Infant Mental Health Clinicians' Best Practices Guide

Documenting and Billing for Infant Mental Health Services

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Florida State University
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The Center for Prevention gratefully acknowledges *Kathryn Shea, LCSW* and her tireless efforts to promote the mental health of Florida's most vulnerable children and families. This document would not have been possible without her comprehensive grasp of the issues and her commitment to expanding the knowledge base for professionals in the field.

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PURPOSE

The purpose of this guide is to help de-mystify the world of Florida Medicaid specifically related to documenting and billing for Infant Mental Health (IMH) services in three ways:

1. Provide an overview of IMH nationally and in Florida;
2. Provide three *case studies* as concrete examples of documentation from the point of assessment to discharge; and
3. Provide some suggestions on best practices (i.e., ways agencies and clinicians can protect themselves from possible quality review (audit) paybacks).

The overall goal for the intended audience of IMH clinicians and leadership is to increase their knowledge of how to navigate the Medicaid system, thereby increasing confidence and security in performing this challenging and rewarding clinical work. As we begin to implement the Statewide Medicaid Managed Care (SMMC) program, it is imperative IMH clinicians have the support and information needed to provide critical mental health services to young children and their families.

INTRODUCTION AND OVERVIEW

The field of Infant Mental Health is ever-evolving and has come a long way since the early work of Selma Fraiberg[1], one of the founding Board members of ZERO TO THREE (ZTT) National Center for Infants, Toddlers, and Families, an organization representing interdisciplinary professional leadership in the field of infant development and mental health. Fraiberg and her colleagues in Ann Arbor, Michigan designed a unique approach to strengthen the development and well-being of infants and young children within stable and secure parent-child relationships.

Fraiberg called the practice "Infant Mental Health." "Infant" referred to children less than three years of age; "Mental" included social, emotional, and cognitive domains; and "Health" referred to the well-being of young children and families. Fraiberg described new knowledge about early development and relationships as "a treasure that should be returned to babies and their families as a gift from science" (Weatherstone, 2000)[2] ZERO TO THREE defines IMH as "the healthy social and emotional development of a child from birth to 3 years, and a growing field of research and practice devoted to the:

- Promotion of healthy social and emotional development;
- Prevention of mental health problems; and
- Treatment of the mental health problems of very young children in the context of their families."[3]

The IMH field has evolved rapidly since the 1970's alongside the increase in knowledge about the first three years of life, attachment, parent-child interactions and factors that influence early brain development. Practice and research that has expanded our knowledge base has also further guided research and policy issues that reflect these shifts and impact our current understanding of factors that shape early development.

Initial IMH Clinical Practice: Development of Diagnostic Codes

As clinical practice within the field of IMH developed, treatment providers and experts in the field realized that the Diagnostic and Statistical Manual of Mental Disorders (DSM)[4] did not adequately describe the clinical issues occurring in infants and young children, nor did it recognize the importance of the clinical dynamics in the parent-child relationship. As a result, many infants and young children were not receiving an appropriate mental health diagnosis—a critical element in treatment planning—nor were they receiving any diagnosis at all. This deficiency in the system left many infants and children untreated, thus increasing the risk for more complicated and costly mental health services down the road.

In 1987, as a result of the analysis of the DSM, a multidisciplinary Diagnostic Classification Task Force was established by ZERO TO THREE. Through expert consensus, an initial set of diagnostic categories emerged, recognizing that this new guide for diagnostic classification of mental disorders in this age group would be tentative. The DC: 0-3 was then published in 1994.

Florida's IMH Coding Accomplishments

In 2001, Florida was the first state in the nation to develop a "crosswalk" from the DC: 0-3 to the *International Classification of Diseases* of the World Health Organization (ICD-9 CM) codes so that IMH services could be billed, thus increasing the capacity for services. The crosswalk was "blessed" by the late Dr. Robert Harmon, a former faculty member at University of Colorado Health Sciences Center and Director of the Irving Harris Program in Child Development and Infant Mental Health who helped author and train on the DC:0-3, and deemed to be "as clinically sound as possible." It was then supported by Florida Medicaid's fiscal agent, the Agency for Health Care Administration (AHCA), and Florida's Department of Children and Families (DCF). Through the work of the Irving B. Harris Institute at FSU's Center for Prevention and Early Intervention Policy (FSU Center), Florida made a concerted effort to train IMH specialists. Since 2000, over 200 IMH specialists have completed a 10-month (2 days each month) intensive training program to deliver these essential IMH services throughout Florida.

In 2013, Florida was recognized for its pioneering work in Infant-Early Childhood Mental Health (I-ECMH) in the new ZERO TO THREE publication, *Nurturing Change: State Strategies for Improving Infant and Early Childhood Mental Health.*[5] Florida's AHCA has led the nation in its efforts to provide permissive language to treat infants, young children, and their families. As early as 2000, the *Community Behavioral Health Services Coverage and Limitations Handbook*[6] was revised to include Section 5, "Services for Children Ages 0-5 Years," which encouraged the use of DC:0-3 for assistance in determining the infant's or child's ICD-9-CM code. Another important change in the 2000 revised handbook was the addition of "Individual and Family Therapy," which gives the treating therapist a mechanism for providing Child-Parent Psychotherapy,[7] with or without the child present.

Recent National Accomplishments

In late 2003, ZERO TO THREE appointed a Revision Task Force to draft a revised version of DC: 0-3 within 2 years. The group reviewed clinical literature and other diagnostic systems, administered two surveys of users worldwide, and obtained draft language and feedback from recognized experts in particular areas. As a result, the DC: 0-3R was published in 2005.

The DC: 0-3R continues the multi-axial classification system that has been so useful in clinical formulation. Use of the multi-axial system for clinical formulation focuses the clinician's attention on the factors that may be contributing to the difficulties of the infant or young child, adaptive strengths, and additional areas of functioning in which intervention may be needed.

The labels for DC: 0-3R's axes are essentially the same as those in DC: 0-3, incorporating some changes in wording recommended by users as follows:

- Axis I: Clinical Disorders
- Axis II: Relationship Classification
- Axis III: Medical and Developmental Disorders and Conditions
- Axis IV: Psychosocial Stressors
- Axis V: Emotional and Social Functioning

The DC0-3R is a major accomplishment within the field of Infant Mental Health services.

CURRENT CHALLENGES

Although the development and revision of these Diagnostic Manuals have been a tremendous tool for practicing IMH clinicians, challenges continue in the implementation of assessment and treatment services for infants and young children due to other factors, such as funding limitations and fundamental issues related to IMH clinicians' billing of Medicaid for IMH services. Many clinicians in Florida work within community mental health centers where the reimbursement for services rendered to Medicaid recipients and third party insurance enrollees are essential to the sustainability of their organization. Billing Medicaid and other insurers requires the use and understanding of ICD-9-CM codes (Implementation of ICD-10 has been delayed until October 2015). Although the DSM-IV diagnostic codes naturally "crosswalked" to the ICD-9-CM codes for billing purposes, the DSM-5 codes and DC:0-3R codes do not. If IMH services cannot be billed to Medicaid or third party insurers, community mental health centers providing treatment cannot offer these services without alternative funding sources. Unfortunately, most do not have any alternative funding sources.

IMH services are being provided statewide, yet very few of the provided IMH services are billed to Medicaid. This is likely due to several concurrent contributing factors:

- Challenge #1: Workforce development and increase in demand for services;
- Challenge #2: Increased climate of accountability within Medicaid; and
- Challenge #3: Unclear definition of "Medical Necessity".

Challenge #1: Workforce Development

An important factor in workforce development is ensuring national standards and adequate financing are available. Ensuring availability and consistency in Infant-Early Childhood Mental Health (I-ECMH) services across the continuum of promotion, prevention, and treatment is challenging, thus prohibiting infants, toddlers, and their families from receiving the necessary services and supports that would help them achieve optimal child development and family stability and security. Barriers and strategies to financing are documented in Making It Happen: Overcoming Barriers to Providing Infant-Early Childhood Mental Health,[8] released by the ZERO TO THREE Policy Center in May, 2012. The document calls for recommendations across several federal agencies, one being the Centers for Medicare and Medicaid Services (CMS).

The paper recommends CMS:

- Issue guidance to state Medicaid agencies expressing the CMS's intent to include infants and young children in mental health treatment.
- Urge consistency across states and regions in I-ECMH screening, diagnosis, and treatment.
- Encourage the development of state policies to support reimbursement of I-ECMH services.[9]

Significant changes within the Substance Abuse and Mental Health Services Administration (SAMHSA)

SAMHSA has now changed their criteria for enrollment of infants and young children into Early Childhood System of Care (EC-SOC) services. Based on recommendations from an Early Childhood Diagnostic Workgroup, and accepted by SAMHSA, young children no longer require an Axis I mental health diagnosis. They can be enrolled with an Axis II Relationship Disorder diagnosis (with a PIR-GAS score of 40 or below) or be determined to be "at risk" of developing a mental health disorder if services are not rendered. This has been much more acceptable to families and has opened the doors for many more young children to receive services and supports they would not otherwise have received. As identified by clinicians working within the EC-SOC sites funded by the SAMHSA and described in the paper, *Early Childhood System of Care Lessons from the Field Update 2011*,[10] an important difference exists between early childhood systems of care and older childhood/adolescent systems of care centered around diagnosing young children.

Early Childhood System of Care Lessons from the Field Update, 2011

"Beyond the logistics, some families/caregivers and early childhood advocates struggle with diagnosing an infant or young child because of concerns about labeling the use of diagnostic classification systems that are not developmentally appropriate for this age group.

Over the years, SAMHSA grantee communities have indicated that the requirement of an Axis I mental health diagnosis for entry into the system of care has dissuaded some families—many of whom are finding out for the first time that their child has a mental health issue—from accessing system of care services."

The paper states the following:

> Diagnosing an infant or young child with a mental health disorder can present logistical, emotional, and philosophical challenges. Although EC-SOC communities have been granted permission by SAMHSA to use the DC: 0-3R diagnostic tool, which allows for more appropriate diagnoses of infants and toddlers than the DSM:IV that is widely used with older populations, communities must use a "crosswalk" to map DC:0-3R diagnostic codes to the DSM:IV diagnostic codes or the ICD-9-CM diagnostic codes for billing purposes. Further, communities must ensure that there is a cadre of mental health clinicians who are trained to skillfully administer the DC: 0-3R—often a gap in the existing workforce.[11]

Workforce Development – The Florida Perspective

Assessing, diagnosing, and treating infants, toddlers, and young children is a specialty area within the mental health field. It requires extensive knowledge of attachment theories, child development (typical and atypical), adult mental health disorders, family systems theories, and reflective practice. It also requires a certain level of knowledge of other disciplines such as occupational and speech therapies. IMH is an interdisciplinary practice and the IMH clinician never works in isolation. In addition to a strong knowledge base, it takes a lot of practice and experience. Building this strong cadre of trained therapists has been a challenge in nearly every state.

Florida has met this workforce development challenge with significant efforts to expand capacity of highly skilled IMH specialists through intensive training provided by Harris Institute at the FSU Center. The Institute's efforts follow the Florida Strategic Plan for IMH with a focus on training in both in-service and pre-service formats statewide to enhance the state's capacity to promote optimal development, prevent social-emotional difficulties, and effectively treat very young children and their families who are in need of intensive parent-child therapy.

To assist in the development and delivery of this training, the FSU Center's Harris Institute developed an empirically-based competency checklist.[12] This checklist has been used since 2006 to evaluate the training of IMH therapists in Florida.

The FSU Center partners with the LSU Harris Center for IMH in New Orleans under the guidance of Dr. Joy Osofsky. As a unique aspect of the program at FSU, some practicing therapists have received training both at the FSU campus and in New Orleans with Dr. Osofsky and her colleagues at the LSU Health Sciences Center. To date, over 200 individuals working in the field have completed the initial 10 month Harris training, with very few receiving the follow-up 12 months of case consultation and reflective practice conducted by phone.

Workforce Development – Other States' Accomplishments

In recent years, a number of states have taken steps to ensure that professionals working with infants, toddlers, and their families are knowledgeable and skilled in promoting social-emotional development.

Michigan — Michigan has long been a leader in the IMH field. The Michigan Association for IMH (MI-AIMH) has developed Core Competencies based on the principle that all development occurs in the context of relationships. They are organized around eight areas: theoretical foundations; law, regulation, and agency policy; systems expertise; direct service skills; working with others; communicating; thinking; and reflection.

A diverse group of MI-AIMH leaders worked for several years to develop them, reaching consensus about existing research, practice, and policy developments in infant and early childhood mental health. Published in 2002, and updated in 2011, the MI-AIMH IMH Competencies and/or its Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting IMH (The Competencies) provide a framework for cross-disciplinary training and workforce development. They serve as the basis for the MI-AIMH Endorsement – a workforce development system that lays out education, training, work experience, and reflective practice requirements for four levels of competency (Infant Family Associate, Infant Family Specialist, IMH Specialist, and IMH Mentor). Professionals can earn endorsement at one of the four levels by submitting a portfolio documenting fulfillment of the requirements and, for levels three and four, completing an exam.[13] To date, seventeen states have purchased licenses to use The Competencies.

California — California has been working for more than a decade to develop a training guide to drive best practice in I-ECMH. In 2009, the California Training Guidelines and Personnel Competencies for Infant-Family and Early Childhood Mental Health,[14] was published. It provides a framework that outlines a coherent foundation of the knowledge and skills necessary to work with very young children and their families with a focus on early relationships and early mental health.

While other states have developed advanced Infant Mental Health training or competencies, Michigan and California are at the forefront.

Workforce Development – The National Perspective

The November 2012 issue of the *Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families*[15] published excellent articles on workforce development, including one titled "Creating and Sustaining an Interdisciplinary IMH Workforce," by Anne Hogan from the Harris Institute at the FSU Center and others. It clearly articulates important questions for consideration when strategically planning workforce development in communities.

Seventeen states now have some form of Certification/ Endorsement process in place for I-ECMH specialists. Some states now **require** certification (Michigan) or a Certificate of Completion of intensive IMH training for any clinician treating a child age five and under. Due to the complexity of this work and the unique skill set required, it is recommended that clinicians pursue intensive training prior to initiating clinical practice with this young population.

Challenge #2: Increased Accountability within Medicaid

Medicaid is the federal and state medical assistance program that provides access to health care for low-income families and individuals in the United States. Medicaid also assists aged and disabled people with the costs of nursing facility care and other medical expenses. Eligibility for Medicaid is usually based on the family's or individual's income and assets.

Per federal regulations, certain services must be offered by all states, but each state can place some limits on the services. There are also optional services that a state may choose to offer, variations in eligibility groups, different limits on income and assets to decide eligibility, and differences in how much each state pays their Medicaid providers.

In Florida, AHCA is the managing entity for Medicaid. The Department of Children and Families acts as AHCA's agent by determining eligibility and enrolling people in Medicaid. AHCA contracts with other state agencies and private organizations to provide a broad range of services.

AHCA is also the lead agency for the Children's Medical Insurance Programs (Title XXI–SCHIP). In Florida, this program is known as the Florida KidCare program and is the state's children health insurance program for uninsured children.

As the climate of accountability has intensified at the federal level and within Florida, there is increased scrutiny on claims documentation and auditing by AHCA for all provided services. Due to these influences, there is a growing need for both clinicians and organizational leadership to understand how to function within this changing environment. However, many CEOs of non-profit agencies in Florida and nationally, as well as individual providers, are reluctant to bill Medicaid due to concerns about adequate documentation of services, the financial consequences of Medicaid audits, and possible paybacks. It becomes even more complex as the state transitions to Medicaid expansion and multiple HMOs/PPOs and other managed care organizations, all with different expectations.

Proper documentation is the primary key to avoiding issues with non-payment of claims by Medicaid/HMOs. The case studies depicted in this document are intended to provide an example of appropriate and required documentation to ensure compliance with Medicaid requirements.

Challenge #3: Definition of Medical Necessity

Why are there varying definitions of "medical necessity"?

The Maternal and Child Health Bureau at the Department of Health and Human Services published a report entitled *The Difficulties in Defining Medical Necessity.*[16] In that report, researchers Ireys, Wehr, and Cooke developed criteria for evaluating definitions of medical necessity. They recommended that the definition should: 1) incorporate appropriate outcomes within a developmental framework; 2) explicitly address the information needed in the decision-making process; 3) identify who will participate in the decision making process; 4) refer to specific standards; and 5) support flexibility in the sites of service delivery.[17]

On the federal level, CMS requires that all Medicaid-funded services must be considered medically necessary. However, medical necessity is not defined in the federal law governing Medicaid - Title XIX section of the Social Security Act. The Florida Legislature and AHCA have both established definitions, albeit different, of the term medically necessary. This lack of one clear definition of a very important term poses a significant challenge for those clinicians relying on reimbursement from Medicaid to pay for services. This Manual specifically addresses this particular challenge: the younger the child, the greater the challenge.

The Florida Legislature defines "medical necessity" under Florida Statutes 409.9131(b) - Special provisions relating to the integrity of the Medicaid program as:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

AHCA's definition of "medically necessary" as outlined in AHCA's *Community Behavioral Health Services and Limitations Handbook* , March 2014 and the *Florida Medicaid Provider General Handbook, July 2012* is:

> "Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:
>
> - Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
> - Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
> - Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

How do we accurately document "medically necessary" for an infant or toddler in order to meet Medicaid standards?

- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
- The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services do not, in itself, make such care, goods or services medically necessary or a covered service.

The last statement, "The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service," leaves ambiguity for a provider and instills a degree of uncertainty when providing services.

For purposes of providing behavioral health services to children 0-5, AHCA referenced in the previous Handbook the following "medically necessary/medical necessity" definition:

Any child age 0-5 must be exhibiting symptoms of an emotional or behavioral nature that are atypical for the child's age and development. For children 0 through 3 years of age, Medicaid encourages use of the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0–3) for assistance in determining the infant or child's ICD-9-CM diagnosis. In addition:

- *There is adequate evidence to indicate that the child is at risk for more intensive, restrictive, and costly mental health services or placement; and*
- *There is adequate evidence to indicate the child's condition cannot be improved with less intensive services or interventions*

Adequate evidence should include:

- Specific emotional or behavioral symptoms, duration and intensity of symptoms, how symptoms interfere with typical development, how symptoms interfere with success at home, child care, community;
- Narrative describing the risk factors/behaviors for child/parent/relationship, including, but not limited to poverty, family history of mental illness, domestic violence, child abuse and neglect, physical illness/developmental delay in child/parent;
- Prenatal and birth history and history of infant/child functional impairment in sensory/ behavior/social emotional development (poor attachment, at risk for expulsion, preterm, etc.);
- Tools that support impaired functioning (TABS, CBCL, PSI, Maternal Depression screening, DECA, CBCL, etc.);
- Failed interventions (parenting classes, PBS, ECMH consultation, etc.); and
- Parent's willingness to participate in treatment and ability to benefit from treatment services.

AHCA supports use of Florida's Crosswalk from DC:0-3R to ICD-9-CM codes for purposes of determining the appropriate ICD-9-CM code for billing. (Appendix B)

Identifying Measureable Goals and Objectives When Treatment is for the Child, Not the Parent

The question of identifying measurable goals and objectives comes up repeatedly by clinicians providing dyadic work with young children and their parents. Medicaid requires a single "identified client" even though the science of I-ECMH points to the infant-parent relationship as the client. Client goals and objectives need to be written in such a way that they are measureable, aimed at improving the emotional and mental well-being of the young child, and resolving the symptoms that necessitated treatment. While this may be challenging when working with young children and their parents, it can be done in a way that satisfies Florida Medicaid requirements. The work with the parents in the treatment sessions, and any "homework" given, must be *directed and documented* in a way that *supports the emotional and cognitive growth of the child*, and without the parental intervention, the child would not be able to improve on their own, and could in fact, worsen. It is *not acceptable to treat the parent's behavioral health condition*, should there be one, within the context of dyadic therapy. Parents need to seek their own individual treatment should that be needed and the co-treating clinicians should communicate frequently regarding progress or lack thereof.

How do we accurately identify and document measureable goals and objectives directed at the child (as the identified client) when most of the real work is with the parents?

Florida's Medicaid Community Mental Health Services Handbook March 2014

Florida's recently released *Community Behavioral Health Services and Limitations Handbook, March 2014* [18] provides the necessary requirements for delivering behavioral health services in Florida covered by Medicaid. The purpose, as stated in the Handbook is:

"… to educate the Medicaid provider about policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients."

The Handbook provides descriptions and instructions on how and when to complete forms, letters or other documentation. Any clinician providing treatment services and billing Medicaid should be very well versed in the Handbook, refer to it often, and seek clarification from their area AHCA office or Managed Care entity/HMO if they are uncertain of the requirements. For purposes of this Guide, the requirements and services most relevant for diagnosing and treating young children are included, but are not exhaustive of all possible services available. Furthermore, authorizations may be required for some of these services and it is important to check for needed authorizations from the Managing Entity or Medicaid HMO prior to rendering the service, as requirements can vastly differ.

Any clinician providing treatment services and billing Medicaid should be very well versed in the Handbook, refer to it often, and seek clarification from their AHCA area office if they are uncertain of the requirements.

The **most significant changes** between the revised October 2004 Handbook and the March 2014 Handbook are as follows:

- There are now three Handbooks;
  - Community Behavioral Health Services Coverage and Limitations Handbook

- Behavioral Health Overlay Services Coverage and Limitations Handbook Adoption
- Specialized Therapeutic Services Coverage and Limitations Handbook Adoption

- The Section for Services for recipient's age 0-5 is omitted. The use of the DC:0-3R for children age 0-3 is omitted.
- There are no ICD codes excluded for diagnosis and treatment
- There are two new provider titles related to Infant Mental Health;
  - *Bachelor's Level Infant Mental Health Practitioner* – A bachelor's level practitioner who provides services to recipients under the age of 6 years.
  - *Infant Mental Health Aides* – A mental health aide who provides services to recipients under the age of 6 years.

Qualifications for the two positions are:

A **bachelor's level infant mental health practitioner** must have completed 20 hours of documented training in the following areas, prior to working with this age population:

- Early childhood development
- Behavior observation
- Developmental screening
- Parent and child intervention and interaction
- Functional assessment
- Developmentally appropriate practice for serving infants
- Young children and their families
- Psychosocial assessment and diagnosis of young children
- Crisis intervention training

Bachelor's level practitioners who have had the above training through conferences, workshops, continuing education credits, or academic training are not required to repeat the training. *Bachelor's level infant mental health practitioners* must be supervised by a master's level practitioner with two years of experience with recipients under the age of 6 years or by a licensed practitioner of the healing arts.

Infant mental health aides must, at a minimum, have a high school diploma or equivalent with at least two years' experience with infants and toddlers, or hold a Child Development Aide certificate. There are notations throughout the assessment/services section of the Handbook that state: "*Practitioners must have training and experience in infant, toddler, and early childhood development and the observation and assessment of young children when treating recipients under the age of 6 years.*"

What should the Recipient Clinical Record Include?

Providers must maintain a clinical record for each recipient treated that contains all of the following documentation:

- Consent for treatment that is signed by the recipient or the recipient's legal guardian. An explanation must be provided for signatures omitted in situations of exception.
- An evaluation or assessment that, at a minimum, contains the components of a brief behavioral health status examination conducted by a physician, psychiatrist, a licensed practitioner of the healing arts (LPHA), or master's level certified addictions professional (CAP) for diagnostic and treatment planning purposes. For new admissions, the evaluation

or assessment by an LPHA for treatment planning purposes must have been completed within the past six months.

- Copies of relevant assessments, reports, and tests.
- Service notes (progress toward treatment plans and goals).
- Documentation of service eligibility, if applicable.
- Current treatment plans (within the last six months), reviews, and addenda.
- Copies of all certification forms (e.g., comprehensive behavioral health assessment).
- The practitioner's orders and results of diagnostic and laboratory tests.
- Documentation of medication assessment, prescription, and management.

Note: For information about electronic records, see the Florida Medicaid Provider General Handbook on page 2-60.

A provider must maintain a medical record for each recipient treated. Written documentation must be maintained to support each service for which Medicaid reimbursement is requested. Documentation must clearly distinguish and reference each separate service billed; and be authenticated with the dated signature of the individual who rendered the service. The date of a claim should be the same as the date the service was rendered.

Service documentation must contain all of the following:

- Recipient's name;
- Date the service was rendered;
- Start and end times for procedures with specified minimum time frames and procedures billed on a per unit basis;
- Identification of the setting in which the service was rendered;
- Identification of the specific problem, behavior, or skill deficit for which the service is being provided;
- Identification of the service rendered, including the specific intervention;
- Updates regarding the recipient's progress toward meeting goals and objectives addressed during the provision of a service
- Dated signature of the individual who rendered the service
- Printed or stamped name identifying the signature of the individual who rendered the service and the credentials (e.g., licensed clinical social worker or functional title)

What Are the Most Commonly Used Services for Infants and Young Children?*

Description of Service	Procedure Code	Modifier 1	Rate	Limits
In-Depth Assessment, New Patient, Mental Health	H0031	HO	$125.00 per assessment	One assessment per fiscal year
In-Depth Assessment, Established Patient, Mental Health	H0031	TS	$100.00 per assessment	One assessment per fiscal year
Treatment Plan Development, New and Established Patient, Mental Health	H0032		$97.00 per event	One event per provider type per state fiscal year
Individual/Family Therapy	H2019	HR	$18.33 per quarter hour	Maximum of 104 quarter-hour units (26 hours) per recipient, per state fiscal year
Group Therapy	H2019	HQ	$6.67 per quarter hour	156 quarter-hour units (39 hours) per state fiscal year
Treatment Plan Review-Mental Health	H0032	TS	$48.50 per event	Maximum of four reviews, per recipient, per state fiscal year

*There are other less commonly used services that could be rendered to the 0-5 population. Please refer to the Community Behavioral Health Services Coverage and Limitations Handbook, Chapter 2 for more information.

Assessment Requirements: Prior to receiving any community behavioral health services, infants and children ages 0 through 5 years must have a current assessment (within a year) that meets the requirements listed below.

In-Depth Assessment Essential Components: For children under the age of 6 years, the in-depth assessment must include the following *additional* components:

- Presenting symptoms and behaviors;
- Developmental and medical history - history of pregnancy and delivery, past and current medical conditions and developmental milestones;
- Family psychosocial and medical history (may be as reported or based upon collateral information);
- Family functioning, cultural and communication patterns and current environmental conditions and stressors;
- Clinical interview with the primary caretaker and observation of the caregiver-infant (child) relationship and interactive patterns;
- Provider's observation and assessment of the child including affective, language, cognitive, motor, sensory, self-care and social functioning.[19]

The assessment must include the elements outlined above, in addition to the components identified in the Handbook (Section 2-9), and must be written in narrative form and provide detailed, individualized information on the components listed above. ***The sole use of checklists or fill in the blank forms is prohibited.***

Integrated Summary: The integrated summary is developed after the assessment has been completed. The integrated summary is written to evaluate, integrate, and interpret from a broad perspective, the history and assessment information collected. The summary identifies and prioritizes the infant or child's needs, establishes a diagnosis, provides an evaluation of the efficacy of past interventions, and helps to establish discharge criteria. The summary should also include the services necessary and why/how these services are medically necessary.

Treatment Plan Development: The individualized treatment plan is a structured, goal-oriented schedule of services with measureable objectives that promotes the maximum reduction of the recipient's disability and restoration to the best possible functional level. The treatment plan must be jointly developed by the recipient and the treatment team. Exceptions require documented explanation. There are also exceptions to the requirement for signature of parent, guardian, or legal custodian. Refer to the Handbook for further guidance.

The required components of the treatment plan are identified in Section 2-13 of the March 2014 Handbook.

Individual and family therapy services include the provision of insight oriented, cognitive behavioral, or supportive therapy to an individual recipient or the recipient's family. Individual and family therapy may involve the recipient, the recipient's family (without the recipient present), or a combination of therapy with the recipient and the recipient's family.

Individual and family therapy services may be provided by a **master's level practitioner.** Medicaid reimburses a **maximum of 104 quarter-hour units** of individual and family therapy services, per recipient, per state fiscal year (July 1 through June 30). There is a maximum daily limit of 4 quarter-hour units.

Individual and family therapy documentation must include the topic, assessment of the recipient(s), level of participation, findings, and plan.

Requesting Exceptions to Service Limits: Requests for exceptions to service limits may be made for recipients under age 21 through Medicaid's prior authorization process.
Note: See Chapter 2 in the *Florida Medicaid Provider Reimbursement Handbook, CMS-1500*[20] for additional information on requesting prior authorizations.

CASE STUDIES (WITH ALL REQUIRED DOCUMENTATION)

Three case studies follow. Review each of these case studies carefully in context of the requirements listed above to better understand the quality of documentation and level of detail necessary to ensure you are meeting Medicaid requirements. Examples of documentation for the treatment of children under the age of 6 years include:

- In-Depth Assessment
- Treatment Plan
- Treatment Plan Review
- Progress Note, and
- Discharge Plan

All case scenarios are true examples of actual cases, but names, places, and any possible identifying information have been changed. The three case scenarios involve:

Case Study #1: A 9 month old with a DC: 0-3R Axis I diagnosis of 411 Regulation Disorder of Sensory Processing. Hypersensitive. Type A: Fearful/Cautious.

Case Study #2: An 18 month old with a DC: 0-3R Axis I diagnosis of 100-Posttraumatic Stress Disorder and a R/O 430-Regulation Disorders of Sensory Processing Sensory Stimulation-Seeking/Impulsive.

Case Study #3: A 30 month old with a DC: 0-3R Axis I diagnosis of 221 Separation Anxiety Disorder and 100 Posttraumatic Stress Disorder, in partial remission.

Case Study #1

9 mo old w Axis I: 411 Regulatory Disorders of Sensory Processing: Hypersensitive, Type A: Fearful/Cautious

Name/Organization/Logo
Address
Somewhere, FL zip-code

IN-DEPTH MENTAL HEALTH ASSESSMENT

Name	Emmy Rose	**Date of assessment**	9/12/10
		Date of birth	12/24/09
Address	123 4th Street Sunshine City, FL 12345	**SS#**	
		Phone	
Parent/ Guardian	Abby Rose	**Insurance Type/ number**	HP Enterprise
Referral source	Teen parenting program		
Date referred		**Date opened**	
Therapist completing assessment:	Licensed therapist	**Date report completed**	

Chief Complaint *(Parent/guardian perception of problem or presenting problems)*

Emmy Rose is a 9 month old bi-racial female infant who resides in Sunshine City, Florida with her mother Ms. Abby Rose and Abby's parents (Emmy's maternal grandparents). Ms. Abby Rose is a high school student who is enrolled in the school's Teen Parent Program. Emmy's father, Mr. Ray Seashell is a senior at Sunshine City High School and is also enrolled in the Teen Parent Program. The couple was referred to This Organization's mental health program following concerns from the Teen Parent Program Director regarding Emmy's inability to be easily calmed or soothed. The director expressed concerns that this behavior was negatively impacting Ms. Rose's relationship with Emmy. Ms. Rose reported to this assessor that Emmy "doesn't like me" and "I can't do this right" when asked about Emmy's ability to calm and be soothed. Emmy is reported to squirm a lot and constantly wants to be put down on the floor to crawl but then wants picked up again. Ms. Rose stated, "Nothing I do makes her happy."

Ms. Rose reported Emmy generally sleeps in 4 hour stretches but still does not sleep through the night. Emmy does take two naps during the day that average between 2 and 3 hours, one in mid morning and then a longer one in the afternoon. Ms. Rose reports, and the Teen Program confirms, that Emmy overreacts to sights, sounds, and touch. She appears fearful of new people or change and can react with prolonged periods of crying and irritability. She vacillates between clingy behavior with her mom and other adults to resisting being held or comforted. She demonstrates distress with changes in routine, care givers, or activities. She does show any self-soothing behaviors that would be expected for her age. No other concerns are reported. Emmy eats well, but has some avoidance to certain textures of foods. Mother reports she is on target with developmental milestones. Emmy is crawling and Ms. Rose stated Emmy will be walking before long.

Medical History

Primary Care Physician: Dr. Pediatrician **Immunization / Well Care Check up Current:** Yes

Prenatal History / Delivery: Ms. Rose reported she was 15 when she became pregnant. Ms. Rose reported she was taking her medication for ADHD up until she went to her first appointment with the OB-GYN. Ms. Rose reported no use of alcohol or other substances during the pregnancy. This was Ms. Rose's first pregnancy and there were no reported complications. Emmy was reportedly born full term at 40 weeks gestation via vaginal delivery. She weighed 8 lbs 2 ounces and was 20 ½ inches in length. APGAR scores were 9 and 9. There were no neonatal complications. Ms. Rose reported she attempted to breastfeed in the hospital but "I couldn't do it" and switched to formula.

Medical Conditions: Emmy had a hearing test that was normal. There are no reported medical conditions. Emmy has completed all well checks. There are no medical concerns at this time.

History of Mental Health Treatment and Response: Emmy does not present with a history of mental health issues at this stage; however, her relationship with her mother is compromised at this time. Ms. Abby Rose was being treated for ADHD with Vyvanse in the first trimester of her pregnancy.

Exposure to Trauma: There are no reports of exposure to trauma.

Family Psychosocial History

Ms. Rose reported she met Mr. Seashell online when she was a preteen and then met him in person when he moved to the area to live with his aunt. Ms. Rose reported beginning an intimate relationship with Mr. Seashell and became pregnant within 2 months of that relationship. Ms. Rose reported trying to hide the pregnancy from her parents because she had "broken up" with Mr. Seashell. Ms. Rose reported she lives in an intact family and that Ms. Rose's mother is disabled and has multiple sclerosis. The discovery of her pregnancy caused "tension" in the family and Ms. Rose reported that Mr. Seashell's race and ethnicity added to the tension in the family. Ms. Rose reported that her mother was supportive of her once the shock was over and Ms. Rose stated her family is very supportive.

Clinical Interview / Observation *(Interviews with caretakers and observation of the caregiver-child relation / interactive patterns)*

Ms. Rose reported that she and Mr. Seashell "got back together" after Mr. Seashell learned about the pregnancy and Ms. Rose's parents are allowing Mr. Seashell to visit Ms. Rose and Emmy in the home. Both parents were observed interacting with Emmy. Both Ms. Rose and Mr. Seashell appeared attentive to Emmy's needs. Ms. Rose placed Emmy on the floor when she squirmed in her arms and Mr. Seashell attempted to engage Emmy with a toy. Emmy crawled away from Mr. Seashell at which time Ms. Rose picked Emmy up again and held her for less than a minute before Emmy squirmed to get back down. Emmy overreacted to a loud sound in the hallway, screaming and covering her ears. It took nearly 20 minutes for her to calm and she rejected her mother's attempts to calm her.

Clinically, it appears the parents have some difficulty reading Emmy's cues and struggle with meeting her needs, especially when it comes to developmentally appropriate play. Ms. Rose was observed to pick Emmy up several times from the floor and Emmy seemed to become frustrated and started to fuss. Ms. Rose attempted to give Emmy a bottle which was rejected. The overall interaction appeared anxious and while the parents are attentive to Emmy's needs, they seem to be misreading many of Emmy's cues thus causing frustration for both child and parent.

Provider's Assessment and Developmental Milestones *(Report from Intake form and other checklists)*

Affect/Emotional Development including range of affect: A range of affect was observed appropriate to the developmental stage. Emmy demonstrated frustration and playfulness, although her overall temperament during the observation was irritable, fussy, and fearful. Mother states this is her temperament the majority of the time. Ms. Rose reported Emmy has a very difficult time being soothed when she is upset and can take up to 30 minutes to calm. There is no consistent intervention that appears to work to calm her.

Language Development (expressive and receptive): Emmy demonstrated some limited pointing and grunting sounds to communicate needs.

Motor Development (fine and gross): Emmy is crawling and pulling up on furniture to cruise. Emmy can play with rattles and balls. She does not explore the environment in a manner that is typical for an infant her age. She appears cautious and has a restricted range of exploration.

Sensory Development: Emmy appears to be restless and did not last long being held, which could indicate some tactile defensiveness. Ms. Rose reported Emmy was not a baby who liked being held closely. She does not like being tossed in the air, swinging, or her head tipped back in play. She can become very upset and is not easily soothed in ways other infants her age are. These patterns have been consistent since birth.

Cognitive Development/Adaptive Functioning: Emmy was able to problem solve to achieve her goals, for example, she squirmed to be put back on the floor when she did not want to be held.

Self-care: Emmy becomes very upset during bath and hair washing and brushing. She is resistant to some textures of clothes and can scream until they are changed. If calm, she can assist with holding out her arms/legs to be dressed, and other age appropriate self care behaviors.

Social Functioning with peers and adults: Emmy appears to be ready to explore her surroundings and is communicating with gestures and sounds. Ms. Rose reported Emmy will look for her in the room when Emmy is exploring. When she is more regulated, she is curious and seeks adult engagement.

Family Functioning *(Cultural communication patterns and current environmental conditions past and present)*

Family history of legal involvement and educational analysis: There is no disclosed history of legal involvement. Both parents are teens and are enrolled in high school. Both parents are receiving services from the Teen Parent Program and Healthy Families.

Family psychiatric history medications for such conditions: Ms. Rose was diagnosed with ADHD as a child and has been on medication. The last medication was Vyvanse. Mr. Seashell also reported he was diagnosed with ADHD as a child but is currently not being treated.

Family drug and alcohol history (include current usage of illegal and/or prescription medications and current addiction status): Ms. Rose reported there is no family history of drug or alcohol abuse. Ms. Rose's mother is on medication for multiple sclerosis. Mr. Seashell reported a family history of both drug and alcohol abuse and stated that was one of the reasons he moved in with his great aunt. Mr. Seashell stated there was no history of treatment in his biological family.

Family resources and strengths/challenges and needs (include willingness and ability to accept or initiate support systems and community services, level of insight into areas): There appears to be a strong family system of support. Ms. Rose and Mr. Seashell are both engaged in services such as the Teen Parent Program, Healthy Families, and mental health services. Barriers to service include the parents' age and transportation issues.

Child Strengths & Resiliency Factors — *Check all that apply*

☐ **Responds positively to adult comforting when upset**	
☒ **Shows affection for familiar adults**	
☒ **Keeps trying when unsuccessful (act persistent)**	
☐ **Handles frustrations well**	
☒ **Tries different things to solve a problem**	
☐ **Shows patience**	
☐ **Says positive things about the future (act optimistic)**	
☐ **Trusts familiar adults and believe what they say**	
☐ **Seeks help from children and adults when necessary**	
☐ **Calms her/himself down when upset**	
☐ **Other:**	**Please List:**
The following identifies strengths of the child from the parent's perspective including what the parent likes about their child, what the child is good at, etc.: Emmy's mother states "she is a good girl and adventurous."	

Behavioral Concerns

Please check all behaviors that apply and explain

☒ **Crying**	☐ **Lying**	☐ **Stealing**
☐ **Sleep Problems**	☒ **Temper Tantrums**	☐ **Runs Away**
☐ **Fights**	☐ **Verbal Defiance**	☐ **Aggressive**
☐ **Bed Wetting**	☐ **Truancy**	☐ **Depression**
☐ **Sexual Acting-Out**	☐ **Parenting Problems**	☐ **Thought Disorders**
☐ **Phobias**	☐ **Avoidance**	☐ **Nervousness**
☐ **Eating Problems**	☒ **Fidgety**	☐ **Off Task Behaviors**
☐ **Easily Distracted**	☐ **Low Self Esteem**	☐ **Fire Setting**
☐ **Poor Concentration**	☐ **Delinquency**	☐ **Cruelty To Self**
☐ **Difficulty Following Rules**	☐ **Angry/Resentful**	☐ **Suicidal Thoughts**
☐ **Suicidal Attempts**	☐ **Blames Others**	☐ **Swears**
☐ **Intimidating To Others**	☐ **Cruel To Animals**	☐ **Drug Use**
☐ **Alcohol Use**	☐ **Sibling Rivalry**	☐ **Hospitalization**

Mental Status Exam *(Check one for each row)*

	GOOD	FAIR	POOR
Orientation	☒	☐	☐
Immediate memory	☒	☐	☐
Recent memory	☒ (seemed to recognize her mother and childcare worker)	☐	☐
Remote memory	Unable to assess as child is 9 months old		
Self image	Unable to assess as child is 9 months old		
Judgment	Unable to assess as child is 9 months old		
Insight	Unable to assess as child is 9 months old		
Attire/grooming	☒ **Appropriate**	☐ **Inappropriate**	
Intelligence	☐ **Above**	☒ **Average**	☐ **Below**

Mood	☒ Difficult and inconsistent temperament interferes w/attachment (inappropriate for age)	☐ **Paranoid**	☐ **Angry**	☐ **Depressed**	☐ **Nervous**
Affect	☒ Fussy/Irritable. Difficulty sustaining joyful state. (inappropriate for age)		☐ **Blunted**		
Attitude	☒ Intermittent cooperativeness	☐ **Withdrawn**	☐ **Evasive**	☐ **Agitated**	☐ **Hostile**	☐ **Manipulative**
Thought content	Unable to assess as child is 9 months old				

Current Mental Status and Functioning *(Summarize the above checklist to include orientation, ideas of reference, appearance of caregiver and child)*

Ms. Rose was oriented to person, place, and time. Her speech and language was appropriate and followed a normal progression of thought. Emmy appeared neat, clean, and free of injury. Emmy was alert and readily explored the environment. Emmy was noticed to visually reference Ms. Rose and Mr. Seashell during the observation. The family presented appropriately and appeared to be fully engaged during assessment.

Provisional DSM / DC: 0-3R Diagnosis:

Check one or both: ☐ **DSM: 5** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R & ICD-9-CM
Axis I	411 Regulation Disorder of Sensory Processing Hypersensitive. Type A: Fearful/Cautious (Provisional) ICD: 313.9
Axis II	PIR GAS: 70 Some Evidence of Anxious Tense Interactions
Axis III	No medical conditions
Axis IV	Teen Parents
Axis V	See Chart Below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**			X				
Complex Gestures and Problem Solving							X
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functions at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functions immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functions inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Has not achieved this capacity.
7. N/A

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Integrated Summary/Justification for Continued Mental Health Services

Summarize the history, assessment, interpretation, diagnosis & need for services including medical necessity along with prognosis with or without services & interventions:
Emmy Rose is a 9 month old bi-racial female infant who resides in Sunshine with her mother Ms. Abby Rose and Abby's parents. Ms. Rose attends Sunshine City High School and is enrolled in the school's Teen Parent Program. The father, Mr. Ray Seashell is a senior at Sunshine City High School and is also enrolled in the Teen Parent Program. The couple was referred for infant mental health services following concerns from the Teen Parent Program director who reported that Emmy has difficulty calming down and is not easily soothed. The director expressed concerns that infant's inability to be soothed and calmed easily was negatively impacting the child/parent relationship. Ms. Rose reported to this assessor that Emmy "doesn't like me" and "I can't do this right" when asked about Emmy's ability to calm and be soothed. Emmy is reported to squirm a lot and constantly wants to be put down on the floor to crawl but then wants picked up again. Ms. Rose stated, "Nothing I do make's her happy." Ms. Rose reported Emmy generally sleeps in 4 hour stretches but still does not sleep through the night. Emmy does take 2 naps during the day that average between 2 and 3 hours, one in mid morning and then a longer one in the afternoon. Ms. Rose did not report any other concerns and reported that Emmy eats well and seems to be on target with developmental milestones. Emmy is crawling and Ms. Rose stated Emmy will be walking before long. Clinician observed behaviors noted above during assessment. Emmy displayed difficulty being soothed, resisted being held or bottle to soothe, fussy/irritable temperament, and periods of intense distress when the adults did not react quickly enough. Mother appears to be taking Emmy's behaviors personally and feels inadequate in meeting Emmy's needs. Currently, Emmy meets criteria for a provisional diagnosis of Regulation Disorders of Sensory Processing- Fearful/Cautious. An Occupational Therapy evaluation is recommended to confirm sensory dysfunction that supports diagnosis. Emmy's symptoms are atypical for her age and the parent/infant pattern are negatively impacting the parent child relationship, which may inhibit developmental progress of the infant without intervention, resulting in more intensive and costly mental health services. Interventions tried by the Teen Parent Program have not worked to date and symptoms appear to be worsening. Prognosis is good if treatment services are rendered. Mental health services are recommended at this time and are considered to be medically necessary.

Treatment Recommendations

Include type/frequency for therapy or other modalities and level of need for family's participations.
Child Parent Psychotherapy is recommended to improve and enhance the relationship and to assist in the process of co-regulation. The Circle of Security is also recommended as an attachment focused parenting group to improve the parents understanding of secure base and encouraging healthy exploration. An Occupational Therapy evaluation is recommended to assess for Regulatory Disorder and treatment if indicated.

Signatures

_____	_____	_____
Assessment Therapist Legible Signature	Title	Date
_____	_____	_____
Licensed Practitioner Legible Signature *(if required)*	Title	Date

Name/Organization/Logo

TREATMENT PLAN

Client Name:	Date:	Start Time:	End Time:	Setting:
Emmy Rose	Follow Medicaid Guidelines for due date	9:30am	10:30	Office

Recommendations from in-depth assessment and other referrals made

Include recommendations from initial assessment and status:		
1. Child Parent Psychotherapy is recommended to improve and enhance the relationship and to assist in the process of co-regulation. 2. The Circle of Security is also recommended as an attachment focused parenting group to improve the parents understanding of secure base and encouraging healthy exploration. 3. An Occupational Therapy evaluation is recommended to assess for Regulatory Disorder and treatment if indicated.		
Date of Referral	**Where Referral Was Made to:**	**Result/Outcome:**
OT referral made on _____	Florida Center OT team	Pending evaluation scheduled for _____

Planning Treatment

Problem #1:

Describe problem with symptoms and behaviors:
Emmy Rose and her mother are experiencing a stressful relationship. Emmy's cues are often difficult to read due to her sensory sensitivities. This causes confusion for both child and parent, resulting in extreme fussiness, irritability, and crying from Emmy lasting 30 minutes or more at times. Ms. Rose is young and unsure of what to do and feels inadequate to meet Emmy's needs. This pattern is creating difficulties in parent/infant attachment.

Goal #1:

Describe Goal of Treatment:
Ms. Rose will learn to better understand Emmy's cues and sensory sensitivities and respond more quickly and appropriately to reduce Emmy's stress and frustration. This will promote a more positive and trusting relationship between the two that is mutually enjoyable.

Measurable Objective #1-A: Target Date: _____

Measurable Objectives to be used as discharge criteria:
Ms. Rose will learn about Emmy's specific sensory profile and how best to intervene during activities that create stress and tantrums (bathing, hair washing, etc.) and report a 60% decrease in these behaviors by time of discharge.

Measurable Objective #1-B: Target Date: _____

Measurable Objectives to be used as discharge criteria:
Ms. Rose and Emmy will demonstrate an improved parent/infant relationship as evidenced by a 60% increase in positive interactions and "circles of communication" witnessed during

therapy sessions by time of discharge.

Interventions / Modality *(Services that will be provided to achieve the goal)*

Modality	Amount (Hr / Min.)	Frequency (Weekly / Monthly)	For duration of	Responsible Party
Individual/Family Counseling	1.0 hr	1 x per week	6 months	Therapist/Family
Case Management Services	as needed			
LFA	.50 Hr.	3 x per year	Annually	Therapist

Check one or both: ☐ **DSM: IV** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R & ICD-9-CM
Axis I	411 Regulation Disorder of Sensory Processing. Hypersensitive. Type A: Fearful/Cautious (Provisional) ICD: 313.9
Axis II	PIR GAS: 70 Some Evidence of Anxious Tense Interactions
Axis III	No medical conditions
Axis IV	Teen Parents
Axis V	See Chart Below

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**			X				
Complex Gestures and Problem Solving							X
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functioning at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functioning immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functioning inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Having not achieved this capacity yet.

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Crisis Intervention Plan

In the event that Emmy's behavior becomes escalated, the family/caretakers should utilize redirection and relaxation / calming techniques such as providing the child with personal space and time, calming language, and strategies identified as effective by family and therapist. Should Emmy's behavior become unmanageable, Ms. Rose should contact a friend or family member to assist with some temporary respite support as well as contacting the infant mental health therapist or pediatrician for assistance.

Individualized Discharge Plan

In order for Emmy to successfully complete treatment, the goals of each problem should be met or partially met as observed by primary caregiver and therapist. Emmy and her mother will demonstrate an enhanced relationship evidenced by positive affect and noticeable mutual enjoyment in activities. Ms. Rose will demonstrate understanding of child development and appropriate expectations of children at different stages. Ms. Rose will express perception of change or improvement in Emmy's behavior and confidence in her ability to respond appropriately.

Treatment Plan Signatures

Treatment Team Members are in agreement with this treatment plan:

_____ _____
IMH Clinician Date

_____ _____
IMH Clinician's Supervisor Date

The services listed above are medically necessary and appropriate to the recipient's diagnosis and treatment needs.

_____ _____
Treatment Team Member / Type 07 Date

I have participated in the development of this treatment plan and I agree to be an active participant in my child's treatment:

_____ _____
Parent / Guardian (if no signature, write explanation on signature line) Date

_____ _____
Parent / Caretaker (if no signature, write explanation on signature line) Date

The child's age of 9 months precludes participation in the development & signing of this treatment plan.

_____ _____
Client (if no signature, write explanation on signature line) Date

I _____ **have invited the following to participate in person, by phone, or in writing in the treatment planning process.**
Parent / Guardian

_____ _____
Other Treatment Team Member Date

Name/Organization/Logo

INFANT MENTAL HEALTH PROGRESS NOTE

CLIENT NAME:	**DOB:**	**DATE**
Emmy Rose	12/24/09	
DIAGNOSIS CODE: 411 Regulation Disorder of Sensory Processing Hypersensitive. Type A: Fearful/Cautious (Provisional)		

Date	**Time**	**Length of Time**	**Service/Setting**	**Note (Signature)**
xx-xx-xx	5pm-6pm	1hr	Individual/Family Counseling in Office	D: TH met with C and MOC for individual/family session. M stated, "she's been acting really crazy this week." M described the C's behavior this past week using a frustrating tone and placed negative attributes on the child such as, "manipulative," "difficult, and "moody." A: M seemed very frustrated with the child today as evidenced by demonstrating limited range of affect toward C. C was visibly distraught during the session seeming to be unsure of what she wanted to do. C wanted to be picked up then wanted to be put down then played a little with the stacking rings for about 2-3 minutes before getting upset again. M would pick up C when C was upset but was unable to soothe C to the C's satisfaction. M began crying at one point expressing hopelessness and fear for her future with the C. We talked about her frustration. TH validated M's feelings and normalized the circumstances. M was praised for her willingness to learn more about herself and her daughter and how their relationship patterns can be improved. TH coached mom in expanding circles of positive communication with the stacking rings, resulting in child smiling and reaching for M. Three positive circles of communication were witnessed during today's session. M felt more positive toward C by the end of the session and was observed kissing C on the cheek as they were leaving. TH explained the CPP process and Circle of Security (COS) in more detail. M seemed eager to understand herself better in the context of her relationship with C. C was neat, clean, and free of any visible injury. P: Continue weekly CPP sessions and begin to incorporate COS. Next session scheduled for 5/27/11. **Legible Signature and Credentials:** **Printed or stamped name:**
Treatment Goal: 1 **Treatment Objective:** 1B				

Name/Organization/Logo

TREATMENT PLAN REVIEW

Client Name:	Date:	Start Time:	End Time:	Setting:
Emmy Rose	Follow Medicaid Guidelines for due date	10:00 am	10:30	Office

Progress or Lack of Progress Is noted in Relation to the Following Treatment Plan Goals

Problem #1/ Goal #1

(Please elaborate on progress or lack of progress related to each Objective related to the Problem and Goal):

Goal# 1: Ms. Rose will learn to better understand Emmy's cues and sensory sensitivities and respond more quickly and appropriately to reduce Emmy's stress and frustration. This will promote a more positive and trusting relationship between the two that is mutually enjoyable.

Objective#1A: Ms. Rose will learn about Emmy's specific sensory profile and how best to intervene during activities that create stress and tantrums (bathing, hair washing, etc.) and report a 60% decrease in these behaviors by time of discharge.

Objective#1B: Ms. Rose and Emmy will demonstrate an improved parent/infant relationship as evidenced by a 60% increase in positive interactions and "circles of communication" witnessed during therapy sessions by time of discharge.

Progress toward Goal #1:

Occupational Therapy evaluation confirmed sensory problems consistent with diagnosis of 411 Regulation Disorder of Sensory Processing Hypersensitive. Type A: Fearful/Cautious. Ms. Rose has been learning about Sensory Processing Disorders, both on her own reading and from the OT. She is better able to identify Emmy's cues of distress and respond in a way that decreases or eliminates Emmy's emotional upset. This has created a more positive and trusting relationship between parent and child and developmental progress is witnessed in areas of mental and emotional development. Emmy is more relational and seeking of adult interaction and appears less fussy and irritable. She is smiling more at her mother. Mother appears more confident in her ability to care for and soothe Emmy. Ms. Rose reported that she sees Emmy out on the "Circle" (COS) a lot and understands now what she (Emmy) is feeling and wanting. Ms. Rose and Emmy have been consistently attending weekly sessions.

☐ **No Progress** ☒ **Some Progress** ☐ **Goal Completed**

Interventions / Modality *(Services that will be provided to achieve the goal)*

Modality	Amount (Hr / Min.)	Frequency (Weekly / Monthly)	For duration of	Responsible Party
Individual/Family Counseling	1.0 hr	1 x per week	6 months	Therapist/Family
Case Management Services	as needed			
LFA	.50 Hr.	3 x per year	Annually	Therapist

Check one or both: ☐ **DSM: IV** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R & ICD-9-CM
Axis I	411 Regulation Disorder of Sensory Processing. Hypersensitive. Type A: Fearful/Cautious ICD: 313.9
Axis II	PIR GAS: 70 Some Evidence of Anxious Tense Interactions
Axis III	No medical conditions
Axis IV	Teen Parents
Axis V	See chart below

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation		X					
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**		X					
Complex Gestures and Problem Solving							X
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functioning at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functioning immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functioning inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Having not achieved this capacity yet.

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Individualized Discharge Plan

In order for Emmy to successfully complete treatment, the goals of each problem should be met or partially met as observed by primary caregiver and therapist. Emmy and her mother will demonstrate an enhanced relationship evidenced by positive affect and noticeable mutual enjoyment in activities. Ms. Rose will demonstrate understanding of child development and appropriate expectations of children at different developmental stages. Ms. Rose will express perception of change or improvement in Emmy's behavior and confidence in her ability to respond appropriately.

Progress

Emmy has demonstrated significant improvement in self regulation. Ms. Rose has gained and is utilizing appropriately her knowledge of age appropriate behavior at different stages of development and how Emmy's sensory system is operating. Ms. Rose's expectations of Emmy seem to be more age appropriate than when treatment began. Ms. Rose's understanding of Emmy's need to be "understood" and "secure" in her relationship with her mother is remarkably improved.

Recommendations

A continuation of dyadic therapy is recommended to promote the progress of self-regulation and alleviate frustration in the relationship.

Client Satisfaction Survey Completed ☒ **Yes** ☐ **No**

Treatment Plan Signatures

Treatment Team Members are in agreement with this treatment plan:

_____ _____
IMH Clinician Date

_____ _____
IMH Clinician's Supervisor Date

The services listed above are medically necessary and appropriate to the recipient's diagnosis and treatment needs.

_____ _____
Treatment Team Member / Type 07 Date

I have participated in the development of this treatment plan and I agree to be an active participant in my child's treatment:

_____ _____
Parent / Guardian (if no signature, write explanation on signature line) Date

_____ _____
Parent / Caretaker (if no signature, write explanation on signature line) Date

The child's age of 9 months precludes participation in the development & signing of this treatment plan.

_____ _____
Client (if no signature, write explanation on signature line) Date

I _____ **have invited the following to participate in person, by phone, or in writing in the treatment planning process.**
Parent / Guardian

_____ _____
Other Treatment Team Member Date

Name/Organization/Logo

EARLY CHILDHOOD MENTAL HEALTH DISCHARGE PLAN

Client Name: Emmy Rose

DOB: 12/24/09

Date Services Began:

Date of Discharge:

Reason for Discharge

☒ **Goals met/Partially met**

Emmy has made significant progress in her ability to self-regulate. She is able to use her blanket and a stuffed animal to soothe herself when upset and is more accepting of help from her mother. Mother has learned Emmy's cues of upset and how her sensory system is functioning and has adapted her perceptions of Emmy. She has also learned different methods/strategies of intervening when Emmy is upset so that Emmy experiences more positive experiences in her environment and interactions with her mother. Child has made progress to the degree that mental health services are no longer deemed medically necessary.

☐ **Not able to engage child/family**

☐ **Child/family unable to continue services at this time**

☐ **Transfer to outside therapist/organization**

☐ **Child/Family moved**

☐ **Other: (explain)**

DSM/DC: 0-3R Diagnosis at Discharge

Axis I: 411: Regulation Disorder of Sensory Processing. Hypersensitive. Type A: Fearful/Cautious (Significantly Improved)

Axis II: PIR-GAS-82 Adapted

Axis III: No Medical Conditions

Axis IV: Teen Parents

Axis V: See chart below

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation	X						
Forming Relationships/Mutual Engagement	X						
***Intentional Two-Way Communication**		X					
Complex Gestures and Problem Solving							X
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

Aftercare

Services/activities to continue following discharge: As Emmy continues to grow she should continue to attend a child care setting to promote on- going social and emotional growth. Occupational therapy to continue to treat Sensory Processing Disorder.

Recommendations made by therapist at time of discharge: It is suggested that the caregivers continue to provide developmentally appropriate responses toward Emmy by incorporating Circle of Security principles in their approach. The caregivers should continue to set developmentally appropriate limits and boundaries in the home environment for Emmy. It is also suggested that the caregivers continue to work on listening, naming, and identifying Emmy's feelings in order to help Emmy understand and verbalize her feelings as she moves along through developmental stages. Should Emmy's emotional or behavioral functioning worsen at any time in the future, they should return for a mental health evaluation.

Referrals made: No Referrals needed at this time

Critical Incident Planning

Is a safety plan needed? ☐ **Yes** ☒ **No**

Is a crisis plan needed? ☐ **Yes** ☒ **No**

Satisfaction Survey Completed By Parent/Caregiver?

☒ **Yes** ☐ **No** **If no please explain:**

_____ _____
Parent/Caregiver Signature Date

_____ _____
Therapist Signature Date

Case Study #2

18 mo old w Axis I: 100 Posttraumatic Stress Disorder and R/O 412 Regulatory Disorders of Sensory Processing: Hypersensitive, Type B: Negative/Defiant

Name/Organization/Logo
Address
Somewhere, FL zip-code

IN-DEPTH MENTAL HEALTH ASSESSMENT

Name	Bradley Sweetheart	**Date of assessment**	7/13/12
		Date of birth	1/12/11
Address	123 Any Rd Happytown, Florida	**SS#**	
		Phone	
Parent/ Guardian		**Insurance Type/ number**	
Referral source	The Helping Hand's House		
Date referred		**Date opened**	
Therapist completing assessment:		**Date report completed**	

Chief Complaint *(Parent/guardian perception of problem or presenting problems)*

Bradley is an 18 month old Caucasian male residing in Happytown, Florida at a homeless shelter with his mother, Megan Sweetheart (28). Bradley's father lives in Georgia and according to Megan, thinks she may have recently had a miscarriage. Megan has been receiving mental health services and her therapist referred Bradley for a speech-language evaluation as well as a mental health assessment.

Megan and Bradley became homeless after Megan's mother physically assaulted her and was subsequently arrested for domestic battery charges. Megan and Bradley stayed briefly at a shelter near the grandmother's home in Oxford, Florida, and then relocated to Venice, Florida in order to reside at Helping Hands House (a homeless women's shelter) where she can live until January 2015. Megan and her mother have little contact and the contact they do have is strained. Megan's father lives in Louisiana with his wife.

The night of the altercation with her mother, Megan reported Bradley was in her arms when Megan's mother ripped the bedroom door off its hinges, screamed obscenities, shoved Megan backward and then pushed her in the face. Megan reported her mother has a long history of alcohol abuse and inconsistency in her mood and behavior. Megan reported Bradley did not cry after witnessing the altercation but became very still and quiet (dissociation possibly).

During the time Megan was staying at her mother's she reported Bradley repeatedly heard his grandmother screaming and threatening Megan. On another occasion, while being held by Megan, Bradley witnessed an incident in which the grandmother threw a bassinet across the room. Megan stated Bradley was startled and even terrified at times while living with his grandmother.

Megan reported Bradley's sleep patterns have changed since the domestic violence incident and there are times when he wakens with intense nightmares, screaming and shaking for awhile before he again falls asleep. Bradley does not have language and becomes easily frustrated, e.g. he tries to put a straw in

a juice box without success becomes whiny and appears to want help but when he is offered the opportunity he throws the juice box and tries to hit his mother. Rather than play with his toys, Bradley throws them repeatedly and when redirected becomes angry and screams for long periods of time. Megan reported she gives into to him when he screams because she feels too frustrated to either ignore him or redirect him. Megan reported Bradley has always been a mama's boy but she finds his clinginess to be almost intolerable. Bradley becomes dysregulated when he comes into contact with strangers and has become more socially withdrawn since the trauma. He is more clingy and wanting to be held more. He demonstrates an exaggerated startle response, witnessed in the session today when a door slammed down the hall and his mother reports the same at home. He will scream, cry, hide under the bed, and cover his ears. These current behaviors are atypical for his age, creating thwarted social emotional development, and placing strain on the parent/child relationship, causing Megan to distance herself from him and his needs.

Medical History

Primary Care Physician: Dr. Little-Ones

Immunization / Well Care Check up Current: Immunizations are current until 2015

Prenatal History / Delivery: Megan's pregnancy was not planned and the father, Jason Good did not believe he was the father and accused Megan of seeing other people. Megan has epilepsy and was treated with Keppra and Lamictal during the pregnancy. Megan did not smoke cigarettes, drink alcohol, or use illegal drugs while pregnant. Megan experienced nausea and vomiting.

Megan reported the pregnancy was uncomplicated and Bradley was delivered a week early via c-section due to previous c-section delivery. Bradley was not admitted to the neonatal intensive care unit and they returned to Megan's father's home.

Megan reported her first child (also unplanned and with a different father) died three and a half years ago of complications just days after birth. Apparently, his lungs were not developed, he had a hernia, there was a cardiac birth defect, and he had a hole in his stomach. Megan reported becoming suicidal at the time but is eventually coming to terms with her son's death. Megan stated she wasn't worried about the same thing happening with her pregnancy with Bradley because the doctors assured her what happened was extremely rare.

Medical Conditions: According to results of speech-language evaluation completed July of last year, Bradley has a speech-language delay, oral sensory/feeding management concerns, and additional sensory processing concerns to be addressed at OT evaluation. Bradley has had at least 6 ear infections. Several months ago Bradley was admitted to the hospital for two days for dehydration.

History of Mental Health Treatment and Response: Bradley has not been evaluated or received mental health services in the past. His mother, Megan, is currently in mental health treatment and is diagnosed with a depressive disorder and prescribed Paxil.

Exposure to Trauma: Bradley was repeatedly exposed to domestic violence from the age of three months until he was approximately nine months old.

Family Psychosocial History

According a Brief Behavioral Health Status Examination completed by Suzie Therapist, LMHC, Megan is exhibiting sleep and eating problems. She expressed she feels resentment and anger at the long term relationship issues with her mother. Megan has a history of depression and also some aggression issues as a teenager. Megan appears anxious and experiencing symptoms of a posttraumatic stress disorder. She is in treatment and working to resolve her abuse issues and dysfunctional and abusive relationship with her mother. At this time, she is in a stable placement and feels secure and safe. She expressed interest in career counseling and parenting classes or therapy to help her with her son.

Megan has little to no support from her family of origin. After moving into "The Helping Hands House" (a temporary group living arrangement for homeless women and children) Megan learned the charges against her mother had been dropped. Megan is in contact with her father but reported he is addicted to gambling and has no money to assist her. Megan is qualified to receive assistance through The Helping Hands House for a total of 2 years. While living at The Helping Hands House, Megan is required to complete coursework for which she will receive compensation in the form of $10 gift cards.

Megan is currently employed at Pizzas Everywhere part time. Megan is unable to drive until she been seizure-free for 1 year. She has had many seizures in the past 6 months and is under the care of a neurologist. The inability to drive limits Megan's ability to work as she has to take the bus for transportation. Megan is also limited due to Bradley's daycare hours.

Clinical Interview / Observation *(Interviews with caretakers and observation of the caregiver-child relation / interactive patterns)*

During the interview, Megan reported Bradley has no fear and doesn't seem to feel pain the way other children feel pain (he had a scrape on his arm and Megan didn't know when it happened as he did not seek her for comfort). Bradley stuffs food into his mouth and uses gestures rather than words to communicate his needs. Megan expressed disappointment that he doesn't use the word "mama." Bradley reacts to loud noises such as the vacuum cleaner. Megan reported Bradley throws everything; he doesn't really play with toys (this was also observed during this assessment).

Upon meeting Bradley for the first time, his breathing became shallow and quick. He began to whine and needed to be picked up by his mother in order to calm down. While in his mother's arms, he pulled her hair and remained hyper vigilant. He was visibly distraught by the introduction of someone new and unfamiliar. Megan reported Bradley hits her in the face and hits her glasses when he is dysregulated. Megan reported she tells him not to do it and raises her voice but Bradley will do it again anyway.

During the assessment it was noted that Megan had placed items on a table in front of the couch within Bradley's reach. These are items that she would prefer he not play with such as pens, sharp nail clippers, and other breakables. When therapist suggested these items might not be safe, mother responded that she does not want to move these items and indicates that "she has given up too much already" and doesn't feel she should have to disrupt her life because Bradley won't listen.

During today's observation, Bradley grabbed a pen off of the table, when Megan told him he couldn't have it, he threw the pen, threw other items off of the table, became defiant, stomping his feet and whining. Megan attempted to set a limit but every limit was met with defiance. Megan tried to soothe Bradley but those attempts were met with more crying and fussing. Megan stated he has to have constant attention. After several minutes, Bradley leaned into Megan and she verbally reassured him. When his assessor praised Bradley for calming down, he threw a crayon across the room. Throughout this encounter, Megan's affect was flat. During the assessment this pattern of interaction occurred several times and at one point Bradley went to the bedroom and came out with a "binky." Megan stated "if I can't calm him down that apparently can."

Bradley and Megan's relationship can best be characterized as underinvolved and angry/hostile interactions as evidenced by the behavioral quality of the relationship. Bradley displays defiant or resistant behavior, and exhibits demanding and/or aggressive behavior. The affective tone between them has a hostile or angry edge (Megan is working on developing coping skills). This observer has noted considerable tension between them and a noticeable lack of enjoyment or enthusiasm. Megan has described the best time of the day with him is when he is sleeping at night. While it is not the case in every interaction, the psychological involvement is one of resentment of Bradley's neediness, which may be due to current life stressors and stem from Megan's early history of emotional deprivation.

Provider's Assessment and Developmental Milestones *(Report from Intake form and other checklists)*

Affect/Emotional Development including range of affect: Bradley's affect is constricted much of the time. Scores on the CBCL are in the normal range for affective problems but are in the borderline range for emotionally reactive and withdrawn.

Language Development (expressive and receptive): According to results of speech-language evaluation completed July of last year, Bradley has a speech-language delay, oral sensory/feeding management concerns. See attached S/L evaluation.

Motor development (fine and gross): ASQ scores indicate no problems with motor development. Although, it should be noted that Bradley did not walk until he was 14 months old.

Sensory Development: Scores on the Short Sensory Profile are in the definite difference range for underresponsive/seeks sensation. Additionally, Megan reported Bradley doesn't seem to feel pain the way other children do and he stuffs his mouth when he eats. Bradley's scores on the Short Sensory Profile tactile sensitivity, taste/smell sensitivity, auditory filtering, and visual auditory sensitivity are in the probable difference range.

Cognitive Development/Adaptive Functioning: Bradley has difficulty with changes in routine and does not transition well from day care to pick up time with his mother especially if visitors are present. Bradley acts out e.g. throwing objects, won't let Megan put him down, and/or tantruming if a limit is set.

Self-care: Bradley will brush his own teeth but will not allow Megan to assist him. Bradley screams and cries during diaper changes and when getting dressed. Bradley uses a pacifier to calm himself down and during play. Bradley does not like his head to be tipped backward to rinse out shampoo.

Social Functioning with peers and adults: Bradley attends Head Start day care on site at The Helping Hands House. He appears to do well in his day care. Bradley has little exposure to adults with the exception of Megan taking him to the Firehouse nearby.

Family Functioning *(Cultural communication patterns and current environmental conditions past and present)*

Family history of legal involvement and educational analysis: Megan was recently assaulted by her mother and obtained a temporary restraining order. Megan had hoped her mother would receive services to address alcohol dependency and help her control her anger. However, Megan learned the charges have been dropped and although her mother took an anger management class; Megan cannot imagine it helped her mother in any significant way.

Megan completed 12th grade and received a certificate of completion. Jason Good is believed to have finished high school (Megan is unsure).

Family psychiatric history medications for such conditions: Megan reported her mother taking Xanax but could not say why it was prescribed. Megan is currently receiving mental health treatment for depression and prescribed Paxil.

Family drug and alcohol history (include current usage of illegal and/or prescription medications and current addiction status): Megan reported her mother has a history of alcohol abuse and prescription drug abuse (she was watching Bradley when she overdosed on alcohol and Xanax-she left the hospital against doctor's orders and arrived at the house naked, the police came and picked her up and took her back to the hospital). That was on the 4th of July and that same day Megan had a seizure. Megan reported her father has a gambling addiction.

Family resources and strengths/challenges and needs (include willingness and ability to accept or initiate support systems and community services, level of insight into areas): Megan is engaged in mental health counseling services. She has never experienced a truly nurturing relationship and experiences periods of depression and anxiety. Through counseling, Megan is discovering inner resources e.g. intelligence and compassion of which she was unaware. Megan has significant challenges in that she experiences her

Helping Hands House case worker as pressuring her rather than supporting her. Megan has no external support systems in place. In the not too distant past, Megan attended church services at The Helping Hand's House with another resident but no longer attends since the other resident has become involved in a relationship. Megan is slowly developing patience for attending to Bradley's needs but needs a great deal of coaching and support to do so. Megan lacks insight into the severity of challenges she faces with parenting and is barely managing to deal with her own lack of emotional support.

Child Strengths & Resiliency Factors — *Check all that apply*

☒ **Responds positively to adult comforting when upset**	
☐ **Shows affection for familiar adults**	
☐ **Keeps trying when unsuccessful (act persistent)**	
☐ **Handles frustrations well**	
☐ **Tries different things to solve a problem**	
☐ **Shows patience**	
☐ **Says positive things about the future (act optimistic)**	
☐ **Trusts familiar adults and believe what they say**	
☒ **Seeks help from children and adults when necessary**	
☒ **Calms her/himself down when upset**	
☐ **Other:**	**Please List:**
The following identifies strengths of the child from the parent's perspective including what the parent likes about their child, what the child is good at, etc.: Emmy's mother states "she is a good girl and adventurous."	

Behavioral Concerns

Please check all behaviors that apply and explain

☒ **Crying**	☐ **Lying**	☐ **Stealing**
☒ **Sleep Problems**	☒ **Temper Tantrums**	☐ **Runs Away**
☐ **Fights**	☐ **Verbal Defiance**	☒ **Aggressive**
☐ **Bed Wetting**	☐ **Truancy**	☐ **Depression**
☐ **Sexual Acting-Out**	☐ **Parenting Problems**	☐ **Thought Disorders**
☐ **Phobias**	☒ **Avoidance**	☐ **Nervousness**
☒ **Eating/Feeding Problems**	☐ **Fidgety**	☐ **Off Task Behaviors**
☒ **Easily Distracted**	☐ **Low Self Esteem**	☐ **Fire Setting**
☒ **Poor Concentration**	☐ **Delinquency**	☐ **Cruelty To Self**
☒ **Difficulty Following Rules**	☐ **Angry/Resentful**	☐ **Suicidal Thoughts**
☐ **Suicidal Attempts**	☐ **Blames Others**	☐ **Swears**
☐ **Intimidating To Others**	☐ **Cruel To Animals**	☐ **Drug Use**
☐ **Alcohol Use**	☐ **Sibling Rivalry**	☐ **Hospitalization**

Mental Status Exam *(Check one for each row)*

	GOOD	FAIR	POOR
Orientation	☐	☐	☐
Immediate memory	☒	☐	☐
Recent memory	☒	☐	☐
Remote memory	☒	☐	☐
Self image	☐	☒	☐
Judgment	☐	☒	☐
Insight	☐	☒	☐

Attire/grooming	☒ **Appropriate**		☐ **Inappropriate**			
Intelligence	☐ **Above**		☒ **Average**	☐ **Below**		
Mood	☐ **Stable**	☐ **Paranoid**	☒ **Angry**	☐ **Depressed**	☐ **Nervous**	
Affect	☐ **Normal**		☒ **Blunted** Bradley has a very limited range of affect			
Attitude	☐ **Cooperative**	☒ **Withdrawn**	☐ **Evasive**	☐ **Agitated**	☐ **Hostile**	☐ **Manipulative**
Thought content	☐ **Logical**	☐ **Coherent**	☐ **Confused**	☐ **Delusional**	☐ **Paranoid**	☐ **Aggressive**

Current Mental Status and Functioning *(Summarize the above checklist to include orientation, ideas of reference, appearance of caregiver and child)*

During this assessment, Bradley was appropriately dressed and nicely groomed. Bradley appeared his stated age. There was no evidence of a thought disorder. Bradley's mood was avoidant and hostile with constricted affect. Bradley did not attempt to engage with this assessor. After much effort and upping affect, Bradley briefly engaged in playful interaction with therapist. He becomes easily disorganized when distressed, which is much of the time. Behavior and emotions deteriorate under stress and he has poor ability to soothe self or accept soothing from adults.

Megan appeared appropriately dressed and nicely groomed. Megan appeared coherent and oriented to person, place, and time. Megan appeared free of any ideations to harm self or others. Megan appeared free of any psychotic features or any abnormal thoughts. She has history of trauma and is currently being treated for depression. Her affect is depressed with elements of anxiety and hostility.

Provisional DSM / DC: 0-3R Diagnosis:

Check one or both: ☐ **DSM: 5** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R
Axis I	100-Posttraumatic Stress Disorder R/O 412-Regulation Disorders of Sensory Processing. Hypersensitive. Type B: Negative/Defiant
Axis II	PIR-GAS 40 Disordered RPCL-Some Evidence of Under-involved and Angry/Hostile
Axis III	315.32 Speech/Language Delay Ear Infections
Axis IV	Child witness Domestic Violence, parent chronic medical condition (epilepsy), parent mental health issues, single parenting with no extended family support, homelessness
Axis V	See Chart Below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement			X				
***Intentional Two-Way Communication**			X				
Complex Gestures and Problem Solving			X				
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

*Per: S/L evaluation: While Bradley vocalizes vowel sounds and combines some consonant- vowels together and uses gestures, such as waving and clapping hands in play, he does not take turns vocalizing nor does he play simple games with others using eye contact. Bradley does not use a variety of consonant sounds and is not babbling syllable strings. Bradley is not using words to communicate and is not imitating words of others. He does not participate in play routines with others.

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functions at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functions immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functions inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Has not achieved this capacity.
7. N/A

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Integrated Summary/Justification for Continued Mental Health Services

Summarize the history, assessment, interpretation, diagnosis & need for services including medical necessity along with prognosis with or without services & interventions:

Megan and Bradley became homeless after Megan's mother physically assaulted her and was subsequently arrested for domestic battery charges. Megan and Bradley stayed briefly at a shelter near the grandmother's home in Orangetown and then relocated to Happytown in order to reside at The Helping Hands House (a homeless women's residence) where she can live for the next two years.

The night of the altercation with her mother, Megan reported Bradley was in her arms when Megan's mother ripped the bedroom door off its hinges, screamed obscenities, shoved Megan back and then pushed her in the face. Megan reported her mother has a long history of alcohol abuse and is very inconsistent in her moods and behavior. Megan reported Bradley did not cry after witnessing the altercation but became very still and quiet.

During the time Megan was staying at her mother's she reported Bradley repeatedly heard his grandmother screaming and threatening Megan. On another occasion, while being held by Megan, Bradley witnessed an incident in which the grandmother threw a bassinet across the room. Megan stated Bradley was startled and even terrified at times while living with his grandmother.

Megan reported Bradley's sleep patterns have changed since the domestic violence incident and there are times when he wakens in the night and whimpers screams. Bradley does not have language and becomes easily frustrated when needs are not met or understood. He is aggressive with his mother at times. Rather than play with his toys, Bradley throws them repeatedly and when redirected becomes angry and screams for long periods of time. Megan reported she gives in to him when he screams because she feels too frustrated to either ignore him or redirect him. Megan reported Bradley has always been a "mama's boy" but she finds his clinginess to be almost intolerable. Bradley becomes dysregulated when he comes into contact with strangers or when Megan attempts to put him down before he is ready.

Therapist observed dysregulated and avoidant behavior by child throughout the assessment. His mood is inconsistent and volatile with extremes. His affect is blunt, angry, and fearful. He is delayed in language and social emotional development. He has few means to soothe himself and does not readily accept it from his mother or therapist.

Bradley and Megan's relationship can best be characterized as having substantial evidence of being under-involved and angry/hostile interactions as evidenced in the behavioral quality of the relationship, indicating a Relationship Disorder diagnosis. Bradley displays defiant or resistant behavior, exhibits demanding and/or aggressive behavior. The affective tone between them has a hostile or angry edge (Megan is working on developing coping skills). This observer has noted considerable tension between them and a noticeable lack of enjoyment or enthusiasm. Megan has described the best time of the day with him as when he is sleeping at night. While it is not the case in every interaction, the psychological involvement is one of resentment of Bradley's neediness which may be due to current life stressors and stem from Megan's early history of emotional deprivation.

Diagnostically, Bradley currently meets all necessary criteria for a diagnosis for Posttraumatic Stress Disorder as evidenced by change in sleep patterns, nightmares, hyperarousal (irritability and/or impulsivity), avoidant behavior, and aggressive behavior. Also, Megan may act as a reminder and trigger Bradley's unpredictable/aggressive responses. His sense of self and of trust in others has become permeated with fear, anger, mistrust, and hypervigilance, responses that are in conflict with age-appropriate strivings for closeness and safety with his parent. Due to Bradley's scores on the Short Sensory Profile a provisional R/O diagnosis of Regulation Disorders of Sensory Processing is added. A referral for an Occupational Therapy Evaluation will be completed.

Due to the atypical behavior presented by Bradley for his age in sensory, language, cognitive, and social emotional domains and the disordered parent child relationship, treatment services are deemed medically necessary. Other interventions, such as support and suggestions from the shelter and suggestions from day

care teacher, have not been successful to date and behavior appears to be worsening. Without mental health interventions, Bradley's behavior is likely to worsen requiring more intensive treatment services as he ages. With treatment interventions at this time, prognosis for child and parent is good. Mother is willing to participate in services and child and parent have the ability to benefit from services.

Treatment Recommendations

Include type/frequency for therapy or other modalities and level of need for family's participations.

It is recommended both Bradley and Megan participate in child-parent psychotherapy sessions once weekly in order to help them to learn to modulate negative emotions and express feelings in socially acceptable ways. Megan will gain insight into Bradley's stress responses that are likely a result of trauma exposure that occurred in infancy.

A referral has been made for an OT evaluation through Early Steps.

Speech therapy services should continue.

Signatures

_____	_____	_____
Assessment Therapist Legible Signature	Title	Date
_____	_____	_____
Licensed Practitioner Legible Signature *(if required)*	Title	Date

Name/Organization/Logo

TREATMENT PLAN

Client Name:	Date:	Start Time:	End Time:	Setting:
Bradley Sweetheart	Follow Medicaid Guidelines for due date	9:30am	10:30	Office

Recommendations from in-depth assessment and other referrals made

Include recommendations from initial assessment and status:
It is recommended both Bradley and Megan participate in child-parent psychotherapy sessions in order to help them to learn to modulate negative emotions and express feelings in socially acceptable ways. Megan will gain insight into Bradley's stress responses that are likely a result of trauma exposure that occurred in infancy. A recommendation for an OT evaluation through Early Steps was made Continue with speech services

Date of Referral	Where Referral Was Made to:	Result/Outcome:
9/12/12	Early Steps for OT evaluation	No results yet. Evaluation scheduled for 9/20/12.

Planning Treatment

Problem #1:

Describe problem with symptoms and behaviors:
Bradley is defiant and he becomes aggressive with Megan when he is angry e.g. hitting or throwing objects.

Goal #1:

Describe Goal of Treatment:
Bradley will learn to regulate his emotions and demonstrate age appropriate behavior when frustrated or upset.

Measurable Objective #1-A: Target Date: 3/15/13

Measurable Objectives to be used as discharge criteria:
On a daily basis, Bradley will be able to identify his feelings through picture cards presented by mom on 2 out of 4 occasions. Megan will present feeling cards to Bradley's and praise him when he is able to point to his feeling, both when calm and upset.

Measurable Objective #1-B: Target Date: 3/15/13

Measurable Objectives to be used as discharge criteria:
Parent and child will participate in child parent psychotherapy on a weekly basis to improve child functioning and parent child relationship.

Interventions / Modality *(Services that will be provided to achieve the goal)*

Modality	Amount (Hr / Min.)	Frequency (Weekly / Monthly)	For duration of	Responsible Party
Individual/Family Counseling	1.0 hr	1 x per week	3 months	Therapist/Family
Case Management Services	as needed			
LFA	.50 Hr.	3 x per year	Annually	Therapist

Check one or both: ☐ **DSM: IV** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R
Axis I	100-Posttraumatic Stress Disorder R/O 412-Regulation Disorders of Sensory Processing Hypersensitive. Type B: Negative/Defiant
Axis II	PIR-GAS 40 Disordered RPCL-Some Evidence of Under-involved and Angry/Hostile
Axis III	315.32 Speech/Language Delay Ear Infections
Axis IV	Child witnessed domestic violence, parent chronic medical condition (epilepsy), mental health issues, single parenting with no extended family support, homelessness
Axis V	See chart below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**			X				
Complex Gestures and Problem Solving							X
Use of Symbols to Express Thoughts/Feelings							X
Connecting Symbols Logically/Abstract Thinking							X

Per S/L evaluation: While Bradley vocalizes vowel sounds and combines some consonant-vowels together and uses gestures, such as waving and clapping hands in play, he does not take turns vocalizing nor does he play simple games with others using eye contact. Bradley does not use a variety of consonant sounds and is not babbling syllable strings. Bradley is not using words to communicate and is not imitating words of others. He does not participate in play routines with others.

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functioning at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functioning immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functioning inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Having not achieved this capacity yet.
7. N/A

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Crisis Intervention Plan

In the event that Bradley's behaviors becomes escalated the family / caretakers should utilize redirection and relaxation / calming techniques such as providing the child with personal space and time, calming language, and strategies identified as effective by family and therapist. Should Bradley's behaviors become unmanageable, the caretaker should contact a friend or family member to assist with some temporary respite support as well as contacting the infant mental health therapist or pediatrician for assistance.

Individualized Discharge Plan

In order for Bradley to successfully complete treatment, the goals of each problem should be met or partially met as observed by primary caregiver and therapist. Bradley will also be able demonstrate ability to self regulate; he and his mother will demonstrate an enhanced relationship evidenced by positive affect and noticeable mutual enjoyment in activities; and Megan will express perception of change or improvement in Bradley's behavior and her ability to respond appropriately. Bradley will be demonstrating social, emotional, and behavioral responses typical of his age. Relationship Disorder will be resolved or nearly resolved.

Treatment Plan Signatures

Treatment Team Members are in agreement with this treatment plan:

_____ _____
IMH Clinician Date

_____ _____
IMH Clinician's Supervisor Date

The services listed above are medically necessary and appropriate to the recipient's diagnosis and treatment needs.

_____ _____
Treatment Team Member / Type 07 Date

I have participated in the development of this treatment plan and I agree to be an active participant in my child's treatment:

_____ _____
Parent / Guardian (if no signature, write explanation on signature line) Date

_____ _____
Parent / Caretaker (if no signature, write explanation on signature line) Date

_____ _____
Client (if no signature, write explanation on signature line) Date

I _____ **have invited the following to participate in person, by phone, or in writing in the treatment planning process.**
Parent / Guardian

_____ _____
Other Treatment Team Member Date

Name/Organization/Logo

INFANT MENTAL HEALTH PROGRESS NOTE

CLIENT NAME:	**DOB:**	**DATE**
Bradley Sweetheart	1/12/11	12/14/12
DIAGNOSIS CODE: DC:0-3R 100-PTSD		

Date	Time	Length of Time	Service'Setting	Note (Signature)
xx-xx-xx	5pm-6 pm	1hr	Individual/Family Counseling/Office	D: TH met with C and MOC for individual/family session. C was guarded and clung to MOC for the first part of the session. TH utilized elevated affect and child centered play therapy techniques in order to engage C in play. MOC reported C falling a great deal and hitting his head during the Thanksgiving holiday but there were no visible bruises. C's language was improved some, however he continues to have speech delays and is in therapy for speech. A: Although C was slow to warm up, he engaged in some reciprocal ball play. TH observed a fleeting shift in C's affect after MOC supposedly playfully hit him in the head when she threw the ball to him. MOC demonstrated an inability to understand how her display of frustration with the child manifests itself in their relationship. TH used the "talking for baby" approach and indicated child was confused/scared when M threw the ball and hit him. MOC said she was only playing and didn't mean to scare him. He approached, w/o language, and hugged her, but affect was still guarded. TH explained the CPP process and MOC seemed eager to understand herself better in the context of her relationship with C. She verbalized she wants child to feel safe with her and does not want to repeat a cycle of abuse and maltreatment. M still involved in her own therapy and reports feeling not as depressed. C was neat, clean, and free of any visible injury. P: Continue weekly CPP sessions. An OT referral has been made through Early Steps; results are pending. Next session scheduled for 3/27/13. **Legible Signature and Credentials:** **Printed or Stamped Name:**
Treatment Goal: 1 **Treatment Objective:** 1B				

Name/Organization/Logo

EARLY CHILDHOOD MENTAL HEALTH DISCHARGE PLAN

Client Name: Bradley Sweetheart **Date Services Began:**

DOB: **Date of Discharge:**

Reason for Discharge

☒ **Goals met/Partially met**

Bradley became involved in mental health treatment when brought for evaluation by his mother. Bradley witnessed numerous episodes of violent and abusive behavior by maternal grandmother to mother and began experiencing symptoms related to a posttraumatic stress disorder. Symptoms included sleep problems, withdrawal, hypervigilance, aggression, regression, exaggerated startle response, and overall defiance and negativity. Mother has history of mental health problems and is diagnosed with depression and prescribed Paxil. Interactive patterns between parent and child showed disturbance and met criteria for a Relationship Disorder, Angry/Hostile. Child and parent have consistently been involved in child parent psychotherapy sessions. Child has made sufficient progress and is functioning at a more typical level of development in social, emotional, and behavioral domains. Symptoms have resolved to the degree that mental health services are no longer deemed medically necessary. Mother instructed to return for re-evaluation if symptoms recur or new symptoms present in the future.

☐ **Not able to engage child/family**

☐ **Child/family unable to continue services at this time**

☐ **Transfer to outside therapist/organization**

☐ **Child/Family moved**

☐ **Other: (explain)**

DSM/DC: 0-3R Diagnosis at Discharge

Axis I: 100. Posttraumatic Stress Disorder (Resolving)

Axis II: PIR-GAS-85-Adapted

Axis III: Speech/Language Delays, History of Ear Infections

Axis IV: Child witnessed Domestic Violence, parent with chronic medicalcondition (epilepsy), parent with mental health issues, single parenting with no extended family support, homelessness

Axis V: See chart below

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation		X					
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**		X					
Complex Gestures and Problem Solving			X				
Use of Symbols to Express Thoughts/Feelings					X		
Connecting Symbols Logically/Abstract Thinking							X

Aftercare

Services/activities to continue following discharge: As Bradley continues to grow he may benefit from getting involved in an organized activity or sport, to help him further develop his social skills. Bradley will continue his OT and speech services.

Recommendations made by therapist at time of discharge: It is suggested that the caregivers continue to implement clear limits and boundaries in the home environment as Bradley appears to do well in a structured and predictable environment. It is also suggested that the caregivers continue to work listening, naming, and identifying Bradley's feelings in order to help Bradley understand and verbalize his feelings to prevent aggressive or defiant behaviors.

Referrals made: Therapist referred client for an occupational therapy (OT) evaluation through Early Steps which was completed on 05-15-01. Bradley did not meet qualifications for services to be covered through Early Steps but did begin OT privately.

Critical Incident Planning

Is a safety plan needed? ☐ **Yes** ☒ **No**

Is a crisis plan needed? ☐ **Yes** ☒ **No**

Satisfaction Survey Completed By Parent/Caregiver?

☒ **Yes** ☐ **No** **If no please explain:**

_____ _____
Parent/Caregiver Signature Date

_____ _____
Therapist Signature Date

Case Study #3

30 mo old with Axis I: 221 Separation Anxiety Disorder and 100. Posttraumatic Stress Disorder, in partial remission

Name/Organization/Logo
Address
Somewhere, FL zip-code

IN-DEPTH MENTAL HEALTH ASSESSMENT

Name	Katie	**Date of assessment**	
		Date of birth	xx/xx/xx
Address	345 Gator Place Sunny, Florida 33333	**SS#**	
		Phone	
Parent/ Guardian		**Insurance Type/ number**	Magellan
Referral source	Child Welfare Case Manager		
Date referred		**Date opened**	
Therapist completing assessment:	Licensed Mental Health Therapist	**Date report completed**	

Chief Complaint *(Parent/guardian perception of problem or presenting problems)*

Katie is a 30-month-old Caucasian female child, who currently lives with her relative caregiver Aunt Mary and Aunt Mary's sons who are ages 6, 10, 14, and 16. Katie was originally referred for services by Sunny County Child Welfare case manager, who was unable to find services for a child of Katie's age in her county. Katie's case manager was concerned about Katie's behavior in light of alleged sexual abuse that occurred in a previous placement.

Aunt Mary, who has been Katie's caregiver and guardian for 10 months, stated that her current concerns include Katie's difficulty with separation. Aunt Mary stated that it is "difficult to go with her to strange places, even places [Katie]'s been several times." Aunt Mary stated that Katie will often cry and "meltdown" when she leaves a room at home or tries to close the door in the bathroom. Aunt Mary also stated that Katie is "defiant" at times, "very emotional" and "demanding," stating…. "it's like she wants more, more, more." Katie will avoid any situation, even a playful one, out of fear and anxiety. This impairs the child's and family's functioning and makes it difficult to go out of the house. These behaviors have been present over four months. Aunt Mary is currently in the process of adopting Katie and is concerned about her current problems and the future.

Aunt Mary stated that Katie has had no previous mental health evaluations and has received no previous diagnoses, either medical or psychological.

Medical History

Primary Care Physician: Dr. Quinn **Immunization / Well Care Check up Current:** Yes

Prenatal History / Delivery: Aunt Mary reported limited knowledge of Katie's mother's (Cathy) pregnancy. Aunt Mary stated that Cathy lived in Kolk County at the time of her pregnancy and "did have some prenatal care." Aunt Mary stated that she believed Cathy smoked, although she did not know how much, and stated she did not know if Cathy drank alcohol. Aunt Mary stated that she had been told by relatives that Cathy was using "crystal meth" and marijuana when she found out she was pregnant, but that Cathy then stopped substance use during the remainder of the pregnancy. This is believed to have been in the second trimester. Aunt Mary stated that she did not believe Cathy had any complications during the pregnancy. Aunt Mary stated that she believed Katie was Cathy's first child and that she was 17 or 18 at the time of Katie's birth. Aunt Mary did not know Katie's birth weight or length, but stated that she was full-term and "normal size." Aunt Mary stated that Katie was born vaginally and did not require any neonatal care. Aunt Mary reported that she was not aware of any complications with feeding, swallowing, or breathing.

Medical Conditions: Aunt Mary reported that Katie was last seen by her pediatrician, Dr. Quinn, at the Center for Family Health, just a few weeks ago. Aunt Mary did not know when Katie's last vision or hearing screening was completed. Aunt Mary stated that she does not suspect any hearing loss. Aunt Mary reported no serious illnesses, accidents, injuries or traumas since Katie entered her care at age 18 months. Aunt Mary reported one ear infection last year, but no tubes in the ears. Aunt Mary reported no allergies, operations, or hospital admissions. Katie does not take any medication. There are reports of sexual abuse/trauma in a previous placement, but details of this abuse are not know at this time or whether medical treatment was rendered.

Developmental Milestones: Aunt Mary reported limited knowledge of Katie's motor development. Aunt Mary stated that Katie was walking when she was placed with her at 18 months of age. Aunt Mary has no concerns about Katie's motor development. Aunt Mary reported that Katie is "starting to" use crayons correctly, plays with age-appropriate toys, and uses her thumb and forefinger to pick up small objects. Aunt Mary stated that Katie does not have established hand dominance, but appears to be on target with fine motor skills. No concerns reported regarding speech and language development. Aunt reported that Katie was using two to three words at a time when she was placed with her at 18 months of age. Aunt Mary was not sure when earlier milestones were met. Aunt Mary stated that Katie does not avoid talking and that others do not have difficulty understanding Katie's speech. She is now able to use four to five word sentences. Aunt Mary reported that there is no known family history of speech and language difficulties. Aunt Mary reported that English is the only language spoken in the home.

Aunt Mary stated that she had no knowledge that Katie had any feeding problems as a baby. Aunt Mary stated that Katie currently has no feeding problems. Aunt Mary stated that Katie "would eat too much if we let her." Aunt Mary stated that Katie does not avoid any foods and that she eats what the rest of the family eats.

Aunt Mary will complete an ASQ for Katie which will further assess for current developmental progress.

History of Mental Health Treatment and Response: Katie has never received any services to address mental health concerns.

Exposure to Trauma: Aunt stated that Katie has not been exposed to any trauma since her placement with her. Suspicions/reports of sexual abuse in previous placement were acknowledged.

Family Psychosocial History

Aunt reports that Katie's mother, Cathy, was the child of two substance-abusing parents. Aunt Mary reported that Cathy was mostly raised by her grandparents, Martha and Joe. Although Aunt Mary stated that Martha and Joe divorced a number of years ago, Aunt reports that they sometimes shared a house.

Aunt Mary stated that it was "well known" in the family that Joe sexually abused Cathy and her sister (his granddaughters). Aunt Mary stated that Joe was "accused" of molesting his granddaughters, but the girls would not testify against him.

Aunt Mary reported that Cathy "lived on the street" for a period of time in her teens, during which time she met Katie's father and became pregnant. Aunt Mary stated that she did not know the name of Katie's father. Aunt Mary reported that Katie was first removed from Cathy's care between one and three months of age. Aunt Mary reported that Katie was placed with her great-grandmother (Katie's grandmother), Martha. Aunt Mary reported that shortly after Katie was placed with her, Martha returned to living with Joe. Aunt Mary stated that Martha was "sick a lot" and Joe was "often the caretaker." Aunt Mary stated that she did not know until months after Katie had been placed with her that Martha was living with Joe. Aunt Mary stated that she had been told by Martha that Katie was removed from her and Joe's care at 18 months of age because of "their age." Conversely, Aunt Mary was told by other sources that sexual abuse allegations made by one or both of the granddaughters were the reason for terminating the placement. Aunt Mary stated that she and Katie have no further contact with Martha and Joe.

Aunt reports that she noticed a "horrible rash" around Katie's genital area when Katie was first placed with her. Aunt reported that Katie said, "Papa hurt it," while getting a diaper change, in the early weeks of the placement with Aunt Mary. Aunt Mary also noted that Katie frequently masturbated and would put "cereal" or other objects inside her vagina. Aunt took child to doctor and a report to the child abuse hotline was made. Uncertain of the outcome of the investigation, Aunt Mary stated that this behavior has drastically diminished to the point that the behavior is no longer a concern. Aunt Mary stated that if Katie's rash returns, her pediatrician plans to test her for sexually-transmitted diseases.

Aunt states that she is currently in the process of pursuing adoption of Katie. Aunt Mary stated that Cathy's rights are "supposed to be terminated soon," while Katie's father's location is unknown. Aunt Mary stated that Cathy has been "in and out of jail" and is "still substance-abusing."

Aunt Mary stated that she recently finalized her divorce from the father of her two younger sons. Aunt Mary stated that her ex-husband has some contact with his sons, but is not involved in the care or support of Katie. Aunt Mary is currently single and is employed as a nurse. Aunt works three twelve-hour night shifts per week so that she can care for Katie and her other children during the day. Aunt Mary stated that her parents live next door and provide help with the children. Aunt Mary stated that her parents have a good relationship with Katie.

Clinical Interview / Observation *(Interviews with caretakers and observation of the caregiver-child relation / interactive patterns)*

Aunt Mary reported that Katie does not respond to limit setting and wants to "run the show." Aunt Mary reported significant difficulties with separation, stating that she "can't leave" Katie, "even to go to the bathroom at home." Aunt Mary reported that Katie sometimes seems to have no sense of danger. Aunt Mary stated that Katie is "moody" and sometimes irritable, with quick mood changes from laughing to sad or angry. Aunt Mary also reported that Katie sometimes "pinches or scratches" herself when she is put in time out. Aunt Mary stated that Katie occasionally "whacks" Aunt Mary's 6-year-old son, Stevie, but that she is not normally aggressive. Aunt Mary did not note any sensory issues, such as over-reaction to tags in shirt, unexpected touch/loud noise, or messy play. Aunt Mary stated that Katie seeks climbing, jumping or swinging activities. Aunt Mary stated that Katie now "does pretty well" with bedtime routines.

When asked to describe specific behavior that was of concern, Aunt Mary stated that Katie is "emotional" and "hard to soothe." Aunt Mary also reported concern about Katie's difficulties with separating from her. Aunt Mary stated that Katie "doesn't like redirection or discipline" and could be described as "defiant." Her separation issues is creating significant distress and impairing family's ability to leave the home for any reason. It is also creating some jealousy with her own biological children.

Along with Katie, Aunt Mary brought her youngest son, Stevie (6yrs), with her to this assessment. Stevie has a congenital disorder which causes significant developmental delays. Stevie and Katie explored the room and the toys while Aunt Mary spoke to the assessor, although Katie initially was clinging to Aunt and not wanting to move. Katie occasionally interrupted to ask Aunt Mary a question or show her something. Katie addressed Aunt Mary as "Mommy" and used physical contact (e.g., touching Aunt Mary's arm or leg) to get her attention. Aunt Mary spoke kindly but firmly to Katie, telling her to "go play" while she spoke to the assessor. Aunt Mary occasionally appeared weary and slightly impatient with Katie's interruptions, particularly while discussing more emotional elements of Katie's history. Aunt Mary pointed out to this assessor when Katie began to pout, stating, "See, she doesn't like hearing no." Visual referencing was observed between both caregiver and child. Aunt Mary responded to Katie's needs. Katie made eye contact with this assessor, although she did not approach the assessor until the assessor joined the children on the floor.

The assessor sat on the floor with Katie as Katie played with circular shape sorter. Katie showed delight as she dropped each shape into the correct space. Katie allowed the assessor to help by turning the ball to the correct spot. Katie asked assessor for help open the shape ball. Katie giggled as the shapes dropped to the rug. Katie asked to do it again and repeated the activity several times. When the assessor noted that Stevie was playing with the blocks, Katie walked over to where the blocks were and began picking up blocks. Katie dropped some of the smaller blocks into the shape sorter ball, expressing delight when they fit. Katie made frequent eye contact with the assessor and seemed to respond to the assessor's level of emotion (e.g., when assessor gave a big smile and said, "Wow," Katie's responded similarly). Aunt Mary directed the children to help clean up. Katie showed some reluctance to leave, but helped put away the blocks after some verbal cajoling from Aunt Mary. Katie held Aunt Mary's hand as the family walked down the hall.

The parent-child relationship can be categorized as mildly perturbed as represented by a PIR-GAS score of 75. Some transient distress is noted in the relationship, but the overall relationship remains characterized by adaptive flexibility. Examples of this transient distress may be evidenced by Aunt Mary's occasional impatience with Katie's interruptions and her vigilance in attempting to show assessor Katie's "moods." Circumstances likely contribute to the observed distress, including Aunt Mary's recent divorce, the complexities of the adoption process and the ongoing demands of raising her four sons, including one with special needs. Overall, the relationship still functions reasonably well and developmental progress has not been impeded. Katie has made steady progress in emotional and behavioral functioning in the eleven months since Aunt Mary has become her caregiver, but social, emotional, and behavioral functioning remain atypical for a child her age. Katie shows a strong, yet still developing attachment to Aunt Mary. Katie's continued difficulty with separation may be evidence that the security of the attachment is still in process. Aunt Mary spoke emotionally about her love for Katie, stating, "Losing her now would be like losing my child."

Provider's Assessment and Developmental Milestones *(Report from Intake form and other checklists)*

Katie demonstrated a normal range of affect while in the assessment room; smiles were observed between caregiver and child. Katie was observed maintaining eye contact with Aunt Mary. In between exploring the room or playing with toys, Katie frequently returned to Aunt Mary to ask questions or seek physical contact. Katie was initially more cautious with the assessor, but made eye contact with her and smiled. Katie was observed pouting when told to "go play" and displayed happiness through facial expression and words during play. Aunt Mary's description of Katie as being "difficult to soothe" and "crying at the drop of a hat" likely indicates that Katie's ability to regulate her emotions is not age appropriate, and is vulnerable to stress.

Language Development (expressive and receptive): Katie's speech was easily understood by this assessor. Katie appeared to understand Aunt Mary's and the assessor's questions and directions, and Katie responded appropriately. Katie's language development seemed to be at least age appropriate.

Motor development (fine and gross): Katie's gross and fine motor development appeared to be age appropriate.

Sensory Development: There are no reported or observed indications of a sensory processing disorder or sensory issues that would interfere with emotional development.

Cognitive Development/Adaptive Functioning: Katie is currently at home with Aunt Mary and does not attend any child care setting. Katie appears to be age appropriate in cognitive development.

Self-care: Katie can feed herself. Katie can mostly dress herself. Katie can sometimes self-soothe. Katie's can participate in self-care activities at an age appropriate level.

Social Functioning with peers and adults: Katie interacted with Aunt Mary and this assessor in an appropriate way. Katie interacted with Aunt Mary's son, Stevie. Aunt Mary reported that Katie plays with similar aged children of Aunt Mary's friends. Aunt Mary reported that Katie interacts with her peers in an age appropriate manner.

Family Functioning *(Cultural communication patterns and current environmental conditions past and present)*

Family history of legal involvement and educational analysis: Aunt Mary reported that Katie's biological mother, Cathy, has been "in and out of jail" for substance-abuse related offenses. Aunt Mary reported that she is currently pursuing adoption through the court system. Aunt Mary stated no other current legal involvement.

Aunt Mary is employed as a nurse.

Family psychiatric history medications for such conditions: Aunt Mary stated that she had no knowledge of any psychiatric diagnoses in the family. Aunt Mary stated that Cathy was a poly-substance abuser whose "use" became "worse" after Katie's birth, resulting in Katie's removal from care.

Family drug and alcohol history (include current usage of illegal and/or prescription medications and current addiction status): Aunt Mary stated that she does not use drugs or alcohol. Aunt Mary reported no known significant medical conditions that run in the family.

Family resources and strengths/challenges and needs (include willingness and ability to accept or initiate support systems and community services. level of insight into areas): Aunt Mary reported that her parents (mother and stepfather) live next door. Aunt Mary stated that her mother "helps with the kids" and that her parents have a "good relationship with Katie." Aunt Mary reported that she is willing to access services in the community. Aunt Mary reported that she has sought services for Stevie in the past. Aunt Mary appeared to have insight into family weaknesses. Aunt Mary's discussion of known sexual abuse in the family raises some questions about level of dysfunction within the extended family. Aunt Mary appears to have broken off ties with that branch of the family, stating that she has had no contact with Martha or Joe for "months."

Child Strengths & Resiliency Factors — *Check all that apply*

☒ **Responds positively to adult comforting when upset**	
☒ **Shows affection for familiar adults**	
☒ **Keeps trying when unsuccessful (act persistent)**	
☐ **Handles frustrations well**	
☒ **Tries different things to solve a problem**	
☐ **Shows patience**	
☒ **Says positive things about the future (act optimistic)**	
☒ **Trusts familiar adults and believe what they say**	
☒ **Seeks help from children and adults when necessary**	
☐ **Calms her/himself down when upset**	
☐ **Other:**	**Please List:**
The following identifies strengths of the child from the parent's perspective including what the parent likes about their child, what the child is good at, etc.: "I like everything about her." "If she were taken away, it would be like taking away my own child."	

Behavioral Concerns

Please check all behaviors that apply and explain

☒ **Crying**—*difficulty regulating emotions*	☒ **Lying**—*will admit she's lied & ask "Are you mad?"*	☐ **Stealing**
☐ **Sleep Problems**	☒ **Temper Tantrums**—*when told "no" or doesn't get her way,' difficulty regulating emotion*	☐ **Runs Away**
☐ **Fights**	☐ **Verbal Defiance**	☐ **Aggressive**
☐ **Bed Wetting**	☐ **Truancy**	☐ **Depression**
☒ **Sexual Acting-Out**—*more significant when she first was placed with Aunt Mary—masturbating, placing objects (e.g., cereal) inside vagina*	☒ **Parenting Problems**—*difficulty knowing how to handle fits, how to comfort, how to discipline*	☐ **Thought Disorders**
☐ **Phobias**	☐ **Avoidance**	☐ **Nervousness**
☐ **Eating Problems**	☐ **Fidgety**	☐ **Off Task Behaviors**
☐ **Easily Distracted**	☐ **Low Self Esteem**	☐ **Fire Setting**
☐ **Poor Concentration**	☐ **Delinquency**	☒ **Cruelty To Self**—*pinches or scratches self when in "time-out"*
☐ **Difficulty Following Rules**	☐ **Angry/Resentful**	☐ **Suicidal Thoughts**
☐ **Suicidal Attempts**	☒ **Blames Others**—*sometimes blames brother Stevie for things*	☐ **Swears**
☐ **Intimidating To Others**	☐ **Cruel To Animals**	☐ **Drug Use**
☐ **Alcohol Use**	☐ **Sibling Rivalry**	☐ **Hospitalization**

Mental Status Exam *(Check one for each row)*

	GOOD	FAIR	POOR
Orientation	☒	☐	☐
Immediate memory	☒	☐	☐
Recent memory	☒	☐	☐
Remote memory	☒	☐	☐
Self image	☒	☐	☐
Judgment	☐	☒	☐
Insight	☐	☒	☐

Attire/grooming	☒ **Appropriate**	☐ **Inappropriate**					
Intelligence	☐ **Above**	☒ **Average**	☐ **Below**				
Mood	☒ **Stable**	☐ **Paranoid**	☐ **Angry**	☐ **Depressed**	☐ **Nervous**		
Affect	☒ **Normal**	☐ **Blunted**					
Attitude	☒ **Cooperative**	☐ **Withdrawn**	☐ **Evasive**	☐ **Agitated**	☐ **Hostile**	☐ **Manipulative**	
Thought content	☒ **Logical**	☒ **Coherent**	☐ **Confused**	☐ **Delusional**	☐ **Paranoid**	☐ **Aggressive**	☐ **Retarded**

Current Mental Status and Functioning *(Summarize the above checklist to include orientation, ideas of reference, appearance of caregiver and child)*

During this assessment, Katie was appropriately dressed and nicely groomed. Katie appeared her stated age. There was no evidence of a thought disorder. Katie's mood was happy / neutral with appropriate affect. Katie was friendly toward this assessor.

Aunt Mary appeared well groomed. Aunt Mary appeared coherent and oriented to person, place, and time. Aunt Mary appeared free of any ideations to harm self or others. Aunt Mary appeared free of any psychotic features or any abnormal thoughts.

Provisional DSM / DC: 0-3R Diagnosis:

Check one or both: ☐ **DSM: 5** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R
Axis I	221 Separation Anxiety Disorder 100 Posttraumatic Stress Disorder, in partial remission
Axis II	PIRGAS: 75-Perturbed
Axis III	None Reported
Axis IV	Recent divorce of caregiver; child in relative care; developmental disability of other child in home; History of sexual abuse; history of parental substance abuse; history of DCF involvement;
Axis V	See Chart Below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement			X				
***Intentional Two-Way Communication**	X						
Complex Gestures and Problem Solving		X					
Use of Symbols to Express Thoughts/Feelings			X				
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

8. Functioning at an age appropriate level under all conditions and with a full range of affect.
9. Functions at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
10. Functions immaturely (i.e., has the capacity, but not an age appropriate level).
11. Functions inconsistently or intermittently unless special structure or sensory-motor support is available.
12. Barely evidences this capacity, even with support.
13. Has not achieved this capacity.
14. N/A

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Integrated Summary/Justification for Continued Mental Health Services

Summarize the history, assessment, interpretation, diagnosis & need for services including medical necessity along with prognosis with or without services & interventions:

Katie is a 30-month-old Caucasian female child who lives in Podunk with her relative caregiver, Aunt Mary, and Aunt Mary's four sons, ages 6, 10, 14, and 16. Katie was referred by Sunny County Child Welfare Coalition, due to symptoms of emotional distress and suspicions of sexual abuse.

Katie was removed from the care of her mother, Cathy, between one and three months of age and placed with Cathy's grandmother, Martha. Aunt Mary reported that Cathy was a polysubstance abuser whose substance abuse became "worse" after the birth of Katie. Aunt Mary stated that Martha, although divorced from Joe, shared a house with him at the time of Katie's placement. Joe is suspected of abusing Cathy and her sister (his granddaughters) and there is strong suspicion that he also sexually abused Katie.

Aunt Mary stated that she "can't leave" Katie, and Katie will often cry and become distressed when Aunt Mary leaves the room without her at home. This distress is extreme and Katie does not stop crying until the Aunt re-enters the room.

Katie appears to be developmentally on target for speech/language and gross/fine motor. Aunt Mary has been given the ASQ and ASQ-SE to further assess developmental progress. A short sensory profile will further assess for sensory processing issues.

Diagnostically, Katie meets the criteria for Separation Anxiety Disorder according to the DC-0-3R (the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition). Katie demonstrates recurrent excess distress when separation from home or major attachment figure occurs or is anticipated. Katie persistently refuses or is reluctant to leave home, even for familiar places. Katie shows persistent fear or reluctance to be alone or without her major attachment figure even in the home. Katie's distress over separation impacts her activities and the family functioning. Katie has demonstrated this distress over separation for greater than one month.

Secondarily, Katie meets some of the criteria for Posttraumatic Stress Disorder, according to the DC: 0-3R. Based on prior history and symptoms, a qualifier of "In Partial Remission" would be accurate. Katie had exposure to a traumatic event. Katie previously, although not currently, reenacted her trauma through excessive masturbation and attempts at object penetration. Katie previously, although not currently, had difficulty sleeping and separating from caregiver at bedtime. Katie continues to display hyper-vigilance and increased irritability, outbursts of anger or extreme fussiness, and temper tantrums. An associated feature of PTSD in young children often involves separation anxiety, which is Katie's primary clinical issue at this time.

Due to behaviors and emotions that are atypical for a child Katie's age, exposure to trauma that has gone untreated, and the degree of stress Katie's behaviors have on the caregiver -child relationship, mental health services are deemed medically necessary at this time. Without treatment, Katie's symptoms could worsen which could impact her social, emotional, and physical development and likely result in more intensive mental health services in the future. With treatment and continuation in a stable home, Katie's prognosis is good.

Appropriate intervention such as Child Parent Psychotherapy (CPP) would enhance the parent child interactions, and improve bonding and attachment in a way that would promote healthy development and improve the child's ability to regulate. Aunt Mary will gain positive strategies to work with Katie in order to enhance their parent-child relationship. The aunt is willing to engage in treatment and the child and aunt have the ability to benefit from treatment.

Treatment Recommendations

Include type/frequency for therapy or other modalities and level of need for family's participations.
It is recommended that Katie and Aunt Mary participate in dyadic therapy such as in Child-Parent Relationship Therapy or CPP to further support attachment bond and address separation anxiety. Sessions will encourage healthy developmental progress. Therapist will contact child welfare agency to try to gain further information regarding sexual abuse and follow up with pediatrician if found to have indicators.

Signatures

_____	_____	_____
Assessment Therapist Legible Signature	Title	Date
_____	_____	_____
Licensed Practitioner Legible Signature *(if required)*	Title	Date

Name/Organization/Logo

TREATMENT PLAN

Client Name:	Date:	Start Time:	End Time:	Setting:
Katie	Follow Medicaid Guidelines for due date	9:30am	10:30	Office

Recommendations from in-depth assessment and other referrals made

Include recommendations from initial assessment and status:		
It is recommended that Katie and Aunt Mary participate in dyadic therapy such as in Child-Parent Relationship Therapy or CPP to further support attachment bond and address separation anxiety. Sessions will encourage healthy developmental progress. Therapist will contact child welfare agency to try to gain further information regarding sexual abuse and follow up with pediatrician if found to have indicators		
Date of Referral	**Where Referral Was Made to:**	**Result/Outcome:**
No referrals have been made at this time.		

Planning Treatment

Problem #1:

Describe problem with symptoms and behaviors:
Katie becomes physically and emotionally distressed to the extreme when separated from her Aunt Mary. This distress is interfering in child and family functioning. She will cry, fall to floor, pound on bath room door until aunt comes out, pinch herself, and cling refusing to let go.

Goal #1:

Describe Goal of Treatment:
Katie will become comfortable being separated from her Aunt Mary and will learn to regulate her physical and emotional responses as it relates to being separated.

Measurable Objective #1-A: Target Date: _____

Measurable Objectives to be used as discharge criteria:
Daily, Katie will deal with separation from aunt in a more age appropriate manner. She will accept holding a picture of her aunt during times of separation or a piece of aunt's clothing or jewelry. Aunt Mary will pre-set separation with words that help prepare her and give her security, i.e., "I'll be right behind the door. I'm not leaving you for long. I'll be back in 10 minutes." Aunt will reinforce all positive attempts of dealing with separation.

Measurable Objective #1-B: Target Date: _____

Measurable Objectives to be used as discharge criteria:
Katie will allow Aunt Mary to practice separation during child parent psychotherapy sessions while therapist supports Katie in this process. Katie's ability to separate at an age appropriate level will increase by 50% over the next three months.

Interventions / Modality *(Services that will be provided to achieve the goal)*

Modality	Amount (Hr / Min.)	Frequency (Weekly / Monthly)	For duration of	Responsible Party
Individual/Family Counseling	1.0 hr	1 x per week	3 months	Therapist/Family
Case Management Services	as needed			
LFA	.50 Hr.	3 x per year	Annually	Therapist

Check one or both: ☐ **DSM: 5** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R
Axis I	221 Separation Anxiety Disorder 100 Posttraumatic Stress Disorder, in partial remission
Axis II	PIRGAS: 75-Perturbed
Axis III	None Reported
Axis IV	Recent divorce of caregiver; child in relative care; developmental disability of other child in home; history of sexual abuse; history of parental substance abuse; history of DCF involvement
Axis V	See chart below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation			X				
Forming Relationships/Mutual Engagement			X				
***Intentional Two-Way Communication**		X					
Complex Gestures and Problem Solving			X				
Use of Symbols to Express Thoughts/Feelings			X				
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functioning at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functioning immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functioning inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Having not achieved this capacity yet.

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Crisis Intervention Plan

In the event that Katie's behaviors becomes escalated the family / caretakers should utilize calming techniques such as providing the child with personal space and time, calming language, and strategies identified as effective by family and therapist. Should Katie's behaviors become unmanageable, the

caretaker should contact a friend or family member to assist with some temporary respite support as well as contacting the infant mental health therapist or pediatrician for assistance.

Individualized Discharge Plan

In order for Katie to successfully complete treatment, the goals of each problem should be met or partially met as observed by primary caregiver and therapist. Katie will also be able demonstrate ability be separated for brief periods of time (minimally) from her Aunt Mary. Katie will demonstrate the ability regulate her physical and emotional responses to being separated at a more age appropriate level. Aunt Mary will express perception of change or improvement in Katie's behavior and her ability to respond appropriately.

Treatment Plan Signatures

Treatment Team Members are in agreement with this treatment plan:

_____ _____
IMH Clinician Date

_____ _____
IMH Clinician's Supervisor Date

The services listed above are medically necessary and appropriate to the recipient's diagnosis and treatment needs.

_____ _____
Treatment Team Member / Type 07 Date

I have participated in the development of this treatment plan and I agree to be an active participant in my child's treatment:

_____ _____
Parent / Guardian (if no signature, write explanation on signature line) Date

_____ _____
Parent / Caretaker (if no signature, write explanation on signature line) Date

The child's age of 9 months precludes participation in the development & signing of this treatment plan.

_____ _____
Client (if no signature, write explanation on signature line) Date

I _____ **have invited the following to participate in person, by phone, or in writing in the treatment planning process.**
Parent / Guardian

_____ _____
Other Treatment Team Member Date

Name/Organization/Logo

INFANT MENTAL HEALTH PROGRESS NOTE

CLIENT NAME:	**DOB:**	**DATE**
Katie	xx/xx/xx	xx/xx/xx
DIAGNOSIS CODE:		
221-Separation Anxiety		

Date	**Time**	**Length of Time**	**Service/Setting**	**Note (Signature)**
xx-xx-xx	5pm to 6 pm	1hr	Individual/Family Counseling/Office	D: TH met with C and Aunt for individual/family session. C was very shy and did not make eye contact initially with TH. TH utilized elevated affect to try and engage child with some success. Aunt stated, "she's still having a hard time being apart from me….but I know it will take time…..I've got all the time in the world". Aunt stated she does not think she can even consider a child care placement at this time as she doesn't feel C could handle it. A: C eventually warmed up to TH and was observed visually referencing Aunt many times. The child seemed very happy and content as long as she has her eyes on the Aunt. At one point, Aunt got up to take a call on her cell phone she stepped out of the office but left one leg visible in the crack of door for C's sake. C became emotionally distraught running to the door and grabbing Aunt's leg. TH was unsuccessful in drawing the child back in the room until Aunt was off the phone and came back in with her. TH used this opportunity to discuss use of words/phrases that promote safety and security for CH. Examples were given and Aunt expressed willingness to use such words/phrases regularly if it would help CH. Aunt seems very capable and grounded as evidenced by her calm demeanor and willingness to help CH despite Aunt having four other children and a full time job. Aunt expressed insight related to her own expression of emotion and the impact negative emotions would have on CH. P: Continue weekly CPP sessions. Next session scheduled for xx/xx/xx. **Legible Signature and Credentials:** **Printed or Stamped Name:**
Treatment Goal: 1 **Treatment Objective:** 1A and 1B				

Name/Organization/Logo

TREATMENT PLAN REVIEW

Client Name:	Date:	Start Time:	End Time:	Setting:
Katie	Follow Medicaid Guidelines for due date	10:00 am	10:30	Office

Progress or Lack of Progress Is noted in Relation to the Following Treatment Plan Goals

Problem #1/ Goal #1

(Please elaborate on progress or lack of progress related to each Objective related to the Problem and Goal):

Goal# 1: Katie will become comfortable being separated from her Aunt Mary and will learn to regulate her physical and emotional responses as it relates to being separated.

Objective#1A: Daily, Aunt Mary will express to Katie language that promotes trust and security. Concurrently, Aunt Mary's behavior will be consistent with this language (e.g. returning when she says she will, etc).

Objective#1B: Aunt Mary and Katie will attend weekly Child Parent Psychotherapy, which will help promote a safe and trusting relationship with healthy boundaries.

Progress toward Goal #1:

Aunt Mary has expressed (and has been observed) utilizing language that promotes safety and trust in her relationship with Katie. Aunt Mary has noticed small improvement in Katie's ability to be separated for just a few moments. Aunt Katie and Katie have been consistently attending weekly CPP sessions.

☐ **No Progress** ☒ **Some Progress** ☐ **Goal Completed**

Interventions / Modality *(Services that will be provided to achieve the goal)*

Modality	Amount (Hr / Min.)	Frequency (Weekly / Monthly)	For duration of	Responsible Party
Individual/Family Counseling	1.0 hr	2 x per week	3 months	Therapist/Family
Case Management Services	as needed			
LFA	.50 Hr.	3 x per year	Annually	Therapist

Check one or both: ☐ **DSM: 5** ☒ **DC: 0-3R**

MULTIAXIAL DIAGNOSIS	DC: 0-3R & ICD-9-CM
Axis I	221 Separation Anxiety Disorder 100 Posttraumatic Stress Disorder, in partial remission
Axis II	PIRGAS: 75
Axis III	None Reported
Axis IV	Recent divorce of caregiver; child in relative care; developmental disability of other child in home; history of sexual abuse; history of parental substance abuse; history of DCF involvement
Axis V	See chart below.

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation		X					
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**	X						
Complex Gestures and Problem Solving	X						
Use of Symbols to Express Thoughts/Feelings			X				
Connecting Symbols Logically/Abstract Thinking							X

For each of the capacities listed above, the clinician may report the child as:

1. Functioning at an age appropriate level under all conditions and with a full range of affect.
2. Functioning at an age appropriate level, but is vulnerable to stress or with a constricted range of affect or both.
3. Functioning immaturely (i.e., has the capacity, but not an age appropriate level).
4. Functioning inconsistently or intermittently unless special structure or sensory-motor support is available.
5. Barely evidences this capacity, even with support.
6. Having not achieved this capacity yet.

**The clinician should use a rating of "not applicable" when the child is below the age at which he would typically be expected to have the capacity in question.*

Individualized Discharge Plan

In order for Katie to successfully complete treatment, the goals of each problem should be met or partially met as observed by primary caregiver and therapist. Katie will also be able demonstrate ability be separated for brief periods of time (minimally) from her Aunt Mary. Katie will demonstrate the ability regulate her physical and emotional responses to being separated. Aunt Mary will express perception of change or improvement in Katie's behavior and her ability to respond appropriately.

Progress

Katie has made slight progress in her ability to be separated from Aunt Mary. Katie's ability to soothe herself and maintain control of her emotions and body for even brief moments is a hopeful sign. Aunt Mary seems very invested in helping Katie overcome her challenges in this area. Aunt Mary has gained and is utilizing appropriately her knowledge of age words/phrases that will help to promote feelings of trust and safety for Katie. Aunt Mary seems to be more hopeful than when treatment began.

Recommendations

A continuation of dyadic therapy is recommended to further promote a safe and trusting relationship, thus lessening Katie's anxiety when separated from her aunt.

Client Satisfaction Survey Completed ☒ **Yes** ☐ **No**

Treatment Plan Signatures

Treatment Team Members are in agreement with this treatment plan:

_____ _____
IMH Clinician Date

_____ _____
IMH Clinician's Supervisor Date

The services listed above are medically necessary and appropriate to the recipient's diagnosis and treatment needs.

_____ _____
Treatment Team Member / Type 07 Date

I have participated in the development of this treatment plan and I agree to be an active participant in my child's treatment:

_____ _____
Parent / Guardian (if no signature, write explanation on signature line) Date

_____ _____
Parent / Caretaker (if no signature, write explanation on signature line) Date

The child's age of 9 months precludes participation in the development & signing of this treatment plan.

_____ _____
Client (if no signature, write explanation on signature line) Date

I _____ **have invited the following to participate in person, by phone, or in writing in the treatment planning process.**
Parent / Guardian

_____ _____
Other Treatment Team Member Date

Name/Organization/Logo

EARLY CHILDHOOD MENTAL HEALTH DISCHARGE PLAN

Client Name: Katie

Date Services Began:

DOB:

Date of Discharge:

Reason for Discharge

☒ **Goals met/Partially met**

☐ **Not able to engage child/family**

☐ **Child/family unable to continue services at this time**

☐ **Transfer to outside therapist/organization**

☐ **Child/Family moved**

☐ **Other: (explain)**

DSM/DC: 0-3R Diagnosis at Discharge

Axis I: Separation Anxiety (Resolving)

Axis II: PIR-GAS-82

Axis III: None reported

Axis IV: Recent divorce of caregiver; child in relative care; developmental disability of other child in home; History of sexual abuse; history of parental substance abuse; history of DCF involvement

Axis V: See chart below

Capacities for Emotional Social Functioning Rating Scale							
Emotional and Social Functioning Capacities	**Functioning Rating**						
	1.	**2.**	**3.**	**4.**	**5.**	**6.**	**n/a**
Attention and Regulation		X					
Forming Relationships/Mutual Engagement		X					
***Intentional Two-Way Communication**		X					
Complex Gestures and Problem Solving		X					
Use of Symbols to Express Thoughts/Feelings			X				
Connecting Symbols Logically/Abstract Thinking							X

Aftercare

Services/activities to continue following discharge: In the near future, Aunt Katie should consider a pre-school placement for Katie. As Katie gets closer to Kindergarten age, it will be of critical importance for her develop healthy social interactions with peers and adults outside of her immediate family unit. This will assist in further developing her confidence when she is away from those who love and care for her.

Recommendations made by therapist at time of discharge: Aunt Mary should continue to be cognizant of Katie's early experiences (prior to her placement) and how they have impacted Katie's brain development and her social/emotional development. Ongoing use of language that promotes trust/security will be important. It is also suggested that the caregivers continue to work on listening to, naming and identifying Katie's feelings in order to help Katie understand and verbalize how she may be feeling.

Referrals made: No referrals made at time of discharge

Critical Incident Planning

Is a safety plan needed? ☐ **Yes** ☒ **No**

Is a crisis plan needed? ☐ **Yes** ☒ **No**

Satisfaction Survey Completed By Parent/Caregiver?

☒ **Yes** ☐ **No** **If no please explain:**

_____ _____
Parent/Caregiver Signature Date

_____ _____
Therapist Signature Date

QUALITY REVIEW PROTECTORS: ENSURING SMOOTH AUDITS AND REDUCING RISK

As stated in the Community Behavioral Health Services and Limitations Handbook, AHCA expects a high level of compliance and quality of care. The language reads:

> "Provider's compliance with service eligibility determination procedures, service authorization policy, staffing requirements, and service documentation requirements can be reviewed periodically by AHCA or its designee. Providers that violate these requirements are subject to recoupments, fines, or termination in accordance with section 409.9113, F.S."

It is AHCA's intention that agencies and individual providers have the necessary infrastructure, training, and skill set to perform all functions of service delivery at an optimal level and in accordance with AHCA requirements. It is to the benefit of all involved, especially the children and families we serve, to provide high quality services that are not subject to termination. Agencies have put strategies and protocols into place that increase the likelihood of successful reviews and reduce the risk of recoupment for services rendered deemed not in compliance. Some of these protocols are listed below.

Continuous Quality Improvement (CQI)

Nationally accredited agencies are required to have a strong internal CQI process. This internal process is designed to ensure agencies are delivering high quality services that are continually evaluated and improved upon based on new learning, feedback from clients, and guidance from national, state, and local experts. It is a flexible process, able to adapt to the ever-changing political and economic climate. Some agencies have incorporated the Results-Based Accountability™ (RBA)[21] model. It is a disciplined way of thinking and taking action that can be used to improve quality of life in communities, cities, counties, states, and nations, as well as to improve the performance of programs. RBA is a simple, plain language approach to measurement that puts the focus on the ends and works backward to the means. Regardless of the model or method of CQI, those agencies with the strongest and most accountable process, fare better in quality reviews.

Reflective Supervision

Reflective supervision is the regular collaborative reflection between a service provider (clinical or other) and supervisor that builds on the supervisee's use of her thoughts, feelings, and values within a service encounter. Supervisor and supervisee meet regularly (for example, for an hour weekly or monthly) to discuss difficult cases. The case and direction of discussion are chosen by the supervisee, who is guided by the supervisor to examine her feelings or thoughts about the case and use this awareness to better serve the client. The relationship between supervisor and supervisee in reflective supervision models the desired relationships between provider and client in a therapeutic/helping relationship. In particular, the relationship is based on collaboration, choice, trust, and control. This style of supervision can have a direct impact on the well-being of the therapist and the quality of services provided.

Peer Case Presentation/Peer Chart Reviews

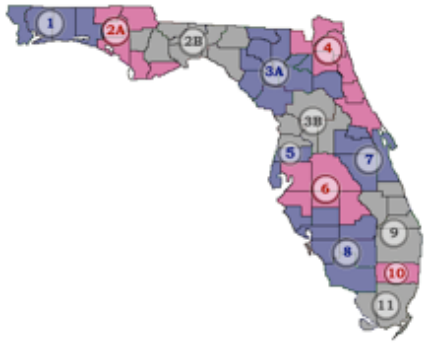
Learn and support: Group or peer case presentation and chart reviews are an excellent way for IMH clinicians to learn and support each other in their work. Each month a clinician shares a current case and discusses diagnosis, goals, objectives, and progress or lack of with one or more clinicians to gain greater insight/feedback on the case. This is done in the context of a reflective and supportive manner, so that all feel secure in discussing their work with their children and families. Ideas and suggestions can be made that can further the work and build on the progress.

Ensure ongoing CQI: Peer chart reviews are also an excellent way to ensure continuous quality improvement and high standards of care, assessing not just the necessary requirements in the chart, but the quality of the work being done. Peer case presentation and chart reviews support clinicians in their work, helping them to not feel so isolated. Clinicians involved in reflective practice and peer case presentation report a higher level of satisfaction in their job, higher job retention, and excitement in their work.

Frequent In-House Medicaid Training and AHCA Training and Guidance

Training: There are numerous requirements to remember when providing behavioral health services and these can change frequently in the Medicaid program. Agencies that provide internal training to their staff on Medicaid reimbursement requirements on a quarterly or semi-annual basis have an improved chance of performing better in quality reviews. The more the information is heard, the better the chances it will be retained and used. This will be reflected in the quality of the work and the way in which it is documented.

Additional training and other assistance are available from AHCA through their regional offices. It is better to get guidance directly from AHCA than to guess incorrectly.



AHCA Regions

RECOMMENDED NEXT STEPS FOR IMH CLINICIANS AND LEADERSHIP

- Read this Manual thoroughly and develop a list of questions on information that is not clear to you.
- Read the Medicaid Community Behavioral Health Handbook for further clarification.
- Know your local Medicaid contacts[22]
- Sign up for updates from AHCA[23] regarding policy/procedure/handbook changes.
- Use a checklist for every client record to ensure all requirements are met.
- Create or join an IMH clinician group in your area and discuss the questions. Brainstorm solutions or ideas for how you might implement strategies/protocols in your area.
- Conduct and attend training about Medicaid reimbursement issues on a regular basis.
- Create a Reflective Supervision process in your agency. Or if you are an individual provider, seek out agencies in your area that provide I-ECMH services and ask if you can join their Reflective Practice group.
- Join the Florida Association for Infant Mental Health (FAIMH).[24] Also, join your local FAIMH chapter. If one does not exist, start one.
- Become involved in local planning groups that do/could infuse I-ECMH principles into their practice. Be a part of the solution.
- While implementing all aspects of Medicaid services and requirements, keep a list of barriers. Report those barriers to your AHCA area office and ask for assistance. Also report barriers and successes to the FAIMH so they can address the barriers with AHCA and spread the word of successes.

Who is my local Medicaid contact?

SUMMARY

Florida has made significant progress since 2000 in recognizing and addressing the mental health needs of infants, toddlers, and young children and their families. The partnership among AHCA, FAIMH and the FSU Center has been a driving force in charting and staying the course in spite of many hurdles. It is hoped this *IMH Clinician's Best Practices Guide* takes us a step further in assisting I-ECMH clinicians with Medicaid documentation so we expand Level 3 capacity in diagnosing and treating young children in our state, further realizing the goals set forth in the *Florida IMH Strategic Plan.*[25]

It is acknowledged that we have "miles to go before we sleep," but each new step creates infinite possibilities for our most vulnerable citizens and their families. You are encouraged to "go forth and do."

Finally, please know you are strongly supported in the difficult work you do to improve and enrich the lives of young children and families in Florida. This work is not easy. It is a work in process and will evolve as children, families, communities, and society evolves. We must all remain committed to continue this journey together so that our young ones can thrive.

Florida's Revised Crosswalk for DC: 0-3R
June, 2010

Background:
Florida Medicaid (Agency for Health Care Administration, AHCA) was one of the first Medicaid programs in the country to recognize the unique differences when assessing and diagnosing the mental health of young children birth through age five. Through the work of a cross-discipline, cross-agency task force including families and providers, Medicaid policy was introduced in July 2000 to specifically address the unique needs of children in this age range in the revised Community Behavioral Health Services Coverage and Limitations Handbook, Section 5 Services for Children Ages 0 through 5 Years. Service requirements are listed below:

> ***Service Requirements***
> **Introduction** Services for children ages 0 through 5 years are subject to additional policy requirements outlined in this section.
>
> Medicaid does not pay for community behavioral health services for treatment of autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation. In order to receive community behavioral health services the infant or child age 0 through 5 years must:
> 1. Have an ICD-9-CM diagnosis in the following range: 290 through 298.9, 300 through 301.9, 302.7, 303 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9. Diagnosis codes are found in the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM).
> 2. Be exhibiting symptoms of an emotional or behavioral nature that are atypical for the child's age and development.
> **For children 0 through 3 years of age, Medicaid encourages use of the *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0–3)* for assistance in determining the infant or child's ICD-9-CM diagnosis.**

In addition, AHCA expanded individual therapy services to include "individual/family therapy;" allowing inclusion of parent/child psychotherapy and dyadic work, as well as therapy with the parents alone without the identified child present. This was a monumental change that gave clinicians the ability to treat infants and very young children in the context of the critical parent/child relationship and be reimbursed for services.

While these very important changes in Medicaid policy were applauded and embraced by all early childhood interventionists, a dilemma still existed in that, unlike the DSM-IV, the DC:0-3 did not automatically crosswalk to the ICD-9-CM codes, thereby making it impossible to bill for assessment and treatment services. Thus, the concept of a "crosswalk" emerged and was supported by the state children's Medicaid and Mental Health directors. Each DC:0-3 diagnosis was carefully reviewed and "crosswalked" to an

ICD-9-CM code that most clinically matched the description of the diagnosis. The Florida DC:0-3 Crosswalk was completed in November, 2001 and reviewed by Dr. Robert Harmon, then a Board member of Zero To Three, a Professor of Psychiatry and Pediatrics and Director of the Irving Harris Program in Child Development and Infant Mental Health in Colorado. Dr. Harmon found the crosswalk to be as "clinically sound" as possible, given the difficulty in aligning some of the DC:0-3 diagnoses with either the DSM-IV or the ICD-9-CM, particularly the category of Regulatory Disorders. The crosswalk was then submitted to Florida Medicaid and the Department of Children and Families, Substance Abuse Mental Health Services Unit where it was endorsed and disseminated statewide. The crosswalk was revised in 2006 following the publication of the *Diagnostic Early Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (DC:0-3R) in 2005.

Current Revision:

Since the creation of the first DC:0-3 crosswalk, a number of other states have created crosswalks to either the DSM-IV-TR or the ICD-9-CM or both classification systems. Some states have moved beyond Florida in funding Early Childhood Mental Health Systems of Care that includes promotion, prevention, and intervention services. Recognition of the importance of intervening early in a child's life has also occurred at the federal level within the Substance Abuse Mental Health Services Administration (SAMHSA). The Comprehensive Community Mental Health Services for Children and Their Families Program has provided grants and cooperative agreements to States, communities, territories, Indian tribes, and tribal organizations to improve and expand their systems of care to meet the needs of children with serious emotional disturbances and their families. The grant program has funded a total of 121 grantees across the country and there are currently 57 active system of care communities. Historically, these cooperative agreements have funded systems of care for older children and adolescents, many for those with co-morbid diagnoses. Prior to 2005 only 2 states received Cooperative Agreements for children under the age of five; Vermont and Colorado. In 2005, SAMHSA made early childhood (children birth to age five) a priority when issuing the RFA and recommended the use of the DC:0-3 for diagnosing children birth through three years of age. Twenty-five Cooperative Agreements were awarded in 2005, with 6 focused on early childhood. Since then SAMHSA has continued to expand services to the early childhood population with now 13 Early Childhood System of Care Communities active around the country, all of which serve children birth through three years of age. The Early Childhood Communities of Practice, with Technical Assistance from SAMHSA and Georgetown University, have formed a cohesive body to collectively examine the challenges and opportunities of implementing a systems of care approach for young children within their communities. Through the work of the Diagnosis and Eligibility Work Group, the Child and Adolescent Branch of SAMHSA adopted recommendations to include not only those infants and young children with a mental health diagnosis, but also those at "imminent risk" of developing a mental health or serious emotional disorder as a component of the eligibility criteria for enrollment into systems of care. This is a huge advancement in recognizing the importance of early childhood mental health prevention and intervention services and supports and creating policy change that will have long-lasting effects.

The 2005 Early Childhood awarded sites are nearing the end of their 5th year of the 6- year Agreement and sustainability of services and supports becomes ever more critical. Likewise for the newly funded early childhood sites, mechanisms to increase funding and create feasible sustainability plans is crucial; especially given the economic climate, reduction in state funds, and Medicaid reform.

With this in mind, Florida's crosswalk is now revised to reflect the integration of the most commonly used/recommended DSM-IV-TR and ICD-9-CM codes that are "crosswalked" from the DC:0-3R diagnostic codes. Crosswalks from ten states were reviewed and consolidated into Florida's revised crosswalk. The ten states are: Florida, California (San Mateo), Maine, Oklahoma, Kentucky (Keys), Michigan, Washington, Indiana, Arizona, and Illinois. It is recommended that if giving a DC:0-3R diagnostic code as Primary on Axis I, that it be directly "crosswalked" to the ICD-9-CM code since that is the coding system Medicaid recognizes.

It is recognized that a crosswalk is merely a mechanism for translating diagnoses into "Medicaid language" so that payment for services rendered can be received. It is also recognized that every state varies in what services and ICD-9-CM codes it will cover within the context of a community mental health services program, so it is important to verify each states specific rules. However, it has been found that at least ten states have a great deal of consistency in the Axis I ICD-9-CM diagnostic codes they are using, with the exception of the diagnostic category 400: Regulation Disorders of Sensory Processing.

There are two hopes in revising Florida's Crosswalk: 1) that it serves as a guide in providing greater consistency in the diagnostic codes we are using to diagnose very young children; and 2) that it makes it easier for other states and early childhood system of care communities to move forward on providing needed clinical services to infants and very young children without having to "re-create the wheel" with Medicaid.

Contact Information:
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Florida's Crosswalk for DC:0-3 R, DSM-IV-TR and ICD-9-CM
Revised June 2010

Axis 1: Clinical Disorders						
DC:0-3 R			**DSM -IV-TR**		**ICD-9-CM**	
100: Posttraumatic Stress Disorder						
100	Posttraumatic Stress Disorder	309.81	Posttraumatic stress disorder		308 308.0 308.2 308.3 308.9 309.81	Acute reaction to stress ** Predominant disturbance of emotions Predominant psychomotor disturbance Other acute reactions to stress Unspecified acute reaction to stress Prolonged posttraumatic stress disorder
150	Deprivation/Maltreatment Disorder	313.89	Reactive Attachment Disorder of Infancy or Early Childhood		313.89 313.90	Other or mixed emotional disturbances of childhood or adolescence, Other (Reactive Attachment Disorder) Unspecified emotional disturbance of childhood or adolescence.
200: Disorders of Affect						
210	Prolonged Bereavement/Grief reaction	V62.82	Bereavement		309.1	Prolonged depressive reaction
220: Anxiety Disorders of Infancy and Early Childhood						
221	Separation Anxiety	309.21	Separation Anxiety Disorder, early onset		309.21	Separation anxiety disorder
222	Specific Phobia	300.29	Specific Phobia		300.29	Other isolated or specific phobias
223	Social Anxiety Disorder (Social Phobia)	300.23	Social Phobia		300.23	Social Phobia
224	Generalized Anxiety Disorder	300.02	Generalize Anxiety Disorder		300.02	Generalized, Anxiety Disorder
225	Anxiety Disorder NOS	300.00	Anxiety Disorder NOS		300.0	Anxiety state, unspecified **
230: Depression of Infancy and Early Childhood						
231	Type I: Major Depression	296.2x 296.3x	Major Depressive Disorder, Single Episode (fifth digit must be inserted) •296.20 Unspecified •296.21 Mild •296.22 Moderate •296.23 Severe w/o psychotic features •296.25 In partial remission •296.26 In full remission Major Depressive Disorder, Recurrent Episode (fifth digit must be inserted): •296.30 Unspecified •296.31 Mild •296.32 Moderate •296.33 Severe w/o psychotic features		296.20 296.3	Major Depressive Disorder single episode Major Depressive Disorder, recurrent episode
			•296.35 In partial remission •296.36 In full remission			

DC:0-3 R		DSM -IV-TR		ICD-9-CM	
232	Type II: Depressive Disorder NOS	311	Depressive Disorder NOS	311 313.1	Depressive Disorder, NOS Misery and Unhappiness Disorder
240	Mixed Disorder of Emotional Expressiveness	296.90	Mood Disorder NOS	313.8 313.9	Other or mixed emotional disturbances of childhood or adolescence** Unspecified emotional disturbance of childhood or adolescence
300	Adjustment Disorder	309.0 309.24 309.28 309.3 309.4 309.9	Adjustment disorder with Depressed Mood Adjustment disorder with Anxiety Adjustment disorder with Mixed Anxiety and Depressed mood Adjustment disorder with Disturbance of Conduct Adjustment disorder with Mixed Disturbance of Emotions and Conduct Adjustment disorder Unspecified	309.0 309.2 309.3 309.4 309.8 309.9	Adjustment disorder w/depressed mood With predominant disturbance of other emotions (range from 309.21-309.29) Adjustment disorder w/disturbance of conduct Adjustment disorder w/mixed disturbance of emotions and conduct Other specified adjustment reactions (range from 309.81-309.89) Unspecified adjustment reaction
400: Regulation Disorders of Sensory Processing					
410: Hypersensitive					
411	Type A Fearful/Cautious	313.9 300.00 300.2	Disorder of Infancy, Childhood or Anxiety Disorder NOS General Anxiety Disorder	300.02 313.00 313.21 313.22 313.9	Generalized Anxiety Disorder Overanxious Disorder Sensitivity/shyness disorder of childhood Introverted disorder of childhood Unspecified emotional disturbance of childhood or adolescence
412	Type B: Negative Defiant	313.9 313.81 312.9	Disorder of Infancy, Childhood or Adolescence NOS Oppositional Defiant Disorder Disruptive Behavior Disorder NOS	313.81 313.9	Oppositional Defiant Disorder Unspecified emotional disturbance of childhood adolescence.
420	Hyposensitive/Under-responsive	313.9	Disorder of Infancy, Childhood or Adolescence NOS	313.20 313.9	Sensitivity, shyness, and social withdrawal disorder Unspecified emotional disturbance of childhood adolescence.
430	Sensory Stimulation-Seeking/Impulsive	313.9 314.01	Disorder of Infancy, Childhood or Adolescence NOS Attention-Deficit/Hyperactivity Disorder, Combined Type or Predominantly	312.3 314	Impulse control disorder, unspecified ** Hyperkinetic syndrome of Impulsive childhood (range from 314.0-314.9)
		312.30	Impulse-Control Disorder NOS	313.9	Unspecified emotional disturbance of childhood adolescence.

DC:0-3 R		DSM -IV-TR		ICD-9-CM	
		314.9	Attention-Deficit/Hyperactivity Disorder NOS		
		312.9	Disruptive Behavior Disorder NOS		
500:Sleep Onset Behavior Disorders					
510	Sleep-Onset Disorder (Protodyssomnia)	307.42	Primary insomnia [*Indicate Axis I or Axis II disorder]* Insomnia related to:	307.41	Transient disorder of initiating or maintaining sleep
		307.45	Circadian Rhythm Sleep Disorder	307.42	Persistent disorder of initiating or maintain sleep
				307.40	Non-organic sleep disorder unspecified
				307.45	Circadian Rhythm sleep disorder of non-organic origin
520	Night-Walking Disorder (Protodyssomnia	307.46	Sleep Terror Disorder	307.41	Transient disorder of initiating or maintaining sleep
		307.47	Dyssomnia NOS, Nightmare disorder, or Parasomnia NOS	307.42	Persistent disorder of initiating or maintain sleep
		307.45	Circadian Rhythm Sleep Disorder	307.45	Circadian Rhythm sleep disorder of non-
				307.46	Sleep arousal disorder
				307.47	Other dysfunction of sleep stages or arousal from sleep
600 Feeding Behavior Disorders					
601	Feeding Disorder of State Regulation	307.59	Feeding Disorder of Infancy or Early Childhood	307.5	Other and unspecified disorders of eating
602	Feeding Disorder of Caregiver - Infant Reciprocity	307.50	Eating Disorder Unspecified	307.50	Eating disorder, unspecified
603	Infantile Anorexia			307.59	Other (feeding disorder of infancy or early childhood of non-organic origin)
604	Sensory Food Aversions				
605	Feeding Disorder Associated with Concurrent Medical Condition				
606	Feeding Disorder Associated with Insults to the Gastrointestinal Tract				

DC:0-3 R		DSM -IV-TR		ICD-9-CM	
700 Disorders of Relating and Communicating					
710	Multisystem Developmental Disorder (MSDD) for children under the age of two years; Pervasive Developmental Disorders can be utilized for children over the age of two if identified.	299.00	Autistic Disorder	299	Pervasive developmental disorders (range from 299.0-299.9) ***
		299.80	Pervasive Developmental Disorder NOS	315.9	Developmental Disorder ***
		313.9	Disorder of Infancy, Childhood or Adolescence NOS		

**** This crosswalk should be used in combination with the actual ICD-9-CM manual. Some diagnoses indicated above require a 4th or 5th digit for billing purposes. Where a range of diagnoses is indicated, the clinician may select the diagnosis that most appropriately fits the presenting symptoms. This crosswalk has been accepted by AHCA (FL Medicaid) and DCF/SAMH Office.**

*****Florida Medicaid does not pay for community mental health services for treatment of Autism, pervasive developmental delay, non-emotional or non-behavioral based developmental disability, or mental retardation.**

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