

# **Integrating IMH and Trauma-Informed Practices into Behavioral and Physical Health Services within the MMA Health Plans**

*A report that addresses how Infant Mental Health and  
trauma-informed practices could be integrated into the  
behavioral and physical health services  
provided through the MMA health plans*



**Florida State University  
Center for Prevention & Early Intervention Policy**



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# 1 Introduction

## Purpose of Report

The purpose of this report is to provide information to the Managed Medical Assistance (MMA) health plans on integrating infant and early childhood mental health and trauma-informed practices into Medicaid services, especially those services that have not historically focused on children ages birth to five. With advances in neuroscience, molecular biology, genomics, developmental psychology, epidemiology, sociology, and economics research, it has become clear that infant and early childhood is a critical period in which the combination of genetics, epigenetics, and environment shape a child's physiological development, impacting both behavioral and physical health for a lifetime.<sup>1</sup>

## Overview of the Report

The report is organized into five main sections: **Introduction, Pediatric Primary Care, Primary Care for Adults, Behavioral Health Care, and Options for Coordination, Co-Location, and Integration of Services.** In the "Introduction," the description and scope of infant and early childhood mental health is discussed to establish that this field is grounded in prevention, intervention, and treatment. The health care implications of toxic stress and trauma are discussed with a brief overview of the physiological implications of early childhood exposure to adverse experiences such as childhood maltreatment. Information is presented that illustrates how trauma exposure and Adverse Childhood Experiences (ACEs) have a direct impact on the overall behavioral and physical health of the child and later, on their adult health. The description of trauma-informed care in this section provides a framework for trauma-informed care principles in the areas of primary care and behavioral health practices.

The remainder of the report focuses on the four key medical practices that are provided as part of the Medicaid services included in the Medicaid Model Contract for MMA health plans that reimburse for primary care and behavioral health services. The range of Medicaid services includes Advanced Registered Nurse Practitioners, Behavioral Health Services, Rural Health Clinics, Federally Qualified Health Centers, County Health Departments, Child Health Check-Ups, and Physician Services. Rather than a review by each Medicaid service, this report is organized by the following practices:

- pediatric primary care
- adult primary care
- behavioral health
- coordination, co-location, and integration

The goal of this report is to show how MMA plans can support primary care, and how behavioral health providers can increase the prevention, screening, assessment, intervention, and treatment of early social, emotional, and behavioral conditions, thereby supporting and improving child-parent relationships and reducing potential negative outcomes of early childhood adversities. The section "Options for Coordination, Co-Location, and Integration of Services" highlights the importance of these strategies when infant and early childhood mental health is provided within primary and behavioral care.

Each section includes a discussion of the actions that could be taken by the MMA health plans, either individually or cooperatively, to expand infant and early childhood mental health principles and practices throughout Medicaid services, as well as promote the use of trauma-informed practices.

## Description and Scope of Infant Mental Health

In 2001, the Zero to Three organization defined infant mental health (IMH) as stated below:

*...the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development.<sup>2</sup>*

This definition may appear to refer primarily to children's social, emotional and/or behavioral milestones; however, the importance of close and secure relationships and the desired outcomes of healthy behaviors is emphasized. The inclusion of relationships and caregiving contexts also broadens the scope of IMH from the developmental needs and strengths of the child to include the capacities of the parent. Recent research on the brain and emerging knowledge of eco-bio-development provide the physiological foundations for this definition of infant mental health. This knowledge is fundamental in understanding the intergenerational transmission of emotional issues that can interfere with parenting.

The age span covered in this report is from birth to five; therefore, the term "infant and early childhood mental health" is used for clarity throughout. Additionally, because the infant and early childhood mental health field concentrates on social, emotional, and behavioral development, these terms appear throughout this report as well.

### Five Key Components in an Infant and Early Childhood Mental Health Approach

Though much has been written to describe the uniqueness of the field of infant and early childhood mental health and its approach, the following five key components capture its essence.<sup>3,4</sup>

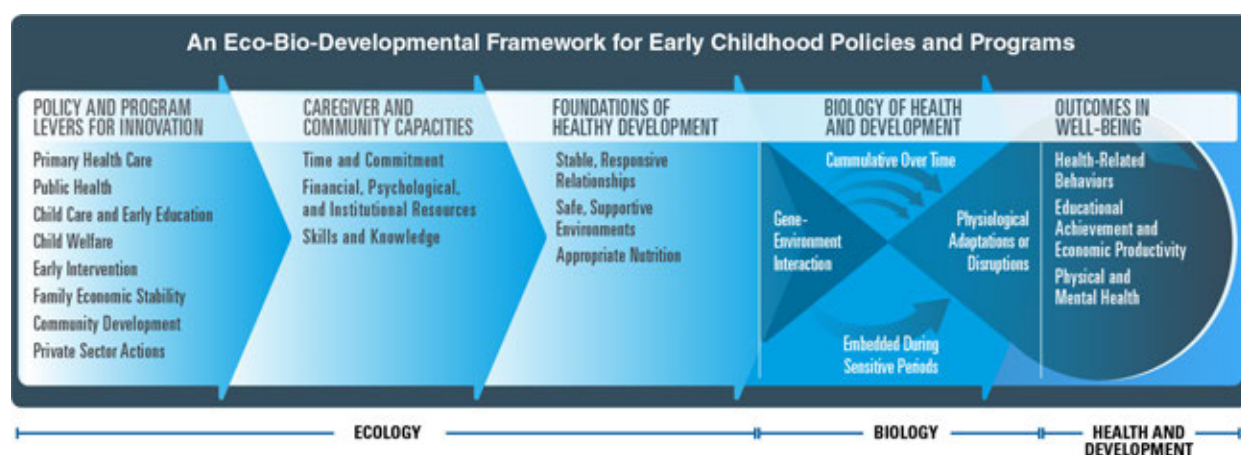
1. **Developmental Orientation** - This component highlights the importance of an understanding of development and learning across the entire lifespan. Though there is unique potential and vulnerability during the prenatal and early childhood periods, it is also clear that knowledge, skills, and positive habits can be learned at any age. Health and mental health professionals can benefit from adopting a developmental orientation with clients of all ages.
2. **Multidisciplinary Perspective** - With the expansion of integrative, multilevel and trans-disciplinary approaches and the increasing interest in social determinants of health, there is clearly a need for expertise from many disciplines to understand health and developmental processes and promote best outcomes. No single discipline or individual can possibly know "all the answers," or even all the questions, that enable them to fully grasp the health needs of children, parents, and families. Availability and access to shared expertise is essential to an infant and early childhood mental health approach.

3. **Relationship-Based Approach** - When considering young children, the essential need for protective and loving relationships with family members is clear. Nurturing family environments can be the primary resource in preventing toxic stress, as well as lessening the negative effects in situations where toxic stress is unavoidable. Secure relationships are a predictor of long-term positive outcomes in many areas of achievement and adjustment.<sup>5</sup> Promoting positive child and family health can support the establishment and maintenance of secure attachments. Unfortunately, families can also be the primary source of a child's toxic stress and trauma. Some families may have difficulty serving as a buffer for their child in the face of extreme or chronic stress (for example, when a parent is so traumatized by the family's violence or disaster exposure that he or she cannot cope with their child's trauma symptoms).<sup>6</sup> When the child's need for nurturance and protection cannot be met, it is imperative that family supports be available or a developmentally-sensitive alternative is provided as soon as possible (for example, in cases of maltreatment, intense diversion programs, kin or foster care may be needed).<sup>7</sup> Beyond the child development benefits, "continuity of care" models with health care providers can also be important in client engagement and sustained participation in many types of services for people of all ages.<sup>8</sup>
4. **Multi-Generational View** - While it is common to think of the "typical family" as consisting of a single unit of parents and children, many families have much more complex units. In addition to networks of parents, step-parents, and children with different degrees of biological-relatedness, many families also have varying degrees of involvement with extended family members of different generations. For adolescent parents, their own parents may be key sources of support or stress in their relationships with their infants and toddlers.<sup>9</sup> Family members may have widely varying perspectives on child-rearing, and views and values regarding essential human functions like eating and sleeping. Adults' health and parenting are strongly influenced by their immediate and extended family. An infant and early childhood mental health approach considers these multiple sources of influence, supports, and potential stress in promoting healthy development and relationships.<sup>10</sup> Awareness of and sensitivity to parents' adverse childhood experiences can help providers have a better understanding of family health behavior and parenting patterns.
5. **Considerations of Cultural and Individual Diversity** - Regardless of their primary professional discipline, providers of infant and early childhood mental health-related services must consider how the cultural and individual diversity of their clients impacts all facets of the provider's efforts with those families.<sup>11</sup> Overall challenges such as racial disparity in health access and outcomes, greater linguistic diversity among clients than providers, immigration policies, and family members' immigration status pose significant barriers to providers and families attempting to address and solve health problems and promote positive outcomes.<sup>12</sup> While individual providers cannot "fix" system difficulties, they can pay attention to how they and their patients each face these challenges in their day-to-day work. This awareness can enhance the quality of their efforts to improve family health and children's outcomes.

To illustrate the application of these five components, the Florida State University Center for Prevention and Early Intervention Policy (FSU Center) developed a 3-level chart in 2006 showing the types of infant and early childhood mental health services—including prevention, intervention, and treatment—that should be available throughout the system. See **Appendix A, Florida's Strategic Plan for Infant Mental**

*Health: 3-Level Chart.* Opportunities to address the key features of infant and early childhood mental health are evident throughout Medicaid services. An infant and early childhood mental health approach offers opportunities to promote positive social, emotional, and behavioral development and break the intergenerational cycle of adverse childhood experiences. According to Dr. Linda C. Mayes of the Yale Child Study Center, “Early chronic, toxic stress compromises not only children’s cognitive and emotional development but also specific capacities in these children as adults that are key to caring for the next generation.”<sup>13</sup>

Infant and early childhood mental health services are central to preventing and treating the impact of toxic stress on behavioral and physical health. Focusing infant and early childhood mental health services on the key ecological components of development has the potential to prevent long-term disease. This relationship between infant and early childhood mental health and ecological development can be understood by reviewing the Eco-bio-developmental Framework graphic described in *The Lifelong Effects of Early Childhood Adversity and Toxic Stress*<sup>14</sup> and adapted from *The Foundations of Lifelong Health Are Built in Early Childhood* (2010) from the Center on the Developing Child at Harvard University ([www.developingchild.harvard.edu](http://www.developingchild.harvard.edu)).



Specifically, infant and early childhood mental health practices directly address the fundamental ecological determinants associated with lifelong well-being as described below:

- **Policy and Program:** It is essential to expand the capacities in these areas to directly address healthy social, emotional, and behavioral development with an emphasis on the relationship between the child and the caregivers. This can be accomplished by infusing the principles and practices of infant and early childhood within the scope of public health, including primary health care, child care, and early intervention.
- **Caregiver and Community Capacities:** Infant and early childhood mental health specialists have the expertise to directly impact the psychological resources of the family. They can provide information to strengthen skills and knowledge in early childhood parental interactions and the relationship with the child, and promote positive early social, emotional, and behavioral development.
- **Foundations of Healthy Development:** Infant and early childhood mental health services focus on the promotion of stable, responsive, nurturing relationships between the child and parent or



other caregivers. Additionally, the field provides extensive information on the need for strong, safe, supportive, and nurturing environments, as well as how to create them and, if necessary, heal them.

The pervasive impact of toxic stress is a call to action. No one discipline, public agency, or community initiative can independently address this extensive social and public health issue. Joining the forces of health and human services and community initiatives is much more efficient and cost effective. The promotion of nurturing child-parent relationships and healthy social, emotional, and behavioral development is important for all children and families. Prevention of, and early intervention in, high-risk situations such as exposure to toxic stress is imperative to meet the goals of improved long-term health outcomes and reducing health care expenditures. The integration of infant and early childhood mental health practices into primary care, behavioral health, and care coordination is a promising start toward this goal.

## Health Implications of Trauma and Toxic Stress

The knowledge of early childhood development has evolved to the point that the actual biological, neurological, and physiological impact 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 it 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.*<sup>15</sup>

Current evidence suggests there are biological consequences of psychological stress that impact the brain, and the endocrine and immune systems.<sup>16,17</sup> Dr. Jack Shonkoff, director of the Center for the Developing Child at Harvard University explains that there are three basic levels of stress:

- **Positive stress response** is a normal and essential part of healthy development, characterized by brief increases in heart rate and mild elevations in hormone levels. Some situations that might trigger a positive stress response are the first day with a new caregiver or receiving an injected immunization.
- **Tolerable stress response** activates the body’s alert systems to a greater degree as a result of more severe, longer-lasting difficulties, such as the loss of a loved one, a natural disaster, or a frightening injury. If the activation is time-limited and buffered by relationships with adults who help the child adapt, the brain and other organs recover from what might otherwise be damaging effects.
- **Toxic stress response** can occur when a child experiences strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress

response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years.<sup>18</sup>

The American Academy of Pediatrics (AAP) article, *The Science of Early Life Toxic Stress for Pediatric Practice and Advocacy*,<sup>19</sup> provides a comprehensive description of the current research findings on how early environments impact human development. The article explains that toxic stress can alter the functioning of the neuroendocrine-immune-network (NEI). This network plays a critical role in physical, cognitive, and socioemotional development by sensing, interpreting, and orchestrating the body's response to stress in the environment. Chronic activation of the stress response affects the regulatory systems, such as the immune system, which are linked to the hypothalamic-pituitary-adrenal (HPA) axis. The HPA axis is responsible for managing metabolic and cardiovascular responses to acute and chronic stress, among other functions. One of the primary consequences of early life toxic stress is the HPA dysregulation, which has broad effects on immune and inflammatory processes. Too much cortisol (stress hormone) suppresses immunity and increases the chance of infections while too little cortisol results in the persistence of the inflammatory immune system response after it is no longer needed. Chronic levels of inflammation contribute to pathophysiology of several chronic conditions, such as cardiovascular disease or type 2 diabetes.<sup>20</sup>

Abnormal endocrine and immune functioning in children exposed to adverse childhood experiences may impact brain development as well. There is growing evidence linking a history of maltreatment to structural and functional brain differences.<sup>21</sup> These findings are seen in children with histories of maltreatment, whether or not they have a mental health diagnosis. Additionally, gender findings were noted in neurostructural alterations. In girls, the affected brain regions were those that involve emotional regulation; where in boys, the affected brain regions were those involved in impulse control.<sup>22</sup>

Experimental research shows that mice exposed to stress early in life experience biochemical changes in their genetic material that result in abnormal expression of key genes regulating the biological response to stress. Through changes known as epigenetic modifications, it is hypothesized that the developing child's ability to respond to stress is similarly changed. For example, when a child senses an unpredictable environment, they may experience a hyperactive stress response, which may also result in an increased burden of disease during childhood and in later life.<sup>23,24</sup>

Research evidence also shows that there appear to be specific windows of vulnerability during brain maturation called "stress sensitive periods" during which brain regions are undergoing active maturation and are thus more susceptible to the effects of overwhelming toxic stress. The data to date strongly suggest that incidents of child maltreatment, as reflected in high ACE (adverse childhood experiences) Scores,<sup>a, 25</sup> may have profound negative effects on executive function, attention, memory,

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<sup>a</sup> The 10 ACEs studied are as follows: 1. Emotional abuse; 2. Physical abuse; 3. Sexual abuse; 4. Emotional neglect; 5. Physical neglect; 6. Witnessing domestic violence; 7. Alcohol or other substance abuse in the home; 8. Mentally ill or suicidal household members; 9. Parental marital discord (as evidenced by separation or divorce); 10. Crime in the home (as evidenced by having a household member imprisoned)

and visual-spatial function.<sup>26</sup> These deficits can impair day-to-day performance and lead to lower overall levels of functioning for a lifetime.

Exposure to adverse childhood experiences is associated with harmful behaviors such as smoking, use of alcohol and illicit drugs, and unhealthy eating. These behaviors are directly related to negative health consequences. Additionally, toxic stress in early childhood has been shown to cause physiological disruptions that persist into adulthood and lead to disease, even in the absence of health threatening lifestyles. To reiterate, the biological manifestations of toxic stress can include alterations in immune function and measurable increase in inflammatory markers, which are associated with poor health outcomes including cardiovascular disease, viral hepatitis, liver cancer, asthma, chronic obstructive pulmonary disease, autoimmune disease, poor dental health, and depression. “Toxic stress can be viewed as the precipitant of a physiologic memory or biological signature that confers lifelong risk well beyond its time of origin.”<sup>27</sup>

In addition to the potential human suffering associated with trauma and toxic stress, there is a huge financial burden. Health care expenditures associated with unhealthy lifestyles are enormous. The costs of chronic diseases that may have their origins early in life consume a substantial percentage of current state and federal budgets (Medicaid). The potential savings in health care costs from even a small reduction in prevalence of disease related conditions would be substantial. This could be achieved through well-executed infant and early childhood programs.<sup>28</sup>

A recent Centers for Disease Control and Prevention (CDC) study, *The Economic Burden of Child Maltreatment in the United States and Implications for Prevention*,<sup>29</sup> found the total lifetime estimated financial costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse, and neglect) is approximately \$124 billion. The CDC study found that for children in the child welfare system, Medicaid costs were \$32,648 higher per victim than for other children. The medical costs included expenditures during childhood from ages 6 through 17 and are expressed in 2010 dollar value. Another \$10,530 is estimated per person for adult medical costs when an individual reaches adulthood. Although all children with high ACE Scores, and who are in the high-risk category, will not be a confirmed child protection case, children who grow up under similar circumstances and chronic stress are at a high risk to have similar medical and social profiles with the associated high costs.

## Description of Trauma-Informed Care

A trauma-informed system of care addresses the family’s exposure to trauma and responds to the impact of toxic stress on behavior and health. **Appendix B, Sources of Resilience and Vulnerabilities**, shows the relationship of exposure to trauma and toxic stress on overall development.

Trauma is often kept secret or ignored. Without intentional inquiry, behavioral and primary care providers may be unaware of past trauma. When people avoid talking about trauma, they may create interactions, experiences, or environments that trigger the trauma and cause re-traumatization to the child. To view the situation through a “trauma lens,” the question is not “What is wrong with you?” but instead, “What happened to you?”

Infants, toddlers, and preschoolers are particularly vulnerable to trauma exposure. Young children rely on their parents and caregivers to keep them safe. They interact with their environment before they become aware of the potential dangers and trust that their parents will protect them. If the parent or caregiver does not have the capacity to provide the necessary protection, the child is at a greater risk for trauma exposure. Young children fall within the highest risk category for exposure to sexual and physical abuse, unintentional injury, and witnessing domestic violence. Other potentially traumatic events for young children include natural disasters, war, terrorism, painful medical procedures, and witnessing a threat to their parent/caregiver.

It is important to be aware that a young child's perception of threatening situations may differ from that of an adult. Because the brain of a young child is still developing, they are at risk of making false assumptions or drawing the wrong conclusions. This can compound the negative impact of the trauma (e.g., "The burn happened because I was bad.") Further, due to a young child's limited verbal skills, it may not always be obvious they have experienced a traumatic event.

Fortunately, most young children are resilient, or experience only transient distress following exposure to a traumatic event. However, studies with injured preschool children have shown that approximately 10% are at risk of developing a chronic Post Traumatic Stress Disorder (PTSD) symptom. A 2-year longitudinal study demonstrated that PTSD symptoms in preschool children with mixed traumatic experiences did not remit over time. According to the National Child Traumatic Stress Network, approximately 25% of children and adolescents in the community have experienced at least one potentially traumatic event during their lifetime such as life threatening accidents, disasters, maltreatment, assault and family or community violence.<sup>30</sup>

The impact of trauma must also be considered within the context of the child-parent relationship. Effective response to trauma in young children is highly dependent on the quality of the child-parent relationship, parental behavioral health, and parenting behaviors. Parents who themselves were traumatized as children bring into the relationship the "ghosts from their nursery" creating barriers to the healing of the child's trauma. For young children, the child-parent relationship is particularly important as they need a sensitive and emotionally available caregiver to cope with strong emotions during times of distress. Additionally, young children often look to their parents to determine how to interpret or respond to an event and may therefore model their parent's fear responses and maladaptive coping responses. Parents can also interfere with their child's recovery from trauma by accommodating avoidance behaviors, or allowing their child to be repeatedly exposed to traumatic events or reminders.

Trauma-informed settings design their service delivery to be sensitive to the possibility of trauma and to ensure that their practices do not inadvertently remind the client of the trauma. Ideally, staff are taught to recognize the presence of trauma symptoms and acknowledge the role that trauma has played in their clients' lives. Some people may not have observable symptoms of trauma but come from high-risk environments.

To adequately address trauma in patients, the behavioral or primary care setting should use a trauma-informed approach to care. In this situation, all components of the organization develop a thorough

understanding of the prevalence and impact of trauma, the types of behaviors associated with trauma, and the complex and varied paths in which people recover and heal from trauma.<sup>31</sup>

### Principles of a Trauma-Informed Approach

According to SAMHSA (Substance Abuse and Mental Health Services Administration) the basic principles of a trauma-informed approach include:<sup>32</sup>

1. **Safety:** throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
2. **Trustworthiness and transparency:** organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.
3. **Collaboration and mutuality:** there is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
4. **Empowerment:** throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.
5. **Voice and choice:** the organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.
6. **Peer support and mutual self-help:** are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
7. **Resilience and strengths-based:** a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.
8. **Inclusiveness and shared purpose:** the organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.
9. **Cultural, historical, and gender issues:** the organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g., based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
10. **Change process:** is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

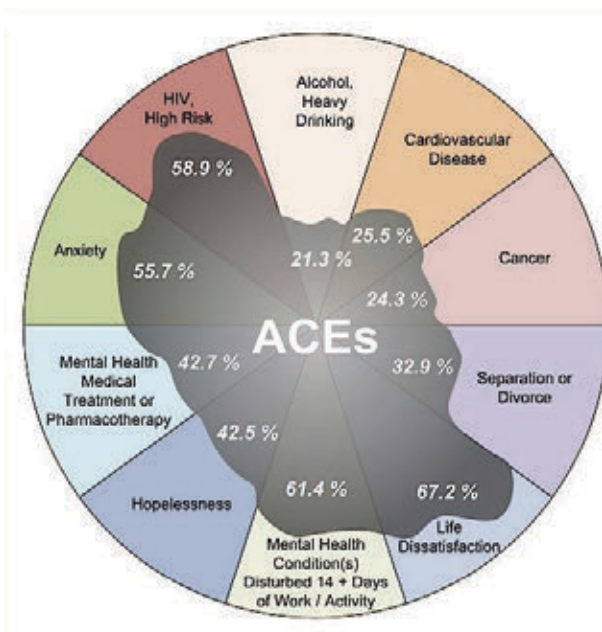
Trauma-informed care is an approach that is gaining momentum throughout the country. It has been shown to improve desired outcomes for individuals, support trauma recovery by reducing re-traumatization, and provide an opportunity for “corrective emotional experience.” A well-designed system also recognizes and decreases vicarious trauma or compassion fatigue of the worker. Systems embracing this approach will assist in more rapid and long-term healing of the trauma survivor and empower them to move beyond their trauma experience(s) into a more healthy lifestyle for themselves, their family, and generations to come.

## Why Infant Mental Health and Trauma-Informed Care Must Be Imbedded in Medicaid Services

The Adverse Childhood Experience (ACE) Study is a landmark research study on the impact of childhood adversity on long-term health. The Study, an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente, describes the negative effect of 10 categories of adverse childhood experiences including forms of child abuse, neglect, exposure to intimate partner violence and other factors on health and social well-being. The Study collected information on 17,000 middle class adults from the Kaiser Permanente Health Plan (private) in San Diego, California. Over 70 publications showing the analysis of the data cohort have shown that:

- ACEs are common in the population.
- ACEs are highly interrelated and often occur together.

The ACE Score (based on number of categories checked “yes” on the ACE questionnaire) has a strong and graded relationship to numerous health and social problems. The synergistic stressor effect of ACEs on human development throughout the lifespan shows that ACEs are major determinants of health. Individuals with a higher ACE Score report increased incidence of addiction, mental illness, social malfunction, health care utilization, chronic diseases, prescription medication use, and premature mortality.<sup>33,34</sup>



Graphic: S. Silveanu, MA, Washington State Family Policy

Many of the children served in pediatric primary care and adults seen in adult primary care have been exposed to adverse childhood experiences. These experiences may have a negative impact on their emotional and physical health. The graphic from the Washington State Family Policy Council illustrates this impact.

Studies have provided biological explanations for the outcomes implicated with ACE Scores. Current evidence suggests there are biological consequences due to psychological stress that impact the brain, and the endocrine and immune systems.<sup>35,36</sup>

The information presented thus far shows that toxic stress and trauma can have a devastating impact on an individual's behavioral and physical health for a lifetime, with associated personal costs to the individual and family, as well as extensive health care costs borne, in many cases, by state and federal governments through programs such as Medicaid. Infant and early childhood mental health practices bring an array of tools, techniques, and knowledge that can address toxic stress and trauma through the promotion of healthy relationships. An infant and early childhood mental health approach should be viewed as one way to avoid the long-term effects of toxic stress and trauma. Establishing trauma-informed primary care and behavioral practices further supports the ability to successfully address health issues and heal trauma to reduce long-term negative consequences.

The Medicaid program serves many low-income individuals who have likely experienced toxic stress and trauma in their past, and may be continuing to do so. Providing these patients with prevention, intervention, and treatment will strengthen the overall functioning of the practitioner's practice, and improve the response to this public health issue. The potential for cost reduction is substantial both in the short- and long-term. The MMA program is an integrated approach to managing health care and the best avenue to incorporating multi-disciplinary practices that better address the complex needs of vulnerable families.

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### ***How the MMA Health Plans Can Work with Provider Networks and Community Partners to Raise Awareness***

- Ensure that providers are aware of infant and early childhood mental health principles and practices.
- Create awareness of trauma and toxic stress and its impact on child development.



## 2 Pediatric Primary Care

### The Capacity of Pediatric Primary Care to Address Early Social, Emotional, and Behavioral Issues in Pediatric Primary Care Settings

The Statewide Medicaid Managed Care (SMMC) program, including the Managed Medical Assistance (MMA) program, places a strong emphasis on primary care, requiring the health plans to develop a program that encourages enrollees to establish a relationship with their primary care provider. Medicaid enrollees have the opportunity to choose their own primary care provider or have one assigned.

The Agency for Health Care Administration's (AHCA) contracts with the MMAs require the health plans to develop and implement an education and tracking system to increase the number of children who receive the Child Health Check-Up according to the established periodicity schedule in the *Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook*. The MMA health plans are expected to achieve a screening rate of 80%.

Pediatric primary care providers (for children under the age of 21) offering services through a MMA health plan are responsible for helping children receive Child Health Check-Ups, ongoing routine care, and acute care as necessary. Therefore, these providers have an opportunity to address infant and early childhood mental health issues and reduce the impact of early childhood exposure to adversity. The importance of this role is illustrated below:

- Between 9.5% and 14.2% of children ages birth to five experience social-emotional problems that negatively impact their functioning and development.<sup>37</sup>
- As many as 1 in 4 children, age birth to five are at moderate or high-risk for developmental, behavioral, or social delay.<sup>38</sup>
- Emotional and behavioral problems in young children may persist or worsen and affect school performance.<sup>39</sup>

Pediatric primary care is well positioned to promote emotional well-being and identify emerging developmental issues as early as possible. The American Academy of Pediatrics (AAP) has identified the following capacities inherent in primary care that can support the emotional well-being of young children and promote nurturing families:

- Long-term, trusting, and empowering therapeutic relationships with children and families.
- Family-centeredness of the primary care practice (medical home).
- Unique opportunities to prevent future mental health problems by:
  - Promoting healthy lifestyles.
  - Reinforcing strengths in the child and family.
  - Recognizing adverse childhood experiences and stressors associated with social and emotional problems.
  - Offering anticipatory guidance.
  - Providing timely interventions for common behavioral, emotional, and social problems encountered in typical infancy and early childhood.



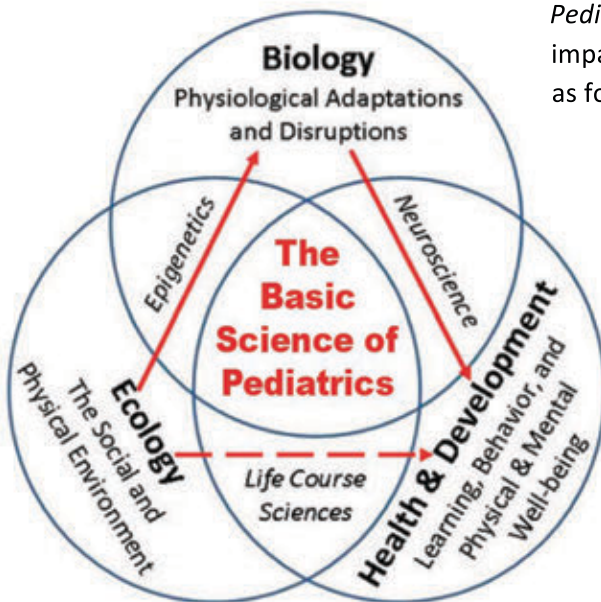
- An understanding of common social, emotional, and educational problems in the context of a child's development and environment.
- Experience working with specialists caring for children with special health care needs.<sup>40</sup>

The need for the involvement of pediatric primary care is further illustrated by the emerging knowledge base of factors affecting healthy development.

## Eco-Bio-Developmental Framework in Pediatrics

The AAP issued a policy statement in 2012 titled, *Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science and Lifelong Health*,<sup>41</sup> which is consistent with the discussion of trauma and toxic stress earlier in this report. The policy statement calls for pediatric primary care providers to complement the early identification of developmental concerns with a greater focus on interventions and community investment that reduces external threats to healthy brain growth. Additionally, the AAP published a companion technical report<sup>42</sup> that describes a new framework for promoting health development, the *Eco-Bio-Developmental (EBD) Framework*, and offers an examination of the extensive evidence of the disruptive impacts of toxic stress. The report provides insights into mechanisms that link early adversity to later impairments in learning, and behavioral, physical, and mental well-being. The research suggests that many adult diseases should be viewed as developmental disorders that begin early in life, and that many of these conditions could have been alleviated if toxic stress was addressed in childhood. This multidisciplinary description of development highlights the importance of infant and early childhood mental health principles and practices. Given that the first years of life present a sensitive period of brain growth and development, a focus on early childhood experiences is imperative.

The AAP graphic, *The Basic Science of Pediatrics*, (from *Pediatrics*, 2012) represents the interaction of factors that impact development. The AAP describes this field of study as follows:



... an emerging, multidisciplinary science of development supports an EBD framework for understanding the evolution of human health and disease across the life span. In recent decades, epidemiology, developmental psychology, and longitudinal studies of early childhood interventions have demonstrated significant associations (hashed red arrow) between the ecology of childhood and a wide range of developmental outcomes and life course trajectories. Concurrently, advance in the biological sciences, particularly in developmental neuroscience and epigenetics, have made parallel progress in beginning to elucidate the biological mechanisms (solid arrows) underlying these important associations. The convergence of these diverse disciplines defines a promising new basic science of pediatrics.<sup>43</sup>

With this knowledge, the attention to parental well-being, environmental stressors, and early social, emotional, and behavioral development should be viewed as a critical approach to preventing and reducing disease rather than as an “add on” to busy primary care practices.<sup>44</sup>

The pediatric primary care practice is an ideal platform for identifying and coordinating the services needed by vulnerable young children and their families. The practice could ensure that needs are identified, state-of-the art management is provided, and credible evaluation is conducted to assess the effects of services that are being delivered.<sup>45</sup> Additionally, pediatricians have a unique opportunity to translate the emerging science of neurobiology into the standard activities of everyday parenting.<sup>46</sup> The importance of infant and early childhood mental health is represented in the *Basic Science of Pediatrics* graphic above in the circle labeled Ecology: The Social and Physical Environment. With its emphasis on positive environmental factors and nurturing relationships, the field offers solutions to prevent and ameliorate childhood exposure to adverse experiences.

## Prevention, Screening, Assessment, and Intervention in Pediatric Primary Care Settings

### Promotion of Infant and Early Childhood Mental Health in Pediatric Primary Care Settings

One of the first steps in integrating infant and early childhood mental health approaches into primary care is to ensure the primary care practice has an understanding of what infant and early childhood mental health encompasses. The practitioner can then focus on the evolving relationship of the child-parent dyad as well as the social, emotional, and developmental needs of the infant and/or young child.

To create an integrative approach, the primary care provider could systematically modify their orientation to focus as much on the emerging relationship between the child and parent as they do physical development.

In 2010, the AAP Task Force on Mental Health published a mental health toolkit to help practitioners implement mental health services within their primary care practices. This toolkit, *Addressing Mental Health Concerns in Primary Care: A Clinicians Toolkit*, can be viewed at <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/Addressing-Mental-Health-Concerns-in-Primary-Care-A-Clinicians-Toolkit.aspx>.

*Enhancing Pediatric Mental Health Care: Strategies for Primary Care Practice*, one of the resources in the AAP Task Force on Mental Health’s Toolkit, provides guidance on key steps to change the pediatric primary care practice to address mental health issues.<sup>47</sup> These steps are also applicable to infant and early childhood mental health. The Toolkit advises the pediatric primary care provider to develop an understanding of community resources and partners before beginning any screening program. The following steps, adapted from the recommendations in the AAP Toolkit, could be taken to strengthen any primary care practice:

- Ensure the primary care practice is well versed in social, emotional, and behavioral development in young children, including child-parent interactions and relationships.

- Implement the Bright Futures guidelines<sup>48</sup> and incorporate conversations about child-parent relationships and social, emotional, and behavioral issues throughout well-child check-ups and other routine medical care.
- Develop a resource guide with the type of services and supports available in the community that support and address mental health issues. (Should be completed prior to initiating screening).
- Develop collaborative relationships with other child-serving practitioners, such as Early Steps, home visiting programs, child care resources, infant and early childhood mental health clinicians and others.
- Use evidence-based engagement practices and recognize the stigma associated with “mental health” by normalizing emotional, social, and behavioral issues as part of the ongoing primary care practice.
- Implement health supervision, screening, assessment, interventions and the referral process oriented toward infant and early childhood mental health.
- Have clear mechanisms for referral and feedback, either directly from the primary care provider or with the assistance of care coordination.

Additionally, the AAP in conjunction with Georgetown University published *Bright Futures in Practice: Mental Health Tool Kit*<sup>49</sup> in 2002, to help pediatric primary care providers incorporate prevention, screening, assessment, and interventions into their pediatric practice. These materials are available at <http://www.brightfutures.org/mentalhealth/pdf/tools.html>.

### **Understanding Infant and Early Childhood Mental Health as a Part of Pediatric Primary Care**

Nurturing the mental health and brain development of young children is the responsibility of the child’s family and those who provide support to the family. Few people have as close an advisory and influential relationship with the family as do pediatric primary care practitioners. Because the family’s role is so important in supporting and fostering brain development in infants and young children, pediatric primary care providers should address the child-parent relationship and the emotional well-being of parents. The parent’s capacity to attune to their infant’s needs is dependent on their own emotional health.<sup>50</sup>

The knowledge of infant and early childhood social, emotional, and behavioral milestones is important for pediatric primary care physicians. Developmental surveillance and anticipatory guidance are two key practices used by primary care practitioners as part of the health supervision of the child.

Developmental surveillance is defined by the AAP as “a flexible, continuous process whereby knowledgeable professionals perform skilled observations of children throughout all encounters during child health care.”<sup>51,52</sup> Anticipatory guidance involves three types of tasks: (1) gathering information, (2) establishing a therapeutic alliance, and (3) providing education and guidance on developmental issues.<sup>53</sup> A deep-seated knowledge of child development is essential to effectively using these practice components. Primary care practitioners may not have received as much training in social, emotional, and behavioral development, and the importance of child-parent relationships as other physical aspects of development. Also, measuring and evaluating social, emotional, and behavioral development may be viewed as more challenging than charting physical development. Primary care practitioners may need additional education or tools when working with these domains.

Attachment theory is also a core component of infant and early childhood mental health, and has contributed significantly to the current view of infant and early childhood development. The formation of attachment relationships is considered the predominant organizing force of infant and young child social development. Early interactions with care providers are critical to basic human survival and form the basis for later, more complex representations of the parent/caregiver as being available and responsive. Individual differences in attachment security are observable in the ways that the child uses the parent/caregiver as a secure base. Through repeated moments of responsive and sensitive care, infants and young children learn to trust caregivers. With the evolving ability to predict if they will be kept safe, typically developing young children explore their surroundings but seek out that special person (attachment figure) as their secure base when feeling vulnerable. When children feel secure, they are able to turn their attention to other developmental tasks and learn how to empathize and act with compassion toward others.<sup>54</sup> Differences in levels of secure attachment have major implications for the child's social and emotional development.<sup>55</sup> The child's capacity to form secure interpersonal relationships is fundamental to healthy development.

Another facet of attachment relationships is their central role in the regulation and management of emotions. Because young children are not able to independently manage or easily control their own emotions, they need the assistance of the parent/caregiver. At birth, infants have the capacity to express distress through crying and other means, which signals the parent to respond. An attentive parent/caregiver's response to these signals keeps the infant's distress within reasonable limits. The infant experiences relief from the stressful situation through the parent/caregivers attention.<sup>56</sup> When the child does not get relief from stress as an infant or young child, they may experience toxic stress, which is ultimately harmful to their health.

The Bright Futures Toolkit referenced earlier is a good resource for early social, emotional, and behavioral development information.

### **Application of Infant and Early Childhood Mental Health Practices in Child Health Check-Ups**

The *Florida Medicaid Child Health Check-Up Coverage and Limitations Handbook* recommends that infants and young children see their pediatric primary care provider at least 13 times by their fourth birthday. Each Child Health Check-Up must cover at least 12 health components including development and behavioral health status. The structure of the Child Health Check-Ups allows the primary care provider to monitor the child's physical, social, and emotional development over time, recognize changes in emotional, social, and behavioral development between visits, and discuss their observations with parents. Although nearly all infant mental health problems affect the child-parent relationship, some problems reside more within the parent or the environment, while others are based on factors intrinsic to the child. The pediatric primary care provider must observe and assess environmental, parent-focused variables. Attention to key infant and early childhood mental health domains can be integrated into each Child Health Check-Up. See **Appendix C, *The Domains of Infant and Early Childhood Mental Health Assessed in Primary Care Settings***.

During the Child Health Check-Up, the primary care practitioner can focus on social, emotional, and behavioral issues through these activities.

- *Medical History.* Information regarding past medical history, and environmental or psychosocial factors can be obtained through routine intake procedures. This information may reveal past history of trauma or high-risk environmental issues.
- *Child Health Visit.* The pediatric primary care physician can use active listening and open-ended “trigger” questions to elicit parental concerns about the social, emotional, and behavioral development of the child. More specific questions could also be asked concerning issues that may impact child health and development.<sup>57</sup>
- *Office Observations.* Observations of child-parent interactions during pediatric health care visits are a rich source of information regarding the relationship between the parent and the young child and provide opportunities for intervention.<sup>58</sup>
- *Physical Examination.* Physical assessment provides the opportunity to teach the parent about the infant’s growth and development. The parent’s and provider’s shared interest in the child’s health is a useful avenue for discussing related psychosocial issues.<sup>59</sup>

## Screening

According to the Centers for Disease Control and Prevention, 17% of children in the United States have a “developmental or behavioral disability;” however, less than half of these cases are identified before the child begins school.<sup>60</sup> Formal screening in infants and toddlers is critical to the early identification of developmental and health issues. Infants and children are at risk for developmental delays particularly if they were of low-birth weight, prenatally drug exposed, or had other adverse experiences early in life. Proper screening is crucial to helping the most vulnerable children receive the care necessary to overcome threats to their well-being. Pediatric screenings should also include social-emotional and behavioral development to ensure all aspects of the child’s health is addressed.

### Screening Algorithm

As mentioned previously, the current detection rates of developmental disorders are lower than their actual prevalence.<sup>61</sup> Research by the AAP indicates that standardized screening should be administered at the 9-, 18-, 24- and 30-month well-child visits to ensure early detection of possible delays.<sup>62</sup> A 2005 study on the screening practices of board certified pediatricians found that of the 894 survey respondents, 71% reported they “almost always used clinical assessment without an accompanying screening instrument to identify children with developmental delays.”<sup>63</sup> Numerous reports have indicated that standardized means of developmental screening are more accurate and more reliable than clinical opinion alone,<sup>64,65</sup> suggesting that physicians and other child health care workers should utilize standardized screening instruments. The AAP developed a detailed algorithm for screenings in 2006. See **Appendix D, Developmental Surveillance and Screening Algorithm**, for further information.

As part of the Toolkit mentioned earlier, (*Enhancing Pediatric Mental Health Care*) the AAP also recommends that pediatric primary care providers screen for mental health issues at the same intervals they screen for other developmental issues using standardized and validated tools.<sup>66</sup> The AAP Task Force on Mental Health based their recommendations on a review of the available literature and the opinion of experts in the field, and updated the 2006 developmental surveillance and screening policy statements for mental health. These recommendations for young children are as follows:<sup>67</sup>

1. Use validated instruments to screen for social-emotional problems in children birth to five years of age with abnormal developmental screening tests (typically performed at 9 months, 18 months, and 24 or 30 months) or abnormal autism screening tests (typically performed at 18 and 24 months); at any time a clinician observes poor growth or attachment, or symptoms such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and at any time the family identifies psychosocial concerns.
2. Obtain a history of trauma exposure and update child and family's psychosocial history (e.g., parental distress or discord, domestic violence, parental substance abuse, or mental illness, child and family social support, grief and loss issues) at each health maintenance visit and as dictated by clinical need.
3. Screen for maternal depression during the child's first year and when psychosocial history indicates. Note that the peak time for maternal postpartum depression is when the baby is between 6 weeks and 3 months old.

The family components (numbers 2 and 3 above) reflect the AAP's recognition that children may be at an increased risk for emotional and behavioral problems due to environmental conditions. It is recommended that primary care providers become knowledgeable of families' situations and administer maternal depression screenings. The United States Preventive Services Task Force (USPSTF) recommends all adults receive a two-question screen for depression derived from the *Edinburgh Postnatal Depression Scale*. A 2006 study<sup>68</sup> found that maternal depression screenings during well-child visits were feasible and beneficial. The USPSTF also reported that studies have shown that it is feasible to use brief, psychometrically sound mental health screening tools in primary care.

Additionally, the AAP Task Force on Mental Health reports that parental stress and the absence of familial social support may impact the child's emotional well-being. Researchers have shown the utility of routinely screening for these issues in primary care. Tools such as the *Parenting Stress Index/Short Form*, the *McMaster*, and the *Multidimensional Scale of Perceived Social Support* reliably measure these domains and should be considered for use in pediatric primary care settings.<sup>69</sup>

The document, *Enhancing Pediatric Mental Health Care: Algorithms for Primary Care* provides a detailed discussion on how the practitioner could implement each of the points in the algorithm. See **Appendix E**, *Algorithm A: Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care* and *Algorithm B: Assessment and Care of Children with Identified, Social, Emotional, Mental Health Concerns* for more information.

### Screening Instruments

The primary care practice should select a screening instrument that best meets the needs of their patients and is feasible to use in the busy clinic environment. The AAP recommended document,



*Pediatric Developmental Screening: Understanding and Selecting Screening Instruments*,<sup>70</sup> provides an overview of how to select a screening instrument that meets the needs of the practice and patients. *Birth to 5: Watch Me Thrive!* is a coordinated federal effort housed in the Administration for Children and Families (ACF) to encourage healthy child development, universal developmental and behavioral screening for children, and provide support for the families and providers who care for them. The ACF published the *Compendium on Developmental Screening*<sup>71</sup> in March 2014, based upon a broader review of screening tools by Child Trends, *Early Childhood Developmental Screening: A Compendium of Measures for Children Ages Birth to Five*. An overview of these instruments is in **Appendix F, General Information About Screeners**.

It appears that the three screening tools most frequently recommended for pediatric settings are the *Ages & Stages Questionnaire (ASQ)*, *Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)* and *Pediatric Evaluation of Developmental Status (PEDS)*. Parents can complete these instruments prior to an appointment, or in the waiting room.

### **Implementing Mental Health Screening for Children under Age Five in Pediatric Primary Care Settings**

Once the screening tool(s) are selected, the primary practice must develop a plan for the logistics and clinical procedures. It is recommended that primary care staff work together to design the flow of the screening process. Given the short time available in fast-paced primary care settings, screens are often completed prior to the appointment or in the waiting room. It is also recommended that the primary care practice notify families of the intent to screen children for mental health issues and explain the purpose of the screening. The screening process is voluntary and parents should be made aware of this.

Developing a method to review and discuss the results of the screen with the parents or caregiver should be considered. The Massachusetts Behavioral Health Initiative requires behavioral health screening in pediatric primary care. They have developed some recommendations on how to handle behavioral health screening results, which with some modifications are shared below for consideration.

#### Responding to the Screening

- The practitioner must review and score any screening form that is given to the parent/caregiver.
- The completed screening form is scored either by a staff member or by the primary care provider. The score is interpreted as “within normal limits” (negative) or “at risk” (positive).
- If a form is not completed, there may be a cultural, language, or literacy problem, or the parent/caregiver may have difficulty comprehending. A staff member could be prepared to read the questions to them. Most screens can be administered as an interview. The interviewer should read the items as written and not reword them or offer explanations or examples.
- The practitioner should verbally acknowledge the screening and its results with the parent/caregiver and share the findings.
- When informing the parent/caregiver of the results, the following procedures are suggested:
  - If the score on the screening form is reassuring (“negative”), acknowledge as such to the parent/caregiver. For example, “Things seem to be going well; that’s terrific.”
  - Ask if any questions came up while the form was being completed, this can help to build the provider-patient relationship.

- If the score on the screening form is concerning (“positive”), state that the result could be indicative of an issue for which more information is needed.

### *Initiating Discussion about a Positive Screen*

Before initiating a discussion about a positive screen, the primary care provider should decide how much time he/she has in the appointment. If there is insufficient time to explore “positive” items, schedule a return visit, arrange a telephone follow-up, or refer to a mental health colleague in the practice for guidance, if appropriate. Referring to a mental health provider without further exploration of the “positive” items may be appropriate for children whose parents have already expressed mental/behavioral concerns.

### *Responding to an Identified Risk for a Behavioral Health Concern*

Following review and discussion of information, the primary care practitioner and parent/caregiver decide the next steps. Completion of a full assessment, either by the primary care provider or through a referral to specialty care, is warranted. The AAP has a list of assessments to be used for children, including children under the age of five, and can be viewed at [http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH\\_ScreeningChart.pdf](http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf). **Appendix G, Summary of Assessment Instruments**, includes a list of assessment instruments recommended for children under the age of five.

At this point, the primary care practitioner must determine if their staff persons have the expertise to provide additional assessments. If the resources are available internally for assessment, the primary care provider could complete the assessments and provide a diagnostic interpretation for the family. In some cases, the primary care provider may have the ability to address the mental health issues through continued developmental guidance and brief supportive counseling.

If the resources are not available internally, the primary care provider should make a facilitated referral to a specialty provider such as a developmental-behavioral pediatrician, infant and early childhood mental health clinician, therapist for child-parent relationships, or other specialist as indicated (speech/language, occupational therapist, etc). When a referral is made for additional social, emotional, and behavioral interventions, the following steps should be considered.

- Discuss with the parent/caregiver the reason for a referral and the benefits of participating.
- Describe the referral process and what it entails (e.g., parent will be given a phone number, and they will speak to an intake worker, other, etc.).
- Some patients and/or families may benefit from a brief description of the experience with the services (e.g., “You will talk with someone alone sometimes and as a family other times.”).
- The family may have multiple risks including functional issues with the child and parent/caregiver. (The child may be at a higher risk for a developmental delay, the parent may have screened positive for a behavioral health issue, and the primary care practitioner may be very concerned about the child-parent relationship.) In this type of case, the primary care practitioner will have to become part of a multi-disciplinary team with the assistance of care coordination.



- Once the family is receiving specialty services, the role of the primary care provider is as follows:
  - Obtain release of information for sharing with other infant and early childhood mental health providers or other programs.
  - Share information on relevant portions of history, observations, and screenings.
  - Establish a communication process to exchange information.
  - Monitor the social, emotional, and behavioral issues on a regular basis, including those children whose families chose not to receive further assistance outside of the primary care setting.
  - Be prepared to intervene further if progress is not made.<sup>72,73</sup>

See **Appendix H**, *Early Childhood System of Care Chart*.

## Trauma-Informed Care in Pediatric Primary Care Settings

The better pediatric primary care practitioners understand trauma, the better they are going to be able to identify signs of trauma in primary care. The information presented in the “Introduction” section of this report includes the type of information that would be helpful to the practitioners. Young children develop responses to trauma through bodily functions and through behaviors. The pediatric primary care practitioner who is familiar with these responses will be better able to detect the possibility of trauma exposure during the well-child checkup. **Appendix I**, *Response to Trauma*, includes this information.

### Screening for Trauma and Toxic Stress

When working with children who are part of the Child Protection System, it is recommended that the practitioner assume the child has been exposed to trauma and toxic stress. For all other children, the primary care practitioner should conduct a screening if exposure to trauma is suspected. Below are some suggested approaches to use when screening for toxic stress:

- Probe for information about toxic stressors in a non-threatening manner. Questions can serve as a prompt for family members to remember or share information that they might not share otherwise. Example: Ask, “Do you know if any really scary or upsetting things have happened to the child?”
- When the practitioner has rapport, he may want to ask direct questions about what is happening in the family, especially if the child is showing any bodily or behavioral signs of toxic stress and trauma.
- There are trauma surveillance and screening tools that are available for use in pediatric primary care for children age three and up. **Appendix J**, *Trauma Surveillance and Screening Tools*, includes a list of these tools.

When exposure to trauma/toxic stress is identified, the practitioner may be the first professional to help the family address the trauma. It is important to explain to the family that the child will need support to stabilize and heal. It is helpful if families realize that the behaviors that the child is showing are normal responses to what the child has experienced and at one time were likely protective responses to the child’s environment. Parents should be reassured that with more support and practice the young child’s brain and body will learn new and more adaptive ways to respond in a safe environment. In some cases,

the pediatric primary care practitioner will be able to address the issues through anticipatory guidance.<sup>74</sup> The AAP publication, *Helping Foster and Adoptive Families Cope with Trauma*, has information to aid the practitioner in helping families understand trauma and conducting anticipatory guidance. The publication can be found at <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf>.

In more severe cases where there are serious issues with child-parent relationships, the practitioner could consider involving an infant and early childhood specialist. One of the evidence-based practices used in infant mental health for children exposed to trauma is *Child-Parent Psychotherapy* (CPP).<sup>75</sup> *Child-Parent Psychotherapy* is designed for children from birth through age five who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence). The child may be experiencing behavior, attachment, and/or mental health problems, including posttraumatic stress disorder (PTSD). CPP focuses on supporting and strengthening the relationship between a child and his or her parent (or caregiver) to restore the child's sense of safety, attachment, and appropriate affect and improve the child's cognitive, behavioral, and social functioning.

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### ***How the MMA Health Plans Can Work with Pediatric Primary Care Practices***

- Provide or arrange for training to the pediatric primary care providers regarding trauma and toxic stress, the American Academy of Pediatrics recommendations on mental health practices, and principles and practices of infant and early childhood mental health.
- Assess the need for and provide or arrange for necessary training on trauma-informed care in behavioral health settings.
- Promote use of standardized developmental screening instruments that address social, emotional, and behavioral issues for young children.
- Encourage anticipatory guidance that supports early childhood social, emotional and behavioral development and positive parent-child relationships.
- Develop protocols or clinical guidelines to assist primary care practitioners in determining next steps when the child has indicators of developmental issues.
- Develop clear referral pathways and linkages for access to infant and early childhood mental health interventions and treatment.
- Establish uniform referral instruments to be used by providers in the network.
- Ensure that care coordination is available to assist the pediatric primary care practice in working with children and families with multiple issues.
- Ensure that there are expectations and mechanisms for ongoing sharing of information among providers.
- Provide or arrange for training to the primary care practices on the importance of supporting the parent's behavioral health, including screening for parental stress or depression.
- Implement protocols for the use of standardized screening instruments for parents and referral programs.

## 3 Primary Care for Adults

### How Early Identification of Parental Behavioral Health Disorders Can Improve Infant and Early Childhood Mental Health

Parents and caregivers provide children with the most intimate context for nurturing and protection. The bond of affection between parents and children is necessary for a healthy child-parent relationship.<sup>76</sup> Parental mental health, substance use, or physical disorders can interfere with the development of the necessary bond of affection and disrupt the child's development. Primary care practitioners can play an important role in supporting family functioning through early identification and intervention for these conditions. Adult primary care has the potential to provide for early identification, intervention, treatment, or referrals to specialty care for parents with behavioral health disorders. These actions can have a direct benefit on the young child's development.

### The Importance of Screening Parents for Mental Health and Substance Use Disorders

#### Why Screening for Behavioral Health Care Issues Is Important

Research shows that early adverse childhood experiences place individuals at a higher risk for poor health outcomes. In the past, the medical profession has primarily focused on physical health care issues.<sup>77</sup> Now, with increasing evidence of the social determinants of health and the emphasis on prevention in the *Federal Patient Protection and Affordable Care Act*, medical practices are beginning to focus on holistic prevention and wellness. One way to achieve better outcomes is to identify both medical and behavioral health care issues as early as possible.

Primary care practices that provide early identification and intervention for behavioral health conditions can help parents improve their capacity to parent. A healthy parent is better equipped to meet the demands of parenting. However, it should be noted that addressing the presence of a behavioral health disorder with the parent may be insufficient to address problems in the child-parent relationships. For example, although screening and treatment of maternal depression is increasing, there is a widespread absence of attention to the mother-child relationship in the treatment of depression of women with young children. Clinical research indicates that the successful treatment of a mother's depression does not generally translate into comparable recovery in her young child unless there is an explicit focus on their dyadic relationship.<sup>78,79</sup> The same situation is likely present for parents with other mental health and substance use disorders. During screening, intervention, and treatment, the primary care practitioner may consider addressing both the possibility of a behavioral health disorder and disruptions in the child-parent relationship.

The U.S. Preventative Services Task Force (USPSTF), under the Agency for Healthcare Research and Quality (AHRQ), makes health care recommendations based on the support of an Evidence-based Practice Center, which conducts systematic reviews of the evidence on specific topics in clinical prevention. Currently, the USPSTF recommends adult screenings for behavioral health disorders of

alcohol misuse, depression, obesity, and smoking.<sup>80</sup> Due to the relatively recent implementations of behavioral health screenings in primary care, and the limited recommendations of the Task Force, this report will concentrate on adult behavioral health screening for depression and substance use disorders, which can have significant implications for child development and subsequent health. It should be noted that there are screening instruments available for other mental health disorders that can be used within primary health care if the primary care provider suspects a mental health disorder and is comfortable with screening. These are included in **Appendix K, Adult Screening & Assessment Instruments**.

The AHRQ has several requirements to guide implementation of behavioral health screening in primary care (AHRQ 2010):

- The clinical situation must be sufficiently common within a target group (primary care practice) to merit screening.
- There must be well-supported methods for applying behavioral health expertise to mitigate the situation in an effort to improve the health outcome and use the health care and patient resources.
- Screening must result in the situation being recognized at an earlier stage when intervention is more effective.
- Screening must have high specificity, meaning that the mechanism is likely to detect the accurate clinical situation (low rate of false positives).
- Screening tests must be feasible in that they are easily administered, with little additional costs incurred, and are acceptable to patients.

### Addressing Patients' Depression in Adult Primary Care Settings

In 2009, the United States Department of Health and Human Services published *Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review*. This publication provides a broad definition of depression, explaining that the term “depression” is not a specific term for a single diagnostic condition. Rather, depressive disorders generally consist of a range of conditions from major depressive disorder, dysthymia, and minor depression. Depressive disorders are commonly seen in primary care practices. The estimated lifetime prevalence of major depressive disorder is 13.3% with a 12-month prevalence of 5% to 7% in adults between the ages of 18 and 64 living in the community.<sup>81</sup> Prevalence for dysthymia in primary care settings is about 2% to 4% and sub-threshold disorders is about 9% in adults.<sup>82,83</sup> Parental depression is also prevalent among low-income mothers of infants and young children. Over 10% of those infants have a mother who is severely depressed and more than half have a mother with some depression.<sup>84</sup> Similarly, of low-income mothers of young children birth to age five, 8.8% had a major depressive episode in the past year. Among mothers who do have a major depressive episode, depression is more severe among low-income mothers than other more affluent mothers.<sup>85</sup>

Depression is also costly. The direct and indirect costs of depression were estimated to be \$83.1 billion in 2000 with the direct medical treatment cost making up 7% of the financial burden.<sup>86</sup> The impact of depression on parenting can result in negative outcomes for the children, therefore increasing financial burdens associated with the cost of additional care for the child.

### Depression Screening and Management in Adult Primary Care Settings

Depression can be screened and managed in an adult primary care setting. Modified in 2009, the United States Preventive Services Task Force (USPSTF) recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. The study cited previously, *Screening for Depression in Adults and Older Adults in Primary Care: An Updated Systematic Review*, found that effectiveness was dependent upon additional supports being available within primary care.<sup>87</sup> The report states that the most comprehensive programs include clinician training and treatment protocols provided at the point of care, patient educational materials, office staff training in providing post-visit follow-up and available mental health referrals. The authors state the additional benefits could result from:

- Enhanced treatment adherence through closer monitoring of treatment tolerability and response.
- Treatment adjustment when needed.
- Psychosocial support.

Although not included in this particular report, the treatment regime could also include assistance in addressing child-parent relational issues and psychosocial supports that address improved parenting.

Depression can be successfully managed in a primary care setting. Several clinical guidelines have been developed that provide guidance to the clinician. It is beyond the scope of this paper to address the specific clinical functions; however, it must be stressed that the clinician must be cognizant of the possibility of suicide, and include screenings and interventions in their practice.

One effective screening instrument used in primary care settings for depression is the *Patient Health Questionnaire* (PHQ), including versions 2 and 9 (PHQ-2 and PHQ-9). The instrument is a self-reporting questionnaire designed for use in the primary care setting and is available in many languages.

#### PHQ-2

- 2-item self-report that inquires about the frequency of depressed mood and anhedonia (inability to experience pleasure from activities usually found enjoyable) over the last two weeks.
- Used to screen for depression as a “first step” approach.
- Includes the first 2 items of the PHQ-9.
- Patients who screen positive with the PHQ-2 should be further evaluated with the PHQ-9, other diagnostic instrument(s), or direct interview.

#### PHQ-9

- Instrument that screens for and diagnoses depression based on DSM-IV criteria.
- Specific items included in the scale include the 9 diagnostic criteria for making a DSM-IV depression diagnosis.
- The brevity and self-report of PHQ-9 lends itself well to clinical practice settings.
- Has the potential of being a dual-purpose instrument that can establish depressive disorder and assess depressive symptom severity. It can also be used in serial fashion to monitor symptoms over time.

- Has questions that screen for the presence and severity of suicidal ideation and functional impairment based on depressive symptomology.<sup>88</sup>

### Maternal Depression Screening

There are multiple maternal depression screening tools available for use. These tools usually can be completed in less than 10 minutes. Most have a specificity ranging from 77% to 100% (anything over 70% is considered adequate). It is important to select a tool with a high sensitivity to maximize the number of depressed patients identified. Many of these screening tools have been validated with specific ethnic populations. Examples of highly sensitive screening tools include the *Edinburgh Postnatal Depression Scale*, *Postpartum Depression Screening Scale*, and *Patient Health Questionnaire-9* (see Additional Resources). The *Edinburgh* is the most frequently referenced tool. For other appropriate screening tools, please visit <http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression>.

### **Screening and Treating Patients for Substance Use Disorders in Adult Primary Care Settings**

Since 1990, the Institute for Medicine has been calling for primary care involvement in the identification and treatment of alcohol use disorders. Most patients with unhealthy alcohol use are not identified by clinicians and 90% of persons with alcohol use disorder receive no specialty treatment.<sup>89</sup> The impetus to include primary care practitioners has been solidified over the last several years through research that shows that substance use disorders are diseases that must be treated in primary care as other chronic care conditions are addressed. Alcohol dependence is a heritable condition (about 45% genetic and 55% environmental).<sup>90</sup> As addressed previously, early childhood environments with high adverse conditions add considerable risk for individuals who may already be predisposed through genetics. Alcohol use disorder, as well as other substance use disorders should be viewed as a chronic condition. Just as with diabetes or hypertension, the condition requires on-going monitoring and treatment adjustments as necessary. Though scientific research shows that substance use disorders are a disease, they are treatable.<sup>91</sup> Childhood exposure to parental substance use disorders can possibly be reduced by early identification of issues in primary care and interventions provided to the parent at the appropriate level of care.

### Screening Instruments for Substance Use Disorders

There is a 10% prevalence rate of alcohol misuse disorders in the adult population in the U.S.; however, the rate of detection in primary care falls below this level, showing that substance use disorder screenings are not adequately and consistently performed. There is a substantial number of studies that support a variety of reliable and valid screening measures for alcohol misuse. At this time, the USPSTF states that there is insufficient evidence for brief, valid, and reliable, screening tools that can be used by primary care practitioner to screen for illicit drug use in their patients.<sup>92</sup>

The most recommended screening instruments for alcohol misuse are:

- **Alcohol Use Disorders Identification Test (AUDIT):** This test is the gold standard for detecting alcohol misuse. It has high sensitivity and specificity in the English-speaking primary care population. The scoring profile identifies patients on a continuum from risky drinking behaviors to abuse and dependency. The briefer AUDIT-C version has similar high rates of sensitivity and moderate specificity.

- **CAGE:** CAGE is a mnemonic acronym for “cut down, annoyed, guilt, and eye-opener.” It can be administered in a standard clinical interviewing screening protocol in primary care and is integrated into a routine history taking. A positive response indicates the need for further assessment. The tool is good at targeting alcohol abuse and dependence, but is less effective at detecting risk in older patients, African Americans, and Latinos with substance abuse symptoms.<sup>93</sup>
- **ASSIST:** The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) was developed for the World Health Organization (WHO) by an international group of substance abuse researchers to detect and manage substance use and related problems in primary and general medical care settings.<sup>94</sup>

#### Use of Screening, Brief Interventions and Referral to Treatment in Adult Primary Care Settings

The model *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) is one of the most promoted methods for primary care practitioners to use to address unhealthy alcohol use. This process goes beyond the conducting of a screen and includes an evidence-based process to follow after a positive screen. (<http://www.integration.samhsa.gov/clinical-practice/SBIRT>). Below is a description of the SBIRT model as described by the Substance Abuse and Mental Health Service Administration (SAMHSA).<sup>95</sup>

- **Screening** is the first component of the SBIRT process and is a quick, simple method of identifying patients who use substances at “at-risk” or “hazardous” levels or who may already have substance use-related disorders. The screening instrument provides specific information and feedback to the patient related to his or her substance use. The screening and risk assessment instruments are easily administered and provide patient-reported information about substance use that any healthcare professional can easily score.
- **Brief Intervention** is a time-limited, patient-centered strategy that focuses on modifying a patient’s behavior by increasing insight and awareness regarding substance use. Depending on severity of use and risk for adverse consequences, a short 5 - 10 minute discussion or a longer discussion of about 20 to 30 minutes to provide the patient with personalized feedback showing concern over drug and/or alcohol use. The topics discussed include how substances can interact with medications, cause or exacerbate health problems, and/or cause problems with personal responsibilities. Brief intervention is intended to motivate patients to change their behavior and prevent the progression of substance use. During the intervention, patients are:
  - Given information about their substance use based on their risk assessment scores.
  - Advised in clear, respectful terms to decrease or abstain from substance use.
  - Encouraged to set goals to decrease substance use and to identify specific steps to reach those goals.
  - Taught behavior change skills that will reduce substance use and limit negative consequences.
  - Provided with a referral for further care, if needed.

Brief interventions are typically provided to patients with less severe alcohol or substance use problems, who do not need a referral to additional treatment and services. In addition to behavioral health professionals, medical personnel (e.g., doctors, nurses, physician assistants, nurse practitioners) can conduct these interventions with minimal training. Motivational interviewing is the recommended practice. In the case of patients with addictions, more



intensive interventions may be needed. Much of the discussion in intensive intervention is similar to that of the brief intervention; however, the intensive sessions tend to be longer (20-30 minutes) and can include multiple sessions, a referral to a substance abuse specialty program, and the addition of a specific pharmacological therapy. While medical personnel who have received additional training may conduct intensive interventions, behavioral health professionals often conduct these longer counseling sessions with a co-located behavioral health care professional.

- **Referral to Treatment.** In some cases, a more advanced treatment option is necessary and the patient is referred to a higher level of care. This specialty care is often provided at specialized substance abuse treatment programs. The referral to treatment process consists of ensuring patients have access to specialized treatment, assisting in choosing treatment facilities, and facilitating the patient navigate any barriers such as cost of treatment or lack of transportation that would prevent them from receiving treatment in a specialty setting. In order for this process to occur smoothly, primary care providers should know what providers are appropriate to use as referrals, initially establish and cultivate relationships with specialty providers, and then develop methods to share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the patient receives the necessary care coordination and follow-up support services is critical to the treatment process and to facilitating and maintaining recovery. However, there are often many issues associated with the successful implementation of this process including confidentiality requirements, billing mechanisms, methods to easily share information across different electronic records, etc. Primary care practices will need assistance in addressing these challenges.

A comprehensive discussion of evidence-based treatment for substance abuse can be found in the FSU *Literature Review to Identify Best Practices for Vulnerable Children and the Related Costs and Benefits to Those Practices*.<sup>96</sup>

#### Substance Use Disorders Increase Medical Costs and Treatment Reduces Costs

Even without regard to the potential effects on child development associated with parental substance use disorders, these conditions are extremely costly. According to the National Institute on Drug Abuse, the U.S. cost associated with substance use disorders is over \$600 billion annually and treatment can help reduce these costs. Treatment for substance use disorders has been shown to reduce associated health and social costs by far more than the cost of the treatment itself. According to several conservative estimates, every dollar invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to healthcare are included, total savings can exceed costs by a ratio of 12 to 1.<sup>97</sup>

Substance use disorders have high levels of co-morbidity with other medical problems. Direct effects of consumption of the substance and the toxicity of possible contaminants impact health. The indirect effects of substance use disorders that are related to associated lifestyles—such as infectious diseases, trauma, nutritional deficiencies, and consequences of intoxication—impact health status.



Examples of multiple medical issues:

- Cardiovascular conditions
- Gastritis or other GI complications
- Liver Disease
- Diabetes
- Neuropathy
- Pancreatitis
- Anemia
- Coronary Artery Disease
- Hypertension
- HIV

Examples of medical cost savings associated with treatment of substance use disorders include:

- A study of the southern region of the U.S. found that 393 acute care inpatient stays per 100,000 were for substance use disorders, and Medicaid paid 36.5% of the costs.<sup>98</sup>
- The highest rates of admission to emergency rooms are patients with severe mental or substance use disorders; patients with co-occurring behavioral health disorders have rates of admission that are twice the rate of patients with other chronic conditions.<sup>99</sup>
- John Hopkins Healthcare reported a return on investment of \$3.65 per \$1 spent on substance abuse intervention.<sup>100</sup>
- The use of brief interventions for patients with substance use disorders showed a \$3.81 per \$1 savings for medical costs using substance abuse screening and interventions.<sup>101</sup> Washington State estimated that their treatment expansion initiative resulted in a \$2 savings for every dollar invested in the treatment expansion.<sup>102</sup>
- Many studies have shown that substance abuse treatment reduces overall health care costs for chronic patients ranging from \$133<sup>103</sup> to \$380 per patient, per month.<sup>104</sup>

The above research shows the direct medical cost savings associated with the treatment of substance use disorders. None of these studies took into account the additional savings associated with the potential avoidance of the negative consequences on child development associated with parental substance use disorders.

### Special Considerations for Pregnant and Breastfeeding Women

The World Health Organization (WHO) recently issued *Guidelines for the identification and management of substance use and substance use disorders in pregnancy*. These guidelines go beyond the recommendations from the USPSTF. These guidelines focus on six areas:

- Screening and brief intervention
- Psychosocial intervention
- Detoxification
- Dependence management
- Infant Feeding
- Management of neonatal withdrawal<sup>105</sup>

See **Appendix L**, *WHO Recommendations Rated as “Strong”*

### Parenting Issues Associated with Behavioral Health Disorders

The AAP materials discussed earlier under “Pediatric Primary Care” make clear reference to the need for primary care to address parental behavioral health care issues.<sup>106</sup> However, there does not seem to be the same recognition and emphasis on the child-parent relationship in primary care for adults. The SBIRT materials reviewed and the recommended clinical guidelines for depression did not address risk factors associated with parenting young children. There is little research or suggestions available in the literature that could help the primary care practitioner identify potential child-parent relationship issues with parents who have a behavioral health disorder. Since screening and treatment of behavioral health in primary care is relatively new to the scope of practice, it is understandable that primary care providers may be hesitant to address parenting issues with patients with young children. However, adult primary care practitioners can make an important contribution to the prevention and treatment of early childhood exposure to toxic stress and trauma. The same parent screening instruments recommended above under “Pediatric Primary Care” could be considered for use in adult primary care. Additionally primary care offices could have brochures available on early social, emotional, and behavioral development with key tips on child-parent relationships.

### Trauma-Informed Care in Adult Primary Care Settings

Practitioners’ knowledge of trauma and trauma-informed care can improve the quality of primary care services. The webinar titled *It’s Just Good Medicine: Trauma-Informed Primary Care* sponsored by the SAMHSA’s Center for Integrated Health Solutions provides an excellent overview of why understanding trauma and applying trauma-informed care in primary care for adults is beneficial. The information presented below is adapted from these materials.<sup>107</sup>

Understanding trauma in the primary care setting is important because:

- Many current problems faced by patients in primary care may be related to trauma and toxic stress in life experiences.
- People who have experienced traumatic life experiences are often very sensitive to situations that remind them of the people, places, or things involved in their trauma history.
- These reminders, known as “triggers” may cause a person to relive a trauma and view primary care as a source of distress rather than a place of healing and wellness. These triggers may include:
  - Sights such as white lab coats, medical equipment, x-ray bibs;
  - Sounds from equipment and a hurried environment; or
  - Smells such as rubbing alcohol, antiseptic orders, and latex gloves
- Medical procedures also may be uncomfortable for persons with a trauma and toxic stress history including:
  - Invasive procedures
  - Removal of clothing
  - Physical touch
  - Personal questions that may be embarrassing or distressing
  - Power found in the dynamics between practitioner and patient
  - Gender of the health care provider

- Vulnerable physical position
- Loss of or lack of privacy

When people are feeling distressed they may not express that they are uncomfortable and instead will show other emotional and behavioral reactions. These reactions may appear out of context to the practitioner if they do not understand the individual's trauma history. Examples of these types of reactions are listed below:

- Emotional reactions such as fear, anxiety, a sense of powerlessness, helplessness, worry, or anger.
- Physical or somatic reactions such as nausea, light headedness, increase in blood pressure, headaches, stomach aches, increased heart rate, respiration or holding of breathe.
- Behavioral reactions may include crying, uncooperative behaviors, and the patient may become argumentative, unresponsive, or restless.
- Cognitively, the person may show memory difficulties, forgetfulness, or inability to give adequate history.

These uncomfortable emotional and behavioral reactions may lead to avoidance of medical care, non-adherence to treatment, or postponing medical services until the situation has become serious. The avoidance of primary care may result in increased emergency department use due to the delay of treatment until the situation has become a crisis which in turn increases health care costs.

To create a trauma-informed primary care setting, the following steps could be considered:

- Train all staff about trauma.
- Screen and assess for trauma.
- Communicate a sensitivity to trauma issues.
- Create a relaxed, safe and comfortable environment.
- Provide services in a trauma informed manner.

When working with patients, the following practices may be helpful.

- Before starting a procedure, ask the patient if they are ready to begin and let them know that they can stop at any time.
- Encourage questions and ask the patient if they have any worries or concerns and how the staff can allay them. Convey to the patient that their concerns are normal and understandable.
- Maintain a personable, respectful, kind and honest manner and be generous with information.
- Talk to the person throughout and let them know what procedures will be conducted during the office visit.
- Encourage the patient to talk about what they feel most comfortable doing such as keeping some clothing on, listening to music, etc. and give them as much choice as possible.
- Be aware of cultural differences such as ethnicity, race, religion, sexual orientation, or issues such as a history of trauma, poverty, or homelessness.<sup>108,109</sup>

SAMHSA has recommended the following screens for the identification of trauma.<sup>110</sup>

- Life Event Checklist (LEC) is a brief, 17-item, self-report measure designed to screen for potentially traumatic events in a respondent's lifetime. The LEC assesses exposure to 16 events known to cause Post-Traumatic Stress Disorder (PTSD) or distress and includes one item assessing any other extraordinarily stressful event not captured in the first 16 items.
- The Abbreviated PCL-C is a shortened version of the PTSD Checklist. The civilian version (PCL-C) was developed for use within primary care or other similar general medical settings.

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### ***How the MMA Health Plans Can Work with Adult Primary Care Providers***

- Provide or arrange for training for adult primary care providers regarding trauma and toxic stress, its impact on long-term health, and principles and practices of infant and early childhood mental health.
- Assess the need for, and provide or arrange for, necessary training on trauma-informed care in primary care settings.
- Promote use of standardized screening instruments for maternal depression and alcohol use, and consider screening instruments for use of other drugs.
- Consider requiring the use of additional screening tools and procedures for pregnant and breastfeeding women.
- Provide protocols or guidelines for the treatment of behavioral health conditions in primary care settings.
- Develop clear referral pathways and linkages for access to behavioral health treatment and interventions for child-parent relationships.
- Establish uniform referral instruments to be used by providers in the network.
- Ensure that care coordination is available to assist the primary care practice in working with families with multiple issues.
- Ensure that there are both the expectations and mechanisms for ongoing sharing of information among providers.
- Provide guidelines for working with parents on child-parent relationships.

## 4 Behavioral Health Care for substance abuse and mental health issues

*Because community behavioral health care services often operate different organizational units for children and adults, this report discusses these two topics separately.*

### Infant and Early Childhood Mental Health and Its Importance in Behavioral Health Care Settings

The emergence of infant and early childhood mental health as a field of study and practice is a relatively recent occurrence as behavioral health care has historically (before the mid-1980s) focused on adults.<sup>b</sup> In the last 14 years in Florida, there has been an increased understanding of what infant and early childhood mental health is; however, increased application and integration of the principles and practices throughout the early childhood system of care and in health care is needed.

The emerging science of trauma and toxic stress, and the recognition that it is a public health crisis,<sup>111</sup> highlights the need to support positive early childhood development and child-parent relationships. The field of infant and early childhood mental health provides the methods to address these issues through prevention, intervention, and treatment. The *Florida Medicaid Community Behavioral Health Services Coverage and Limitations Handbook* includes several services that can be used (when medically necessary) to address the needs of social, emotional, and behavioral needs of young children and their families. These services have been extensively addressed in other FSU Center publications.<sup>112,113</sup>

Examples of these services include assessments, treatment planning, individual and family therapy, and therapeutic behavioral on-site services. Although these services are available for young children under the age of five, there is little information available that shows the utilization. Anecdotal information from the field indicates that utilization of Medicaid behavioral health services may be low for this age group when compared to older children. The need to increase the identification of social, emotional, and behavioral issues, as well as child-parent problems throughout the health care system may be one explanation. Other reasons may be that infant and early childhood mental health is not usually a primary focus of the community mental health system, that practitioners in this field are more aligned with the early childhood system than the Medicaid health care system and are not employed by enrolled Medicaid behavioral health services providers.

<sup>b</sup> In 1982, Jane Knitzer's ground-breaking report *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services* helped to bring attention to the lack of availability of children's mental health and was an impetus for additional federal funding in this area, but the focus was on older children with Severe Emotional Disturbance (SED). In 2000, the seminal Institute of Medicine's work of *Neurons to Neighborhoods* focused the nation's attention on the importance of early childhood development. The World Association for Infant Mental Health's (WAIMH) *Infant Mental Health Journal* was first published in 1996 while Florida's Association of Infant Mental Health started in 2000. The Florida Infant Mental Health Strategic Plan was first published in 2000 and later updated in July 2008. It can be found at <http://faimh.org/2008IMHPlan.pdf>

### Trauma-Informed Care for Young Children in Behavioral Health Care Settings

Trauma-informed care is essential in the behavioral health system. The Department of Health and Human Services published a Medicaid State Director letter on July 11, 2013 promoting attention to trauma and encouraged the integrated use of trauma-focused screening, functional assessments, and evidence-based practices in child-serving settings for the purpose of improved child well-being.<sup>114</sup>

A trauma-informed mental health program for children and families should have the overall understanding of the impact of trauma and toxic stress and ensure that staff are properly trained in trauma-informed care as discussed earlier in this report. Additionally, behavioral health programs should have high-quality treatments and interventions that effectively address trauma exposure and experiences, and that are delivered by behavioral health practitioners who are trained in utilizing trauma-focused treatments.

Mental health clinicians, supervisors, and administrators should:

- Prepare their organizations to implement evidence-based practice models for infants, young children, and their families.
- Ensure clinically competent practice.
- Successfully implement trauma-focused interventions and treatments.<sup>115</sup>
- Ensure practices are appropriate for children under the age of five.

#### Trauma Assessment

In most cases, when children are referred to a specialty mental health provider for services, there is a presenting problem already identified. When conducting assessments, clinicians should consider the possible impact of trauma on the child's behavior and be knowledgeable about the signs and symptoms of trauma exposure (See **Appendix M, Signs and Symptoms of Trauma and Toxic Stress in Young Children**).

When assessing trauma in young children, the clinician should focus on the presenting problem in the context of the child's overall development. Sources for understanding the child's development include: interviews with the parents/significant caregivers in the child's life, observation of the parent/caregiver-child interaction, and standardized assessment tools. Clinical assessment should include a review of the specifics of the traumatic experience(s) including:

- Reactions of the child and parents/caregivers.
- Changes in the child's behavior.
- Possible environmental supports to stabilize the child and family.
- Quality of the child's primary attachment relationships.
- Ability of parents/caregivers to promote and nurture the child's healthy social, emotional, psychological, and cognitive development.

The clinician should also assess developmental delays (e.g., gross/fine motor, speech/language, sensory processing), which may indicate that the child could benefit from evaluation and/or services from another professional (e.g., occupational therapist, speech/language therapist, physical therapist). It is often helpful to consult and/or to work collaboratively with these professionals.<sup>116</sup>

As recommended in the “Pediatric Primary Care” section, the clinician should also observe the parent for indications of trauma and toxic stress exposure and behavioral health disorders. Once a rapport is established, the clinician should consider screening the parent for trauma/toxic stress exposure and/or a behavioral health disorder.

The screening and assessment instruments recommended for use with young children are included in **Appendix N, *Instruments for Screening and Assessing Traumatic Stress in Young Children***. The list also includes instruments that can be used with the parent.

### *Intervention and Treatment*

When the clinical situation is related to the child-parent relationships, CPP (Child-Parent Psychotherapy) should be considered as an intervention. As mentioned earlier, the therapeutic practice is appropriate for children from birth through age five who have experienced at least one traumatic event (e.g., maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence). Other evidence-based practices for young children and their families are reported in the FSU Center’s *Literature Review to Identify Best Practices for Vulnerable Children and the Related Costs and Benefits to Those Practices*. See **Appendix O, *Evidence-Based Practice for Young Children and Families***.

## How to Support Parents with Mental Health and Substance Use Disorders in Behavioral Health Care Settings

Children whose parents have a behavioral disorder are at a high risk for emotional, social, and behavioral disorders.<sup>117</sup> To improve parenting and address the needs of young children, the needs of the parents must also be addressed, including both treatment and parenting support.

### **Parents with Mental Health Disorders**

Parents with mental health disorders and their children often suffer in silence as their needs are not routinely identified by the behavioral and health care systems. The adult mental health services delivery system may not routinely address the issue of parenting with their patients. Although it is known that 67% of women and 75% of men, living with severe and persistent mental illness in the community are parents,<sup>118</sup> and that their children are at a high risk for emotional and behavioral problems,<sup>119</sup> the behavioral health system is not currently well structured to help prevent exposure to trauma and toxic stress for young children whose parents have a mental illness. The evidence-base for parenting programs in mental health settings is just emerging and is currently dependent upon knowledge gained from existing programs both in the United States and elsewhere. In 2006, the National Council for Behavioral Healthcare conducted a survey of programs for parents with mental illness and their families. Additionally, the United Kingdom published a guide for serving parents with mental illness in 2014 titled, *Think Child, Think Parent, Think Family: A Guide to Parental Mental Health and Child Welfare*.

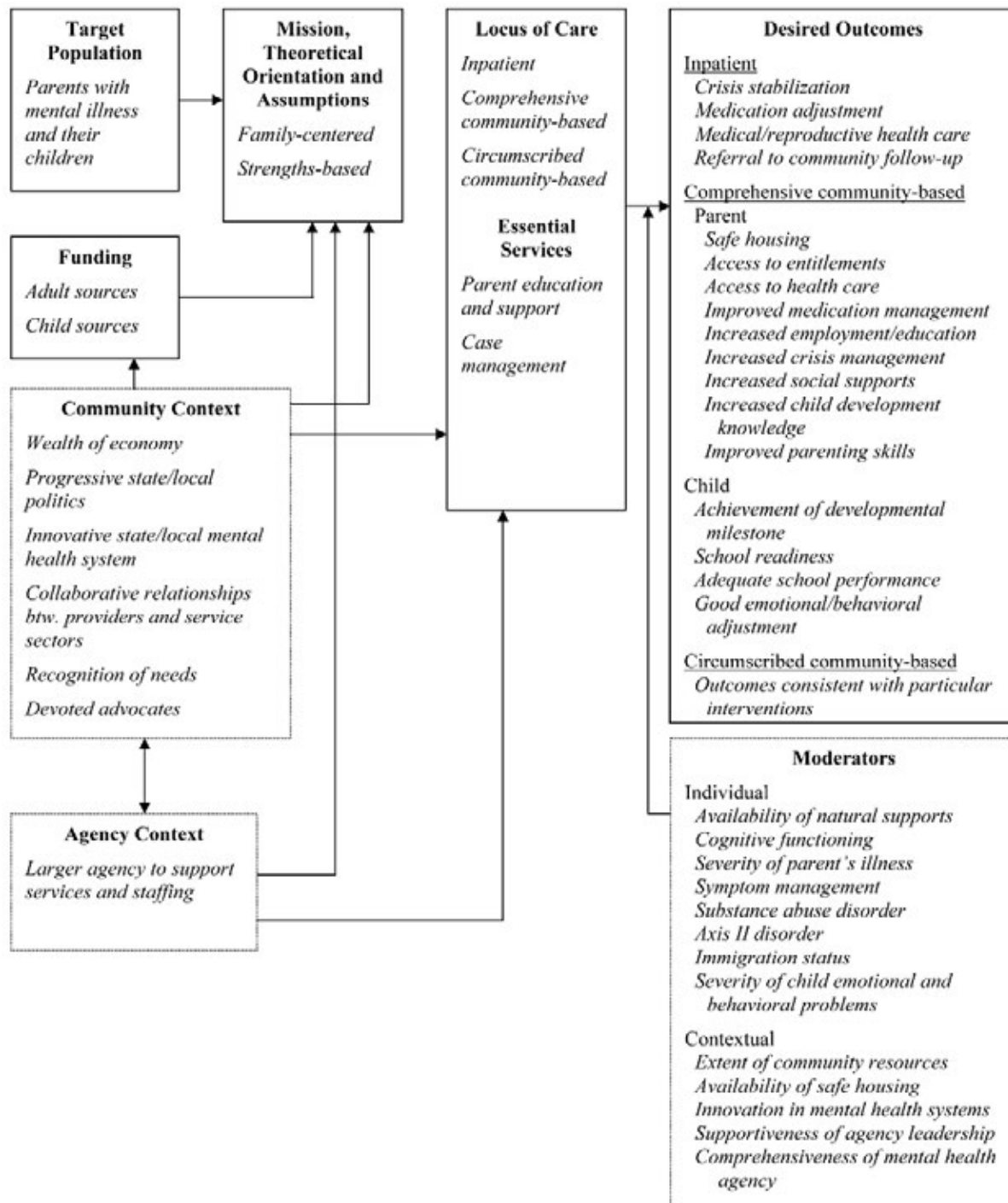
Both of these publications document the common characteristics of a system that supports parents with mental health disorders. These findings are summarized below:

- Create an organization that assumes many of the patients are parents and ask them about their children.
- Understand parents' fears about revealing parenting issues (may be afraid of losing custody or their ability to parent questioned) and provide a supportive environment to discuss these issues.
- Change the focus from pathology and deficits to individual strengths and interventions that are strongly associated with promoting mental health and recovery, sustaining families, and promoting inclusion.
- Create a family-centered program that views the family as a unit and focuses on positive interdependency and supportive, healthy relationships.
- Help parents to understand their mental health problems, their treatment plan, and the potential impact of mental health problems on their parenting, the child-parent relationship, and the child.
- Help parents to:
  - Understand the developmental needs of children.
  - Develop the ability to respond appropriately to their children's needs.
  - Appreciate how their broader family relationships and other environmental factors impact their parenting.
  - Understand and address how the child's behaviors may be impacting the parent's mental health and develop coping skills.
  - Be focused on the well-being and safety of their children.
- Ensure the service array includes the essential services:
  - High quality treatment programs that also address parenting.
  - Strengths-based case management to coordinate adult and children's programs and provide access to concrete services such as housing, transportation, job-finding, etc.
  - Dyadic therapy for parent and child relationships (Child-Parent Psychotherapy).
  - Parenting programs.<sup>120,121</sup>

The following logic model shows the components of a system of care that could address the needs of parents with mental illness. It illustrates the multiple needs of this population that do not appear to be well addressed in Florida. Work in this area offers an opportunity to significantly reduce adversities and promote child and family health.



Logic Model for Interventions for Families Affected by Parental Mental Illness



**Source:** Hinden, B.R., Biebel, K., Nicholson, J., Henry, A., & Katz-Leavy, J. (2006). A survey of programs for parents with mental illness and their families: Identifying common elements to build the evidence base. *The Journal of Behavioral Health Services & Research*, 33(1), 21-38.

### Screening for Children of Parents with Behavioral Health Disorders

The U.S. Department of Health and Human Services recommends that behavioral health providers address developmental and behavioral health screening for children under the age of five with parents with behavioral health disorders. The 2014 initiative *Birth to Five: Watch Me Thrive* includes a *Behavioral Health Provider's Guide for Developmental and Behavioral Screening*.<sup>122</sup>

According to the guide, the behavioral health provider is well positioned to assist parents of young children as the behavioral health provider:

- Knows the patient well and has a foundation of trust established.
- Provides an opportunity to explore the parent's perspective on how their child is doing, reinforce their expertise on their child, and validate their desire to help their child's development.
- Can share important information about healthy child development and the importance of regular developmental and behavioral screening. (The conversation should underscore that screening is a routine part of health care for a young child.)
- Can introduce the idea that the behavioral health provider is part of a team of health care that may include the child's pediatrician, other caregivers, other specialists such as occupational or speech therapist, etc., and the team can work together toward a common goal of wellness for the child and family. (The parent should be recognized as the center of the team.)

The behavioral health provider can work with the parent to determine if the child has received developmental screenings elsewhere and help the parent understand how to interpret the results of the screening. If the child has not been screened, the behavioral health care provider can suggest that the parent request a screen from the pediatrician, or offer to conduct a screening. If the screen shows the child to be "at risk," the behavioral health care provider can explain the results and help the parent access the necessary services for the child. The behavioral health care provider should work with the parent to monitor progress.

### Using a Family-Centered Approach to Assessment and Planning

When working with a family as a unit, the behavioral health provider is required to take a broader perspective. The suggestions below are from the United Kingdom's integrated work with parents with mental health disorders.<sup>123</sup>

- Take a systemic and socially inclusive approach to assessment, understanding that parents may need advice on several issues that may impact their recovery.
- Involve as many members of the family as possible to help locate other natural supports to help in caregiving if necessary.
- Establish good working relationships with other providers, including health care, and those in the early childhood system of care.
- Be very clear about what information can be shared with which parties and protect confidentiality when necessary.
- Be able to recognize the most vulnerable families and know how to quickly access necessary services.
- Be well informed about what types of behaviors associated with mental health disorders may present risk of harm to children.

- Have protocols established to safeguard children when necessary.
- Ensure that care planning is holistic and includes the appropriate care for individual members of the family, as well as contingency and crisis preparation for both predictable and unseen situations should the parent become unstable.

The recommendations listed above go far beyond the typical practice in community behavioral health; however, as family-centered practice evolves, these types of programs may become more available. In 2012, SAMHSA published a *Supporting Infants, Toddlers, and Families Impacted by Caregiver Mental Health Problems, Substance Abuse and Trauma: A Community Action Guide* that includes suggestions on how communities can strengthen their supports and services to these vulnerable families. It is available at <http://store.samhsa.gov/product/Supporting-Infants-Toddlers-and-Families-Impacted-by-Caregiver-Mental-Health-Problems-Substance-Abuse-and-Trauma/SMA12-4726>.

### Parents with Substance Use Disorders

The recommendations presented above are applicable to parents with substance use disorders as well. It should be noted that many parents have both mental health and substance use disorders so the programs must be able to co-occur (treat both mental health and substance use disorders concurrently). Providers working with families with substance use disorders have long recognized the need to address the needs of the parent's young children. *The Substance Abuse Prevention and Treatment Act* requires that states provide services to pregnant and parenting women, which has created national attention to the issue.

Comprehensive substance abuse treatment programs that address the needs of mothers with substance use disorders have shown better results than traditional programs. These programs take into account the following:

- The role that trauma plays in women's addiction.
- The importance of their role as a mother.
- Child care and training and support on parenting.

Attention to the parenting role is critical to the ongoing health of the mother and child. If unaddressed, problems in parenting can build and may trigger a relapse. Some programs offer intensive child-parent therapy to rebuild the disrupted relationship when the parent abuses substances.<sup>124</sup> As with the mental health disorders described previously, services need a family-centered approach. If possible, the array of services to the child and parent should be provided through a comprehensive provider, or closely coordinated through case management.

## Trauma-Informed Care in Adult Behavioral Health Care Settings

A trauma-informed approach to the delivery of behavioral health services requires an understanding of trauma, and an awareness of the impact it can have on the individual. Trauma should be viewed through an ecological and cultural lens that recognizes that context plays a major role in how individuals perceive and process traumatic events, whether acute or chronic. Trauma-informed care is strengths-based and emphasizes the importance of a personal sense of physical, psychological, and emotional safety for both providers and patients. This sense of safety helps persons impacted by trauma to rebuild a sense of personal control and empowerment. Providing a trauma-informed environment requires that the organization review its practices to ensure they do not present situations that could re-traumatize the individual. It is important to ensure that the individual is fully involved in all aspects of planning service delivery.<sup>125</sup> This should be underscored for family-centered approaches when the parent and children are involved together. The parent must feel safe and in control of planning for their family.

Behavioral health care providers must ensure that trauma-specific treatment services are available. These services are evidence-based and promising practices that facilitate recovery from trauma. The term “trauma-specific services” refers to prevention, intervention, or treatment services that address traumatic stress, as well as any co-occurring disorders (including substance use and mental disorders) that may be associated with the trauma.<sup>126</sup>

SAMHSA has developed a detailed Treatment Improvement Protocol (TIP) titled *Trauma-Informed Care in Behavioral Health Services*. This publication includes a detailed guideline for the implementation of trauma-informed care in behavioral health care settings.<sup>127</sup>

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### ***How the MMA Health Plans Can Work with Behavioral Health Service Providers***

- Ensure that the provider network has an adequate number of therapists trained in infant and early childhood mental health.
- Assess the need for, and provide or arrange for, necessary training on trauma-informed care in behavioral health settings.
- Promote connections and linkages with primary care.
- Promote access to referral sources for evidence-based parenting programs.
- Promote a family orientation throughout the behavioral health network including offering assistance to patients on parenting.
- Ensure the behavioral health network has an adequate number of providers trained to assess for trauma and conduct specific therapy.

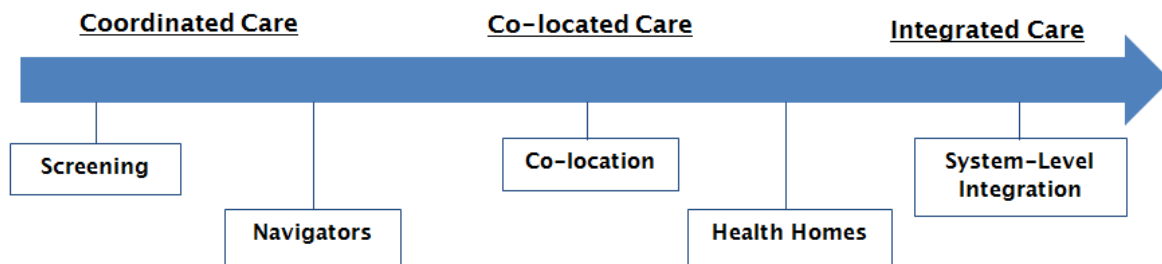
## 5 Options for Coordination, Co-location, and Integration of Services

### From Coordination to Integration

The need to improve the coordination, co-location, and integration of early childhood services is understood throughout the United States. The Kaiser Commission on Medicaid and the Uninsured identified several strategies to achieve various levels of integration of care in their February 2014 brief, *Integration Physical and Behavioral Health Care Promising Medicaid Models*.<sup>128</sup> Additionally, the AAP identified similar strategies.<sup>129</sup> These recommended models range from coordinated care through full system integration. The graphic<sup>130</sup> below from the Kaiser Commission shows the range of options.

**Appendix P, Array of Options for Coordination, Co-location, & Integration**, provides a more detailed description of these levels.

### Continuum of Physical and Behavioral Health Care Integration



### Components of Coordinated / Integrated Systems

- **Screening:** As stated above, and described in the Kaiser report, the first component of a coordinated / integrated system is screening. The infants and young children must be screened for developmental and mental health issues according to the periodicity schedule recommended by the AAP. Parents should receive routine screening, especially for depression and substance use, in adult primary care settings as well. Likewise, routine screening should take place for children of parents served in the behavioral health care system.
- **Care Coordination:** Referring families for care and ensuring that they receive the appropriate services can be challenging. Medicaid programs, such as Florida's MMA program, use care coordinators to help families and providers locate services (other systems call them Navigators). Care coordination must be available for all families; however, for families with multiple risk factors, the care coordination is essential to link the families with necessary services and coordinate the various aspects of care.

- **Consultation and Shared Care:** As part of a coordinated system, the AAP described situations in which other practitioners are brought in to assist primary care with consultation.<sup>131</sup> In one instance, the primary care provider does not possess the skills necessary to provide the specialty care; however, they provide the primary care and serve as the coordinator with other programs such as early childhood and specialty services. The primary care practitioner has professional relationships with specialists such as an infant and mental health practitioner, occupational therapists, or speech and language therapists. In another instance, the primary care practitioner completes the initial screen and assessment and then asks the mental health specialist to provide additional information about the types of treatment that may be of benefit. For example, the primary care practitioner may work with the family directly to support positive parenting techniques but may ask an infant and early childhood mental health practitioner to recommend materials that the family could use on their own. The primary care practitioner may also ask the mental health specialist to assist with complicating conditions such as new behavioral problems or other high-risk situations. This type of consultation may involve working with the child and family face-to-face, or intermittent communications between the specialist and the primary care physician, including the use of telehealth. Although this method is described for pediatric primary care, it is equally plausible for adult primary care.

“Shared care” as described by the AAP, requires that the primary care practitioner develop relationships that enable the clinicians to “share” the management of the infant and childhood mental health and other developmental issues. Primary care practitioners may find the following practices helpful:

- Having a mental health clinician provide not only the initial assessment but also provide the ongoing treatment with communication back to the primary care provider. The treatment could include behavioral health therapy for the parent and dyadic child-parent interventions.
- Creating a multidisciplinary team which may include the child and parents’ behavioral health provider (mental health or substance abuse), care coordinator or case manager, other involved therapists, professionals from child welfare, or other early intervention programs such as Early Steps. Multidisciplinary teams are often used in multi-risk or high-need situations.

Key features of the AAP “shared care” model are:

- The family maintains a central role in developing the plan of care.
- There is a mutual understanding of the roles that the family members will play, as well as other service providers, including the frequency of responsibility for follow-up. Infant and early childhood mental health practitioners or adult behavioral specialists assume the responsibility of not just the treatment provision but also the safety of the child.
- The general health supervision is provided by the primary care clinician, including care of any medical illnesses, immunizations and other preventive services, and coordination of specialty and early childhood care.
- A communication protocol is in place that includes obtaining parental consent for the exchange of information, ensuring a clear understanding of respective responsibilities, creating mechanisms for monitoring progress of therapeutic goals, sharing information, and maintaining contact information for practitioners for each service component.

- **Co-location:** This option is used when behavioral and primary care services are provided on the same site. *The Best Beginning*,<sup>132</sup> funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and published in 2005, is a resource to give health care providers and policy makers at all levels an overview of a range of innovative efforts across the country where health care providers have attempted to treat families as a whole, provide care in the context of a medical home, identify mental health and substance abuse disorders earlier, and make successful referrals and linkages to community-based mental health and substance abuse services and supports. The report recommended that, whenever feasible, services should be co-located. Co-locating services and supports to families allows health care practitioners to more effectively attend to the variety of needs that a family may have. *The Best Beginning* project found that not only does co-location increase the likelihood that families will access behavioral health services, it can also help reduce the stigma associated with receipt of these services.

The co-location trend is frequently used in community health centers (federally qualified health centers). In 2010, the National Association of Community Health Centers reported that over 70% of the centers provided mental health services, 55% provided substance abuse treatment services, and 65% provided integrated care with a shared treatment plan that addressed both behavioral and physical health care.<sup>133</sup> There may be an opportunity to increase the use of infant and early childhood mental practices in community health centers since they provide both pediatric and adult primary care to many Medicaid and low-income families.

- **System Level Integration:** Each of the options presented above go beyond traditional care and provide improved methods to coordinate care. However, they do not represent a fully integrated model. A fully integrated model includes responsibility for both behavioral and physical health care with fiscal accountability. The Florida Medicaid program has established a specialty Managed Medical Assistance program which from a broad perspective creates an integrated model for the delivery of both behavioral and physical health care. The newly established Managed Medical Assistance program creates a health care environment that embraces integrated care. This change in Medicaid service delivery provides a new opportunity to enhance patient outcomes, contain costs, and streamline care. These changes may encourage health plans to reshape the way infant and early childhood mental health are provided in conjunction with primary care.

Although integration of services initially concentrated on adult services, over the last few years models of pediatric integration have emerged. As the information presented in both “Pediatric Primary Care” and “Adult Primary Care” sections of this paper, there are numerous opportunities to incorporate coordination, co-locations, and integrative practices to further promote infant and early childhood mental health approaches. Although the evidence base for several of these options is just emerging, the field of behavioral health and primary care are moving in the direction of improved coordination and integration.<sup>134</sup>

### Patient-Centered Medical Home

The term “Health Home” is used to refer to primary care care practices that integrate behavioral health and primary care with other community-based programs. However, the term “medical home” is more frequently used in the literature related to pediatric primary care. Therefore the term “medical home” is used in this report rather than “health home.” The Agency for Health Care Research and Quality (AHRQ) describes the Patient-Centered Medical Home (medical home)<sup>135</sup> as not necessarily a place, but



a way of providing primary care that is based on core functions. The information presented below is based upon the AHRQ definition and was modified to illustrate how this approach could promote the integration of infant and early childhood mental health approaches into medical homes.

- **Comprehensive Care:** The primary care provider is accountable for meeting a large portion of the patients' physical and behavioral health care needs including prevention and wellness, acute care, and chronic care. Providing this type of care requires a team of providers that might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, care coordinators, behavioral health care practitioners such as those specializing in infant and early childhood mental health, and other therapists. Although some settings may have many of these practitioners on the same site, other practices may build virtual teams linking the practice and their patients to providers in their communities. The discussion above on coordinated and shared care are examples of this type of approach.
- **Patient Centered:** The medical home provides primary care that is relationship-based with an orientation toward the whole person. In the case of families with multi-risk conditions associated with trauma and toxic stress, the medical home could partner with the family to address the multiple issues. This type of partnership requires understanding and respect of each family's unique needs, culture, values, and preferences. A knowledge of the impact of trauma and toxic stress may help primary care teams better appreciate the complexity of the family's conditions. To be responsive to the needs of these families, the medical home would also be knowledgeable about the importance of child-parent relationships, how to support these relationships and what interventions and treatment must be necessary to address any emerging problems. The medical home practice actively supports families in learning to manage and organize their own care to the degree that they are comfortable with the responsibilities. The patients and family are recognized as core members of the team. Medical practices ensure that they are fully informed partners in establishing care plans.
- **Coordinated Care:** The medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, behavioral health care, and other therapeutic and community services. When required by the families' condition, coordination in medical homes is comprehensive and resembles the multidisciplinary and "shared care" models. Medical home practices have clear and open communication among patients, family members, the primary care practice members, and the broader care team. When working with families where there is the possibility of child maltreatment or domestic violence the medical home must be cognizant of the state and federal rules for reporting child maltreatment and would become part of the team to keep the children safe.
- **Accessible Services:** Medical homes deliver accessible services with short waiting times for urgent needs, offer increased hours of availability, and are responsive to families' preferences regarding access to a member of the care team. In situations where young children and parents with behavioral health care concerns are paramount, the medical home would need to have linkages available for behavioral health assistance on an after-hour basis as well.
- **Quality and Safety:** The medical home is committed to quality improvement by continual engagement with families, use of evidence-based medicine, and clinical decision-support tools to guide shared decision making with patients and families. The use of performance measurement and improvement is important to measure and respond to patients' experiences and satisfaction with care, and practice population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

## ***How the MMA Health Plans Can Work with Care Coordination Units and Promote Integration***

- Provide or arrange training for care coordinators regarding trauma and toxic stress, its impact on children's and adults' health, and the principles and practices of infant and early childhood mental health.
- Provide or arrange training and technical assistance on the early childhood system of care and how Medicaid services are imbedded in that system.
- Ensure that an adequate amount of care coordination is available for families with young children with multiple or complex issues.
- Consider piloting different approaches for integration of infant and early childhood mental health services.
- Work with provider networks to:
  - Determine areas where there is a high level of need.
  - Implement an integration strategy where there is interest and capacity.

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