581 – WORKING WITH THE BIRTH THROUGH FIVE POPULATION[1]

EFFECTIVE DATES: UPON PUBLISHING[2]

APPROVAL DATES: 02/08/24[3]

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS/CHP (CHP), and DES/DDD (DDD) Contractors. This Policy is an optional resource for Fee-For-Service programs and is not a requirement for FFS providers. This Policy is designed to strengthen the capacity of Arizona's Integrated System of Care in response to the unique needs of children aged through five. The goal of this Policy is the promotion of treatment that is targeted at best practices for infants and toddlers, that is critical to the prevention and mitigation of mental and physical disorders throughout their lifespan.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including :

ARIZONA EARLY INTERVENTION PROGRAM (AZEIP)	**CENTERS FOR DISEASE CONTROL (CDC)**	**CONTRACTOR**
DESIGNATED REPRESENTATIVE (DR)	**FOOD AND DRUG ADMINISTRATION (FDA)**	**HEALTH CARE DECISION MAKER (HCDM)**
MEMBER		

III. POLICY

The Contractor shall ensure an effective approach to promoting healthy social and emotional development that includes equal attention to the full continuum of health services including promotion, prevention, and treatment, plus improvement in system capacity for effective service delivery. Essential components of a comprehensive system include:

1. Supporting the use of evidence-based early childhood service delivery models.
2. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals.
3. Improving access to services.

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[1] AMPM Behavioral Health Practice Tool 210 and 211 are being reserved with pertinent information incorporated into the new AMPM Policy 581
[2] Date Policy is effective.
[3] Date policy is approved.

A. ESSENTIAL PROCESSES FOR ASSESSMENT, SCREENING, AND SERVICE PLANNING

The Contractor shall ensure the following best practices outlined for screening, assessment and service planning are utilized by their subcontracted network of providers.

1. Best practices in Infant and Early Childhood Behavioral Health integrate all aspects of child development such as organic factors (genetics and health) with the child's experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

2. Evaluation practices with respect to children age birth to five involve awareness on the part of the behavioral health practitioner that all children have their own individual developmental progression, affective, cognitive, language, motor, sensory and interactive patterns.

3. A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of the child's most significant relationships. This is best done over several sessions, in different settings (e.g., home, childcare, clinic), and whenever possible with all significant caregivers. In order to support a child in demonstrating the child's true capacities, screening and assessment processes are most effectively offered in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and that reflect their daily life experiences.

4. Identification of all significant caregivers and the child's relationship with each individual is a critical part of assessment practice.

B. DEVELOPMENTAL CHECKLISTS AND SCREENINGS

The Centers for Disease Control (CDC) recommends that developmental checklists are used by parents to monitor whether their children are meeting developmental milestones. The resource provided through the CDC website is Milestone Moments Checklist.

1. The Contractor shall ensure their subcontracted network of providers working with the birth to five population:
   a. Provide parents with developmental checklists and educates them about developmental milestones,
   b. Utilize developmental screenings as part of the assessment process for infants and toddlers, to establish a baseline to which subsequent screenings can be compared, and
   c. Utilize developmental screening that are evidence-based, standardized, current and specific to age ranges birth to five. AHCCCS neither endorses, recommends, nor requires any specific screening tool over another.

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2. Should there be delays in meeting standard developmental milestones, the Contractor shall ensure providers:
   a. Refer to the child’s PCP for further evaluation,
   b. For children birth to three, make a referral to Arizona Early Intervention Program (AzEIP) when warranted,
   c. For children three to five, make a referral to the public school system when warranted, and
   d. Assist families with the application process for DDD if indicated.

C. ASSESSMENT

The Contractor shall adhere to the following minimum elements in a behavioral health assessment, as specified in AMPM Policy 320-O. AMPM Policy 320-O also identifies the Early Childhood Service Intensity Instrument (ECSII) as an assessment option for this population.

1. Best practices for behavioral health assessment of children age birth to five involves:
   a. The philosophical orientation that work is done on behalf of the child, predominantly through the child’s parent or caregiver(s),
   b. Interviewing the parent/primary caregiver(s) about the child’s birth, developmental and medical histories,
   c. Direct observation of family functioning,
   d. Gaining information, through direct observation and report, about the child’s individual characteristics, language, cognition, and affective expression,
   e. Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,[i]
   f. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/learning, and to help regulate emotions,
   g. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship,
   h. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, behavioral health, parenting, legal, educational, domestic violence, military),
   i. Determining the child and family’s strengths, difficulties, risk, and protective factors,
   j. Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,
   k. Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns to the child’s competencies and difficulties, and
   l. How the service planning process will address these areas.[ii]

It is best practice that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the Diagnostic Classification of Behavioral Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-5).

AMPM Policy 310-B and AMPM Policy 320-O provide additional information on the types of behavioral health providers that may conduct assessments.

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There are multiple evidence-based assessment tools that can provide additional information when assessing developmental, behavioral, emotional, and social concerns, trauma, and attachment. AHCCCS neither endorses, recommends, nor requires any specific tool over another; providers shall use assessment tools as clinically indicated. Refer to Attachment C for an example of an assessment tool for gathering initial information when working with children aged birth to five.

D. SERVICE PLANNING – USE OF CFT PRACTICE

The early development of an engaged relationship with the child, parent/caregiver, and family as part of the CFT process, is required practice when working with children age birth to five. The Contractor shall ensure the use of CFT practice with children and families. Refer to AMPM Policy 580 Child and Family Team Practice for additional information on the specific components and the required service expectations of this practice model.

While a comprehensive and accurate assessment forms the foundation for effective service planning and is required before a service plan can be fully developed, The Contractor shall ensure that needed services are not be delayed.

1. The Contractor shall ensure:
   a. All service plan development with children age birth to five is completed collaboratively with the child's parent or primary caregiver,
   b. Development and prioritization of service plan goals are not focused solely on the child,
   c. Service planning includes the parent, caregiver, and the needs of the family as a whole,
   d. Due rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives,
   e. At the time of the Annual Update, the service plan shall be modified to align with the needs identified in the updated assessment. Refer to AMPM Policy 320-O for further information on the minimum elements for assessments, service plans, and required timeframes for completion,
   f. The use of all service settings, the full array of covered services, and skilled, experienced providers are to be considered as identified by the Child and Family Team during the service planning process, and
   g. Service planning that includes the use of Support and Rehabilitative Services is often an essential part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community (refer to AMPM Policy 582).

2. For children that are under the custody of Arizona Department of Child Safety (DCS) and are referred through the Integrated Rapid Response process, the Contractor shall ensure that behavioral health provider consider a full range of services at the time of removal. Multiple AHCCCS policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:
   a. AMPM Behavioral Health Practice Tool (BHPT) 260,
   b. ACOM Policy 417,
   c. ACOM Policy 449,
   d. AMPM Policy 310-B
   e. AMPM Policy 320-O,

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f. AMPM Policy 320-W, and
g. AMPM Policy 541.

3. The Contractor shall ensure that providers screen children involved with DCS for developmental delays and determine if a referral for additional services or any other type of assistance is needed. Attachment A includes example questions that should be considered when assessing a child age birth to five that is in the custody of DCS.

4. As part of the service planning process behavioral health staff who work with children age birth to five need to be familiar with community services and programs that serve young children. The Contractor shall ensure that providers who work with this population are knowledgeable about the resources that exist and at minimum, have familiarity with referrals for AzEIP, Head Start, Division of Developmental Disabilities (DDD), ADHS Office of Children with Special Health Care Needs, First Things First, and school district services.

5. Clinical Approaches

   The Contractor shall ensure that providers utilize psychotherapeutic treatment interventions that are supported by current studies and considered best practice. Determination of the best psychotherapeutic approach is done in conjunction with the Child and Family Team (CFT) and qualified infant and early childhood behavioral health practitioners. For examples of psychotherapeutic interventions considered best practice, refer to Attachment B.

E. PSYCHIATRIC EVALUATION

General practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. For infants and toddlers significant effort should be made to ensure that the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist with training or experience in the treatment of young children, age birth to five.[iii] Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention for children age birth to five.[iv] Psychiatric evaluation, which may be part of the extensive assessment process, can be used to guide treatment and make clinical recommendations prior to psychopharmacological intervention.

Best practice for psychiatric evaluation includes the following components:

1. Information from those persons who are most familiar with the child, as well as direct observation of the child with their primary caregiver especially if changes have occurred within the caregiver constellation since the initial assessment.

2. Any potential changes in the reason for referral including changes in the child's social, emotional, and behavioral symptoms.

3. Updates related to the detailed medical and developmental history.

4. Updates related to current medical and developmental concerns and status.

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5. Changes in family, community, childcare and cultural contexts which may influence a child's clinical presentation.

6. Newly identified parental and environmental stressors and supports.

7. Ongoing or recent changes in HCDM, DR's perception of the child, ability to read/respond to child's cues, and willingness to interact with the child, based on.

8. Review of any previously completed assessments.

9. Review of psychotherapeutic interventions provided and outcomes of those interventions.

10. Children's birth to five mental status exam:
    a. Appearance and general presentation,
    b. Reaction to changes (e.g., new people, settings, situations),
    c. Emotional and behavioral regulation,
    d. Motor function,
    e. Vocalizations/speech,
    f. Thought content/process,
    g. Affect and mood,
    h. Ability to play/explore,
    i. Cognitive functioning, and
    j. Relatedness to HCDM, DR.

11. Use of standardized instruments to identify baseline functioning and track progress over time.

12. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved.

13. Collaboration with other agencies involved with the child and family including but not limited to:
    a. Arizona Department of Child Safety (DCS),
    b. Division of Developmental Disabilities (DDD),
    c. Arizona Early Intervention Program (AzEIP),
    d. First Things First,
    e. Community-based programs,
    f. Head Start,
    g. The local school district,
    h. Healthy Families Arizona, and
    i. Other educational programs.

14. Development of DSM-5 Diagnosis and DC: 0 TO 5 Diagnosis following:
    a. Diagnostic Classification of Behavioral health and Developmental Disorders in Infancy and Early Childhood" (DC: 0-5), and
    b. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).

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AHCCCS neither endorses, recommends, nor requires any specific tool over another, below are examples that may be utilized:

NAME OF TOOL	PURPOSE/DESCRIPTION	AGE/POPULATION	USER
PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA); (EGGER & ANGOLD, 2006)[v]	Psychiatric diagnosis incorporating both DSM[vi] and DC: 0-5.[vii]	Ages 2 to 5 years Boys/Girls Multicultural.	Professional only Training required.
MCHAT-R (2009)[viii]	A parent report screening tool to assess risk for Autism Spectrum Disorder (ASD).	Designed for use at 16 – 24 months of age.	Completed by parents and scored by pediatricians, child psychiatrists or child psychologists.

F. INFORMED CONSENT AND COORDINATION

1. Informed consent, as specified in AMPM Policy 320-Q, is an active, ongoing process that continues over the course of treatment through active dialogue between the prescribing Behavioral Health Medical Professional (BHMP) and HCDM about the following essential elements:
   a. The diagnosis and target symptoms for the medication recommended,
   b. The possible benefits/intended outcome of treatment,
   c. The possible risks and side effects,
   d. The possible alternatives,
   e. The possible results of not taking the recommended medication,
   f. FDA status of the medication, and
   g. Level of evidence supporting the recommended medication.

Although there are medications approved by the Food and Drug Administration (FDA) for young children under the age of five, an FDA indication reflects empirical support but may not be first line treatment in alignment with best practice. In addition, lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy. The Physician's Desk Reference states the following: "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. Thus, BHMPs shall document the rationale for medication choice and the provision of informed consent to HCDM.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. Refer to AMPM Policy 310-V for requirements on Prescription Medications/Pharmacy Services.

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The Contractor shall ensure documentation in the clinical record is required, showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment. Refer to AMPM Policy 940 for further information on medical records.

G. WORKFORCE DEVELOPMENT

The Contractor shall ensure a network that includes qualified practitioners for working with the birth to five population. Practitioners working with infants and toddlers need to acquire and demonstrate a range of interpersonal skills in their work to build individualized, respectful, responsive, and supportive relationships with families.

1. These skills include:
   a. The ability to listen carefully,
   b. Demonstrate concern and empathy,
   c. Promote reflection,
   d. Observe and highlight the child-parent/caregiver relationship,
   e. Respond thoughtfully during emotionally intense interactions,
   f. Understand, regulate, and use one's own feelings,[ix]
   g. Have comprehensive knowledge of early childhood development,
   h. Possess relationship-building skills with children and adults,
   i. Be able to identify resources and needs within the family/caregiving environment, and
   j. Communicate assessment results in a comprehensible manner to parents/primary caregivers and other professionals.

The Infant and Toddler Mental Health Coalition of Arizona (ITMHCA) has adopted Endorsement© process under the Alliance for the Advancement of Infant Mental Health. Endorsement© recognizes the professional development of practitioners in the infant and family field.

It is recommended that provider agencies have practitioners endorsed. For additional information, refer to The Infant/Toddler Mental Health Coalition of Arizona and Attachment D for population recommended resources. The Contractor shall ensure their subcontracted network of providers includes individuals that have achieved Endorsement©.

H. TRAINING

The Contractor shall ensure that all behavioral health practitioners working with this population (children age birth to five) receive specialized training. Professional development in the area of infant and early childhood behavioral health is necessary at all levels of the Behavioral Health System, along with the personnel of service systems that interface with behavioral health professionals, such as DCS, and DDD.

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The Contractor shall ensure that staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth to five be well trained and clinically supervised in the application of this Policy. Whenever this Policy is updated or revised, the Contractor shall ensure that their subcontracted network and provider agencies are notified and required staff are retrained to meet requirements as specified in this Policy. The Contractor shall provide evidence that providers have been trained on this Policy upon request from AHCCCS.

I. SUPERVISION

Supervision regarding implementation of this Policy is to be incorporated into other supervision processes that the Contractor and their subcontracted network and provider agencies have in place for direct care clinical staff.

Reflective Supervision is considered a best practice for providers working with the birth to five population. It is the recommendation of AHCCCS that personnel who supervise staff providing service delivery to children age birth to five and their families, receive adequate training in the elements of Reflective Supervision.

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[i] Zero to Three (2016). DC: 0-5TM Diagnostic classification of mental health and developmental disorders in infancy and early childhood. Washington, DC: Zero to Three Press.

[ii] Zero to Three (2016). DC: 0-5TM Diagnostic classification of mental health and developmental disorders in infancy and early childhood. Washington, DC: Zero to Three Press.

[iii] American Academy of Child & Adolescent Psychiatry. (February 2012) A Guide for Community Child Serving Agencies on Psychotropic Medications for Children and Adolescents. [On-line]. Available: http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf

[iv] Egger, H. (2010). A perilous disconnect: Antipsychotic drug use in very young children. Journal of the American Academy of Child & Adolescent Psychiatry, 49(1), 3-6.

[v] Egger & Angold cited in Carter, A.S., Godoy, L., Marakovitz, S.E., & Briggs-Gowan, M.J. (2009) in Zeanah, C. H. JR. (ED.). Handbook Of Infant Toddler Mental Health, (PP 233-251). New York: Gilford Press.

[vi] American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5th ed.) (DSM-5). Washington, DC.

vii Zero to Three (2016). DC: 0-5TM Diagnostic classification of mental health and developmental disorders in infancy and early childhood. Washington, DC: Zero to Three Press.

viii http://mchatscreen.com/; https://www.m-chat.org/mchat.php

ix Gilkerson, L. & Taylor Ritzler, T. (January 2005). The role of reflective process in infusing relationship-based practice into an early intervention system. In Finello, K.M. (Ed.). The Handbook of Training and Practice in Infant and Preschool Mental Health. Jossey-Bass.

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~~210 – WORKING WITH THE BIRTH THROUGH FIVE POPULATION~~

~~EFFECTIVE DATES: 07/01/16, 10/01/21~~

~~APPROVAL DATE: 08/12/21~~

~~I. PURPOSE~~

~~This Behavioral Health Practice Tool applies to ACC, ALTCS E/PD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), and RBHA Contractors. This Behavioral Health Practice Tool is an optional resource for the Fee-For-Service Programs and is not a requirement for the Fee-For-Service Programs. It is designed to strengthen the capacity of Arizona's Behavioral Health System in response to the unique needs of children age birth through five. This tool emphasizes early intervention through the use of clinical assessment, service planning, and treatment, all of which focus on identification of situations that may potentially impede infants'/toddlers' ability to:~~

1. ~~Form close parent/caregiver relationships with those in the child's environment (these may be long term or temporary, familial, or non-familial),~~
2. ~~Experience, regulate and express their emotions, and~~
3. ~~Explore their environment.~~

~~A. TARGET AUDIENCE~~

~~This Practice Tool is specifically targeted to the Contractor, their subcontracted network, and provider agency behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management, and other clinical services. This may also include supervising staff that provide service delivery to children age birth through five and their families.~~

~~B. TARGET POPULATION(S)~~

~~All children, birth through five years of age (up to age six), that are receiving behavioral health services, in collaboration with their caregiver(s).~~

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[1]AMPM Behavioral Health Practice Tool 210 is reserved with pertinent information incorporated into the new AMPM Policy 581

C. ~~BACKGROUND AND EVIDENCE-BASED SUPPORT~~

~~The promotion of behavioral health in infants and toddlers is critical to the prevention and mitigation of mental disorders throughout the lifespan. Over the past decade, the research has demonstrated mounting evidence pointing to the detrimental impact that early, negative childhood experiences can have on the developing brain. A well-known example of that research is a study conducted by a California Health Maintenance Organization.[i] This longitudinal study, known as the ACES study (Adverse Early Childhood Experiences), showed a positive correlation between frequency of negative early childhood events (e.g. neglect, violence, trauma) and development of physical and behavioral health challenges~~

~~in adulthood. The more negative events that occurred during early childhood, the more adults tended to have physical and behavioral health conditions in adulthood such as depression, alcoholism, obesity, and heart disease.[ii] Although the ACES study points to the negative impact of adverse early childhood experience, the field of infant behavioral health has promulgated the knowledge in intervention techniques designed to mitigate negative effects of early abuse, trauma or violence.~~

~~Early childhood experiences can build strong foundations or fragile ones and can affect the way children react and respond to the world around them for the rest of their lives. The early social and emotional development of infants and toddlers is vulnerable to factors, such as repeated exposure to violence, persistent fear and stress, abuse and neglect, severe chronic maternal depression, biological factors such as prematurity and low birth weight, and conditions associated with prenatal substance exposure.[iii] Without intervention, these risk factors can result in behavioral health disorders including depression, attachment disorders, and traumatic stress disorders, which can have an effect on later school performance and daily life functioning.[iv]~~

~~Children who have been maltreated are at an increased risk for behavioral health concerns, poor psychological adaptation and lifelong health difficulties.[v] Children entering the child welfare system have higher rates of exposure to traumatic events with most victims of child abuse and neglect being under the age of five. Important assets such as health attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of trauma.[vi]~~

1. ~~An effective approach to promoting healthy social and emotional development shall include equal attention to the full continuum of behavioral health services including promotion, prevention and treatment, plus improvement in system capacity for effective service delivery. Essential components of a comprehensive system include:~~

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a. Supporting the use of evidence-based early childhood service delivery models,
b. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals, and
c. Improving access to services.

Untreated behavioral health disorders can have disastrous effects on children's functioning and future outcomes.[vii] Unlike adults, infants and toddlers have a fairly limited repertoire of coping responses to stress and trauma.[viii] Behavioral Health disorders in young infants might be reflected through physical symptoms such as poor weight gain, slow growth and constipation, as well as overall delayed development and inconsolable crying. In older infants, excessive tantrums, eating and sleeping problems, aggressive or impulsive behavior and developmental delays can be present. Toddlers may also present with paralyzing fears and withdrawal from social interaction.[ix]

Early attachment disorders (including those resulting from early traumatic separations from parents and placement in foster care) can predict subsequent aggressive behavior. Some early behavioral health disorders have lasting effects and may appear to be precursors of behavioral health problems later in life. Early signs and symptoms of behavioral health disorders may include withdrawal, sleeplessness, or lack of appetite due to depression, anxiety, and trauma stress reactions.[x]

Increasingly, young children are being expelled from childcare and preschool for behavior problems, including biting, tantrums, hitting, throwing objects, or inconsolable crying.[xi] Even if they do remain in a program, young children with behavioral concerns are challenging to teach and quickly lose motivation for learning. Additionally, they may withdraw from their peers or face social rejection.[xii]

Healthy social-emotional development is strongly linked to success in elementary school. Children who are not secure in relating to others and do not trust adults are not motivated to learn. Furthermore, children who are unable to respond to calming influences initiated by themselves or others will not be responsive to teaching methods or benefit from their early educational experiences and may lag behind their peers.

Parent's behavioral health can affect young children. Maternal depression, anxiety disorders and other forms of chronic depression often disrupt the parent-child bond as parents with an untreated mental disorder are less able to provide developmentally-appropriate stimulation and parent-child interactions.[xiii] Parenting and child development are most affected when depression simultaneously occurs with other factors such as extreme poverty, substance abuse, adolescence, and maltreatment.[xiv]/[xv] Infants of clinically depressed mothers often withdraw from their caregivers, which ultimately affects their language skills, as well as their physical and cognitive development. Older children of depressed mothers show poor self-control, aggression, poor peer relationships, and difficulties in school.[xvi] Although these sources cite maternal depression as a factor, these effects can also be attributed to relationships the young child has with other primary caregiver(s).

2. Increased training in early childhood behavioral health is necessary and essential. In-depth knowledge of child development systems and multi-disciplinary approaches, as well as possession of diagnostic and clinical skills are critical components for professionals who assess and treat young children.[xvii] Additionally, practitioners need to acquire and

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demonstrate a range of interpersonal skills in their work in order to build individualized, respectful, responsive and supportive relationships with families. These skills include:

a. The ability to listen carefully,
b. Demonstrate concern and empathy,
c. Promote reflection,
d. Observe and highlight the child-parent/caregiver relationship,
e. Respond thoughtfully during emotionally intense interactions, and
f. Understand, regulate, and use one's own feelings.[xviii]

Scientific advances in neurobiology have provided birth through five practitioners with greater insight into the complex system of the brain. The development of the central nervous system begins with the formation of the neural tube, which nears completion by three to four weeks of gestation and is the basis for all further nervous system development.[xix] Genes determine when specific brain circuits are formed and each child's experiences then shape how that formation develops. Stable and responsive relationships along with proper sensory input through hearing and vision are what build healthy "brain architecture". Thus, the most important relationships begin with the child's family and extend outward to other adults important in that child's life such as day care and educational providers.[xx]

3. Empirical evidence has shown that young children are greatly impacted by their early development and experiences. By understanding how specific events impact a young child's brain function, the behavioral health professional is able to formulate individualized interventions. Therefore, it is incumbent upon all practitioners to become educated about brain development, functions of various parts of the brain and their role in the physical and emotional development of the child. Some additional resources in the area of brain development include:
   a. "Brain Facts, A Primer on the Brain and Nervous System" through the Society for Neuroscience,[xxi]
   b. "Starting Smart—How Early Experiences Affect Brain Development",[xxii]
   c. "From Neurons to Neighborhoods: The Science of Early Childhood Development",[xxiii] and
   d. C.H. Zeanah, Jr., (Ed.). (2009). Handbook of Infant Toddler Behavioral Health.[xxiv]

D. METHODOLOGY

In an ongoing effort to improve the delivery of behavioral health services in an effective and recovery-oriented fashion, the Arizona Vision, as established by the Jason K. Settlement Agreement in 2001, implemented the use of the Child and Family Team (CFT) practice model and the 12 Arizona Principles, both of which strongly support the critical components of behavioral health practice with children birth through five and their families. Infant and Early Childhood Behavioral Health practice integrates all aspects of child development such as organic factors (genetics and health) with the child's experiences (relationships, events, opportunities for exploration). This is especially important in the first three years of life when changes in social-emotional development and adaptive functioning are rapid and significant.

The nature and pace of these changes, as well as the preverbal nature of this young population present the behavioral health professionals with uniquely complex challenges. It is crucial for

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children to rely on the knowledge of the parents/caregivers and the expertise of a multidisciplinary team of professionals to provide them with information when conducting behavioral health evaluations, developing service plans, and implementing

clinical interventions. Qualified professionals shall have an understanding of the correct use and interpretation of screening, assessment, and evaluation tools and processes, plus how to use these results for service planning and implementing clinical interventions

1. Assessment and treatment of children age birth through five is based on the philosophical orientation that work is done on behalf of the child, predominantly through the child's parent or caregiver(s). Child development takes place within the context of the caregiving relationship, which is strongly influenced by child characteristics, parent/caregiver characteristics, and perhaps most importantly the unique match or "fit" between a child and the child's caregivers. It is important that trained personnel:
   a. Have comprehensive knowledge of early childhood development,
   b. Possess excellent observational and relationship-building skills with children and adults,
   c. Be able to identify resources and needs within the family/caregiving environment, and
   d. Communicate assessment results in a comprehensible manner to parents/primary caregivers and other professionals.

2. For children that are under the custody of Department of Child Safety (DCS) and are being served by CHP who are referred through the Rapid Response process, it is important for the behavioral health provider to consider a full range of services at the time of removal. Multiple AHCCCS policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:
   a. ACOM Policy 417,
   b. ACOM Policy 449,
   c. AMPM Policy 310-B
   d. AMPM Policy 320-O, and
   e. AMPM Policy 541.

   As part of the assessment process, ongoing evaluation of the child after the initial removal is needed to assess the child's physical appearance, areas of functioning, the child's relationships, and adjustment to the new environment. If the child is placed with a different caregiver, re-assess again to monitor the child's adjustment to the new setting. When assessing children involved with DCS who are showing delays which can be due to the trauma of removal, neglect, or abuse, determine if a referral for additional services or any other type of assistance is needed. Refer to Attachment A, for use with children living in a kinship placement, DCS resource parents (foster or adoptive), or congregate care (shelter or group home). Additional information outlining special considerations for providing services to infants, toddlers and pre- school aged children involved in the child welfare system can be accessed through: "The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS" (refer to AMPM Behavioral Health Practice Tool 260).

II. ESSENTIAL PROCESSES FOR ASSESSMENT, SCREENING AND SERVICE PLANNING

Evaluation practices with respect to children age birth through five involve awareness on the part of the behavioral health practitioner that all children have their own individual developmental

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progression, affective, cognitive, language, motor, sensory and interactive patterns. All children age birth through five are participants in relationships, with the child's most significant relationships being those with their primary caregiver(s). A full evaluation requires a clear understanding of how the child is developing in each area of functioning and the quality of the child's most significant relationships. This is best done over several sessions, in different settings (e.g. home, child care, clinic), and whenever possible with all significant caregivers. In order to support a child in demonstrating the child's true capacities, screening and assessment processes are most effectively offered in natural and non-threatening settings, in the presence of a familiar and trusted caregiver, with materials and activities that are culturally sensitive and that reflect their daily life experiences. Identification of all significant caregivers and the child's relationship with each individual is a critical part of assessment practice.

A. DEVELOPMENTAL SCREENING

Screening for sensory, behavioral, and developmental concerns initially begins an ongoing process that organizes continuous observations regarding the needs, challenges, strengths and abilities of the child and parent/caregiver. Screening or testing instruments become part of comprehensive assessment practice, are intended to be used for the specified purpose they were designed for, shall be reliable and valid, and are not to be used in isolation to render a diagnosis.

The use of Attachment B, provides assessors and caregivers with a set of dimensional milestones (e.g. movement, visual, hearing, smell, touch, speech, social and emotional, language, cognitive, hand and finger skills), as well as growth and developmental "red flags". As part of the assessment process for infants and young children, developmental checklists establish a baseline to which subsequent screenings during the course of treatment can be compared. Developmental checklists provide opportunities to assess the degree to which children are meeting developmental milestones. Should there be delays in meeting standard developmental milestones, it may be necessary to refer to the child's PCP for further evaluation. For children birth to three, a referral to Arizona Early Intervention Program (AzEIP) may be warranted; for children three to five, a referral to the public school system may be more appropriate. Multiple developmental screening tools are available. Some are suggested directly within this document and others are provided as attachments. These tools are available as accompaniments to this Practice .

B. ASSESSMENT CONSIDERATIONS

It is essential that behavioral health practitioners continually evaluate their screening and assessment tools because the practice of infant and early childhood behavioral health is

dynamic and continually changes due to improved technology and newly developed research techniques, strategies and results. While AHCCCS does not require the use of a specific assessment tool, minimum elements have been established that shall be included in any comprehensive behavioral health assessment as specified in AMPM Policy 320-O. (refer to Attachment C, as one example of an assessment tool for children age birth through five).

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~~Additional options for assessments specific to children birth through five, are included as attachments to this policy.~~

1. ~~There is no single tool that encompasses the full range of social, emotional and developmental skills and challenges that can occur in young children. The following tools and resources can provide additional information when assessing developmental milestones, behavioral, emotional and social concerns, trauma and attachment:~~
   a. ~~Ages and Stages Questionnairexxv (ASQ): developmental and social-emotional screening for children age one month to five and ½ years,~~
   b. ~~Hawaii Early Learning Profilexxvi (HELP): curriculum-based assessment covering regulatory/sensory organization, cognitive, language, gross and fine motor, social and self-help areas for children birth to three years, separate profile available for three to six year old children,~~
   c. ~~Infant-Toddler Social-Emotional Assessmentxxvii (ITSEA©): measures social- emotional and behavioral domains for children one to three years of age,~~
   d. ~~Connor's Early Childhood Assessment:xxviii aids in the early identification of behavioral, social, and emotional concerns and achievement of developmental milestones for children two to six years of age,~~
   e. ~~Parents' Evaluation of Developmental Statusxxix (PEDS): evidence-based screening of developmental and behavioral concerns for children birth to eight years, and~~
   f. ~~Trauma-Attachment Belief Scalesxxx (TABSTM): measure cognitive beliefs about self and others for parents/caregivers age 17 and older to assist with identifying possible trauma history and its potential impact on the attachment relationship between the parent/caregiver and the child.~~

   ~~Considerable skill is required in the administration of the assessment process, integration of the data obtained from the assessment, and development of initial clinical conceptualizations and intervention recommendations. Refer to Technical Assistance Paper No. 4, "Developmental Screening, Assessment, and Evaluation: Key Elements for Individualizing Curricula in Early Head Start Programs" for further information on other resources and test reviews of screening and assessment instruments.[xxxi]~~

   ~~Assessment with children age birth through five is a specialty area that requires specific competencies. Competent providers recognize the limitations of their knowledge and scope of practice. When necessary, they make use of the expertise of more experienced behavioral health practitioners, as well as the range of disciplines that address questions related to early development (e.g. pediatrics, speech/language therapy, occupational therapy, physical therapy) through collaboration, consultation, and referral practices.~~

2. ~~Behavioral Health Assessment practice with children age birth through five typically involves:~~
   a. ~~Interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories,~~
   b. ~~Direct observation of family functioning,~~
   c. ~~Gaining information, through direct observation and report, about the child's individual characteristics, language, cognition, and affective expression,~~
   d. ~~Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,xxxii~~

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e. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/learning, and to help regulate emotions,

f. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship, and

g. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g. medical, behavioral health, parenting, legal, educational, domestic violence, military).

AMPM Policy 310-B and AMPM Policy 320-O provide additional information on the types of behavioral health providers that may conduct assessments.

C. DIAGNOSTIC CONSIDERATIONS

The diagnostic process consists of two aspects: the classification of disorders and the assessment of individuals. In classifying disorders, practitioners are able to communicate with one another about descriptive syndromes using universal terms and language. The diagnostic process is ongoing rather than a onetime "snapshot" of symptoms. Behavioral Health practitioners collect information over time in order to understand multiple aspects of the presenting concerns, as well as variations in adaptation and development that are revealed on different occasions within various contexts.[xxxiii]

It is suggested that clinical personnel who conduct assessments of young children receive training to become proficient in the use of the Diagnostic Classification of Behavioral Health and Developmental Disorders in Infancy and Early Childhood (DC: 0-5). This diagnostic manual, which draws on empirical research and clinical practice that has occurred worldwide since the manual was first published in 1994 as the DC: 0-3 and revised in 2016. The DC: 0-5 is designed to help behavioral health and other professionals recognize behavioral health and developmental challenges in young children, understand how relationships and environmental factors contribute to behavioral health and developmental disorders, use diagnostic criteria effectively for classification and intervention, and work more effectively with parents and other professionals to develop effective service plans. The updated version provides clear and specific criteria for all diagnostic categories. Examples include:

1. Criteria for identifying Autism Spectrum Disorders in children as young as 2, introduces.

2. New criteria for disorders of sleep, eating, relating, and communicating.

3. Clarifies the Parent-Infant Relationship Global Assessment Scale (PIRGAS).

4. Checklists for identifying relationship problems, psychosocial and environmental stressors.

Copies of the DC: 0-5 manual are available through the Zero to Three Press.[xxxiv] This manual contains the DC: 0-5 codes that correspond to DSM-5 codes, as well as THE ICD-10 codes.

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D. ANNUAL ASSESSMENT UPDATE

While assessment is an ongoing process that offers new information throughout the continuum of service delivery, a formal assessment update shall be completed on an annual basis, or sooner, if there has been a significant change in the child's/family's status. A child's response to treatment might be affected by significant events or trauma that have occurred since the last assessment/update, such as changes in the child's living environment, childcare arrangements, death of a primary caregiver, as well as medical/developmental conditions and hospitalizations. Input from the family/caregiver, as well as observation(s) of the child in conjunction with a review of the clinical record, provides the information necessary for summarizing their response to treatment and progress toward meeting goals over the past year.

A review of the child's current level of functioning would include updating information related to the child's emotional and behavioral regulation, quality of the parent-child interaction, relationships with caregivers/significant others, living environment, family stressors, safety concerns, and stability of home/relationships. Developmental screening as part of the annual update, and during the course of treatment, will assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral.

E. SERVICE PLANNING CONSIDERATION

1. Use of CFT Practice

The early development of an engaged relationship with the child, parent/caregiver, and family as part of the CFT process, is required practice when working with children age birth through five. This critical work directly involves the entire family and it is the family that guides the therapeutic process. Refer to the Child and Family Team Practice Tool on the AHCCCS website under Guides - Manuals – Policies -AMPM-Chapter 200. This Practice Tool provides additional information on the specific components and the required service expectations of this practice model.

Infants and young children benefit from planning processes that support the inclusion of the following components:

a. Ongoing and nurturing relationships with one or two deeply attached individuals,
b. Physical protection, safety and regulation at all times,
c. Experiences suited to individual differences to include regular one-to-one interaction between the caregiver and child,
d. Developmentally appropriate experiences (e.g. one-to-one interaction that encourages an emotional dialogue that fosters a sense of self, problem solving, communication skills and a sense of purpose),
e. Limit setting, structure and expectations (e.g. clear messages and routines), and
f. Stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

Families with young children are often socially isolated especially if they have a child who is exhibiting behavioral concerns and/or developmental delays. An essential part of the therapeutic process is to help reduce this social isolation. Encouraging the exploration of

natural supports can spur a family to begin thinking differently about their support system(s).

Whenever possible, the utilization of natural environments for clinical intervention is recommended. If the natural environment is not a conducive setting due to a lack of privacy, site of traumatic event for the child/parent and/or safety concerns, alternative settings need to be considered with input from the family. In addition to location, natural environments also include the everyday routines, relationships, activities, people and places in the lives of the child and family.[xxxv]

5. Community Collaboration

Starting with the assessment process, intervention strategies incorporate information from all involved providers serving the child, parent, or caregiver. This may include healthcare, childcare, and early intervention providers, the parent's/caregiver's behavioral health provider(s), as well as friends and extended family that are important in the family's life. Examples of several early intervention providers include Head Start/Early Head Start, the Arizona Early Intervention Program, Early Childhood Education through the Arizona Department of Education, and the Division of Developmental Disabilities. These individuals, if the parent/caregiver wishes, then become part of the Child and Family Team who will develop an effective service plan that employs natural supports in conjunction with formalized services (Refer to "Child and Family Team Practice Tool" on the AHCCCS website under Resources: Guides - Manuals – Policies – AMPM – Chapter 200). The size, scope and intensity of team member involvement are determined by the objectives established for the child and needs of the family in providing for the child.

In order to make informed referrals as part of the service planning process it is imperative that behavioral health professionals and technicians (BHPs & BHTs) who work with children age birth through five and their families, become familiar with community services and programs that serve young children, as well as the local school district programs for children three to five years of age. At minimum, BHPs and BHTs should have familiarity with AzEIP, Head Start, Division of Developmental Disabilities, ADHS Office of Children with Special Health Care Needs, First Things First, and school district services that may be available for children eligible for preschool.

If at any time throughout the assessment, treatment delivery, or service planning processes a behavioral health practitioner believes that a child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a duty to report that belief to a peace officer or Department of Child Safety per A.R.S. §13-3620. Behavioral Health staff is to consult with their supervisor if they are unclear about their duty to report a situation.

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication, and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care. For non-enrolled children who are not Medicaid eligible, coordination and communication should occur with any known health care provider. Refer to AMPM

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~~Behavioral Health Practice Tool 211 for additional information on the use and coordination of psychotherapeutic and psychopharmacological interventions.~~

~~Documentation in the clinical record is required to show the communication and coordination of care efforts with the health care provider related to the child's behavioral health treatment (refer to AMPM Policy 320-O and AMPM Policy 940).~~

~~F. SERVICE PLAN DEVELOPMENT~~

1. ~~While a comprehensive and accurate assessment forms the foundation for effective service planning and is required before a service plan can be fully developed, needed services should not be delayed while the initial assessment process is being completed. In addition to consideration of clinical disorders, findings from a comprehensive assessment of children birth through five years of age should lead to preliminary ideas about:~~
   a. ~~The nature of the child's pattern of strengths and difficulties, risk and protective factors,~~
   b. ~~Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,~~
   c. ~~Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns, etc. to the child's competencies and difficulties, and~~
   d. ~~How the service planning process will address these areas.xxxvi~~

   ~~Service plans should be strength-based in addressing needs and whenever possible draw upon natural supports. For young children, home-based services, which virtually always include the child's principal caregiver, may be especially well-suited to enhancing parents' well-being and the child-parent relationship.xxxvii~~

   ~~A comprehensive and intensive approach to service planning would include attention to those factors that place young children's healthy attachment and social-emotional development at risk. Critical planning includes interventions that address a parent's/caregiver's behavioral health concerns and how these may affect the ability of that parent/caregiver to interact with and respond sensitively to the child's emotional and physical needs. Prematurity, low birth weight and conditions associated with prenatal substance exposure may require specific interventions when they affect the early social and emotional development of infants and toddlersxxxviii.~~

   ~~Service planning also needs to address a child's ability to form close parent/caregiver relationships. These relationships can be undermined by traumatic events such as repeated exposure to violence, abuse or neglect, or when children experience multiple caregiver changes. When the child/family has multi-agency involvement, every effort should be made to collectively develop a single, unified plan that addresses the needs and mandates of all the parties involved. Additionally, planning should address collaboration with early intervention service providers and early education programs. This is especially important for those children who are experiencing expulsion from childcare or preschool settings due to behavioral concerns.~~

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~~The use of all service settings, the full array of covered services, and skilled, experienced providers are to be considered as identified by the Child and Family Team during the service planning process. Service planning that includes the use of Support and Rehabilitative Services is often an essential part of community-based practice and culturally competent care, which focuses on helping young children to live successfully with their families as part of their community (refer to AMPM Behavioral Health Practice Tool 230) .~~

~~All service plan development with children age birth through five is completed collaboratively with the child's parent or primary caregiver. Development and prioritization of service plan goals are not focused solely on the child. It is essential to include the parent, caregiver, and the needs of the family as a whole. Due to the age of the birth through five population and the rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives. At the time of the Annual Update, the service plan should be modified to align with the needs identified in the updated Assessment. Refer to AMPM Policy 320-O for further information on the minimum elements for Assessments, Service Plans, and required timeframes for completion.~~

~~2. Clinical Practice~~

~~The guiding principle in the practice of infant and early childhood behavioral health is to "do no harm". Clinical intervention assumes a preventative, early intervention treatment focus based on sound clinical practice, delivered in a timely manner across all settings, and implementation in accordance with the Arizona Vision and 12 Principles. Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.~~

~~a. Infant and early childhood therapeutic approaches are supported by the following conceptual premises:xxxix~~
   ~~i. The child's attachment relationships are the main organizer of the child's responses to danger and safety in the first five years of life,~~
   ~~ii. Emotional and behavioral problems in early childhood are best addressed within the context of the child's primary attachment relationships, and~~
   ~~iii. Promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.~~
~~b. The following skills and strategies are fundamental to the work of infant and early childhood behavioral health:~~
   ~~i. Building relationships and using them as instruments of change,~~
   ~~ii. Meeting with the infant and parent/caregiver together throughout the period of intervention,~~
   ~~iii. Sharing in the observation of the infant's growth and development,~~
   ~~iv. Offering anticipatory guidance to the parent/caregiver that is specific to the infant,~~
   ~~v. Alerting the parent/caregiver to the infant's individual accomplishments and needs,~~
   ~~vi. Helping the parent/caregiver to find pleasure in the relationship with the infant,~~
   ~~vii. Creating opportunities for interaction and exchange between parent/caregiver(s) and infant or parent/caregiver(s) and practitioner,~~

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viii. Allowing the parent/caregiver to take the lead in interacting with the infant or determining the 'agenda' or 'topic for discussion',
ix. Identifying and enhancing the capacities that each parent/caregiver brings to the care of the infant,
x. Wondering about the parent/caregiver's thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood,
xi. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent,
xii. Listening for the past as it is expressed in the present, inquiring, and talking,
xiii. Allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing, and talking about them as the parent is able,
xiv. Attending and responding to parental histories of abandonment, separation, and unresolved loss as they affect the care of the infant's development, the parent/caregiver's emotional health and the early developing relationship,
xv. Attending and responding to the infant's history and early care within the developing parent/caregiver-infant relationship,
xvi. Identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness and family dysfunction, and
xvii. Remaining open, curious and reflective."xl

While all the skills and strategies noted above are pertinent in working with children and families, item "xi" through "xvii" are of unique importance to the practice of the infant and early childhood behavioral health practitioner. These seven strategies address the emotional health and development of both the parent/caregiver and the child. The practitioner focuses on past and present relationships and the complexities many parents/caregivers encounter when nurturing, protecting, and responding to the emotional needs of their children. Within this context, the practitioner and parent/caregiver may think deeply about the care of the young child, the emotional health of the parent/caregiver, the many challenges of early parenthood, and the possibilities for growth and change.xli

3. Clinical Approaches

Information obtained through the assessment process will guide infant and early childhood trained practitioners in determining which intervention(s) is most conducive in meeting the needs of the young child and the child's family. More than one approach may be utilized and integrated into the service plan.

Support is the most basic intervention, where behavioral health personnel function as a resource to assist primary caregivers in accessing community resources, such as housing, employment, child care, health services and food. Emotional support may also be provided to families when they are faced with a crisis related to the care of their child(ren). This support can be shown by the clinician's attention to the expressed concerns of the caregiver, acknowledgement of the caregiver's needs and strengths, and showing empathy in response

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~~to the situation. Support and Rehabilitation services can also assist with reducing the family's distress so that they are able to focus on the care requirements of their young child.~~

~~Advocacy can take the form of helping caregivers find their voice in expressing their needs and navigating systems of care. It can be challenging for clinicians to know when and how to speak effectively on behalf of young children and their families, especially those who may be involved with the child welfare system.~~

~~Developmental Guidance provides information to the primary caregiver(s) on a young child's abilities, developmental milestones and needs, as well as practical caretaking guidance that may be delivered individually or in a group format. Within the therapeutic environment, the clinician can offer opportunities to the caregiver to enhance positive interaction and playful exchange with the child. These exchanges, if based on the child's developmental needs, reinforce what the caregiver is able to do with the child and may promote a mutually pleasurable experience and purposeful response at the child/caregiver relationship level.~~

~~Relational Guidance helps primary caregivers to increase their knowledge of and experience with their infant or young child through spontaneous interactions. Caregivers are taught how to attend to their child's distinctive cues with clinicians modeling parenting behavior. When using guided interaction strategies, clinicians can then provide feedback directly or review videotapes with the caregiver.~~

~~The following two approaches to therapy focus on the relationship between the primary caregiver and the infant. Child-parent psychotherapy offers the opportunity for thoughtful exploration with the caregiver of the child's ideas about parenthood and the continuing needs of the infant or toddler. The clinician assists the primary caregiver in gaining access to repressed early experiences, re-examining the feelings associated with them and achieving insight into how these experiences may affect the caregiver's capacity to be responsive to the infant. Relational difficulties with the infant may take the form of a caregiver's inability to hold or feed their baby, set limits that are appropriate in keeping young children safe, or interacting in ways that will arouse the child's curiosity. The infant is included as a catalyst for change, with the clinician guiding the caregiver to interact in a different way with their infant. A second approach, child-parent dyadic therapy, reflects the perspective that infants contribute to relationships and holds that the infant is able to use the time therapeutically for him/herself, similarly to the caregiver.~~

~~Attachment theory based in part on John Bowlby's internal working model, proposes that early experiences with the parent or primary caregiver forms the basis of memory patterns or "internal working models" that influence behaviors for other social relationshipsxlii. Interventions are consistent with attachment theory if they include the following elements:~~

~~a. Provide emotional and physical access to the mother/caregiver,~~
~~b. Focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals,~~
~~c. Place the mother/caregiver in a non-intrusive stance,~~

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d. Provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver, and
e. Provide a clinician who functions as a secure base for the dyad.

Developmental approaches to therapy offer an alternative to the traditional behavioral approach. Modalities under this approach can provide a framework for understanding and organizing assessment and intervention strategies when working with children with developmental delays and behavioral health concerns.

Reference materials on infant and early childhood mental health practice have been provided as a supplemental resource. This resource list is not meant to be exhaustive, given that research and clinical practice in this area continue to evolve.

G. TRAINING AND SUPERVISION RECOMMENDATIONS

Behavioral Health over the past several decades, has experienced significant advances in the understanding of early child development and the effects of trauma on early brain development. The need to have providers with trained expertise in this area has risen dramatically and is well recognized nationally and in Arizona. AHCCCS is focused on efforts in several areas to build workforce expertise and availability of services to children age birth through five and their families.

H. WORKFORCE DEVELOPMENT

The Infant and Toddler Behavioral Health Coalition of Arizona (ITMHCA) has adopted the Michigan Association for Infant Behavioral Health Endorsement® for Culturally Sensitive, Relationship-Based Practice Promoting Infant Behavioral Health. Endorsement® recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family field. This endorsement® model describes the areas of expertise, responsibilities, and behaviors that demonstrate competency and verifies that professionals have attained a specified level of understanding and functioning linked to the promotion of infant behavioral health. Of additional importance, endorsement provides an organized approach to workforce development that identifies competency- based trainings and reflective supervision experiences that enhance confidence and credibility among infant, toddler and family clinicians (Behavioral Health Professionals), as well as other professionals who work with this population (Behavioral Health Technicians/Behavioral Health Paraprofessionals). While competency-based training and reflective supervision supports behavioral health practitioners who work primarily with young children and their families, this expertise may also be applied to professionals working with adults with a serious mental illness or substance use concerns who are parenting their own infants/toddlers.

It is recommended that provider agencies have practitioners endorsed as appropriate to the mission of the agency. Endorsement® through the ITMHCA includes four levels of competency:xliii

1. Level 1: Infant Family Associate-- Individuals who possess Child Development Associate (CDA), or academic degree, or two years of infant and early childhood- related paid work experience; recommended for childcare or respite workers.

2. Level 2: Infant Family Specialist-- Bachelor's, Master's or Doctoral (e.g. Social Work, "Applied" studies, nursing, behavioral health related) degree and a minimum of two years' work related experience with infants/toddlers and families; recommended for behavioral health staff involved in service planning and delivery such as case management and peer/family support, support and rehabilitation service provider personnel, parent educators, childcare consultants, and Department of Child Safety workers.
3. Level 3: Infant Behavioral Health Specialist-- Masters, MSN (Nursing), PhD, PsyD, EdD, M.D. or D.O. with two years post-graduate work and training in infant, early childhood and family fields; recommended for behavioral health clinicians and supervisors, infant behavioral health specialists, clinical nurse practitioners, psychologists, and early intervention specialists. Reflective Supervision is required.

4. Level 4: Infant Behavioral Health Mentor-- (Clinical, Policy, or Research/Faculty)- Individuals at the mastery level (Master's, Post Graduate, Doctorate, Post Doctorate, MD or DO) qualified to train other professionals; recommended for infant and early childhood program supervisors, administrators, policy specialists, and physicians/psychiatrists.xliv

   Endorsement information and application materials are available through the local Infant Toddler Behavioral Health website: Infant Toddler Behavioral Health Coalition of Arizona (www.itmhca.org).

I. TRAINING

This Practice Tool applies to Contractors and their subcontracted network and provider agencies, including the behavioral health staff that provide direct service delivery to children age birth through five and their families. Behavioral health practitioners working with this population (children age birth through five) require specialized training. Professional development in the area of infant and early childhood behavioral health is necessary at all levels of the Behavioral Health System, along with the personnel of service systems that interface with behavioral health professionals, such as Department of Child Safety, Division of Developmental Disabilities, Arizona Early Intervention Program (AzEIP) and other community-based early intervention programs.

Behavioral Health practitioners seeking increased knowledge in this area are encouraged to attend infant and early childhood behavioral health trainings that include:

1. A multidisciplinary approach that is strengths-based.

2. Effective interviewing and observational techniques.

3. Assessment of parent-infant relationships.

4. Screening and diagnostic measures for infants and toddlers.

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5. Early childhood development.

6. Effects of early adverse experiences and trauma.

7. Understanding parent-child interactions and healthy attachment,

8. Cultural influences in parenting and family development,

9. Building a therapeutic alliance,
10. Treatment and intervention strategies/modalities endorsed by AHCCCS,

11. Collaboration practices with other providers/caregivers, and

12. A reflective practice focus.

It is the expectation of AHCCCS that behavioral health staff who complete assessments, participate in the service planning process, provide therapy, case management and other clinical services, or supervise staff that provide service delivery to children age birth through five and their families, be well trained and clinically supervised in the application of this tool. Each Contractor shall establish their own process for ensuring that all agency clinical and support services staff working with this population understand the recommended processes and procedures contained in this tool. Whenever this Practice Tool is updated or revised, each Contractor ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

J. SUPERVISION

Supervision regarding implementation of this Practice Tool is to be incorporated into other supervision processes which the Contractor and their subcontracted network and provider agencies have in place for direct care clinical staff, in alignment with A.A.C. R9-20-205 Clinical Supervision requirements.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development (different from administrative or clinical supervision)xlv that focuses attention on supporting the growth of relationships that is critical to effective infant and early childhood behavioral health practice. How each of these relationships interrelates and influences the others is explored through reflective supervision and is referred to as the "parallel process".

1. Relationship between supervisor and practitioner.

2. Relationship between practitioner, parent/caregiver/child.

3. Relationship between parent/caregiver/child.

4. Relationship between all of the above.

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In each of these relationships there is an emphasis on learning, personal growth, and empathy. Through this process, supervisors assist practitioners in professional skill development and ensure that practitioners are maintaining the agency's standards for clinical performance.xlvi

Key elements of reflective supervision include reflection, collaboration, and consistency. With supervisory support, the practitioner reflects on the emotional content of the work and how one's reaction to this content affects their work. Supervisors support a practitioner's professional development through the acquisition of new knowledge by encouraging the supervisee to assess their own performance. The supervisor's ability to listen and wait allows the practitioner an opportunity to analyze their own work and its implications, and to discover solutions, concepts or perceptions on one's own, without interruption. Collaborative supervision is characterized by the development of a trusting relationship between the supervisor and practitioner in which both parties can safely communicate ideas and share responsibility for decision-making without fear of judgment. Establishment of a consistent and predictable schedule of supervisory sessions supports the professional development of infant and early childhood behavioral health practitioners.

It is the recommendation of AHCCCS that personnel who supervise staff providing service delivery to children age birth through five and their families, receive adequate training in the elements of Reflective Practice and Supervision before implementing this approach in their supervisory activities. Criteria for provision of reflective practice is outlined on the Michigan Infant Toddler Behavioral Health xlvii website, but at minimum, Reflective Supervision requires Endorsement® for Infant Behavioral Health Specialist or Infant Behavioral Health Mentor with a minimum of 50 clock hours within a one to two year timeframe. Additional information is also available within Attachment E, for additional resource materials on reflective supervision and consultative practices.

Training and supervision support the acquisition of specific knowledge, skills, and competencies critical to delivering effective relationship-based services to children age birth through five and their families. While training and other academic learning venues build the practitioner's understanding of core concepts, it is through supervision that

practitioners can assess their level of competency when applying these concepts within their scope of practice. When evaluating a practitioner's level of knowledge as part of supervisory activities, supervisors can compare the skills of the clinician with Endorsement® Competency Guidelines and Requirements available on either the Arizonaxlviii or Michiganxlix Infant Toddler Behavioral Health websites. However, possession of similar knowledge and skills does not equate to actual Endorsement®, given the proprietary nature of the Endorsement® process (e.g. evidence-based training standards, testing, ethical standards).

K. ANTICIPATED OUTCOMES

1. Increased community and professional awareness of infant and early childhood behavioral health,

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2. ~~Improved use of effective screening, assessment, and service planning practices specific to the needs of children age birth through five and their families,~~

3. ~~Increased knowledge and referrals to early intervention resources in the community, and~~

4. ~~Improved outcomes through the use of accepted approaches in working with children age birth through five and their caregivers.~~

~~i C.H. Zeanah, Jr. & P.D. Zeanah. (2009). The scope of infant mental health. In C.H. Zeanah, Jr. (Ed.), Handbook of Infant Mental Health (pp 5-21), (3rd ed). New York: The Guilford Press.~~

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RESERVED[1]

~~211 – PSYCHIATRIC AND PSYCHOTHERAPEUTIC BEST PRACTICES FOR CHILDREN BIRTH THROUGH FIVE YEARS OF AGE~~

~~EFFECTIVE DATES: 07/01/16, 10/01/21~~

~~APPROVAL DATE: 08/12/21~~

~~I. PURPOSE~~

~~This Behavioral Health Practice Tool applies to ACC, ALTCS E/PD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), and RBHA Contractors. This Behavioral Health Practice Tool is an optional resource for the Fee-For-Service Programs; it is not a requirement for the Fee-For-Service Programs. This Behavioral Health Practice Tool establishes best practice processes and goals for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions for children birth through five years of age.~~

~~A. TARGET AUDIENCE~~

~~The AMPM Behavioral Health Practice Tool is specifically targeted to the Contractors, their subcontracted network and providers who furnish psychotherapeutic assessments and interventions, complete psychiatric evaluations, and prescribe psychopharmacological treatment for children birth through five years of age.~~

~~B. TARGET POPULATION(S)~~

~~The target populations include all enrolled behavioral health members, birth through five (up to age six), in collaboration with their caregiver(s) and Child and Family Teams (CFT). Additionally, the AMPM Behavioral Health Practice Tool is also applicable when working with parents and/or caregivers who have children aged birth through five, regardless of whether the child(ren) or parent were referred or are seeking services.~~

[1]AMPM Behavioral Health Practice Tool 211 is reserved with pertinent information incorporated into the new AMPM Policy 581

II. BACKGROUND AND EVIDENCE-BASED SUPPORT

Psychiatric disorders presenting in young children are a public health concern, and they can negatively impact normative developmental trajectories in all spheres—social, emotional, and cognitive. One of the challenges in the field of behavioral health care for young children is the belief that young children cannot develop behavioral health disorders[ix]. Yet, these disorders if not recognized and appropriately diagnosed, may result in challenging behaviors, such as significant aggression toward others (e.g. biting, hitting, kicking) and emotional dysregulation (e.g. uncontrollable tantrums or crying). These behaviors, when not addressed, can result in serious consequences such as child care expulsion, difficulty participating in family activities, and impaired peer relationships, making early intervention extremely important for families and caregivers that have young children with behavioral challenges.

Because of the complexities in treating infants and toddlers, the field of infant behavioral health has evolved to promote recognition of the rapid developmental processes and the importance of a healthy relationship between a secure child and the caregiver[ix] (either temporary or permanent caregiver for treatment purposes). Given the unique needs of infants and toddlers, numerous therapeutic interventions exist, summarized in a table (page 8), that can aid in reducing potentially damaging consequences. There is robust evidence supporting the use of relationship-based interventions, which focus on the child and parent/guardian/designated representative relationship. Generally, these treatment approaches focus on improving[ix] child and family/guardian/designated representative functioning relative to the identified emotional and/or behavioral challenges and can often be successful without introduction of pharmacological intervention.

In the absence of marked or sustained improvement, it may be necessary to follow the appropriate steps toward psychotropic intervention. However, “Psychotropic medications are only one component of a comprehensive biopsychosocial treatment plan that shall include other components in addition to medication,” according to American Academy of Child and Adolescent Psychiatry.[ix]

It is critical to recognize that there are physical causes for behavioral health and developmental delays that may cause signs and symptoms which overlap with behavioral and developmental concerns. It is therefore essential to first ensure that potential physical health issues, such as lead poisoning, have been ruled out. AMPM Policy 430 provides guidance for standard screening and testing for lead poisoning, which includes blood testing whenever a concern arises that indicates a need for blood lead testing.”[ix]

The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. While considering whether medication should be introduced in treatment, the benefits of the medication shall be evaluated and compared to the potential biological and psychosocial side effects. According to a 2007 set of Guidelines by the Preschool Psychological Working Group,[ix] little is known about the potential effects on neurodevelopmental processes in very young children when exposed to psychotropic medications. Research summaries indicate that younger children metabolize medications differently than older children. Moreover, a review of the current literature demonstrates that there is more evidence to support psychotherapeutic rather than psychopharmacologic interventions in young children presenting with psychiatric symptoms. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications.[ix]

Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.[ix]

Due to the concerns outlined above, evidence of substantial increases in prescribing antipsychotics for children[ixix] and increased federal and state attention toward prescribing practices, Arizona has recognized the need to implement revised initiatives for young children to address psychotropic medication use. As of May 2016, AHCCCS provided analysis and trending of current psychotropic prescribing practices, particularly for young children and children in the foster care system.[ix]

Data analysis for this report, revealed several key findings including:

- For Arizona in general, psychotropic prescribing rates in 2013 were higher for all foster children zero to 18, when compared to non-foster care children zero to 18,
- For Arizona, foster care children zero to six were prescribed psychotropics at a rate 4.6 times higher than non-foster care children zero to six in Arizona's Medicaid system.

Based on the AHCCCS May 2016 report and the recognition that, despite continued lack of consistent national guidelines, AHCCCS has reorganized the original practice guideline into five sections, which align with current process within Arizona. Additional revisions focus on updated research and findings with regard to psychotropic prescribing practices. Focus has been added to align with current Maternal Child Health/Early and Periodic Screening Diagnostic and Treatment (MCH/EPSDT) practice, plus Bright Futures. As such, the Guidelines within this document now comprise:

A. Assessment by Behavioral Health Professional/Provider,
B. Psychotherapeutic Interventions,
C. Psychiatric Evaluation,
D. Psychopharmacological Interventions, and
E. EPSDT: Assessing Physical and Behavioral Needs Through Developmental Surveillance, Anticipatory Guidance, and Social/Emotional Growth.

Refer to AMPM Behavioral Health Practice Tool 210 for additional information on behavioral health screening, assessment, and treatment for children birth through five years of age.

A. ASSESSMENT BY BEHAVIORAL HEALTH PROFESSIONAL/PROVIDER

~~The initial assessment for a young child, at a minimum, consists of the following components as described in The American Academy for the Psychiatric Assessment of Infants and Toddlers (0-36 Months):[ix]~~

1. ~~Gathering information from those individuals who are most familiar with the child, as well as direct observation of the child with their Health Care Decision Maker (HCDM) or caregiver, if directly involved with the child for treatment purposes (caregiver may be a family member foster parent – either temporary or permanent).~~
2. ~~Reason for referral including the child's social, emotional, and behavioral symptoms,~~
3. ~~Detailed medical and developmental history,~~
4. ~~Current medical and developmental concerns and status,~~
5. ~~Family, community, childcare and cultural contexts which may influence a child's clinical presentation,~~
6. ~~Parental and environmental stressors and supports,~~
7. ~~Parent/guardian/designated representative perception of the child, ability to read/respond to child's cues, and willingness to interact with the child,~~
8. ~~Children's birth through five mental status exam:~~
   a. ~~Appearance and general presentation,~~
   b. ~~Reaction to changes (e.g., new people, settings, situations),~~
   c. ~~Emotional and behavioral regulation,~~
   d. ~~Motor function,~~
   e. ~~Vocalizations/speech,~~
   f. ~~Thought content/process,~~
   g. ~~Affect and mood,~~
   h. ~~Ability to play/explore,~~
   i. ~~Cognitive functioning, and~~
   j. ~~Relatedness to parent/guardian/designated representative.~~

   ~~Use of standardized instruments to identify baseline functioning and track progress over time. Examples of such instruments include, yet are not limited to the following:~~

~~NAME OF TOOL~~	~~PURPOSE/DESCRIPTION~~	~~AGE/POPULATION~~	~~USER~~
~~INFANT TODDLER SOCIAL-EMOTIONAL ASSESSMENT (BITSEA)~~ [ix]	~~*Social/Emotional* Brief report questionnaire focused on child symptomatology~~	~~12 to 36 mos. Multicultural~~	~~Professional or Parents/guardians/designated representatives~~
~~BEHAVIORAL ASSESSMENT OF BABY'S EMOTIONAL~~	~~*Behavioral Screening for temperament*, ability to~~	~~Ages birth to 36 months~~	~~Parent/guardian/designated representative (for use in~~

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~~AND SOCIAL STYLE (BABES)~~[ix]	~~self-soothe and regulate~~		~~pediatric practices or early intervention programs)~~
~~CHILD BEHAVIOR CHECKLIST 1-5 (ASEBA)~~[ix] ~~(ACHENBACH AND RESCORLA; 2001)~~	~~*Social/Emotional*~~ ~~Parent and teacher ratings, descriptions and concerns of child behaviors; Corresponds to DSM~~	~~Ages 1.5 years+ Multicultural~~	~~Professional Training required~~
~~PRESCHOOL AGE PSYCHIATRIC ASSESSMENT (PAPA); (EGGER & ANGOLD, 2006)~~ [ix]	~~Psychiatric diagnosis incorporating both DSM and DC:0-3R~~	~~Ages 2 to 5 years Boys/Girls Multicultural~~	~~Professional only Training required~~
~~**NAME OF TOOL**~~	~~**Purpose/Description**~~	~~**Age/Population**~~	~~**User**~~
~~CLINICAL PROBLEM SOLVING PROCEDURE (CROWELL AND FLEISHMANN; 2000)~~ [ix]	~~Structured observations of parent/child interactions~~	~~Ages 1 year to 5 years~~	~~Professional Videotaping essential~~
~~AGES AND STAGES QUESTIONNAIRE (ASQ-3)~~ [ix]	~~Routine screening to assess developmental performance~~	~~Ages at various points from 1 month to 66 months; Boys & girls Multicultural~~	~~Parent completion~~
~~CONNOR'S EARLY CHILDHOOD ASSESSMENT~~[ix]	~~Measures specific patterns related to ADHD, cognitive and behavioral challenges~~	~~Ages 3 to 6+ Boys and Girls~~	~~Parent & teacher responses~~
~~HAWAII EARLY LEARNING PROFILE (HELP)~~ [ix]	~~Assessment of developmental skills and behaviors~~	~~Ages 0 to 3 Boys & girls~~	~~Training required for use~~
~~PARENTS' EVALUATION OF DEVELOPMENTAL STATUS (PEDS)~~ [ix]	~~Developmental Screening Tool – variety of domains~~	~~Birth to 8 years Boys & girls~~	~~Parent completion~~
~~TRAUMATIC SYMPTOM CHECKLIST FOR YOUNG CHILDREN (TSCYC)~~ [ix]	~~Assessment of PTSD Symptoms~~	~~Normed separately for boys and girls Ages 3 to 5~~	~~Can be completed by paraprofessionals~~
~~MCHAT (2009)~~ [ix]	~~A parent report screening tool to assess risk for Autism Spectrum~~	~~Designed for use at 18 – 24 months of age~~	~~Completed by parents and scored by pediatricians, child psychiatrists or child~~

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	Disorder (ASD)		psychologists

B. PSYCHOTHERAPEUTIC INTERVENTIONS

There is strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnoses. Thus, these specialized approaches should be the initial interventions before considering a psychopharmacologic trial (see table on following page and the AMPM Behavioral Health Practice Tool 210)

The recommended psychotherapeutic treatment interventions outlined in the table below are supported by current studies and best practice. Determination of the best psychotherapeutic approach is done in conjunction with the CFT and qualified infant and early childhood behavioral health practitioners. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. Other examples of accepted therapeutic approaches with this population are referenced in AMPM Behavioral Health Practice Tool 210. The psychotherapeutic intervention selected and length of treatment should be clearly documented in the clinical record.

Suggested Best Practice Interventions for Infants and Toddlers (*Table not inclusive of all available therapeutic modalities – any modalities utilized will be at the discretion of the threating BHP or BHMP*)

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
FAMILY THERAPY[i*] Training through various organizations, institutional or educational settings; Numerous masters level educational programs have dedicated programs in marriage and family therapy	Focus on conflict management and influence of marital conflict during high risk perinatal period; can also be used prenatally; Goal is to ensure parent/guardian / designated representative consensus regarding child's behavioral health status	Infants, toddlers, preschoolers and family triad (e.g. including mother and father);	Intervention takes place at the marital relationship level, as well as the relationships between each parent and the child; focus on evaluating and changing interaction patterns between triadic members	Behavioral challenges are linked to patterns of relationship challenges; an intervention directed at one family member will always have an effect on another family member; Can change behavior by changing relationships (dyadic, triadic, family system)

Marriage and Family Therapists receive specific training and clinical supervision that focuses on working with family members at the relationship level (e.g. parent-parent, parent-child or child-child)	AND that parenting strategies are consistent			*Theoretical assumptions, which guide family therapy intervention techniques, provide essential element of clinical framework for relationship-based work within Circle of Security, and Infant/Child Parent Psychotherapy*

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TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
CHILD PARENT PSYCHOTHERAPY (CPP)[ix] Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals[ix]	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and parent/guardian/des-ignated representative	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with their high-risk parents/guardian/designated representative	Work at relationship level to promote partnership between child and parent/guardian/des-ignated representative that results in increased positive interaction and reduced discordant relationship styles	Based on premise that "nurturance, protection, culturally and age appropriate socialization from the attachment figure(s) comprise the cornerstone of behavioral health in infancy and early childhood…"
INFANT PARENT PSYCHOTHERAPY (IPP) [ix] Training through various organizations,	Similar to Child Parent Psychotherapy, but with greater emphasis on impact of upbringing of	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express	Focus on parent/child relationship to build relationship with parent by helping caregiver understand the	IPP more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological

~~institutional or educational settings; Lieberman and Van Horn are originators of intervention principals~~	~~parent/guardian /designated representative and how that impacts current parent/guardian /des-ignated representative perceptions of infant and relationship with infant[ix]~~	~~feelings~~	~~basis for infant behaviors and perceptions of their world (e.g. behavior based on need for safety and security)~~	~~challenges of parent/guardian/designated representative as child and how those challenges impact ability to act as nurturing, protective parent/guardian/designated representative~~

~~**TYPE OF INTERVENTION**~~	~~**TREATMENT APPROACH**~~	~~**TARGETED POPULATIONS**~~	~~**TREATMENT GOALS**~~	~~**GUIDING ASSUMPTION AND THEORETICAL ORIENTATION**~~
~~**CIRCLE OF SECURITY**[ix]~~ ~~Training through Circle of Security International~~	~~Therapist builds trusting relationship with parent/guardian / des-ignated representative (secure base) as therapist moves through relationship-based interventions to identify relational distress~~	~~Infants, toddlers & preschoolers and their parent/guardian/ designated representative~~	~~Use Circle of Security interview to gain information about parent/guardian / designated representative "internal working model" regarding relationship with their child~~	~~The need for a secure attachment base is essential for building healthy relationships~~ ~~*Based on Attachment Theory (joint work of John Bowlby and Mary Ainsworth;[ix] also based on relationship-based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*~~

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TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
APPLIED BEHAVIORAL ANALYSIS[ix] [ix]	Applied behavior analysis is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior[ix]	Applied Behavioral Analysis Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnoses. An Early Intensive ABA (EI/ABA) program specifically for children with Autism Spectrum Disorder who begin treatment before age 4 has been described by Lovaas and others.	ABA techniques are used to decrease unwanted behaviors and increase desired behaviors through a systematic and consistent intervention. EI/ABA is provided with the goal of integrating a young child with ASD into a regular education classroom with reduced behavioral symptoms by the entry into Grade 1.	That systematic behavioral intervention can decrease unwanted behaviors and increase desired behaviors.

C. PSYCHIATRIC EVALUATION

General practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. Birth through five

~~behavioral health significant effort should be made to ensure that the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist with training or experience in the treatment of young children, aged 0 to 5.~~[ix]

~~The psychiatric evaluation for a young child continues to focus on gathering supplemental information that may be needed since completion of the comprehensive assessment. This is especially critical for identification of any additions or changes that may impact the child's functioning. Components may be very similar:~~

1. ~~Information from those persons who are most familiar with the child, as well as direct observation of the child with their parent/guardian/designated representative especially if changes have occurred within the caregiver constellation since the initial assessment.~~
2. ~~Any potential changes in the reason for referral including changes in the child's social, emotional, and behavioral symptoms.~~
3. ~~Updates related to the detailed medical and developmental history.~~
4. ~~Updates related to current medical and developmental concerns and status.~~
5. ~~Changes in family, community, childcare and cultural contexts which may influence a child's clinical presentation.~~
6. ~~Newly identified parental and environmental stressors and supports.~~
7. ~~Ongoing or recent changes in parent/guardian/designated representative perception of the child, ability to read/respond to child's cues, and willingness to interact with the child.~~
8. ~~Use of the AMPM Behavioral Health Practice Tool 210 to ensure use of evidence-based Behavioral Health Practice Tool for working with infants and toddlers.~~
9. ~~Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved.~~
10. ~~Collaboration with other agencies involved with the child and family including but not limited to Department of Child Safety (DCS), Division of Developmental Disabilities (DDD), Arizona Early Intervention Program (AzEIP), First Things First, Head Start, the local school district, Healthy Families Arizona and , other educational programs.~~
11. ~~Development of DSM-5 Diagnoses and DC: 0 TO 5 Diagnosis following:~~
    a. ~~Diagnostic Classification of Behavioral health and Developmental Disorders in Infancy and Early Childhood" (DC: 0-5), and~~[ix]
    b. ~~The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5).~~[ix]

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~~Current best practice for infants and toddlers, utilizes the DC: 0-5 for a number of reasons. First, it is based on Behavioral Health normed developmental trajectories, family systemic and relationship-based approaches, along with attention to individual differences in motor, cognitive, sensory, and language capabilities. Secondly, it allows for more thorough and developmentally appropriate diagnosis of behavioral health conditions in early childhood. An important feature of the DC: 0-5 is that it includes both the DSM-5 diagnostic references, as well as the corresponding ICD-10 codes. The DC: 0-5 manual was first published in 1994 as the "DC 0-3" and then revised in 2016 by Zero to Three: National Center for Infants, Toddlers, and Families (now known as "Zero to Three").~~

~~D. PSYCHOPHARMACOLOGICAL INTERVENTIONS~~

~~1. General Guidelines~~

~~If it is determined that a psychopharmacologic intervention is indicated, goals of treatment should include facilitating normative developmental processes and maximizing the potential for effective psychotherapeutic interventions. Medications are to be reserved for children with moderate to severe psychiatric symptoms that significantly interfere with their normal development and result in impairment that persists despite the use of clinically appropriate psychotherapeutic interventions, as the evidence base for the treatment of young children under the age of five is quite limited.~~
~~Clear and specific target symptoms shall be identified and documented in the clinical record prior to the initiation of a medication trial. Target symptoms and progress are continually documented in the clinical record throughout the course of treatment (AMPM Policy 940).~~

~~Medication is always started at the lowest possible dose with subsequent increases in medication undertaken with caution. Dosing can be challenging as young children may metabolize medications more rapidly than older children. In addition, children age birth through five experience rapid growth during this timeframe, which may change the dose that is required for optimal treatment over short periods. Since these young children are often very sensitive to side effects, they shall be monitored closely.~~[ix]

~~2. Informed Consent~~

~~Informed consent, as specified in AMPM 320-Q, is an active, ongoing process that continues over the course of treatment through active dialogue between the prescribing BHMP and parent or Health Care Decision Maker about the following essential elements (Please refer to AMPM Policy 310-V and AMPM Policy 310-V, Attachment A for more information):~~

- ~~a. The diagnosis and target symptoms for the medication recommended,~~
- ~~b. The possible benefits/intended outcome of treatment,~~
- ~~c. The possible risks and side effects,~~
- ~~d. The possible alternatives,~~
- ~~e. The possible results of not taking the recommended medication,~~
- ~~f. FDA status of the medication, and~~
- ~~g. Level of evidence supporting the recommended medication.~~

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Although there are medications approved by the Food and Drug Administration (FDA) for young children under the age of five, an FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. In addition, lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy. The Physician's Desk Reference states the following: "Accepted medical practice includes drug use that is not reflected in approved drug labeling." In the United States only a small percentage of medications are FDA indicated for use in pediatrics. Thus, BHMPs shall document the rationale for medication choice and the provision of informed consent to parents/ guardians/designated representatives.

3. Monitoring

Medications that have been shown to adversely affect hepatic, renal, endocrine, cardiac and other functions or require serum level monitoring shall be assessed via appropriate laboratory studies and medical care shall be coordinated with the child's primary care physician.[ix]

4. Coordination of Care

In Arizona, the behavioral health program has historically been separated from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI). Both models have been structured such that eligible persons receive general medical services through health plans and covered behavioral health services through the Contractor. Because of this separation in responsibilities, communication and coordination between behavioral health providers, AHCCCS Health Plan Primary Care Providers (PCPs) and Behavioral Health Coordinators is essential to ensure the well-being of young children receiving services from both systems. Since October 1, 2019, there has been a system-wide shift toward medical health homes and provision of integrated and coordinated care, which is bringing about a shift in provider practices to address early intervention needs using a more holistic approach

Duplicative medication prescribing, contraindicated combinations of prescriptions and/or incompatible treatment approaches could be detrimental to a young child. For this reason, communication and coordination of care between behavioral health providers and PCPs shall occur on a regular basis to ensure safety and positive clinical outcomes for young children receiving care.

For Contractor enrolled children not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider. Documentation in the clinical record is required, showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment. Please refer to AMPM Policy 940 for further information.

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~~5. Polypharmacy~~

~~Polypharmacy is defined as using more than one psychotropic medication at a time with this population and is not recommended. This definition excludes a medication cross taper, where the young child may be on two medications for a short period in order to avoid abrupt withdrawal symptoms. More than one medication should only be considered and used in extreme situations where severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express their emotions, and developmental progress.~~

~~Complementary, alternative and over-the-counter medications should be taken into consideration when evaluating the use of polypharmacy and potential drug interactions. If more than one medication is prescribed, there shall be documentation of clear target symptoms for each medication in the child's clinical record. When applicable, the Controlled Substance Prescription Monitoring Program (CSPMP) database should be checked (Refer to AMPM Policy 940).~~

~~6. Medication Taper~~

~~In children who have a positive response to medication, as indicated by a remission of symptoms, a taper off medication should be considered at six to eight months of treatment.[ix] This consideration shall be clearly documented in the clinical record. The BHMP shall weigh the risks vs. benefits of each approach with the parent/guardian/ designated representative, which includes the importance of reassessing the need for medication in the rapidly developing young child. Every six to eight months, a medication taper should be considered until the child reaches the age of five. The BHMP should reassess for a persistent diagnosis and need for continuing medication at reasonable intervals beyond age five.~~

~~If the decision to taper the child off medication is made, the CFT shall be informed of this decision in order to discuss and address possible behavior disruptions that may arise as a result of this taper. The CFT shall also ensure that the need for additional supports or services for the child and/or caregiver be considered and implemented as necessary to maintain the child's stability (For specific guidelines for children involved with the Department of Child Safety and/or foster care, refer to AMPM Behavioral Health Practice Tool 260, AMPM 320-Q, and A.R.S. § 8-514.05). Documentation of medication taper should be made with clinical rationale provided.~~

~~7. Prescription by a Non-Child Psychiatrist~~

~~As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services to young children shall have training and possess experience in both~~

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psychotherapeutic and psychopharmacological interventions for children age birth through five. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible; in rural or underserved locations, this may be met through the use of telemedicine. A non-child psychiatrist BHMP shall adhere to the following when prescribing psychotropic medication for children birth through five years of age:

a. After the psychiatric evaluation has been completed and it is determined that the child may benefit from psychotropic medication(s), the case shall be reviewed with the designated child psychiatric provider as determined by the Contractor. The review shall include, at a minimum, the following elements:
   i. The proposed medication with the starting dosage,
   ii. Identified target symptoms,
   iii. The clinical rationale for the proposed treatment,
   iv. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/holistic providers,
   v. Drug Review/Adverse Reactions,
   vi. A plan for monitoring, potential side effects such as weight gain, and/or abnormal/involuntary movements, (based on recommended standards of care, and
   vii. Identified targeted outcomes.
b. Follow-up consultation with a designated child psychiatric provider shall occur in the following instances:
   i. If the child is not making progress towards identified treatment goals (at minimum of every three months),
   ii. In the event that reconsideration of diagnosis is appropriate,
   iii. When a new medication is being considered or when more than one medication is prescribed.

E. BIRTH THROUGH FIVE EPSDT: ASSESSING PHYSICAL AND BEHAVIORAL NEEDS THROUGH DEVELOPMENTAL SURVEILLANCE, ANTICIPATORY GUIDANCE AND SOCIAL/EMOTIONAL GROWTH

AHCCCS has historically incorporated the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program to ensure that members under the age of 21 receive appropriate preventive and early intervention services for physical and behavioral health conditions (refer to AMPM Policy 430). Through formal policy and reporting requirements under CMS guidelines, participation has been measured in part through use of forms designated as "EPSDT Tracking Forms" (refer to AMPM Policy 430, Attachment E).

Although AHCCCS requires use of specific EPSDT forms available on the AHCCCS website, further guidance on the use of the forms is also available through Bright Futures.[ix] Both the Bright Futures website and Bright Futures Pocket Guide[x] offer more detailed guidance on use of content within the tracking forms. The focus of the last section of this AMPM Behavioral Health Practice Tool is to assist PCPs and/or pediatricians in identifying concerns related to three central EPSDT domains:

- Anticipatory Guidance,
- Developmental Surveillance, and
- Social/Emotional Growth.

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Often, the primary care setting is the most robust situation available for parents to address early developmental or behavioral concerns.[ix] During the course of EPSDT-required well-child visits, physicians and pediatricians have multiple opportunities over time to build relationships with parents and their young children, while simultaneously gathering valuable information. Through discussions guided by the use of the three domains listed above, they have the chance to identify strengths, needs and stressors for the parents and children that they follow. With thoughtful use of items within these domains, it is possible for physicians to identify a physical health concern that may also involve the need for further behavioral health services. For example, a language delay or developmental regression could be due to numerous physical causes. However, both are also symptoms of early childhood trauma for children birth to three years of age.[ix] Additionally, symptoms often associated with Attention Deficit Hyperactivity Disorder (ADHD) can mirror child traumatic stress.[ix]

The challenge for physicians, due to lack of training and knowledge, is often the ability to clearly identify behavioral and developmental concerns and then link parents/guardians/ designated representatives to adequate resources.[ix] Some physicians are comfortable providing basic treatment, whereas others are not. According to one study, PCPs had various comfort levels to conduct treatment or make referrals, but it related to the diagnoses involved.[ix] There was a comfort level treating ADHD but not depression – the preference for the latter, in most instances was to make a behavioral health referral.

Given acknowledgement to the lack of behavioral health training within the pediatric community,[ix] dedicated and thorough use of EPSDT forms, as well as guidance provided under Bright Futures, can aid physicians in providing appropriate and early intervention treatment for children birth through five. The center sections of EPSDT forms offer opportunity to work with parents/guardians/designated representatives to offer guidance and encourage referrals to and use of behavioral health system when there is concern about behaviors that may indicate a potential behavioral health condition.

Although it is not the purpose of this AMPM Behavioral Health Practice Tool to offer extensive details regarding early childhood developmental and behavioral health issues, the table below provides some examples of how EPSDT Developmental Screening sections can prompt opportunities (based on specific age-appropriate EPSDT domains) for discussion between parents/HCDM and PCPs regarding observations and concerns identified during visits. PCPs have multiple options at these visits to suggest community supports, case manager involvement (if available under the Medical Health Home model) or refer to behavioral health system/provider for further assistance (Refer to AMPM Policy 580 for information on the Behavioral Health Referral Process) or contact information at
https://azahcccs.gov/Members/Downloads/AccessingBHSystem.pdf

The table below is designed to present bivariate ways (e.g. physical or behavioral) to examine developmental milestones, environmental factors and level of social/emotional growth. Because physical and familial environments have such a tremendous impact on the developing brain, it is important to recognize that if infants and toddlers are not meeting milestones, there could be either physical, environmental or behavioral health reasons.

EPSDT DOMAIN SAMPLE TABLE: POTENTIAL INDICATORS FOR REFERRAL TO BH SERVICES (BASED ON AGE, DOMAIN & NEED (AMPM POLICY 430, ATTACHMENT E; BRIGHT FUTURES, 4TH EDITION)

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
DEVELOPMENTAL SURVEILLANCE	6 months	Sits without support, babbles sound such as "ma", "ba", "ga", looks when name is called.	Parent/guardian/designated representative engages with and is attentive toward infant; if infant is engaging in these early milestone behaviors, and there is lack of reaction or acknowledgement from parent, or reciprocal engagement explore further for evidence of potential maternal depression or other environmental factors (unsafe environment, violence, neglect) that may be causing stress or trauma for the infant.

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
ANTICIPATORY GUIDANCE PROVIDED	6 months	Discussion of social determinants of health (e.g. safe sleep, sleep/wake cycles, tobacco use, safe environment).	Any potential risk factors identified under this domain may warrant referral for community supports or referral for behavioral health services if there is concern about parental depression, substance use, neglect of child or dangerous environment).
SOCIAL EMOTIONAL HEALTH	6 months	Appropriate bonding and responsive to needs.	Is parent/guardian/designated representative feeding infant and engaging while feeding or is infant being fed

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			~~via bottle propping while in carrier or crib? Lack of infant/parent engagement may warrant further discussion and referral to behavioral health system due to potential indicators for maternal depression or lack of appropriate bonding/attachment. Lack of appropriate bonding can manifest in multiple ways (lack of eye contact between baby and caregiver, baby shows signs of discomfort when being held, inability for caregiver to help baby sooth).~~

~~EPSDT DOMAINS~~	~~AGE~~	~~DISCUSSION CHECKLIST ELEMENT~~	~~POTENTIAL BEHAVIORAL HEALTH NEED~~
~~ANTICIPATORY GUIDANCE PROVIDED~~	~~1 yr.~~	~~Continued focus on social determinants of health such as food security, safe environment, parental use of tobacco, alcohol or other substances.~~	~~If there are parental risk factors for social determinants of health, there are opportunities to refer for community supports or behavioral health; in case there are underlying behavioral health needs (e.g. parental depression, substance use).~~
~~SOCIAL EMOTIONAL HEALTH~~	~~1 yr.~~	~~Prefers primary caregiver over others, shy with others, tantrums.~~	~~Lack of preference for primary caregiver could indicate insecure attachment for variety of reasons (e.g. lack of trust, abuse, neglect, early trauma); consider unaddressed behavioral health issues in parent.~~

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DEVELOPMENTAL SURVEILLANCE	3 yrs.	Eats independently, uses three word sentences, plays cooperatively and shares.	Lack of these observed developmental milestones may be indicative of physical issues or lack of parental engagement with child; consider referral for community supports and/or behavioral health system to address potential for undiagnosed behavioral health issue on the part of the parent or child (barring any evidence of physical reasons).

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
ANTICIPATORY GUIDANCE PROVIDED	3 yrs.	Allow child to play independently; be available if child seeks out parent or caregiver.	Attachment issues can manifest as fear in child to play independently, even if allowed (over-dependence on caregiver), or reluctance of child to seek out parent/guardian/designated representative due to lack of secure "attachment" base. Could also be signs/symptoms related to abuse.
SOCIAL EMOTIONAL HEALTH	3 yrs.	Separates easily from parent, shows interest in other children, kindness to animals.	Observe parental conversations and interaction; is parent positive with child, offering praise, setting appropriate boundaries; lack of these observed behaviors on the part of either parent or child may indicate unaddressed child/parent relationship issues or potential mental issue issues for either parent

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			or child.

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