PSYCHIATRIC AND PSYCHOTHERAPEUTIC BEST PRACTICES FOR CHILDREN

BIRTH THROUGH FIVE YEARS OF AGE

EFFECTIVE DATE: 07/01/16

I. GOAL/WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS TOOL?

To define best practice for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions with children birth through five years of age.

A. TARGET AUDIENCE

These guidelines are specifically targeted to Contractors, Regional Behavioral Health Authorities (RBHAs) 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)

All enrolled behavioral health recipients, birth through five, in collaboration with their caregiver(s) and Child and Family Teams (CFT).

II. BACKGROUND

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[i]. 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, secure child and parent/guardian/designated representative relationship.[ii] 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[iii] 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 must include other components in addition to medication," according to American Academy of Child and Adolescent Psychiatry.[iv]

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 must 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,[v] 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.[vi] Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention.[vii]

Due to the concerns outlined above, evidence of substantial increases in prescribing antipsychotics for children[viiiix]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.[x]

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 0 to 18, when compared to non-foster care children 0 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, as well as the recognition that despite continued lack of consistent national guidelines, AHCCCS has reorganized the prevailing practice guideline into five sections that 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, and 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.

Please refer to the AHCCCS Practice Tool "Working with the Birth Through Five Population" 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):[xi]

1. Gathering information from those persons who are most familiar with the child, as well as direct observation of the child with his/her parent/guardian/designated representative,

2. Reason for referral including child's social, emotional, and behavioral symptoms,

3. Detailed medical and developmental history,

4. Current medical and developmental concerns and status,

5. Family, community, child care 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,
   j. Relatedness to parent/guardian/designated representative and

9. 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)[xii]	*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 and Social Style (BABES)[xiii]	*Behavioral Screening for temperament*, ability to self-soothe and regulate	Ages birth to 36 months	Parent/guardian/designated representative(for use in pediatric practices or early intervention programs)
Child Behavior Checklist 1-5 (ASEBA)[xiv] (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)[xv]	Psychiatric diagnosis incorporating both DSM and DC:0-3R	Ages 2 to 5 years Boys/Girls Multicultural	Professional only Training required
Clinical Problem Solving Procedure (Crowell and Fleishmann; 2000)[xvi]	Structured observations of parent/child interactions	Ages 1 year to 5 years	Professional Video taping essential
Ages and Stages Questionnaire (ASQ-3)[xvii]	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[xviii]	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)[xix]	Assessment of developmental skills and behaviors	Ages 0 to 3 Boys & girls	Training required for use
Parents' Evaluation of Developmental Status (PEDS)[xx]	Developmental Screening Tool – variety of domains	Birth to 8 years Boys & girls	Parent completion
Traumatic Symptom Checklist for Young Children (TSCYC)[xxi]	Assessment of PTSD Symptoms	Normed separately for boys and girls Ages 3 to 5	Can be completed by paraprofessionals
MCHAT (2009)[xxii]	A parent report screening tool to assess risk for Autism Spectrum Disorder (ASD)	Designed for use at 18 – 24 months of age	Completed by parents and scored by pediatricians, child psychiatrists or child 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 "Working with the Birth Through Five Population" available on the AHCCCS website under "AHCCCS Behavioral Health System Practice Tools.")

Active engagement and participation by the young child's parents/guardians/designated representatives is crucial when providing psychotherapeutic interventions, as this relationship forms the foundation for treatment success. In addition, as the service planning in Arizona is

coordinated through CFT practice, all service delivery should be coordinated within this team context. Details and guidelines for providing effective CFT practice related to service planning, development and implementation can be found within the "Child and Family Team Practice Tool," available on the AHCCCS website under "AHCCS Behavioral Health System Practice Tools."

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. Psycho-education 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 the "Working with the Birth Through Five Population Practice Tool". 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[xxiii] Training through various organizations, institutional or educational settings; Numerous masters level educational programs have dedicated programs in marriage and family therapy 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)	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 AND that parenting strategies are consistent	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) *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*

Type of Intervention	Treatment Approach	Targeted Populations	Treatment Goals	Guiding Assumption and Theoretical Orientation
Child Parent Psychotherapy (CPP)[xxiv] Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals[xxv]	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and parent/guardian/designated representative	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with and their high risk parents/guardian/ designated representative	Work at relationship level to promote partnership between child and parent/guardian/designated 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)[xxvi] Training through various organizations, institutional or educational settings; Lieberman and Van Horn are originators of intervention principals	Similar to Child Parent Psychotherapy, but with greater emphasis on impact of upbringing of parent/guardian/designated representative and how that impacts current parent/guardian/designated representative perceptions of infant and relationship with infant[xxvii]	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express feelings	Focus on parent/child relationship to build relationship with parent by helping parent/guardian/designated representative understand the basis for infant behaviors and perceptions of their world (e.g. behavior based on need for safety and security)	IPP more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological challenges of parent/guardian/designated representative as child and how those challenges impact ability to act as nurturing, protective parent/guardian/designated representative
Circle of Security[xxviii] Training through Circle of Security International	Therapist builds trusting relationship with parent/guardian/designated 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;*[xxix] *also based on relationship-based interventions arising out of family therapy and family systems guiding assumptions and psychoanalytic theory*

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
Applied Behavioral Analysis[xxx] [xxxi]	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[xxxii]	Applied Behavioral Analysis Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnoses. An Early Intensive ABA (EIABA) 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. [xxxiii]

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 his/her 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, child care 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 "Working with Birth Through Five Population Practice Tool" to ensure use of evidence-based guidelines 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)[xxxiv]
    b. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, (DSM-5)[xxxv]

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 must 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 individuals. 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 of time. Since these young children are often very sensitive to side effects they must be monitored closely.[xxxvi]

2. Informed Consent

Informed consent is an active, ongoing process that continues over the course of treatment through active dialogue between the prescribing BHMP and parent/guardian/designated representative about the following essential elements (Please refer to AMPM Policy 310-V and 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.

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 must be assessed via appropriate laboratory studies and medical care must be coordinated with the child's primary care physician.[xxxvii]

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. Although there is a shift toward medical health homes and provision of integrated and coordinated care, separate behavioral and physical systems continue to exist in Arizona, making it challenging to provide an appropriate continuum of care for infants and toddlers, especially in the presence of special health care needs.

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 must 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.

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 of time 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 his/her 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 must be documentation of clear target symptoms for each medication in the child's clinical record. When applicable, the Controlled Substance Prescription Monitoring Program (CSPMP) data base should be checked (see 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.[xxxviii] This consideration must be clearly documented in the clinical record. The BHMP must 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 must 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 must 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. 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 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 must 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 must 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 must 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 (see 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" (see AMPM Appendix B).

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.[xxxix] Both the Bright Futures website and Bright Futures Pocket Guide[xl] offer more detailed guidance on use of content within the tracking forms. The focus of the last section of this guidance document is to assist PCPs and/or pediatricians in identifying concerns related to three central EPSDT domains:

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

Often, the primary care setting is the most robust situation available for parents to address early developmental or behavioral concerns.[xli] 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.[xlii] Additionally, symptoms often associated with Attention Deficit Hyperactivity Disorder (ADHD) can mirror child traumatic stress.[xliii]

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.[xliv] 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.[xlv] 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,[xlvi] 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 not the purpose of this guidance document 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/guardians/ designated representatives 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 (See AMPM Policy 580 for information on the Behavioral Health Referral and Intake 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 (AHCCCS AMPM EPSDT Appendix B; Bright Futures, 4TH Edition)

EPSDT Domains	Age	Discussion Checklist Element	Potential Behavioral Health Need
Developmental Surveillance	6 months	Sits without support, babbles sounds 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 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).
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.

EPSDT DOMAINS	AGE	DISCUSSION CHECKLIST ELEMENT	POTENTIAL BEHAVIORAL HEALTH NEED
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).
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 or child.

[i] American Psychological Association (2011, February 22). Babies and Toddlers Can Suffer Mental Illness, Seldom Get Treatment [Press Release] [On-line]. Available: www.apa.org/news/press/release/2011/02/babies-mental illness.asp (accessed 4/13/17).

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