DBHS Practice Protocol

Psychiatric Best Practice Guidelines 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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NOTE:
This Clinical Practice Protocol has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.

Title
Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age

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

Target Audience
This Protocol is specifically targeted to Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency behavioral health staff who complete psychiatric evaluations, prescribe psychopharmacological treatment, and identify psychotherapeutic interventions for the treatment of 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).

Attachments

Attachment A: Sleep Hygiene

Definitions

Assessment

Behavioral Health Medical Professional (BHMP)

Child and Family Team

Designated Child Psychiatric Provider

Infant and Early Childhood Mental Health

Privileging

Young Child

Background

"In 2000 the American Academy of Child and Adolescent Psychiatry's Research Forum highlighted the developmental, logistical, and ethical challenges related to preschool psychopharmacological research (Greenhill et al., 2003). The group recommended the development of guidelines for the pharmacological treatment of preschoolers with psychiatric disorders. Where randomized controlled data were not available, the group recommended that guidelines be derived from clinical experience and community standards. To date, our

field lacks these guidelines. Thus, clinicians and families face a delicate balancing process, weighing the risks of medications with the risks of not intervening in complex clinical situations that are resistant to nonpharmacological interventions. The risks associated with psychiatric disorders are not insignificant; preschool psychiatric disorders can be associated with child care expulsion, inability to participate in family activities, impaired peer relationships, high-risk behaviors (Byrne et al., 2003; Egger and Angold, 2006; Gilliam, 2005), and future mental health problems (e.g. Lavigne et al., 1998).

Of preschoolers with psychiatric disorders, only a small proportion are referred for mental health treatment, and the primary treatment modality for most very young children is psychotherapeutic rather than psychopharmacological (AACAP, 1997b; Egger and Angold, 2006; Lavigne et al., 1993). Studies using varied methods yielded estimates that 3 to 9/1,000 U.S. preschoolers received prescriptions for psychotropic medications in the 1990's (DeBar et al., 2003; Zito et al., 2000).

A few studies have examined patterns of prescriptions for children with psychiatric diagnoses. Across a variety of populations including community, HMO, and Medicaid, the majority of prescriptions written for preschoolers are for stimulants (DeBar et al., 2003; Luby et al., 2007; Zito et al., 2007). In a community sample, Luby et al. (2007) reported that 12% (12/123) of preschoolers with a DSM-IV diagnosis had received medication for at least 1 month.

These early studies of preschool psychopharmacological practices suggest that the majority of preschoolers with mental health problems do not receive psychopharmacological treatment. Access to other mental health services appears variable. Prescription patterns support the value of clearly defined treatment recommendations for rational use of medications."[1]

Best practice recommendations state a trial of psychotherapeutic interventions should always be used prior to initiating medications. Despite this, the literature reflects that a majority of these young children do not receive psychotherapeutic interventions prior to the initiation of medications. [1]

Procedures

"Child and Family Team (CFT) practice and the 12 Arizona Principles support the critical components of mental health practice with children age birth to five and their families."[2] Refer to the *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population* for additional information on developmental screening, assessment, and evaluation considerations, as well as service planning guidelines through the use of CFT practice. For requirements regarding assessment, refer to *ADHS/DBHS Provider Manual Section 3.9*.

Psychiatric Assessment/Evaluation Process: A comprehensive assessment may include a psychiatric evaluation when clinically indicated. The psychiatric evaluation should take multiple sessions and must be completed prior to the initiation of psychotropic medication. The evaluation must be completed by a Behavioral Health Medical Professional (BHMP) with training and experience in the assessment and treatment of children age birth to five years of age. The BHMP must meet privileging standards per *ADHS/DBHS Provider Manual Section 3.20, Credentialing and Privileging* and be able to demonstrate the competencies and expertise in providing mental health treatment with this young population. Whenever possible, psychiatric evaluation should be conducted by a board certified or board qualified child and adolescent psychiatrist.

[1] 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.
[2] *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population*

While the psychiatric evaluation process for young children is similar to the process for older children, adolescents, and adults, special attention to the following guidelines is required when providing mental health evaluation services for this young population:

- Psychiatric evaluation as part of assessment practice must include 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);

- Evaluation components must include the following:
    1. Reason for referral including child's social, emotional, and behavioral symptoms
    2. Detailed medical and developmental history
    3. Current medical and developmental concerns and status
    4. Family, community, child care and cultural contexts which may influence a child's clinical presentation
    5. Parental and environmental stressors and supports
    6. Parent/Caregiver(s) perception of the child, ability to read/respond to child's cues, and willingness to interact with the child
    7. Children birth to five mental status exam:
        - Appearance and general presentation
        - Reaction to changes (e.g., new people, settings, situations)
        - 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)
    8. 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 such as:
            - 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 Behavioral Health Assessment: Birth-Five* 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)
    9. Collaboration with pediatrician/primary care physician and/or developmental pediatricians involved
    10. 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.)

Service planning is done as part of a collaborative process according to Child and Family Team practice. 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.

Service Expectation: The psychiatric evaluation, as part of a comprehensive assessment, must be completed prior to the initiation of psychotropic medication.

Diagnosis: Not all preschoolers who have clinically significant symptoms will meet full criteria for a diagnosis. For those who do not, recognizing subthreshold disorders can help focus service planning. 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. The updated DC: 0-3R addresses developmentally specific clinical presentations of mental health concerns with infants and toddlers and their relationships with primary caregivers while providing age-appropriate diagnostic criteria for many of the DSM-IV-TR child psychiatric disorders. In addition, the DC: 0-3R adds Regulation Disorders of Sensory Processing (defined as constitutionally based responses to sensory stimuli) on Axis I and Relationship Disorders on Axis II. An additional resource for use is the *ADHS/DBHS Crosswalk*, which cross-references the DC: 0-3R, DSM-IV-TR, and the *International Classification of Diseases, Ninth Revision-Clinical Modification Manual (ICD-9 CM)*. This crosswalk is strictly a tool to assist the behavioral health provider in assigning the correct diagnostic code when working with children in the first four years of life and is referenced as a sample document. **Maintenance of this document with up-to-date diagnostic codes is a T/RBHA responsibility.**

Treatment: There is a relatively strong evidence base for the use of psychotherapeutic interventions. Psychotherapeutic approaches should be considered as the initial intervention before psychopharmacological treatment, be clearly documented in the clinical record, must include the active participation of the child's parents/primary caregiver(s), and be developed and implemented in conjunction with the Child and Family Team. Psycho-educational and supportive therapeutic approaches are considered the most basic interventions and should form the basis of any comprehensive service plan.

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*.

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 age of five.

If the decision to taper the child off medication is made, the Child and Family Team 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 Child and Family Team must also ensure that additional supports or services for the child and/or caregiver be implemented to maintain the child's stability. Documentation of this taper should be made with clinical rationale provided if the taper is unsuccessful.

As noted earlier with assessment and evaluation practice standards, BHMPs who provide treatment services have completed training and possess experience in both psychotherapeutic and psychopharmacological interventions for young children age birth to five. In addition, BHMPs meet privileging standards that demonstrate expertise and competency in performing these treatment interventions. 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

Service Expectations:

1. Clear and specific target symptoms must be identified and documented in the clinical record prior to the initiation of a medication trial.

2. The non-child psychiatrist BHMP must consult with the designated child psychiatric provider in the following situations:

- **Prior to the initiation of medication;**
- **If the child is not making progress towards identified treatment goals *at a minimum of every three months*; and**
- **In the event that a taper off of medications *at six to eight months* of treatment is not clinically indicated or unsuccessful.**

3. In children who have a positive response to medication, a taper off medication is considered and clearly documented in the clinical record every six to eight months of treatment until the child reaches the age of five.

Dosing: 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.

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.[3] 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.

Service Expectation: Documentation in the clinical record by the BHMP is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment.

Polypharmacy: Polypharmacy is defined as using more than one psychotropic medication at a time in this population and is not recommended for children age birth to five. It is important to note that the use of the term polypharmacy in this population differs from the definition used in other age groups. In addition, 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. Please refer to *ADHS/DBHS Provider Manual 3.15 Psychotropic Medications: Prescribing and Monitoring* for further information.

Polypharmacy 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. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, consultation with the designated child and adolescent psychiatric provider must occur before the young child receives more than one medication.

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

Service Expectation: When more than one medication is prescribed there must be documentation of clear target symptoms for each medication in the child's clinical record. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, re-consultation with the designated child psychiatric provider must occur before the young child receives more than one medication.

FDA indicated medications: The following medications are approved by the Food and Drug Administration (FDA) for young children under the age of five at the time of this writing: haloperidol (Haldol), dextroamphetamines (Dexedrine, Dextrostat), chlorpromazine (Thorazine), and risperidone (Risperdal) (Greenhill, 1998). A FDA indication reflects empirical support but is not synonymous with a recommendation for use consistent with current studies and best practice. Only two of the FDA-approved medications (dextroamphetamines and risperidone) listed above are recommended treatment interventions consistent with current studies and best practices for this population. Lack of an FDA indication does not necessarily reflect a lack of evidence for efficacy.

The Physicians 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. As new drugs become available and approved, or research demonstrates usefulness, safety and efficacy, practitioners should document the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians. Informed consent includes the following:

- FDA status of the medication
- Level of evidence supporting the recommended medication; for example, the use of methylphenidate as a first line medication for the treatment of Attention Deficit Hyperactivity Disorder (ADHD) in young children
- Potential risks, benefits, and alternatives to its use

Service Expectation: The behavioral health medical practitioner shall document in the child's clinical record the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians must contain the elements outlined in this protocol.

Recommended Treatment: The following recommended psychotherapeutic and psychopharmacological treatment interventions are supported by current studies and best practice, and are diagnosis specific. Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders. **A trial of one of the recommended psychotherapeutic interventions should always precede a psychopharmacologic trial.** 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.

While the following psychotherapeutic interventions are supported by studies and best practice for specific diagnoses, other examples of accepted therapeutic approaches with this population are referenced in the *ADHS/DBHS Practice Protocol: Working with the Birth to Five Population*. Determination of the best psychotherapeutic approach is done in conjunction with the Child and Family Team and other qualified infant and early childhood mental health practitioners.

While not all of the medications listed below have FDA indications, all the listed medications are supported by clear evidence demonstrating efficacy with this age group. First (1st) line and other medication options are outlined below. **However, BHMPs should exercise their clinical judgment and determine if an alternative psychopharmacologic intervention is preferential in meeting the optimal and unique needs of each child.**

1. **Attention Deficit Hyperactivity Disorder**:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 8 weeks: Parent Management Training or other Behavioral Intervention
- Psychopharmacologic Trial:
  I. Methylphenidate (Ritalin, Concerta, Metadate): 1st line
  II. Dextroamphetamine/amphetamine formulations (Adderall), detroamphetamine formulations (Dexedrine, Dextrostat): 2nd line
  III. Alpha-agonists: clonidine (Catapres), guanfacine (Tenex): 3rd line
  IV. Atomoxetine (Strattera): 3rd line

2. Disruptive Behavior Disorders:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 10-20 weeks: Parent Management Training or other Behavioral Intervention
- Psychopharmacologic Trial:
  I. Presence of co-morbid disorder: follow recommendations for the co-occurring disorders first, such as ADHD where there is more treatment evidence
  II. Medications should be considered only after a trial of psychotherapy and in the case of safety concerns or extreme impairment in multiple settings and relationships for the treatment of disruptive behavior disorders. Risperidone (Risperdal) is recommended as the first medication choice for treating children with disruptive behavior disorders with severe aggression without co-occuring ADHD.

3. Major Depressive Disorder:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 3 to 6 months: interventions that target dyadic relationship between the young child and his/her parent/primary caregiver
- Psychopharmacologic Trial:
  I. Presence of co-morbid disorder: follow recommendations for the co-occurring disorders first, such as ADHD where there is more treatment evidence
  II. Fluoxetine (Prozac): 1st line for treatment of clear depressive symptoms

4. Bipolar disorder:

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 8 to 12 sessions: dyadic psychotherapy, target emotional regulation
- Psychopharmacologic Trial:
  I. Risperidone (Risperdal): 1st line
  II. Consider adding lithium (Lithonate, Eskalith, Lithobid, Cibalith) or valproic acid (Depakene), divalproex sodium (Depakote) with partial response to risperidone and extreme symptoms
  III. With an insufficient or negative response to risperidone, may consider another atypical antipsychotic such as quetiapine (Seroquel) or olanzapine (Zyprexa)

5. Anxiety Disorders: Separation Anxiety Disorder, Generalized Anxiety Disorder, Selective Mutism, Specific Phobia

- Psychotherapeutic Interventions: Psychotherapy for a minimum of 12 weeks: Behavioral Interventions, Cognitive Behavioral Therapy (CBT)
- Psychopharmacologic Trial:
  I. Fluoxetine (Prozac): 1st line

II. With insufficient response and extreme impairment and distress in multiple settings, may try fluvoxamine (Luvox)

6. **Post Traumatic Stress Disorder:**
   - Psychotherapeutic Interventions: Psychotherapy: Child-Parent Psychotherapy for a minimum of 6 months, Preschool CBT for a minimum of 12 weeks, or Play therapy for a minimum of 6 months
   - Psychopharmacologic Trial: With extreme impairment after failure of, or inability to participate in psychotherapeutic intervention, consider use of a selective serotonin reuptake inhibitor or alpha-agonist

7. **Obsessive Compulsive Disorder**:
   - Psychotherapeutic Interventions: Psychotherapy for a minimum of 12 weeks: CBT with parent involvement
   - Psychopharmacologic Trial:
     I. Fluoxetine (Prozac), fluvoxamine (Luvox), or sertraline (Zoloft): 1st line
     II. Clomipramine (Anafranil)-only for severe resistant symptoms

8. **Pervasive Developmental Disorders:**
   - Psychotherapeutic Interventions: Multi-modal, Multidisciplinary treatment focused on language, social development, adaptive functioning, decreasing aggression, and repetitive behaviors
   - Psychopharmacologic Trial:
     I. Risperidone (Risperdal) is approved by the FDA for treatment of severe aggression/irritability in children with autism in this age group: 1st line

9. **Sleep Disorders**:
   - Psychotherapeutic Interventions: Parent education, Behavioral-based sleep interventions including sleep hygiene implementation for a minimum of 2 to 4 weeks; please refer to *Attachment A: Sleep Hygiene*
   - Psychopharmacologic Trial:
     I. Melatonin 1-3 mg at bedtime for a minimum of 10 days if tolerated -1st line (**Special Note: Melatonin is an over the counter supplement that is not regulated by the FDA nor covered on the ADHS/DBHS formulary**)
     II. With insufficient response and severe symptoms may try short term use of clonidine (Catapres)

Training and Supervision Expectations

The T/RBHA shall implement a privileging 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 protocol.

It is the expectation of ADHS/DBHS that behavioral health staff who complete psychiatric evaluations, prescribe psychopharmacological treatment, and identify psychotherapeutic interventions for the treatment of children birth to five years of age be adequately trained and clinically supervised in the application of this

protocol. 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 Protocol is updated or revised ensures that their subcontracted network and provider agencies are notified and required staff are retrained as necessary on the changes.

Anticipated Outcomes and How They Will Be Measured

Anticipated Outcomes include:

- Improved use of effective psychiatric evaluation procedures specific to the needs of young children
- Increased awareness of the risks involved with polypharmacy use with young children
- Improved outcomes through the use of accepted psychotherapeutic and psychopharmacological treatment interventions in working with young children

How will outcomes be measured?

- Record reviews utilizing the ADHS/DBHS Birth-5 Practice Protocol Review Tool
- Monitoring of medication utilization quarterly reviews in Birth-5 population by provider type

How will Fidelity be Monitored?

Each T/RBHA must have a process in place to monitor the use of medications and psychotherapeutic interventions with this population**.** At a minimum, this will include record reviews utilizing the ADHS/DBHS Birth-5 Practice Protocol Review Tool.

T/RBHAs: Monitoring of referrals/second opinion reviews in the following situations:

- Children prescribed 4 or more psychotropic medications: chart review and medication utilization quarterly reviews
- Children prescribed 5 or more psychotropic medications: face-to-face assessment and medication utilization quarterly reviews

ADHS/DBHS will monitor fidelity through:
Monitoring and Oversight Department audits (audit of T/RBHA provider chart reviews, quarterly medication utilization submissions).

Service Expectation: The T/RBHA is responsible for maintaining a process to monitor the use of medications with this population.

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Desktop Guide

- **Service Expectations:**
  - **The psychiatric evaluation, as part of a comprehensive assessment, must be completed prior to the initiation of psychotropic medication.**
  - **Clear and specific target symptoms must be indentified and documented in the clinical record prior to the initiation of a medication trial.**
  - **The non-child psychiatrist BHMP must consult with the designated child psychiatric provider in the following situations:**
    - **Prior to the initiation of medication**
    - **If the child is not making progress towards identified treatment goals *at a minimum of every three months***
    - **In the event that a taper off of medications *at six to eight months* of treatment is not clinically indicated or unsuccessful**
  - **In children who have a positive response to medication, a taper off medication is considered and clearly documented in the clinical record every 6 to 8 months of treatment until the child reaches the age of five.**
  - **Documentation in the clinical record by the BHMP is required showing the communication and coordination of care efforts with the health care provider related to the child's behavioral health psychopharmacological treatment.**
  - **When more than one medication is prescribed there must be documentation of clear target symptoms for each medication in the child's clinical record. If the BHMP prescribing the medications is not a child and adolescent psychiatrist, re-consultation with the designated child psychiatric provider must occur before the young child receives more than one medication.**
  - **The behavioral health medical practitioner shall document in the child's clinical record the rationale for medication choice and the provision of informed consent to parents/caregivers/ guardians must contain the elements outlined in this protocol.**
  - **The T/RBHA is responsible for maintaining a process to monitor the use of medications with this population.**

- **<u>Key elements to remember about this best practice:</u>**
  - Preschool psychiatric disorders can be associated with child care expulsion, inability to participate in family activities, impaired peer relationships, high-risk behaviors and future mental health problems.
  - Psychiatric evaluation as part of assessment practice must include 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).
  - Not all preschoolers who have clinically significant symptoms will meet full criteria for a diagnosis.
  - Psychotherapeutic approaches should be considered as the initial intervention before psychopharmacological treatment.
  - 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.
  - Psychotherapeutic interventions should continue during the period of medication treatment.
  - Dosing can be challenging as young children may metabolize medications more rapidly than older individuals.
  - Young children are often very sensitive to side effects and must be monitored closely.
  - Polypharmacy 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.
  - Lack of an FDA indication does not necessarily reflect a lack of evidence or a prohibition of use in this population.
  - Psychoeducation and early intervention are essential components of any psychotherapeutic intervention program and therefore should be included in the treatment of all disorders.

- **<u>Benefits of using this best practice:</u>**
  - Improved use of effective psychiatric evaluation procedures specific to the needs of young children
  - Increased awareness of the risks involved with polypharmacy use with young children
  - Improved outcomes through the use of accepted psychotherapeutic and psychopharmacological treatment interventions in working with children age birth to five