

Start Spreading the News

New York State's DC:0–5 Initiative

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Abstract

In this article, the authors describe a 3-year initiative in New York state, led by the New York Center for Child Development (NYCCD), through which more than 2,500 mental health clinicians were trained in the DC:0–5. Funding was provided through the creative use of the Preschool Development, Birth to Five federally funded Block Grant, and collaborations are described with a public and a university partner to advance the dissemination and application of the classification system. The authors describe the “community of practice” follow-up sessions for trainees, targeted content workshops in infant and early childhood mental health (IECMH), and offering continuing education for professional development. Data from participant evaluations demonstrate the high impact of the training. The authors provide lessons learned in service of the question that Selma Fraiberg asked more than 40 years ago: What about the baby?

From the inaugural edition in 1994, the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–3; ZERO TO THREE) was nothing short of groundbreaking. Previously, the tendency to view the particulars of infant, toddler, and early childhood development and pathology as downward extensions of what was known about older children and adults was largely the rule. DC:0–3 ushered in a fresh focus on the unique features of the early years that stand out as ones of exponential growth and development; progression from virtual helplessness and relationship dependence to growing separateness, autonomy, and developmental differentiation; and both continuity and discontinuity in developmental trajectories. DC:0–3 and its revision, DC:0–3R (ZERO TO THREE, 2005), were innovative efforts to identify, codify, and classify patterns and trajectories of developmental and mental health pathologies that were unique both qualitatively and quantitatively to the infant period.

DC:0–5™: *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0–5; ZERO TO THREE, 2016) not only expanded the age range and number of differential diagnoses in Axis I but retained and revised the multiaxial system (see Box 1) in light of clinical and empirical evidence from an international, cross-disciplinary, cross-cultural perspective. The scope of DC:0–5 was enlarged and refined from an interdisciplinary

Box 1. DC:0–5's Multiaxial System

A multiaxial system for diagnosis allows clinicians to consider the variety of contexts and factors that may be contributing to a child's difficulties:

- **Axis I: Clinical Diagnosis**—describes clinical disorders and the symptoms necessary to meet diagnostic criteria.
- **Axis II: Relational Context**—focuses on the child's dyadic relational context and family systems.
- **Axis III: Physical Health Conditions and Considerations**—provides a framework for considering the impact of a child's developmental functioning and physical health on clinical symptoms.
- **Axis IV: Psychosocial Stressors**—considers the stressors that may influence a child, including social, economic, housing, employment, legal, or familial challenges.
- **Axis V: Developmental Competence**—integrates information about a child's emotional, social, cognitive, and motor skills.

outlook and embraces important features such as the inclusion of the sensory processing disorders in Axis I, the only diagnostic classification system to do so, bringing these disorders into the purview of mental health and the mental health professions. The expansion of health and well-being (Axis III) emphasizes health as foundational, the body as the mirror of the forming inner life in young children, and lays to rest any lingering controversies over the so-called medical versus educational/psychosocial models. An expanded and revised list of psychosocial stressors (Axis IV) reifies what is now known about the potential derailing impact of stress and

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trauma on early development and across the lifespan so that excessive stress and trauma can be identified early. A qualitative appraisal of relationship context and dynamics that are child–caregiver specific through an attachment lens (Axis II, Part A) and a related but distinct scale (Axis II, Part B) that appraises the systemic, “web-of-caregiving,” network, yield outcomes on an adaptive continuum rather than as categorical parenting styles, neutralizing the potential for stigmatizing parents by “de-pathologizing” and in turn embracing the concept of parenthood as a developmental process. The Developmental Competency domain (Axis V) was expanded to include communication, cognition, and movement, lending itself to capturing a developmental overview with an important specific profile of the relative evenness or unevenness in the contour of developmental domain strengths and weaknesses.

DC:0–5 affirms the merits of early diagnosis, demonstrating the balance of benefit over risk. DC:0–5 provides a standardized nomenclature that promotes cross-disciplinary work by lowering some of the semantic roadblocks. And it is important to note that DC:0–5 supports a much more “precision approach” to targeting the most appropriate differential evidence-based interventions based on refined differential diagnosis. The use of DC:0–5 can yield important baseline information against which to measure change over time with repeated reassessment and re-diagnosis as key safeguards against a child being derailed and trapped in a system and setting that may no longer be the most appropriate. The contextual, family, and cultural lens speaks to relational and family differences and assists in identifying needed supports for the entire caregiving system. Differential diagnosis and nomenclature are key to collecting prevalence data, tracking developmental trajectories, and complementing bio-markers with descriptive indices for research. Nomenclature gives access to literature and other data bases as well as sources of reimbursement. DC:0–5 may be one of the most important vehicles to access critical early intervention—striking when the nervous system is most ready, plastic, and amenable to change all within the caregiving and cultural context. By expanding the Axis I to include 42 separate diagnoses, and including newly developed categories that include diagnoses that are both empirically sound and clinically meaningful, clinicians move closer to the goal of more precise and accurate descriptions of impairments, rather than settling on diagnoses that may not be the best fit, but which are the only ones available.

The New York DC:0–5 Initiative

In the summer of 2019, the New York State Office of Mental Health launched a statewide training initiative on the DC:0–5 in partnership with the New York Center for Child Development (NYCCD) and the New York University (NYU) McSilver Institute for Poverty Policy and Research. This 3-year project was funded through the Preschool Development, Birth to Five federally funded Block Grant. NYCCD has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of early childhood mental health through training, research initiatives, and direct



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DC:0–3 ushered in a fresh focus on the unique features of the early years that stand out as ones of exponential growth and development.

practice. Building on their strong partnership with NYU’s McSilver Institute for Poverty Policy and Research, they have offered trainings to professionals across the state.

The DC:0–5 training provides a conceptual framework for professionals working with infants and young children, taking into consideration the child’s health, psychosocial stressors, developmental profile, and culture as well as the nature of the child’s relationships with key caregivers and the broader caregiving context and system. DC:0–5’s multiaxial approach has been a major contribution because existing classification systems such as the *DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (American Psychiatric Association, 2013) do not adequately reflect the unique contextual, developmental, and relational experiences of infants and young children and the general impact that context bears on the developing child.

When this initiative was launched, NYCCD partnered with ZERO TO THREE and offered an introductory webinar with Kathleen Mulrooney (ZERO TO THREE staff member and a member of the DC:0–5 Task Force) to provide a foundational overview for all professionals working with infants and young children. Throughout the project, the DC:0–5 trainers also compiled a resource compendium of further readings—articles and materials to support learning about the infant and early childhood mental health field (IECMH) field and DC:0–5. (See [Learn More](#).)

Community of Practice Meetings

Trainings began in July 2019 and were offered in person throughout the five New York State Office of Mental Health regions in New York state. In March 2020, with the onset of COVID-19, training pivoted to remote offerings. Through October 2022, more than 2,500 professionals have been trained through this initiative. Trainings have been provided by Dr. Gerard Costa and Dr. Gilbert Foley, national experts and members of NYCCD’s Advisory Board. Dr. Costa was also a

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DC:0–5 affirms the merits of early diagnosis, demonstrating the balance of benefit over risk.

member of the 2016 international cohort of ZERO TO THREE–selected Expert Faculty and Dr. Foley’s contribution to DC:0–5 are recognized in the book’s acknowledgments.

The trainings were each followed up by community of practice/mentorship web-based meetings. These meetings provided a forum for rich discussion and the opportunity for participants to be able to walk through the multiaxial diagnostic framework with their own cases, making the process specifically clinically relevant and meaningful. These community of practice sessions afforded participants an opportunity to learn and reflect together in a way that was intended to make the diagnostic process mindful, three-dimensional, and fully alive. The DC:0–5 trainers, who also led these community of practice sessions, have found this to be the case, particularly when a participant presented a real case to share so that the DC:0–5 multiaxial diagnostic formulation could be completed “in vivo” as a process of shared clinical reasoning and mindfulness.

To illustrate, in late 2022, in a session led by Dr. Foley, a social worker presented a case of a preschooler with a complex and tragic trauma history. The DC:0–5 multiaxial approach to diagnostic formulation helps to organize clinical material in a systematic and logical way that illuminates transactions among axes and informs an Axis I diagnosis in an enriched, clarifying, and multifactorial way. Posttraumatic stress disorder best described this little boy’s symptom picture and profile. Only after we had completed the process did the social worker reveal the child had been assigned the diagnosis of adjustment disorder by another mental health professional. By embedding the diagnostic process within a broad context and culturally sensitive way, DC:0–5 clearly helped to stimulate a more complex analysis and consideration of differential diagnoses and to identify the severity and etiology of the presenting problem more accurately. This diagnosis hopefully opened up the door for this child to receive treatment of an intensity and duration that would likely not have been supported and justified by an adjustment disorder diagnosis.

The New York State Office of Mental Health has been actively promoting and supporting this conceptual framework as a mechanism to further develop the foundational knowledge of the diverse workforce that serves the birth to age 5 population and their families. The New York State Office of Mental Health has also been actively collaborating with the New York State Department of Health to work toward making the DC:0–5 the recommended diagnostic tool for the birth to age 5 population in New York state, mirroring the goal of ZERO TO THREE and of initiatives underway in other states. The goal is to ensure that each child and family receive developmentally and diagnostically appropriate interventions to meet their needs. Appropriate diagnoses not only result in developmentally appropriate treatment, but also help keep the child on track developmentally and prevent more severe social, emotional, and behavioral problems later in childhood and adolescence. The differential diagnostic process ensures that the intervention is treating the right symptoms.

The trainings provide clinicians with content knowledge related to each axis in a systematic and comprehensive manner grounded in conceptual, clinical, and research support. The training includes activities through which the participants practice “walking through” two case write-ups, using the five-axial diagnostic formulation. Using these written cases as simulations of actual cases affords the participants, working in teams, concrete opportunities to make actual diagnoses with support and to assess outcomes against the criteria established by the crafters of the DC:0–5 classification system. The concept-to-operation approach—“learning by doing”—is key in that the participant leaves with an introductory level of skill to actually start applying DC:0–5 in their own clinical settings.

A Brief Training on a Complex System: Two Metaphors

In describing the nature of the workshop, Dr. Costa used two metaphors: “Speed-dating” and “Getting a Driver’s License”:

- Because the 12-hour DC:0–5 workshop cannot cover the entirety of the manual, and in particular the 42 Axis-I diagnoses, the training is described as “speed-dating” with the manual. There is no substitute to an in-depth reading and review of the manual, but the workshop provides the participant with an overview of the history of the manual’s development, the structure of the five-axial formulation, the contextual and culturally sensitive approach to diagnoses, the critical importance of differential diagnoses, and the need to engage in self-reflection as the clinician examines each axis and diagnoses.
- The acquisition of a driver’s “license” certifies that the licensee possesses adequate knowledge of how to operate a vehicle safely and that the user has sufficient (not all) knowledge of the “rules of the road.” Similarly, participants are reminded that, at the end of the training, they should feel sufficiently prepared to know how to use the DC:0–5 classification system, but just like in the case of driving a car, one really learns how to drive only after obtaining the license. Further, it is made clear to participants that

completing this training does not legally qualify a participant to make diagnoses, if that function is not within the scope of their professional license. In this regard, opportunities to “practice” with a community of colleagues is essential and is initially supported by the community of practice sessions.

Use of Case Reports in the Training

The DC:0–5 Task Force prepared several case reports for use in the training, and the cases used in this training were “Turner” and “Emma.” The case of Turner is more structured and closely guided by the leaders as the participants are led through one axis at a time, following the recommended approach of beginning with Axis III, then Axis IV, V, and II, before identifying Axis I diagnoses and developing the clinical formulation. The second case of Emma is processed in a more open-ended and self-directed format to give teams greater independence in the use of the system and then to come together to co-construct the five-axis diagnoses with the leaders and assess outcomes against the crafters’ criterion diagnoses for each axis and a case formulation.

Opportunity for team discussion following each axial diagnosis provided an opening to discuss the cultural context and implications, and to reflect on alternate diagnostic hypotheses (differential diagnoses). This process further gives participants an opportunity to explicate their clinical reasoning, which may be even more important than arriving at the criterion diagnoses. Clinical reasoning encompasses the ability to identify patterns of function and derailment within and across developmental lines (considered directly in developmental competence, Axis V), and to consider both quantitative and qualitative data, family history, relationship style and quality, health factors, and psychosocial stressors through the lenses of culture and community. What emerges is a multifactorial, transactional, and dynamic systems approach to identifying patterns consistent with Axis I diagnoses. All the axes are interdependent and inform each other in the assignment of an Axis I diagnosis.

Approach to Diagnoses

The contribution of a multiaxial framework is clear in considering differential diagnoses. As noted previously, the recommended approach to the diagnostic process is to begin with Axis III (Health and Developmental Considerations), then consider Axis IV (Psychosocial Stressors). The DC:0–5 approach emphasizes strengths as well as impairments and difficulties, which is reflected in the completion of Axis V (Developmental Competence), where five inter-related domains of development are examined. The centrality of relationships is illustrated by the two components of Axis II (Relational Context), in which the adaptive nature of the child’s relationship with each primary caregiver is considered (Part A), and also the nature of the relationships among the caregivers—the “web of caregiving”—is assessed (Part B). Only after considering these four axes and the cultural context, is the



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The DC:0–5 training provides a conceptual framework for professionals working with infants and young children, taking into consideration the child’s health, psychosocial stressors, developmental profile, and culture.

clinician able to consider diagnoses, and differential diagnoses, in Axis I.

To illustrate, health factors may be decisive in ruling out an eating, sleeping, or crying diagnosis as primary or secondary. Psychosocial stressors give important clues as to a stress, trauma, and deprivation diagnosis or may suggest the presence of notable protective and resiliency strengths. The level of adaptive child–caregiver functioning (Axis II) provides important cross-validation in assigning an Axis I diagnosis of relationship-specific disorder and illuminates decisive caregiving strengths as well as contributions to diagnosis. The cultural formulation may provide critical insight in determining whether the symptom profile reaches the threshold of being an impairment. The extensive information provided as a part of each Axis I disorder, especially possible disorders to rule out or those that may be comorbid with the disorder being considered, gives the clinician a kind of decision tree to follow in the analytic process. Thus DC:0–5 training, in the broad brush, shapes a way of thinking and a *weltanschauung* (worldview) that embraces complexity, meaning it is multicausal, transactional, and dynamic systems theory in scope and depth.

As a system, DC:0–5 gives the clinician a framework to organize large amounts of information in an orderly, logical, and differential format so that multiple factors can be considered, compared, and contrasted and analyzed both as parts and as a whole. While DC:0–5 includes space for subjective reflections and insights, intuition, and clinical norms, it also demystifies diagnosis, affords greater precision and uniformity in diagnosis, and reduces the error of substituting the part for the whole. In addition, the system has multiple safeguards built in to protect against overinclusion, overpathologizing, and including behaviors that may appear atypical but are actually a part of average

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Appropriate diagnoses not only result in developmentally appropriate treatment, but also help keep the child on track developmentally and prevent more severe social, emotional, and behavioral problems later in childhood and adolescence.

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expectable development. Two case vignettes drawn from the community of practice sessions are presented in the Box 2, to further illustrate how the DC:0–5 process illuminates clinical features not previously considered or addressed, expanded and amplified case analysis, and even altered diagnostic impressions of children who had a preexisting diagnosis, shedding light on DC:0–5’s value added.

Scope and Evaluation

From the onset, an evaluation plan was developed to assess the impact of the New York DC:0–5 Training Initiative. Trainings, which began in July 2019, were held as 2-day in-person events until March 2020, when the COVID pandemic precipitated the shift to the training being delivered as a workshop series of 11–12 hour sessions over 3 days. Twenty-six in-person trainings were delivered, and 1,003 participants completed the workshop series. The virtual trainings began in October 2020, and 1,349 participants completed the workshop series (11–12 hours over 3 days). During this period ending in September 2022, 58 virtual trainings were delivered.

While there was almost no drop-off of participants from Day 1 to Day 2 in the in-person trainings, there was an observed drop-off in the virtual workshop, notably from Day 1 to Day 2, and to a much lesser extent from Day 2 to Day 3. Accordingly, while 1,664 participants registered for Day 1 of the virtual workshop trainings, 1,349 completed the series, yielding an 81% completion rate.

With the onset of the virtual workshop training, an electronic evaluation survey was administered at the end of each workshop series to all participants. The results of that 2-year evaluation period (October 2020–September 2022) are presented in Table 1. Collectively, these findings provide

Box 2. Two Case Vignettes

Case 1: 5-Year-Old Identical Twin Boy, With a Neonatal Intensive Care Unit (NICU) Experience

DC:0–5 helped to more crisply differentiate between the developmental course of the siblings. The twin being diagnosed had a NICU experience while the other twin did not. The impact of the rocky early course proved to have a notable impact on relational patterns with the primary caretaker who defined the identified twin in terms of fragility and vulnerability and held him especially close. The death of a maternal grandmother stood out as significant for this twin who was identified more closely with the grandmother in the eyes of the mother and who became the object of projected maternal grief, all of which created a climate of greater sadness and anxiety in the relationship and risk for enmeshment. These were just some of the salient differentiating clinical features that the DC:0–5 diagnostic process brought to bear on the case formulation.

Case 2: 3-Year-Old With a Pre-Existing Diagnosis

A 3-year-old with a pre-existing diagnosis of undereating disorder was reviewed using the DC:0–5 framework and an analysis of Axis II, IV, and I shed new light on understanding the symptom profile. The child had been in the NICU, where invasive feeding procedures had been implemented, including repeated endoscopies, and the child met criteria for a tactile over-responsivity disorder. Thus, the role of stressors and sensory contributions reframed not only the presenting problem but suggested a comorbid diagnosis and the proposed addition of occupational therapy to his program and child–parent psychotherapy to address the trauma contributions not only to the child but the family as well.

support for the positive impact of the dissemination and delivery of the DC:0–5 training.

Evaluation of the Community of Practice Calls

A survey was sent out to all DC:0–5 training participants to gather more information about the community of practice calls. Those who took part in the calls were asked to provide more information about their experience. The response was overwhelmingly positive with 94% of respondents reporting that they were extremely satisfied with the calls. The respondents also indicated that they benefited from taking part in the community of practice calls, with 96% reporting that they agree they were able to learn from other participants’ questions during the calls and 94% of participants agreeing that being on the call enhanced their confidence to use the DC:0–5. While not all calls had a case presented, for those that did, 97% reported that walking through the five-axis diagnosis was an effective learning experience. Most (84%) felt that the 90-minute call was just the right length of time. In sum, the community of practice meetings were an experience that helped to translate DC:0–5 training into practice by giving participants an opportunity to learn from each other.

Table 1. Evaluation of Training, October 2020–September 2022**Part A**

Participants used a 5-point Likert scale with 1 = minimum/low agreement and 5 = maximum/high agreement

Question	n = Respondents	Mean rating
The training was useful to me.	902	4.55
The training was well-organized/ clearly presented.	900	4.57
I am more knowledgeable about DC:0–5™ development, revisions, and new disorders.	899	4.61
I learned the recommended approach for diagnosing disorders in infancy and early childhood.	904	4.52
I have a better understanding of the purpose, risks, and benefits of diagnosis for infants/young children.	904	4.54
I am more familiar with DC:0–5 multiaxial system and clinical disorders.	904	4.57
Parent's Observations of Social Interactions (POSI)	4.55	4.55

Part B

Participants rated how confident they feel in administering these strategies as a result of this training, using a 5-point Likert scale with 1 = minimum/low agreement and 5 = maximum/high agreement

Question	n = Respondents	Mean rating
Considering the contextual issues impacting the child and family in my diagnostic formulation	903	4.22
Considering the child's relationship with his/her parents and other important caregivers in my diagnostic formulation	904	4.39
Considering alternative causes for the presentation of symptoms	903	4.22

Part C

Participants rated how likely they are to implement what they have learned in this training in their practice, with 1 = not likely, 2 = somewhat likely, 3 = very likely, and 4 = n/a. This training was not applicable. Each cell reports the number of respondents.

Rating	1	2	3	4	
Number of respondents	20	231	595	19	865

Data summary provided by: New York University, McSilver Institute for Poverty Policy and Research, and Moira R. Riley, PhD, and Tyler S. Bellick, MA, at the Center for Human Services Research. University at Albany, State University of New York.

Lessons Learned

Collectively, over a 3-year period, the New York DC:0–5 Training Initiative resulted in more than 2,500 New York State mental health clinicians being prepared to use the DC:0–5 framework. As Table 1 indicates, the general response from the participating clinicians was overwhelmingly positive. The initiative also provided an opportunity to reflect on the planning and implementation of the project, and the authors formulated the following list of “lessons learned:”

1. **New to the Field:** From the onset, the trainers recognized that a significant majority of participants in the DC:0–5 training were new to the field of IECMH. While our team initially was initially concerned that the training represented “putting the cart before the horse,” we also recognized that this training accomplished two important outcomes:
 - a. Participants were engaged to reflect about the unique mental health and diagnostics regarding infants and young children in ways very different from that of older children and adults. This heightened awareness led participants to desire further trainings and led the NYCCD team to develop 90-minute targeted workshops that addressed “IECMH Foundational Topics” and “Axis I-Related Content Workshops” that were incorporated into the community of practice/mentorship” meetings (see Box 3). In addition, NYCCD had developed the New York City Early Childhood Mental Health Training and Technical Assistance Center (TTACNY), in partnership with NYU’s McSilver Institute for Poverty Policy and Research, funded by the New York City Department of Health and Mental Hygiene. Through the TTACNY connection, participants were encouraged to seek additional training and experience and draw upon TTACNY’s extensive library of recorded webinars by leaders in the field of IECMH. (See Learn More sidebar for a link to the TTACNY website.)

Box 3. Infant and Early Childhood Mental Health Foundational Workshops

- Guiding Principles in Infant and Early Childhood Mental Health
- Reflective Practice: A Foundation of Infant and Early Childhood Mental Health

Axis I-Related Workshops:

- Stress, Trauma, and the Impact on the Infant and Child Brain
- Sensory Processing, Sensory Processing Disorders, & Infant and Early Childhood Mental Health



Opportunity for team discussion following each axial diagnosis provided an opening to discuss the cultural context and implications, and to reflect on alternate diagnostic hypotheses (differential diagnoses).

- b. The training led participants to discern the value of applying the system to the diagnostic process and the multiaxial framework to clinical formulations at all developmental levels. The training experience motivated a number of participants to become “change agents” promoting interest in DC:0–5 in their own clinical settings as well as promoting advocacy for use of the DC:0–5 framework to colleagues.
2. **Continuing Education Credit:** Clinicians from all disciplines (e.g., psychology, social work, counseling, psychiatry, pediatrics) required continuing education credits to support their professional development and licensure. The NYCCD and NYU collaborated to offer continuing education units for social workers and licensed mental health counselors for both the DC:0–5 workshops and the Foundational Workshops that were delivered.
3. **The Importance of Colleagues and Cohorts:** From the beginning, the trainers observed the benefit to participants when trainees from the same agency/organization participated in the workshop together. This supported the possibility of change and implementation when returning to their own agency as early adopters and created a cohort of “like-minded kindred spirits” to ensure that “old ways” were challenged and modified in accord with the DC:0–5 approach. On reflection, this may lead the team to offer “site-specific” trainings so that staff in the same organization are provided with the DC:0–5 training on-site and might even include a section on “strategic planning” to ensure change and implementation.
4. **Community of Practice and Mentorship:** From the start, the team recognized that one-time trainings will likely have only limited impact unless follow-up mentorship and support were provided. However, one disappointing

lesson is that very few staff have sufficient “protected time” to participate in the sessions that were offered. In the future, agencies may be asked to ensure that when staff are provided the training at no cost to the agency, that agency must also provide assurances that the staff are paid for required follow-up mentorship meetings. Unfortunately, guaranteeing this time may require additional funding, and raises the need for administrative buy-in at the top for such staff training.

5. **Identify Incentives to Promote Participation.** The opportunity to participate in the training through the convenience of web-based platforms may also reduce the incentive to attend once registered, and to participate in the training after attendance on Day 1. While the number of participants on Day 1 was often quite fewer than the number of registrants, in some cases less than half, participants who came on Day 1 generally participated in Days 2 and 3. However, at one point during the summer of 2022, the organizers observed several workshop series where a significant number of Day 1 participants were absent on Day 2. (Note that participants who missed Day 2 were not permitted to attend Day 3 or receive any continuing education units and were required to register anew if they were so interested.) A survey was developed and sent to those participants who “dropped off” in several workshop series, in an effort to better understand the nature of the problem. The most significant reason identified was a competing clinical demand beyond the participant’s control. This result again suggests the need for administrative support and “buy-in” to ensure protected time.
6. **Strengths and Questions.** The overwhelming anecdotal feedback deemed DC:0–5 to be a comprehensive framework that facilitated clinicians’ ability to (a) organize large amounts of data in a systematic, logical, and inter-related way and (b) process with more in-depth clinical reasoning while considering the contextual impact of more contributing variables, all in service of a more informed and precise Axis I diagnosis and the construction of a more integrated formulation than approaches currently being used. The matter of added time needed to complete a five-axial diagnosis in a stretched clinical setting was a recurring theme. A question that has been raised, by both the trainers and a number of participants, was how to translate a comprehensive, clinically and academically sound five-axial diagnoses, which could be quite daunting, to parents and caregivers in a way that is helpful and not hurtful.
7. **Reflective Space for the DC: 0–5 Trainers.** Soon after the project began, the need for the trainers to meet regularly and discuss their experiences became apparent. Of course such reflective practice has long been honored in the field of IECMH, and this practice extends to those who engage in professional development. The project administrator, Nichole Aiello, met regularly with

the trainers to discuss the following: (1) Allow feedback and sharing of the experience—including about practices and activities that “worked” or needed adjustment. (2) Exploration of the “subjective” experience of the trainers with regard to the participants’ responses to the workshops—including sharing of stories and vignettes about workshop experiences. (3) Gather feedback about the curriculum itself so that the trainers could benefit from each other and gather ideas to share with the ZERO TO THREE team as revisions were being considered.

Next Steps: What About the Baby?

The field of IECMH awaits the regulatory changes in state mental health, Medicaid, and insurance systems that will finally allow the widespread application of the DC:0–5 classification for infants and children from birth to 5 years old and their families. This initiative in New York has led to a readiness among the cadre of trained mental health professionals to quickly implement the much-needed reforms on how the multidisciplinary professionals and mental health systems think about the nature of, and intervention for, developmental and mental health concerns in babies, toddlers, and young children and to ensure that mental health has a place in early intervention.

When the required enabling changes occur, we would anticipate the need for “booster” sessions among those trained thus far, and a widespread plan to educate and support the new cohorts of professionals who will eagerly seek these opportunities.

While “spreading the news” is a critical step in systems’ change, we all await the day when mental health classification systems will affirmatively answer the question that Selma Fraiberg asked over 40 years ago: What about the baby?

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Health factors may be decisive in ruling out an eating, sleeping, or crying diagnosis as primary or secondary.

the Stella and Charles Guttman Foundation and serves on the boards of the New York Zero to Three Network (past president), the New York State Association for Infant Mental Health, and the Coalition for Behavioral Health. Recognizing the importance of early childhood mental health as a major foundation for all learning and development, a significant focus of Ms. Blanck’s work has been on promoting the integration of early childhood mental health in education, primary care, and all child-serving systems; building the capacities of those working with infants and young children through training and technical assistance; and promoting policies to support this work.

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Learn about DC:0–5™ *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* and the DC:0–5™ Clinical Training
<https://www.zerotothree.org/our-work/learn-professional-development/dc0-5-manual-and-training>

Assistance Center. He is Endorsed as an Infant Mental Health/Clinical Mentor, Level IV, and is a founding board member of the New York State Association of Infant Mental Health and was a founding board member of the Pennsylvania Association of Infant Mental Health. He is a senior faculty member of the Profectum Academy and is on the editorial board of the *Journal of Infant, Child and Adolescent Psychotherapy*. Dr. Foley is the co-author of the *Cognitive Observation Guide*, *The Supportive Play Model*, *Mental Health in Early Intervention*, and *Linking Sensory Integration and Mental Health: Nurturing Self-Regulation in Infants and Young Children* (a revised and updated edition of *Sensory Integration and Self-Regulation in Infants and Toddlers*). He has written more than 40 scholarly articles and chapters and lectures widely nationally and internationally.

Gerard Costa, PhD, DIR-C®, IMHM-C®, was the founding director of the Center for Autism and Early Childhood Mental Health and is a professor in the Department of Family Sciences and Human Development at Montclair State University. He is a member of the faculty of the Infant and Early Childhood Development (IECD) doctoral program at Fielding University (formerly the Interdisciplinary Council on Development and Learning Graduate School). He serves as a trustee and president of the Interdisciplinary Council on Development and Learning, founded by Drs. Stanley Greenspan and Serena Wieder, and has served as a consultant to ZERO TO THREE for the more than

20 years. Dr. Costa is one of the first 16 Expert Faculty selected by ZERO TO THREE in the new DC:0–5 (2016) classification system. He was appointed by two New Jersey governors to serve on the New Jersey Council for Young Children, where he headed the Infancy and Early Childhood Mental Health committee. He received his doctorate in developmental psychology from Temple University and was one of the first 16 recipients of the DIR certificate by Dr. Stanley Greenspan and Dr. Serena Wieder. He is a trained faculty member in the Brazelton Touchpoints Model and holds a “Self-Reg” Certificate from the MEHRIT Center in Canada, led by Dr. Stuart Shanker. He holds an endorsement as an Infant Mental Health Clinical Mentor, through the New Jersey Association for Infant Mental Health and Michigan Association for Infant Mental Health. Since 2018, he has served as the coordinator of the *Northeast Regional Terrorism and Disaster Coalition*. He is past president of the New Jersey Association for Infant Mental Health, and is president of the Interdisciplinary Council on Development and Learning. Dr. Costa has conducted presentations and trainings in 31 states and 11 countries, and he is the recipient of numerous awards. He is a licensed psychologist in New Jersey and is the author of articles and book chapters on autism, infant mental health, and professional formation. He is the 2021 recipient of the *Weatherston Leadership in Infant Mental Health Award*, from the Alliance for the Advancement of Infant Mental Health.

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