Spring 5-10-2024

Developing a Practice Guide for Occupational Therapy Services Within a Novel Interdisciplinary Infant Mental Health Clinic in Atlanta, Georgia

Allyssa Bidwell
Georgia State University

Developing a Practice Guide for Occupational Therapy Services Within a Novel Interdisciplinary Infant Mental Health Clinic in Atlanta, Georgia

by

Allyssa Bidwell

A Capstone Project Presented to the

FACULTY OF OCCUPATIONAL THERAPY

GEORGIA STATE UNIVERSITY

In Partial Fulfillment of the

Requirements for the Degree

OCCUPATIONAL THERAPY DOCTORATE

April 2024

DEPARTMENT OF OCCUPATIONAL THERAPY
Byrdine F. Lewis College of Nursing and Health Professions

Mailing Address
P.O. Box 3995
Atlanta, GA 30302-3995

Phone 404-413-1446
Fax 404-413-1450

Georgia State University

CAPSTONE FINAL PAPER APPROVAL FORM

The Capstone Final Paper is the final product that the OTD students need to complete to report her Capstone Project and her Capstone Experience.

Student's Name	Allyssa Bidwell
Degree Sought	Occupational Therapy Doctorate (OTD)
Department	Occupational Therapy
Program	Occupational Therapy Doctorate (OTD)

We, the undersigned, recommend that the Capstone Final Paper completed by the student listed above, in partial fulfillment of the degree requirements, be accepted by the Georgia State University.

Kinsuk Maitra	Kinsuk Maitra	04/25/2024
Faculty Mentor's Printed Name	Faculty Mentor's Signature	Date
Laura Jane Miller	Laura J. Miller	4/26/2024
Site Mentor's Printed Name	Site Mentor's Signature	Date
Carolyn R. Podolski	Carolyn Podolski	4/26/2024
Capstone Coordinator's Printed Name	Capstone Coordinator's Signature	Date

Acknowledgments

I am deeply grateful to those closest to my heart whose unwavering support and love have helped me throughout this journey towards becoming an Occupational Therapist. I want to dedicate this project to my mother, Tara Randall, the first advocate I have known and the first to teach me how to champion the underserved in our society. I want to thank my father and stepfather, Frank Bidwell and Thomas Randall, who have stood by my side and supported my endeavors in ways that are too numerous to describe. My family members and close friends, too numerous to name individually, have inspired me more than they will ever know with their love and encouragement and have shown me the importance of loving, steadfast, and supportive relationships. With special gratitude, I would love to thank my fiancé, Mason Scott, who has been my rock, biggest cheerleader, and constant supporter, and I am at a loss for words to describe my gratitude and love for you. To my fellow members of the 2024 OTD Cohort, your collective effort and support have been instrumental in completing this project. I am so thankful for the lifelong friendships that have been forged and united from our love for the field of occupational therapy. I want to thank the faculty at Georgia State University for your support and guidance during this program- I have learned and grown so much from each of you. Dr. Maitra and Dr. Nelson, my faculty mentors, thank you so much for the constant guidance and mentorship throughout the completion of this project. Lastly, I would love to thank my site mentor, Dr. Laura Jane Miller. I have loved and been challenged by the last 14 weeks and have loved balancing between feeling heartbroken for those struggling and having hope for the future. This dream of developing a novel infant and early childhood mental health clinic would not have been possible without your vision and dedication to the families and young children in Georgia.

Abstract

Georgia faces a significant pediatric mental health crisis, with an estimated 126,000 out of 900,000 children aged 0–6 years old needing mental health services (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). The detrimental impact of toxic stress, trauma, and adverse childhood experiences (ACEs) on a child's developing brain is well-documented (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). Early exposure to trauma and toxic stress can lead to behavioral and emotional difficulties, developmental delays, and deficits in executive function, affecting occupational performance (Nelson et al., 2020). Despite the proven efficacy of early interventions in mitigating brain architecture damage and fostering resilience, there exists a knowledge gap concerning the role of occupational therapy in addressing ACEs and toxic stress during childhood. (Kingsley et al., 2020; National Scientific Council on the Developing Child, 2005/2014). While studies emphasize the importance of early support for infants and families affected by trauma, occupational therapy remains notably absent from intervention discussions (Center on the Developing Child at Harvard University, 2021; Kingsley et al., 2020). This capstone project aims to address this gap by outlining the utilization of occupational therapy services within an interdisciplinary team and identifying billing strategies and funding sources to fund the establishment and delivery of occupational therapy services within the novel infant and early childhood mental health clinic. This project seeks to set the foundation for creating comprehensive mental health services within Georgia's infant and early childhood population, ultimately enhancing the well-being of young children and their families.

Keywords: occupational therapy, infant and early childhood mental health, adverse childhood experiences, pediatric trauma

Table of Contents

Summary Pages

Purpose

Research Question: What is the role and scope of occupational therapy services within a novel interdisciplinary infant mental clinic offering early intervention mental health services for children ages birth to five and their caregivers?

My capstone project will investigate Occupational Therapy's role in delivering trauma-informed assessments and interventions with children and infants aged 0-5 and their families with identified social-emotional and relational challenges. The Supporting Parent Relationships with Infants Through Early Childhood (SPRITE) offers mental health services for infants and children in early childhood and their families through interventions from a clinical psychiatrist. The lead clinical psychiatrist at the clinic has been interested in developing a novel multi-disciplinary infant mental health clinic located in Hughes Spalding at Children's Healthcare of Atlanta that includes occupational therapy services. Such interest provides opportunities to advocate for and develop occupational therapy programs within infant and early childhood mental health. The outcome I am seeking is the development of a roadmap outlining how to utilize Occupational Therapy services and identify potential billing strategies and funding sources to fund the establishment and delivery of occupational therapy services within the novel infant and early childhood mental health clinic.

Background

Georgia is home to over 900,000 children ages 0–6 years old, with 126,000 children who are estimated to need mental health services (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). Abundant literature describes the detrimental effects of toxic stress, trauma, and adverse childhood experiences (ACEs) on a child's developing brain, potentially

negatively impacting future learning, behavior, and health (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). In addition, exposure to trauma and toxic stress in infancy and early childhood may result in behavior and emotional challenges, developmental delays, and deficits in executive function, which can impact occupational performance (Nelson et al., 2020). There is a knowledge gap regarding the role of occupational therapy in addressing ACEs and toxic stress in childhood. Studies have shown that interventions conducted before age 3 are more effective in reducing potential damage to a child's developing brain architecture and promoting greater resilience (Kingsley et al., 2020; National Scientific Council on the Developing Child, 2005/2014). Yet, in the literature addressing support and resources for infants and families who have experienced trauma, occupational therapy is not mentioned as an appropriate intervention (Center on the Developing Child at Harvard University, 2021; Kingsley et al., 2020). In December 2018, AOTA's societal statement on stress, trauma, and posttraumatic stress disorder described the impacts of trauma as a significant public health problem and as "having pervasive influences on health, wellness, and the ability to safely and functionally participate in everyday roles, routines, and occupations" ("AOTA's Societal Statement on Stress, Trauma, and Posttraumatic Stress Disorder," 2018). AOTA emphasized the role of occupational therapy practitioners in evaluating and providing interventions to address areas of development and functional performance negatively impacted by exposure to toxic stress and traumatic experiences ("AOTA's Societal Statement on Stress, Trauma, and Posttraumatic Stress Disorder," 2018). Implementing interdisciplinary structured infant and early childhood mental health programs that include occupational therapy is essential to advance evidence-based research. This capstone project is dedicated to closing the knowledge gap of

occupational therapy's role in early childhood and infant mental health and developing services to meet the mental health needs of young children and their families in Georgia.

Methods

To articulate the role of occupational therapy within a novel infant and early childhood mental health clinic, I completed a literature review to examine topics relating to early intervention mental health services for children aged 0-5 years and their caregivers, the developmental impact of adversity, and toxic stress in early childhood, and occupational therapy assessments and interventions within infant and early childhood mental health. Simultaneously, a needs assessment was developed based on current literature and expert opinion from relevant stakeholders to ascertain the need for occupational therapy services within the clinic. Integrated findings were utilized to create an occupational therapy practice guide tailored to the clinic's unique needs. Lastly, I created a service delivery structure for occupational therapy services at the novel infant mental health clinic, addressing billing associated costs and developing a budget for startup costs while considering grant funding and the use of insurance for funding.

Outcomes

My capstone project addresses crucial gaps in early childhood development service delivery and responds to a pressing need for high-quality, inclusive support and resources for families and young children (Center on the Developing Child at Harvard University, 2021). By advocating for the use of occupational therapy assessments and interventions rooted in developmental science and evidence-based practices, the project aims to create clinical teams that can accommodate families' diverse backgrounds and experiences. Additionally, my project addresses the growing demand for effective parent education and family support programs. Parents inexperienced in caregiving, experiencing economic insecurity, and significant stress and

trauma often need professional support and community resources to help build child competence and healthy brain development to prevent/ address developmental problems (National Scientific Council on the Developing Child, 2005/2014). However, there is a relatively limited number of professionals with adequate training in maternal and early childhood mental health and a lack of a clear definition of occupational therapy's role in addressing trauma, toxic stress, and adverse childhood experiences in infancy and early childhood ("AOTA's Societal Statement on Stress, Trauma, and Posttraumatic Stress Disorder," 2018; Center on the Developing Child, 2007). Furthermore, by articulating the role of occupational therapists in addressing trauma, toxic stress, and adverse childhood experiences during infancy and early childhood, the project aims to fill a critical knowledge gap and contribute substantially to improving outcomes for children and their families.

Chapter 1: Literature Review

Terms and Definitions

The following terms were used throughout the literature review.

Table 1

Relevant Terms for Literature Review

Terms	*Definitions*	*Citations*
Toxic Stress Response	"Prolonged activation of the stress response systems that can disrupt the development of brain architecture and other organ systems and increase the risk for stress-related disease and cognitive impairment, well into the adult years"	(Nelson et al., 2020)
Adverse Childhood Experiences (ACEs)	"A traumatic event or situation that a person identifies as having directly experienced or observed from birth through the age of 18 years. For example, experiencing violence, abuse, or neglect, witnessing violence in the home or community, or having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use	(Centers for Disease Control and Prevention, 2023b)

	problems, mental health problems, instability due to parental separation, or household members being in jail or prison"	
Individual Trauma	"an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being"	(Substance Abuse and Mental Health Services Administration, 2014)

In the first critical few years of life, the human brain forms over 1 million new neural connections every second, shaping the brain's architecture and the foundation for future learning, behavior, and health (Center on the Developing Child, 2007; Clinton et al., 2016; Hare et al., 2023; National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). Experiences early in life impact the neural connections that are developed and the quality of the brain architecture (Center on the Developing Child, 2007). There is abundant literature describing how toxic stress and adversity disrupt this process, thus negatively impacting a child's developing brain architecture (Center on the Developing Child, 2007; Clinton et al., 2016; Hare et al., 2023; National Scientific Council on the Developing Child, 2005/2014; Nelson et al.,

2020). Within the context of addressing the developmental impacts of adversity and toxic stress, infant mental health emerges as an interdisciplinary field of research, practice, and policy, with a central focus on enhancing the social-emotional development and well-being of infants and young children within the context of their caregiving environments (FSU Center for Prevention and Early Intervention Policy, 2016c; Zeanah, 2018).

Exposure to adversity in infancy and early childhood may result in behavioral and emotional challenges, developmental delays, and deficits in executive function, which impact children's functional and occupational performance (Nelson et al., 2020). However, in the literature addressing how to support and serve infants and families who have experienced trauma and toxic stress, occupational therapy is often not mentioned as an appropriate intervention (Center on the Developing Child at Harvard University, 2021). As the field of infant mental health recognizes the foundational significance of early relationships and experiences on an infant's cognitive, emotional, and social development, there is a gap in understanding occupational therapy's role in addressing infant mental health (FSU Center for Prevention and Early Intervention Policy, 2016c; Kingsley et al., 2020). This literature review aims to seek insight into the role and scope of occupational therapy within infant and early childhood mental health.

Adversity & Toxic Stress Impact on Development

Learning to cope with daily stressors is essential to a child's development. In the face of new or stressful situations, the body responds by increasing heart rate, blood pressure, and stress hormones to help the child overcome or cope with the presenting stressor (National Scientific Council on the Developing Child, 2005/2014). When a young child's stress response systems activate within the context of safe and dependable relationships, the supportive caregiver can

help the child cope with the stressor, and the child's heart rate, blood pressure, and stress hormones can return to baseline (National Scientific Council on the Developing Child, 2005/2014). Over time, brief activations and deactivations of the stress response systems result in healthy stress response systems (National Scientific Council on the Developing Child, 2005/2014).

Suppose the stress response is extreme and long-lasting, and there is inadequate caregiver support to help the child cope- toxic stress develops, damaging bodily systems and brain architecture, with lifelong consequences (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). In such cases, the stress response triggers extensive activations, potentially causing structural and functional differences in the young child's brain development, disruptions in organ development, and increased risks for stress-related diseases, impacting cognitive functions (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). Furthermore, in severe cases of chronic abuse during early periods of brain development, imbalances in the child's neural connections may form (National Scientific Council on the Developing Child, 2005/2014). Brain regions involved in fear, anxiety, and impulsive responses may overproduce connections, and regions dedicated to reasoning, planning, and behavioral control may produce fewer connections (National Scientific Council on the Developing Child, 2005/2014). Extreme exposure to toxic stress can alter the stress response system so it activates more frequently, for more extended periods, and to events not perceived as stressful to others (National Scientific Council on the Developing Child, 2005/2014). This overactive stress response system can increase the risk of stress-related physical and mental illness later in life (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020).

Children growing up in conditions of economic hardship often show elevated stress hormone levels, especially in chronic situations of poverty with cumulative adverse conditions like overcrowding, noise, substandard housing, separation from caregivers, exposure to violence, and family turmoil (National Scientific Council on the Developing Child, 2005/2014). Additionally, the impact of economic hardship on children's stress systems is exacerbated when mothers experience symptoms of depression, with recent research demonstrating that a mother's depression during her child's early years increases the child's cortisol reactions to adverse family conditions later in childhood (National Scientific Council on the Developing Child, 2005/2014).

Early Childhood Exposure to Adversity and Toxic Stress: A Public Health Issue

The physical and mental health consequences of early adversity significantly strain the public health resources of the United States (Gronski et al., 2013). Childhood adversities are associated with a greater risk of adult chronic conditions, such as cardiovascular disease, stroke, cancer, asthma, chronic obstructive pulmonary disease, kidney disease, diabetes, obesity, and depression, as well as increased health risk behaviors (Nelson et al., 2020). Children exposed to trauma are at higher risk of several psychiatric disorders, including depression, PTSD, conduct problems, substance abuse, self-harm, and suicidal ideation and attempts (Nelson et al., 2020). National Center for Injury Prevention and Control (2021/2023) reported that Adverse Childhood Experience (ACE) related illness accounts for an estimated $748 billion in financial costs each year and that a 10% reduction in ACEs could equate to an annual savings of $56 billion.

Parents who are facing economic insecurity, trauma, and significant stress often need professional support and community resources to help build caregiving competence and facilitate their child's healthy development (National Scientific Council on the Developing Child, 2005/2014). However, a gap exists between knowledge of adversity's developmental impacts on

children and families and the practical supports, workplace practices, and public policies and programs to promote healthy coping (National Scientific Council on the Developing Child, 2005/2014). In the United States, there is minimal access to parental and family leave following the birth or adoption of a child and insufficient financial assistance for parents who desire to stay home but lack the economic means to support their families without paid work (National Scientific Council on the Developing Child, 2005/2014). Inadequate access to family leave can create situations where the supportive relationships needed to build attachment and help very young children cope with stress are sporadic or seriously compromised (National Scientific Council on the Developing Child, 2005/2014). Working parents are often left juggling work and child-rearing secondary to limited access to convenient, affordable, high-quality early childcare and education, flexible job and healthcare scheduling, and community-centered assistance (National Scientific Council on the Developing Child, 2005/2014). The balance is often challenging for low-income, working families who are reliant on multiple low-wage jobs, often during non-standard working hours, as well as families whose children have chronic health problems or developmental disabilities that require numerous medical appointments and specialized childcare (National Scientific Council on the Developing Child, 2005/2014).

Public health strategies must address primary, secondary, and tertiary prevention and treatment, incorporating universal and targeted interventions for children and families experiencing toxic stress (Nelson et al., 2020). At the individual level, creating services focused on active skill-building for children and caregivers (Center on the Developing Child at Harvard University, 2021). At the human services level, services may focus on the role of relationships in promoting healthy development, supportive parenting, and economic productivity (Center on the Developing Child at Harvard University, 2021). At a systemic level, creating policies to

reduce structural inequities and sources of stress, such as unequal access to high-quality health care and childcare, disparities in school funding, and bias in lending (Center on the Developing Child at Harvard University, 2021). Systemic supports and resources have historically denied opportunities to families of color, and many systems and support services for children and families crumbled during the COVID-19 pandemic (Center on the Developing Child at Harvard University, 2021). Policies and systems created to support families and children in infancy and early childhood need to be based on developmental science and evidence-based practices and rebuilt to be inclusive to families of diverse backgrounds and experiences (Center on the Developing Child at Harvard University, 2021). However, there is a relatively limited number of professionals with adequate training in maternal and early childhood mental health and limited availability of mental health resources for very young children and families (National Scientific Council on the Developing Child, 2005/2014). The lack of available support and resources is particularly challenging for child welfare agencies that are mandated to assess children and families dealing with adversity and toxic stress (National Scientific Council on the Developing Child, 2005/2014)

Interdisciplinary Early Intervention

The brain's capacity for change decreases with age, and the brain is most flexible, or "plastic," early in life. Therefore, interventions initiated before the age of 3 tend to be more successful and effective than intervening later in reducing potential damage to a child's developing brain architecture and promoting greater resilience (Center on the Developing Child, 2007; Kingsley et al., 2020; National Scientific Council on the Developing Child, 2005/2014). As the maturing brain becomes more specialized to assume more complex functions, it is less capable of reorganizing and adapting to new or unexpected challenges (Center on the

Developing Child, 2007). Early plasticity means it is easier and more effective to influence a baby's developing brain architecture than to rewire parts of its circuitry in the adult years of age (Center on the Developing Child, 2007).

Research also underscores the importance of timely assessments and intervention services for children living in stressful environments who show early signs of developmental difficulties (National Scientific Council on the Developing Child, 2005/2014). Responses to suspected child abuse or neglect should include assessments of the child's developmental status, including cognitive, linguistic, emotional, and social competence (National Scientific Council on the Developing Child, 2005/2014). A more holistic approach to addressing early childhood adversity can be achieved through closer collaboration between child welfare services and early intervention programs for children with developmental delays or disabilities as mandated by the Keeping Children and Families Safe Act of 2003, the Individuals with Disabilities Education Act (IDEA) or through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit (National Scientific Council on the Developing Child, 2005/2014).

Role of Occupational Therapy Within Early Intervention

The composition of interdisciplinary early intervention teams may vary, with each discipline uniquely assessing and managing gross and fine motor skills, feeding, and language (FSU Center for Prevention and Early Intervention Policy, 2016b; Orton et al., 2018). Occupational therapists support infants' development and participation in daily activities and occupations, including play and self-care (FSU Center for Prevention and Early Intervention Policy, 2016b; Orton et al., 2018). The occupational therapist provides specific assessment and intervention related to fine and gross motor function, sensory processing, activities of daily living, and play development (Orton et al., 2018). Social, emotional, and overall mental health

have not been frequently promoted as a priority in Occupational Therapy service delivery, even though challenges in these areas can overwhelm a child's ability to learn and perform age-appropriate occupations when faced with adverse childhood experiences (Gronski et al., 2013). While not treating the trauma itself, pediatric occupational therapists focus on interventions and education to mitigate the trauma's impact on activities, school readiness and performance, and social participation (Gronski et al., 2013). Occupational therapy practitioners provide interventions at multiple levels: by building a child and family's capacity, identifying and intervening with those at risk for toxic stress, partnering with community agencies to support families, collaboratively promoting new program development, and expanding the capacity of existing programs to serve unmet needs, and by advocating for policy changes (Gronski et al., 2013). Additionally, for children who experienced early childhood trauma, occupational therapy practitioners play a crucial role in implementing activities and strategies to support stabilization, self-regulation, development, attachment, and occupational participation("AOTA's Societal Statement on Stress, Trauma, and Posttraumatic Stress Disorder," 2018; FSU Center for Prevention and Early Intervention Policy, 2016b*).* Occupational therapy plays a crucial role in addressing the adverse effects of trauma and toxic stress on children's functional abilities and daily participation in roles, routines, and habits (FSU Center for Prevention and Early Intervention Policy, 2016b; Gronski et al., 2013).

Current occupational therapy services are mainly remediation-focused, lacking sufficient attention to health promotion and prevention, despite the crucial need for a shift towards a proactive, community-based interdisciplinary approach to address toxic stress in early childhood as a public health issue (Gronski et al., 2013). The remediation model requires waiting for children to struggle before identifying and addressing the problem and limits eligibility for

services targeting infant mental health (Gronski et al., 2013). Occupational therapists typically receive referrals based on identified developmental delays or limitations affecting major life activities, but addressing toxic stress in early childhood, which may not manifest obvious delays, requires innovative approaches to reach at-risk children and families for effective prevention and intervention strategies (Gronski et al., 2013). Occupational therapy practitioners face challenges practicing and receiving reimbursement within their full scope due to the prevailing payment system centered on a "sick care" model rather than prevention (Gronski et al., 2013). Shifting to an interdisciplinary, early intervention approach in infant mental health requires the creation of innovative payment mechanisms and new community partnerships to support emerging occupational therapy roles (Gronski et al., 2013). It is crucial for occupational therapists to advocate at the state and national levels for systemic changes in reimbursement strategies that enable occupational therapy practitioners to provide services in evidence-based infant mental health programs (Gronski et al., 2013).

The Importance of Parent-Child Relationships

Understanding the profound impact of the parent-infant relationship is crucial for programs targeting infant mental health, as it serves as a critical protective factor, influencing the child's behavioral and emotional regulation and functioning in subsequent developmental stages (Hare et al., 2023). The attachment relationship between infants and caregivers is crucial for healthy childhood development and is a distinct aspect of the relationship focused on making the child feel safe and secure (Clinton et al., 2016; Hare et al., 2023). Supportive family relationships can mitigate the impact of toxic stress on the developing child so that even in situations of stress, secure relationships can help safeguard the developing brain from significant harm (Clinton et al., 2016; Nelson et al., 2020). Secure, warm, and predictable early

relationships positively influence neural structures and improve physical and mental health outcomes (Clinton et al., 2016; Nelson et al., 2020). A secure social and emotional base is a launching pad for all other physical, motor, and cognitive development that prepares children for school and eventual success in life (Clinton et al., 2016).

If early relationships are highly stressful secondary to poverty, caregiver absence, unpredictability, or violence, the neural pathways created are more attuned to reactivity, putting children at greater risk for challenges in life (Clinton et al., 2016; Nelson et al., 2020). Intergenerational trauma is a phenomenon that occurs when "parents with trauma history struggle to nurture and care for their children, creating a vicious cycle of abuse that can be passed on from generation to generation" (Lynch et al., 2021).

Mutually rewarding "serve and return" interactions between babies and the adults who care for them facilitate cognitive, social, and emotional development (National Scientific Council on the Developing Child, 2012). Young children naturally reach out or "serve" for connection through babbling, facial expressions, gestures, and words, and adults respond or "return" with contingent vocalizing and gesturing back (National Scientific Council on the Developing Child, 2012). This "serve and return" behavior continues back and forth, similar to a game of tennis or volleyball (National Scientific Council on the Developing Child, 2012). To assess the quality and impact of caregiver–infant interactions, researchers and clinicians utilize constructs such as reciprocity, which encompasses synchrony, attunement, coordination, and mutual influence (Aubuchon-Endsley et al., 2020). Defined as the mutual engagement between infant and caregiver, involving bidirectional relationships in actions and psychological states, the construct of reciprocity holds relevant significance to occupational therapy given the theoretical overlap between reciprocity and co-occupation (Aubuchon-Endsley et al., 2020). Co-

occupations refer to occupations that involve mutual engagement and active participation of two or more individuals, with tasks involving aspects of shared physicality, shared emotionality, and shared intentionality (Aubuchon-Endsley et al., 2020; "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). Co-occupation is the give-and-take between caregivers and infants engaged in socially interactive routines like feeding, bedtime, bathing, and comforting (Aubuchon-Endsley et al., 2020; "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). Aubuchon-Endsley et al. (2020) describe the relationship between physicality, emotionality, and intentionality within the co-occupation of feeding:

> "Intentionality would describe an infant crawling toward a caregiver, recognizing that it is time to eat upon seeing the caregiver pulling a bottle out of a bag… physicality would describe the caregiver picking the infant up to cradle while feeding and emotionality would describe the caregiver speaking soothing words to the infant."

Activities of Daily Living and Caregiving Routines

Occupational therapy's primary focus is restoring meaningful engagement across occupational domains, including activities of daily living (ADLs), instrumental activities of daily living (iADLs), rest and sleep, education, work, play, leisure, social participation, and health management ("Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). ADLs include basic self-care activities such as eating, toileting, dressing, and bathing and may result in physiological dysregulation, affecting bodily functions essential for successful ADL participation ("Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). For instance, children exposed to trauma may struggle with interoception, hindering their awareness of internal sensations (Lynch et al., 2021). Recognizing

bodily cues, such as hunger or the need to use the bathroom, can be challenging for these children, disrupting eating and toileting routines (Lynch et al., 2021). Engaging in ADLs tied to past traumatic experiences can trigger adverse reactions (Lynch et al., 2021). For example, a child with a history of painful or rough diaper changes may exhibit a fight-or-flight response during routine diaper changes or toilet training (Lynch et al., 2021). Trauma-informed occupational therapy practitioners address ADL difficulties by exploring the meaning activities hold for the child due to past trauma (Lynch et al., 2021). Understanding the impact of trauma on neurodevelopment, practitioners integrate this knowledge into occupation-based activity analysis to enhance success in ADLs (Lynch et al., 2021). For instance, with diaper changes, practitioners may use visual aids to depict each step and suggest incorporating preferred items to create a more comfortable experience for the child (Lynch et al., 2021). Occupational therapy practitioners are adept at helping caregivers sensitively engage children during ADL completion and address any sensory or motor skill deficits that may impact participation (Lynch et al., 2021).

Children develop early impressions through caregiving interactions and daily routines, whether their needs for safety, comfort, warmth, food, and sleep will be consistently met, shaping patterns of self-regulation (FSU Center for Prevention and Early Intervention Policy, 2016b). Parental interventions to soothe the child's discomfort or stress establish patterns for future self-regulation, and fundamental caregiving activities like bath time, changing, or bedtime provide the opportunity for these quality interactions (FSU Center for Prevention and Early Intervention Policy, 2016b). However, unpredictable or insensitive caregiving routines and interactions can contribute to a sense of chaos in the home, creating future problems in establishing adequate sleep, waking, and feeding cycles- creating a compounding cycle (FSU Center for Prevention and Early Intervention Policy, 2016b). A child who is challenging to

soothe and has unpredictable routines disrupts family routines, creating tired and stressed parents who struggle to be consistently nurturing and responsive (FSU Center for Prevention and Early Intervention Policy, 2016b).

It is within Occupational therapy's scope of practice to help children and families navigate everyday routines, offering expertise in modifying typical activities and environments (FSU Center for Prevention and Early Intervention Policy, 2016b; "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). Recognizing the importance of structure and routines in play, mealtimes, and grooming, occupational therapy practitioners contribute to developing skills and fostering meaningful engagement in family relationships (O'Donnell & McKinnon, 2022). Signs that the child and caregivers are struggling may manifest in difficulties with the child's daily routines and delays in developmental milestones (FSU Center for Prevention and Early Intervention Policy, 2016b). Delays in acquiring associated developmental skills can reflect disruptions in these routines, with common concerns including feeding or sleeping difficulties (FSU Center for Prevention and Early Intervention Policy, 2016b). A young child relies entirely on caregivers for both physical and emotional needs. When caregivers face stressful situations such as mental illness, separation, divorce, substance use, or other challenges, they may become emotionally unavailable to meet the child's emotional and physical needs (FSU Center for Prevention and Early Intervention Policy, 2016b). This lack of responsiveness can have a lasting impact on foundational brain development, which is crucial for later developmental outcomes (FSU Center for Prevention and Early Intervention Policy, 2016b). In early intervention, occupational therapists can provide coaching to help caregivers interact effectively with their infants during daily routines (FSU Center for Prevention and Early Intervention Policy, 2016b). This support enables parents to find joy in these interactions and

enhances their confidence in their caregiving abilities (FSU Center for Prevention and Early Intervention Policy, 2016a).

Sensory Based Interventions

Early experiences, especially with caregivers, influence brain and behavior development (Méndez Leal et al., 2023). Caregivers shape various aspects of a child's development, such as language acquisition and emotional regulation, and may similarly shape sensory processing development (Méndez Leal et al., 2023). In typical development, caregivers help children make sense of their surroundings by providing attention, emotional support, and context to guide the interpretation of sensory input from the environment (Méndez Leal et al., 2023). The absence of a stable caregiver during early life may alter sensory development through reduced caregiver scaffolding of initial sensory responses (Méndez Leal et al., 2023). Without a stable caregiver, a child may develop a heightened sensitivity to unpredictable or stressful environments, possibly leading to sensory over-responsivity (Méndez Leal et al., 2023). Sensory over-responsivity is defined by extreme or atypical responses to sensory stimuli, and sensory under-responsivity is an unawareness or delayed response to sensory stimuli (Méndez Leal et al., 2023; Zeanah, 2018). Childhood experiences, particularly those involving early caregiving adversity, can alter the development of brain regions like the amygdala, which is crucial for detecting and evaluating emotional stimuli (Méndez Leal et al., 2023). Furthermore, the impact of early childhood adversity on prefrontal regulatory circuits can affect attentional and emotional self-regulatory processes, potentially leading to psychopathology in later years (Méndez Leal et al., 2023).

Underlying the developmental component of sensory integration, the ability to neurologically process sensory stimuli to generate behavioral responses assumes that learning stems from one’s ability to detect, process, and use sensory information from the environment

and from one's movement to plan and organize behavior (Zeanah, 2018). Sensory processing challenges are estimated to affect 5–16% of children, with higher rates in vulnerable populations, including those from low socioeconomic backgrounds and exposed to trauma (Armstrong-Heimsoth et al., 2021). Emerging evidence suggests that early childhood adversity increases the risk for sensory processing challenges that can disrupt daily functioning and that individuals modulate sensory input (Méndez Leal et al., 2023). Recognizing and identifying underlying sensory processing patterns and challenges is crucial for appropriate referrals, environmental adaptations, and preventive/intervention services, especially for vulnerable populations (Armstrong-Heimsoth et al., 2021). The most common measure of sensory processing in children is the Sensory Profile, which has adaptive versions for preschool-aged children, infants, and toddlers (Zeanah, 2018).

Sensory-based interventions, such as auditory, tactile, visual, and vestibular stimulation, have been shown to enhance parent-infant interactions, particularly mother-preterm infant dyads in the intensive care unit (Neel et al., 2023). A systematic review conducted by Lehr et al. (2023) explored the use of sensory-based and trauma-informed care approaches to interventions within pediatric occupational therapy with children with trauma histories. The review supported the efficacy of occupational therapy practitioners in addressing self-regulation and engagement in occupations using sensory-based interventions (Lehr et al., 2023). Individual interventions in the review met identified outcomes from treatment. However, a standard methodology is lacking, and more research is needed to identify specific strategies and guidelines for formulating meaningful intervention that prioritizes principles of trauma-informed care to help reduce the negative impact of trauma on children's daily participation in occupations within the context of

occupational therapy practitioners' skills in addressing the need for safe sensory and occupation-based experiences (Lehr et al., 2023).

Knowledge Gaps

Integrating occupational therapy into programs targeting infant and early childhood mental health stands out as a promising avenue to address the public health crisis of early adversity and toxic stress to support the healthy development of young children and their families. Designing new programs with a more holistic approach to addressing infant and early childhood mental health adversity can be achieved through closer collaboration between child welfare services, early intervention programs for children with developmental delays or disabilities, and traditional pediatric mental health services (National Scientific Council on the Developing Child, 2005/2014). Despite increasing evidence supporting the role and scope of occupational therapy in addressing early adversity and infant and early childhood mental health, the need for systematic research becomes evident. High-quality, evidence-based research within the field of infant and early childhood mental health would establish a foundation for novel programs, ensuring the safe and effective implementation of occupational therapy services for infant and early childhood mental health. This enhances the credibility of such programs and facilitates the dissemination of best practices, fostering a broader acceptance of Occupational Therapists as valuable members of the infant and early childhood mental health team. This capstone project is dedicated to developing a roadmap to establishing and utilizing occupational therapy services within an interdisciplinary team to offer holistic services to families and young children with mental health needs. Additionally, the project aims to educate professionals of multiple disciplines on the role and scope of occupational therapy within infant and early childhood mental health.

Chapter 2: Needs Assessment

My capstone project investigates occupational therapy's role in delivering assessments and interventions for children and infants aged 0-5 and their families who have identified social-emotional and relational challenges. This project is rooted in initiatives to develop a novel multi-disciplinary infant mental health clinic targeting children receiving primary care services at the Children's Healthcare of Atlanta Hughes Spalding Hospital in Atlanta, Georgia. The primary funding source is an endowment given to Children's Healthcare of Atlanta to develop pediatric mental health services and programs. Identifying proper billing mechanisms, shortage of qualified infant and early childhood mental health providers, and decreased awareness of the role and scope of occupational therapy within infant mental health have been a barrier to the development of the clinic. While the clinic's mission is yet to be defined, efforts are directed at ensuring a cohesive, interdisciplinary approach to infant and early childhood mental health. My site mentor expressed interest in the role of occupational therapy services to monitor developmental outcomes, assess sensory integration, and explore the use of infant occupations or co-occupations with parents to help identify self-regulation, co-regulation strategies, and attachment with the caregiver. Currently, the clinic plans to bill for services, but billing strategies have not been identified.

Community Profile

Georgia is home to over 900,000 children ages 0–6, among whom an estimated 126,000 need mental health services (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). National estimates underscore the prevalence of mental, behavioral, or developmental disorders among U.S. children aged 2–8 years (Centers for Disease Control and Prevention, 2023a). Among children aged 3-17 years, in 2016, 1 in 6 U.S. children aged 2–8

years (17.4%) had a diagnosed mental, behavioral, or developmental disorder, with higher rates, more than 1 in 5 (22%), among children living below the federal poverty level (Centers for Disease Control and Prevention, 2023a). In Georgia, more than one in five children live in low-income households (IECMH State Issue Brief #1, 2021). Living in poverty is also shown to impact the social-emotional well-being of children negatively, and adverse experiences and high rates of parenting stress in families with low-income further compound the adverse effects (Centers for Disease Control and Prevention, 2023a). In Georgia, 8.4% of infants and toddlers have already had two or more Adverse childhood events (ACEs), which exceeds the national average of 7.7% (IECMH State Issue Brief #1, 2021). Despite ongoing discussions about emotional well-being, the mental health of our youngest citizens is often overlooked or misunderstood. In response to a growing need for infant and early childhood mental health services in Georgia, this needs assessment is designed to identify the specific needs, barriers, and opportunities for establishing a novel interdisciplinary Infant Mental Health Clinic in Atlanta, Georgia.

Children's Healthcare of Atlanta Hughes Spalding Hospital is located in downtown Atlanta near Edgewood Avenue and Grady Memorial Hospital. The Hughes Spalding Hospital serves approximately 1,000 newborns and 16,000 total children in the Hughes Spalding primary care practice, which serves as a medical home for children ages 0-18 (Constantino, 2024). Children's at Hughes Spalding manages more than 75,000 patients annually, with 90% of the children seen in the clinic insured by Medicaid (Constantino, 2024).

Financial Inaccessibility

Approximately 40 percent of all children in Georgia receive healthcare coverage by Medicaid or the Children's Health Insurance Program (CHIP), public health coverage plans for

low-income families, or families with specific health needs (the Georgia IECMH Taskforce's Policy and Finance Workgroup, 2022). Mental health parity refers to the equal treatment of mental and physical health conditions in insurance plans (Constantino, 2023). A significant barrier to providing effective pediatric mental health services is the disparity between Medicaid reimbursement and the true cost of pediatric mental health care (Constantino, 2023; Eldridge, 2022). Quality pediatric mental healthcare is often prohibitively expensive, causing providers to bear the financial costs when insurance does not reimburse the actual cost of care, leading many behavioral mental healthcare not to take insurance (Constantino, 2023; Eldridge, 2022; Georgia Mental Health Policy Partnership, 2022). A study by the actuarial firm Milliman found that Children in Georgia are ten times more likely to receive outpatient mental health care out of network compared to primary care visits (Georgia Mental Health Policy Partnership, 2022). Under Georgia Medicaid-funded Behavioral Health Services for children aged 0-6, Occupational Therapy is listed as a covered benefit under Children's Intervention Services (CIS), as well as for Children's Intervention School Services, which provides opportunities for the increased utilization of occupational therapy within behavioral health (Georgia Department of Community Health, 2022). Covered benefits for CIS include services for activities of daily living, sensory or perceptual motor development and integration, and adaptive behavior and play development (Georgia Department of Community Health, 2022).

Workforce Shortages

Inadequate provider networks are a primary problem in accessible pediatric mental healthcare services in Georgia, with many insurers claiming that an overall shortage in behavioral healthcare providers is causing inadequate insurance-provider networks (Eldridge, 2022; Georgia Mental Health Policy Partnership, 2022). There are significantly fewer behavioral

health care professionals that are a part of insurer networks than the total number of behavioral health care professionals in the state of Georgia, necessitating a need for more services that utilize insurance (Georgia Mental Health Policy Partnership, 2022). There is a need not only to develop new pediatric mental healthcare services that are financially accessible but also to increase the capacity of providers of different disciplines, particularly occupational therapists, to address social-emotional and behavioral healthcare needs in their assessments and interventions.

Integrated and Multi-Disciplinary Services

Creating a sustainable infant and early childhood mental health system of care infrastructure in Georgia necessitates cross-agency collaborations to fund, coordinate, and deliver services (IECMH State Issue Brief #2, 2023). Families with young children interact with numerous systems as they navigate the first six years of their child's life (IECMH State Issue Brief #1, 2021). Families' awareness of and access to the infant and early childhood mental health workforce is critical to ensure treatment services reach those in need (IECMH State Issue Brief #2, 2023). Coordination and communication across caregivers, early childhood educators, pediatricians, and behavioral health care providers can streamline access to care (IECMH State Issue Brief #2, 2023). A continued focus on ensuring the collaboration of multiple systems will be needed so that children with infant and early childhood mental health concerns can be identified early and receive the treatment they need to thrive and grow (IECMH State Issue Brief #1, 2021).

Reducing Cost

Early childhood Social-emotional problems have enduring consequences, imposing financial burdens on states. The costs of untreated trauma are paid by both state systems and the

private sector, with expenditures manifesting in various system budgets, including child welfare, foster care, juvenile detention, adult incarceration, emergency room, and mental health hospitalization (IECMH State Issue Brief #1, 2021). Some states have quantified the annual cost of unaddressed trauma, with Tennessee finding that the cost was $5.2 billion in a single year and Ohio reporting costs of $10 billion annually across state-run systems and the private sector (IECMH State Issue Brief #1, 2021). Recognizing the financial impact, Funding infant and early childhood mental health programs is a solid investment, with each dollar invested into these programs shown to return $3.64 in prevented treatments later in life (ZERO TO THREE, n.d.).

This capstone project bridges the identified gaps in Georgia's infant and early childhood mental healthcare. Through collaboration with my site mentor, this project aims to develop a program guide and service delivery structure for conducting occupational therapy services within a novel interdisciplinary infant and early childhood mental health clinic. By focusing on financial accessibility, occupational therapy provider capacity building, and integration of occupational therapy within the broader infant and early childhood mental health system, this project aligns with the urgent need for comprehensive and effective solutions to support the mental health and well-being of infants and young children in the state.

Chapter 3: Capstone Experience Protocol

Literature Review and Needs Assessment

A literature review was conducted to inform the development of the practice guide. This review examined topics relating to early intervention mental health services for children aged 0-5 years and their caregivers. Sources searched included electronic databases (e.g., PubMed, CINAHL, Google Scholar, AJOT), government websites, textbooks, and professional organization recommendations. Key terms and search phrases for electronic databases included "infant mental health," "adverse childhood experiences," "occupational therapy", "early intervention", "early childhood mental health", and "pediatric trauma". Articles published within the last 15 years were included in the review, while publications in languages other than English were excluded. The review focused on understanding the developmental impact of adversity and toxic stress in early childhood and exploring existing occupational therapy assessments and interventions within the context of infant and early childhood mental health.

Simultaneously, a needs assessment was conducted to gain valuable insights and facilitate aligning services with identified needs for occupational therapy services within the novel infant and early childhood mental health clinic. Several sources were utilized for information, including current literature, government websites, professional organization recommendations, expert opinion from relevant stakeholders, and collaboration with my site mentor, a psychiatrist with expertise in infant and early childhood mental health. The needs assessment aimed to identify gaps and opportunities within the current mental health services for infants and young children, focusing on the potential contributions of occupational therapy.

Practice Guide for Novel Infant and Early Childhood Mental Health Clinic

The literature review findings and needs assessment results were integrated to develop a practice guide tailored to the unique needs of the infant and early childhood mental health clinic. Drawing from the literature, the practice guide recognized the potential impact of adversity and toxic stress on children's behavioral and emotional challenges, developmental delays, sensory processing difficulties, and deficits in executive function. Additionally, the importance of considering both the caregiver and child as clients in the clinic was emphasized, acknowledging the influential role of the parent-child relationship on infant behavioral and emotional regulation. The practice guide was designed to provide knowledge and structure for delivering evidence-based infant and early childhood mental health services and interdisciplinary collaboration, emphasizing occupational therapy assessment and intervention. This is needed to provide occupational therapists and members of the multidisciplinary team with knowledge of the role and scope of occupational therapy within the clinic.

Service Delivery Structure

Because approximately 40 percent of children in Georgia rely on Medicaid or CHIP for healthcare coverage, as well as the 90% of patients are insured by Medicaid receiving care at Children’s at Hughes Spalding, it became evident, following a thorough needs assessment, that there was a pressing need to establish financially accessible services that could leverage Medicaid and grant funding (Constantino, 2024; the Georgia IECMH Taskforce’s Policy and Finance Workgroup, 2022). Subsequently, a service delivery structure for occupational therapy services within the novel clinic was developed, drawing upon current legislative policies regarding Medicaid in Georgia. Careful consideration was given to the utilization of Medicaid to fund the clinic to ensure financial accessibility of the services offered within the clinic.

Chapter 4: Results

Practice Guide for Novel Infant and Early Childhood Mental Health Clinic

The product of this capstone project is a practice guide for Occupational Therapists and members of the interdisciplinary team working in the novel infant and early childhood mental health clinic. This product aims to educate occupational therapists on the role and scope of occupational therapists on the interdisciplinary team.

Introduction

The first section of the practice guide contains information regarding the importance of occupational therapy within infant and early childhood mental health and an overview of the interdisciplinary infant and early childhood mental health clinic. This section provides context regarding the population served at the clinic, the needs of this population, and the mission of this clinic.

Patient Population

The Hughes Spalding Hospital serves approximately 3,000 children between ages 0-3, 6,000 ages 0-6, and 1,000 new babies per year in the Hughes Spalding primary care practice, which serves as a medical home for children ages 0-18 (Constantino, 2024). The novel interdisciplinary infant and early childhood mental health clinic targets children aged 0-5 years and their families receiving primary care services at the Hughes Spalding.

Interdisciplinary Collaboration

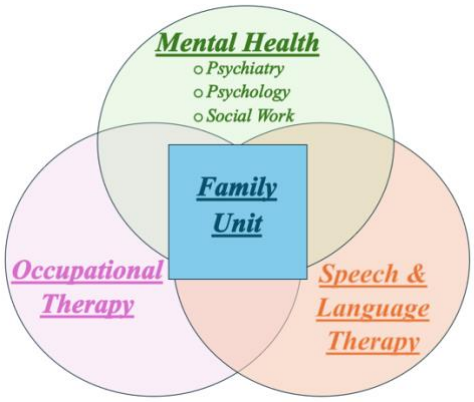
The second section of the practice guide delineates the roles of different disciplines within the clinic throughout the assessment and intervention process, emphasizing effective collaboration. This section also identifies when case conferences and team meetings occur and revolve around the importance of family-centered goals and intervention planning.

Interdisciplinary Team Model

The following disciplines will be members of the team: speech and language pathologists, occupational therapists, and mental health care providers. Team members intentionally coordinate evaluations and intervention approaches to avoid service duplication, reinforce the other specialties' intervention goals, and reduce care fragmentation (FSU Center for Prevention and Early Intervention Policy, 2016a). Each discipline will conduct evaluations and interventions separately according to the individual discipline's expertise. Still, goal setting and treatment planning involve interdisciplinary collaboration and family input (FSU Center for Prevention and Early Intervention Policy, 2016a). Collaboration among disciplines is essential to provide comprehensive care that addresses the complex mental health needs of young children and their families. Figure 1 visually depicts the interdisciplinary team model implemented within the clinic. Each discipline is portrayed with equal size and importance, symbolizing the team members' differing expertise and perspectives. At the center lies the family, where all three disciplines overlap and intersect, representing the collaboration of all three disciplines and the family to get a complete picture of the child's social-emotional health and well-being.

Figure 1

Infant and Early Childhood Mental Health Interdisciplinary Team



The Role of Occupational Therapy within the Interdisciplinary Team

The occupational therapist's scope of practice includes supporting infants and young children's development and participation in daily activities and occupations, including play and self-care (FSU Center for Prevention and Early Intervention Policy, 2016b; Orton et al., 2018). The occupational therapist provides specific assessment and intervention related to fine and gross motor function, sensory processing, activities of daily living, and play development (Orton et al., 2018). The occupational therapist will provide screenings and evaluations to determine eligibility for occupational therapy services, determine occupational therapy goals, and provide relevant referrals (FSU Center for Prevention and Early Intervention Policy, 2016b).

Team Meetings and Case Conferences

In the novel infant and early childhood mental health clinic, collaboration among team members is ongoing, emphasizing the importance of communication for goal development, treatment planning, problem-solving, and progress monitoring (FSU Center for Prevention and Early Intervention Policy, 2016a). Utilizing team meetings and case conferences serves as a method to ensure collaboration with both team members and the family. Team meetings involve each team member coming together to discuss goals and treatment planning after each discipline conducts separate evaluations and re-evaluations. Similarly, case conferences involving two or more interdisciplinary team members and the family focus on treatment planning, progress, and goals.

Family-centered care is central to successful early intervention approaches in infant mental health, where the family actively participates in all aspects of service delivery (FSU Center for Prevention and Early Intervention Policy, 2016a). A collaborative team recognizes the child within the context of their family, allowing the family's needs and priorities to guide

service provision (FSU Center for Prevention and Early Intervention Policy, 2016a). Outcomes are identified regarding family functioning, the parent-child relationship, and the family's capacity to support the child's development (FSU Center for Prevention and Early Intervention Policy, 2016a). As intervention outcomes are achieved, the team must adapt to meet evolving needs (FSU Center for Prevention and Early Intervention Policy, 2016a).

Interdisciplinary Evaluation Process

Collaborating with my site mentor, we devised a novel evaluation process for the infant and early childhood mental health clinic. This process integrates occupational therapy, speech and language therapy, and mental health evaluations over three appointments within three weeks. We aimed to utilize the expertise of all three disciplines to create a holistic assessment of the child's social-emotional health, functional performance, and the parent-child relationship. We prioritized efficiency in the evaluation process to minimize appointment duration and enhance accessibility for families seeking care.

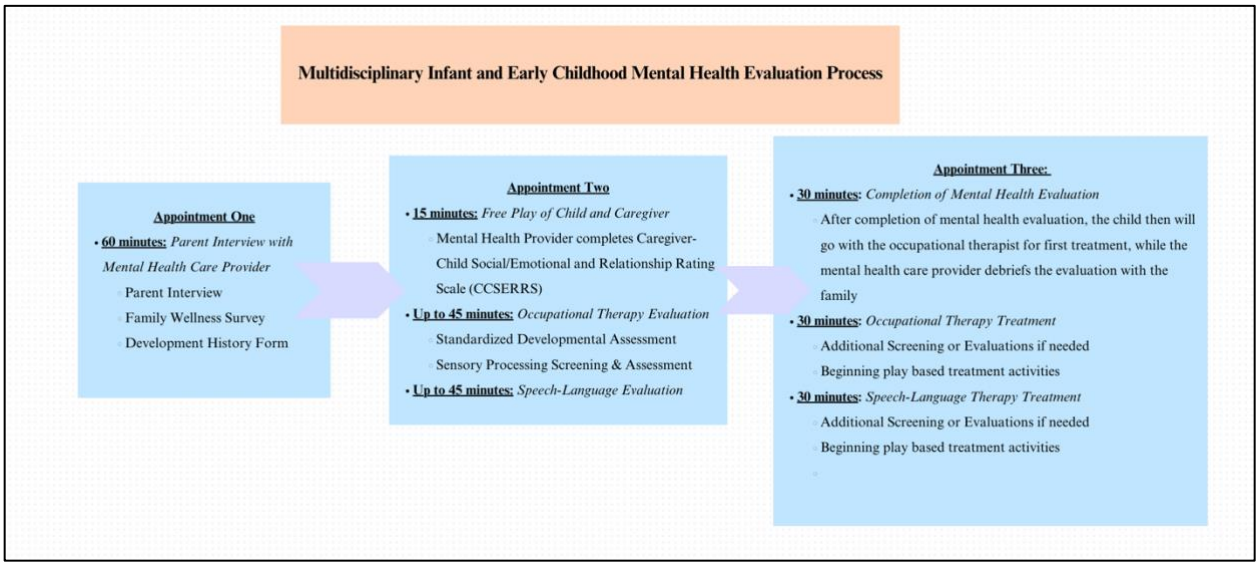
Pediatricians within the Hughes Spalding primary care clinic will serve as the primary referral source, screening families for various factors, including Adverse Childhood Experiences (ACEs), developmental delay, and relational challenges, to identify young children and families needing mental health services. Pediatrician referrals are necessary for Medicaid coverage of the initial occupational therapy, speech and language therapy, and mental health evaluations (Amerigroup Member Services, 2021; Peach State Health Plan, 2021).

The evaluation process unfolds across three appointments over three weeks. The initial appointment, conducted by the mental health care provider, consists of a parent interview to assess family concerns, the parent-child relationship, family and child social-emotional wellness, and developmental history. The second appointment consists of a free play session to observe

caregiver-child interactions and conduct evaluations by occupational therapists and speech-language pathologists. During the first part of the appointment, the child and the caregiver will engage in free play. At the same time, the mental health care provider completes the Caregiver-Child Social/Emotional and Relationship Rating Scale (CCSERRS), and the occupational therapist completes sensory processing observations (Lynch et al., 2021). The second portion of this appointment will transition to an occupational therapy evaluation. First, the occupational therapist will complete a standardized developmental assessment. Examples of assessments used are Peabody Developmental Motor Scales–Third Edition (PDMS-3), Beery-Buktenica Developmental Test of Visual-Motor Integration (Beery VMI), and the Bayley Scales of Infant and Toddler Development (BSID) (Lynch et al., 2021). Then, the occupational therapist will complete screening and assessment of a child's sensory processing. Examples of assessments used are the Sensory Processing Measure, Second Edition (SPM-2), and the Sensory Profile 2 (Lynch et al., 2021). The final portion of the second appointment will be a speech-language evaluation completed by the speech-language pathologist. The final appointment in the evaluation process will begin with the mental health care provider completing the mental health evaluation. After completion of the mental health evaluation, the child then goes to the first occupational treatment to begin play-based treatment activities. At the same time, the mental health care provider debriefs the evaluation with the family. The child will attend their first speech-language treatment after the first occupational therapy treatment.

Figure 2

Interdisciplinary Infant and Early Childhood Mental Health Evaluation Process



Note. This flowchart depicts the interdisciplinary collaboration and sequencing of the proposed evaluation process.

Occupational Therapy Assessment and Evaluation

The third section of the practice guide explores different standardized assessments and evaluation tools for occupational therapists to use during evaluations within an infant and early childhood mental health setting. Assessment tools, including occupational profiles, clinical observations, and standardized measures, are tailored to individual cases, considering specific clinical reasoning and contextual factors (Lynch et al., 2021).

Conducting Trauma Informed Evaluations

The Substance Abuse and Mental Health Services Administration (SAMHSA) principles of trauma-informed practice serve as a valuable framework for integrating trauma-informed assessment and interventions within the infant and early childhood mental health clinic (Lynch et al., 2021; Substance Abuse and Mental Health Services Administration, 2014). The chart below

demonstrates how SAMHSA's principles can be modified to complete trauma-informed occupational therapy evaluations in an infant and early childhood mental health setting.

Figure 3

SAMSHA's Principles Modified for Trauma-Informed Occupational Therapy Evaluations in an Infant and Early Childhood Mental Health Setting

SAMHSA Principle	Evaluation Considerations	Examples
Safety	Throughout the evaluation process, the clinician, the child, and the family feel physically and psychologically safe. The occupational therapy practitioner makes efforts to establish the child and family's physical and psychological safety. This involves attentiveness to physical safety in various settings such as homes, schools, and childcare facilities. The practitioner demonstrates an understanding of the child and family's inherent worth and a willingness to adapt practices to be more inclusive	▪ Ensure the evaluation environment is kid-friendly and safe for the child and caregiver. ▪ Review and revise forms for inclusivity and clarity. ▪ Offer breaks if the child or caregiver feels uncomfortable, with a reminder that they can request breaks or skip questions. ▪ Be mindful of past experiences affecting a person's sense of safety. ▪ Establish safety in initial interactions before administering standardized assessments, prioritizing felt safety over rigidity
Trustworthiness and Transparency	Evaluations and assessments are conducted with transparency, clarifying their purpose and results to build and maintain trust with the child and family. Trust is established when the occupational therapist's actions align with stated beliefs and values.	▪ Take caregivers' experiences and concerns seriously during evaluations, avoiding assumptions. ▪ Communicate expectations regarding therapy evaluation clearly to address any fears, such as separation anxiety, ensuring caregiver and child feel

		supported and informed throughout the process.
Peer Support	Peer support and mutual self-help play vital roles in establishing safety and hope, fostering trust, enhancing collaboration, and utilizing shared stories and lived experiences to promote recovery and healing.	▪ The evaluating occupational therapist refers the family to support groups and community programs to facilitate social support and community.
Collaboration and Mutuality	Importance is placed on partnering and equalizing power dynamics between the occupational therapist and the family. The occupational therapist acknowledges that healing occurs within relationships and through meaningful sharing of power and decision-making. Collaborative evaluation methods allow for integrating cultural preferences, habits, routines, rituals, and rules into goal-setting processes.	▪ Families actively participate in goal setting, and the occupational therapy practitioner validates and integrates the family's identified priorities throughout the therapy process.
Empowerment, Voice, and Choice	The occupational therapist emphasizes recognizing and building upon the child's and family's strengths and experiences throughout the evaluation process. The occupational therapist instills a belief in the resilience of the family unit and in the ability of families, children, and communities to heal from trauma. The therapist acknowledges historical power differentials and clients' potential to be	▪ Acknowledge the caregiver's expertise by stating, "You are the expert of your child," empowering them and granting autonomy in the therapeutic process. ▪ Provide opportunities for families and the child to voice priorities and preferences throughout the evaluation. For instance, families may prioritize regulation over fine

	marginalized in decision-making processes. Families and caregivers are actively supported in shared decision-making, choice, and goal-setting.	motor skills or have children choose the order of activities
Cultural, Historical, and Gender Issues	Occupational therapists actively challenge cultural stereotypes and biases across various dimensions, such as race, ethnicity, sexual orientation, age, religion, gender identity, and socio-economic status. They do so by incorporating policies, protocols, and processes sensitive to the racial, ethnic, and cultural needs of the individuals they serve while recognizing and addressing historical trauma.	▪ Trauma-informed therapists should conduct culturally respectful evaluations, incorporating recommended components related to race, ethnicity, and cultural factors. ▪ Assumptions and microaggressions should be avoided, with therapists promptly apologizing and striving to improve if they occur.

Sources. (Lynch et al., 2021; Substance Abuse and Mental Health Services Administration, 2014)

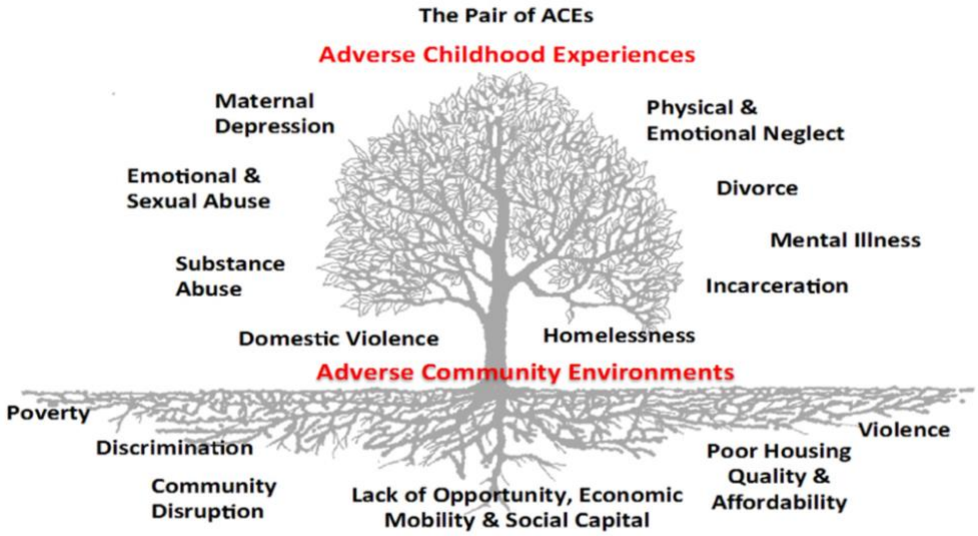
Identifying Signs and Symptoms of Childhood Toxic Stress

Trauma-informed screening and assessment practices are essential for clinicians working within infant and early childhood mental health settings working with children and families with histories of trauma and adversity (Lynch et al., 2021). By recognizing various adverse childhood experiences and adverse community environments, as well as the symptoms of adversity and toxic stress, clinicians can effectively identify needs and tailor interventions early on in the therapeutic process (Ellis et al., 2022; Lynch et al., 2021). The Pair of ACEs Tree image, developed by Ellis et al. (2022), illustrates how Adverse Childhood Experiences experienced at the individual level within the family intersect with Adverse Community Environments to impact a child's development. The leaves on the tree represent the symptoms of ACEs that can be recognized and screened for in school and clinical settings (Ellis et al., 2022). The image

underscores the impact of systemic inequities on child development and community well-being, emphasizing the necessity for interventions that address a child's individual and community experiences (Ellis et al., 2022). See Figure 4 for a depiction of the Pair of ACEs Tree.

Figure 4

Pair Of ACEs Tree



Ellis, W., Dietz, W.H., Chen, K.D. (2022). Community Resilience: A Dynamic Model for Public Health 3.0. Journal of Public Health Management and Practice, (28)1, S18-S26. doi: 10.1097/PHH.0000000000001413

Identifying signs and symptoms of childhood toxic stress is an important aspect of occupational therapy evaluation in an infant and early childhood mental health clinic. Due to their limited language abilities, babies and toddlers often express emotions such as confusion, fear, or worry through observable behaviors (Lynch et al., 2021; Parlakian, 2012). The chart below outlines some of the most common behaviors seen in children who have had traumatic experiences. Recognizing these cues enables caregivers and providers to understand the child's emotional state and potential exposure to toxic stress (Lynch et al., 2021; Parlakian, 2012). Through attunement to these behavioral indicators, caregivers and professionals can proactively

address the underlying stressors and provide appropriate support and interventions to promote the child's resilience and well-being (Lynch et al., 2021; Parlakian, 2012).

Figure 4

Common Behavioral Expressions of Trauma in Young Children

Common Behavioral Expressions of Trauma in Young Children
• Increased clinginess and unusual difficulty separating from caregiver • Decreased frustration tolerance • Increased crying and the child is more difficult to comfort and console • Child appears more withdrawn, quiet, or indifferent and harder to engage in play and interactions • Child appears less happy and may seem to have a flat expression. Babies may have a worried or hyper-alert expression • Increased aggressive behavior • Changes in sleeping, eating, and toileting patterns • A return to behaviors typically considered young for their age, for example • Acting out stressful events in play

Sources. (Lynch et al., 2021; Parlakian, 2012)

A young child's behavioral expressions of stress should be viewed as expressions of need. Clinicians should consider what the child needs or is communicating, how the family or caregiver experiences the child's behavior, and how the occupations of both the child and the caregiver affect the child's behavioral expressions of trauma (Lynch et al., 2021; Parlakian, 2012).

Creating an Occupational Profile

The "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition" (2020) states that every evaluation should include an occupational profile. An occupational profile provides a comprehensive summary of the child and family's occupational history and experiences, patterns of daily living, interests, values, needs, and relevant contexts ("Improve Your Documentation and Quality of Care With AOTA's Updated Occupational Profile Template," 2021; "Occupational Therapy Practice Framework: Domain and Process—Fourth

Edition," 2020). Within an infant and early childhood mental health setting, family members or caregivers are relied upon as the primary source for gathering information (FSU Center for Prevention and Early Intervention Policy, 2016b). Typically compiled during a formal parent interview, the occupational profile is further enriched through casual conversations and observations during interactions between the parent and occupational therapist with the child (FSU Center for Prevention and Early Intervention Policy, 2016b). The occupational profile gathers qualitative information about the child and family's strengths, needs, and current concerns (FSU Center for Prevention and Early Intervention Policy, 2016b; "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020). It summarizes the child's and family's routines or patterns of daily living while also addressing any past experiences to add context to the child and family concerns and challenges (FSU Center for Prevention and Early Intervention Policy, 2016b; "Occupational Therapy Practice Framework: Domain and Process—Fourth Edition," 2020).

Occupational Therapy Assessments

Children who have experienced early adversity are at an increased risk for developmental challenges, including delays in motor coordination, sensory processing issues, executive functioning deficits, and other mental health needs (Lynch et al., 2021; Nelson et al., 2020; Zeanah, 2018). Standardized tools can provide valuable insights into a client's strengths and needs within specific skill areas. See Figure 5 for a chart listing common standardized assessments utilized within an infant and early childhood mental health setting.

Figure 5

Common Standardized Occupational Therapy Assessments Used Within Infant and Early Childhood Mental Health Settings

Developmental	Sensory Processing	Visual Perceptual/ Visual Motor	Regulation	Parental Stress
Peabody Developmental Motor Scales, Third Edition	Sensory Processing Measure	Beery-Buktenica Developmental Test of Visual-Motor Integration (VMI-6)	Comprehensive Assessment of Interoceptive Awareness	Parental Stress Index
Bayley Scales of Infant and Toddler Development, Fourth Edition	Sensory Profile 2		Behavior Rating Inventory of Executive Function	

Sources. (Lehr et al., 2023; Lynch et al., 2021; Skuthan & Stav, 2023)

Occupational Therapy Interventions

The fourth section of the practice guide, Occupational Therapy Interventions, discusses utilizing evidence-based practice within treatment sessions.

Role and Scope of Occupational Therapy Intervention within Infant and Early Childhood Mental Health

Within the novel interdisciplinary infant and early childhood mental health clinic, the occupational therapist will conduct interventions to support young children's development and participation in daily activities, encompassing play, activities of daily living, fine and gross motor function, and sensory processing (FSU Center for Prevention and Early Intervention Policy, 2016b; Orton et al., 2018). Within the interdisciplinary team, the mental health provider

focuses on directly treating trauma and addressing parent-child attachment styles. Meanwhile, the occupational therapist concentrates on interventions and education to alleviate trauma's impact on activities, school readiness, performance, and social participation (Gronski et al., 2013). Occupational therapy practitioners provide interventions at multiple levels: by building a child and family's capacity, identifying and intervening with those at risk for toxic stress, partnering with community agencies to support families, collaboratively promoting new program development, and expanding the capacity of existing programs to serve unmet needs, and by advocating for policy changes (Gronski et al., 2013).

Parent Coaching

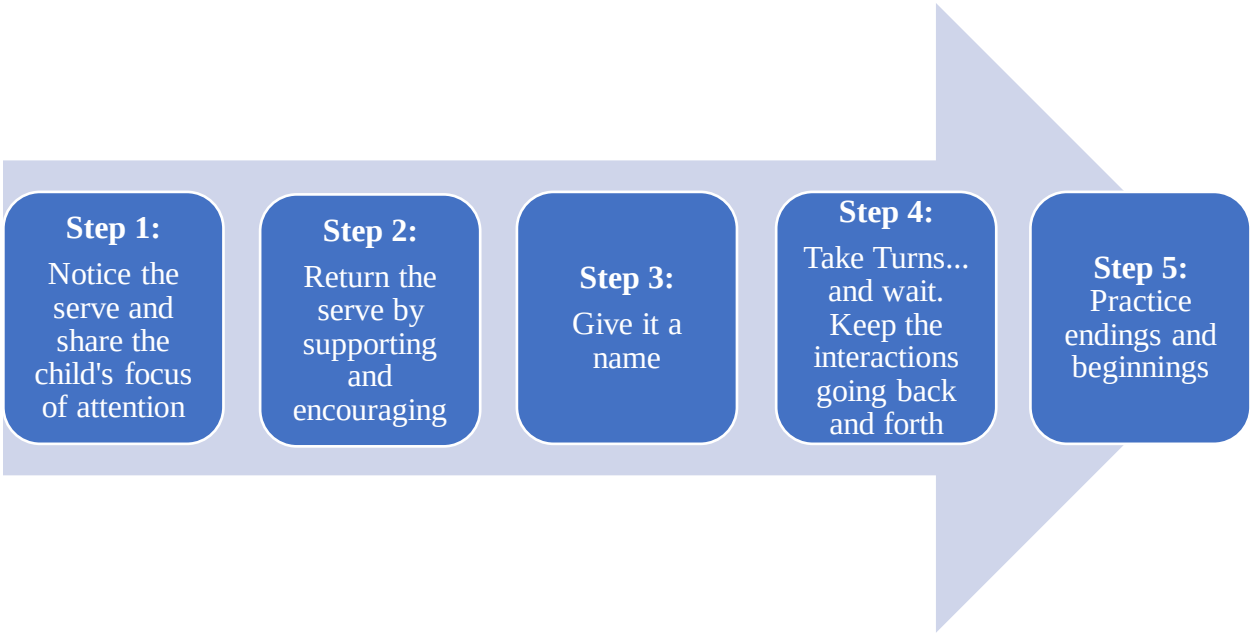
Understanding the profound impact of the parent-infant relationship is crucial for occupational therapy interventions to improve infant and early childhood mental health. The parent-child relationship profoundly influences the child's behavioral and emotional regulation, shaping their development in subsequent stages (Hare et al., 2023). Attachment between infants and caregivers is paramount for healthy childhood development, ensuring the child feels safe and secure (Clinton et al., 2016; Hare et al., 2023). Supportive family relationships mitigate the impact of toxic stress on children, safeguarding their developing brains from harm and positively influencing neural structures and overall physical and mental health outcomes (Clinton et al., 2016; Nelson et al., 2020).

Occupational therapists can educate parents on mutually rewarding “serve and return” interactions between babies and the adults caring for them to facilitate cognitive, social, and emotional development (Center on the Developing Child, 2024; National Scientific Council on the Developing Child, 2012). Young children naturally reach out or “serve” for connection through babbling, facial expressions, gestures, and words, and adults respond or “return” with

the same kind of vocalizing and gesturing back (Center on the Developing Child, 2024; National Scientific Council on the Developing Child, 2012). This “serve and return” behavior continues back and forth, similar to a game of tennis or volleyball (Center on the Developing Child, 2024; National Scientific Council on the Developing Child, 2012). By guiding parents in serve and return interactions, occupational therapists can empower the parents to enhance their child's development and foster a sense of value and competency in their caregiver role (Center on the Developing Child, 2024). See Figure 6 and Figure 7 for the five steps for brain-building serve and return interactions.

Figure 6

Five Steps for Serve and Return Interactions



Source. (Center on the Developing Child, 2024)

Figure 7

Serve and Return Interactions Within Occupational Therapy Practice

5 Steps of Serve and Return Interactions	Definition	Practical Example
Step 1: *Notice the serve and share the child's focus of attention*	Recognize the child's cues: Are they looking, pointing, making sounds, or moving their arms and legs? These actions signify a "serve." By observing serves, you gain insights into the child's abilities, interests, and needs, fostering exploration and strengthening the bond between you and the child.	The child looks and points to car toys within the therapy gym
Step 2: *Return the serve by supporting and encouraging*	Acknowledge their actions with sounds or facial expressions, such as saying "I see!" or smiling and nodding. Responding to their cues reinforces their interests and curiosity, like picking up objects they point to. This acknowledgment reassures the child that their thoughts and feelings are valued, reducing potential stress and strengthening the bond between you and the child.	The occupational therapist looks and smiles at the child and walks over to the car toys.
Step 3: *Give it a name*	Responding to a child's actions or emotions with verbal acknowledgment helps build crucial language connections in their brain from an early age. This naming process, identifying objects, actions, or feelings, aids in the child's understanding of their surroundings and fosters language	The occupational therapist responds, “Yes, those are cars. Let’s play with the cars.”

	development. This practice not only helps children grasp the world around them and anticipate what to expect but also equips them with vocabulary and communicates your care and attention	
Step 4: *Take Turns... and wait. Keep the interactions going back and forth*	Encourage turn-taking by giving the child opportunities to respond after you return a serve. Turns can be brief or extended, depending on the situation. Patience is key. Children require time to process and formulate responses, and waiting facilitates ongoing interaction. Turn-taking fosters self-control and social skills in children. Waiting allows them to develop their thoughts, confidence, and independence. It also aids in understanding their needs.	The occupational therapist waits for the child to respond. The child takes the car and rolls the car to the therapist. The occupational therapist rolls the car back to the child, saying, “Vroom vroom.”
Step 5: *Practice endings and beginnings*	Children indicate their readiness to transition or end an activity in various ways, such as releasing a toy, picking up a new one, looking at something else, walking away, fussing, or verbalizing "All done." You will recognize these signals by aligning with the child's focus and know when they are ready for a change. Allowing children to lead in these moments supports their exploration of the world and increases opportunities for serve and return interactions.	The child puts down the car and points to a puzzle. The occupational therapist says, “Are you all done playing with the cars?”

Source. (Center on the Developing Child, 2024)

Family-centered approaches in early intervention include modeling and coaching (Fraser et al., 2019). These approaches support families through training within the child's natural contexts (Fraser et al., 2019). The clinician can facilitate a dynamic conversation with the parent, which will result in the implementation of strategic behaviors (Fraser et al., 2019). Through coaching and modeling, the OT can support the family by increasing their competence in supporting their child's development (Center on the Developing Child, 2024; Fraser et al., 2019). This modeling and coaching should also address the relationship between the parent and child (Fraser et al., 2019). The occupational therapist should be alert for signs that the parent is struggling with interactions and be supportive of the parent as they learn to respond to their child's needs (Fraser et al., 2019). During intervention with the child, the Occupational Therapist can model strategies or behaviors that can be copied by the parents (Center on the Developing Child, 2024; Fraser et al., 2019). By observing the strategies' success, the parent can add them to their repertoire of actions (Center on the Developing Child, 2024; Fraser et al., 2019).

Service Delivery Structure for Novel Infant and Early Childhood Mental Health Clinic

The second product of this capstone project is developing a service delivery structure for Occupational Therapists and members of the interdisciplinary team working in the novel infant and early childhood mental health clinic. This product aims to develop billing strategies and mechanisms for the infant mental health clinic.

Billing Strategies and Mechanisms

My site mentor and I developed billing strategies to leverage Medicaid for funding services because approximately 40 percent of children in Georgia rely on Medicaid for healthcare coverage, and Medicaid insures 90% of children receiving care at Children's at Hughes Spalding (Constantino, 2024; the Georgia IECMH Taskforce's Policy and Finance

Workgroup, 2022). Georgia Families is a statewide program designed to deliver healthcare services to members of Medicaid, PeachCare for Kids, and Planning for Healthy Babies recipients (Georgia Department of Community Health Division of Medicaid, 2024). The Georgia Families program is a partnership between the Department of Community Health and private care management organizations (CMOs) (Georgia Department of Community Health Division of Medicaid, 2024). The Department of Community Health has contracted with three CMOs to provide these services: Amerigroup Community Care, CareSource, and Peach State Health Plan (Georgia Department of Community Health Division of Medicaid, 2024). The Children's Intervention Service (CIS) program within Georgia Families covers restorative and rehabilitative services (Georgia Department of Community Health Division of Medicaid, 2024). The CIS program includes seven intervention services: audiology, nursing, nutrition by licensed dietitians, occupational therapy, physical therapy, counseling by licensed clinical social workers, and speech-language pathology (Georgia Department of Community Health Division of Medicaid, 2024).

To bill Medicaid for services within the infant and early childhood mental health clinic, occupational therapists must enroll in the Georgia Medicaid Management Information System (GAMMIS) (Georgia Department of Community Health Division of Medicaid, 2024). Individual practitioners must enroll and submit their professional licenses, ensuring they have met continuing education requirements (Georgia Department of Community Health Division of Medicaid, 2024). Within the infant and early childhood mental health clinic, each provider intending to bill for services must enroll separately and bill for services directly provided under their provider number (Georgia Department of Community Health Division of Medicaid, 2024).

Occupational therapists billing for services under the CIS program must document and justify medical necessity for service delivery (Georgia Department of Community Health Division of Medicaid, 2024). Documentation of medical diagnosis, a Letter of Medical Necessity, a Plan of Care, and progress notes from the provider are needed to support this justification (Georgia Department of Community Health Division of Medicaid, 2024). The Plan of Care and the Letter of Medical Necessity can be merged into a single document containing all required elements (Georgia Department of Community Health Division of Medicaid, 2024). The primary care physician must review and approve this document by signing it or providing an electronic signature prior(Georgia Department of Community Health Division of Medicaid, 2024).

Before beginning services, a family must receive an occupational therapy evaluation referral from their primary care physician (Georgia Department of Community Health Division of Medicaid, 2024). Following the evaluation, the evaluating occupational therapist must complete and submit the necessary paperwork within 24 hours for pre-authorization and to justify the medical necessity of occupational therapy services before beginning treatment (Georgia Department of Community Health Division of Medicaid, 2024). Once submitted, if Medicaid approves that occupational therapy services are needed and medically necessary, Medicaid will provide a pre-authorization (PA) for services, which is good for up to 180 calendar days (Georgia Department of Community Health Division of Medicaid, 2024). See Figure 9 for the description of the plan of care components.

Figure 9

Components of Plan of Care for Occupational Therapy Services For Medicaid Preauthorization

Components of the Occupational Therapy Plan of Care for Medicaid Prior Authorization	Member's name and member ID number
	Date of birth
	Diagnosis and/or condition requiring treatment
	Modalities
	Description of services requested
	Evaluation and date the evaluation was conducted
	Plan of care start and end dates with the frequency and duration of services
	Location of service provision
	Team members that are treating the patient
	Current level of function
	Child's progress
	Functional outcome: rehabilitation potential and long term goals of therapy
	Treatment goals with time line to reach goals
	Relevant medical information

Source. (Georgia Department of Community Health Division of Medicaid, 2024)

Under the Children's Intervention Services program, the service limit for occupational therapy services is eight monthly units (Georgia Department of Community Health Division of Medicaid, 2024). See Figure 10 for billable procedure codes for occupational therapy services under CIS. Once exhausted, additional units need pre-authorization for reimbursement (Georgia

Department of Community Health Division of Medicaid, 2024). Subsequent claims after completing the eighth unit will be denied unless pre-authorized (Georgia Department of Community Health Division of Medicaid, 2024).

Figure 10

Procedure Codes to Bill for Occupational Therapy Under Children's Intervention Services

CPT CODE	***Maximum Allowable:***	***Service Limits***
97167 Occupational therapy evaluation, high complexity	$67.21	1 per year
97166 Occupational therapy evaluation, moderate complexity	$67.21	1 per year
97165 Occupational therapy evaluation, low complexity	$67.21	1 per year
97168 Occupational therapy re-evaluation	$44.40	1 every 180 days
96112 Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/or executive functions by standardized developmental instruments when performed) by physician or other qualified health care professional, with interpretation and report, first hour	$110.42	2 units per calendar year
96113 Each additional 30 minutes (List separately in addition to code for primary procedure.)	$50.48	2 units per calendar year
97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	$28.23	8 units per calendar month or combination of 8 units per calendar month
97535 Self-care/home management training (e.g., activities of daily living [ADLs] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment), direct one-on-one contact, each 15 minutes	$28.23	8 units per calendar month or combination of 8 units per calendar month
97550 Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving,	$44.05	

safety practices) (without the patient present), face to face; initial 30 minutes		
97551 Each additional 15 minutes (List separately in addition to code for primary service)	$21.86	
97552 Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [ADLs], instrumental ADLs [IADLs], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	$18.55	

Source. (Georgia Department of Community Health Division of Medicaid, 2024)

Chapter 5: Discussion and Impact

The discussion section of this capstone project delves into the pressing pediatric mental health crisis in Georgia, particularly focusing on the significant number of children requiring mental health services, especially those aged 0-6 years (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). The impact of toxic stress, trauma, and adverse childhood experiences (ACEs) on children's developing brains is well-documented, often resulting in behavioral, emotional, and developmental challenges (National Scientific Council on the Developing Child, 2005/2014; Nelson et al., 2020). Despite the well-documented efficacy of early interventions in mitigating these effects and fostering resilience, there exists a notable gap in understanding the role of occupational therapy in addressing ACEs and toxic stress during childhood (Kingsley et al., 2020; National Scientific Council on the Developing Child, 2005/2014). This project sought to bridge this gap by investigating the role of occupational therapy in delivering trauma-informed assessments and interventions to young children and their families facing social-emotional and relational challenges. I developed a roadmap to integrate occupational therapy services within an interdisciplinary team while identifying feasible billing strategies and funding sources for establishing and delivering these services within the novel infant and early childhood mental health clinic. This project lays the foundation for a tailored mental health service specifically catering to the needs of Georgia's infant and early childhood population served within Hughes Spalding's Primary Care Clinic.

My site mentor and I were dedicated to developing evidence-based, trauma-informed, and culturally responsive infant mental health services infant and early childhood mental health services. By fostering collaboration among various healthcare professionals, including child psychiatrists, occupational therapists, and speech and language pathologists, the novel clinic

aims to streamline care delivery and minimize fragmentation, thereby enhancing provider communication and collaboration. This collaborative approach is essential in ensuring that children with mental health concerns are identified early and receive the holistic support they need to thrive. Integrated and multi-disciplinary services are crucial for creating a sustainable infrastructure for Georgia's infant and early childhood mental health care to fund, coordinate, and deliver services (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). Coordination and communication among caregivers, early childhood educators, pediatricians, and behavioral healthcare providers are paramount to streamline access to care and ensure that children with mental health concerns receive the support they need to thrive and grow (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023).

The development of the roadmap not only created opportunities for other occupational therapy capstone students and providers to implement similar strategies but also paved the way for future data collection and research to elucidate further the role of occupational therapy within infant early childhood mental health. Despite being in the early stages of development, the clinic aspires to be a leading force in early intervention infant and early childhood mental health services, ultimately ensuring that every infant and family receives the necessary care and support for optimal social well-being.

Various barriers and challenges exist in accessing pediatric mental healthcare in Georgia, including financial inaccessibility and workforce shortages. Financial constraints pose a significant obstacle to accessing pediatric mental health services, particularly for low-income families (Centers for Disease Control and Prevention, 2023a; IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). Approximately 40 percent of all children in Georgia receive healthcare coverage through Medicaid or the Children’s Health Insurance Program, yet

disparities in reimbursement rates often fail to cover the true cost of care (Constantino, 2023; Eldridge, 2022; Georgia Mental Health Policy Partnership, 2022; the Georgia IECMH Taskforce's Policy and Finance Workgroup, 2022). This financial strain is exacerbated by the prohibitively high costs of quality pediatric mental healthcare, leading many providers to bear the financial burden or opt out of accepting insurance altogether (Constantino, 2023; Eldridge, 2022; Georgia Mental Health Policy Partnership, 2022). Inadequate provider networks also contribute to the accessibility challenges in pediatric mental healthcare, as insufficient behavioral healthcare providers participating in insurance networks create barriers to accessing care (Constantino, 2023; Eldridge, 2022; Georgia Mental Health Policy Partnership, 2022). This shortage underscores the importance of developing new pediatric mental healthcare services that are financially accessible and equipping occupational therapists to address the social-emotional and behavioral healthcare needs of children and their families. Developing a streamlined road map for providers on delivering and billing holistic, interdisciplinary infant mental health services aims to increase the ability of early childhood mental health care providers to utilize Medicaid for funding their services, ensuring that our families in Georgia can afford early childhood mental health services.

The financial impact of untreated trauma cannot be overstated, with costs borne by state systems and private sector life (IECMH State Issue Brief #1, 2021; ZERO TO THREE, n.d.). Recognizing the significance of investing in infant and early childhood mental health programs, funding allocations can yield substantial returns, with each dollar invested shown to prevent $3.64 in treatments later in life (IECMH State Issue Brief #1, 2021; ZERO TO THREE, n.d.). The financial impact of untreated trauma is highlighted, emphasizing the importance of investing in infant and early childhood mental health programs as a solid investment.

This capstone project highlights the urgent need for innovative solutions to address the pediatric mental health crisis in Georgia, especially among children aged 0-6 years. By exploring the role of occupational therapy in delivering trauma-informed care, the project has laid the foundation for integrating holistic mental health services within an interdisciplinary framework. Investing in infant and early childhood mental health programs is essential despite financial constraints and workforce shortages. Through collaboration, innovation, and advocacy, the interdisciplinary clinic aims to provide evidence-based care and advance the field of infant and early childhood mental health, ensuring optimal support for every child and family.

Limitations

While this capstone project aims to make significant contributions to integrating occupational therapy services within infant and early childhood mental health, some limitations may impact the generalizability and scope of the project. The findings and recommendations of this capstone project may not be universally applicable to all infant and early childhood mental health clinics. Regional variations in healthcare infrastructure, cultural differences, and clinic-specific policies may limit the generalizability of the developed occupational therapy practice guide and service delivery structure. The project's recommendations, particularly those related to clinic financial funding, are based on general estimations. The actual financial feasibility and resource availability may vary based on the specific circumstances of the infant and early childhood mental health clinic and the availability of funding sources. The 14-week capstone timeline constraints the project's implementation. Long-term impact assessment or the real-world testing of the developed practice guide requires a longer duration for comprehensive evaluation.

Healthcare policies, including Medicaid funding and insurance reimbursement, are subject to change. The project's recommendations may be influenced by policy shifts, potentially impacting the feasibility and sustainability of the developed service delivery structure. Lastly, Stakeholders' opinions and expert inputs may be subject to bias or limited perspectives based on individual experiences. Efforts were made to include diverse stakeholders; however, inherent biases or perspectives may influence the project's outcomes.

Despite these limitations, this capstone project is a valuable foundation for future research and implementation efforts. Recognizing these constraints allows for a more nuanced interpretation of the results and provides insights into potential areas for refinement and improvement in future initiatives. The capstone project's success will depend on ongoing

collaboration, adaptability, and a commitment to addressing emerging challenges in the evolving landscape of infant and early childhood mental health services.

Sustainability Plan

Due to the limited 14-week timeframe of the capstone experience, program materials were designed to pave the way for the implementation of occupational therapy services within the novel interdisciplinary infant and early childhood mental health clinic. Despite completion of the capstone project experience, it is noteworthy that the interdisciplinary clinic remains in its early planning stages and has yet to see patients or begin staff recruitment. Throughout this capstone's development and planning phases, careful consideration was dedicated to ensuring the sustained viability of this project and the integration of occupational therapy within the clinic. While this project primarily focused on exploring the role and scope of occupational therapy within the clinic, exploring the roles of speech and language pathology and mental healthcare providers within infant and early childhood mental health was not exhaustive. However, both disciplines were intentionally incorporated into the program guide and service delivery structure, underscoring the equality and significance of all disciplines involved. As the clinic progresses through the hiring process and ongoing planning, deliberate efforts will be made to recruit speech and language pathologists and mental health care providers who will further explore the respective roles and scopes within the clinic.

The continuous demand for collaborative services and the evolution of infant and early childhood mental health programs present opportunities for clinical research and scholarly projects to perpetuate this endeavor. To ensure the inclusion of occupational therapy services within the novel clinic, the clinic's leadership will formulate job descriptions to hire an occupational therapist dedicated to delivering services within the clinic as outlined by the program guide. By developing comprehensive job descriptions for new hires, the clinic

establishes clarity in roles and responsibilities, bolstering the sustainability and efficacy of its infant and early childhood mental health care services.

The innovative evaluation process, service delivery structures, and program guide meticulously outline evaluation and intervention procedures and billing strategies, facilitating seamless implementation in the ongoing development of the clinic post-capstone project completion. Moreover, there exist abundant opportunities for future occupational therapy capstone students to carry forward this work and advance the dissemination of occupational therapy's role within infant and early childhood mental health.

Conclusion

In conclusion, this capstone project addresses a critical gap in providing mental health services for young children and their families in Georgia (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023). With a substantial portion of the population in need of support, particularly concerning the effects of toxic stress, trauma, and ACEs, there exists an urgent call for comprehensive and interdisciplinary approaches to infant and early childhood mental health care (IECMH State Issue Brief #1, 2021; IECMH State Issue Brief #2, 2023; National Scientific Council on the Developing Child, 2005/2014, 2020). Despite the proven effectiveness of interventions conducted before age 3 in mitigating the impact of such challenges on a child's developing brain, the role of occupational therapy in this context has been largely overlooked (Center on the Developing Child at Harvard University, 2021; Kingsley et al., 2020).

This capstone project seeks to address the knowledge gap of occupational therapy's role in early childhood and infant mental health by laying the groundwork for integrating occupational therapy services within an interdisciplinary infant and early childhood mental health clinic. Through the development of a literature review, needs assessment, innovative evaluation processes, and the development of sustainable service delivery structures, this endeavor aims to address the critical mental health needs of young children and their families in Georgia. Collaborative efforts with stakeholders have been instrumental in shaping the project's direction, ensuring alignment with the clinic's mission and goals of providing evidence-based, developmentally appropriate, trauma-informed, and culturally responsive infant mental health services that recognize the unique and diverse needs of each child in the context of the family unit.

By leveraging existing resources such as Medicaid coverage and grant funding and by creating educational materials to enhance clinician understanding and dissemination of occupational therapy's role, this project aims to foster the long-term sustainability and effectiveness of the clinic's services. Emphasizing collaboration and interdisciplinary teamwork underscores the importance of a holistic approach to infant and early childhood mental health care. Continuing to refine and expand upon the initiatives established in this capstone project is essential. This includes further exploration of the roles and scopes of other disciplines within the clinic, ongoing evaluation of program efficacy, and continued advocacy for integrating occupational therapy services in infant and early childhood mental health settings. By remaining committed to equity, inclusivity, and evidence-based practice, we can advance the well-being of young children and families in our communities.

This capstone project is a stepping stone toward a more comprehensive and holistic approach to infant and early childhood mental health care. By recognizing the vital role of occupational therapy in promoting the health and development of our youngest population, we take significant strides toward addressing the public health crisis of early adversity and toxic stress, ultimately supporting the healthy growth, and flourishing of children and families in Georgia.

References

Amerigroup Member Services. (2021). *Georgia Families Medicaid*. Amerigroup Corporation. https://www.myamerigroup.com/ga/your-plan/georgia-families-medicaid.html

AOTA's Societal Statement on Stress, Trauma, and Posttraumatic Stress Disorder. (2018). *The American Journal of Occupational Therapy*, *72*(Supplement_2), 7212410080p7212410081-7212410080p7212410083. https://doi.org/10.5014/ajot.2018.72S208

Aubuchon-Endsley, N. L., Gee, B. M., Devine, N., Ramsdell-Hudock, H. L., Swann-Thomsen, H., & Brumley, M. R. (2020). A Cohort Study of Relations Among Caregiver–Infant Co-Occupation and Reciprocity. *OTJR: Occupational Therapy Journal of Research*, *40*(4), 261-269. https://doi.org/10.1177/1539449220905791

Center on the Developing Child. (2007). The Science of Early Childhood Development (InBrief). Retrieved from www.developingchild.harvard.edu.

Center on the Developing Child. (2024). 5 Steps for Brain-Building Serve and Return. In. Harvard University

Center on the Developing Child at Harvard University. (2021). Three Principles to Improve Outcomes for Children and Families, 2021 Update. In.

Centers for Disease Control and Prevention. (2023a, March 8, 2023). *Data and statistics on children's mental health*.

Centers for Disease Control and Prevention. (2023b). Fast Facts: Preventing Adverse Childhood Experiences. In. U.S. Department of Health & Human Services: Centers for Disease Control and Prevention.

Clinton, J., Feller, A. F., & Williams, R. C. (2016). The importance of infant mental health. *Paediatr Child Health*, *21*(5), 239-241. https://doi.org/10.1093/pch/21.5.239

Constantino, J. N. (2023). Bridging the Divide Between Health and Mental Health: New Opportunity for Parity in Childhood. *J Am Acad Child Adolesc Psychiatry*, *62*(11), 1182-1184. https://doi.org/10.1016/j.jaac.2023.03.019

Constantino, J. N. (2024). Opening Strategy for Discovery Platform, BMH@CHOA (DRAFT 30 January 2024).

Eldridge, E. (2022). Children's Healthcare of Atlanta is opening a 10-acre mental health center, thanks to donor funds. *Georgia Public Broadcasting*. https://www.gpb.org/news/2022/11/14/childrens-healthcare-of-atlanta-opening-10-acre-mental-health-center-thanks-donor

Ellis, W., Dietz, W. H., & Chen, K.-L. D. (2022). Community Resilience: A Dynamic Model for Public Health 3.0. *Journal of Public Health Management and Practice*, *28*(Supplement 1), S18-S26. https://doi.org/10.1097/phh.0000000000001413

Fraser, K., MacKenzie, D., & Versnel, J. (2019). What is the Current State of Occupational Therapy Practice with Children and Adolescents with Complex Trauma? *Occupational Therapy in Mental Health*, *35*(4), 317-338. https://doi.org/10.1080/0164212X.2019.1652132

FSU Center for Prevention and Early Intervention Policy. (2016a). Interprofessional Teams Supporting Early Childhood Mental Health. In *Therapeutic Practitioner Brief 5*. Early Childhood Health Optimization Series.

FSU Center for Prevention and Early Intervention Policy. (2016b). Supporting Infant and Early Childhood Mental Health in Occupational Therapy. In *Therapeutic Practitioner Brief 3*. Early Childhood Health Optimization Series.

FSU Center for Prevention and Early Intervention Policy. (2016c). What is Infant Mental Health and What Does it Mean to Other Disciplines? In *Therapeutic Practitioner Brief 1*. Early Childhood Health Optimization Series.

Georgia Department of Community Health. (2022). Medicaid-funded Behavioral Health Services: Ages 0-6. In.

Georgia Department of Community Health Division of Medicaid. (2024). POLICIES AND PROCEDURES for CHILDREN'S INTERVENTION SERVICES In. GEORGIA DEPARTMENT OF COMMUNITY HEALTH DIVISION OF MEDICAID ,.

Georgia Mental Health Policy Partnership. (2022). A Unified Vision for Transforming Mental Health and Substance Use Care in Georgia In.

Gronski, M. P., Bogan, K. E., Kloeckner, J., Russell-Thomas, D., Taff, S. D., Walker, K. A., & Berg, C. (2013). Childhood Toxic Stress: A Community Role in Health Promotion for Occupational Therapists. *The American Journal of Occupational Therapy*, *67*(6), e148-e153. https://doi.org/10.5014/ajot.2013.008755

Hare, M. M., Landis, T. D., Hernandez, M. L., & Graziano, P. A. (2023). A Systematic Review of Infant Mental Health Prevention and Treatment Programs. *Evidence-Based Practice in Child and Adolescent Mental Health*, 1-24. https://doi.org/10.1080/23794925.2022.2140458

IECMH State Issue Brief #1. (2021). Prioritizing the Mental Health of Infants and Toddlers in Georgia: Why It's Important and What Comes Next. https://www.decal.ga.gov/Prek/InfantandEarlyChildhoodMentalHealth.aspx

IECMH State Issue Brief #2. (2023). *Infant and Early Childhood Mental Health: Building Georgia's System of Care*. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.decal.ga.gov/documents/attachments/DecalIssuebrief.pdf

Improve Your Documentation and Quality of Care With AOTA's Updated Occupational Profile Template. (2021). *The American Journal of Occupational Therapy*, *75*(2). https://doi.org/10.5014/ajot.2021.752001

Kingsley, K., Sagester, G., & Weaver, L. L. (2020). Interventions Supporting Mental Health and Positive Behavior in Children Ages Birth-5 Yr: A Systematic Review. *Am J Occup Ther*, *74*(2), 7402180050p7402180051-7402180050p7402180029. https://doi.org/10.5014/ajot.2020.039768

Lehr, V., Sullivan, A. F., Champagne, T., & Szklut, S. E. (2023). Trauma-Informed, Sensory-Based Pediatric OT Interventions: A Systematic Review. *The American Journal of Occupational Therapy*, *77*(Supplement_2), 7711505060p7711505061-7711505060p7711505061. https://doi.org/10.5014/ajot.2023.77S2-PO60

Lynch, A., Ashcraft, R., & Tekell, L. (2021). *Trauma, Occupation, and Participation: Foundations and Population Considerations in Occupational Therapy*. AOTA Press. https://books.google.com/books?id=JFzozgEACAAJ

Méndez Leal, A. S., Alba, L. A., Cummings, K. K., Jung, J., Waizman, Y. H., Guassi Moreira, J. F., Saragosa-Harris, N. M., Ninova, E., Waterman, J. M., Langley, A. K., Tottenham, N.,

Silvers, J. A., & Green, S. A. (2023). Sensory processing challenges as a novel link between early caregiving experiences and mental health. *Dev Psychopathol*, *35*(4), 1968-1981. https://doi.org/10.1017/s0954579422000633

National Center for Injury Prevention and Control, D. o. V. P. (2021/2023). We Can Prevent Childhood Adversity In *The Science of Adverse Childhood Experiences (ACEs) Shows We Can Improve People's Lives and Help Them Thrive*. Centers for Disease Control and Prevention.

National Scientific Council on the Developing Child. (2005/2014). Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper No. 3. Updated Edition. In.

National Scientific Council on the Developing Child. (2012). *The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain: Working Paper No. 12.* Retrieved from www.developingchild.harvard.edu.

National Scientific Council on the Developing Child. (2020). Connecting the Brain to the Rest of the Body: Early Childhood Development and Lifelong Health Are Deeply Intertwined: Working Paper No. 15. Retrieved from www.developingchild.harvard.edu

Nelson, C. A., Scott, R. D., Bhutta, Z. A., Harris, N. B., Danese, A., & Samara, M. (2020). Adversity in childhood is linked to mental and physical health throughout life. *BMJ*, *371*, m3048. https://doi.org/10.1136/bmj.m3048

O'Donnell, M., & McKinnon, S. (2022). Advocating for Change to Meet the Developmental Needs of Young Children Experiencing Homelessness. *The American Journal of Occupational Therapy*, *76*(5). https://doi.org/10.5014/ajot.2022.050114

Occupational Therapy Practice Framework: Domain and Process—Fourth Edition. (2020). *The American Journal of Occupational Therapy*, *74*(Supplement_2),

7412410010p7412410011-7412410010p7412410087. https://doi.org/10.5014/ajot.2020.74S2001

Orton, J. L., Olsen, J. E., Ong, K., Lester, R., & Spittle, A. J. (2018). NICU Graduates: The Role of the Allied Health Team in Follow-Up. *Pediatric Annals*, *47*(4), 165-171. https://doi.org/https://doi.org/10.3928/19382359-20180325-02

Parlakian, R. (2012). A Big Impact on Little Kids: Understanding How Traumatic Experiences Affect Very Young Children. In. ZERO TO THREE.

Clinical Policy: Physical, Occupational, Speech, and Feeding Therapy, (2021). https://www.pshpgeorgia.com/content/dam/centene/peachstate/pdfs/508_GA.CP.MP.49-POSF-Therapy.pdf

Skuthan, A., & Stav, W. (2023). Profile of Assessments in Pediatric Occupational Therapy Practice. *The American Journal of Occupational Therapy*, *77*(5). https://doi.org/10.5014/ajot.2023.050190

Substance Abuse and Mental Health Services Administration. (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. In (Vol. 14-4884). HHS Publication: Rockville, MD: Substance Abuse and Mental Health Services Administration, .

the Georgia IECMH Taskforce's Policy and Finance Workgroup. (2022). Billing Guide for Infant and Early Childhood Mental Health Services: Dyadic Models. In *Infant and Early Childhood Mental Health Toolkit*

Zeanah, C. H. (2018). *Handbook of Infant Mental Health*. Guilford Publications. https://books.google.com/books?id=xS5bDwAAQBAJ&lpg=PP1&ots=g2r_pXnso5&dq

=handbook%20on%20infant%20mental%20health&lr&pg=PP1#v=onepage&q=handbook%20on%20infant%20mental%20health&f=false

ZERO TO THREE. (n.d.). *Infant and Early Childhood Mental Health*. https://www.zerotothree.org/issue-areas/infant-and-early-childhood-mental-health/

Appendix 1: Learning Objectives

Learning objectives (LTGs)	Short-term objectives (STGs)	Learning activities	Outcome measures	Timeline for completion
1. Over the 14-week capstone experience, I will articulate the role of occupational therapists at a novel infant mental health clinic in delivering trauma-informed assessments and interventions within an interdisciplinary team.	1A. Complete a literature review on early intervention services for children aged 0-3 and their caregivers with a history of ACEs and identifying the role of OT with this population. 1B. Complete needs assessments for OT services at the novel infant mental health clinic 1C. Summarize results of needs assessment and literature review to create an outline for the occupational therapy	1A. Gather and review articles to conduct a literature review. 1B. Meet with relevant stakeholders and community experts in infant mental health to conduct needs assessment. 1C. Conduct interviews, observations, and questionnaires to conduct a needs assessment.	I. Complete literature review to have reviewed by site and faculty mentor. iv. Complete the final needs assessment to be reviewed by the faculty and site mentor.	Within 3 weeks of the 14-week capstone experience

	assessments and interventions in an infant mental health setting.			
2. Over the 14-week capstone experience, I will create a service delivery structure for OT services at the novel infant mental health clinic infant.	2A. Identify how to establish and bill for Occupational Therapy services at a novel clinic using grant funding, as well as patient insurance. 2B. Identify costs of standardized assessments and necessary equipment needed for occupational therapy services, 2C. Create a budget to identify funding needed to establish OT services at the novel infant	2A. Conduct interviews with relevant experts in the community on how to establish OT services at an existing clinic. 2B. Conduct a review on necessary standardized assessments and equipment for the delivery of services. 2d. Identify and explore how to bill for services through Medicaid	i. Complete an outline plan to establish OT services at the novel infant mental health clinic to have reviewed by site and faculty mentor. ii. Complete review of necessary standardized assessments and equipment to have reviewed by site and faculty mentor. iii. Complete an itemized budget to	Within 8 weeks of the 14-week capstone experience

	mental health clinic to review with faculty and site mentor.		have reviewed by the site and faculty mentor. iv. Complete review of additional funding sources by site and faculty mentor.	
3. Over the 14-week capstone experience, I will provide a program guide to articulate the role of occupational therapists at a novel infant mental health clinic to other interdisciplinary team members and occupational therapists.	3A. Develop roles and scope members of the interdisciplinary team. 3B. Develop evidence based occupational therapy evaluations within an infant mental health setting. 3C. Develop evidence based occupational therapy interventions within an infant mental health setting.	3A. Utilize existing literature and expert opinion to identify and develop the role and scope of interdisciplinary team members. 3B. Utilize existing literature and expert opinion to identify and describe occupational therapy evaluation within an infant and early	I. The site and faculty mentor will review the complete role and scope of interdisciplinary team members. ii. Complete evidence-based evaluation and intervention sections to be reviewed by the site and faculty mentor. iii. Complete educational	Completed by 14 weeks of mentored capstone experience

		childhood mental health setting. 3C. Utilize existing literature and expert opinion to identify and describe occupational therapy evaluation within an infant and early childhood mental health setting.	handouts and brochures to be reviewed by the site and faculty mentor.	

Appendix 2: Supervision Plan

The purpose of this Capstone Supervision plan is to:

(i) Articulate the roles and responsibilities of those involved in the supervisory relationship.

a. Adapted from University of Florida: Doctor of Occupational Therapy Capstone Experience & Project Manual chrome extension://efaidnbmnnnibpcajpcglclefindmkaj/https://ot.phhp.ufl.edu/wordpress/files/2020/05/OTD_Capstone_Student_Manual.pdf

b. Student Responsibilities

i. Maintaining regular contact with the site mentor and faculty mentor once assigned

ii. Completing a needs assessment and literature review before the Capstone Experience

iii. Collaborating with site and faculty mentor on individualized specific goals/objectives, evaluation, and supervision plan for Capstone Experience and Capstone Project

iv. Notifying the Capstone Coordinator and mentors of any absences or concerns about performance

v. Completing a minimum of 560 hours of Capstone Experience and time-tracking log

vi. Disseminating an individual doctoral-level Capstone Project that relates to the Capstone Experience

vii. Evaluating the site and site mentor to help continue to improve educational outcomes

c. Faculty Mentor

i. Collaborating with the Capstone Coordinator, site mentor, and student on learning objectives for the Capstone Experience

ii. Signing the MOU to demonstrate agreement with the student's individualized objectives and plan

iii. Assuring alignment with the curriculum

iv. Collaborating with the site and student

v. Providing feedback on and grading the Capstone Project

vi. Participating in the plan for supervision

vii. Collaborating with the student and capstone coordinator during Doctoral Mentorship 3 and 4 courses, providing expert content feedback on course assignments.

d. Site Mentor

i. Collaborating with student, capstone coordinator, and faculty mentor

ii. Collaborating on individualized specific objectives and plan for supervision

iii. Signing the MOU to demonstrate agreement with the student's individualized objectives and plan

iv. Providing onsite supervision and mentoring of the student (state licensure laws are applicable)

v. Providing project and experience feedback to the student based on expertise

vi. Evaluating and assessing student performance at midterm and final

vii. Verifying the student time log

e. Capstone Coordinator

i. Assuring compliance with ACOTE® D standards

ii. Obtaining contracts with all Capstone Experience sites

iii. Advising students on site selection

iv. Confirming willingness/commitment from the site

v. Obtaining/monitoring Georgia State University legal contracts for the doctoral capstone experience

vi. Training faculty mentors

vii. Tracking paperwork logistics (signatures on MOU)

viii. Signing the MOU to demonstrate agreement with the student's individualized objectives and plan

ix. Collaborating on any student issues for experience

x. Collaborating with site-on-site issues

xi. Serving as a faculty mentor as applicable

(ii) Ensure a consistent and positive learning experience by students irrespective of their location or the mode of delivery of supervision.

a. Scheduled meetings/communication method

i. Meetings scheduled weekly to take place either in-person, over the phone, or over Webex to track the progress of the capstone project

b. How to resolve possible disputes

i. Schedule a meeting to either speak in person or via phone call or Webex