

OUTPATIENT MENTAL HEALTH PRACTICE PARAMETERS FOR TREATING CHILDREN UNDER FIVE YEARS OF AGE

I. DEFINITION:

The provision of outpatient mental health services to a child who is less than five years of age. When at all possible, clinicians are encouraged to reference this guideline and explore the listed resources in addition to using current knowledge and techniques designed specifically for the psychiatric treatment of children in this age range.

II. INTRODUCTION:

While the DSM-IV-TR includes disorders that are typically diagnosed during childhood, it is known that all psychiatric disorders listed in DSM-IV-TR can begin during childhood. Psychiatric disorders in children are increasingly coming into focus as serious but treatable conditions and as possible precursors of adult psychopathology. These disorders often emerge in combinations, change in presentation during maturation, interact with one another over time, and can be obscured or amplified by intervening developmental events. Due to these additional assessment and diagnostic challenges, evaluators may reference the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC 0-3R) in addition to the DSM IV-TR in determining appropriate diagnoses and treatment recommendations.

Because a child less than 5 or a young child, in comparison with an adult, is capable of only a limited number of behavioral patterns or responses to various stresses, some overlap of symptoms among diagnoses is inevitable. The following guidelines may be used in determining which diagnosis takes precedence:

- Posttraumatic Stress Disorder should be primary if it is clear that the child's disordered behavior or emotions would not be present without the stress of a specific overwhelming episode or multiple repeated traumas.
- Regulatory disorders should be considered if there is a clear constitutional or maturational based sensory, motor, processing, organizational, or integration difficulty.
- Multi-system Developmental Disorder is a DC: 0-3R alternative for Pervasive Developmental Disorder for children less than two years old and can be an appropriate diagnosis for children who display the following characteristics:
 1. Significant impairment in the ability to engage in a social/emotional relationship with the primary caregiver.
 2. Impairment in forming, maintaining, and/or developing pre-verbal communication.

3. Dysfunction in the processing of visual, auditory, tactile, proprioceptive, and/or vestibular sensations, including hyperactivity and hyporeactivity to sensory input. Significant dysfunction in motor planning.
- Adjustment disorder should be considered if the presenting problems are mild and have relatively short duration (less than four months), and are associated with a clear environmental event.
 - Disorders of mood and affect should be considered when there is neither a clear constitutional or maturational based vulnerability, nor a severe or significant stress or trauma, and when the difficulty is neither mild or of short duration.
 - Relationship disorder should be considered where a particular difficulty occurs only in relationship to a particular person. (Relationship disorders as defined in DSM-IV-TR are V codes and therefore not a covered diagnosis for Medicaid members.)
 - The diagnosis of Reactive Attachment Disorder is reserved for children in whom persistently inadequate basic physical, psychological and emotional care is believed responsible for disturbing the client's ability to relate in most contexts appropriately to others. Deprivation/Maltreatment Disorder in DC 0-3R offers clinicians an alternative to Reactive Attachment Disorder as a diagnosis. This disorder occurs in the context of deprivation or maltreatment, including persistent and severe parental neglect or documented physical or psychological abuse.
 - On rare occasions, the child may have two primary conditions.
 - When it is difficult to make a decision between two or more Axis I diagnoses, use a "rule-out" diagnosis for the second diagnosis.
 - Although Axis IV diagnoses are not sufficient for an increased level of care, the Relationship Disorder Classification can greatly contribute to the child's overall level of impairment, and should be taken into account in recommending an appropriate level of care.

Children are highly dependent on their parents/caretakers and are rapidly changing as a result of developmental and maturational processes. A comprehensive mental health assessment for children age five and under, when at all possible, should include information from the child/family, care agency, school, physicians, and any other professional or agency that regularly interacts with the child. Clinicians might consider the following components/approaches to assist in their assessments:

1. Presenting symptoms and behaviors, and the reason for the referral,
2. Developmental history--past and current affective, language, cognitive, motor, sensory, family, and interactive functioning,

3. Family functioning, cultural and community patterns, and how this may impact treatment.
4. How the parent's experience of being raised is influencing their current expectations,
5. Relational and interactive patterns between each parent and the child,
6. Child and family strengths
7. Informal and formal resources and supports available to the family
8. The constitutional-maturational characteristics of the child including prenatal complications, e.g., pregnancy and delivery complications, drug and alcohol use,
9. An appropriate mental health status as determined through the use of an instrument such as the Infant and Toddler Mental Status Exam (ITMSE).
10. Possibly conducting part of the assessment in the family home or child's daycare/school setting.

III. ADMISSION CRITERIA:

ALL of the following criteria are necessary for admission:

- A. Completion of all identified assessment elements;
- B. Description of the child's and family's difficulties as well as strengths;
- C. Description of the relative contribution of the different areas assessed to the child's difficulties and competencies;
- D. A covered Axis I diagnosis supported by A, B, and C incorporated with DC 0-3R classifications;
- E. A comprehensive treatment plan that focuses on the problem(s), uses the strengths of the child/family, reflects cultural considerations and specifies family/legal guardian involvement in treatment. Failure of a treatment plan with these elements could necessitate a change in level of care.

IV. EXCLUSION CRITERIA:

ANY of the following criteria is sufficient for exclusion from this level of care:

- A. The assessment has not been completed;
- B. The assessment data does not support a covered Axis I diagnosis;
- C. The family or caretaker is not actively participating in the treatment process.
- D. Based on the child's behaviors/symptoms, a higher level of care for treatment is needed;
- E. The primary focus of treatment is the parent(s) or caretaker(s) behaviors/symptoms rather than the child's. Comment: In the treatment of

young children the needed intervention may indeed be a significant change in the caregiver's behaviors toward the child. This intervention is separate from services needed for the parent to treat the parent's mental illness. This is not treating the symptoms of the parents mental illness but treatment directed at changing the parents behavior toward the child. This may be a direct result of the parents having a mental illness (depression) or the parents may not have a diagnosed mental illness and be negatively impacting the child's mental health by their behavior toward the child. The work with the family to change parent behaviors is best provided by a early childhood mental health clinician as this professional is going to have expertise related to child development, attachment, and attunement between child and caregiver that a clinician who typically treats adults will not.

V. CONTINUED CARE CRITERIA:

ALL of the following criteria are necessary for continuing treatment at this level of care:

- A. The child's condition continues to meet admission criteria at this level of care;
- B. Treatment is individualized, appropriate to the individual's changing condition, with realistic, attainable, and measurable goals.
- C. The parent(s) or caretaker(s) are actively participating in the treatment;
- D. The treatment is designed to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.

VI. FREQUENCY OF REVIEW:

Up to four (4) sessions for assessment and formulation of the treatment plan may be registered. The service plan must be completed within 30 days. Then, telephonic review must be for each ten-outpatient sessions requested.

BIBLIOGRAPHY

- 1. Textbook of Clinical Psychiatry, fourth edition. Hales, Robert E & Yudofsky, Stuart. American Psychiatric Publishing Co.: Washington, D.C., 2002.
- 2. D C: 0-3 Casebook. Lieberman, Alicia F., Wieder, Serena & Fenichel, Emily. National Center for Infants, Toddlers and Families. Zero to Three: National Center for Infants, Toddlers and Families. 1997.

3. Egger, H. et al. (2005). *DC:0-3R Diagnostic classification of mental health and developmental disorders of infancy and early childhood*: Revised edition. Zero to three press: Washington, DC.
4. Diagnostic Classification: 0-3. Wieder, Serena. National Center for Infants, Toddlers and Families. 1997.
5. Practice Parameters for the Psychiatric Assessment of Infants and Toddlers. American Academy of Child and Adolescent Psychiatry. 1997.