OVERVIEW

This document is provided to offer additional information on best practices that relate to AMPM Policy 581, and the activities involved in working in an optimal fashion when providing assessment, service planning, and treatment for children birth through five years of age.

A. BACKGROUND AND EVIDENCE-BASED SUPPORT

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. The longitudinal study, known as the ACES study (Adverse Childhood Experiences)[i], 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].

Important assets such as healthy attachment, social and emotional competency, self-assurance, confidence, and independence can be undermined as a result of trauma.[v]

B. EVIDENCE-BASED SUPPORT FOR EARLY INTERVENTION

The 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.[vi] 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.[vii]

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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,[viii] functions of various parts of the brain and their role in the physical and emotional development of the child.

C. IMPORTANCE OF HEALTHY EARLY CHILDHOOD DEVELOPMENT

Unlike adults, infants and toddlers have a limited repertoire of coping responses to stress and trauma.[ix] 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.[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 may not be responsive to teaching methods or benefit from their early educational experiences and may lag behind their peers.

The 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 one or more behaviors such as:

1. Poor self-control.
2. Aggression.
3. Poor peer relationships.
4. 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).

D. 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 one-time snapshot of symptoms. Behavioral Health practitioners collect information over time 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.[xvii]

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). 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 (copies of the DC: 0-5 manual are available through the Zero to Three Press).[xviii] Examples include:

1. Criteria for identifying autism spectrum disorders in children as young as two.
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.

E. ANNUAL ASSESSMENT UPDATE

While the 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 more frequently 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, shall assist the behavioral health provider with identifying any potential developmental concerns that may require additional intervention or referral.

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 are to consult with their supervisor if they are unclear about their duty to report a situation.

F. CONSIDERATIONS FOR LINKING ASSESSMENT AND SERVICE PLANNING

Starting with the assessment process, strategies that incorporate information from all involved providers serving the child, parent, or caregiver shall lead to optimal service planning. Other providers that may be involved could 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 shall develop an effective service plan that employs natural supports in conjunction with formalized services (Refer to AMPM Policy 580). 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.

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

1. Ongoing and nurturing relationships with one or two deeply attached individuals.

2. Physical protection, safety, and regulation at all times.

3. Experiences suited to individual differences to include regular one-to-one interaction between the caregiver and child.

4. 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).

5. Limit setting, structure, and expectations (e.g., clear messages and routines).

6. Stable, supportive communities and cultural continuity which can be met through solid relationships between the child and one or two primary caregivers.

The 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.[xix]

G. SERVICE PLAN DEVELOPMENT

The information obtained through the assessment process shall 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.

The 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.[xx]

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 toddlers[xxi].

The 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.

The 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, childcare, 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 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.

The 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.

H. 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 that can be found in AMPM Policy 100 and AMPM Policy 580. Relationship-based models of intervention have been found to be the most effective in working with young children and their caregivers.

The infant and early childhood therapeutic approaches are supported by the following conceptual premises:[xxii]

1. 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:
   a. Emotional and behavioral problems in early childhood are best addressed within the context of the child's primary attachment relationships, and
   b. Promoting growth in the child-caregiver relationship supports healthy development of the child after the intervention ends.

2. The following skills and strategies are fundamental to the work of infant and early childhood behavioral health:
   a. Building relationships and using them as instruments of change,
   b. Meeting with the infant and parent/caregiver together throughout the period of intervention, and
   c. Sharing in the observation of the infant's growth and development:
      i. Offering anticipatory guidance to the parent/caregiver that is specific to the infant,
      ii. Alerting the parent/caregiver to the infant's individual accomplishments and needs,
      iii. Helping the parent/caregiver to find pleasure in the relationship with the infant,
      iv. Creating opportunities for interaction and exchange between parent/ caregiver(s) and infant or parent/caregiver(s) and practitioner,
      v. Allowing the parent/caregiver to take the lead in interacting with the infant or determining the 'agenda' or 'topic for discussion',

vi. Identifying and enhancing the capacities that each parent/caregiver brings to the care of the infant,
vii. Asking the parents/caregivers about their thoughts and feelings related to the presence and care of the infant and the changing responsibilities of parenthood,
viii. Wondering about the infant's experiences and feelings in interaction with and relationship to the caregiving parent,
ix. Listening for the past as it is expressed in the present, inquiring, and talking,
x. Allowing core relational conflicts and emotions to be expressed by the parent/caregiver; holding, containing, and talking about them as the parent is able,
xi. 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,
xii. Attending and responding to the infant's history and early care within the developing parent/caregiver-infant relationship,
xiii. Identifying, treating and/or collaborating with others if needed, in the treatment of the disorders of infancy, delays and disabilities, parental mental illness, family dysfunction, and
xiv. Remaining open, curious, and reflective.[xxiii]

While all the skills and strategies noted above are pertinent in working with children and families, items "xi" through "xiv" are of unique importance to the practice of the infant and early childhood behavioral health practitioner. These 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.[xxiv]

The 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 can do with the child and may promote a mutually pleasurable experience and purposeful response at the child/caregiver relationship level.

The 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 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 relationships[xxv]. The interventions are consistent with attachment theory if they include the following elements:

1. Provide emotional and physical access to the mother/caregiver.

2. Focus directly on maternal/caregiver sensitivity and responsiveness to the infant's behavior and emotional signals.

3. Place the mother/caregiver in a non-intrusive stance.

4. Provide space in which the infant can work through relational struggles through play and interaction with the mother/caregiver.

5. Provide a clinician who functions as a secure base for the father.

The 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.

The general reference materials on infant and early childhood mental health practice have been provided as AMPM Policy 581 Attachment D (Population Recommended Resources). This resource list is not meant to be exhaustive, given that research and clinical practice in this area continue to evolve.

The Arizona Association for Infant Mental Health (AzAIMH) has adopted the Endorsement® process under the Alliance for the Advancement of Infant Mental Health. Endorsement recognizes the professional development of practitioners within the diverse and rapidly expanding infant and family fields. 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. Endorsement also provides an organized approach to workforce development that identifies competency-based training and reflective supervision experiences that enhance credibility among individuals that work with or on behalf of infants and toddlers. The endorsement process is open to anyone interested in gaining this level of expertise, provided they meet minimum expectations outlined on the Alliance for the Advancement of Infant Mental Health webpage. 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.

I. ADDITIONAL INTERVENTION STRATEGIES FOR CHILDREN BIRTH THROUGH FIVE:

The 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 has been the belief that young children cannot develop behavioral health disorders[xxvi]. 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 childcare 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.

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,[xxvii] 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.[xxviii]

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.[xxix]

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

The 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.

J. PSYCHOTHERAPEUTIC INTERVENTIONS

There is strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnosis. The recommended psychotherapeutic treatment interventions outlined in the table below are supported by current studies and best practice and should be the initial interventions before considering a psychopharmacologic trial. 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.

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
FAMILY THERAPY[xxxi] Marriage and Family Therapists receive training and supervision on working with family 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. The goal is to ensure caregiver 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).	The 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.	The 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.

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
CHILD PARENT PSYCHOTHERAPY (CPP)[xxxii] Lieberman and Van Horn are originators of intervention principals[xxxiii]	Relationship-based; focus on parent perceptions and behaviors to promote mutual positive exchanges between child and caregiver.	Infants, toddlers, & preschoolers with or at risk for behavioral health problems along with their high-risk caregivers.	Work at relationship level to promote partnership between child and caregiver 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…".

TYPE OF INTERVENTION	TREATMENT APPROACH	TARGETED POPULATIONS	TREATMENT GOALS	GUIDING ASSUMPTION AND THEORETICAL ORIENTATION
INFANT PARENT PSYCHOTHERAPY (IPP) [xxxiv] Lieberman and Van Horn are originators of intervention principles	Similar to Child Parent Psychotherapy, but with greater emphasis on the impact of upbringing of caregivers and how that impacts current caregiver perceptions of infants and relationship with infant[xxxv].	Infants, typically birth to 24 months or prior to onset of language, locomotion, and ability to express feelings.	Focus on child/caregiver relationships to build relationships by helping caregiver understand the basis for infant behaviors and perceptions of their world (e.g., behavior based on need for safety and security).	IPP is more reliant on the psychoanalytic work of Selma Fraiberg; focus on impact of psychological challenges of caregivers and how those challenges impact ability to act nurturing and protective.
CIRCLE OF SECURITY[xxxvi] Training through Circle of Security International	Therapists build trusting relationships with caregivers (secure base) as therapists move through relationship-based interventions to identify relational distress.	Infants, toddlers & preschoolers, and their caregivers.	Use Circle of Security interview to gain information about the caregiver's "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;[xxxvii] 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 (ABA)[xxxviii] [xxxix]	ABA 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.[xl]	ABA Techniques can be used with persons of all ages, with both behavioral health and developmental disabilities diagnosis. Refer to AMPM Policies 320-S and AMPM Policy 310-B for additional information.	ABA techniques are used to decrease unwanted behaviors and increase desired behaviors through a systematic and consistent intervention.	That systematic behavioral intervention can decrease unwanted behaviors and increase desired behaviors.

K. PSYCHOPHARMACOLOGICAL INTERVENTIONS

If it is determined that a psychopharmacologic intervention is indicated, goals of treatment shall 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.

The 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 aged 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.[xli]

The Polypharmacy is defined as using more than one psychotropic medication at a time and it is not recommended for the birth through five population. Recommendations are to consider use of more than one medication only in extreme situations when severe symptoms and functional impairment are interfering with the child's ability to form close relationships, experience, regulate and express their emotions, and make 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).

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.[xlii] Every six to eight months, a medication taper should be considered until the child reaches the age of five. The Physician shall 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 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 Policy 585, AMPM Policy 320-Q, and ARS § 8-514.05). Documentation of medication taper should be made with clinical rationale provided.

As noted earlier with assessment and evaluation practice standards, physicians 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[xliii] or qualified child and adolescent psychiatrist whenever possible; in rural or underserved locations, this may be met through the use of telemedicine. A physician (non-child psychiatrist) shall adhere to clinical and evidence-based practice standards when prescribing psychotropic medication for children birth through five years of age.

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

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. Often, the primary care setting is the most robust situation available for parents to address early developmental or behavioral concerns.[xliv] 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 using 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.[xlv]

Additionally, symptoms often associated with attention deficit hyperactivity disorder (ADHD) can mirror child traumatic stress.[xlvi] Other conditions, such as lead poisoning, may also need to be 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."[xlvii]

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 Clinical Sample Templates, refer to AMPM Policy 430, Attachment E: AHCCCS EPSDT Clinical Sample Templates.

These EPSDT forms offer the capacity for practitioners in a primary care setting to identify ways to address the needs of children birth through five, based on specific age-related EPSDT forms (e.g., 6 months, 12 months, 18 months, 24 months, etc.). These forms address age specific requirements for what should be addressed by the child's physician from multiple perspectives such as, but not limited to nutrition, developmental milestones, environmental safety, and social-emotional health. The forms assist in the identification of the need for referrals, based on observation and conversations with the parent/caregiver.

Although these forms are available to physicians who may be treating children birth through five, it is important to recognize that they can also be a resource for behavioral health providers. They can provide the impetus to have discussions with parents and caregivers to encourage them to schedule EPSDT appointments and utilize these valuable preventive and routine services.

M. TRAINING AND SUPERVISION

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; building a therapeutic alliance.
3. Assessment of parent-infant relationships; Understanding parent-child interactions and healthy attachment.
4. Screening and diagnostic measures for infants and toddlers.
5. Early childhood development.
6. Effects of early adverse experiences and trauma.
7. Cultural influences in parenting and family development.
8. Collaboration practices with other providers/caregivers.
9. A focus on reflective practice.

The 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.

The 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 services to children age birth through five and their families, receive adequate training in the elements of Reflective Supervision. Criteria for provision of reflective practice is outlined on the Michigan Association for Infant Mental Health[xlviii] website, but at minimum, Reflective Supervision requires Endorsement for Infant Behavioral Health Specialist or Infant Behavioral Health Mentor. Additional information is also available within AMPM Policy 581, Attachment D for additional resource materials on reflective supervision and consultative practices.

Reflective Supervision, as one aspect of Reflective Practice, is a distinctive style of professional development (different from administrative or clinical supervision)[xlix] 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 the 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.

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.[l]

The 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.

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 (AzAIMH)[li] or Michigan Association for Infant Mental Health[lii]. 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).

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