581 – WORKING WITH THE BIRTH THROUGH FIVE POPULATION

EFFECTIVE DATES: 04/29/24, 05/21/26

APPROVAL DATES: 02/08/24, 03/26/26

I. PURPOSE

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

II. DEFINITIONS

Refer to the AHCCCS ACOM and AMPM Dictionary for common terms found in this Policy.

III. POLICY

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

1. Supporting the use of evidence-based early childhood service delivery models.

2. Increasing the quality and capacity of trained infant and early childhood behavioral health professionals.

3. Improving access to services.

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

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

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

2. The behavioral health practitioner conducting the assessment must be aware that all children have their own developmental progression, affective, cognitive, language, motor, sensory and interactive patterns.

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

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

B. DEVELOPMENTAL CHECKLISTS AND SCREENINGS

1. The Contractor shall ensure their subcontracted network of providers working with the birth to five population:
   a. Provide parents with developmental checklists and educate them about developmental milestones. The Centers for Disease Control (CDC) recommends that developmental checklists are used by parents to monitor whether their children are meeting developmental milestones. The resource provided through the CDC website is Milestone Moments Checklist,
   b. Utilize developmental screenings as part of the assessment process to establish a baseline to which subsequent screenings can be compared, and
   c. Utilize developmental screening that are evidence-based, standardized, current and specific to age ranges birth to five. AHCCCS neither endorses, recommends, nor requires any specific screening tool over another.

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

C. ASSESSMENT

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

1. The best practices for behavioral health assessment of children age birth to five involves:
   a. The philosophical orientation that work is done on behalf of the child, predominantly through the child's parent or caregiver(s),
   b. Interviewing the parent/primary caregiver(s) about the child's birth, developmental and medical histories,
   c. Direct observation of family functioning,
   d. Gaining information, through direct observation and report, about the child's individual characteristics, language, cognition, and affective expression,
   e. Assessment of sensory reactivity and processing, motor tone, and motor planning capacities,[i]

f. Observation of how the child uses the primary caregiving relationship to develop a sense of safety and security, to support exploration/learning, and to help regulate emotions,
g. Obtaining information on how the child and parent/caregiver think and feel about each other and themselves within the context of the relationship,
h. Interviewing the parent/primary caregiver(s) with respect to their own history and experiences (e.g., medical, behavioral health, parenting, legal, educational, domestic violence, military),
i. Determining the child and family's strengths, difficulties, risk, and protective factors,
j. Level of overall adaptive capacity and functioning in the major developmental areas as compared to age-expected developmental patterns,
k. Contribution of family relationships, environmental protective factors, stress, interactive and maturational patterns to the child's competencies and difficulties, and
l. Identification of underlying needs and recommendations for the service planning process.[ii]

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

AMPM Policy 310-B and AMPM Policy 320-O provide additional information on the types of behavioral health providers that may conduct assessments. The Contractor shall ensure that providers determine the appropriate level of case management during the assessment process and on-going as clinical indicators change, refer to AMPM Policy 570.

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

D. SERVICE PLANNING – USE OF CHILD AND FAMILY TEAM (CFT) PRACTICE

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

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

1. The Contractor shall ensure:
   a. All service plan development with children age birth to five is completed collaboratively with the child's parent or primary caregiver,
   b. Service plan goals are not focused solely on the child,
      and include the needs of the parent, caregiver, and the family as a whole,

c. Due to rapid changes in the growth and development of children during this time, monitoring activities need to include frequent reviews of the service plan goals and objectives,
d. At the time of the Annual Update, the service plan shall be modified to align with the needs identified in the updated assessment. Refer to AMPM Policy 320-O for further information on the minimum elements for assessments, service plans, and required timeframes for completion,
e. The use of all covered services, service settings, and available providers are to be considered by the Child and Family Team during the service planning process, and
f. The service planning that includes the use of Support and Rehabilitation Services that provided community-based and culturally competent care and focus on helping young children to live successfully with their families as part of their community (refer to AMPM Policy 582).

2. For children that are under the custody of Arizona Department of Child Safety (DCS) and are referred through the Integrated Rapid Response process, the Contractor shall ensure that behavioral health provider considers a full range of services at the time of removal. Multiple AHCCCS policies provide additional information regarding expectations working with children served by DCS including but not limited to the below:
   a. AMPM Policy 585,
   b. ACOM Policy 417,
   c. ACOM Policy 449,
   d. AMPM Policy 310-B,
   e. AMPM Policy 320-O,
   f. AMPM Policy 320-W, and
   g. AMPM Policy 541.

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

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

5. Clinical Approaches

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

E. PSYCHIATRIC EVALUATION

The general practice within Arizona's System of Care includes a comprehensive behavioral health assessment prior to a psychiatric evaluation. A psychiatric evaluation may be completed based on CFT decision making and when clinically indicated. The psychiatric evaluation may take multiple sessions and is completed prior to the initiation of psychotropic medication. For children birth through five, 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..[iii] Best practice recommends at least three months of extensive assessment and psychotherapeutic intervention prior to any consideration of psychopharmacological intervention for children age birth to five.[iv] Psychiatric evaluation, which may be part of the extensive assessment process, can be used to guide treatment and make clinical recommendations prior to psychopharmacological intervention.

The best practice for psychiatric evaluation includes the following components:

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

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

3. The updates related to the detailed medical and developmental history.

4. The updates related to current medical and developmental concerns and status.

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

6. The newly identified parental and environmental stressors and supports.

7. The ongoing or recent changes in Health Care Decision Maker (HCDM), Designated Representative (DR)'s perception of the child, ability to read/respond to child's cues, and willingness to interact with the child, based on.

8. The review of any previously completed assessments.

9. The review of psychotherapeutic interventions provided and outcomes of those interventions.

10. The children's birth to five mental status exam:
    a. Appearance and general presentation,
    b. Reaction to changes (e.g., new people, settings, situations),
    c. Emotional and behavioral regulation,
    d. Motor function,
    e. Vocalizations/speech,
    f. Thought content/process,

g. Affect and mood,
h. Ability to play/explore,
i. Cognitive functioning, and
j. Relatedness to HCDM, DR.

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

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

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

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

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

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

F. INFORMED CONSENT AND COORDINATION

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

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

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

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

G. WORKFORCE DEVELOPMENT

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

1. The Contractors shall ensure that providers coach and evaluate practitioners for these skills:
   a. The ability to listen carefully,
   b. Demonstrate concern and empathy,
   c. Promote reflection,
   d. Observe and highlight the child-parent/caregiver relationship,

e. Respond thoughtfully during emotionally intense interactions,
f. Understand, regulate, and use one's own feelings,[ix]
g. Have comprehensive knowledge of early childhood development,
h. Possess relationship-building skills with children and adults,
i. Demonstration of cultural humility in their understanding of parenting practices,
j. Be able to identify resources and needs within the family/caregiving environment, and
k. Communicate assessment results in a comprehensible manner to parents/primary caregivers and other professionals.

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

It is recommended that Contractors' provider networks and provider agencies have practitioners endorsed. For additional information, refer to The Arizona Association for Infant Mental Health and Attachment D for population recommended resources.

H. TRAINING

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

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

I. SUPERVISION

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

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 to five and their families receive adequate training in the elements of reflective supervision. Additional information is also available within AMPM Policy 581, Attachment B and Attachment D for additional resource materials on reflective supervision.

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

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

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

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

[v] Egger & Angold cited in Carter, A.S., Godoy, L., Marakovitz, S.E., & Briggs-Gowan, M.J. (2009) in Zeanah, C. H. JR. (ED.). Handbook Of Infant Toddler Mental Health, (PP 233-251). New York: Gilford Press
[vi] American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5th ed.) (DSM-5). Washington, DC.

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

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

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