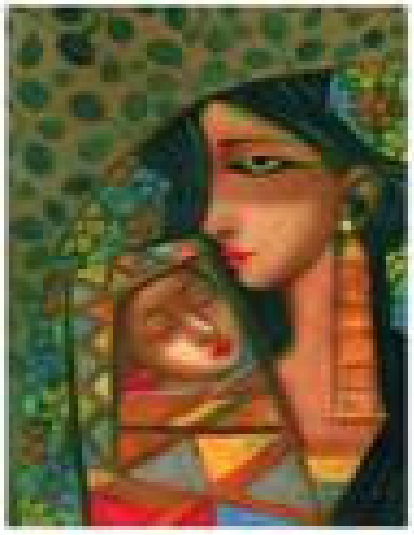
CHILDREN, YOUTH AND FAMILIES DEPARTMENT

BEHAVIORAL HEALTH SERVICES

2019-2020
INFANT AND EARLY CHILDHOOD MENTAL HEALTH TEAM MANUAL



cyfd
New Mexico Children, Youth & Families Department
PULLTOGETHER

INFANT MENTAL HEALTH TEAM MANUAL

I. PREFACE:

CYFD Behavioral Health Services - Infant and Early Childhood Mental Health Section (IECMH) updated and revised the Infant Mental Health (IMH) program in 2019 to reflect the decision to bring trauma centered clinical services. Decades worth of research, supplemented by new technology, has allowed for observation of how the brain changes. And has revealed the extraordinary capacity of the infant/toddler brain to grow and change during the first few years of their life. Through scans of the brain, that same technology shows the physical evidence of emotional issues in the brain, reflecting the importance of early social and emotional development, specifically attachment and regulation. The higher the level of trauma suffered by toddlers and infants, the more important early intervention becomes. Therefore, IECMH has chosen to restructure the delivery of clinical services for the (IMH) program around Child Parent Psychotherapy (CPP). CPP is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship.

The effectiveness of CPP relies on increased capacity across the state and on a competent team of clinicians and providers who can comply with the fidelity of the model, as they confidently engage with infants, assess opportunities to intervene and foster change in the thinking and behavior of caregivers. CPP trauma treatment and clinical interventions are affected by the therapist understanding of the infant's environment, circumstances, history and present life. To ensure the capacity and competency of IMH clinicians in New Mexico, IECMH has partnered with Dr. Alicia Lieberman, the developer of CPP, for ongoing training and consultation Dr. Lieberman is also the Irving B. Harris Endowed Chair in Infant Mental Health; Professor and Vice Chair for Academic Affairs at the University of California, San Francisco, Department of Psychiatry; Director of the Child Trauma Research Program at San Francisco General Hospital.

In addition to updating the IMH manual, in order to support the focus on CPP, the IECMH Section has made additional systemic changes. The scope of work for IMH providers with CYFD BHS IMH contracts have been developed to clearly outline the clinical focus on trauma and relationship and the program procedures have been revised to mirror the practice of CPP. Several indicators are included in the SOW to make sure the clinicians and management can track their own performance and reach the established goals. Furthermore, two new tools have been designed by New Mexico professionals to suit the needs of our population: DIAPER a tool to observe and rate the pathology of relationship disturbances between a caregiver-infant/child manifested in developmental pathways affecting the cyclic nature of interactions and, the CIAP, a tool to track the progress of the case in view of the clinical objectives. In the management side, output and performance measures for PIPs and IMHTs are being tracked to mirror the three-year internal strategic plan developed in FY18.

II. IMHT Foster Parent Intervening

In order to support the Infant, when the Infant's symptomatology, reaction to stressors (e.g., visitation), or past trauma experience are problematic in the foster home setting, the IMH Foster Parent Program may provide Foster Parent Intervening. Foster Parent Intervening consist of developmental guidance and relational support to the Foster Parent(s). Foster Parent(s) may receive Foster Parent Intervening without any Parent involvement for up to four (4) months. If the Parent(s) are not actively participating in Dyadic, Triadic or Collateral sessions for four (4) months, the case should be discharged from Team and opened under Foster Parent Program. The clinician may continue providing the PPW and/or the

courts is/are reports and/or updates regarding the case.

i. Foster Parent Intervening:

The Clinician may provide this support to the Infant and the Foster Parent(s) throughout the case. Foster Parent Intervening provides the Foster Parent(s) with developmental guidance, involving not only giving information but also helping the Foster Parent(s) appreciate the Infant's construction of the world.

1. Twelve Common Developmental Themes are:
    a. Crying and proximity-seeking are the Infants most basic communication tools, and infants develop a health sense of competence and self-esteem when the parent or caregiver responds by offering comfort.
    b. Infants have a strong desire to love their parents and/or caregivers, although parents/caregivers are often unaware of this.
    c. Separation anxiety is an expression of love and fear of loss rather than a manipulative ploy.
    d. Infants fear losing their parent's love and approval.
    e. Infants imitate their parents/caregivers because they want to be like them.
    f. Infants blame themselves when their parent/caregiver is angry or upset or when something wrong. This tendency is an emotional by-product of the cognitive egocentrism of infants, which leads them to overestimate their role in the relationship between cause and effect.
    g. Infants believe that the parents/caregivers are always right, know everything, and can do anything they wish. This belief in the parents'/caregivers' omnipotence goes hand in hand, often paradoxically, with infant's belief in their own power and their determination to assert it.
    h. Infants feel loved and protected when parents/caregivers are confident about their child-rearing practices and enforce their rules about what is safe and what is dangerous, right and wrong, allowed, and forbidden.
    i. Infants and preschoolers use the word "no" as a way of establishing a sense of autonomy, not out of disrespect for the parents.
    j. Infants remember. They have a well-developed memories from an early age, and their capacity to remember precedes their events that evoke strong emotions, such as joy, anger, or fear. The memories may not be completely accurate because they are influenced by the child's affective state and cognitive level, including their understanding of cause-effect relations. Infants are keen observers of what happens around them and may remember it for a long time afterward.
    k. Infants feel intensely but do not yet know how to regulate their emotions. Intense crying, tantrums, and aggression are not expressions of the infant's intrinsic nature but manifestations of distress that the infant is too immature to express in socially acceptable ways.
    l. Conflicts between parents and infants are inevitable due to their different goals, personalities, and developmental agendas. Conflicts can serve a valuable developmental function when they are used to

highlight the separate but equal legitimacy of the partners' goals and wishes and to mobilize collaboration for the purpose of resolution. (Lieberman, A. F., Horn, P. V., & Ippen, C. G., 2015)

- ❖ It is recommended that Clinicians review the Twelve Common Developmental Themes further explained in the CPP Manual *Don't Hit My Mommy!* (pg33).

ii. CPP Goals:
1. Goals may include: (Pg. 28 Common Features targeting the main symptoms of the traumatic response)
2. Global CPP Goals-Objectives:
   a. Encourage normal development: adapt to infant or young child's developmental capacity
   b. Offer unstructured reflective developmental guidance
   c. Encourage and model appropriate protective behavior
   d. Maintain regular levels of affective arousal
   e. Interpret feelings and actions
   f. Establish awareness and trust in bodily sensations
   g. Achieve reciprocity in the caregiver-child relationship
   h. Provide emotional support/empathic communication
   i. Resolution of trauma-related symptomatology
3. Trauma-Related Goals-Objectives of CPP:
   a. Increased capacity to respond realistically to threat
   b. Differentiation between reliving and remembering
   c. Normalization of the traumatic response
   d. Placing the traumatic experience in perspective
   e. Co-construction of a mutually meaningful trauma narrative
   f. Promote developmental progress through play, physical contact, and language

III. CLINICAL INSTRUMENTS:

Complete the clinical instrument listed below with the Infant and/or Caregiver(s) upon opening the case under the Foster Parent Program.

i. The clinical instrument must be administered per the periodicity indicated below.
1. DIAPER w/the DIAPER Observational Video Event (DOVE)
   a. Complete the full clinical instrument upon admitting the case into the Foster Parent Program, at discharge, and every three (3) months in between. See Table below.

Intake	3 months from Intake	6 months from Intake	12 months from Intake	Discharge

2. The IMH Foster Parent Program supervisor may request an exception in writing from the IECMH Program Director if additional time is needed to complete the assessment.

ii. The clinical instrument must be entered under the referred Infant's Client ID in the IMH Database.

IV. IMHT SUPPLEMENTAL PROCEDURES

Adhere to IMH Foster Parent Program guidelines by providing and participating in the following for all IMH Foster Parent Program cases:

a. Staffing
    i. Share and review information gathered with supervisor and/or colleagues to continually assess the effectiveness of the treatment.
b. Family Centered Meetings
    i. Hold meetings with the family, caregivers, other provider, and/or CYFD to identify and coordinate how to work together in the best interest of the Infant and the family.
c. Team Meetings
    i. Face to Face or telephonic multidisciplinary meetings to discuss, plan, coordinate, review, and/or identify needs and services for the Infant and the family.
        1. The family is not present during these meetings.
d. Observation Sessions:

    The Clinician may conduct Observation Sessions during all phases of CPP:
    i. Between the Infant and Parent(s)
        1. To obtain information regarding quality of the relationship, and overall safety conditions.
        2. To provide recommendations to CYFD such as visitation frequency and duration to support the Parent and Infant relationship.
    ii. Of the Infant in child care settings:
        1. To observe any behavioral concerns and gather information relevant to treatment.
        2. Observations made should be addressed in subsequent sessions (collateral, dyadic, triadic, foster parent, or team meetings).
    iii. Between the Infant and Foster Parent(s)
        1. To understand the relationship and determine the appropriate developmental guidance and relational support to be provided.

V. DOCUMENTATION:

As part of the IMH SOW there are various documentation requirements and standards that must be adhered to.

a. Each service being billed to the IMH Foster Parent Program contract must be entered into the IMH Database with an appropriate note as per the IMH Procedures List.
    i. CPP Fidelity Trackers for Case Rate Medicaid Billable Procedures:
        1. Must be entered under the case in the IMH Database.
        2. Should be concise, and effectively describe the interventions utilized by the Clinician during session.
        3. Observations noted should be related to objectives and strategies used during the session.
        4. Information entered should be related to progress in treatment and future treatment plans.
    ii. CPT Codes for Providers unable to currently bill Medicaid:
        1. Must be entered under the case in the IMH Database using the appropriate CPT

Code.

2. CPT Code Notes entered into the IMH Database must document Medically Necessary Behavioral Health Services.
    a. Medically Necessary Behavioral Health Service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
3. CPT Code usage must follow the Medicaid Regulations and Limitations:
    a. No more than one (1) individual session, regardless of length of session, may be billed per day per client.
    b. Family Sessions:
        i. With or without the client cannot be billed on the same day.
        ii. With or without the client can be billed on the same day as an individual session.

iii. Notes for Case Rate Services (Non-Medicaid Billable Procedures):
1. Must be entered under the Clinician in the IMH Database.
2. Must specifically indicate how the time being billed was spent.

iv. Treatment Plans:
1. Must be developed for each client.
2. Must adhere to Medicaid requirements for Individual Service Plans.
3. Must be updated every three (3) months.
4. Must be maintained in the client's file and available for review by CYFD during site visits.

v. Clinical Instruments:
1. In order to be considered to complete, every question for each clinical instrument must be answered and entered in the IMH Database under the Infant.
2. Refer to the IMH Procedures List for instructions on clinical instrument protocols and periodicity.

vi. Judicial Report Writing:
1. The IMH Status Report should be submitted to the PPW for the following hearings:
    a. Initial Judicial Review
    b. Initial Permanency Hearing
    c. Permanency Hearing
2. IMH Status Reports requested for any other hearings can be completed at the discretion of the Clinician.

vii. Billing:
1. With each month's invoice, Providers must submit the following:
    a. The Case rate billing for CPP Fidelity Tracker report from the IMH Database for the month being invoiced.
    b. Summary documentation to confirm that a CPT code was billed for each corresponding CPP Fidelity Tracker entered in the IMH Database.

References

Lieberman, A. F., & Horn, P. V. (2015). *Dont hit my mommy!: A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, D.C.: Zero to Three.