Discussion Guide for Care Coordinators:
Addressing Trauma & Toxic Stress through Care Coordination

Accompanies the Early Childhood Health Optimization Module

PURPOSE

Care coordinators serve a pivotal role in linking their patients with necessary services. The purpose of this Discussion Guide is to provide the care coordinators working for the Managed Medical Assistance health plans additional information on trauma and toxic stress and the impact on development, and the role of resilience. This information is intended to provide the care coordinators with a better understanding of the issues to enable the application of these concepts to their work. The document also includes a section on how care coordinators could use the information and science to strengthen their services to infants, young children, and their families. The materials will assist care coordinators in better understanding the children and families that they serve who have been exposed to trauma, to identify the population within their enrollees, and to formulate care plans that address both their strengths and needs. Preferably, the practitioner will have completed the Module prior to reading this Discussion Guide.

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CONTENTS

PURPOSE....1
MODULE OVERVIEW....2
- How Early Experiences Build Brain Architecture....2
  - Experiences and Relationships Matter....2
- Understanding Toxic Stress....2
  - Stress Impacts Development....2
  - Toxic Stress Disrupts Development....3
  - Adverse Childhood Experiences (ACEs), Toxic Stress, and Complex Trauma....3
  - Adversity and Health....4
  - Buffering Children from Toxic Stress....4
- Executive Function - Skills for Life, Learning, and Health....4
  - Coordinated Functions and Skills....4
  - Executive Function Across the Lifespan....4
- Strengthening the Foundations of Resilience....5
  - Resilience Requires Relationships....5
  - The Science of Resilience....5
  - Protective Factors that Build Resilience....5

CONNECTING THE SCIENCE TO PRACTICE....6
WHAT IS INFANT MENTAL HEALTH?....6
MULTI-RISK FAMILIES....8
CARE COORDINATION: HOW PRACTICE CAN PREVENT OR AMELIORATE THE IMPACT OF TRAUMA AND TOXIC STRESS....9
- Identification of Risk....10
- Organizational Level....10
- Direct Service Level....11
- Assessment of Need....11
  - Organizational Level....11
  - Direct Service Level....12
- Creating the Plan of Care....14
  - Organizational Level....15
  - Direct Service Level....15
- Implementing the Plan of Care....16
  - Organizational Level....16
  - Direct Services Level....16
- Monitoring Services....16
- Transitioning Care Coordination....16

SUMMARY....17
REFERENCES....17
The Array of Infant Mental Health Services....Appendix

Continued on next page

MODULE OVERVIEW

This discussion guide is designed to accompany the Module that provides practitioners from multiple disciplines information and approaches to promote the healthy development of young children, through understanding brain development. The Module presents the information in four segments:

1. **Understanding how early experiences build brain architecture**
2. **The science behind the effects of toxic stress on brain development**
3. **The role that executive function plays in health and learning**
4. **Building resilience across the lifespan**

How Early Experiences Build Brain Architecture

The brain is the only organ not fully formed at birth. During infancy, billions of brain cells send electrical signals to communicate with each other. 700 new neural connections are formed every second. Their circuits and connections proliferate at a rapid pace and are reinforced through repeated use as they become the basic foundation of brain architecture.

Our experiences and environments determine which connections get the most use. Those used more frequently grow stronger and more permanent and create pathways. Less frequently used connections are "pruned" and fade away. Through this early process, neurons form strong circuits and connections for emotions, visual processing, motor skills, behavioral control, memory, logic, and language. With repeated use, these circuits become reinforced, more efficient, stabilized and then rapidly connect with other parts of the brain.

Thus, at birth and in the first five years of life, the brain is most plastic and easily influenced by experience. Over time, the brain loses some of its flexibility and it takes more physiological effort to enhance the neural connections. Therefore learning new tasks and skills becomes more difficult, takes greater effort, and is a less efficient process.

Experiences and Relationships Matter

Relationships are also central in formulating the basic foundation of the brain. Interactions between nurturing adults and babies support the development of emotional and cognitive skills needed in life. Adults and babies are interactive partners in learning. It is this "serve and return" interaction that is the basis of the relationship. An infant "serves" through babbling, facial expressions and gestures while an adult "returns" through meaningful and directed responses (facial and vocal). When parents are responding to a child's cues—the smiles, the cries—in a positive way, it reinforces neural connections in the brain that send signals that the world is a safe place and stress levels remain at a low or manageable level. Serve and return interactions can take many forms, starting at birth and continuing through childhood. Parents, family members and any important adult in a child's life can return a child's serve. However, it needs to be mutual and reciprocal in order to create the opportunity for development. This serve and return interaction forms the foundation of brain architecture upon which all ensuing development will be constructed. It helps to create neural connections between all different areas of the brain, building the emotional and cognitive skills needed for future life, learning, and health.

Understanding Toxic Stress

Stress Impacts Development

The experience of certain types of stress is an important part of the development of a healthy child. There are three general types of stress.

Mild/Positive Stress is associated with a brief increase in heart rate with small temporary elevations in stress hormones. Example: A toddler who hesitantly approaches a new slide at the playground is fearful but excited. Her parents encourage her to try it and stand close by for support. She climbs slowly with repeated glances back to her parents for acknowledgment that she is safe. Her heart is beating rapidly and her body is shaking slightly. However, she slides down and feels thrilled. Her parents meet her at the bottom and celebrate her accomplishment. Her stress response was activated and remained heightened after the experience but once she was lifted and embraced by her parents, the stress response normalized. Experiences such as this encourage children to grow, especially when adults are present to help them to learn coping skills which then calms the stress response.

Tolerable Stress is more serious stress. This is bearable if buffered by supportive relationships and responses to bring the stress level back to baseline. This type of stress causes no lasting harm. Example: A child is a passenger in a non-fatal car accident. The mother is injured and removed from the scene by ambulance. The child is taken to the

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hospital as well. He is understandably confused and afraid while he waits for his father to arrive. The father takes him to see his mother who was admitted. The child has never seen a hospital room nor has he seen his mother in this condition before. Fear has activated the stress response system, first at the scene of the accident and then continuously as the child struggles to understand what happened to his mother. The father must talk to him and reassure him that he is safe before the child will get in the car to go home. He is hyper-alert and scared with every stop and turn. Once at home, the father reassures the son and gives him a transitional object to sleep with. The mother is discharged from the hospital and makes a point of showing her son all of her injuries so that he knows she is healing. The parents demonstrate patience and caring when their son has nightmares or when he cries before getting into the car again. It takes several weeks for the child to return to normal. The presence of his parents and their continual reassurances ultimately brings his stress response back to baseline.

Toxic Stress is the prolonged activation of the stress response system without the presence of supportive adults to help. This could be the accumulation of adverse childhood experiences (ACEs) such as neglect, abuse, or severe maternal depression, or pervasive stress-producing conditions like extreme poverty or community violence. This unrelieved activation of the body's stress response can weaken the architecture of the developing brain and damage the immune, cardiovascular, and other organ systems. Example: The mother of an infant has severe postpartum depression. She feels frustrated by the infant's cries and tends to leave him alone for long periods. Initially he coos and babbles in order to engage the mother. Once he becomes cold, wet and hungry, he begins to cry and scream. The mother is further distanced by this and instead of coming to nurture and calm him, she retreats. The infant ultimately withdraws and falls asleep. The stress response is repeatedly activated as this scenario occurs frequently. The infant learns that his cries will not bring help and the infant's stress levels remain heightened.

Toxic Stress Disrupts Development

Although learning to deal with stress is an important part of development, toxic stress can be highly detrimental. When the child's stress response system is activated, the body and brain go on alert. There is an increased rush of adrenaline and other stress hormone levels causing physiologic responses in the body e.g. heart rate increase, constriction of muscles, etc. When stress is relieved after a short time, or the child receives support from caring adults, the stress response winds down and the body quickly returns to normal.

In severe situations of ongoing abuse and neglect, when there is no caring adult to buffer against the stress, the stress response stays activated. Even when there is no apparent direct harm occurring, the extended absence of adults can perpetuate an active stress response system. Without a reassuring nurturing adult, the child's stress response system stays on high alert. Constant activation of the stress response system overloads the developing body, with lifelong consequences for the child. Over time, this results in the stress response system set permanently on high alert. A system which is continuously on high alert, becomes fatigued and overworked. All areas of the brain and the neural connections that comprise brain architecture become weaker and fewer in numbers just at the time when the brain should be growing new neural connections. This frequently manifests itself as learning and reasoning deficits, hyperactivity and attention issues and/ or behavior disorders. The remainder of the body is also negatively impacted since all organs are regulated by the nervous, endocrine, and immune systems. Frequent acute illnesses and chronic diseases can ensue. Individuals who have an overloaded stress response system then become repeated users of the health care system. Toxic stress can be avoided if we ensure that the environments in which children grow and develop, are nurturing, stable, and engaging.

Adverse Childhood Experiences (ACEs), Toxic Stress, and Complex Trauma

ACEs are "adverse childhood experiences" which are potentially negative and damaging experiences in childhood. Extensive research links an accumulation of ACEs to poor outcomes later in life (poor school achievement, substance abuse, physical and mental health issues, as well as chronic disease, disability, and early death). Toxic stress is the body's biological response to ACEs and other stress causing situations that may occur outside of the family (extreme poverty, community violence, or neighborhood chaos). Toxic stress helps to explain why ACEs can be so detrimental to long-term outcomes. Complex trauma refers to both the ACEs, the chronic exposure to serious traumatic events—most often within a child's caregiving system—and the multidimensional impact of that exposure.

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The ACE score is a simple and widely accepted way of assessing exposure to complex trauma. These ten categories of adverse experiences are associated with a wide range of poor outcomes across multiple domains of life. The ten categories are:

1. Physical abuse
2. Emotional abuse
3. Sexual abuse
4. Emotional neglect
5. Physical neglect
6. Domestic violence
7. Mental illness or mental health disorder
8. Parental separation or divorce
9. Substance use disorder
10. Incarceration of a family member

Adversity and Health

Significant adversity impairs development in the first three years of life. Children from birth to age three are the most likely to experience maltreatment, with infants before their first birthday at highest risk. When there is maltreatment in the home, there is a greater likelihood for the existence of other adverse experiences such as poverty, domestic violence, substance abuse, or mental illness. Children with 6-7 adverse risk factors have a 90-100% chance of a developmental delay by age three that is serious enough to warrant special services when they reach school age. Risk factors for adult illnesses are also embedded in adverse childhood experiences. Adults who had 5 or more ACEs in childhood have 5 times the likelihood of having clinical depression as an adult.

Adults who had 7 or 8 ACEs in childhood have 3 times the likelihood of having heart disease as an adult. This is explained from the "wear and tear" effect on physical health when the regulatory system is chronically stressed.

Buffering Children from Toxic Stress

A great deal is known about how to reduce the consequences of toxic stress. Interventions can begin prenatally by screening expectant mothers and their partners for exposure to adverse experiences and providing trauma informed interventions to heal the parents' trauma history before the baby is born. Home visiting can begin prenatally and extend until school age to strengthen families and provide parents with guidance about how to be nurturing, responsive and provide optimal interactions at each stage of the child's development. Quality early childcare and education can offer nurturance and stimulation to promote positive child outcomes, serving as a protective factor from stress at home.

Infant mental health services are beneficial for parents and their infants when the parent reports depression, anxiety, or other mental health problems, or for parents who have a negative perception of their infant or have unresolved trauma history that is interfering with their ability to relate to their child. Infant mental health interventions like Child-Parent Psychotherapy address the parent's unresolved childhood adversities while simultaneously building the attachment relationship with their child, optimizing outcomes for both parent and child. Two-generation programs that address both the needs of the parents and the children hold the most potential for optimal outcomes.

Executive Function - Skills for Life, Learning, and Health

Coordinated Functions and Skills

The brain's multiple functions operate in a richly coordinated fashion. Cognitive, emotional, and social capacities are completely intertwined in the brain; we cannot build one without the others. Emotional well-being and social competence, developed in the early years, provide a strong foundation for emerging cognitive abilities. Together they are the bricks and mortar that comprise the foundation of human development.

Executive Function Across the Lifespan

Executive Function and Self-regulation skills such as working memory, inhibitory control and cognitive flexibility are established in early childhood but continue to grow and develop into early adulthood. These skills shape adults' ability to remember, filter, focus, plan, monitor, adjust, resist and persevere. The development of Executive Function is intricate and complicated but integral to learning, work, behavior and health. It involves the pre-frontal cortex which controls behavior through interactions with all other parts of the brain. Children's Executive Function and Self-regulation are key ingredients to their lifetime performance, not just what they need for early childhood education. They must be able to work effectively with others, manage competing demands and filter distractions. Children who are struggling with these capacities often look like children who cannot pay attention and are deliberately not controlling themselves.

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Executive Function and Self-regulation are key contributors to the development of resilience. These skills help us:

- Exercise impulse control
- Use working memory to remember to take medicines and comply with other medical regimes
- Use mental flexibility to adapt to changing or stressful situations

For both children AND adults, these skills can be built through coaching and practice. However, toxic stress can derail the development of Executive Function skills. Certain strategies support the healthy development of Executive Function skills:

Early childhood care and education

- Address stressors in children's lives
- Foster social interactions
- Progressively increase the demand on executive function skills
- Include repeated practice throughout the day
- Encourage vigorous physical exercise

To foster health and well-being at home:

- Get adequate sleep and regular exercise
- Practice stress management techniques

Strengthening the Foundations of Resilience

Resilience Requires Relationships

Not all children exposed to stressful circumstances experience long-lasting harm. Regardless of their adversity, the single most common factor for children who end up doing well, have at least one stable and committed relationship with a supportive parent, caregiver, or other adult in their lives. Health care practitioners have an important role in these children's lives as well. They have the opportunity to support the parents' and caregivers' relationships with the child. These relationships provide the protection needed to buffer children from disrupted development and support the child's capacity to plan, regulate behavior, and adapt to changing circumstances. This combination of supportive relationships, adaptive skill-building, and positive experiences is the foundation of resilience, enabling children to respond to adversity and thrive.

The Science of Resilience

When we experience something stressful, our body's stress response systems are activated. A healthy stress response features a sharp increase followed by a rapid decrease in activation. When the system is resilient, the stress response system adapts over time—learning that certain situations are not threatening—leading to less activation each time a similar stressor is experienced. But when the stress response does not activate the way it should, fails to turn off when the experience is over, or fails to adapt to similar types of stressor over time, it is not functioning properly. With a dysfunctional stress response system, the same physiological response is triggered over and over with no signs of adaptation. When this happens, it disrupts the body's chemical balance and can change the neuronal architecture of specific regions of the developing brain. Our experiences reinforce neuronal connections within the brain that promotes resiliency such that the brain adapts.

Protective Factors that Build Resilience

Research across multiple fields has identified a common set of factors that help children achieve positive outcomes in the face of significant adversity. These factors encompass the strengths that originate from the child; supportive adult-child relationships, including health care professionals; and positive broader social environments. When these positive influences are operating effectively, they "stack the scale" with positive weight, optimizing resilience and counterbalancing adverse situations (See Figure 1). These counterbalancing factors include:

1. Supportive adult-child relationships
2. A sense of self-efficacy and perceived control
3. Strong adaptive skills and self-regulatory capacities
4. Supportive faith, hope, and cultural traditions

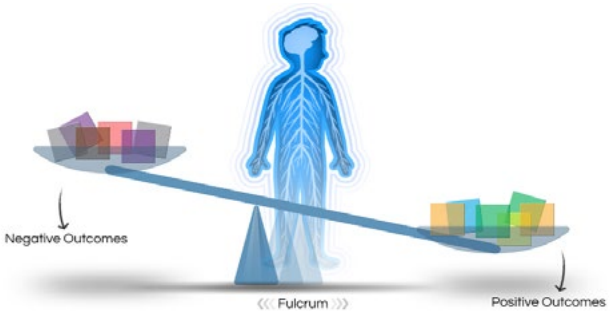

Figure 1. Image courtesy Center on the Developing Child at Harvard University (2015) Source: National Scientific Council on the Developing Child (2015). Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13. Visit developingchild.harvard.edu/resilience for more information on the science of resilience.

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CONNECTING THE SCIENCE TO PRACTICE

The complex interplay of biology, adverse childhood experiences, biological development and behavior needs to be understood by the professionals who serve families. The behavior that is exhibited by adults and children served by the MMA health plans is the result of both biological and physiological functions.

The knowledge of early childhood development has evolved to the point that the actual biological, neurological, and physiological impacts on social, emotional, and behavioral development and long-term health are becoming clear. Dr. Nadine Burke Harris addresses this linkage and offers a call for action in her 2014 essay, "*The Chronic Stress of Poverty: Toxic to Children*" in *The Shriver Report: A Woman's Nation Pushes Back from the Brink.*

> "All in all, this convergence of basic science, clinical research, and public health is reframing a problem so common that is was hidden in plain sight. Chronic stress and trauma are toxic to our children. We now know the targets to go after—early childhood brain development, HPA (hypothalamic-pituitary-adrenal) axis regulation, and chronic inflammation—and that creates opportunities for intervention. We have an obligation to our kids, to their caregivers, and to our society to advance the standard of practice to meet the state of the science."[1]

WHAT IS INFANT MENTAL HEALTH?

Research clearly shows that the child's exposure to stress can have deleterious effects. The negative impact of stress is related to the intensity and duration of the bodily stress response. The impact is determined by the intensity of the traumatic event itself, whether the child has safe relationships to turn to for support, and how often and for how long the body's stress system has been activated in the past.[2]

Infant mental health is a field of research and practice that is focused on the optimal social-emotional development in the first three years of life. At the core of the philosophy is that early relationships between the parent and the child create the foundation for mental health and strong interpersonal relationships throughout the lifespan.

The first year of life forms the foundation for social emotional development, which consists of trust and emotional security, self regulation and self concept. From the classic research of Bowlby and Ainsworth, an attachment theory highlights "falling in love" with one's baby and the importance of a secure relationship. Some parents feel connected when they first hold their baby; for others it is a slow process that occurs throughout the pregnancy and culminates after birth. For some, it never happens. Lack of bonding and attachment can cause life-long mental health problems for the child. Because of the strong impact on development, the emotional quality of the parent child relationship is the focus for promoting mental health in early childhood. Multigenerational interventions that seek to emphasize the interconnectedness of the child and the family are most effective in enriching the parent child relationship by increasing feelings of safety, security and reciprocity.

These early attachments influence emotional wellbeing throughout adulthood. Secure attachments are developed through nurturing responsive caregiving over time. As newborns, babies learn about empathy when they cry and are soothed; when they smile and are greeted with a reciprocal smile, receive warm loving touches, a gentle voice, and soothing interactions. When they coo and smile and the parent gives them a smile and a coo back they learn about reciprocal relationships. And when things are scary or hurtful, they can call for help and will get a response that tells them that all is OK. Throughout all these encounters, they experience being loved. They know that they are special and others find joy in their presence.

These children form a secure emotional attachment with their parents and caregivers that is mutually rewarding. This attachment creates the foundation for healthy exploration of their environment. They feel capable of moving beyond the immediate proximity of the parent, to learn about their world and then return to the comforting "safe base" of their parents when they become tired, stressed, or need reassurance that everything is safe. Through these interactions the children develop a sense of self and others, and establish the necessary basis for social-emotional development, and mental and physical health.[3]

Insecure attachments may occur when the baby's physical and/or emotional needs are not met as a result of erratic or inconsistent caregiving, separations, abuse or neglect, addictions or other reasons for emotional or physical unavailability.

The field of infant mental health is also concerned with early intervention and or treatment when circumstances do

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not provide the infant and young child with the responsive relationships necessary for development. Some children may be born with biological challenges resulting in difficulties calming themselves, being consoled, and in eating or sleeping. Children also may face stressful or traumatic situations when they live in violent neighborhoods, witness interpersonal violence or have parents who cannot meet their needs due to extreme poverty, or medical or behavioral illness. For some children, there is adequate support in the family and natural environment to enable the child's development with no or some early interventions. For other children, the cumulative effects of the risk factors pose serious threats to their development and require higher levels of intervention and treatment. In some cases the parent and child need access to an infant mental health specialist to provide targeted mental health supports. In other situations, the child's and family's needs are such that a team of experts may be required to address the complex situation.

The principles and practices of infant mental health are concerned with the welfare of the child, the parent, the environment, and the relationship with the parent and the child. The term dyad is used frequently to refer to this child-parent relationship. The scope of infant mental health is broad, encompassing promotion/prevention, intervention, and treatment. The Florida State University Center for Prevention and Early Intervention Policy uses this three level framework to describe infant mental health. Please see *The Array of Infant Mental Health Services* document in the back of this Discussion Guide.

In general, these areas encompass the following:

Promotion/Prevention: Services focus on supporting early development of safe, functional, nurturing and loving relationships between infants, their parents, and other caregivers. Prevention provides services to reduce the effects of risk and stress, and address possible emerging difficulties in the child-parent relationship or vulnerabilities that impact early development. Early screenings to track development, pediatricians' support of the parent as they learn to care for their child, home visiting programs and community based functions that promote positive and joyful parenting are examples of activities focused on promotion and prevention.

Early Intervention: Services that address developmental delays. An example intervention for developmental delays in early childhood is Early Steps. Programs that target families with certain risk factors include Healthy Families and Healthy Start. See the *Practitioner Resource Guide* for more information.

Treatment (Discipline-Specific): Services include assessment, diagnosis, consultation, and/or treatment focused on improving overall individual and/or dyadic functioning. Treatment may be aimed at interpersonal functioning within important relationships in the presence of potential risk factors, such as poor physical or mental health or substance use disorders, and histories of adversity and trauma. This work requires specialized training, skills, experience, and the possession of a professional license or appropriate credentials to perform these services. The expertise must include the ability to work with the parent, the child, and the child-parent relationship. Examples of interventions include Child Parent Psychotherapy, Parent-Child Interaction Therapy, and for working with parental behavioral health disorders, Trauma-focused Cognitive Behavioral Therapy.[4]

Infant mental health is multi-disciplinary. Families with young children may receive treatment services from more than one treatment provider simultaneously. For example, a child may be receiving speech therapy; the parent may be receiving mental health treatment; and as the dyad participating in child-parent psychotherapy. Each one of the disciplines must be aware of the care for the individuals involved (child and parent) the child-parent relationship and the environment that surrounds them. For example, a speech therapist working with a child on a language delay would be attending specifically to the needs of the child, but would also be concerned with any disruptions in the relationship associated with the child's delays or related to other issues in the family. Even when the practitioner is treating an individual member of the dyad, the functioning of the dyad must be kept in mind and addressed if there are suspected issues.[5]

Therefore, infant mental health is unique in its focus on the dyadic relationship. This relationship evolves within human systems that are impacted by bio-psycho-social factors and that are interrelated and interacting to include:

- Attachment – safety, security, and love
- Meaning-making – learning the ways of being in your environment
- Behavioral-cueing – gesturing, reflexes and communicating
- Self-regulation
- Sensory – body, affect, and senses

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- Neurodevelopmental / Neuroendocrine – hormonal, stress / arousal and epigenetic
- Memory
- Mentalizing – reflection on the state of self and others
- Inter-subjective – shared dyadic (between parent and child) mental states and attention[6]

The above list of concepts encompasses the areas of interest in infant mental health. Although the scope of this document does not allow full discussion of each of these concepts, it is helpful for care coordinators to be aware of the multiple components that are addressed in infant mental health prevention, promotion, intervention, and treatment. Trauma exposure can disrupt any of these components, requiring repair. Infant mental health treatment focuses on this repair across the above areas of interaction and development.

MULTI-RISK FAMILIES

There are several situations that can place a child at risk for less than optimal development. These are listed below:

- Child is at risk due to a genetic or biological condition.
- Parent is diagnosed with a substance use or mental health disorder or a significant developmental disability.
- Parent is coping with an overwhelming amount of sociological or environmental challenges such as extreme poverty, unstable housing, and other conditions that compromise the parent's ability to provide a safe and secure environment for the child.
- Parent is unable to provide adequate nurturing and responsive interactions with the child and may routinely interact harshly and angrily or even use abusive discipline or conversely, withdraws and neglects the child.[7]

Risks and their resulting vulnerabilities are transmitted to children through genetic transmission, parenting interactions, brain development, and resulting behavior and development as shown in the Figure 2 below.

Families dealing with multiple risks at one time face the cumulative impact and may find it extremely difficult to address these issues on their own. All families have their own unique set of circumstances, yet there are some characteristics of families that tend to put them at greater risk. Families with multiple risks may include the following:

- Teenage parents
- Mothers with depression
- Parents with serious mental health disorders
- Parents with substance use disorders
- Parents with unresolved loss and trauma
- Parents experiencing violence - both interpersonal and external

Of course these patterns are not mutually exclusive; many families experience several of these characteristics simultaneously, such as a family with a single mother with depression, unresolved trauma, and experiencing interpersonal violence. These families need expert and highly coordinated assistance. As discussed above, the intervention must encompass the parent, the child, the dyad and the environment.

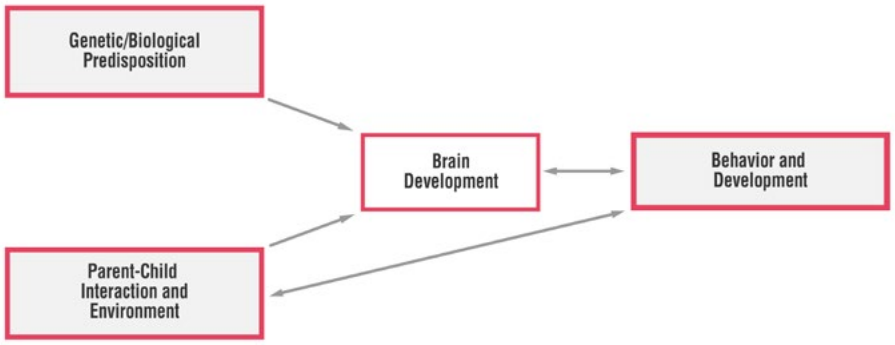

Figure 2. A transactional model for the development of child difficulties. Genetic/biological predispositions and parent-child interactions and the environment influence brain development, which then influences behavior and development, which has a two- way relationship with parent-child interaction. Source: Early Intervention with Multi-Risk Families - Integrative Approach, by Sarah Lane, PhD and Rosanne Menna, PhD.

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CARE COORDINATION: HOW PRACTICE CAN PREVENT OR AMELIORATE THE IMPACT OF TRAUMA AND TOXIC STRESS

As discussed above, early childhood is a period when children develop the foundations of physical, behavioral and social/emotional health that will impact their health and other personal outcomes for a lifetime. Healthcare practitioners and care coordinators play an essential role in promoting positive child development through their interactions with children and their families. Work with young children is a four-pronged approach. The care coordinator must be concerned with the child, the parent, the environment, and the child-parent relationship. Care coordinators help families decrease exposure to toxic stress when they connect the children and families to the necessary services, supports, and treatment. There is both a social and monetary incentive for early identification and coordinated care for children and families experiencing chronic stress. Intervention is of greatest value when it begins early. Delaying services often results in the need for more treatment and a greater intensity of services, over a longer period of time with less-effective results.[8]

> The care coordinator must be concerned with the child, the parent, the environment, and the child-parent relationship.

Families' exposure to traumatic events and/or toxic stress may place infants and young children at greater risk for poor outcomes because the infant or young child is faced with a situation that overwhelms their immature coping system. In situations of abuse or neglect, the child is left in a desperate situation in which the people to whom he looks to for the fundamental physical and emotional support are unable to give it. The child reacts to the condition through a complex interplay of physical and emotional responses. Children and families in these situations are in crisis. Their numerous needs exceed their ability to manage. However, unlike persons with frequent hospital visits or numerous clearly documented chronic conditions, these families can go unnoticed until the child begins to exhibit serious physical or behavioral dysfunctions or the parent is identified because of their medical or behavioral health conditions.

The managed care system has abundant opportunities to identify these families. Daily, the parents and children present themselves in the offices of health care providers including pediatricians, family practitioners, obstetricians, therapists (speech and language, occupational, and physical), as well as at behavioral health clinics. However, their full array of needs, especially the social and emotional issues associated with trauma, may go undetected or be so complex that the practitioner is unable to address them within the scope of their practice. Coordination of care is time consuming for busy health care practitioners and often beyond their capacity, especially for small practices without social service components. Making appropriate referrals requires an in-depth knowledge of resources available in the community. However, even with this knowledge, studies have found that trained care coordinators needed to contact an average of 5.5 service providers to find an appropriate referral[9]—which may exceed the time available in a busy practice. The care coordination available in managed care plans can assist the practitioner to help parents and children access necessary services.

The managed care structure is well positioned to address the needs of these children and families through the creation of an organized network of providers with the necessary expertise. With the knowledge of the array of provider services in the network and community resources, coupled with the ability to assess, plan, link and coordinate services, care coordination can provide the vital connection to services needed by these families. This coordination can occur both within the managed care network of providers and with other services provided outside of the plan's benefit package.

This section of the Discussion Guide focuses on two levels of care coordination—the organizational level and the direct service level. The organizational level refers to the ability to impact overall practice within the managed care system which is usually a function provided by the care coordination manager. The direct service level entails the direct interactions between the case manager, the family, and the managed care providers performed by the care coordination staff. Activities at these two levels are discussed according to the following functions:

- Identification of Risk
- Assessment of Need
- Creating the Plan of Care
- Implementing the Care Plan
- Monitoring Services
- Transitioning Care

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Identification of Risk

Unlike physical disabilities or clearly diagnosable behavioral disorders, children and families struggling with a trauma history or toxic stress are not easily identified unless the practitioner is aware of and trained to detect the risks. To be able to do so, multiple disciplines must be aware of the possibility or the impact of trauma and be prepared to identify the occurrence. Companion documents for pediatricians, obstetricians, therapists, and home visiting staff include suggestions as to how to identify children with social and emotional issues and parents in excessively stressful situations. When practitioners identify these situations they may not be able to provide the necessary support to address the needs. Care coordination can provide the assistance necessary to help providers, children, and families obtain appropriate services and care.

Organizational Level

At the organizational level, the care coordination manager works with internal leadership to ensure that the health plan has the appropriate services and systems in place to address the needs of the enrollees. The health plan likely has a clear protocol for how to manage persons that are identified as high risk because of multiple chronic conditions, high utilization of services, or children with documented special health care needs. Yet, the care coordination system may not be organized to support the identification of children and families exposed to trauma or children with social/emotional delays. With the understanding of the ramifications of under-identifying and serving this population, the care coordination manager is in the position to promote screening for social/emotional/behavioral/cognitive problems and trauma exposure for infants and young children and their parents throughout the provider network. The care coordination program could establish protocols with clear expectations and processes in place to accept these referrals from the provider network practitioners to serve these children and families.

Undeniably it is difficult to identify families struggling with exposure to trauma or toxic stress if the family is not forthcoming with the information. There are numerous reasons that parents may not be comfortable sharing the information. They may be fearful of negative judgment and ramifications, have guilt associated with the child's exposure to trauma or not understand the potential negative outcomes for their young child if left untreated. Families who have experienced trauma and toxic stress often have multiple risks. They may be living in neighborhoods prone to violence, be experiencing interpersonal violence, exposed to poverty,

The care coordination program could establish protocols with clear expectations and processes in place to accept these referrals from the provider network practitioners to serve these children and families.

or dealing with parental behavioral health disorders. The multiple individual issues of the family members contribute to the complexity of the needs. For example, parents may have been exposed to trauma themselves, experiencing depression or other medical conditions while the child is also experiencing symptoms of exposure to trauma and toxic stress. These cumulative factors may make it very difficult for families to face these issues for the benefit of their children. Therefore, the managed care plan may want to develop an array of methods to identify families and offer assistance. Below are some suggestions for how the managed care company could establish systems to identify families.

- Require that primary care providers and practitioners working with families, such as therapists (behavioral, speech, occupational, and physical), screen for social and emotional delays, trauma, or toxic stress. Refer to *Brief #1: Overview of Screening for Developmental and Social Emotional Delays* for more information.
- Train providers to recognize child-parent relationship issues in their practices, asking questions such as:
  - How does the dyad recover or respond to disruptions in the rhythm of their relationships? When disruptions occur, is the dyad able to establish and maintain a state of calm?
  - How does the dyad manage and make use of sensory information in providing support to the infant and young children?
  - How does the caregiver in this dyad, manage personal stress and furthermore, support the stress recovery systems of the child?
  - What is the capacity of the dyad to maintain a regulated emotional state?[10]

When the practitioner or the care coordinator determines that the infant-parent dyad has significant difficulties in maintaining regulation, recovering from distress, or managing intense affect, and that these difficulties are negatively impacting the developmental process, a referral for care coordination and a formal assessment for child-parent issues may be warranted.

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Another means to identify families is through the use of data analytics to identify children and families that may be facing cumulative risks such as:

- Parents with documented behavioral health or other chronic medical conditions with children under the age of five.
- Parents with young children who have been treated for a serious accident, domestic violence, or other significant medical conditions that may interfere with the parent's ability to respond to the needs of young children.
- Children whose screening scores, identified in the well-child check-up, indicate social and emotional delays or disorders.
- Psychotropic drugs given to young children that would indicate the need for further review.

Direct Service Level

At the direct service level, the care coordinator may receive referrals from the network providers regarding young children or parents who are having physical or behavioral difficulties. The care coordinator has an opportunity to work with the providers and families to identify not only the presenting issue but other complicating factors that may be contributing to the situation and undermining the well-being of the children. The care coordinator could consider the following inquiries when receiving such a referral:

- Is there any indication that this family has recently been exposed to traumatic events or that the child has experienced child maltreatment?
- Did the practitioner screen for trauma? If so, what were the findings?
- If the parents have documented behavioral health or chronic medical conditions, was a developmental screening, including one that looks at social and emotional domains, completed for the child?
- What is the level of complexity of the case? Does the family have multiple risk factors such as poverty, few natural supports, multiple family issues, a history of chronic conditions, or interpersonal violence?

Based upon this and other pertinent information, the care coordinator can determine the degree to which they need to be involved in the case. Consideration should be given to the needs of the whole family unit—the needs of the child, the parent, environmental conditions and/or the child-parent relationship. If the care coordinator only looks at the needs of one family member in isolation from the entire family unit, the complexity of the multiple needs of the family may be overlooked. Therefore, the care coordinator should consider collecting as much information as possible on the whole family to determine the true needs of the family unit. In some cases, there may not be evidence of multiple-risk situations and with the assistance of the care coordinator, the network provider can make a referral and coordinate the necessary services. In other situations, the complexity of the case may require that the health plan provide care coordination, and in some cases integrated and extensive care coordination, to address the needs of the young child and family within the array of network and community services..

Assessment of Need

Care coordinators are responsible for assessing the needs of the persons that are referred to them. The accuracy of the entire care coordination process depends on the quality of the information gathered during the assessment. Most managed care companies have an assessment protocol and instruments used to determine the health status of the individual. These health care assessments provide the care coordinator with the information needed to develop the care coordination plan. The process of collecting information could include interviewing the referral source, the parents, other members of the medical team, and community providers. Additional information may be gathered through reviewing the service history of both the parents and the child.

Given the required focus of care coordination on persons with identified complex and expensive medical conditions, the current health care assessments may be geared to only these populations and may not have assessment items that are appropriate to determine the needs of infants and young children. Consideration should be given to developing a health care assessment that looks at the needs of vulnerable young children within the context of the whole family.

Organizational Level

At the organizational level, the care coordination manager could recommend that when children or parents with young children are referred to care coordination (for whatever reason) that the health assessment include items that examine the possibility of adverse experiences,

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toxic stress, and social/emotional/cognitive and behavioral delays. The assessments might include the following questions:

- Has the family recently experienced a traumatic experience?
- Has the family recently been involved with the Department of Children and Families for an abuse/neglect allegation?
- How does the child's development compare with expected milestones?
- Are there any behaviors present with the child or parent that indicate the possibility of exposure to toxic stress?
- Does the parent have a serious behavioral or physical health care condition that might impact parenting?
- What types of natural supports does the family have?
- Does the preschool or child care staff report any concerns?

Additionally, the care coordination manager may wish to consider how the care coordinator will complete the assessment process. The care coordination manager may want to provide additional training to the staff regarding effective ways to work with parents who may have experienced trauma themselves or who have children who have experienced trauma. Issues such as "trauma triggers" or signs of defensiveness that a parent may exhibit are topics that would be helpful. Also, the care coordination department may want to have field staff who are prepared to collect the information face-to-face with the parent in a community setting rather than over the phone. Cultural awareness and sensitivity should also be considered.

Direct Service Level

When the care coordinator receives a referral for young children, the level of need and the array of services required by the family needs to be determined. Initially, it may appear that the child needs to be linked to a single service; however, after further inquiry it may become apparent that the child's needs go beyond the single referral. When the care coordinator receives a referral for a young child or a parent with a young child, the care coordinator may want to look more closely at the situation to determine if there are other less obvious issues associated with the presenting condition. For example, if a child is referred for language delay, the care coordinator may ask the physician what other types of behaviors she has observed, that might indicate a multi-risk situation.

Collecting the Information

When the care coordinator suspects that the situation may include exposure to trauma or multiple risks, the managed care assessment process could include gathering information on the following:

Past medical or behavioral history

- History of abuse or neglect, either with the parent when they were a child, or with the child (subject of the referral)
- History of parental substance use disorders, including prescription drug use, mental health issues, and/or domestic violence
- Prenatal exposure to substances
- Parental incarceration

Factors associated with socioeconomic status and family circumstances

- How long has the family been on Medicaid?
- Employment status of the parent(s)
- Safe and stable housing status
- Access to nutritious food
- Recent loss of a parent or caregiver – divorce, military deployment, death
- Neighborhood safety – exposure to violence
- Presence of extended family support
- Sibling referrals

Current medical or behavioral health issues for child

- Has the health care practitioner completed any developmental screenings and what were the results?
- Has the child been exposed to a traumatic event?
- Does the child have atypical behavioral issues at home or in child care?
  - Aggression
  - Inability to form relationships
  - Inability to self-regulate
  - Atypical fears or avoidance of activities
  - Hoarding food
  - Inappropriate touching
  - Overly withdrawn, timid, or depressed – lacks joy
  - Other behaviors of concern by caregivers or health care practitioner

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- Does the child have issues identified in the health care arena such as:
  - Sleep disturbances
  - Problems with nursing or eating disturbances
  - Atypical delays or behavioral issues associated with toileting
  - Enuresis
  - Obesity
  - Skill regression (reappearance of behaviors common to an earlier developmental phase)
  - Physical health issues that are interfering with the child-parent relationship

Current medical or behavioral issues for the parent

- Present substance use, including prescription drugs, or mental health disorder
- Present serious medical condition
- Grief or significant loss
- Recent or past exposure to traumatic event
- Domestic violence
- Parent incarceration

Child-parent relationship issues

- Has any health care practitioner conducted any type of screening or assessment on parenting or child-parent relationships? What was the result?
- What are the levels of parental stress in the relationship?
- Has any health care practitioner completed a trauma screen? What was the result?
- How does the parent describe the child and the parenting relationship? Is it in positive terms?
- What is the parent's form of discipline?
- Has any member of the team observed the child and parent interactions? If an infant, does the parent appear able to soothe and calm the child. Does the parent hold and handle the baby in a nurturing fashion? If a toddler, does the child appear to use the parent as a safe base?

Psycho-social support system

- Does the parent have a positive natural support system?
  - Grandparents
  - Faith-based associations
  - Neighborhood supports
  - Friendships
  - Community organizations and functions
- Does the parent utilize these supports?

Collecting the above information may be challenging. The development of memoranda of understanding or service system agreements may increase the ability to share information. Confidentiality of information is of utmost importance and must be addressed through appropriate release of information collected in accordance with the managed care policies. Accessing information outside of the managed care provider network may be even more challenging and will require release of information and careful communication with all parties.

When collecting the information, the case coordinator will likely begin the interviews with the referral source and collect as much of the above information from them as possible. The care coordinator may also discuss the case with other members of the managed care team to determine if any of the needed information is available through the managed care electronic system or through personal knowledge of the family by the team members. If there are any indications of medical or behavioral issues with the parents, the care coordinator may want to interview the parents' primary care provider.

After collecting as much basic information as possible, the care coordinator will contact the parent to discuss the referral and the families' needs. In conversations with the parents, the care coordinator should strive to be proactive and nonthreatening, perceived as an advocate,and viewed as a source of support for the family. The care coordinator can also encourage the parent to be participatory, which is accomplished by the care coordinator's supportive approach, avoiding overly directive or controlling behavior.[11] Given the sensitive nature of the information to be collected, the care coordinator should consider the sequence of conversations very carefully. Since the first contact with the parent is so important to the overall success of the case, the care coordinator may decide not to delve into some of the more sensitive subject matter

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during this first conversation and may instead focus on the referral. Establishing a supportive rapport and determining how the parent perceives their needs will promote a cooperative relationship..

Engaging the Parents

If it appears that the parent may not fully understand the purpose of the referral or may not be willing to share the full range of information, the care coordinator may want to carefully plan the subsequent conversations and use motivation interviewing techniques to assist the communication. Refer to the *What Is Motivational Interviewing?* guide for more information. In circumstances involving parents and their children, face-to-face interactions may be preferable to phone conversations. Where it appears that the family has multiple risks, and the managed care company has field case managers, it may be more beneficial for the field staff to make contact with the family. Face-to-face interactions may strengthen the possibility for forming a working alliance and allow the care coordinator to observe the living environment, the child, parent functioning levels, and their interactions.

In many situations, the parents may demonstrate that they appreciate the importance of strengthening their parenting behaviors, that they will address the develop- mental needs of their child or their child's exposure to trauma, and show that they are motivated and able to take action. After careful analysis, the care coordinator and the team may think that the family is well-positioned to address their issues themselves and that a referral to community programs may be sufficient with follow-up and monitoring. Formal treatment and care coordination may not be required.

In other situations, the family members may not be as forth-coming with the information regarding the status of their child and their family. Information about the child-parent relationship may not be available through collateral contacts and interviews. If the referral source—such as the primary care pediatrician—has a good relationship with the parent, the care coordinator may seek the assistance from the practitioner to further explain the importance of obtaining assistance for the family and child and further address the parent-child relationship.

The care coordinator may need to work with the parent to understand the nature of the issues in question and obtain the parents' agreement to participate in formal assessments. For assessments of the child-parent relationships, the family should be referred to a licensed mental health practitioner who is experienced in assessing and treating families and addressing the child-parent relationship. The assessment must include direct observations of the child-parent interactions. The assessment is a process and should be comprehensive and look at the perceptions, behavior, history, and interactions. Figure 3 below shows the components that should be included in the assessment.

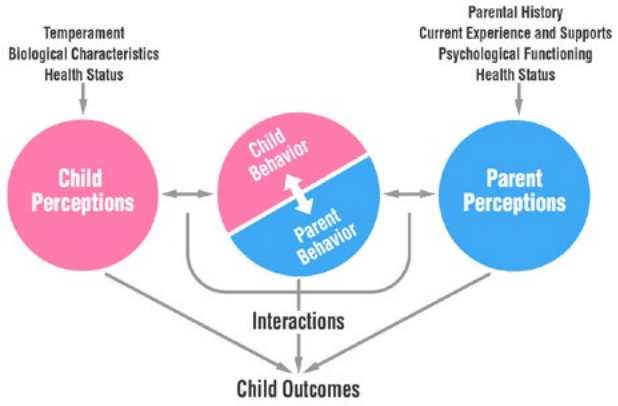

Figure 3. A diagram depicting how the interactions of the child and parent are at the center of inner circles of proximal, or close, variables that have a direct effect on the development of the child. An understanding of the impact of proximal variables is key to understanding child development. Source: Early Intervention with Multi-Risk Families - Integrative Approach, by Sarah Lane, PhD and Rosanne Menna, PhD.

The care coordinator should contact the behavioral health care team in their managed care plan or their behavioral health organization sub-contractor to determine which behavioral health care providers in the network have the capacity to provide these assessments.

Depending on the needs of the family, other assessments may need to be considered such as:

- Parental behavioral health (mental health or substance use disorders)
- Speech and language, occupational, or physical therapy
- Pediatric developmental assessment

Once all the information and formal assessments are completed, the care coordinator and other team members must synthesize the information and develop an overall understanding of the needs of the family.

Creating the Plan of Care

In cases where there is likely exposure to toxic stress and trauma, and the family has multiple complex needs, the case may require an integrated care plan. Both medical and behavioral team members and the family will need to work together for successful outcomes.

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Organizational Level

An integrated care coordination plan of care may be needed for families with multiple risks associated with exposure to trauma and toxic stress. The complexity of the case may be a result of numerous issues within the family unit rather than an individual's multiple chronic conditions, as is often the situation with other patients in the care coordinator's caseload. The pediatric population, especially very young children, poses unique challenges to care coordination, because meeting the needs of the children are completely dependent upon their caregivers.[12] Effective care coordination must therefore address the needs of the parents and the child. Additionally, in the work with young children exposed to trauma or toxic stress, the care plan must also address the child-parent relationship, if issues are present. The care plan will likely include coordination of treatment and services with multiple providers, some of whom may not be in the managed care network. The care coordinator will need to be prepared to work with this level of complexity in developing and monitoring the care plan. The care coordination manager may want to provide additional training and supervision around how to create and monitor this type of plan. Coordination of practitioners' specific treatment plans is also of concern when working with this type of case. Practitioners may want to consider how their specific treatment plans might influence others, and/or how the child's environment relates to the overall plan execution.[13] The managed care plan may want to determine the best way to promote this type of integration of the treatment within their provider network when working with young children and their families exposed to trauma and toxic stress.

A review of the health plan's protocol for reporting child abuse may also be warranted. Additionally, providing an appropriate workshop or individual consultations to assist the care coordinators in determining their own ACE score may be helpful in preparing them to work with these challenging families.

Direct Service Level

The care coordinator will need to gather all the information and assessment results to form the plan of care. This plan should be developed with the parent and other involved providers or stakeholders and be built on the strengths of the family. The plan of care should provide for assistance to the parent to more fully understand the needs of the child and to help the family build self-management skills. With multi-risk families that have a history of trauma or toxic stress, the process to develop self-management skills may take time, especially if a parent has a behavioral health disorder. In situations where the child is involved with the child welfare system, it is paramount that the child welfare case manager and or foster parent, if appropriate, be involved in the development of the plan of care. As the team develops the plan, they may want to consider other resources outside of the managed care plan's network. Please see the *Practitioner Resource Guide* for additional information.

When creating the plan of care for cases where child-parent relationships need to be addressed, there are additional factors to consider. These include the type of services available in the provider network and community, the specific needs of the family, the family's characteristics, and the motivation of the family members. The most common interventions in Florida are Parent-Child Interaction Therapy, Circle of Security, Child Parent Psychotherapy, and home visiting programs. The first two resources are based on a behavioral training and parental skill building approach. These interventions may be a good fit for parents who can incorporate new skills fairly quickly and are highly motivated to learn more and want to participate. With cooperative families, these models can produce improvements if implemented with fidelity to the model. These models work best when there is not chronic pathology within the family system. When the child-parent relationship has significant problems and the parent may have experienced significant trauma, a more extensive therapeutic psychodynamic treatment approach, such as Child-Parent Psychotherapy, could be considered.[14] Most home visiting programs are geared to families without current child welfare involvement. Some home visiting programs have special features that make them appropriate for families with multi-risks such as Nurse Family Partnership which works with first time young mothers. The Healthy Families home visiting program works with families that are at risk for child abuse.

As discussed, the plan of care may span multiple different providers and agencies as illustrated below in Figure 4.

Figure 4. Plan of Care.

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Implementing the Plan of Care

Implementing the plan of care will likely require work within the managed care network and the local early childhood system of care. The early childhood system of care is very different than the system of care for adults or older children. Successful work within this system will require the development of a new set of working relation- ships, linkages, and follow-up methodologies.

Organizational Level

For care coordination to be effective, the care coordination manager may want to ensure that the care coordinators are aware of all the services and supports available for young children and their families. An established relationship with primary referral sources and a referral and communication protocol is key to a successful referral system. The upfront work, completed by the care coordination department, with the early childhood system of care will help the care coordinators work more effectively within the system and be more successful in arranging and coordinating services.

Direct Services Level

The care coordinator should strive to implement the care plan through the participation of the family and other team members. Helping the parents fully understand the purpose of all referrals, what services can be arranged, what parental participation is necessary, and what interactions to expect with practitioners, is ultimately the responsibility of the care coordinator. The care coordinator can coach and assist the parent in making and attending appointments. Depending upon the ability or current motivation of the parent, the care coordinator may need to provide a fairly high level of assistance at the beginning of the case to encourage the parent to access the necessary treatment and support. Assistance can then slowly fade as the parent becomes more proficient. **As stated above, the only way to really serve the child is to serve the parent.** The end goal of the child's well-being should be utmost in the mind of the care coordinator.

In complex cases with multi-risk families, the care coordinator serves as the communication conduit and "glue" necessary to integrate services. To be effective, all the different provider team members and community partners must work together with consistent approaches and messages. The care coordinator can work with the parent/family to make sure that all the parties are working toward the same goal and that the therapeutic services and supports are complementary. For example, if one of the parents is receiving treatment for depression from one provider and child-parent psychotherapy from another, the care coordinator will want to ensure that the treatment is coordinated and the therapists are in communication. The primary care provider must also be knowledgeable of the status of the respective treatments.

Monitoring Services

During this phase of care coordination, the implementation of the plan is evaluated. The care coordinator determines if the services have been put in place and are effectively meeting the needs of the family. Given the multiple needs of the population, the care coordinator focuses on the integration of services and the collective impact of the treatment and services to address the needs of the parents and children. If the family is not benefiting or participating in services, the care coordinator will evaluate the care plan, and with the family and the multi-disciplinary team, make recommendations for changes in the plan. This process, including conducting additional assessments, will continue to adjust to the needs of the family and children.

Transitioning Care Coordination

At some point, the family should have benefited substantially from treatment and services and will be developing the skills to manage and coordinate their own care. The care coordinator will begin to work with the family to transition the case to another level of care and likely reduce the level of coordination provided to the family.

The considerations at this point are as follows:

- Have the therapeutic services improved the ability of the parents to support the needs of the child?
- If additional natural supports are needed, are these supports in place and are they sustainable?
- Do the parents have a good understanding of the needs of the child? Have they demonstrated the ability to address the needs?
- If other community services are contributing to the stability of the family, is the continuation of these services assured?
- Are necessary aftercare or continuation services in place, such as recovery supports for the parents and quality child care for the child?
- If the child needs additional therapeutic services such as speech, occupational, or physical therapy, are these services established and will they be authorized for the level of services needed.
- Are the parents prepared to coordinate the level of care and services needed?
- Is there a post-transition plan in place where follow-up will be conducted to check on the status of the family?

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SUMMARY

Medicaid Managed Medical Assistance health plans have an opportunity to significantly address the needs of enrollees who have been exposed to trauma and toxic stress. The managed care health plan can develop methods to identify families with exposure to trauma and toxic stress and enable care coordination to work with these multi-risk families to arrange and secure appropriate services across the provider network and within the community. The care coordination program within the managed care program is especially well positioned to help the network practitioners meet the complex needs of trauma-exposed children and families.

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The Array of Infant Mental Health Services

What is the Array of Infant Mental Health Services?	Level 1 Prevention/Promotion Strengthening the Caregiver/Child Relationship, Responsive Caregiving	Level 2 Intervention Developmental, Relationship-Focused Early Intervention	Level 3 Treatment Infant Mental Health Treatment
Priority population	**Expectant families and families of all children birth to age five.**	**Families of children with delays, disabilities, health problems, trauma, toxic stress, or multiple risk factors.**	**Families with children or primary caregivers with severe mental health problems or who have experienced complex trauma.**
Description of services/ interventions	**Strengthening the caregiver/ child bond by:** ▪ Helping caregivers to understand and respond appropriately to baby's cues. ▪ Incorporating brain development research and attachment theory into all aspects of pregnancy, birthing and child's daily care. ▪ Promoting continuity of care. ▪ Supporting the child's on-going emotional development within the context and culture of the family. ▪ Modeling responsive caregiving. ▪ Providing family support and education. ▪ Identifying early signs of problems that might impede the parent-child relationship. ▪ Ensuring caregivers understand the negative impacts of stress and trauma on young children. ▪ Referring for further screening/ assessment.	**Strengthening the caregiver/ child bond through:** ▪ Identifying emotional or attachment concerns. ▪ Integrating relationship-based practices and a trauma-informed approach into the child's existing services (therapies, medical treatment, foster care). ▪ Reframing challenging behaviors that may indicate underlying trauma or unmet emotional needs. ▪ Providing services based on context, culture, and needs of the child and family. ▪ Providing consultation to enhance responsive caregiving. ▪ Assisting the family in accessing specific infant mental health treatment as needed.	**Strengthening the caregiver/ child dyad and family through:** ▪ Establishing a nurturing relationship based on trust and respect of family strengths. ▪ Identifying the trauma history, its effects on the family, and utilizing this knowledge in practice. ▪ Using developmentally appropriate observation, assessment and diagnostic systems. ▪ Providing therapeutic interventions for caregivers and young children with specific mental health and/or trauma-related needs. ▪ Providing ongoing, intensive treatment with parent/child dyad. ▪ Serving as a consultant to other service providers who work with young children and families.
Professionals responsible for Infant Mental Health services	**Front-line caregivers including:** ▪ Parents ▪ Child Care Providers ▪ Health Care Providers ▪ Home Visitors ▪ Parent Educators ▪ Social Workers ▪ Child Protection Case Workers ▪ Police Officers, Judges, Lawyers	**Developmental Professionals including:** ▪ Social Workers, Psychologists, Mental Health Therapists (Master's level or licensed) ▪ Child Development Specialists ▪ Early Interventionists ▪ Therapists (Occupational, Physical and Speech) ▪ Maternal and Child Health Nurses ▪ Developmental Pediatricians working in conjunction with child welfare, legal systems, & family service programs	**Licensed mental health professionals having additional training in infant mental health including:** ▪ Child, adolescent, and adult psychopathology ▪ Infant/toddler development ▪ Parent/infant attachment ▪ Assessment and treatment within the parenting relationship ▪ Complex trauma and toxic stress ▪ An understanding of context, culture and family systems ▪ Dyadic, infant/parent psycho-therapy and other evidence-based treatments

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