Guidance to Adopt DC:0–5 in State Policy
Infant and Early Childhood Mental Health Financing Policy Project Technical Assistance Tool

ZERO TO THREE
Early connections last a lifetime

PRINCIPLES GUIDING THE DEVELOPMENT OF DC:0–5™

- Infants/young children develop within the context of primary caregiver and family relationships. Families exist and function in the context of culture and community.
- Impairment in functioning is necessary for the diagnosis of every disorder.
- Each infant/young child is unique. Individual developmental status, temperamental disposition, sensory profile, learning style, and physical health have a major impact on the way children experience and process their life events.
- A caregiver's sensitive response to their child can mitigate early challenges and promote healthy development.
- An effective working relationship between clinician and primary caregivers is essential to the diagnostic process. The diagnostic process is fluid and bi-directional involving ongoing assessment.
- DC:0–5 is not an assessment tool; it is a framework for organizing data to inform diagnosis.

Introduction: *DC:0–5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* is a diagnostic classification system for children from birth through five years old. It was created to provide information about mental health and developmental disorders in infants/young children, including developmentally appropriate diagnostic criteria. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5, 2013) is a comparable classification system for older children, adolescents, and adults.

The first classification of mental health and developmental disorders specific to young children, *DC:0–3 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood,* was published in 1994 by ZERO TO THREE. Over the years, the nosology has been revised, first in 2005 resulting in the publication of *DC:0–3R Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood-Revised*, and then again in 2016 and 2021 resulting in the most recent version, DC:0–5 *V 2.0 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.* DC:0–5 is grounded in empirical research as well as clinical practice happening across the world.

DC:0–5 broadened the scope of the previous versions by expanding the age range to birth through five years. This most recent classification system functions as a comprehensive and free-standing nosology with discreet diagnostic codes.

DC:0–5 is specifically designed to account for the rapid and ongoing development of infants/young children. Because infants/young children grow in the context of relationships with adult caregivers and each relationship is unique, DC:0–5 is constructed to focus on the adaptive qualities between the infant/young child and their primary caregiver(s).

General Guidelines to Adopt DC:0–5 within State Policy

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that administers Medicaid and sets Medicaid rules; however, because state Medicaid offices may interpret or apply federal rules differently, each state has different Medicaid policies. Below are general strategies to guide states to integrate DC:0–5 into state policy and practice. The guidance may need to be adjusted to align with a state's current policies and may occur in a different order based on the context in each state.

1. ***Determine if Medicaid will Allow or Require DC:0–5***

   A first step in recognizing DC:0–5 is to determine if it will be required or allowed by the state Medicaid office. Some states allow it (Colorado and Massachusetts), while others require it (Arkansas, Illinois, and Washington). Initially a state may recommend the use of DC:0–5 to provide time for clinicians to receive the necessary training to competently implement DC:0–5 and, in time, may require its use. To assist in building state capacity, a progressive, supported process including clinical training, identification of qualified professionals, and subsequent training of trainers is available.

   It is also necessary to determine if the state Behavioral Health Agency (also called Mental Health in some states), has the authority to change the diagnostic classification system used or if Medicaid and Mental Health, working in partnership, determine the system. When it is decided that DC:0–5 will be allowed or required, a crosswalk between DC:0–5 and the International Classification of Diseases (ICD-11) codes is needed, because all third-party payers require an ICD-11 code to bill a service. This crosswalk should be used by all providers within the state.

   CMS allows treatment based on Z codes, which are found in the DSM-5 and ICD-11, and indicate issues or conditions that may impact caregiver-child relationship and quality of life but are not considered a clinical mental health diagnosis. Z codes are critically important to documenting social determinants of health and their impact on child and family wellbeing. Some states allow billing for a Z code as the primary diagnosis (California and Oregon).

> Social determinants of health (SDOH) are defined by the World Health Organization as the "conditions in the environment in which people are born, grow, live, learn, work, play, worship, and age that shape health." Several factors can be considered SDOH including housing, food insecurity, neighborhood, and access to health care. SDOH related Z codes range from Z55 to Z65. https://www.cms.gov/files/document/zcodes-infographic.pdf

2. ***Develop Professional Competence in the Use of DC:0–5***

   Clinical Providers: Infant and early childhood mental health (IECMH) clinicians are licensed mental health professionals with specialized education, training, and expertise to assess, diagnose, and treat children from birth to 5 years old. Clinicians and leaders from the fields of mental health, physical health, and early intervention whose work focuses on assessment, diagnosis, and case formulation need to be trained in the use of DC:0–5. A 12-hour, 3-session comprehensive training on DC:0–5 provides history and background around the need for a specialized diagnostic classification system during infancy and early childhood. The training explores approaches in diagnosis from an IECMH perspective which is developmentally informed, relationship-based, contextual, and culturally-responsive. Participants learn about the multiaxial approach to diagnosis and learn to apply the contents of each axis, including Axis I clinical disorders, to case examples.

   Clinicians new to using DC:0–5 to support diagnosis and case formulation benefit from additional support. It can be helpful to follow the 3-session training with a community of practice (CoP). During a CoP, newly trained clinicians can review and apply the multiaxial diagnostic process to additional case examples. The CoP can help clinicians reflect on cultural, environmental, physical health, and relational contexts.

DC:0–5™ Clinical Training is a total of 12 clock hours and can be delivered virtually or in-person by ZERO TO THREE certified trainers or faculty. All participants are required to have the DC:0–5 manual which is used throughout the training series. Participants learn from didactic presentations, video clips, and case vignettes/reports. Throughout the three sessions, trainers facilitate large- and small-group discussions and encourage reflections and questions from clinicians. These activities deepen learning by allowing clinicians to apply knowledge and build peer networks and reliability.

Allied Professionals: It is helpful for non-clinical early childhood professionals to have a basic understanding of DC:0–5. Allied professionals such as home visitors, physical and occupational therapists, developmental specialists, educators, and others often work in partnership with clinical staff. A common language and a basic understanding of DC:0–5 supports communication among these professionals. With a fundamental awareness of DC:0–5, allied professionals are more adept at seeing the whole child and family including caregiving relationships, psychosocial stressors, and environment. A 4-hour DC:0–5 training for professionals who do not diagnose may help providers recognize that a child needs additional help or further assessment. A 90-minute overview training is available for other related professionals such as program administrators, policy makers, and funders.

Reflective Supervision/Consultation: All professionals working with young children and their families benefit from regularly scheduled reflective practice sessions. Reflective Supervision/Consultation (RS/C) provides an opportunity to better understand the interactions with families and helps professionals recognize their own experiences, dilemmas, and biases raised when working with young children and their families. Three primary facets of reflective supervision are reflection, collaboration, and regulation. Reflection refers to the provider and supervisor's ability to explore feelings, thinking, and observations from multiple perspectives. Collaboration encompasses non-judgmental exchanges dependent on the complete attention of the provider and supervisor. Regulation refers to the predictability of meetings during which established emotional safety allows for the exploration of strengths and areas requiring attention and growth.

RS/C recognizes that learning takes place in the context of relationships, for infants/young children as well as adults. All relationships are reciprocal and what occurs in one relationship can impact other relationships. The foundation of reflective practice sets up parallels between policy and administration, administration and supervisors, supervisors and providers, providers and caregivers, and caregivers and babies. To promote healing for families, providers need to be supported and cared for through safe discussions and partnerships. When the provider is supported, they can better offer care to families who, in turn, are better able to provide support to their children.

DC:0–5 Training Topics

History and Foundations of Diagnosis of Mental Health Disorders in Infancy and Early Childhood: Participants learn about how diagnosis in infancy and early childhood has evolved over the years. This information helps clinicians understand the common concerns and misunderstandings about diagnosis in infancy and early childhood. They gain the ability to recognize efforts to promote early identification and service delivery for young children and their families while avoiding over-pathologizing normative variations in developmental or transient behavioral patterns in young children.

Approaches to Diagnostic Formulation: Participants learn about DC:0–5 approaches to diagnosis which are developmentally sensitive, relationship-based, culturally-aware, and contextually-grounded. The importance of thorough diagnostic assessment and a multiaxial approach to diagnosis is emphasized.

Cultural Formulation for Use in Infancy and Toddlerhood: Cultural context and implications for diagnosis are explored throughout DC:0–5. Additionally, the inclusion of the "Cultural Formulation for Use with Infants and Toddlers" Table presents an important approach to incorporating cultural perspectives in the mental health assessment of infants/young children.

Axis III – Physical Conditions and Considerations: Participants explore the critical importance of including physical conditions and considerations in conducting diagnostic assessment in infancy and early childhood. This module provides an overview of Axis III including key categories for physical conditions and considerations.

Axis IV – Psychosocial Stressors: Participants are introduced to psychosocial stressors and protective factors and learn how each contributes to the nature and course of and treatment options for mental health and developmental disorders in infancy and early childhood.

Axis V – Developmental Competence: Participants learn how DC:0–5 has expanded the developmental domains considered in understanding the infant/young child's developmental competence. This module also covers how to rate and describe developmental competence considering the child's capacities to integrate developmental milestones across emotional, social-relational, language-social communication, cognitive, and physical-motor domains.

Axis II – Relational Context: Participants learn to conduct the Axis II rating to capture the relational context of the infant/young child's life, examining the level of adaption of the primary caregiving relationship(s) and the level of adaption of the broader caregiving environment, including coparenting, sibling, and other important family relationships.

Axis I – Clinical Disorders: This module provides an overview of all diagnostic categories and their respective disorders and highlights several of the newest disorders in more depth.

Relationships among DC:0–5, DSM-5, and ICD-11: Participants learn about similarities and differences among the three major nosologies and discuss benefits and limitations of using crosswalks for billing and record keeping.

Clinical Case Application: Participants review two full case reports and discuss possible diagnostic summaries, sharing differential diagnostic considerations.

3. ***Identify Credentials of Providers Allowed to Bill for Assessment and Diagnosis***
   State Medicaid policies need to identify who is allowed to bill for specific services based on their credentials. Some states have additional requirements beyond a credential such as training in DC:0–5, while other states have expanded their workforce by allowing qualified trainees to provide services. The mental health professionals allowed to engage in diagnosis and treatment should be identified in state Medicaid policies and provider guidance materials. Credentials could be referenced broadly (e.g., "licensed professionals of the healing arts") or more specifically by profession (e.g., licensed clinical social worker, licensed professional counselor, advanced practice nurse practitioner).

4. ***Specify Number of Assessment Sessions Allowed***
   Since multiple modes of assessment are needed to accurately diagnose an infant/young child, three to five intake and assessment sessions should be reimbursable. Clinicians will interview primary caregivers(s), observe caregiver – child interactions, and observe and interact with the child. Information is collected from other providers such as pediatricians, home visitors, or childcare providers. Formal testing procedures and clinical judgment also contribute to a diagnosis. Some states, such as Minnesota and Washington, allow reimbursement for multiple intake and assessment sessions.

5. ***Identify Allowable Place of Service***
   It is important to specify where services can be provided. Although federal guidelines allow assessments and services to be provided anywhere, some states limit the place of service to a clinic or hospital. For infants/young children, it may be essential to allow for assessment to occur outside a clinical setting such as within the home or childcare setting (e.g., as allowed in Washington). Observations of the child and caregiver, which are typically included in an assessment, are best completed in an environment that is familiar to the family.

6. ***Awareness Among Clinicians and Infrastructure Staff***
   When DC:0–5 is adopted, efforts are needed to be sure clinicians and allied professionals know DC:0–5 is an acceptable (and perhaps required) diagnostic classification system. All who are involved in service delivery, including the clinician, billing staff, and Medicaid staff (including those approving services), need to know about DC:0–5. In states with Medicaid managed care, there may be multiple managed care organizations involved in the authorization of services and each of these would need DC:0–5 education and outreach.

   Sometimes clinical services are denied because a DSM-5 or ICD-11 diagnosis is not used. Some states require prior authorization, so it is essential for the reviewer to know if a DC:0–5 diagnosis is allowed and to have the appropriate training and understanding of the classification system. Reviewers need to understand what qualifies as appropriate clinical documentation to support medical necessity requirements. Information Technology may need to adjust the electronic health record to reflect the use of DC:0–5.

   Clinicians using DC:0–5 need guidance from Medicaid on how to bill and how to use the crosswalk. Internal administrators also need a clear understanding of billing processes when a DC:0–5 diagnosis is used. If clinical treatment is regularly denied, providers may become discouraged and stop providing services to infants/young children because the administrative labor is prohibitively cumbersome.

Other professionals that need to know that DC:0–5 is an accepted classification system, include:

a. Medicaid policy staff
b. Internal Medicaid reviewers of clinical work ensuring billable services
c. External quality assurance staff who review treatment plans
d. Medicaid Managed Care administrators and policy staff
e. Dedicated Managed Care Organizations for children in child welfare
f. Utilization management staff in child behavioral health units
g. Leadership and staff from child welfare and early intervention services
h. Administration, leadership, and clinicians in mental health safety net provider agencies
i. Finance departments within agencies

Although it may seem that only IECMH clinicians need to understand and accept the use of DC:0–5, many others in the service delivery continuum are critical for an efficient and effective assessment, diagnostic, and treatment process.

Conclusion

Infants/young children develop rapidly in the first five years of life and are highly attuned to their caregiving environments. DC:0–5 is uniquely suited to guide clinical case conceptualization and diagnosis of infants/young children precisely because it grounds empirical knowledge of mental health disorders in that developmental and relational context. In order to give infants/young children access to developmentally appropriate and effective assessment, diagnosis, and intervention, states can and should take a systems level approach to supporting the utilization of DC:0-5.