Advancing Infant and Early Childhood Mental Health: The Integration of DC:0–5™ Into State Policy and Systems

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ZERO TO THREE
Early connections last a lifetime

Infants and young children can have mental health and developmental disorders that affect development. When a young child has a mental health disorder, it is important to identify and treat the disorder as early as possible so that impairment, suffering, and effects on overall health and development can be reduced. Early childhood mental health and developmental disorders can be seen as early as infancy or may emerge through the preschool years. These include disorders that are specific to the early childhood stage of development (e.g., Overactivity Disorder of Toddlerhood or Excessive Crying Disorder) as well as general disorders that manifest in unique ways in the infant and early childhood population (e.g., Social Phobia or Autism Spectrum Disorder). If properly identified using diagnostic criteria relevant to infant and early childhood development and experiences, many of these disorders can be effectively treated.

Accurate identification of a mental health disorder for a young child is only possible with a developmentally appropriate diagnostic classification system. In this paper, we explore how states are integrating an age-appropriate diagnostic classification, *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5)*[i] into state policy and systems. DC:0–5, published by ZERO TO THREE in December 2016, is a tool used by clinicians to accurately diagnose and classify infant and early childhood mental health (IECMH) disorders. Adopting DC:0–5 as a standard of practice can be an effective strategy for (a) improving access to IECMH services and supports and (b) improving outcomes for children, and many states are pursuing this approach.

This paper discusses why and how states are integrating DC:0–5 into state policy and systems; provides state examples to highlight some of the strategies that states have used to allow, promote, or require the use of DC:0–5; and provides recommendations for further improvements in state IECMH policy and practice. It is important to note that this paper provides a point-in-time overview of how DC:0–5 is being integrated into state systems and policies. The state examples included here are a sample of the innovative work going on across the United States.

What Is DC:0–5™?

DC:0–5 is a system for classification of mental health and developmental disorders for infants and toddlers.

DC:0–5 was published in December 2016. It revised and updated DC:0–3R by expanding the age range from 3 years to 5 years old, extending criteria to younger ages, and including all disorders relevant for young children.

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Why Use DC:0–5?

DC:0-5 is an important tool for clinicians, researchers, and early childhood professionals. Prior to 1996, the early childhood field lacked any widely accepted system to classify mental health and developmental disorders for infants and toddlers. Since the publication of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*[ii] in 1996, much progress has been made to describe and categorize, through research and empirical evidence, mental health disorders specific to infants and toddlers. The most recent edition, DC:0–5, represents the best available evidence for accurate identification of early childhood mental health disorders. Existing classification systems, such as the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*[iii], are geared toward disorders in school-age children, adolescents, and adults, and do not adequately reflect mental health disorders that are typically first diagnosed in infancy and early childhood.

DC:0–5 also provides a common language that allows individuals across disciplines—including mental health clinicians, counselors, physicians, nurses, early interventionists, social workers, and researchers—to communicate accurately and efficiently with each other. An accurate diagnosis using the DC:0–5 guides treatment for the child, may indicate services needed for the family, and can help determine the need for additional services. It also allows clinicians and researchers to link knowledge about early childhood disorders to treatment approaches and outcomes. Finally, a DC:0–5 diagnosis may serve to authorize treatment and reimbursement.

What Is IECMH and Why Is It Important?

Infant and Early Childhood Mental Health (IECMH) is the developing capacity of the child from birth to 5 years old to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn—all in the context of family, culture, and community.

IECMH, also known as healthy social and emotional development, is the cornerstone of early brain development, providing the foundation upon which all future development rests. Babies who engage with responsive, consistent, and nurturing caregivers are more likely to have strong emotional health throughout life.

Integrating DC:0–5 Into State Policy And Systems

Pediatric and mental health clinicians use DC:0–5 because it allows for age-appropriate diagnostic assessment and more effective treatment planning. States adopt DC:0–5 for a variety of reasons. For example, including DC:0–5 as a guideline or requirement for the diagnostic assessment of children under 5 years old provides an evidence-informed and age-appropriate standard of practice for IECMH assessment and diagnosis. Providers (and parents) want to avoid over- or underdiagnosing IECMH conditions in young children. It is important to identify mental health disorders as early as possible in a child's life and to begin appropriate treatment. It is also important to use empirically derived criteria such as those in DC:0–5 to rule out mental health disorders and avoid unnecessary "labeling." Consistent use of DC:0–5 results in more accurate and developmentally appropriate diagnosis, and a consistent process for establishing medical necessity. "Medical necessity" is a term used by third-party payers to describe criteria they feel are essential for determining the need for service and reimbursement of services. Medical necessity may include such criteria as diagnosis, level of impairment, and responsiveness of the condition to treatment.

States and clinicians want to improve the developmental appropriateness of IECMH services so that the most effective services can be delivered as early as possible to children who need them. States are also interested in cost-efficiency and sustainability. Use of DC:0–5 can facilitate reimbursement from public and commercial insurers by establishing a consistent process for establishing medical necessity.

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Finally, all states are concerned with shortages of qualified child psychiatrists, psychologists, and other mental health providers. Providing training in DC:0–5 and IECMH treatment strategies can help to ensure access to a cadre of qualified mental health clinicians.

States have pursued a variety of strategies to integrate DC:0–5 in state policy and systems. State Medicaid policies, for example, may allow, promote, or even require that mental health clinicians use DC:0–5 for IECMH diagnoses to receive reimbursement. While most commonly used in the mental health system, states can also use DC:0–5 to determine eligibility for Part C Early Intervention services. Several states have included DC:0–5 in cross-sector workforce development and have used the tool in research and data collection efforts.

As part of an effort to improve state IECMH and overall early childhood health policy, ZERO TO THREE recommends that states consider one or more of the following specific strategies to increase the use of DC:0–5.

1. Formally recognize DC:0–5 in public and commercial insurance programs, including Medicaid, through legislation, contract language, or regulatory changes.
2. Develop and disseminate resources (e.g., crosswalk to other disorder classification, practical guidance documents) to help providers use the DC:0–5 for eligibility determination, treatment planning, and billing purposes.
3. Recognize DC:0–5 disorders as eligibility criteria for Part C Early Intervention services.
4. Include DC:0–5 in cross-sector IECMH workforce development.

Each of these strategies are described in more detail in the sections below, and illustrated with state examples.

State DC:0–5 Strategies

States have initiated a variety of policy and practice changes to advance IECMH services. In the sections below, state examples are provided to illustrate strategies for integrating DC:0–5 into policy and practice.

1. Formally recognize DC:0–5 in public and commercial insurance programs, including Medicaid, through legislation, contract language, or regulatory changes.

States can act to ensure that providers are able to receive insurance reimbursement when they use DC:0–5 to diagnose an IECMH disorder and provide appropriate treatment. Because Medicaid is the largest payer[iv] for mental health services, many of the examples in this paper are drawn from state Medicaid policy. States may also choose to include language about the use of DC:0–5 in contracts with behavioral health and health managed care providers.

In some cases, state policy may explicitly call for the use of DC:0–5 when diagnosing young children enrolled in Medicaid. States can recognize DC:0–5 in the Medicaid state plan by including it in the medical necessity criteria. Within federal Medicaid guidelines, states have the flexibility to set parameters for how a determination is made as to whether there is a medical necessity to cover a medical service or treatment.

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In this context, states could refer to the DC:0–5 as a way that mental health care providers can demonstrate the medical necessity or need for IECMH services. Then, for an eligible child to receive treatment, most insurers require a diagnostic assessment to establish a mental health diagnosis and to guide treatment planning. The more accurate the diagnosis, the more likely it is that an effective treatment will be provided and a better outcome achieved. Setting expectations for age-appropriate diagnosis helps improve how providers deliver services, and it promotes statewide consistency in the availability and quality of diagnostic process and service provision.

Because an accurate diagnosis with DC:0–5 can take several sessions with a clinician, states may also need to reimburse providers for multiple diagnostic visits. The DC:0–5 manual recommends a minimum of 3-5 sessions of 45 minutes or more each for a comprehensive evaluation[iv].

Some states have explicitly called for the use of DC:0–5 in state policy. For example:

Arkansas: The Arkansas legislature recently approved a Behavioral Health Transformation package that includes changes to Medicaid aimed at improving diagnosis and treatment of very young children with mental health disorders. The revised outpatient behavioral health rules[v] require providers to use the DC:0-3R (and subsequent revisions) to diagnose mental health conditions in children through the age of 47 months, and to crosswalk the DC:0-3R diagnosis to a DSM diagnosis. Use of this age-appropriate classification system increases the chances that a child will be appropriately diagnosed and referred to evidence-based treatment. The rule also implements changes so that, for the first time, Arkansas Medicaid will reimburse providers for dyadic therapies, which treat infants and their caregivers in the context of their relationship. Approval of this package was the result of years of work on the part of the Department of Human Services, mental health and substance abuse treatment clinicians, and families who advocated for change. Key factors influencing policy change included: a review of Medicaid data showing high usage of psychotropic medications for children and a lack of billable codes for infant mental health therapy, as well as the work of the Arkansas Children's Behavioral Health Commission and a listening tour by Arkansas' First Lady. These changes have been effective since July 1, 2017.

Minnesota: As part of a larger state initiative to expand IECMH services, Minnesota changed Medicaid regulations in 2011 to require that providers use DC:0-3R (and subsequent revisions), with a state-provided billing crosswalk, as the diagnostic assessment for children less than 5 years old. This change was made as part of a revision of Medicaid outpatient rules. After considering what it takes to use the DC:0-3R to diagnose effectively, Minnesota enacted an extended diagnosis rule for complicated clients over the lifespan (birth through seniors) that allows providers to assess a child or adult over three sessions and receive a higher reimbursement for that assessment. This represents more sessions than are typically covered for the diagnosis process. Minnesota Medicaid also covers dyadic therapy (family psychotherapy) across the lifespan if it is medically necessary as documented in the diagnostic assessment.

Thus, family psychotherapy between the caregiver and the infant can be billed under the caregiver or the infant, depending on the outcome of the diagnostic assessment (i.e., that there is a diagnosis) and the medical necessity for that dyadic service.

Nevada: More than a decade ago, the Nevada Department of Health and Human Services adopted the DC:0-3R and added it to the state's Medicaid manual. This change allowed DC:0-3R diagnoses to be recorded in the electronic health record and services billed for children up to 48 months old. The inclusion

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of DC:0-3R (and subsequent revisions) was advocated by early childhood mental health clinicians who had been trained on the original DC:0-3 in the 1990s. These clinicians took part in the Behavioral Health Redesign process, and they successfully presented the challenges of using the DSM to assess and diagnose disorders in young children. Subsequent to the policy change, all mental health clinicians employed by the Nevada Division of Child and Family Services (DCFS) have been trained on DC:0-3R, as have some community partners. Although specific language about DC:0–5 was removed from the Medicaid State Manual in a recent revision, DCFS and some private clinicians continue to use the DC:0–5 and to crosswalk the DC:0–5 disorders to the 10th edition of the International Classification of Diseases and Related Health Problems (ICD-10)[vi] for eligibility and billing purposes.

Beyond these strategies, states and some communities have developed other policy approaches to promote the use of DC:0–5 for Medicaid-eligible children. For example, **Los Angeles County, California,** includes DC:0-3R in their "Infancy, Childhood, and Relationship Enrichment Initial Assessment" form[vii] used by mental health clinicians for assessment of young children. On this form, clinicians note any DC:0-3R diagnoses and then crosswalk to ICD-10 for billing purposes. The County Department of Mental Health has drafted an updated assessment form to reflect the DC:0–5 diagnosis being crosswalked to the ICD-10 diagnosis, and as of March 2018, is waiting on approval of the updated language.

North Carolina, while not explicitly promoting DC:0–5 in Medicaid policy, allows behavioral health providers to bill for a certain number of visits without a specific medical diagnosis. This policy can allow providers the necessary time to effectively use DC:0–5 to arrive at a diagnosis. Since 2001, North Carolina has allowed unmanaged visits (now 16) and the first 6 visits can have a Z-code/non-specific code for diagnosis. In addition, North Carolina will be including DC:0–5 in Medicaid guidance for clinicians when DC:0–5 training has been completed in the state.

2. Develop and disseminate resources (e.g., crosswalk to other disorder classification, guidance documents) to help providers use the DC:0–5 for eligibility determination, treatment planning, and billing purposes.

Regardless of whether a state formally recognizes DC:0–5 in Medicaid or other policy, mental health providers may choose to use DC:0–5 because it is an age-appropriate diagnostic tool for children less than 5 years old. However, if the state has not explicitly called for the use of DC:0–5, providers may need to link the DC:0–5 disorder to a recognized mental health condition or diagnostic code from the DSM and/or ICD-10. The mechanism to link DC:0–5 to other diagnoses or codes is called a "crosswalk." ZERO TO THREE created a sample crosswalk with links between DC:0–5, DSM-5 and ICD-10 conditions. States may use or customize the crosswalk according to their state's policies. Please see the Additional Resources section of this paper for more information on this crosswalk.

It may be necessary to crosswalk DC:0–5 with DSM and/or ICD-10 codes to establish a mental health diagnosis recognized by the state as an eligible behavioral health condition. All third-party insurance billing and payments are triggered by a determination of eligibility. *Eligibility* is typically based on codes from ICD-10. Payment for *treatment* services is based on the Healthcare Common Procedure Coding System (HCPCS) Current Procedural Terminology (CPT) codes. Each state specifies the codes Medicaid reimburses and establishes billing requirements.

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States have also created guidance documents and practice guidelines to assist providers in conducting age-appropriate diagnosis processes, properly documenting diagnostic codes, and submitting procedural codes for billing purposes. For example:

Oregon: Although Oregon had previously developed and disseminated a state-specific DC:0-3R crosswalk, it wasn't widely used and there was confusion among clinicians and early childhood stakeholders about what IECMH services were reimbursable. When DC:0–5 was released, a team in Oregon participating in the ZERO TO THREE IECMH Policy Project updated the crosswalk[viii] and thoughtfully considered how they could address the barriers that prevented broader uptake of the previous version. They took a number of steps as a result, including: adding information specific to Oregon's Medicaid plan to the crosswalk, posting the Oregon Early Childhood Diagnostic Crosswalk to the official Oregon Health Authority's website, creating companion documents outlining how and why the crosswalk should be used, and developing PowerPoint™ presentations of different lengths and detail to introduce the crosswalk to varied audiences. Presentations have been given around the state to clinician groups, Medicaid managed care organizations, early learning hubs (regional organizations that coordinate early childhood services), and other stakeholders. Oregon also had ZERO TO THREE provide two webinars giving an overview of DC:0–5 to further generate interest.

North Carolina: State leaders from North Carolina participated in a 9-month ZERO TO THREE IECMH Policy Project in 2016–2017. As part of their goals, the North Carolina team developed a state-specific DC:0–5 crosswalk and engaged stakeholders on how to implement DC:0–5 through a statewide IECMH summit. State leaders are currently supporting workforce training in DC:0–5 and exploring how to expand use of DC:0–5 and the crosswalk as well as seeking funding for infrastructure for the North Carolina Infant Mental Health Association. The North Carolina team has also made recommendations for IECMH in the plan for upcoming Medicaid changes in the state.

Use of a crosswalk between an early childhood-appropriate diagnosis and a more widely recognized adult mental health diagnosis is a common strategy in several other states. For example, **Michigan's** Mental Health Code requires the use of the most recent DSM published by the American Psychiatric Association and approved by the department, but the state has long supported use of the DC:0-3R (now DC:0–5). The state mental health agency provides a state-specific crosswalk to the DC:0-3R, as well as related training to encourage providers to use this tool. Similarly, **New Mexico's** Medicaid policy requires an ICD-10 code to establish medical necessity, but many trained mental health providers use the DC:0–5 and crosswalk to ICD-10 codes so that they have an early childhood-appropriate diagnosis for treatment planning as well as a connection to a recognized eligibility code.

3. Recognize DC:0–5 disorders as eligibility criteria for Part C Early Intervention services.

State leaders can also explore using the DC:0–5 to demonstrate children's eligibility for early intervention through Part C of the Individuals With Disabilities Act (IDEA). Use of the DC:0–5 for Part C eligibility can help to build professional IECMH capacity in the Early Intervention field and ensure that more young children with social–emotional delays receive appropriate services. The following state examples illustrate how states are using DC:0–5 in their early intervention systems.

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Minnesota: Since its last rule revision in 2006, Minnesota has maintained a moderate (medium) definition of developmental delay as categorized by the Early Childhood Technical Assistance Center. An infant or toddler may be determined eligible with a delay of -1.5 standard deviations in any one of five domains of development or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay by kindergarten if intervention is not provided. In addition, Minnesota has chosen to use all categories of eligibility included in Part B of IDEA as an option for determining eligibility for infants and toddlers. Guidance has been provided by the state to clarify which diagnoses are included as "established conditions." Some DC:0-3 conditions were included in that guidance. As the State of Minnesota will officially require the use of the DC:0–5 in place of the DC:0-3R beginning July 1, 2018, the Minnesota Mental Health Division (Minnesota Department of Human Services) and the Department of Education are now reviewing the diagnoses in the DC:0–5 to identify those diagnoses that would be considered conditions that constitute a high probability of delay. The list will be finalized in June 2018.

New York: In 1999, the New York State Department of Health, which oversees the state's Part C program—the Early Intervention Program (EIP), released Early Intervention Guidance Memorandum 1999-2 to specify the diagnosed conditions with a high probability of resulting in developmental delay that can be used to establish a child's eligibility for the EIP. This memorandum contained an extensive appendix with a list of conditions; the conditions were also associated with the ICD-9. Children with these diagnosed conditions do not have to be experiencing developmental delays to receive specific services available under the EIP. For children who are found eligible for the EIP on this basis, the primary purpose of early intervention is to mitigate the impact of the condition on the child's developmental progress.

Currently, the two specific DC:0–5 diagnoses included in the list—Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder—are indicative of social–emotional deficits and are diagnosed conditions with a high probability of resulting in developmental delay that can be used to establish a child's eligibility for the EIP. While not all DC:0–5 diagnoses are specified as a high probability of resulting in developmental delay for Part C eligibility, other DC:0–5 disorders can serve as evidence toward eligibility. In addition, New York City's Bureau of Early Intervention also sponsored DC:0–5 training for Part C leadership. This was in preparation for the New York State Department of Health Early Intervention release of the EIP published Meeting the Social-Emotional Developmental Needs of Infants and Toddlers: Guidance for Early Intervention Program Providers and Other Early Childhood Professionals[ix] This EIP guidance document provides case examples within the context of the DC:0–5 and outlines how providers can support young children through early intervention.

4. Include DC:0-5 in cross-sector IECMH workforce development.

To promote widespread use of DC:0–5 and improve professional knowledge about IECMH disorders, states can include DC:0–5 in a broader early childhood workforce development strategy. Training may be targeted toward clinicians in psychiatry, child psychiatry, pediatrics, mental health, nursing and early intervention. These clinicians can use DC:0–5 to inform diagnosis, consider aspects of the caregiver–child relationship that affect development, and take into account significant medical and psychosocial influences on the child's mental health. Other early childhood professionals, such as those in early care and education and home visiting, may also benefit from better understanding how common IECMH disorders manifest in infants and young children, aspects of the caregiver–child relationship, medical and psychosocial influences, etc.

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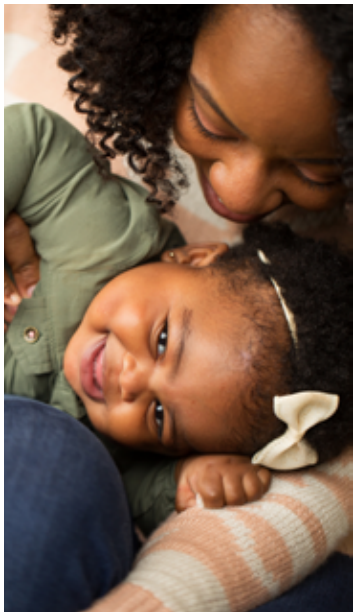

In partnership with ZERO TO THREE, **New York City, Northern New Jersey,** and **Philadelphia, Pennsylvania,** piloted a Certified DC:0–5 Training of Trainers initiative funded by a private foundation. Training of Trainer participants were selected from applicants who had previously received official DC:0–5 training and met rigorous eligibility requirements to become certified DC:0–5 trainers. The pilot Training of Trainer events was held in April and June 2018, and will be followed by a 1-year Community of Learners consultation.

Some states have also worked with ZERO TO THREE-approved Expert Faculty and certified DC:0–5 trainers to train individuals in the child welfare system on DC:0–5, particularly as part of the Safe Babies Court Teams™ approach to better meet the mental health and developmental needs of children in foster care. For example, in **Des Moines, Iowa,** Safe Babies Court Team clinicians providing Child–Parent Psychotherapy and other therapy services were trained on DC:0–5. As a result, several improvements in the assessment process were made. Since the DC:0–5 training, the psychosocial assessment of children birth to 5 years old has been revised to align with DC:0–5. A mental health status exam specific to infants and toddlers was added, and a more thorough psychosocial stressor section was included. In addition, for each child, clinicians now conduct a screening for Fetal Alcohol Spectrum Disorder, complete the competency domain rating scale from Axis V, and assess the caregiving relationship using the dimensions of caregiving in Axis II of DC:0–5. All fives axes of DC:0–5 are used for case conceptualization and treatment planning. A crosswalk from DC:0–5 to ICD-10 is used for billing purposes to comply with managed care requirements.

State and community stakeholders may consider offering DC:0–5 training in both higher education and in-service trainings, as well as ongoing opportunities for reflective consultation and clinical discussions. For example, embedding DC:0–5 content in higher education curricula can help prepare future mental health professionals to better understand IECMH and to use the DC:0–5 in clinical practice. ZERO TO THREE has developed DC:0–5 faculty guidance for classroom instruction.[x] **Minnesota's** Department of Human Services has promoted this strategy by sponsoring statewide full-day training for higher education faculty on how to include DC:0–5 in pre-service and graduate coursework. Minnesota has purchased DC:0-5 guidance materials for all relevant higher education faculty across the state.

Several states and communities have implemented in-service training on DC:0–5 for mental health and other child-serving professionals. These trainings, provided by ZERO TO THREE-approved Expert Faculty and certified DC:0–5 trainers, may be offered under a variety of auspices (e.g., state and local agencies or IECMH associations) and are supported through various public and private funding sources. Please see the Additional Resources section of this paper for more information on DC:0–5 training. A variety of states and communities have recently invested in DC:0–5 training, each taking an approach appropriate to their context. In-service training opportunities may include: intensive 2-day trainings for clinicians, an ongoing series of shorter trainings, as well as seminars or online modules. More intensive training models are typically targeted to mental health professionals who will use the tool in clinical practice. The following are examples of states and communities with significant investment in training:

Colorado: Through a federal Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Colorado was able to expand DC:0–5 training to reach a wider variety of professionals who come in contact with or provide treatment services to young children and help them to learn a common

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language and understanding of mental health disorders and supports. Colorado invests these funds in DC:0–5 training for their early childhood mental health consultants, 34 full-time positions that provide consultation in child care settings. This required training helps mental health consultants to understand the processes of IECMH disorders and to be able to communicate the therapeutic concerns should children need more intensive treatment services. Additional training slots were offered to IECMH clinicians, child psychiatry residents, and clinical supervisors. Thus far, the state has trained 150 professionals in DC:0–5.

Los Angeles County, California: Los Angeles County Department of Mental Health has developed a workforce development plan to expand mental health providers' knowledge and use of DC:0–5, including introductory webinars and 2-day trainings. The county is considering plans to expand training to reach other types of professionals, such as home visitors, as well as more rural areas of the county, and is exploring including DC:0–5 in the Department of Mental Health's core competency training. These trainings have been funded through the state Mental Health Services Act Prevention and Early Intervention funding, a dedicated funding source to target underserved populations. The California Children and Families 1998 Act (Prop 10-First 5) expanded on and supported training and services for the birth to 5 population. Los Angeles County Department of Mental Health has partnered with First 5 LA to build capacity to serve this population.

Michigan: Michigan had previously invested in training mental health clinicians in DC:0-3R. With the release of DC:0–5, Michigan is again investing in professional development, using federal Mental Health Block Grant funds, to ensure that mental health clinicians working with young children are using age-appropriate diagnostic tools. Webinar series are held throughout the state to teach clinicians how to use DC:0–5, as well as how to use a crosswalk to DSM diagnosis, to allow for reimbursement.

Minnesota: In addition to new Medicaid rules requiring the use of DC:0–5, Minnesota has invested in significant statewide training on the DC:0-3R (now DC:0–5), reaching more than 2,000 clinicians. At the same time, Minnesota provided training in three research-based interventions (Parent Child Interaction Therapy, Child–Parent Psychotherapy, and Attachment and Biobehavioral Catch-up). Documented training in DC:0-3R/DC:0–5 is required before clinicians are admitted to the above trainings on treatment interventions. Since 2009, the state has made investments of more than $15 million through state appropriations and Community Mental Health Block Grant Funds in training the early childhood mental health workforce in evidenced-based assessment and treatments, as well as serving children and their families who are uninsured and underinsured. The purpose of this DC:0-5 training is to ensure that clinicians know how to use the tool, how it is suited to the developmental needs of young children, how to document it for billing purposes, and how to do billing. They have also incorporated a full day of developmental training prior to the 2-day DC:0–5 training to provide context and increase provider awareness that this is clinically the appropriate diagnostic instrument. Clinicians who attend the 3-day DC:0–5 training are then eligible to participate in a monthly consultation group to hone their assessment skills. Professional development opportunities are offered for free, and the state offers grants to cover billed hours that clinicians lose to participation. Successful completion of the trainings is required for providers interested in being on a "preferred provider list" with the state.

New Mexico: Through state general funds, the New Mexico Department of Children, Youth, and Families has provided no-cost trainings in Albuquerque and Las Cruces on DC:0–5 to multiple agencies and clinicians. To better support ongoing workforce development, some states have

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followed up in-service training with reflective consultation, a learning community, or clinical discussion model, where clinicians take part in regularly scheduled case-based discussions about how they are using DC:0–5 and challenges that they have faced. **New Mexico** and **Minnesota** both have case consultation networks where clinicians discuss recent cases where they have used DC:0–5. **Minnesota's** Great Start clinician group serves as a voluntary and no-cost peer learning opportunity. The group meets once a month in person in St. Paul and via technology throughout the state. IECMH providers interested in being on the Minnesota Department of Human Services, Mental Health Division preferred provider list are required to present a redacted case using DC:0–5 for diagnostic assessment to this clinician group.

New Mexico integrated DC:0–5 into the skill development and clinical process for all state-funded IECMH teams working with children in foster care, as well as Parent Infant Psychotherapy clinicians. In these programs, DC:0–5 is one of several tools used to inform clinical case formulation, treatment objectives, and discharge planning. DC:0–5 also provides the New Mexico IECMH teams with an overarching summative classification system to determine effective intervention approaches.

Conclusion and Future Directions

This briefing paper provides a point-in-time perspective on why and how some states are integrating DC:0–5 into state policy and systems. The state examples we have highlighted provide just a sample of the innovative work going on across the United States. Many other states are in the early stages of considering how to improve their continuum of IECMH services and supports, assure quality and consistency in diagnosing IECMH disorders, improve access to appropriate treatment, expand the IECMH workforce, and maximize funding for these services.

States should take concrete action to integrate DC:0-5 into IECMH policy and practice, and improve the availability and quality of IECMH services and supports. We offer the following recommendations for further improvements in state IECMH policy and practice:

- Acknowledge that qualified IECMH providers are scarce and make efforts to significantly increase the availability of qualified IECMH providers. In addition to supporting training and reflective supervision opportunities, states should consider strategies for building capacity and stability among the IECMH workforce, including reviewing the adequacy of current reimbursement rates for IECMH providers, higher reimbursement rates for providers using the DC:0–5 diagnostic classification, and adequate coverage for multiple diagnostic assessment sessions.
- Include DC:0–5 diagnoses in medical necessity criteria for children under 5 years old.
- Consider creating or updating standard Medicaid, behavioral health, and managed care contract language requiring (or at a minimum, encouraging) providers to use DC:0–5 in their diagnostic assessment of children under 5 years old.
- Include DC:0–5 training in the requirements for child psychiatry, psychology, and social work as well as mental health continuing education, IECMH endorsement, and related early childhood professional credentials.
- Use DC:0–5 as a consistent tool in research and data collection to better understand children's need for and use of mental health services and how current service delivery meets these needs. For example, capturing DC:0–5 diagnoses and treatment in medical records could allow the state to track trends over time, document the need for IECMH clinicians, and review the types of interventions being provided.

It is clear that state agencies must attend to the mental health needs of infants and young children if they want to improve health and developmental outcomes, prevent impairment due to early adversity, provide

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trauma-informed care, and ultimately, see better returns on investment. Adopting an age-appropriate diagnosis and treatment is a significant step toward assuring better overall health for infants, young children, and their families.

Additional Resources

DC:0–5 Manual and Training: Information about the DC:0–5 manual, how to request DC:0–5 training, and training resources is available on the ZERO TO THREE web site: https://www.zerotothree.org/resources/2218-dc-0–5-training-offerings

DC:0–5 Crosswalk: ZERO TO THREE created a crosswalk between DC:0–5 diagnoses, DSM diagnoses, and ICD-10 codes. States and agencies may need to adapt the links from DC:0–5 to DSM and ICD codes based on their own service delivery policies. Available at https://www.zerotothree.org/resources/1540-crosswalk-from-dc-0–5-to-dsm-5-and-icd-10

IECMH Policy Series: Five briefing papers on topics including the basics of IECMH, IECMH consultation, IECMH competencies, DC:0–5, and the DC:0–5 crosswalk. Available at https://www.zerotothree.org/resources/series/infant-and-early-childhood-mental-health-iecmh-policy-series

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About Us

The ZERO TO THREE Policy Center is a nonpartisan, research-based, nonprofit organization committed to promoting the healthy development of our nation's infants and toddlers. To learn more about this topic or about the ZERO TO THREE Policy Center, please visit our website at www.zerotothree.org/public-policy.

Resources

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