

***UTAH PUBLIC MENTAL HEALTH SYSTEM***

***PREFERRED PRACTICE GUIDELINES***

***JANUARY 2009***

Utah Public Mental Health System  
Preferred Practice Guidelines  
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UNDER THE AUSPICES OF THE UTAH DIVISION OF MENTAL HEALTH  
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## Acknowledgments

This is a test for the contributors. If any of you read this and want your name here or have a creative acknowledgment since we are kids people, please write away!

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## Statement of Intent

These practice guidelines are not to be construed to limit in any way, the individualization of treatment, clinician creativity, or the ability of the clinician to provide treatment in the best interests of the client. Standards of care are determined on the basis of all clinical data available for an individual child/youth and are subject to change as scientific knowledge and technology advance and patterns evolve. These guidelines for practice within system of care values should be considered guidelines only. Adherence to them will not ensure a successful outcome in every instance, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. It is recognized that optimal outcomes will not always be obtained in treatment.

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## Assessment of Children and Youth

### OPTIMAL OUTCOME OF ASSESSMENT

The assessment results in the identification of reasons and factors leading to referral, current level of functioning, significant changes in functioning over time, nature and extent of behavioral and subjective difficulties, and individual, family and/or environmental factors, strengths, challenges and resources, which lead to appropriate DSM-IVR diagnoses and individualized, child/youth guided treatment goals. During this process, a mutually trusting working relationship with the child/youth, family, and significant others is established for continued planning and treatment.

### ASSESSMENT PRINCIPLES

1. Assessment of children and youth is an ongoing process. Initially, based upon presenting information, the evaluator should develop an assessment plan including identification of strategies for collecting information and possible assessment instruments to be utilized. These should be adapted as information becomes available. Assessments will be strength-based and person centered. Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s) as well as other pertinent factors should form the basis for all assessment and subsequent treatment.
2. The assessment should be provided in a manner which does not attribute blame to families. Staff should provide the services needed with sensitivity and patience building on the strengths and culture of the child/youth and family.
3. The assessment process will result in an initial diagnosis and development of treatment goals and strategies. As further data is gathered, the diagnosis and subsequent treatment goals and strategies will be revisited and revised, as appropriate.
4. Whenever a child/adolescent is seen who has a previous psychiatric diagnosis, the assessing clinician should re-evaluate the appropriateness of the diagnosis(es).
5. Diagnosis(es) should be made with adherence to the DSM-IVR diagnostic criteria and not based on idiosyncratic/anecdotal impressions. Full use should be made of DSM-IVR criteria for co-morbid conditions, atypical presentations, V codes, deferred and provisional diagnoses.
6. Family/care givers are a primary source of information about the child/youth and should be involved in all aspects of the assessment and subsequent treatment planning and implementation.
7. Mental Health staff should encourage and facilitate parents in signing appropriate "release of information" forms in order to gather critical data from multiple individuals and sources significant to the child/youth. This data is essential in forming an accurate

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picture of the child/youth's functioning. Whenever possible, the clinician should directly contact the primary source of information, i.e., current school teacher for school functioning, family physician for health status, etc.

8. A thorough assessment of a child/youth should include the following areas:
  - Developmental milestones to include receptive and expressive language development
  - Psychiatric and medical history, including vision and hearing problems
  - School functioning and performance including any formal testing conducted by the school
  - Emotional development and temperament
  - Peer relations
  - Family relationships, responsibilities, and perceptions of the child/youth and his/her difficulty and the subsequent impact on the family
  - Strengths, interests, and hobbies
  - Natural supports
  - Cultural influences, religious beliefs, spiritual beliefs
  - Unusual family or environmental circumstances
  - Parental/family medical and behavioral health history and impact on child/youth
  - Substance use
  - Traumatic circumstances including child abuse, domestic violence, family substance abuse
  - Legal involvement
  - Reason for referral and present concerns: nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s) mental status examination, including thought (content and process), perception, mood, level of suicidal risk, affect, memory, judgment, appearance, and orientation.
  
9. Assessment will be provided in a culturally sensitive and appropriate manner consistent with the unique characteristics of the child and family, taking into consideration factors including, but not limited to: language, socio-economic factors, family and extended family structure, religious practices, geographic location, immediate community, etc. When indicated, the assessor will seek assistance in order to assure that the assessment will be conducted consistent with the language and culture of the child/youth and family.
  
10. Standardized behavioral assessments from parents, teachers, for school-age children or youth may be useful. All evaluation instruments will be selected and administered by appropriately trained personnel in compliance with administration standards provided by their producer(s) as being appropriate for the sex, age, and race of the child/youth. Conclusions derived from any instrument should be made in the context of all information gathered.
  
11. Depending upon age and developmental factors, the child/youth should be interviewed individually and with the parent(s)/significant others. The setting is critical to the success of the interview and must be sensitive to the need to accommodate for the

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child's cognitive, language and emotional status. Specific techniques may include interactive play, projective approaches, and direct discussion. Structured observations or other means of seeking information should be utilized. Care should be taken to avoid questions that lead a child to answer in a particular way.

12. The Serious Emotional Disorders (SED) form should be completed.
13. Information about the results of this assessment process, diagnosis(es), and implications for subsequent treatment for the child/youth and family should be shared with the parent(s) or guardian. Plans for subsequent treatment interventions should be developed with the child (as appropriate), youth and family and/or other caregiver.

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## Treatment of Disorders in Children and Youth

### **OPTIMAL OUTCOME OF TREATMENT**

The child/youth attains a level of wellness that is seen as appropriate by the child/youth, primary care-givers, family, therapist, and other systems of care representatives. The child/youth achieves healthy development and growth, and is better able to manage future episodes of illness and engage in meaningful activities of life.

### **TREATMENT PRINCIPLES**

1. The family/ primary care-giver provides support and nurturance for each child/youth and, as such, should be involved in a working partnership with the mental health professional in all aspects of treatment development, implementation, and evaluation. In instances where children are in state custody and parent's rights have not been terminated, families of origin should be included in treatment planning when clinically indicated.
2. Treatment goals and strategies should be collaboratively derived and based on reasons for referral, data collected during the assessment process (per assessment guidelines), and responsive to the needs of the child/youth as she or he functions across daily living environments and situations. Discharge criteria should be addressed at this time.
3. Treatment plans should be individualized to support the recovery process and consider the following:
  - Cognitive, developmental, and personally differentiating characteristics
  - of the child/youth
  - Unique family characteristics
  - Cultural customs
  - Community expectations
  - Environmental demands, including care giver and school standards
4. Treatment plans should identify indicators of progress to include time-frames and responsibility for data collection and analysis. Progress data should be collected from multiple sources across the settings and environments in which the child/youth functions. This should include response to medication and compliance.
5. Family therapy, including siblings and extended family members, and parent training should be considered in treatment planning.
6. Crisis and safety intervention planning should be considered as part of the overall treatment plan and/or developed as a separate document with the relevant parties.

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7. Services must be frequent enough and of appropriate duration to benefit the child/youth and family. Flexibility will be required in scheduling and in being responsive during emergencies.
8. The setting for treatment should be child/youth and family friendly. The setting should be accessible and not place undue stress upon the family. Treatment in the child/youth's natural environment should be sought whenever appropriate.
9. Wrap-around services should be extended beyond the child/youth to include family members and other natural supports, which may include: collaborative consultation, respite care, family support, mentoring, boy/girl scouts and recreational activities not limited to the mental health center. In areas where available, referrals should be made to parent and youth support organizations.
10. Each treatment plan should identify a contact person for the child/youth and family who will coordinate the treatment within the agency as well as with other service providers.
11. Staff working with children/youth should be competent in specialized skills. Complex treatment issues may benefit from a second opinion. In areas where a child/youth specialist is not available, on-going supervision, training, and support should be provided to the generalist practitioner.
12. After-care and follow-up services are a critical component of planning treatment transitions in order to anticipate the natural maturation and developmental processes.

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## Preferred Practice Guidelines

### Disruptive Behavior Disorders in Child and Youth

(Attention Deficit Hyperactivity Disorder, Conduct Disorder, Oppositional/Defiant Disorder, Disruptive Behavior Disorder NOS)

#### **OPTIMAL OUTCOME OF TREATMENT**

The child/youth attains a level of functioning in the areas of education, social situations, family relationships, peer relationships, leisure time, and/or legal involvement, as agreed upon by parents/guardian, youth, clinical team and involved others.

#### **ASSESSMENT GUIDELINES** (See Assessment Guidelines for Children/Youth.)

1. Children/youth should be assessed at intake for possible danger to self and others:
  - 1.1 Assess for suicide risk since it is as high with these diagnoses as with depression.
  - 1.2 Assess risk of violence, including but not limited to: gang involvement, access to weapons, violence towards family members, substance use, etc.
2. Assessment should include the ability to: 1) empathize with others, 2) control impulses, and 3) feel guilt and remorse. Assessment should also address traumatic events such as prolonged separation, sickness, head injury, etc. The mental status exam should be age appropriate. Hallucinations are often missed in youth and should be included in the mental status evaluation. Comments of feeling extremely bored should cue further evaluation for depression.
3. Drug screens should be recommended when substance use is suspected, and when hallucinations are present. Standardized screening tools may be helpful in identifying substance abuse.
4. Assess for co-morbidity with mood disorders, substance abuse, developmental disorders, learning disabilities, communication disorders, intellectual impairment, and psychosis. The presence of one disruptive behavior disorder increases the likelihood of other disorders being present.
5. Care must be taken to accurately distinguish oppositional defiant disorder from conduct disorder. The treatment prognosis is often very different.
6. Standardized behavioral instruments from parents and teachers for school-age children or youth may be useful.
7. Assess the context and severity of the disruptive behavior and settings in which it occurs (home, school, community). The context includes whether problem behaviors occur when alone or with peers, frequency of behaviors, intent to do harm, and

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whether actual damage occurred. These are also important prognostic indicators. For conduct disordered youth, prognosis worsens with early onset.

- 8 Assess the family, including discipline patterns and beliefs; age appropriateness of behavioral expectations for the child; substance abuse and attitudes of family members; marital discord and/or domestic violence; current and past maltreatment (including sexual/physical/emotional abuse and neglect); the child's role in the family, Children/youth with disruptive disorders are more likely to be/have been abused than the general population, and this requires careful evaluation. Also, families with domestic violence have a greater likelihood of children being abused.

### **TREATMENT GUIDELINES** (See Treatment Guidelines for Children and Youth)

1. Disruptive disorders often manifest in uncooperative and angry behavior. Intense negative reactions towards these children/youth are common. Clinical staff members have the responsibility to be aware of and manage these reactions, and should seek supervision when appropriate.
2. Families should be informed of serious concerns regarding possible danger to self or others. Legal standards regarding duty to warn also apply.
3. Special skills are needed by families and others involved with children/youth with these conditions. Providing such skills to the family should be emphasized. Therapists may need to teach families how to independently access supportive community resources and other natural supports. All team members should avoid language that blames parents. Collaboratively developed behavior management plans are a critical element of treatment.
4. Family, group, social, and self-management skills development interventions are highly recommended treatment modalities. Individual therapy is generally not effective as the only treatment, especially for conduct disordered youth. Group process therapy with other conduct disordered youth is contraindicated.
5. Medication may be effective in management of specific symptoms and symptom clusters, especially when other interventions have failed and the child/youth is at risk of placement in a more restrictive environment. Medications are usually effective in assisting ADHD children and youth with school, home, and peer functioning. Psychosocial interventions are generally also necessary.
6. Important elements of treatment include:
  - building on strengths
  - focusing on specific behaviors  
symptom management and/or control
  - child/youth accountability
  - consideration of multiple environmental factors.

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7. Wrap-around services such as respite, in-home, or in-school interventions and behavioral aide (trackers, youth proctors, mentors, etc.) are often very useful interventions.
8. Close coordination with partners, including direct contact with the school, is highly recommended. This coordination is important initially, and for ongoing evaluation of treatment progress. Advocacy for services to the child/youth may be needed.

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## Mood Disorders in Children and Youth

### **OPTIMAL OUTCOME OF TREATMENT**

The child/youth attains an agreed upon level of functioning; the child/youth and primary care giver(s) learn skills to prevent or manage future episodes of illness. These skills can include increased awareness of mood disorder symptoms, continuation of preventative medication, and changes in behavior and thinking about themselves, their environment, and their future which facilitate health.

### **ASSESSMENT GUIDELINES** (See Assessment Guidelines for Children/Youth)

Assessment of children and youth involves gathering data from multiple sources which may include schools, family, caseworkers, and child care providers.

1. Children/youth with mood disorders should be assessed at intake for possible danger to self and others when appropriate, and crisis intervention provided as needed. Families should be informed of serious concerns regarding possible danger to self or others. Age appropriate instruments may be helpful to aid in the evaluation of symptoms. When clinically indicated, a crisis and/or safety plan will be developed and documented at both the initial assessment and throughout treatment. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plan.
2. Children/youth who are SED with a mood disorder should be screened and prioritized for necessary services. Depending upon the individual needs of the child and his/her family, services to be considered in addition to the traditional outpatient services may include, but not be limited to, case management, respite care, and in-home services.
3. Children/Youth with a mood disorder should be referred, as indicated, to a medical provider for evaluation for the presence of general medical conditions contributing to the mood disorder.

**TREATMENT GUIDELINES** (See Treatment Guidelines for Children/Youth) Appropriate psychotherapy, family and child/youth education, as well as medication management are important factors in the effective treatment of mood disorders.

1. Therapists working with children/youth who are mood disordered should actively involve the family, school, and others as appropriate. Focus should be on collaboratively-developed goals and the use of effective, age appropriate treatment methods for children/youth. Individualized approaches outside the traditional office setting are encouraged when therapeutically indicated. Such services may include, but not be limited to, respite care, in-home and on-site services, and case management.

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2. Education about mood disorders in children and youth and the options for treatment should be provided to children/youth and families. This is a valuable aid to treatment. Therapists should provide families and the child/youth the opportunity to discuss the information provided.
3. Medication is frequently an effective component in the treatment of children and youth with mood disorders. Medication evaluation should be considered for those children/youth whose symptoms meet the diagnostic criteria for a mood disorder. In addition to diagnostic criteria, some indicators are:
  - Suicidality
  - Psychosis
  - Severe disruptive behaviors
  - Marked decrease in academic performance
  - Sense of boredom
  - Withdrawal from friends
  - Increased irritability
  - Obsessional somatic concerns
4. The medical provider is responsible for providing the child/youth and families with information about medication, including potential benefits and side effects for children/youth. Families and the child/youth should be encouraged to ask questions and discuss concerns.
5. When a client misses a scheduled appointment, the intensity and immediacy of outreach should be clinically determined.
6. An assigned staff person should assume primary responsibility for the coordination of treatment between care providers. All providers should work collaboratively and each provider assumes responsibility for appropriate documentation of their services.

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## Psychotic Disorders in Children and Youth

### **OPTIMAL OUTCOME OF TREATMENT**

The child/youth and family learns to manage the illness through developing an awareness of the illness, and acquires skills to overcome or accommodate to symptom fluctuations. The child/youth develops age appropriate living, educational and social skills, and interacts and functions appropriately within the family. In the recovery process, the family will experience a sense of emotionally rewarding interactions and stability while simultaneously accommodating for the child's illness with minimal need for support or treatment.

**ASSESSMENT GUIDELINES** (See Assessment Guidelines for Children/Youth) All staff should provide services which are non-threatening and affirming of the child/youth's rights.

1. While the primary source of information in this diagnosis is the observation of the child/youth, it is important that parents/care givers be actively involved in the assessment process. Collateral sources of information may include, but not be limited to, school, significant others, screening tools and medical information.
2. Children/youth with psychotic disorders should be carefully triaged to establish the immediacy of need for services. This should include evaluation of possible danger to self or others, with referrals and follow-up to the appropriate levels of care.
3. Children/youth with Psychotic Disorders should be assessed for the need for a neurological, psychiatric, substance abuse and medical evaluation.
4. Assessment of the family system is a critical component in determining appropriate treatment.

**TREATMENT GUIDELINES** (See Treatment Guidelines for Children/Youth)

1. Treatment of the family system is essential with particular emphasis on techniques that will encourage and strengthen the family's ability to have positive interactions with their child/youth.
2. Psychoeducational information should be provided for family members. The family should be helped in understanding the child's illness may not disappear, but symptoms may be managed and controlled.

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3. Family support including, but not limited to, respite services for the primary care giver, are critical areas to be addressed in treatment planning.
4. Collaborative exchanges of information from all agencies or individuals involved with the child/youth is essential in evaluating the efficacy of treatment, e.g., parents, care givers, teachers, respite care providers, case managers, etc.
5. Medication is critical in the treatment of psychotic disorders. Medication arrangements should be made in accordance with the child/youth's assessed needs. Medical staff have primary responsibility to obtain informed consent from the parent(s)/legal guardians and periodically review medication with the child/youth and caregiver. With direction from the medical staff, all team members should work collaboratively in the ongoing medication management and follow-up process.
6. Family should be made aware of support groups and other community resources.
7. A safety plan will be developed and documented at both the initial assessment and throughout treatment. In times of active psychosis, a crisis plan will also be developed. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plans.

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**Reactive Attachment Disorders in Children**

Problems associated with attachment difficulties and disruptions occurring in early years may persist throughout childhood and adolescence. It is imperative that treatment be provided with full cognizance of the history of early attachment difficulties and actively includes a caregiver or parent figure. Treatment must be highly individualized to the child and his/her family.

**OPTIMAL OUTCOME OF TREATMENT**

The child shall attain a level of functioning that enables him/her to develop positive attachments and engage in meaningful life experiences. Family members will gain skills to implement behavioral interventions within a supportive structure that provides nurturing guidance.

**ASSESSMENT GUIDELINES (See Assessment Guidelines for Children/Youth)**

Unless the diagnosis was made prior to age five, symptoms, profile and history must exist before the age of five. Older children should receive a diagnosis based on their current emotional and behavioral symptoms. Assessment of children under age five, as well as older children who experienced early attachment difficulties or disruptions, involves gathering data from multiple sources. The assessment must focus on family and extended family relationships, responsibilities, and upon the naturally occurring community supports.

1. In order to make the diagnosis, a history of maltreatment or neglect with a consequent adverse impact on the child's ability to form trusting relationships must be established
2. The family plays a vital role in diagnosis and treatment. Efforts should be made to obtain as much information as possible about the child to include
  - developmental milestones;
  - psychiatric and medical history;
  - parental/family medical, psychiatric, genetic history and their impact on child/youth;
  - family substance abuse history;
  - traumatic circumstances including but not limited to child abuse, domestic violence, removals from the home, disrupted placements, prolonged separations;
  - family perceptions of the child/youth and his/her difficulty;
  - perceptions of the parent's role relative to the child's difficulty; and
  - the degree of "victimization" felt by the parent(s)/caregivers of the child.
3. Assess for co-morbidity with other disorders and disabilities and medical conditions.

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4. When clinically indicated, a crisis and/or safety plan will be developed and documented at both the initial assessment and throughout treatment. The client and his/her caretakers will help develop and receive a copy of the crisis/safety plan.
5. Assessment strategies for diagnosing trauma and maltreatment in children should be developmentally appropriate and should use a variety of techniques and settings, such as observing interactive play, caregiver-child interaction across situations and/or settings such as school and independent play.
6. The assessment should include the ability to 1) empathize with others, 2) control impulses, and 3) feel remorse.

## 2

### **TREATMENT GUIDELINES (See Treatment Guidelines for Children and Youth)**

1. Treatment strategies need to focus on helping the child develop trusting, secure relationships with significant others. A multimode approach should be utilized to achieve optimal outcomes including parent-child treatment, psychodynamic therapy, play therapy, filial therapy, family therapy, cognitive therapy, and behavioral strategies. The treatment goals should be based on the developmental age of the child.
2. No coercive methods of treatment will be approved, whether performed by a therapist or caregiver (e.g., when the treatment involves the use of coercive physical constraints to evoke a child's rage or cause a child to undergo a "rebirth" experience). Such coercive treatment methods are not to be confused with appropriate treatment methods used to intervene with a child who has become a danger to themselves or others in a therapeutic environment.
3. Parents/caregivers should be provided education on the following:
  - A child's acting out is directed at testing the parent-child relationship due to the child's history of mistrust and neglect.
  - Acting out is not actually a vendetta against the parent.
  - Families may require high levels of support and respite services using formal and informal supports;
  - Support/education groups that address positive and negative experiences may be helpful; and
  - Multiple family placements of the child should be strongly discouraged.
4. Treatment goals should be based on the developmental age of the child.
5. Behavioral interventions must be used judiciously with an understanding that the underlying emotional problems must be carefully addressed. Focusing solely on the behavior may result in high levels of frustration for the child and the parent.
6. Skills development for both the child and family members should be incorporated. Observing the child/parent interaction and then coaching the parent in providing

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corrective behavioral interventions is recommended while utilizing an understanding, empathic approach to the child.

7. Role models with peer and adult mentors for the child are recommended.
8. The following are treatment considerations:
  - Structure and consistency;
  - Parent-child interaction therapy;
  - Wraparound planning and delivery should help with containment for safety;
  - Medicate only for co-morbid conditions, not attachment issues;
  - Case management with school for continuity is helpful;
  - Look for environmental antecedents to troubling behaviors and make direct interventions; and
  - Teach parent(s) about redirecting behavior and utilizing natural consequences.

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**For Infants and Toddlers - Birth to Five**

**OPTIMAL OUTCOME OF TREATMENT**

Infant mental health is reflected in appropriate cognitive, social, emotional, and physical development. Recognizing the unique characteristics of each infant and family's healthy mental development for children, birth-five can be characterized as:

- Secure attachments and positive relationships
- Confidence and curiosity
- Effective communication
- Increasing self-regulation
- Social competence and self-awareness.

**SCREENING GUIDELINES**

1. Screening is a relatively brief process designed to identify infants/toddlers who are at increased risk of having disorders that warrant immediate attention, including a more comprehensive assessment and subsequent intervention/treatment.
2. Identifying the need for further assessment is the primary purpose for screening. Mental health screenings are never used to diagnose a child and, therefore, a wide range of people may administer screening instruments. Screening results are used to inform families, caregivers and other formal and informal supports.
3. Children who need further evaluation should be referred for a systematic and comprehensive assessment including the specific areas of concern.

**ASSESSMENT GUIDELINES** (see assessment guidelines for Children/Youth)

1. The purpose of a diagnostic assessment is to define the infant/toddlers problems and use the information to develop a comprehensive treatment plan. The assessment results in the identification of reasons and factors leading to treatment and/or referral.
2. Assessment using the current DSM is an acceptable tool to use for diagnosis. However, use of the DC: 0-3 may provide more developmentally relevant diagnostic guidance. A thorough assessment of a child birth to five should include the following areas:
  - Developmental milestones;
  - Psychiatric and medical history, including vision and hearing problems;
  - A mental status exam;
  - Pre-School reports including any formal testing;

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- Emotional development, temperament, strengths, and interests;
  - Family relationships, responsibilities, difficulties and perceptions of the child and the subsequent impact on the family;
  - Unusual family or environmental circumstances;
  - Family medical, psychiatric history, substance use/abuse, history of child abuse including neglect, or domestic violence in the home;
  - Involvement with outside agencies including juvenile court dependency or custody hearings; and
  - Reason for referral and present concerns, including the nature, duration, frequency, precipitants, circumstances, and consequences of the problem(s).
3. Family/care givers are a primary source of information about the child/youth and should be involved in all aspects of the assessment and subsequent treatment planning and implementation.
  4. Mental Health staff should encourage and facilitate parents in signing appropriate "release of information" forms in order to gather critical data from multiple individuals and sources significant to the infant/toddler.

## **INTERVENTION/TREATMENT GUIDELINES**

1. Effective infant and early childhood mental health services are based on a multi-disciplinary approach and involve collaboration across the multiple systems of health care, human services, education, and mental health. Mental health intervention/treatment is warranted when:
  - A child demonstrates a significant delay in emotional, behavioral and temperamental functioning,
  - The parent/child relationship is disturbed, and/or
  - A screening and subsequent assessment tool administered to the child would indicate further intervention.
2. When a possible disruption in social-emotional development has been identified, effective mental health strategies for infants and toddlers will be based on the following principles:
  - Infant and early childhood mental health services focus on the parent-child relationship and are accessible in a variety of settings;
  - Interventions strengthen the optimal social/emotional development of the infant or young child, and enhance the emotional well being of the family;
  - Families are partners in determining quality/science-based interventions that are provided in a non-stigmatizing, affordable, culturally competent, individualized, timely manner;
  - The importance of fathers or other male caregiver's involvement in the care and nurturance of their children beginning at birth, is recognized, supported, and facilitated.

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- Families have opportunities within their communities to share parenting experiences and concerns.
- 4a. Generally, it is not the role of the clinician to seek substantiation of reported trauma. However, all pediatric health care providers have access to information and training related to disorder or maladaptive clinical health issues. Clinical health issues should be used to determine the necessity of seeking substantiation.
  3. Mental health professionals provide education to team members to encourage understanding that individual differences in children, cultures, communities, family structure, and language are not evidence of a problem.
  - 5a. Assessment of co-morbid conditions and personality disorders may be helpful in determining the need for specialized services.
  - 6a. Utah law requires that licensed mental health professionals provide mental health services. Specialized training in infant and early childhood mental health is encouraged. Co-morbid conditions (such as substance abuse, personality disorders, and mood disorders) are likely to occur with this condition, and should be assessed and diagnosed.
  - 7a. Protective factors, such as social support and self-soothing skills, should be assessed and incorporated into the treatment plan.

## PROMOTION & PROACTIVE INTERVENTION GUIDELINES

Promotion and proactive intervention are the activities and strategies that agencies participate in to support and promote positive social-emotional development in infants/toddlers birth to five.

### 1. *Promotion* activities include:

- Individualized care
- Parent education
- Problem-focused counseling
- Case management
- Information and support to promote positive social-emotional development

### 2. *Proactive* intervention includes:

- Mental health consultation services for children birth to five and their families;
- Services to pregnant women with biological, medical or environmental concerns;
- Services for at risk infants/toddlers;
- Development of interagency agreements;
- Access to tools for screening, referrals and response to risk factors; and
- Access to training of biological, medical or environmental concerns.

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1. The therapist should be aware of the possibility that underlying medical causes may produce anxiety symptoms. Medical evaluation may be indicated to determine that there is no underlying physical problem, i.e., sleep apnea, mitral valve prolapse, thyroid conditions, etc.
2. Clients with anxiety disorders may be at increased risk for suicide. Clients should be assessed for possible danger to self or others and crisis intervention should be provided as needed.
3. Clients with anxiety disorders often self-medicate. Clinicians should assess for use or abuse of over-the-counter, prescription, or street drugs and alcohol.
4. Clients with anxiety, symptoms should be assessed for depressive features. If the symptoms of depression meet the full criteria for a DSM-I V diagnosis, this diagnosis should also be made.

Post-Traumatic Stress Disorder (PTSD)

- 1a. The clinician should differentiate between Acute and Chronic PTSD, utilizing DSM IV criteria, to determine treatment approach.
- 2a. The relative prominence of dissociative features should be assessed. Predominately dissociative symptoms are often an index of severity and may be predictive of chronicity.
- 3a. The meaning of the traumatic circumstance should be assessed according to the individual's interpretation. Ethnic and cultural factors may be important in this assessment.

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