

SYSTEMS-BASED PRACTICE EARLY CHILDHOOD SYSTEM Updated April, 2020

SYSTEMS-BASED PRACTICE: EARLY CHILDHOOD SYSTEM OBJECTIVES*

Note: Throughout this module, the use of the term “young children” refers to infants, toddlers and preschool-aged children ages 5 and under.

Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) The importance of early relationships in child development
- 2) The multiple systems involved with young children and the organizational structure of these services at a state and local level.
- 3) Services available to young children at a state and local level.
- 4) The purpose and target population of early intervention programs.
- 5) The purpose and structure of the Head Start program and Parts B and C of IDEA (Individuals with Disabilities Education Act).
- 6) The role of other early childhood providers, such as pediatricians, nurses and early interventionists.
- 7) The roles of child protective services and the legal system for young children and their families, who have been validated (substantiated) as abused, neglected or abandoned.
- 8) Other diagnostic systems for infants and toddlers, such as the Zero to Five classification system.
- 9) The standardized tool to determine intensity of services, the Early Childhood Service Intensity Instrument.
- 10) When age-based transitions between service programs occur in local areas.
- 11) The standards for quality child care and its importance for infant mental health and child development.
- 12) The principles of wraparound services and how these are applicable to the care of young children.
- 13) The multiple roles of a child psychiatrist including advocate, consultant, system navigator, medical case manager, diagnostician, psychotherapist, and psycho-pharmacologist.

Skills

The resident will demonstrate the ability to:

- 1) Collaborate effectively with multiple players involved with infants and toddlers, including the family and other service providers.
 - 2) The ability to engage families in an effective partnership based on respect for and understanding of developmental niche and culturally relevant parenting practices.
 - 3) Make appropriate referrals of young children for additional services, such as Head Start, pre-school special education programs, Infant and Toddler Programs, and speech, physical, and occupational therapies.
 - 4) Act as a case manager to support families with age-based service transitions.
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- 5) Demonstrate flexibility and a willingness to play multiple roles in the community-based care of young children.

Attitude

The resident will demonstrate the commitment to:

- 1) Appreciate the centrality of the young child's relationships with caregivers and the impact of the family environment.
- 2) Maintain a commitment to providing trauma-informed care to children and their families.
- 3) Recognize the importance of early identification of emotional and behavioral health needs for young children.
- 4) Recognize the value of interdisciplinary approaches to serving young children and their families.
- 5) Advocate for young children and their families' health and well-being.

****Appendix 1 describes the systems-based practice competency in the RRC Program Requirements¹**

OVERVIEW

This module will help the reader understand the many services available for young children (and their families) with developmental and mental health challenges. The reader will also learn that each state organizes these services in different ways. The module will also familiarize the reader with existing barriers and gaps in the organization of systems and funding mechanisms that may complicate the delivery of appropriate services to young children and their families.

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I. INTRODUCTION

In order for states and local communities to provide high quality services for young children, they must base the design of their programs on sound scientific research. For example, in their review of child development research and public policy, the authors of *Neurons to Neighborhoods: the Science of Early Childhood Development* clearly state that strong, loving, caregiving relationships are essential to normative psychological development. They write:

“Virtually every aspect of early human development, from the brain’s evolving circuitry to the child’s capacity for empathy is affected by the environments and experiences that are encountered in a cumulative fashion, beginning early in the prenatal period and extending throughout the early childhood years. The science of early development is also clear about the specific importance of parenting and regular caregiving relationships more generally...” (p. 6)²

Thus, as one of their primary goals, community-based early childhood programs must emphasize the preservation of relationships between young children and their parents/caregivers.

In addition, both basic science research and outcomes research can provide insights into how to best develop programs. Courchesne et al. found that by twelve months of age, young children who would later be diagnosed with autism had significantly larger head circumferences and brain volumes than typically developing children.³ This basic research provides support for the early identification of children at risk for autism using such tools as the Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F) and the development of specific programs to provide treatment to children in this age group at risk for autism.⁴

David Olds et al.'s research on the long-term benefits of nurse home visitation during pregnancy and in the immediate post-natal period underscores the benefits of such a program in the prevention of anti-social behavior and substance abuse as the infant develops into adolescence.⁵ The fifteen year follow-up showed significant reductions in these behaviors in contrast with a group of pregnant mothers who received standard pre-natal care. The research of Olds et al., then, can inform the development of community-based prevention programs aimed at reducing adolescent criminal behavior.

In addition, wellness promotion is vital prior to pregnancy in the preconception period, during pregnancy, and in the postpartum period, because, from a public health perspective, "early childhood" begins prior to the actual birth of the child.⁶

Maternal wellness is essential for the health of both the woman and the offspring. Ideally, in accordance with the principles of preconception health care, education and health promotion for wellness needs to begin prior to onset of a pregnancy.⁷ It is much easier for a woman to maintain healthy habits acquired prior to being pregnant than afterwards. Wellness, beginning during preconception, then continues through pregnancy and postnatally. Specific aspects of maternal wellness involve all of the following: preconception care, prenatal care, screening for maternal depression and substance use, optimal nutrition, adequate sleep, appropriate exercise, supportive relationships, and avoidance of all harmful substances. When maternal illness exists, judicious use of prescription medication is recommended. Prenatal use of drugs, especially alcohol and tobacco, can lead to very serious and potentially irreversible damage to the child's brain and should be avoided. If the mother has substance abuse issues, evaluation, diagnostic and treatment services should be provided. After the child's birth, it is important to screen for postpartum depression and other mental health concerns that may be present.

II. FEDERAL GRANT PROGRAMS TO PROMOTE EARLY CHILDHOOD SERVICES

Project LAUNCH (Linking Actions for Unmet Need in Children's Health)

In addition to long-standing funding of such early childhood programs such as Head Start and Early Head Start, discussed below, the federal government initiated a specific grant program in 2008 that seeks to improve the quality and cohesiveness of early childhood services. Project LAUNCH is a federal grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) with the goal of advancing the health and wellbeing of young children. Five-year grants were awarded to specific states, tribes and local communities to promote a public health approach to young children from birth to 8 years of age and their families. Project LAUNCH addresses both service delivery and systems change. Systems change is intended to "occur across multiple sections of the child services delivery system," and involves the following:

.....ensuring availability and access to quality prevention services for young children and families, sustaining services over time; addressing service gaps in order to improve the health, well-being, and school readiness of young children

and families and reduce health disparities; and eliminating fragmentation in systems and funding streams”⁸.

Project LAUNCH supports and monitors multiple prevention and promotion strategies: screening and assessment of young children in multiple child-serving settings, for social and emotional well-being, developmental delays, and behavioral concerns; integration of behavioral health into primary care settings; mental health consultation in early care and education; home visiting based on demonstrated evidence-based models; and family strengthening and parent skills training, to help parents promote their child’s healthy development.

Viewed from a systems perspective, Project LAUNCH represents a transformative initiative by the federal government to support young children and their families. In response to the disparate, fragmented nature of early childhood systems of care, Project LAUNCH seeks to increase the knowledge, engagement and collaboration of multiple stakeholders including families, and promote the use of services that address the needs of young children and their families. The challenge is for all states and communities to learn from this initiative in order to improve their systems of care for young children and their families.

III. STATE AND LOCAL ORGANIZATIONAL STRUCTURES AND SYSTEMS OF CARE FOR EARLY CHILDHOOD SERVICES

Navigating the service array for young children can be a complex task, as often the elements of the service array for young children are administered by several state agencies. For example, a three year old foster child with speech delays, spina bifida and frequent, severe tantrums may be receiving services from Child Protective Services, the local school district, the community mental health center and the state agency charged with providing services to children with physical disabilities.

In addition, the administrative structure for many of these services may vary from state to state. For example, there is significant variation across the U.S. in how early childhood services are administered at the state level and local levels. Frequently, early intervention services are administered by the same state agency that provides child welfare services; two such examples are Arizona and Vermont. In Maryland, the Department of Education administers both the early intervention and special education programs for pre-school children. In New Mexico and Massachusetts, early intervention services are administered by the state Department of Health.

IV. THE EARLY CHILDHOOD SYSTEM AND SERVICE ARRAY

Early Intervention

Early intervention programs are focused on improving the function of children with intellectual disability, cerebral palsy, genetic conditions/syndromes, and those at high risk of developmental disabilities due to other biological conditions or environmental risk factors.⁹ Once the child and family are assessed, an individualized family service plan is developed by a multidisciplinary team including the parents. There is an emphasis in the planning process on coordination of services and providing access to needed therapies, such as speech, occupational and physical.

Eligibility for early intervention services in many states extends beyond documented developmental delay to include environmental risk and the presence of emotional disturbances. Early intervention services are available up to approximately three years of age. Then, the child may be eligible for early childhood special education services.

The national agenda for an early intervention system for infants and toddlers with established disabilities culminated with the passage of the Education of the Handicapped Act Amendments of 1986, with continuing refinements incorporated into the Individuals with Disabilities Education Act (IDEA) that was reauthorized in 2004. Part C of the act states: “to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that provides early intervention services for infants and toddlers with disabilities and their families.” Structural components of the system included establishing eligibility criteria and a process to ensure that all children meeting those criteria in a state were served. A “child find” system and public awareness program were included to promote awareness of children’s developmental problems by parents and professionals and to encourage early detection and identification.

Special Education Services

According to federal law (IDEA, Public Law 108-446), children with documented impairment (physical, cognitive, or behavioral) that interferes with the ability to benefit from instruction in the general classroom curriculum are eligible for special education services in a public school from ages 3 to 21.¹⁰ Public schools are obligated to provide a nondiscriminatory evaluation for any child suspected of having a disability and parental consent is required prior to the evaluation. Early referral for such an evaluation when emotional disturbance or developmental delay is suspected is essential. The purpose of the evaluation is to determine whether a child has a disability and, if present, to establish the educational needs of the child. A child is usually evaluated by a multidisciplinary team of professionals that uses a comprehensive assessment process to address the child’s strengths, interests, goals, and needs. The multidisciplinary team must follow specific guidelines during the evaluation of the child. The key mandates are that a number of tests must be used to determine if the child has a disability and that parental input must be included. Once a disability is identified, an individualized education program (IEP) is developed with the parents and the school team. The IEP is based on the strengths of the child, the concerns of the parents, the results of the recent evaluations, and the academic, developmental, and functional needs of the child. After age three, the public schools also become the gateway for all needed therapies (physical, speech and occupational).

Federal funding for IDEA services is received by the state education agency and distributed to the local school districts. Federal funds cover less than the 40% of the cost of educating students with special needs as described in IDEA.¹¹ In addition, the federal government caps the number of students in special education in each state to 12% of the total number of school-age students. This accounts to some extent for the variability of the application of the law across states and districts.

Head Start

Head Start is a federally funded program that started in 1965 that promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social and other services to enrolled children and families. The Head Start

program provides grants to local public and private non-profit and for-profit agencies to provide comprehensive child developmental services to economically disadvantaged children and families. There is a special focus on helping preschoolers develop the early reading and math skills for school readiness.¹² In 1995, the Early Head Start program was established to serve children from birth to three years of age, pregnant women, and their families. Significant emphasis is placed on the involvement of parents in the process. Funding for the program goes directly from the federal government to local grantees. The federal government provides 80% of the yearly cost to operate a Head Start program, and the remaining 20% must come from a “local match” or “in-kind” contribution.¹³

Physical Health Care

Pediatricians and family practice physicians are most often the first and primary contact for young children and their families within the health care system. The high frequency of well-child visits in the infant and toddler years offers an excellent opportunity for physicians to monitor the general development and specific social and emotional development of a child. Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) for mental health is required at each visit with a child. Pediatricians are usually the first to identify developmental and behavioral concerns, e.g. feeding and sleep problems, withdrawn behavior, impulsivity and oppositional behavior, and special issues of vulnerable young children with medical problems. The concept of the medical home is important for a child and their family for continuity of a relationship with a caring provider who knows the child.¹⁴ This helps a parent feel more comfortable in asking questions about developmental concerns they may be having. Pediatricians offer basic mental health care to children and their families by doing initial screening for and beginning assessment of behavioral health problems. Pediatricians also give advice on promoting good social and emotional growth and good parenting practices. When problems become severe enough that a pediatrician can no longer manage them in the office, formal mental health consultation to pediatricians is important. An especially critical time is when newborns have spent time in a neonatal intensive care unit (NICU). Mental health consultation and support is very important to families during the NICU stay and upon receiving their child home and in follow up. Consultation and linkage to formal mental health assessment and treatment in their community are critical parts of an early childhood system of care.

Child Care

Child care workers see children for many hours a day and can be the first to identify behavioral and developmental needs. There are federal and state requirements that monitor the quality of child care settings. Nevertheless, the National Institute of Child Health and Human Development (NICHD) Early Child Care study in 2006 found the majority of child care center classes for children less than 2 years old did not meet recommended guidelines for group size and adult-to-child ratio.¹⁵ Many states require continuing education classes for child care staff, often linked to greater reimbursement rates. These classes will ideally focus on increasing the expertise of child care staff in promoting the basic social and emotional needs of the children in their care and assisting the child who is having behavioral difficulties. The Center for the Social and Emotional Foundations of Early Learning (CSEFEL) has a Web site with a wealth of materials for child care and other early childhood providers that is very useful for continuing education about promoting social and emotional growth and managing behavioral health problems. Many states

are providing mental health consultation to child care settings to assist child care staff in working with children with behavioral health needs.

Child Welfare

Professionals working with children are required by law in most states to report to child protective services suspicions of abuse or neglect of a child [I have deleted “serious” because professionals need to report any suspicions and not make their own pre-judgment as to whether or not their suspicion is “serious”]. Many young children unfortunately must enter the foster care system at early ages for their protection because of abuse and/or neglect. Approximately 30% of children in foster care are under the age of 6. Trauma experienced prior to removal from their family and the trauma of separation from their family must be addressed with foster care children. There are specific evidenced-based practices to treat the social and emotional impact of trauma, such as child-parent psychotherapy or adaptations of cognitive behavioral therapy. The child welfare system needs to promote the concept of trauma-informed care, which involves an awareness of the effects of trauma on behavior and the provision of a recovery-oriented intervention approach that avoids re-traumatizing the child and parents. Screening for mental health and developmental needs should be done for all children entering the foster care system, as children in foster care have higher rates of these disorders than the general population. A comprehensive mental health assessment for all children on removal from their family is a federal requirement and should be done periodically throughout their time in foster care. It is particularly necessary when a child shows signs of behavioral health need. Mental health care should ideally be organized through a child and family team that includes birth and foster families and others involved in the child’s life. Mental health providers should be trained in the specific needs of foster care children, including the effects of disrupted attachments and the need for loving and committed caregiving.

Family Court

When children enter the foster care system they come under the responsibility of family court, sometimes called juvenile court or dependency court. The family court is responsible for making decisions about the custody of the child and rules on termination of parental rights. Family courts operate under the mandate of Adoption and Safe Families Act (ASFA), a federal law passed in 1997, the goal of which is to shorten the time between when a child enters the child welfare system and the time that child achieves placement permanency. When children have been in foster care for more than 15 of the past 22 months, ASFA requires the county child welfare agency to return the children to their parents or to terminate parental rights and free children for adoption or other permanent alternatives for the child. ASFA also changed the meaning of reasonable efforts and established that reasonable efforts to return a child home need not be made when aggravated circumstances are found to exist by the court. Family courts in many states have also begun collaborating with service providers in offering innovative interventions to improve parent-child attachment and address parental trauma and substance abuse. For example, Zeanah and his colleagues have developed a program in Louisiana for the comprehensive evaluation of children placed in the foster care system that worked with both the birth parents and the foster parents.¹⁶ The program resulted in a significant reduction in the maltreatment of the child in care and subsequent children by mothers who were enrolled in the program.

Developmental Therapy Services

Young children with developmental delays will often require access to ongoing therapy services in order to maximize their potential. These therapies usually include speech, physical and occupational and are accessed as part of early intervention prior to age three. After age three, these therapies are available as part of a pre-school special education or Head Start program. The need for developmental therapies is determined by assessments completed when a child enters these programs. The need must be documented in the Individual and Family Service Plan (IFSP) in early intervention or in the Individualized Education Plan (IEP) in pre-school special education programs.

Mental Health Services

Identification and Diagnosis

Early identification of the young child's social and emotional behavioral health needs is critical. Mental health consultation to early childhood settings is a very important way to identify young children with behavioral health needs. Consultation to maternal-infant home visiting programs, Early Head Start, Head Start, child care, pre-school and pre-K school programs and IDEA Part C Infant and Toddler programs ideally should be available throughout all states. As teachers, child care workers, early childhood professionals, and pediatricians and their office staff identify a child with social and emotional needs, a mental health consultant to staff can help the staff program more appropriately for a child's needs or more directly assess a child with input from their family

Until 1994, the Diagnostic and Statistical Manual was the only diagnostic classification system available for the diagnosis of young children, but many clinicians found it of limited usefulness with this population. In that year, the Diagnostic Classification: Zero to Three (DC: 0-3) was introduced, a significant advance for several reasons. The DC: 0-3 adapted a number of established diagnoses such as depression and anxiety in order to better describe these disorders in infants and toddlers. In addition, the DC: 0-3 and its revised version, DC: 0-3R introduced two new diagnostic categories: Relationship Disorders and Disorders of Regulation. The Relationship Disorders category identifies maladaptive interactional patterns between mother and child. Disorders of Regulation "are characterized by the infant or young child's difficulties in regulating behavior and psychological, sensory, attentional and motor or affective processes, and in organizing a calm, alert, or affectively positive state."¹⁷ Florida was the first state to use the DC: 0-3 for reimbursement purposes in 2001. A "crosswalk" was developed between the DC: 0-3 and ICD-9 so that early childhood mental health clinicians could effectively bill for their services to young children and their families.¹⁸ Several other states have subsequently developed their own "crosswalks" to assist with reimbursement. In 2002, the Research Diagnostic Criteria – Preschool Age (RDC – PA) was also introduced, providing another set of diagnostic criteria of this age group.¹⁹

In 2016 the Diagnostic Classification: Zero to Five (DC: 0-5) was published as an update to this series. It continues to emphasize the importance of the infant/young child and caregiver relationship:

"Diagnosing an infant or young child who is experiencing mental health problems must include developing an understanding and appreciation of the family's cultural

background and the parents’ socioeconomic conditions, national origin and history, immigration status, ethnic and racial identity, sexual orientation, religious and spiritual practices, and other sources of diversity.” (p. 9)²⁰

A crosswalk from DC: 0-5 to DSM – 5 and ICD – 10 has been developed by ZERO TO THREE as a guide for states and agencies.²¹

Early Childhood Service Intensity Instrument (ECSII)

The ECSII is a standardized tool, developed by the American Academy of Child and Adolescent Psychiatry, which is used to determine the intensity of services needed for infants, toddlers, and children from ages 0-5 years.²³ This tool is based on the System of Care approach that embraces a family-driven and child-centered model of care that integrates and coordinates efforts of different agencies in the least restrictive setting that is clinically appropriate.

The ECSII is used by providers involved in the care of young children with emotional, behavioral, and/or developmental needs including those children and families experiencing environmental stressors that may put them at risk for such problems. The instrument provides guidance for providers and families seeking services from a variety of agencies and providers including child welfare, mental health, primary and specialty health care, and other community-based supports. The ECSII provides a common language for these diverse individuals and offers guidance in selecting specific services and supports at the appropriate intensity for young child.

The ECSII is based on the concept of Service Intensity as opposed to traditionally defined “level of care”. Traditionally, level of care has implied the need for facility-based programs to achieve higher levels of service intensity. The ECSII emphasizes intensive home and community-based services to provide higher intensity when needed. Service intensity involves multiple factors, including not only the frequency and quantity of services, but also the extent to which multiple providers or agencies are involved and the level of care coordination required.

Treatment Planning

An emphasis on collaborating with the child’s parents and caregivers is an essential part of developing a treatment plan. If needs cannot be met in the early childhood setting, the child and family can be referred to an office-based early childhood mental health clinician or program, including a free-standing infant mental health clinic for follow up and more direct treatment. Therapy for infants always involves a parent with the child in dyadic therapy. Parents can be supported to relate, attach and pick up their child’s communications to them better. Toddlers and young pre-school children can engage in play therapy. The clinician can directly work with the child with or without their parent present. Involvement with family and caregivers is a critical component of treatment with all children.

If a child needs more intensive mental health treatment, many states have therapeutic nurseries, which are partial day programs for young children often accessed through early intervention or pre-school special education programs. A child and adolescent psychiatrist can provide consultation directly to early childhood settings, consultation to clinicians working with early childhood programs, or directly provide assessment and therapy to the child and their family.

V. SERVICE TRANSITIONS

There are multiple age-dependent transitions for young children receiving services in the early childhood system of care. Specialized home-based and clinic-based services for children who have spent the first weeks of their lives in Neonatal Intensive Care Units (“NICU grads”) vary in the length of program follow-up and also in the robustness of their coordination with local early intervention programs. Denise Merrill, in her article “Six Simple Steps to Building a Medical and Early Intervention Transitional Coalition,” describes one state’s efforts to build a strong coalition:

“The state of Colorado developed such a coalition, which consisted of nurses, therapists, social workers and various state agencies, community centers, and parents of special needs children. They met for two years to develop the basic principles and a guidebook that implements the plan to ensure that children at risk for developmental delay are identified and referred to community-resources. This group was also successful in writing and implementing an interim IFSP [Individualized Family Service Plan] for use in the NICU.”²³

However, Ms. Merrill indicates that these coalitions are rare across the country. Thus, the responsibility for ensuring a smooth transition between services often falls to primary care physicians and others with a special interest in the community treatment of infants.

Typically the transition from early intervention to school-based services occurs at age three. Upon entrance into school-based services the children’s needs are re-assessed and the young child and their families are linked to the needed services. There is a great deal of variability in the length of time it takes to schedule the initial evaluation and then to become linked to the needed developmental therapies and other services. Children typically “age out” of specialized pre-school services by age 6, though there is some variation across the country in the age of transition into the community-based system of care for older children and adolescents.

Each state and local area will vary in how much support is given to the family in managing these service transitions. These transitions may be easier in systems of care where there are dedicated case management services for young children.

VI. INDIVIDUALIZED SERVICE PLAN/USE OF WRAPAROUND

The principles of wraparound (individualized service planning/child and family team process) are as applicable to the community-based treatment of young children as they are to the treatment of older children and adolescents. Programs such as the Community Wraparound Initiative in Lyons, Riverside, and Proviso Townships in Illinois use these principles to provide needed services and supports to both the young children and their caregivers who have a chronic mental illness or a substance abuse diagnosis:

“...Staff at the Community Wraparound Initiative has learned the benefit of working with the entire range of strengths and needs with which families enter services and of drawing on informal and formal supports to offer the parents what they need to be better caretakers of their children.”²⁴

In Arizona, the state’s Division of Behavioral Health Services has implemented the use of the Child and Family Teams for all children and adolescents. Their “Practice Protocol: Working with the Birth to Five Population” clearly indicates that use of these principles is integral to the system-based care of infants, toddlers and pre-school age children.²⁵

In the absence of a community mental health center or specialized program for young children using the child and family team process, the child psychiatrist may choose to use the principles of wraparound in their consultation and/or treatment of infants, toddlers and pre-school children. The mobilization of both professional and natural supports can be essential to stabilizing the family of a young child with multiple medical, developmental and mental health needs. For example, linking a single mother of a young child with complex needs to a support group may be the key to improving her ability to effectively parent her child.

VII. THE MULTIPLE ROLES OF THE CHILD AND ADOLESCENT PSYCHIATRIST IN EARLY CHILDHOOD SYSTEMS

To be an effective health care provider and advocate for infants, toddlers and pre-school children, the child psychiatrist must be flexible and be willing to play multiple roles in their community-based care. These roles include:

- *System Navigator*: to assist families by having a good working knowledge of the organizational structure of the services available for young children at the state and local level. The System Navigator must also assist with transition from service array to service array as the young child ages out of early childhood services.
- *Medical Case Manager*: to assist with access to services or to identify and collaborate with the local providers and case managers of services for young children (where they are part of the service array for the early childhood population).
- *Advocate*: whether it is as part of a child and family team (individualized service planning/child and family team process), or simply as a member of the community, for access to needed services. The child psychiatrist may also need to be an advocate for the child and their family with the broader medical community to obtain needed medical or psychiatric services.
- *Medical Member of a Child and Family Team*: the child psychiatrist can identify those future needs for the team that are dictated by the child’s developmental and medical conditions.
- *Diagnostician*: to use the DC: 0-5 to identify appropriate foci for treatment in this age group. To be able to assess the psychiatric needs of the young child, and also to recognize the psychiatric needs of the young child’s caregivers
- *Psychotherapist to the Child*: to provide or refer as necessary for the needed psychotherapeutic treatment, typically with the involvement of the child’s caregivers.

- *Psychotherapist to the Family*: to provide or refer as needed for family therapy or behavior management training.
- *Psychopharmacologist*: to judiciously use psychopharmacological intervention when necessary as part of a comprehensive treatment plan with the wisdom to be very careful with young children.

VIII. CONCLUSION

The Early Childhood System is composed of many child-serving systems working together to support young children and families to provide their specific services when needed. These systems include education, physical health, mental health, child care, child welfare, family court, and developmental services. Due to many child-serving systems being involved, this can lead to even more barriers and problems accessing and obtaining these services. It is vital that child and adolescent psychiatrists understand this system, so that they can help their young patients and their families obtain the services that they need.

APPENDIX 1*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277. July 1, 2019.

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Early Childhood System – Discussion Vignette I – Trainee Version

You are a consultant to a pediatrics practice and have been asked to see Max, a twenty month old “NICU grad” who presents with ongoing developmental delays and poor sleep. Max’s parents appear exhausted and are concerned that Max’s only words are “Momma” and “Dada.” Max and his family received some nurse visitation as part of a community-based NICU follow-up program, but that ended almost a year ago. Max’s parents are unsure how to access needed services for him.

1. How would you proceed with this referral?

Max is referred to you again at 34 months. He continues to have speech delays and now will have tantrums when he cannot communicate his needs effectively. Max’s parents are quite anxious because they have been told by the early intervention program that they must stop providing services to him in two months.

2. How would you advise the family now?

One of the team members wants to know more about Head Start and asks you later:

4. What is the goal of the Head Start Program?

5. Describe the funding for Head Start Programs.