DBHS Practice Guideline
Psychiatric Best Practice for Children
Birth to Five Years of Age

Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services
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Title
Psychiatric Best Practice for Children Birth to Five Years of Age

Goal/What Do We Want to Achieve Through the Use of these Guidelines?
To define best practice for psychiatric evaluation and the use of psychotherapeutic and psychopharmacological interventions with children birth to five years of age.

Target Audience
These guidelines are specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency behavioral health medical practitioners (BHMPs) who complete psychiatric evaluations, identify and provide psychotherapeutic interventions, and prescribe psychopharmacological treatment for children birth to five years of age.

Target Population(s)
All enrolled behavioral health recipients, birth to five years of age (up to age 5), in collaboration with their caregiver(s).

Definitions
Assessment
Behavioral Health Medical Practitioner (BHMP)
Caregiver
Child and Family Team
Credentialing
Designated Child Psychiatric Provider
Infant and Early Childhood Mental Health
Informed Consent
Privileging
Young Child

Background
Psychiatric disorders presenting in young children is a public health concern, including the ability to impact normative developmental trajectories in all spheres—cognitive, emotional, and social. The prevalence of psychiatric disorders in young children is similar to the overall rate of disorders reported for older children; rates of psychiatric disorders across four preschool studies range from 14–26.4% with a mean of 19.5%.[1] Challenging behaviors resulting from these disorders may include aggression toward others (i.e., biting, hitting, kicking, etc.) and emotional dysregulation (i.e., uncontrollable tantrums, crying, etc.). These behaviors can result in child care expulsion, difficulty participating in family activities, and impaired peer relationships and thus have serious consequences if not addressed.[2]

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

[1]Egger, Helen L. and Angold, Adrian (2006) Common emotional and behavioral disorders in preschool children: presentation, nosology, and epidemiology. *Journal of Child Psychology and Psychiatry* 47:3/4, 313–337.
[2] Gleason, M.D., Mary Margaret et al. (2007, December). Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines [Special Communication]. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46(12), 1532-1572.

interventions prior to the initiation of medications.[2] The use of medications to treat psychiatric disorders in young children raises unique developmental and ethical challenges. "Currently, it is not known whether exposure to psychopharmacological agents in the early years has a harmful influence on CNS maturation or whether early medication exposure and normalization of functioning may be protective against later psychopathologies and measurable CNS dynamics."[3]

Due to the aforementioned concerns, Arizona has prioritized key initiatives for young children, including improvements in prescribing practices of psychotropic medications. These Arizona guidelines are derived from a review of the current available literature, as national guidelines for this target population are not yet available.

These practice guidelines are organized into four sections:

I. Psychiatric Evaluation;
II. Psychotherapeutic Interventions;
III. Psychopharmacological Interventions; and
IV. T/RBHA Expectations for Credentialing, Training, Oversight and Monitoring.

Please refer to the ADHS/DBHS Practice Protocol *Working with the Birth to Five Population* for additional information on behavioral health screening, assessment, and treatment for children birth to five years of age.

I. Psychiatric Evaluation

A comprehensive behavioral health assessment may include a psychiatric evaluation when clinically indicated. The psychiatric evaluation takes multiple sessions and is completed prior to the initiation of psychotropic medication. The evaluation is completed by a Behavioral Health Medical Practitioner (BHMP) with training and experience in the assessment and treatment of children age birth to five years of age. The BHMP meets requirements as per *ADHS/DBHS Provider Manual Section 3.20, Credentialing and Recredentialing* and is able to demonstrate the competencies and expertise in providing mental health treatment with this young population. Whenever possible, the psychiatric evaluation is conducted by a board certified or board qualified child and adolescent psychiatrist.

The psychiatric evaluation for a young child, at a minimum, consists of the following components:

- Gathering information from those persons who are most familiar with the child, as well as direct observation of the child with his/her parent/primary caregiver(s)
- Reason for referral including child's social, emotional, and behavioral symptoms
- Detailed medical and developmental history
- Current medical and developmental concerns and status
- Family, community, child care and cultural contexts which may influence a child's clinical presentation
- Parental and environmental stressors and supports
- Parent/Caregiver(s) perception of the child, ability to read/respond to child's cues, and willingness to interact with the child
- Children birth to five mental status exam
    - Appearance and general presentation
    - Reaction to changes (e.g., new people, settings, situations)

[3] Fanton, John and Mary Margaret Gleason (2009) Psychopharmacology and Preschoolers: A Critical Review of Current Conditions. *Child and Adolescent Clinics of North America,* 18: 753-771

    - Emotional and behavioral regulation
    - Motor function
    - Vocalizations/speech
    - Thought content/process
    - Affect and mood
    - Ability to play/explore
    - Cognitive functioning
    - Relatedness to parent/primary caregiver(s)
- 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:
    - Brief parent report questionnaires focused on child symptomatology
        - Infant Toddler Social-Emotional Assessment (Briggs-Gowan, 1998)
        - Child Behavior Checklist 1-5 (Achenbach and Rescoria, 2000)
    - Diagnostic interviews
        - Preschool Age Psychiatric Assessment (Egger et al., 2006b)
    - Structured observations of parent-child interactions
        - Clinical Problem Solving Procedure (Crowell and Fleischmann, 2000)
    - ADHS/DBHS Practice Protocol *Working with the Birth to Five Population* which includes age-appropriate developmental checklists
    - Additional screening tools
        - Ages and Stages Questionnaires (ASQ)
        - Hawaii Early Learning Profile (HELP)
        - Parents Evaluation of Developmental Status (PEDS)
- Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved
- Collaboration with other agencies involved with the child and family (e.g. Arizona Early Intervention Program [AzEIP], Child Protective Services [CPS], Division of Developmental Disabilities [DDD], childcare, Head Start, the local school district, Healthy Families Arizona, other educational programs, etc.)
- Brief Summary/bio-psycho-social formulation
- Multi-Axial Diagnoses I-V

Although the *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition, Text Revision (DSM-IV-TR)* lacks attention to young children, the *Research Diagnostic Criteria: Preschool Age* (AACAP Task Force on Research Diagnostic Criteria: Infancy Preschool Age, 2003) and the *Diagnostic Classification of Mental Health and Developmental Disorders in Infancy and Early Childhood: Revised Edition (DC: 0-3R)* (Zero to Three Diagnostic Classification Task Force, 2005) are both developmentally sensitive, evidence-informed modifications of the DSM-IV criteria for young children and therefore present alternative diagnostic classification systems when working with this population. However, not all preschoolers who have clinically significant symptoms will meet full criteria for a diagnosis. For those who do not, recognizing sub threshold disorders can help focus service planning, which would typically not include the use of psychotropic medication.

II. **Psychotherapeutic Interventions**

There is a relatively strong evidence base for the use of psychotherapeutic interventions for young children with psychiatric diagnoses and thus these should be the initial interventions before considering a

psychopharmacologic trial. Active engagement and participation by the young child's parents/primary caregiver(s) 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 Child and Family Team (CFT) practice, all service delivery should be coordinated within this team context; please refer to the ADHS/DBHS Practice Protocol *Child and Family Team Practice* for further information on effective CFT practice related to service planning development and implementation.

The recommended psychotherapeutic treatment interventions[2] outlined in *Table 1* are diagnosis specific and are supported by current studies and best practice. Determination of the best psychotherapeutic approach is done in conjunction with the CFT and other qualified infant and early childhood mental 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 ADHS/DBHS Practice Protocol *Working with the Birth to Five Population*. The psychotherapeutic intervention selected and length of treatment should be clearly documented in the clinical record.

Table 1

Diagnosis	Recommended Psychotherapeutic Intervention(s)	Recommended Minimum Length of Time or # Sessions
Attention Deficit Hyperactivity Disorder	Parent Management Training*	8 weeks
Anxiety Disorder **Separation Anxiety Disorder, Generalized Anxiety Disorder, Selective Mutism, Specific Phobia**	Cognitive Behavioral Therapy (CBT)*	12 weeks
Bipolar Disorder	Dyadic psychotherapy	8 to 12 sessions
Disruptive Behavior Disorders	Parent Child Interaction Therapy (PCIT) Parent Management Training*	9-16 sessions 10-20 weeks
Major Depressive Disorder	Dyadic relationship interventions that target the young child and his/her parent/primary caregiver	3-6 months
Obsessive Compulsive Disorder	CBT with parent involvement	12 weeks
Pervasive Developmental Disorders	Multi-modal and multi-disciplinary treatment focused on language, social development, adaptive functioning, decreasing aggression, and repetitive behaviors	
Post Traumatic Stress Disorder	Child-Parent Psychotherapy Preschool CBT Play Therapy	6 months 12 weeks 6 months
Sleep Disorders	Parent education Behavioral-based sleep interventions including sleep hygiene	2 to 4 weeks

*Or other behavioral intervention

III. Psychopharmacological Interventions

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. Even with the use of psychopharmacological treatment, psychotherapeutic interventions should continue during the period of medication treatment. The use of medication is not indicated in situations when mild or single context impairment is present.

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 consistent with criteria contained in the ADHS/DBHS Provider Manual 3.15 *Psychotropic Medication: Prescribing and Monitoring*.

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 to 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.

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 about the following essential elements (Please refer to ADHS/DBHS Provider Manual Section 3.15 *Psychotropic Medication: Prescribing and Monitoring* for more information):

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible results of not taking the recommended medication;
- FDA status of the medication; and
- 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 should document the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians.

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. Please refer to ADHS/DBHS Provider Manual 3.15 *Psychotropic Medication: Prescribing and Monitoring* for further information.

Coordination of Care
In Arizona, the behavioral health program was developed as a carve-out from the acute care Medicaid program (Title XIX) and the State Children's Health Insurance Program (KidsCare/SCHIP/Title XXI), a model in which eligible persons receive general medical services through health plans and covered behavioral health services through the T/RBHAs. 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.

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 T/RBHA enrolled children not eligible for Title XIX or Title XXI coverage, coordination and communication should occur with any known health care provider.[4] 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 *Provider Manual Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers* for further information.

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 progress developmentally.

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.

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. This consideration must be clearly documented in the clinical record. The BHMP must weigh the risks vs. benefits of each approach with the guardian, 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

[4] *ADHS/DBHS PM Section 4.3 Coordination of Care with AHCCCS Health Plans, Primary Care Providers & Medicare Providers*

age of five. Additionally, some conditions are not chronic and 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 this taper should be made with clinical rationale provided if the taper is unsuccessful.

Prescription by a Non-Child Psychiatrist

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services to young children have completed training and possess experience in both psychotherapeutic and psychopharmacological interventions for children age birth to five. Medication management should be provided by a board certified or qualified child and adolescent psychiatrist whenever possible. In rural or underserved locations where this may not be possible, the non-child psychiatrist BHMP must adhere to the following when prescribing psychotropic medication for children birth to five years of age:

- 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 T/RBHA. The review shall include, at a minimum, the following elements:
    1. The proposed medication with the starting dosage
    2. Identified target symptoms
    3. The clinical rationale for the proposed treatment
    4. Review of all medications the child is currently taking, including over the counter and those prescribed by other medical/naturalistic providers
    5. A plan for monitoring, including monitoring frequency (e.g., weekly, monthly)
    6. Identified targeted outcomes
- Re-consultation with a designated child psychiatric provider must occur in the following instances:
    1. When the child is not making progress towards identified treatment goals *at a minimum of every three months*
    2. In the event that a taper off of medications *at six to eight months* of treatment is either not clinically indicated or unsuccessful
    3. When a new medication is being considered or when more than one medication is prescribed

IV. T/RBHA Expectations for Credentialing, Training, Oversight and Monitoring

The T/RBHA shall implement a credentialing mechanism which reviews the level of skills and training, as well as the scope of practice of behavioral health staff who are prescribing psychopharmacological treatments to the birth to five population. Each T/RBHA shall implement a process which allows for child psychiatric oversight for non-child psychiatrist BHMPs who are prescribing medication treatment to young children. For non-child psychiatrist BHMPs, the T/RBHA will define the frequency of communication and collaboration with a designated child psychiatric provider over the course of the child's psychopharmacological treatment to be consistent with the minimum standards established in this Practice Guideline.

It is the expectation of ADHS/DBHS that BHMPs who complete psychiatric evaluations, identify and provide psychotherapeutic interventions, and prescribe psychopharmacological treatment for young children be adequately trained and clinically supervised in the application of this Practice Guideline. Each T/RBHA shall establish their own process for ensuring that clinical staff working with this population understands the recommended process and procedures and whenever this Practice Guideline is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes.

Each T/RBHA must have a process in place to monitor the use of medications with this population**.** At a minimum, this will include requirements detailed in the ADHS/DBHS Medical Management/Utilization Management (MM/UM) Plan.