MIDD Briefing Paper

BP 40 Prevention of Serious Mental Health Problems in Young Children

Existing MIDD Program/Strategy Review ☐ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept x (Attach New Concept Form)

SUMMARY: This new concept would implement Infant Mental Health training for the mental health practitioner workforce. It would increase the number of community mental health professionals able to accurately assess, diagnose, and provide evidence based mental health treatment services to infants, young children and families. The training would increase clinicians' ability to assess severity of problems, respond to serious mental health needs as soon as they occur, and reduce or prevent serious and ongoing mental health problems as children age. Training component examples include: very early child development; screening, assessing, and diagnosing very young children; supporting resiliency in parents and caregivers; providing trauma informed intervention; providing culturally responsive treatment; maternal depression, recognition of trauma, grief and loss in young children; and, Child-Parent Psychotherapy, an evidence based model of dyadic therapy for children under the age of six who have been exposed to trauma.

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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?

This new concept would implement Infant Mental Health training for the mental health practitioner workforce. It would increase the number of community mental health professionals able to accurately assess, diagnose, and provide evidence based mental health treatment services to infants, young children and families. The training would increase clinicians' ability to assess severity of problems, respond to serious mental health needs as soon as they occur, and reduce or prevent serious and ongoing mental health problems as children age. Training component examples include: very early child development; screening, assessing, and diagnosing very young children; supporting resiliency in parents and caregivers; providing trauma informed intervention; providing culturally responsive treatment; maternal depression, recognition of trauma, grief and loss in young children; and, Child-Parent Psychotherapy, an evidence based model of dyadic therapy for children under the age of six who have been exposed to trauma.

The new concept proposes two components of Infant Mental Health workforce training. The first would provide training on diagnostics and assessment, including training on the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3R], the manual guiding diagnosis and treatment for infants and young children, in order to increase the number of clinicians who are able to use the tool. Component one includes three days of training followed by consultation calls over a one year period. It would train forty clinicians and ten supervisors/consultants who could become proficient to train others, incorporating a train the trainer model to maximize the training's impact.

The field of Infant and Early Childhood Mental Health [IECMH][1] is an area of mental health service specialization and an emerging practice area in Washington State's community mental health system,[2] and the current Washington State Revised Code of Washington 71.24.055[3] references 'assessment and diagnosis for children under five years of age shall be determined using a nationally accepted assessment tool designed specifically for children of that age…' The DC: 0-3R, the referenced tool, is not taught in graduate schools for those pursuing professional mental health clinical careers. This new concept would take steps to correct this inadequacy in workforce preparation and readiness, thereby increasing service availability.

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[1] Barnard Center for Infant Mental Health & Development, University of Washington, School of Nursing

[2] One indication was the explicit reference to the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] in the initial Access to Care Standards published by the Washington State Mental Health Division November 25, 2003.[2] It establishes the eligibility for Medicaid funded services provided by the community mental health system. Page 13 states, "*CGAS is generally not considered valid for children under the age of six. The DC03 may be substituted…. Very young children in need of mental health care may not readily fit diagnostic criteria [of DSM-IV]. The degree of functional impairment related to the symptoms of an emotional disorder or mental illness should determine eligibility…*" Further detail follows.

[3] http://apps.leg.wa.gov/RCW/default.aspx?cite=71.24.055

Secondly, the new concept proposes to train clinicians in Child Parent Psychotherapy, an evidence based model of dyadic therapy for children under the age of six who have been exposed to trauma. This second component of workforce training would involve seven days of training spread over a fifteen month period with small group consultation calls in between training days. The training would accommodate approximately 50 clinicians.

The two training components would support mental health clinicians to meet requirements of 'Endorsement' as an Infant Mental Health Specialist and/or an Infant Mental Health Mentor. 'Endorsement' is a copyrighted concept[4] brought to Washington State by the Washington Association of Infant Mental Health [WA-AIMH].[5] Infant Mental Health Endorsement is a formal credentialing system that validates competence, overlaying and not replacing licensure or certification. It verifies the expertise of professionals and organizes a set of standardized competencies that must be met to ensure families receive high-quality, culturally-sensitive, relationship-focused therapeutic and evidence based services that promote infant and early childhood mental health.[6] Additional fees are required for practitioners wishing to become endorsed beyond training, practice, and supervision requirements. The new concept includes a third component proposal to support the necessary consultation with WA-AIMH and fees for endorsement that clinicians will need.

Infant Early Childhood Mental Health [IECMH] focuses on the social and emotional development of children during their first five years of life. During the first five years, children develop a fundamental sense of themselves and their worlds. As they learn to experience, express and regulate emotions, form close relationships, and explore and learn from the environment, we say they are thriving according to the principles of infant and early childhood mental health. Infants and children seen by the Washington State community mental health system are those who are not thriving developmentally and are in need of mental health services.

This relates to MIDD I Strategy 4a, prevention services to children of substance abusers, and MIDD II Strategy Areas, Prevention and Early Intervention, and System Improvements.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

[4] Initially developed in Michigan [MI] and currently implemented in eighteen states with the addition of Washington State. Information presented at the WA-AIMH Endorsement Launch event, February 6, 2015.

[5] Washington Association of Infant Mental Health, Endorsement process, http://www.wa-aimh.org/endorsement/

[6] Background on IMH Endorsement: In the 1983, the Michigan [MI] Department of Mental Health funded infant mental health services through community mental health agencies where staff training was integral to program design. In 1986, the Michigan Association of Infant Mental Health [MI-AIMH] approved and published a two-page document, *Training Guidelines,* summarizing guidelines for IMH training and supervision, inspired by Selma Fraiberg's work in the 1970's and implementation of IMH home visiting services in MI. In 1990, ZERO TO THREE published *Task Documents* for the infant and family field, encouraging knowledge, skills, collegial and supervisory support. By 1997, MI-AIMH members completed core competency areas for IMH professionals. In 2000, MI-AIMH completed a systematic plan for professional workforce development calling the plan an endorsement *The MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health*.

Prevention and Early Intervention: increase access to person centered, culturally appropriate treatment, education and training services by individuals and families and reduce risk factors for substance use and mental health disorders, for both parents/caregivers and infants/young children.
System Improvements: expand provider workforce capacity; increase availability of specialized behavioral health services at optimal time of learning and structural brain development; improve quality of care; improve care coordination; use collaborative recovery/strengths based system of care approach; increase use of evidence based practices and specialized assessment tools.
Crisis Diversion: decrease harm to infant/young child and parenting relationship for those in crisis or at risk for crisis; increase system coordination among those serving infant and family.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

1. Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.

Infants and children receiving community mental health system services are those who are not thriving developmentally. Children, ages birth to three, are the most vulnerable group of children in our state. Over one third live in poverty, more than any other age group. They are the most likely age group to suffer abuse and neglect and/or be in foster care. Diagnosing and treating mental health issues for this population requires specialized training.

Based on 2013 population estimates, there are over 125,000 children under five years of age in King County. Over 40,000, one in three, are low income, which puts them at a higher risk for Adverse Childhood Experiences [ACEs].[7] Approximately 25,000 new babies are born in King County every year. Approximately 28 percent of all babies born yearly in Washington State are born in King County. Of those births, approximately 8,500, one in three, are Medicaid funded births each year. While there is an estimated 10 percent occurrence of Postpartum Mood Disorders [PPMD] in the general population, screening of Washington State's First Steps participants (Medicaid) found up to 40 percent of that population screened positive for PPMD. It is estimated between 9.5 percent and 14.2 percent of children age birth to five experience emotional or behavioral disturbance.[8]

Using 2013 population estimates of those ages birth to four in King County cited above and a conservative estimate of 11 percent of those living in low income households (<200% of federal poverty level guidelines), it is possible to conservatively estimate the number of children needing services in a single year. These estimates don't include those age five.

Eleven percent of the 40,000 infants and young children living in poverty is 4400 children. King County's Behavioral Health and Recovery Division [formerly Mental Health Chemical Abuse and Dependency Division] served 1,090 children less than six years old in 2013, 1,101 in 2014, and 980 in 2015 (through September 2015).

[7] http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/LocalHealthResourcesandTools/MaternalandChildHealthBlockGrant/AdverseChildhoodExperiences
[8] Public Health Reports 121, 2006, 303-310; and Zero to Three, Making It Happen, 2012.

Healthy Options/Washington Apple Health provides Medicaid funded mental health services through four Managed Care Organizations. Molina, Amerigroup and Coordinated Care report a total of 1,739 King County children under age five receiving services since January 2013. United Health Care only had 2014 numbers and reported seven children receiving care that year.[9]

In 2013 the State Policy Advocacy and Reform Center [SPARC] authored a study on *Medicaid and Children in Foster Care*.[10] Despite nearly 90 percent of young children entering foster care with physical health problems, 55 percent having two or more chronic conditions, and almost 25 percent having three or more chronic conditions, and 35 percent having significant dental and oral problems, chief among their health-related needs are behavioral health needs. In 2012 Washington State ranked fourth for the most children under one year entering foster care. Nationwide, infants are almost always the most represented age group.[11]

The King County RSN has been able to meet approximately 25- 30 percent of the conservatively established need, based on 2013 poverty rates and correlative ACEs and Child Welfare studies. Adding in Apple Health data at best reaches fifty percent of the need periodically. In addition to a lack of sufficient service availability for this population, there is also currently geographic disproportionality in the location of services.

Children under six served 10/1/14 through 9/30/15 by region of last reported zip code:

Region	# of Kids	Percent of all
North	62	6%
Seattle	255	26%
South	533	54%
East	100	10%
Unknown	4	0%
Out of county	25	3%
All under six	**979**	**100%**

Of the current fourteen contracted agencies providing mental health services to youth and families, over 50 percent of the Infant and Early Childhood services are handled by one agency. The next highest serves 18 percent of the total served, and the third highest serves less than 10 percent. There is a need not only to increase the number of clinicians able to serve the infant and early childhood and family population, but also to improve system capacity geographically throughout the county.

The data presented above estimates yearly need for new mental health outpatient benefits. In order to further understand capacity needs, it is important to combine the above information with average length of stay in care data below from the current major provider of IECMH services in King County's community mental health system.

Service Year	Average length of time in service [in days]

[9] HCA, Managed Care Program Manager, 1/8/16.
[10] https://childwelfaresparc.files.wordpress.com/2013/03/medicaid-and-children-in-foster-care.pdf
[1111]Partners for Our Children, data portal: http://pocdata.org/visualizations/entry-rates

2013	565
2014	517
2015	424
Average across all three years = 502 days	

There is a current unmet need. Coupled with information about the effect of Adverse Childhood Experiences, not closing the gap of these unmet needs leads to a comparable replication seen in the education, juvenile and criminal justice systems, where the result of a lack of skill development, support and care for youth leads to truancy, dropouts, criminal behavior, homelessness, and untreated behavioral health needs. All of these experiences are markers of children not meeting earlier and current developmental challenges necessary for a healthy, successful, integrated life. A healthy foundation begins in infancy and early childhood.

Current infant and early childhood brain science research has helped us understand that the brain develops most rapidly during the first five years of life.[12] Every baby is born with a brain that contains hundreds of billions of neurons. From day one, those neurons connect, and the brain begins to get wired for life. The brain is wired to grow. In the first five years of life, the brain makes 700 neural connections every single second. Above anything else, the one thing that helps young brains grow strong and healthy is healthy adult-child relationships. The first five years are when the brain builds its foundation, so children can thrive as adolescents and adults. Learning doesn't start at school. It begins at birth. Studies with those less than three days old have replicated the responsive ability of a 10 hour old infant to imitate a caregiver's movement in a purposeful manner.[13] Infants are in relationship from the moment they are born, reflecting and learning from those caring for them.

The Adverse Childhood Experiences Study [ACE] is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being.[14] To date, more than fifty scientific articles have been published and more than one hundred conference and workshop presentations have been made.[15] The ACE study findings suggest that certain experiences are major risk factors for leading causes of illness and death as well as poor quality of life in the U.S., including childhood experiences of abuse, neglect, and family dysfunction (which include mental illness and/or substance abuse of a parent/caregiver, divorce and/or incarceration of a parent, domestic violence).

One of the best ways to bend the cost curve of health care and criminal justice costs is to provide mental health services as soon as indicated to infants, young children, and their parents/caregivers.

2. **Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.**

[12] VROOM, http://www.joinvroom.org
[13] Developmental Psychology, 1989 Nov: 25(6): 954-962, Meltzoff, Andrew N., Moore, M. Keith.
[14] The Adverse Childhood Experiences Study is a collaboration between the Centers for Disease Control and Prevention, and Kaiser Permanente's Health Appraisal Clinic in San Diego
[15] http://www.cdc.gov/violenceprevention/acestudy/

The new concept proposes two components to Infant Mental Health workforce training and a third, smaller amount of money to support clinicians applying for endorsement as an Infant Mental Health Specialist or Infant Mental Health Mentor. The first component is training on diagnostics and assessment, including training on the DC: 0-3R, the manual guiding diagnosis and treatment for infants and young children, in order to increase the number of clinicians who are able to use the tool. The new concept proposes to directly train clinicians as well as supervisor/consultants in a train the trainer model in order to maximize training effect. Currently this information and training is not integrated into bachelor's or advanced degrees in counseling, social work or psychology. Workforce training is the way to correct this preparation deficiency.

The DC: 0-3R is organized around three primary principles: 1) that children's psychological functioning unfolds in the context of relationships, 2) that individual differences in temperament and constitutional strengths and vulnerabilities play a major role in how children experience and process events, and, 3) that the family's cultural context is important for the understanding of the child's developmental course.[16] One differential aspect of IMH services is the multi-generational nature of the work and a prominent focus on cultural competence as an essential component of competent service provision. Mental health services for very young children always take place in the context of their primary relationships, so they are at least dyadic in nature.

The new concept proposes a second component to train clinicians in Child Parent Psychotherapy, an evidence-based model of dyadic therapy for children under the age of six who have been exposed to trauma.

Providing these two components of infant mental health workforce training to King County's clinicians has an additional multiplier effect. If the family member seeking mental health services is an older sibling who is helping to raise their younger siblings or a parent, increasing workforce competence in infant mental health concepts allows the potential for an increased service penetration for the infant and young children who are relatives of the person seeking services. It would increase the clinical and diagnostic skills of those working with parents and siblings stressed by family expectations of participation in parenting responsibilities, enabling clinicians to teach and support client skill development in this area.

Infants and young children who are at elevated risk for experiencing poverty, parental mental health disorders, household exposure to substance use, domestic violence, and maltreatment, increase their risk of poor mental and physical health outcomes as adolescents and adults.[17] Decades of research have shown that secure attachment in infancy and early childhood is a key developmental building block that predicts adjustment and promotes resilience in children who grow up under stressful circumstances. Because secure attachment develops from caregiver sensitivity and responsiveness, it is critical to address the infant/young child's needs in a relationship-based, skill development context with their caregivers. This is the work of Infant Mental Health specialists, and is consistent with the diagnostic manual and conceptual framework for infant and early childhood mental health services, the DC: 0-3R.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published

[16] Lieberman, A., Wieder, S. & Fenichel, E. (Eds.), (1997). DC: 0-3 Casebook. Zero to Three Publisher.
[17] A Primary Prevention Trial to Strengthen Child Attachment in a Native Community, Booth-LaForce, University of WA. http://depts.washington.edu/chdd/ucedd/cimhd_3/A_primary_3.htm

research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

There is already an unmet need as identified above. Coupled with information about the effect of Adverse Childhood Experiences, not closing the gap of these unmet needs leads to a comparable replication seen in the education, juvenile and criminal justice systems where the result of a lack of skill development, support and care for youth leads to truancy, dropouts, criminal behavior, homelessness, and untreated behavioral health needs. All of these experiences are markers of children not meeting the early and current developmental challenges necessary for a healthy, successful, integrated, and productive life. A healthy foundation begins in infancy and early childhood. Some parents and infants and young children need mental health therapeutic services to meet the gaps of information and challenges they face due to abuse, neglect, mental illness, substance abuse, domestic violence, poverty, etc.

Current infant and early childhood brain science research[18] has helped us understand the brain develops most rapidly during the first five years of life.[19] Every baby is born with a brain that contains hundreds of billions of neurons. From day one, those neurons connect and the brain begins to get wired for life. The brain is wired to grow. In the first five years of life, the brain makes 700 neural connections every single second. Above anything else, the one thing that helps young brains grow strong and healthy is healthy adult-child relationships. The first five years are when the brain builds its foundation, so kids can thrive as adults. Learning doesn't start at school. It begins at birth. Studies with those less than three days old have replicated the responsive ability of an infant to imitate a caregiver's movement in a purposeful manner.[20] Infants are in relationship from the moment they are born, reflecting and learning from those caring for them.

The Adverse Childhood Experiences Study [ACE] is one of the largest investigations ever conducted to assess associations between childhood maltreatment and later-life health and well-being.[21] To date, more than fifty scientific articles have been published and more than one hundred conference and workshop presentations have been made.[22] The ACE study findings suggest that certain experiences are major risk factors for leading causes of illness and death as well as poor quality of life in the U.S., including childhood experiences of abuse, neglect, and family dysfunction (which include mental illness and/or substance abuse of a parent, divorce and/or incarceration of a parent, domestic violence).

One of the best ways to bend the cost curve of health care and criminal justice costs is to provide mental health services as soon as indicated to infants, young children and their parents/caregivers. It is also not insignificant that most children entering foster care are infants with the majority being under five years of age.

[18] University of Washington, Institute For Learning and Brain Sciences, http://ilabs.washington.edu/
[19] VROOM, http://www.joinvroom.org
[20] Developmental Psychology, 1989 Nov: 25(6): 954-962, Meltzoff, Andrew N., Moore, M. Keith.
[21] The Adverse Childhood Experiences Study is a collaboration between the Centers for Disease Control and Prevention, and Kaiser Permanente's Health Appraisal Clinic in San Diego
[22] http://www.cdc.gov/violenceprevention/acestudy/

4. **Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.**

Child Parent Psychotherapy[23] is an evidence based practice recently highlighted at a keynote of the Zero to Three 30th National Training Institute, Dec 2-5, 2015. It was developed by Dr. Alicia Lieberman and her colleagues at the University of California, San Francisco Medical School.

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* [DC: 0-3R] is the assessment and diagnostic guide for IECMH practitioners as the DSM-5 is for mental health practitioners serving those six and above. In December 2016, an update to the DC: 0-3R, titled DC: 0-5, will be published and will close the age gap between the two guiding manuals.

The DC: 0-3R is based on the most current research available and is constructed by recognized researchers and leaders in the field, as is the comparable DSM-5 for those older than five.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

The county would see an increase in capacity to provide infant mental health services. This can be tracked via data submitted by behavioral health providers. Over time it would be possible to track related reductions in use of other types of services. As the county prepares to implement behavioral health integration and, in 2020, integration with physical health care, service referrals and usage data would be available to see the result of this investment. There will also be data on numbers of clinicians achieving levels of endorsement.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☒ **Children 0-5**
- ☐ **Children 6-12**
- ☒ **Teens 13-18**
- ☒ **Transition age youth 18-25**
- ☒ **Adults**
- ☐ **Older Adults**
- ☒ **Families**
- ☐ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☒ **Racial-Ethnic minority (any)**
- ☒ **Black/African-American**
- ☒ **Hispanic/Latino**
- ☒ **Asian/Pacific Islander**
- ☒ **First Nations/American Indian/Native American**
- ☒ **Immigrant/Refugee**
- ☒ **Veteran/US Military**
- ☒ **Homeless**
- ☒ **GLBT**
- ☒ **Women**

[23] http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/Child_Parent_Psychotherapy_CPP_fact_sheet_3-20-07.pdf

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

All the infants, young children and parents/caregivers receiving services from the mental health providers being trained would benefit. Parents are often teens or transition aged youth. All families would be included.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Currently, 54 percent of IECMH services occur in the South County; 26 percent occur in Seattle; 10 percent occur in the East County and six percent occur in the North County. Over half of all the services are provided by one agency. This new concept aims to strengthen and diversify the geographic availability of these services countywide.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

It will be important to collaborate with the Best Start for Kids (BSK) Levy Implementation work, the Veterans Levy and Public Health and Early Intervention programs and services to insure coordination of efforts, a lack of duplication of effort, and referrals to the additional resources this workforce training will create.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The Best Start for Kids, including the Accountable Communities of Opportunity, might enhance the context and increase the infrastructure in which Infant Mental Health services reside. State Representative Kagi is also considering not yet specified legislation related to infant and early childhood services in the current state legislative session, which might be a factor in implementing this new concept. The managed care approach to health services for those infants and youth who are dependents of Washington's child welfare system, and the integration of physical and behavioral health care in 2020 may be additional drivers and/or a factors in implementing this workforce training and increasing system capacity for the provision of infant and early childhood mental health services,

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

There are general challenges in the community mental health workforce that may be barriers. These potential barriers are: a) a lack of qualified applicants for currently open positions county wide; b) high turnover due to the stressful nature of the work and the lack of adequate professional salaries for professional work; c) an insufficient number of individuals qualified to provide reflective supervision,

one of the requirements for the practice portion of the endorsement process, as well as a necessity for maintaining fidelity in ongoing clinical service provision; d) the lack of agency support for staff to participate in the proposed training, either via time off for training and/or monetary support, if training fees are charged; e) agency productivity expectations of clinicians; f) agency expectations of caseload sizes higher than recommended for IECMH work; and, g) supervisors' time focused on administrative, supervisory issues with insufficient clinical supervision time.

Another set of barriers is the siloed or disjointed nature of the public, private, tribal and urban Indian health care systems, the early intervention, domestic violence, and general infant, child and family services systems. These are the likely sources of referrals in addition to the public, private, tribal and urban Indian child welfare system.

Coordinating this work with the work of Public Health and the Best Start for Kids implementation is one way of overcoming these barriers. Additionally, the behavioral health provider agency administrative and clinical leadership need to be engaged to gain their support for both the proposed training and service implementation and ongoing support issues, to insure clinical skills are maintained through reflective supervision.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

Part of implementation will include some form of advertising of the availability of these services and explaining to potential referral sources what to look for and how early a referral might be warranted. It is feasible that demand for IECMH services might overload the community mental health providers' capacity to provide services to all ages seeking services.

Trained clinicians might leave the community mental health system, choosing to go into private practice. This would necessitate ongoing support for training a changing workforce.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

- An increase in the behavioral health related demands on other health care and children serving systems, including the educational system with an accompanying inability to meet those demands.

- Based on ACEs research, an increase in health needs for adolescents and adults based on untreated childhood adverse experiences that are heavily correlated to significant and chronic health care costs beyond childhood into adulthood.

- Not providing the workforce training and administrative support for provision of IECMH services is to plan for increased and ongoing health care costs, including mental health, substance abuse, diabetes, heart disease, etc.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New**

Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?

One alternative is for the WA-AIMH or some other entity like the University of Washington (UW) or Washington State University (WSU) to offer less frequent training, and/or to do so at full cost with no partial or fully paid slots for King County mental health clinicians, thereby requiring poorly paid professional mental health staff to bear the burden of seeking the necessary training, clinical experience and endorsement status.

The costs proposed by this new concept are not significant and increase the likelihood both of clinicians seeking this training and IECMH services to Medicaid funded individuals and families being more available countywide.

Another alternative is relying on other health systems (private insurance, Healthy Options Managed Care Organizations, Tribal , Urban Indian) services to meet this service need. Based on the data shared for the past three years, this approach is unlikely to meet demand or need.

E. Countywide Policies and Priorities

1. **How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?**

This concept would provide the workforce for a portion of the continuum of care for which Best Starts for Kids, Behavioral Health Integration, Health and Human Services Transformation, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy all overlap. One driver behind Behavioral Health Integration is the assumption that treating the whole person in a coordinated and integrated manner will result in better health care for the individual, more streamlined health care provision, and bend the health care cost curve.

This concept would help implement the possibility of providing specialized services as soon as needed.

2. **How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?**

Infants, young children and their families needing IECMH services are evidencing behaviors that indicate they are experiencing trauma, are in a traumatic environment/caregiving relationship, are lacking the necessary support to be resilient to the challenges they are facing including inadequate food, mental illness, substance abuse, homelessness, poverty, institutionalized racism, etc. IECMH services focus on building upon and developing healthy strengths and the ability to be resilient.

3. **How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?**

One of the core principles of IECMH services and the DC: 0-3R, the core assessment and diagnostic manual, is that the family's cultural context is important for the understanding of the child's developmental course.[24] One differential aspect of IMH services is the multi-generational nature of the work, and a prominent focus on cultural competence as an essential component of competent service provision.

One way of profoundly addressing institutionalized racism, homophobia, ableism, classism, domestic violence, abuse, and trauma etc. is to deliver services with an integrated practice consciousness of the presence of these factors in individuals' and families' lives.

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

The proposer of this new concept did not propose any costs for the resources indicated here. There was a suggestion they would manage finding space, handling registrations, etc. It is unknown what funds would be used for these efforts. An RFP would clarify if there is a need to include these types of costs via MIDD funding.

2. **Estimated ANNUAL COST. $100,001-500,000 Provide unit or other specific costs if known.**

Component One: The estimate for each training series in Assessment/Diagnostic Skills is $41,000.
Component Two: The estimate for each training series of Child Parent Psychotherapy Training Collaborative is $82,000.
Component Three: An estimated fund of $20,000 to help clinicians gain support for the endorsement process and related endorsement fees.

The total annual cost would depend on how many training series of components one and two are funded by MIDD. The estimates do not include needed resources such as those mentioned in F.1. above. Depending on the successful RFP bidder, there may be additional costs for such resources (staff, physical space, etc.)

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

It is unknown if the WA-AIMH, the UW or the WSU (the most likely RFP applicants) is receiving or seeking grant or legislatively mandated funds for this new concept. None have been mentioned in clarification of this new concept with the proposer.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**
    b. **What are the steps needed for implementation?**
    c. **Does this need an RFP?**

There would need to be an RFP. Depending on the successful bidder, specific trainers and training resources were included in the new concept proposal. Planning training dates, sufficient notice to providers, KC BHRD leadership engaging provider leadership, and sufficient BHRD staff to provide program oversight and direction might be additional time factors.

[24] Lieberman, A., Wieder, S. & Fenichel, E. (Eds.), (1997). DC: 0-3 Casebook. Zero to Three Publisher.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

When a child falls and skins their knee, we teach the parents and youth the importance of washing their hands and then their knee with soap, covering it with an antibiotic cream and a band-aid and maintaining the cleanliness of the injury site. We do not wait for the child's knee to have a serious infection that requires an appointment with a primary care provider and one or more courses of oral antibiotics including possible follow-up visits to insure proper healing.

Workforce training to increase the provision of infant early childhood mental health services allows very young children and their caregivers to begin more healthy interactions earlier, which results in a reduction of later and more serious childhood, adolescent and adult health care needs, and lessens current social and emotional suffering of all family members receiving services.

40

Working Title of Concept: Prevention of Serious Mental Health problems in Young Children

Name of Person Submitting Concept: Nina Auerbach
Organization(s), if any: Washington Association for Infant Mental Health
Phone: 206-617-1951
Email: nina@wa-aimh.org
Mailing Address: 225 14thAve. East, Seattle, WA 98112

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Our concept involves providing training and support for Endorsement® for mental health practitioners who treat or wish to treat very young children (birth-age 3) and their families. WA-AIMH has recently brought a well-respected model of endorsement® to our State that for the first time provides a set of competencies that clinicians need to meet in order to provide specialized assessment and treatment to this population. WA-AIMH has developed a Foundational Training plan that provides specific training that will help professionals meet the competencies. According to our constituency there is a great need for training in: very early child development, screening, assessing and diagnosing very young children; supporting resiliency in parents and caregivers; providing trauma informed intervention; providing culturally responsive treatment; and others. The training that we have provided so far has all sold out in days, revealing that there is a need to expand this training. In addition, providers who wish to become endorsed need advising from WA-AIMH and do have to pay fees. Some of them could use help paying these fees.

And training needs to be affordable as well as accessible. Increasing reasonably priced or free training in our county would help build the supply of trained professionals who can assess severity of problems before they progress too far and provide high quality services to young children living in traumatic circumstances or otherwise needing intensive dyadic treatment services.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Infant Mental Health is a field of practice that promotes healthy social emotional development in young children, prevents serous mental health disturbances and/or treats mental health issues in young children when needed. Children ages birth-three are the most vulnerable group of children in our state. Over 1/3 live in poverty, more than any other age group. They are the most likely age group to suffer abuse and neglect and/or be in foster care. Events like these are called Adverse Childhood Experiences, and research tells us that there are lifelong consequences when these are present – such as difficulties in learning, behavior problems, drug addiction, alcoholism, and even chronic health conditions. Services for very young children always take place in the context of their primary relationships – so they are dyadic in nature. Because of this and because of the challenges of diagnosing mental health issues for young children, it is difficult for mental health professionals to get these services covered unless they have specific training in use of diagnostic tools such as the DC-03, which is a generally accepted tool that has been cross walked with the DSM. They also need to understand very early child development, maternal depression, recognition of trauma, grief and loss in young children and many other concepts in order to intervene before problems progress too far. The competencies that WA-AIMH has brought to Washington makes it clear what practitioners need to know to do an effective job of assessing and treating young children in the context of their families. Being trained in these competencies is an essential component of achieving them. WA-AIMH did a training survey of mental health practitioners and related professionals earlier this year and found that there were significant gaps in training and a huge desire on the part of practitioners to gain more knowledge and training. Every training that WA-AIMH has offered since bringing endorsement to Washington has sold out within days.

3. How would your concept address the need?
Please be specific.

We would do some additional surveys specifically of practitioners in King County to assess their specific level of need for training. We would then develop a training plan that fits the need and deliver the trainings. Trainings could be in a variety of formats – in person, on-line, guided learning communities, etc. WA-AIMH would handle all aspects of the training – securing expert trainers, the venue, registration, and other training logistics. In person trainings would be offered in all parts of the County and at an affordable rate. Trainers would be carefully vetted by WA-AIMH.

4. Who would benefit? Please describe potential program participants.

All practitioners who currently work with or wish to develop the expertise to work with this age group would be invited to attend trainings.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

We would evaluate all trainings. Specific outcomes would include: there will be an increase in the number of practitioners who feel that they meet the competencies to provide infant mental health services. We could measure this by gathering information on the current number that serve this population in King County and comparing it to the number that provide these services after our training program has been in effect for a year. We can also ask practitioners to give examples in their training evaluations of how the

training has helped them to understand the specific competencies that are part of the training and how they will use the knowledge in their work.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Note: For the previous questions, the form is not allowing me to check the Prevention and Early Intervention box, but that is what this concept pertains to.
In terms of fitting with the MIDD II Objective, WA-AIMH feels that the fact that so few children ages birth-five are being served through our mental health system points to a social justice issue. These children deserve treatment as much as older children do yet they are disproportionately underserved. It is also true that there are a disproportionate number of low income children and children of color that are living in traumatic circumstances and thus, are at risk of developing mental health disorders. To the extent that we can intervene early, we can prevent mental health problems from occurring and/or escalating.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Community mental health organizations, home visiting programs, early intervention programs that employ practitioners, and the King County Mental Health department itself.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**