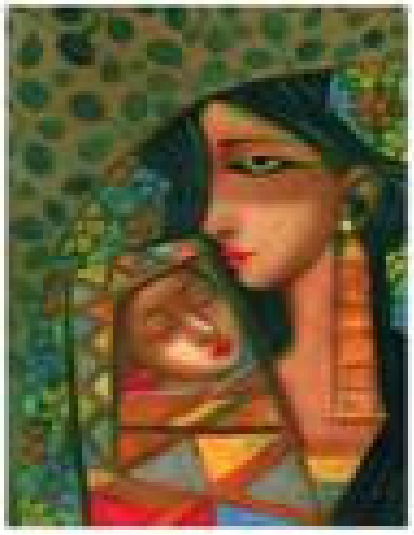
CHILDREN, YOUTH AND FAMILIES DEPARTMENT

BEHAVIORAL HEALTH SERVICES

2019-2020
INFANT AND EARLY CHILDHOOD MENTAL HEALTH TEAM MANUAL



cyfd
New Mexico Children, Youth & Families Department
PULLTOGETHER

INFANT MENTAL HEALTH TEAM MANUAL

The mission of IMH is to ameliorate the transmission of intergenerational trauma between parents and Infants through effective dyadic and triadic clinical work.

I. PREFACE:

CYFD Behavioral Health Services - Infant and Early Childhood Mental Health Section (IECMH) updated and revised the Infant Mental Health (IMH) program in 2019 to reflect the decision to bring trauma centered clinical services. Decades worth of research, supplemented by new technology, has allowed for observation of how the brain changes. And has revealed the extraordinary capacity of the infant/toddler brain to grow and change during the first few years of their life. Through scans of the brain, that same technology shows the physical evidence of emotional issues in the brain, reflecting the importance of early social and emotional development, specifically attachment and regulation. The higher the level of trauma suffered by toddlers and infants, the more important early intervention becomes. Therefore, IECMH has chosen to restructure the delivery of clinical services for the (IMH) program around Child Parent Psychotherapy (CPP). CPP is an intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems, including posttraumatic stress disorder. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver as a vehicle for restoring the child's cognitive, behavioral, and social functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship.

The effectiveness of CPP relies on increased capacity across the state and on a competent team of clinicians and providers who can comply with the fidelity of the model, as they confidently engage with infants, assess opportunities to intervene and foster change in the thinking and behavior of caregivers. CPP trauma treatment and clinical interventions are affected by the therapist understanding of the infant's environment, circumstances, history and present life. To ensure the capacity and competency of IMH clinicians in New Mexico, IECMH has partnered with Dr. Alicia Lieberman, the developer of CPP, for ongoing training and consultation Dr. Lieberman is also the Irving B. Harris Endowed Chair in Infant Mental Health; Professor and Vice Chair for Academic Affairs at the University of California, San Francisco, Department of Psychiatry; Director of the Child Trauma Research Program at San Francisco General Hospital.

In addition to updating the IMH manual, in order to support the focus on CPP, the IECMH Section has made additional systemic changes. The scope of work for IMH providers with CYFD BHS IMH contracts have been developed to clearly outline the clinical focus on trauma and relationship and the program procedures have been revised to mirror the practice of CPP. Several indicators are included in the SOW to make sure the clinicians and management can track their own performance and reach the established goals. Furthermore, two new tools have been designed by New Mexico professionals to suit the needs of our population: DIAPER a tool to observe and rate the pathology of relationship disturbances between a caregiver-infant/child manifested in developmental pathways affecting the cyclic nature of interactions and, the CIAP, a tool to track the progress of the case in view of the clinical objectives. In the management side, output and performance measures for PIPs and IMHTs are being tracked to mirror the three-year internal strategic plan developed in FY18.

II. TREATMENT

Child Parent Psychotherapy (CPP) is the only approved clinical modality for providing Infant Mental Health Services in the New Mexico's Children Youth and Family Department (CYFD) Behavioral

Health Services (BHS) Infant Mental Health Team (IMHT) Scope of Work.
As the only evidence based treatment model available for infants and young children (Infant) which includes trauma as a clinical element, CPP was chosen for its effectiveness in ameliorating transmission of intergenerational trauma between parent(s) and Infant(s).

The effectiveness of CPP is based on the following elements:

a. CPP Premises:
    i. Premise 1: The attachment system is the main organizer of children's responses to danger and safety in the first 5 years of life.
    ii. Premise 2: Emotional and behavioral problems in infancy and early childhood are best addressed in the context of the child's primary attachment relationships.
    iii. Premise 3: The cultural and socioeconomic ecology of the family must be an integral component of clinical formulations and treatment plans.
    iv. Premise 4: Interpersonal violence is a traumatic stressor that has specific pathogenic Repercussions on those who witness it and those who experience it.
    v. Premise 5: The therapeutic relationship is a fundamental mutative factor in treatment.
    vi. Premise 6: Treatment includes "speaking the unspeakable" while promoting safety and hope.
b. CPP Fidelities:
    i. Strand 1: Reflective Practice Fidelity
        1. "How are you is important as what you do" (Pawl & St. John, 1988)
        2. "It is not possible to work on behalf of human beings to try to help them without having powerful feelings aroused in yourself…In working with families who are in great difficulty, rage can become the most familiar affect, -at the system, at a world with too much violence that creates too much helplessness and also at a family who will not be better or even seem to try." (Pawl, 1995, p. 24)
    ii. Strand 2: Emotional Process Fidelity
        1. "What is it…that determines whether the conflicted past of the parent will be repeated with his child?" (Fraiberg et al., 1975, p.419)
    iii. Strand 3: Dyadic Relational Fidelity
        1. "There is no such thing as a baby." (Winnicott, 1965)
    iv. Strand 4: Trauma Framework Fidelity
        1. "On knowing what you're not supposed to know and feeling what you're not supposed to feel." (Bowlby, 1988)
    v. Strand 5: Procedural Fidelity
        1. "CPP fidelity is guided by reflection, not by rigid adherence to what might be perceived as perfection." Ghosh Ippen et al., 2014
    vi. Strand 6: Content Fidelity
        1. How can you write a measure that is faithful?
        2. To history, authenticity, the evolving needs of each child and family?
c. CPP Goals:
    i. Goals may include: (Pg. 28 Common Features targeting the main symptoms of the traumatic response)
    ii. Global CPP Goals-Objectives:
        1. Encourage normal development: adapt to infant or young child's developmental capacity
        2. Offer unstructured reflective developmental guidance

3. Encourage and model appropriate protective behavior
4. Maintain regular levels of affective arousal
5. Interpret feelings and actions
6. Establish awareness and trust in bodily sensations
7. Achieve reciprocity in the caregiver-child relationship
8. Provide emotional support/empathic communication
9. Resolution of trauma-related symptomatology

iii. Trauma-Related Goals-Objectives of CPP:

1. Increased capacity to respond realistically to threat
2. Differentiation between reliving and remembering
3. Normalization of the traumatic response
4. Placing the traumatic experience in perspective
5. Co-construction of a mutually meaningful trauma narrative
6. Promote developmental progress through play, physical contact, and language

III. IMHT TREATMENT AND SERVICES ASPECTS:

a. CYFD BHS Infant and Early Childhood Mental Health (IECMH) Section recognizes the parent(s) or caregiver(s) (Parent) listed on the affidavit as the therapeutic partner in treatment.
b. CPP is divided into four (4) main phases: Foundational Phase, Feedback Phase, Core Intervention Phase, and Recapitulation/Termination Phase.
    i. Activities for each phase are detailed below
c. When an IMHT clinician (Clinician) identifies the Parent(s) is ready for dyadic therapy, the unit of treatment is the relationship between the Infant and Parent.
d. Services can be provided in the home, or in an office or other community setting.
e. Although the Clinician may observe supervised visits between Infant and Parent at CYFD offices, treatment should not take place during CYFD scheduled supervised visits.
f. As progress is made in treatment, the Clinician may recommend to CYFD, based upon the most natural setting appropriate to the Infant's needs and safety, supervised visits be moved to a setting outside the department.
g. Due to the intensity of CPP treatment it is recommended to limit sessions to 60 minutes.
h. The Clinician should regularly conduct face to face or telephonic multidisciplinary meetings to discuss, plan, coordinate, review, and/or identify needs and services for the Infant and the family.

IV. FOUNDATIONAL PHASE:

During the Foundational Phase of CPP the Clinician will complete the following activities in order to begin conceptualizing treatment. The activities and clinical instruments completed during the Foundational Phase gives the Clinician an in depth understanding of the trauma and clinical concerns needing to be addressed during CPP treatment.

a. Referrals and Intake
    i. Referrals should be for Infants between the ages of birth-to-three (0-3), who are in CYFD custody and have already had a 10-day custody hearing.
    ii. Referrals must be accompanied by an Affidavit and a copy of the Children's Protective Services (CPS) Treatment plan, indicating IMHT services are required.
    iii. After receiving a referral, the IMHT Program Director assigns a Clinician to the case. The Clinician contacts the Parent(s) to schedule an Intake to introduce them to IMHT services.

iv. Intake is conducted without the Infant present. This time should be used to discuss with the Parent(s) the reason for referral, and their feelings about treatment.
v. Complete any agency required paperwork during Intake session(s).
vi. Upon completion of the first Intake session the Clinician must register and "admit" the family in the IMH Database.
    1. When entering the family in the IMH Database, only enter the information for the referred Infant, Parent(s), and Foster Parent(s)/Guardian(s), who are engaged in services.
    2. If a family has more than one Infant, each Infant should be entered as a separate case.
vii. Begin IMHT required Clinical instruments after completion of Intake.

b. Clinical Instruments:
Complete the clinical instruments listed below with the Infant and/or Parent(s) prior to transitioning to the Feedback Phase or the Core Intervention Phase. Although there is no specific order for the clinical instruments to be completed, it is recommended to do the Psychosocial, ACES, LSC, and TESI first.
    i. Clinical Instruments must be administered per the periodicity indicated below.
        1. Adverse Childhood Experiences (ACES Adult and ACES Child)
            a. ACES Adult is completed once during the Foundational Phase with each Parent.
            b. ACES Child is completed once during the Foundational Phase with each Parent on behalf of the Infant.
        2. DIAPER w/the DIAPER Observational Video Event (DOVE)
            a. Complete the full clinical instrument once during the Foundational Phase, every 12 months from Intake and at discharge. Complete questions three (3) & eleven (11) every other six (6) months thereafter with each Parent. See Table below.

Intake	6 months from Intake	12 months from Intake	18 months from Intake
Full Assessment	Questions 3 & 11 ONLY	Full Assessment	Questions 3 & 11 ONLY

        3. DC: 0-5 Axis II Caregiver Dimensions
            a. Completed during the Foundational Phase, and every six (6) months thereafter.
        4. Clinical Information And Progress (CIAP)
            a. Completed during the Foundational Phase, and every six (6) months thereafter on each Parent.
        5. Trauma Events Screening Inventory (TESI)
            a. Completed once during the Foundational Phase on the Infant.
        6. Life Stressor Check (LSC)
            a. Completed once during the Foundational Phase on each Parent.
    ii. All clinical instruments must be completed within four (4) months of the first visit.
        1. The IMHT supervisor may request an exception in writing from the IECMH Program Director if additional time is needed.
    iii. All clinical instruments must be entered under the referred Infant's Client ID in the

IMH Database.

iv. All clinical instruments must be completed in order to conceptualize the case and move into the Feedback Phase.
    1. Per CPP, it is important that a therapeutic partnership is formed and established with the Parent(s) on behalf of the Infant before moving into the Feedback Phase. Additionally, the Parent(s) must be able to acknowledge and talk about the Infant's history of trauma.

v. During this time you may also begin providing support to the Parent(s), in an attempt to prepare them for the Feedback Phase and Core Intervention Phase. Some of the ways you can support the Parent(s) during the Foundational Phase are:
    1. Creating a therapeutic climate where the caregiver feels supported in speaking about difficult circumstances, including traumatic experiences.
    2. Conveying an attitude of self-competence and hope that improvement is possible.
    3. Addressing possible sources of negative transference and resistance, such as mandated treatment.
    4. Taking steps to understand sources of danger and to increase safety.
    5. Establishing a dialogue about cultural values and approaches to child-rearing, including the caregiver's attitudes about mentioning the child's trauma during treatment.
    6. Developing a joint formulation of the child's presenting problems that incorporates a trauma-informed perspective, sensitivity to the caregiver's psychological functioning, and attention to the family's ecological context.
    7. Co-creating with the parent a treatment plan that includes an agreement about how to address traumatic events, presenting problems, and other difficult topics with the child.

    (Lieberman, A. F., Horn, P. V., & Ippen, C. G., 2015).

❖ It is recommended that Clinicians review the Foundational Phase Assessment and Engagement Form in the CPP Manual *Don't Hit My Mommy!* (pg254) in order to monitor fidelity to the CPP strands.

V. FEEDBACK PHASE:

After all the clinical instruments are completed, when the Clinician has formed a therapeutic partnership with the Parent(s), and the Parent(s) are be able to acknowledge and talk about the Infant's history of trauma, the case moves to the Feedback Phase. Keep in mind that abruptly moving to the Feedback Phase without a therapeutic partnership or before the Parent(s) are able to discuss the Infant's trauma history can adversely impact the effectiveness of treatment.

a. Feedback Phase Activities:
    i. Conduct Feedback Session(s) with the Parent
        1. Offer participatory guidance on how the Infant might act during dyadic sessions
        2. Co-create a treatment plan with the Parent, eliciting the Parent's perspective, questions, or concerns.
        3. Review the clinical instrument materials.
        4. Formulate your treatment conceptualization by developing a triangle of explanation for your own reference and identify core treatment objectives.
        5. Be prepared to listen to what the Parent(s) has/have learned, how the Parent(s)

connects with the Infant's experiences and functioning, and what the Parent(s) sees as core objectives.

6. Meet alone with the Parent(s) to discuss what has been learned, plan treatment, and talk about how to introduce the Infant to treatment, including how to bring up the Infant's trauma history.
7. Ensure the Parent(s) understand why CPP is conducted jointly with the Infant and the Parent(s)
8. Determine the appropriateness of including Infant to CPP.
9. Develop CPP triangle of Explanations with Parent(s)
10. Create the Triangle of Explanations with the Parent by developing a working agreement about what and how the Infant will be told during the Core Intervention Phase why he or she is coming to treatment.
    a. Experience: You saw, you heard…
    b. Behavior/Feelings: And now, you…..
    c. Treatment: This is a place where…..
11. Develop a CPP treatment plan based on case conceptualization with specific objectives and strategies utilizing information gathered from the clinical instruments.
    a. Treatment Plan must be reviewed and updated quarterly
12. Listed below are points for discussion during feedback sessions:
    a. Elicit Parent(s) perception about assessment process and Foundational Phase
    b. Share clinician's perspective and recommendations
    c. Provide other referrals as needed for Infant and Parent(s)
    d. Provide rational for dyadic treatment
    e. Process cultural beliefs about talking about trauma
    f. Discuss how play is used in CPP to process experiences and build relationships
    g. Request permission to introduce trauma-related toys (for Infants old enough to use play to process experiences)
    h. Discuss the Infant's need for emotion regulation while processing trauma (for Infants old enough to process trauma). Help the Parent(s) understand that the Infant may need to take breaks while processing traumatic experiences and help the Parent(s) identify ways to support the Infant during these breaks.
    i. Discuss with the Parent(s) the need and importance for regular weekly sessions

(Lieberman, A. F., Horn, P. V., & Ippen, C. G., 2015).

ii. The Feedback Phase must be completed in four (4) months. The IMHT supervisor may request an exception in writing from the IECMH Program Director if additional time is needed.

It is recommended that Clinicians review the Case Consultation and Content Fidelity Form in the CPP Manual *Don't Hit My Mommy!* (pg266) in order to monitor fidelity to the CPP strands.

VI. CORE INTERVENTION PHASE:

The Core Intervention Phase begins with introducing the Infant to CPP and beginning the dyadic and/or triadic treatment format. Dyadic and/or triadic sessions may not begin until the Foundational

Phase and the Feedback Phase have been completed. CPP has a very specific outline and sequence to treatment, jumping ahead and/or skipping phases could be detrimental to treatment and outcomes. It is important as a Clinician to have a clear perspective of the family's needs and what services will look like before beginning dyadic and/or triadic sessions.

a. Core Intervention Phase Activities:
    i. Collateral Sessions (as needed)
    Initially, the Core Intervention Phase, may consist of individual meetings with only the Parent(s) through Collateral Sessions.
        1. Focus on developing and/or enhancing the Parent's capacity to acknowledge the Infant's experience of trauma and/or focus on physical and/or emotional safety by holding the Infant's needs in mind.
        2. Are conducted without the Infant present.
    ii. First Dyadic/Triadic Session
        1. Explain to the Infant why they are going to be working together and what the Clinician and the Parent(s) are trying to do, to improve the Parent/Infant relationship.
        2. Describe, how together, the Parent(s), the Clinician and the Infant will work towards decreasing the Infants trauma symptoms.
    iii. Ongoing Dyadic and/or Triadic Sessions:
        1. Support and strengthen the relationship between an Infant and Parent(s).
        2. Restore the Infant's sense of safety, attachment, and appropriate affect and improve the Infant's cognitive, behavioral, and social functioning.
        3. Are conducted only with Parent(s).
    iv. Case Tracker Graph:
        1. Completed within thirty (30) days, following twelve (12) months of the Core Intervention to assess progress in treatment.
        2. If no progress is indicated on the Graph, the case should be discharged.
        3. The IMHT supervisor may request, in writing to the IECMH Program Director, an exception to the discharge within the same thirty (30) days. If requesting an exception to the discharge, the Case Tracker Graph must be submitted in addition to the written request to the IECMH Program Director.
        4. If the case is to be discharged due to no progress in treatment, immediately move to the Recapitulation and Termination Phase.

VII. RECAPITULATION AND TERMINATION PHASE:

When a permanency decision is made by the court, or when there is no progress in treatment, the case moves into the Recapitulation and Termination Phase.

a. Recapitulation and Termination Phase Activities:
    i. When possible and clinically appropriate, gradually decrease sessions while acknowledging that treatment is coming to an end.
b. Prepare the family for termination:
    i. Reflect on Termination
    ii. Plan Termination with Parent(s)
    iii. Plan treatment evaluation
    iv. Complete treatment evaluation
    v. Discuss termination with Infant
    vi. Plan termination with Parent(s) and Infant

vii. Process the goodbye
viii. Countdown the sessions with Parent(s) and Infant
ix. Review the family story
x. Treatment evaluation feedback
xi. Plan for the future and discuss trauma reminders with Parent(s)
xii. Hold last session

c. Discharge the case in the IMH Database within seven (7) days of the last session.
    i. Select the appropriate discharge reason in the IMH Database.

VIII. IMHT SUPPLEMENTAL PROCEDURES

Adhere to IMHT guidelines by providing and participating in the following for all IMHT cases:

a. Case Conceptualization
    i. Review what has been learned during the Foundational Phase, the Core Intervention Phase, and/or the Recapitulation Phase and develop a clinical formulation that includes how the presenting symptoms in the Infant and the Parent may be related to their trauma, as well as areas of strengths and vulnerability.
b. Staffing
    i. Share and review information gathered with supervisor and/or colleagues to continually assess the effectiveness of the treatment.
c. Family Centered Meetings
    i. Hold meetings with the family, caregivers, other provider, and/or CYFD to identify and coordinate how to work together in the best interest of the Infant and the family.
d. Team Meetings
    i. Face to Face or telephonic multidisciplinary meetings to discuss, plan, coordinate, review, and/or identify needs and services for the Infant and the family.
        1. The family is not present during these meetings.
e. Observation Sessions:

    The Clinician may conduct Observation Sessions during all phases of CPP:
    i. Between the Infant and Parent(s)
        1. To obtain information regarding quality of the relationship, and overall safety conditions.
        2. To provide recommendations to CYFD such as visitation frequency and duration to support the Parent and Infant relationship.
    ii. Of the Infant in child care settings:
        1. To observe any behavioral concerns and gather information relevant to treatment.
        2. Observations made should be addressed in subsequent sessions (collateral, dyadic, triadic, foster parent, or team meetings).
    iii. Between the Infant and Foster Parent(s)
        1. To understand the relationship and determine the appropriate developmental guidance and relational support to be provided.

IX. IMHT Foster Parent Intervening

In order to support the Infant, when the Infant's symptomatology, reaction to stressors (e.g., visitation), or past trauma experience are problematic in the foster home setting, the IMHT may provide Foster Parent Intervening. Foster Parent Intervening consist of developmental guidance and relational support to the Foster Parent(s). Foster Parent(s) may receive Foster Parent Intervening while the Parent(s) are

actively engaged in IMHT services. If the Parent(s) are not actively participating in Dyadic, Triadic or Collateral sessions for four (4) months, the case should be discharged from Team. The case may remain open in Team if the PPW and/or the courts is/are still requesting reports and/or updates from the Clinician. The case may then be opened under the Foster Parent Program if the Foster Parent(s) wish to continue receiving developmental guidance.

i. Foster Parent Intervening:

The Clinician may provide this support to the Infant and the Foster Parent(s) throughout the case. Foster Parent Intervening provides the Foster Parent(s) with developmental guidance, involving not only giving information but also helping the Foster Parent(s) appreciate the Infant's construction of the world.

1. Twelve Common Developmental Themes are:
    a. Crying and proximity-seeking are the Infants most basic communication tools, and infants develop a health sense of competence and self-esteem when the parent or caregiver responds by offering comfort.
    b. Infants have a strong desire to love their parents and/or caregivers, although parents/caregivers are often unaware of this.
    c. Separation anxiety is an expression of love and fear of loss rather than a manipulative ploy.
    d. Infants fear losing their parent's love and approval.
    e. Infants imitate their parents/caregivers because they want to be like them.
    f. Infants blame themselves when their parent/caregiver is angry or upset or when something wrong. This tendency is an emotional by-product of the cognitive egocentrism of infants, which leads them to overestimate their role in the relationship between cause and effect.
    g. Infants believe that the parents/caregivers are always right, know everything, and can do anything they wish. This belief in the parents'/caregivers' omnipotence goes hand in hand, often paradoxically, with infant's belief in their own power and their determination to assert it.
    h. Infants feel loved and protected when parents/caregivers are confident about their child-rearing practices and enforce their rules about what is safe and what is dangerous, right and wrong, allowed, and forbidden.
    i. Infants and preschoolers use the word "no" as a way of establishing a sense of autonomy, not out of disrespect for the parents.
    j. Infants remember. They have a well-developed memories from an early age, and their capacity to remember precedes their events that evoke strong emotions, such as joy, anger, or fear. The memories may not be completely accurate because they are influenced by the child's affective state and cognitive level, including their understanding of cause-effect relations. Infants are keen observers of what happens around them and may remember it for a long time afterward.
    k. Infants feel intensely but do not yet know how to regulate their emotions. Intense crying, tantrums, and aggression are not expressions of the infant's intrinsic nature but manifestations of distress that the infant is too immature to express in socially acceptable ways.

l. Conflicts between parents and infants are inevitable due to their different goals, personalities, and developmental agendas. Conflicts can serve a valuable developmental function when they are used to highlight the separate but equal legitimacy of the partners' goals and wishes and to mobilize collaboration for the purpose of resolution. (Lieberman, A. F., Horn, P. V., & Ippen, C. G., 2015)

X. DOCUMENTATION:

As part of the IMH SOW there are various documentation requirements and standards that must be adhered to.

a. Each service being billed to the IMH TEAM contract must be entered into the IMH Database with an appropriate note as per the IMH Procedures List.
   i. CPP Fidelity Trackers for Case Rate Medicaid Billable Procedures:
      1. Must be entered under the case in the IMH Database.
      2. Should be concise, and effectively describe the interventions utilized by the Clinician during session.
      3. Observations noted should be related to objectives and strategies used during the session.
      4. Information entered should be related to progress in treatment and future treatment plans.
   ii. CPT Codes for Providers unable to currently bill Medicaid:
      1. Must be entered under the case in the IMH Database using the appropriate CPT Code.
      2. CPT Code Notes entered into the IMH Database must document Medically Necessary Behavioral Health Services.
         a. Medically Necessary Behavioral Health Service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction.
      3. CPT Code usage must follow the Medicaid Regulations and Limitations:
         a. No more than one (1) individual session, regardless of length of session, may be billed per day per client.
         b. Family Sessions:
            i. With or without the client cannot be billed on the same day.
            ii. With or without the client can be billed on the same day as an individual session.
   iii. Notes for Case Rate Services (Non-Medicaid Billable Procedures):
      1. Must be entered under the Clinician in the IMH Database.
      2. Must specifically indicate how the time being billed was spent.
   iv. Treatment Plans:
      1. Must be developed for each client.
      2. Must adhere to Medicaid requirements for Individual Service Plans.
      3. Must be updated every three (3) months.
      4. Must be maintained in the client's file and available for review by CYFD during site visits.
   v. Clinical Instruments:

1. In order to be considered to complete, every question for each clinical instrument must be answered and entered in the IMH Database under the Infant.
    a. The TESI and the LSC are not entered into the database. However, you must check the appropriate box in the IMH Database indicating which clinical instrument was performed.
    b. When either check box is marked, a paper copy of corresponding clinical instrument must be kept in the client file and available for CYFD review upon request.
2. Refer to the IMH Procedures List for instructions on Clinical instrument protocols and periodicity.

vi. Judicial Report Writing:
1. The IMHT Status Report should be submitted to the PPW for the following hearings:
    a. Initial Judicial Review
    b. Initial Permanency Hearing
    c. Permanency Hearing
2. IMHT Status Reports requested for any other hearings can be completed at the discretion of the Clinician.

vii. Billing:
1. With each month's invoice, Providers must submit the following:
    a. The Case rate billing for CPP Fidelity Tracker report from the IMH Database for the month being invoiced.
    b. Summary documentation to confirm that a CPT code was billed for each corresponding CPP Fidelity Tracker entered in the IMH Database.

References

Lieberman, A. F., & Horn, P. V. (2015). *Dont hit my mommy!: A manual for child-parent psychotherapy with young witnesses of family violence*. Washington, D.C.: Zero to Three.