PEDIATRIC MENTAL HEALTH INSTITUTE

Behavioral Health in Pediatric Primary Care:

Approaches for Supporting and Treating Children and Families Today

Digital Resource Guide

November 8-9, 2024

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Welcome to the Behavioral Health in Pediatric Primary Care Digital Resource Guide! We're thrilled you're here and hope you find these resources helpful and insightful. Our team is here to support you every step of the way, so please don't hesitate to reach out if you have any questions about the information provided in this guide.

For general inquiries or if you need guidance navigating these resources, please feel free to contact:

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Clickable Table of Contents

ADHD and Disruptive Behavior

ADHD and Disruptive Behavior (Presentation Slides)

ADHD and Disruptive Behavior - CoPPCAP - ADHD Colorado Cares Guide

ADHD and Disruptive Behavior - CoPPCAP - Disruptive Behaviors Colorado Cares Guide

ADHD and Disruptive Behavior - Full Vanderbilt Assessment Packet

ADHD and Disruptive Behavior - Medication Guide

ADHD and Disruptive Behavior - Additional Resources

Anxiety

Anxiety - Anxiety and OCD Book Recommendations

Anxiety - CoPPCAP - Anxiety Colorado Cares Guide

Anxiety - Helping Your Anxious Child handout

Anxiety - Parents' Medication Guide

Behavioral Health Model Change

Behavioral Health Model Change - Supporting a Practice Through a Behavioral Healthcare Model Change (Presentation Slides)

Behavioral Health Model Change - CIHS_Level_of_Integrated Behavioral Health

Behavioral Health Model Change - CIHS_Quickstart_Integrated Behavioral Health

Behavioral Health Model Change - Integrated Behavioral Health Needs Assessment

Behavioral Health Model Change - The New Comprehensive Healthcare Integration Framework

Beyond to Questionnaire - Screening and Assessment

Beyond the Questionnaire - The ART of Screening and Assessment (Presentation Slides)

Beyond the Questionnaire - CoPPCAP - Colorado Pediatric Psychiatry Consultation and Access Program

Beyond the Questionnaire - CoPPCAP - Screening and Assessment in Pediatric Primary Care

Beyond the Questionnaire - CoPPCAP - Suicide Colorado Cares Guide

Depression

Depression - Brief Behavioral Health Interventions for Depression (Presentation Slides)

Depression - Children's Affective Lability Scale (CALS)

Depression - CoPPCAP - Depression Colorado Cares Guide

Depression - Mood Disorder Questionnaire

Depression - Parents' Medication Guide

Depression - Additional Resources

Financial Challenges

Financial Challenges (Presentation Slides)

Financial Challenges - Five Steps For Collaborative Care Billing Success (Presentation Slides)

Financial Challenges - Collaborative Care Model - Billing Basics

Financial Challenges - Additional Resources

Roles and Scopes of Team Members

Roles and Scopes of Team Members (Presentation Slides)

Roles and Scopes of Team Members - Community Health Worker Program Course Checklist

Roles and Scopes of Team Members - Community Health Worker Training Pathways

Roles and Scopes of Team Members - Community Health Worker Training Program Marketing Flyer

Roles and Scopes of Team Members - Fact Sheet For Community Health Worker Training Program

Roles and Scopes of Team Members - HRSA Community Health Worker Flyer Overall Recruitment

Roles and Scopes of Team Members - HRSA Community Health Worker Training Program Newsletter Blurb

Roles and Scopes of Team Members - Sample Community Health Worker Learning Plan

Other Topics

AAP Toolkits Package

Behavioral Health and the EHR Workflow Optimization (Presentation Slides)

Collaborative Foundations - Promoting Behavioral Health Integration in Primary Care (Slides)

Integrating Behavioral Health in the Outpatient Setting

Lessons from Primary Care - Strategies for Behavioral Health Clinic Culture Shift (Presentation Slides)

Looking Up and Looking Out - The Need for Advocacy and System Change (Presentation Slides)

Managing a Behavioral Health Crisis in Primary Care & Escalation Pathways (Presentation Slides)

On the Forefront of Colorado's Youth Mental Health Crisis - The Promise of Primary Care (Presentation Slides)

Schools - How to Partner More Effectively with Schools (Presentation Slides)

High Impact Behavioral Health Interventions for ADHD & Disruptive Behaviors

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1

Disclosures

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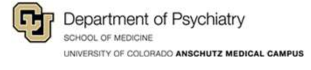

2

Objectives

1. Outline common screening tools used in primary care settings for identification of ADHD/Disruptive Behaviors.
1. Describe psychotherapeutic treatments for ADHD/Disruptive Behaviors.
1. Summarize pharmacological treatments for ADHD/Disruptive Behaviors.

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Introduction[1,2]

- The CDC has reported ADHD/behavioral concerns are the most common mental health concerns in youth.[1]
  - 9.8% have received an ADHD diagnosis
  - 8.9% have received a disruptive behavior diagnosis
- ADHD Risk Factors: Having a first degree relative with ADHD, premature birth/low birth-weight, perinatal exposure to cigarettes, drugs, or alcohol
- DBD Risk Factors: A "difficult temperament," comorbid MH difficulties, authoritarian/permissive parenting, low SES, parental stress/MH concerns
- Possibility of a variety of negative life outcomes including mental health concerns, substance abuse, educational/career difficulties, poorer physical health, legal problems, and social concerns.

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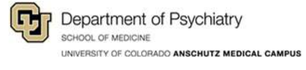

4

Screening & Diagnosing in Primary Care

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5

ADHD & DBDs in Primary Care Settings[2,3]

- Children with ADHD/DBDs are most likely to present to their PCP
- Relying solely on clinical judgment to identify MH concerns = 30% accurately identified
- Using a validated screening measure to identify MH concerns = 70% accurately identified
- Boys more likely to be diagnosed with ADHD and/or DBDs compared to girls.
  - White youth are more likely to be diagnosed with ADHD
  - Black and Latino youth are more likely to be diagnosed with DBDs

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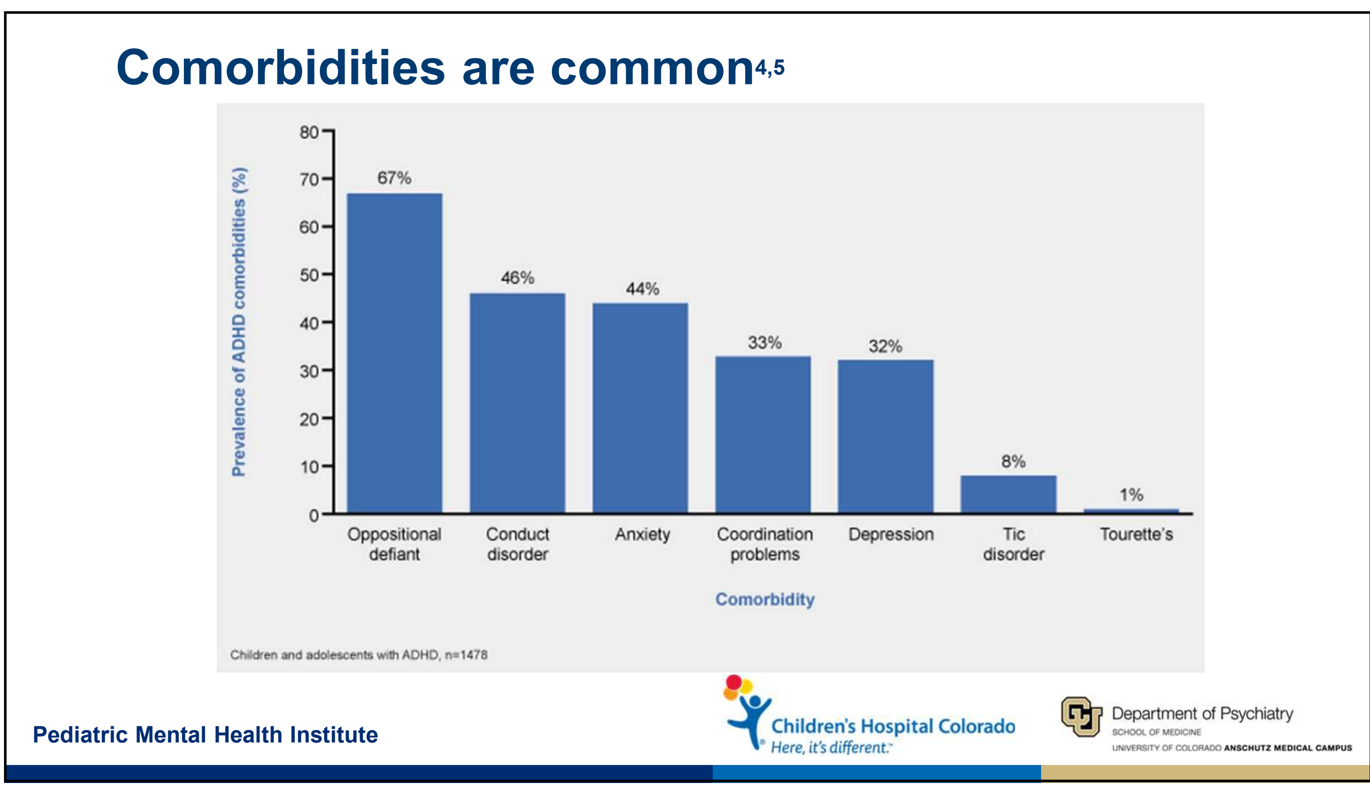
Comborbidities are common[4,5]



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7

Screening Measures

- ADHD Specific
  - NICHQ Vanderbilt Assessment Scale[6]
- DBD Specific
  - Eyberg Child Behavior Inventory (ECBI)[7]
- Broadband Measures
  - Pediatric Symptom Checklist (PSC)[8]
  - Strengths and Difficulties Questionnaire (SDQ)[9]
- Narrowband Measures
  - PHQ-A (depression)[10], GAD-7 (anxiety)[11]
  - CATS (trauma)[12]
  - PROMIS Measures (depression, anxiety, anger)[13]

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ___________________________ Date of Birth: _______________

Parent's Name: ___________________________ Parent's Phone Number: ___________________________

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3

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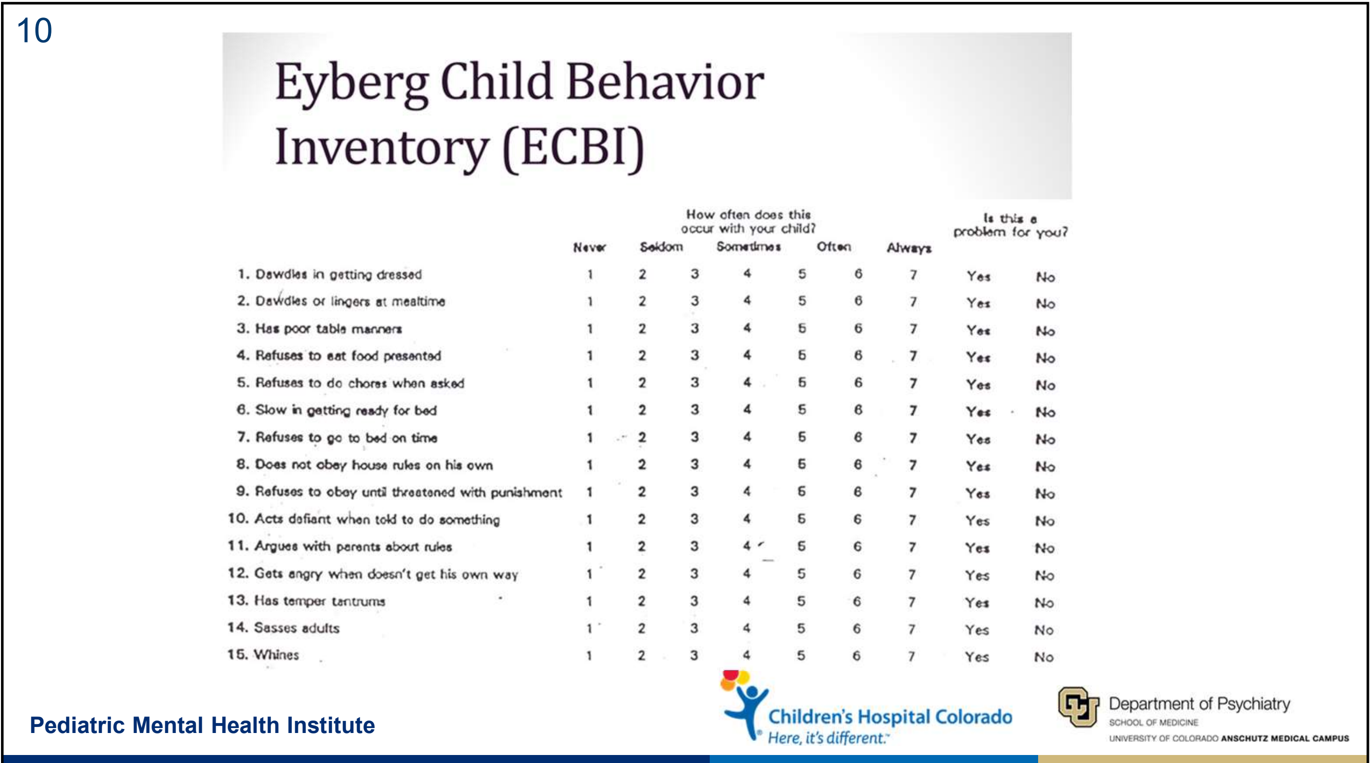

10

Eyberg Child Behavior Inventory (ECBI)

	How often does this occur with your child?							Is this a problem for you?	
	Never	Seldom		Sometimes		Often	Always		
1. Dawdles in getting dressed	1	2	3	4	5	6	7	Yes	No
2. Dawdles or lingers at mealtime	1	2	3	4	5	6	7	Yes	No
3. Has poor table manners	1	2	3	4	5	6	7	Yes	No
4. Refuses to eat food presented	1	2	3	4	5	6	7	Yes	No
5. Refuses to do chores when asked	1	2	3	4	5	6	7	Yes	No
6. Slow in getting ready for bed	1	2	3	4	5	6	7	Yes	No
7. Refuses to go to bed on time	1	2	3	4	5	6	7	Yes	No
8. Does not obey house rules on his own	1	2	3	4	5	6	7	Yes	No
9. Refuses to obey until threatened with punishment	1	2	3	4	5	6	7	Yes	No
10. Acts defiant when told to do something	1	2	3	4	5	6	7	Yes	No
11. Argues with parents about rules	1	2	3	4	5	6	7	Yes	No
12. Gets angry when doesn't get his own way	1	2	3	4	5	6	7	Yes	No
13. Has temper tantrums	1	2	3	4	5	6	7	Yes	No
14. Sasses adults	1	2	3	4	5	6	7	Yes	No
15. Whines	1	2	3	4	5	6	7	Yes	No

10

11

DSM-5 Diagnostic Criteria for ADHD[14]

- ADHD reclassified as a neurodevelopmental disorder

Type of ADHD	Symptoms	
Inattentive (6/9)	• Doesn't pay attention to details/Makes careless mistakes • Difficulty sustaining attention • Doesn't seem to listen when spoken to • Doesn't follow through with instructions/fails to finish tasks	• Difficulty organizing • Avoids tasks requiring sustained mental effort • Loses things • Easily distracted • Forgetful
Hyperactive /Impulsive (6/9)	• Fidgets/squirms • Leaves seat when sitting is expected • Runs/climbs in inappropriate situations • Unable to play quietly	• Is "driven by a motor" or restless • Talks excessively • Blurts out answers • Difficulty waiting their turn • Interrupts or intrudes on others
Combined	Meets criteria for Inattentive and Hyperactive/Impulsive Criteria	

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Additional Diagnostic Criteria[14]

- Several symptoms must be present prior to age 12 and persist for 6+ months to a degree that is **inconsistent with developmental level**
- Symptoms must be present in **2 or more settings**
- Cause **clinically significant impairment**
- Symptoms aren't better explained by another disorder
  - Noncompliance due to ODD, Inattention due to depression or anxiety
- Autism is no longer an exclusion criterion

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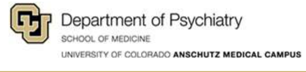

12

Diagnosing ADHD

- Medical exam, including vision/hearing screenings
- Clinical interview
  - Functional Assessment
  - Symptoms **must** be present in at least 2 major settings
- Behavioral Observations
- ***Should always assess for mental health comorbidities***

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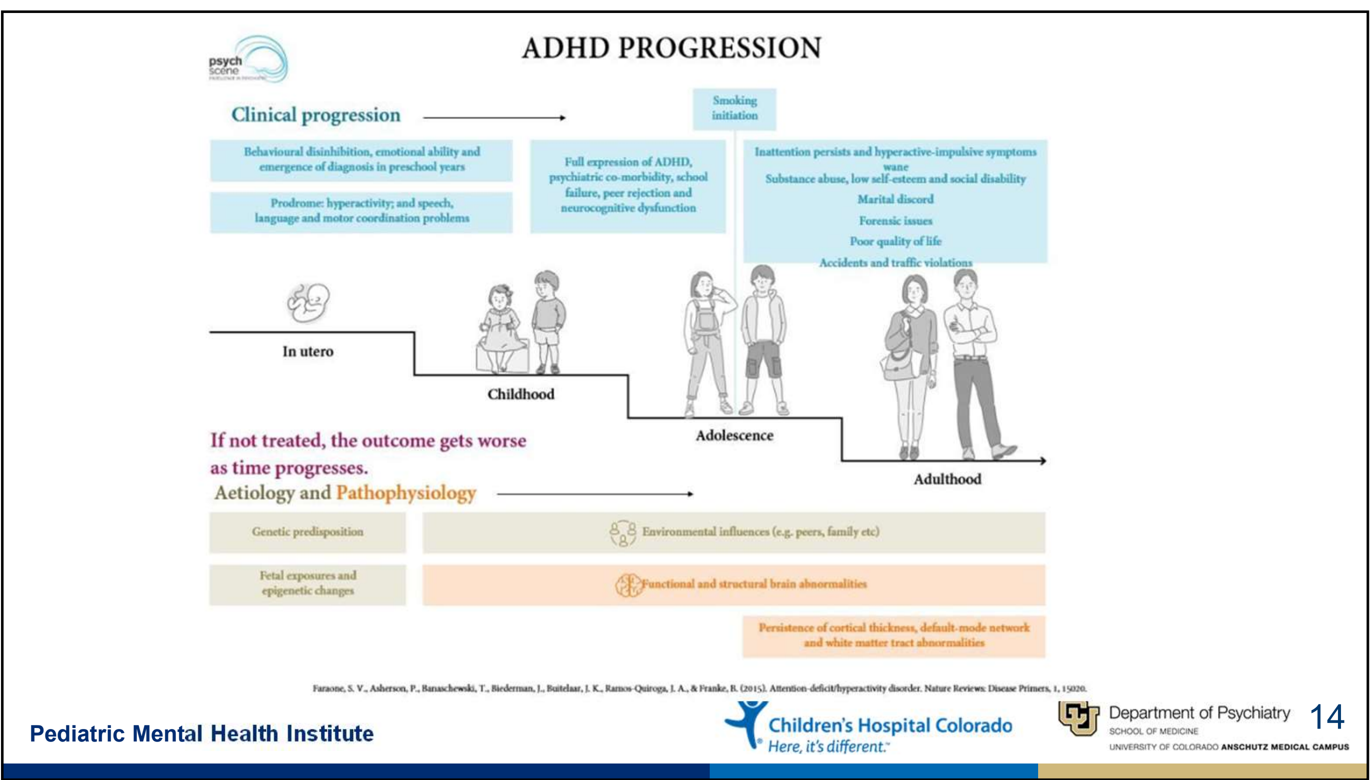
13



14

Disruptive Behaviors & the DSM-5[14]

- Disruptive, Impulse Control, and Conduct Disorders
  - Oppositional Defiant Disorder
  - Conduct Disorder
  - Intermittent Explosive Disorder
  - Unspecified Disruptive Behavior Disorder
- Attention-Deficit/Hyperactivity Disorder
  - Reclassified but highly comorbid
- Disruptive Mood Dysregulation Disorder
  - Internalizing disorder but oftentimes manifests externally

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15

15

Developmental Progression of DBDs

Continuous nature of conduct problems

- Normative vs. Atypical
- Noncompliance as a "keystone behavior."

Early Starter Pathway

- Onset in preschool years
- High degree of continuity

Callous-Unemotional Trait

- Unique predictor of more severe and stable pattern of CP
- High emotional dysregulation and low behavioral inhibition

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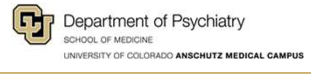

16

Psychotherapeutic Interventions

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17

Psychosocial Treatment of ADHD

- Under 6: Parent Management Training (PMT) as first line treatment[15]
- Meta-Analysis[16]
  - Treatment components predictive of largest effect included:
    - Positive Reinforcement (Praise)
    - Natural/logical consequences (Ignoring, Timeout)
  - Components with moderate or trending effect included:
    - Proactive Parenting (Rules, Monitoring)
    - Parental Self-Management (Emotion Regulation, Problem Solving)

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18

- Ages 6+: Gold standard = Behavior therapy + med management

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19

19

School-Based Interventions[18,19]

Classroom Supports	• Daily Report Card • Preferential Seating • Organizational Planner • Time Limits
Social Supports	• Friendship Group • Peer Tutor
Formal Supports	• 504 Plan • Individualized Education Plan

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20

20

Pharmacological Interventions

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21

AAP Guidelines from 2019

- Pediatrician or Primary Care Clinician should initiate evaluation for ADHD for any child ages 4-18 who presents with behavioral or academic problems
- Use DSM-5 criteria with impairment in 1 setting
- Screen for comorbid conditions
- Use a chronic care model for ADHD, similar to other health needs

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22

AAP Guidelines from 2019

- 4-5 years
  - First line: PMT/school interventions
  - Second line: Methylphenidate (MPH) w/ caution
- 6 years and up
  - FDA-approved ADHD medication (teenagers will need to assent)
  - Behavioral intervention and/or
  - School interventions/accommodations

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23

23

Multimodal Treatment of ADHD Study

Asked the question: How do different treatment options compare?

Design:

- A total of 579, 7-10 year old, children were included
- 4 groups, randomized, parallel design, multi-site[21]
  - Medication
  - Psychosocial treatment
  - Combined treatment
  - Community care

A 14-Month Randomized Clinical Trial of Treatment Strategies for Attention-Deficit/Hyperactivity Disorder

The MTA Cooperative Group

Author Affiliations | Article Information

Arch Gen Psychiatry. 1999;56(12):1073-1086. doi:10.1001/archpsyc.56.12.1073

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24

Multimodal Treatment of ADHD Study

Results:

- All 4 groups showed improvement over time
- Combined treatment and Medication management only groups showed the most improvement in ADHD rating scales, however, they did not differ significantly.
- Combined treatment group was better for sub-groups of kids
  - Disruptive behavior (oppositional or aggressive)
  - Internalizing symptoms
  - Teacher-rated social skills
  - Parent-child relationships

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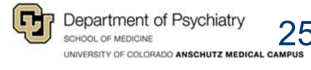
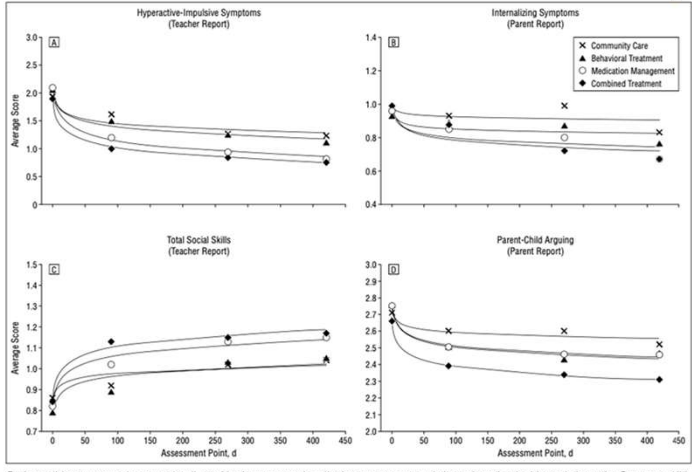


25

Multimodal Treatment of ADHD Study



For internalizing symptoms (parent reported), combined treatment and medication management symbols overlapped at the 14-month data point. For parent-child arguing (power assertion, parent reported), medication management and intensive behavioral treatment symbols overlapped at the 3-month and 14-month data points. A, Combined treatment and medication management were more effective than community care. B, Combined treatment was more effective than behavioral treatment and community care. C, Combined treatment and medication management were more effective than community care. D, Combined and behavioral treatment were more effective than community care.

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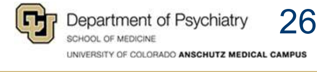
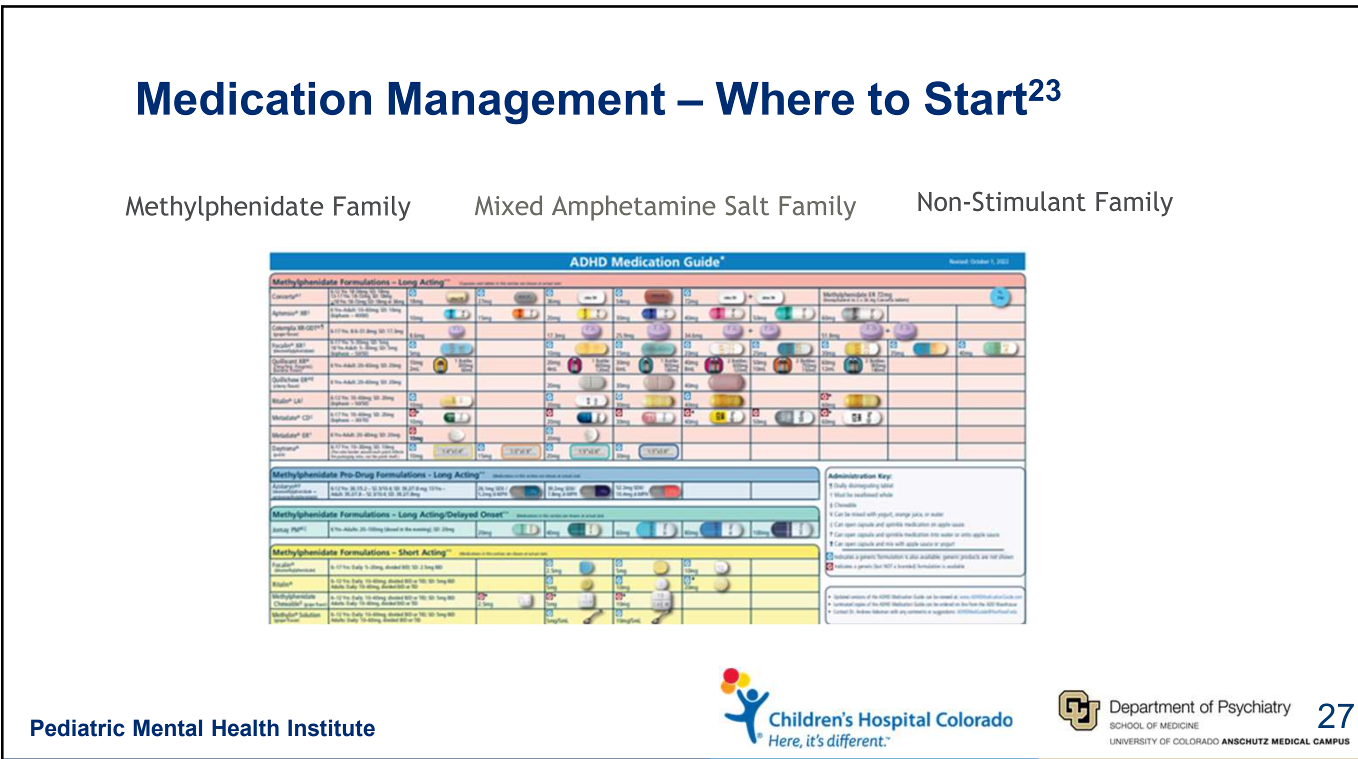


26

Medication Management – Where to Start[23]

Methylphenidate Family | Mixed Amphetamine Salt Family | Non-Stimulant Family



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27

27

Medication Management - Pearls

1. Start low, but go all the way (can adjust weekly)
2. Don't be afraid to change
3. Longer-acting medications are great for most children and teens
4. Stimulants and non-stimulants just have *different* side effect profile
5. Unless concerning side effects, good to continue 7 days per week

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28

28

Dosing of Stimulants (aka, not weight based)[22,23]

Mixed Amphetamine Salts

IR: >6 years: 5 mg in the AM or BID; increase by 5 mg at weekly intervals

XR: 5 to 10 mg once daily in the AM; increase daily dose by 5 mg or 10 mg at weekly intervals until optimal response is obtained

Max: 40 mg/day

Methylphenidate

IR: 5 mg once or twice a day; increase by 5 mg intervals; usually needed 2-3 times per day

Max is 60 mg/day

LA (intermediate formulations): 10 mg in AM; increase as above

- May need a PM booster

ER: 18 mg in the AM;

Increase 18 mg at weekly intervals

Max: 56 mg for <12 or 72 mg for teens

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29

Dosing of Stimulants (aka, not weight based)[22,23]

Mixed Amphetamine Salts

Lisdexamphetamine: 10 to 20 mg in the AM;

Increase by 10-20 mg weekly

Max: 70 mg

Dexmethylphenidate

IR: Start 2.5 mg once or twice daily; Increase by 2.5 mg weekly, would likely need divided daily dose BID or TID

Max dose: 20 mg per day

XR: Start 5 mg once daily;

Increase weekly by 5 mg increments

Max dose: 30 mg per day

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30

31

	Dose range (mg)	Delivery
Stimulants		
Methylphenidate (short; duration of 4 h)		
Methylphenidate, immediate release	10–60	Tablet
Methylphenidate, oral solution	10–60	Liquid
Dexmethylphenidate, immediate release	2·5–20	Tablet
Methylphenidate (intermediate; duration of 6–8 h)		
Methylphenidate hydrochloride, sustained release	10–60	Tablet
Methylphenidate, long-acting	10–60	Capsule; contents can be sprinkled onto soft food
Methylphenidate (long; duration of 8–12 h)		
Dexmethylphenidate, extended release	5–30	Capsule; contents can be sprinkled onto soft food
Methylphenidate, oral solution, extended release	20–60	Liquid or chewable tablet
Methylphenidate, osmotic release	18–54 for children; 18–72 for adults	Tablet; osmotic-release oral system
Methylphenidate, transdermal	10–30	Patch
Methylphenidate hydrochloride, extended release	10–60	Capsule; contents can be sprinkled onto soft food
Amphetamine (short; duration of action 4–6 h)		
Dextroamphetamine	5–40	Tablet and liquid
Dextroamphetamine-amphetamine	5–30	Tablet
Amphetamine (long; duration of action 8–12 h)		
Dextroamphetamine-amphetamine, extended release	5–30	Capsule; contents can be sprinkled onto soft food
Dextroamphetamine, sustained release	5–40	Capsule
Lisdexamfetamine	10–70	Capsule; contents can be dissolved in liquid

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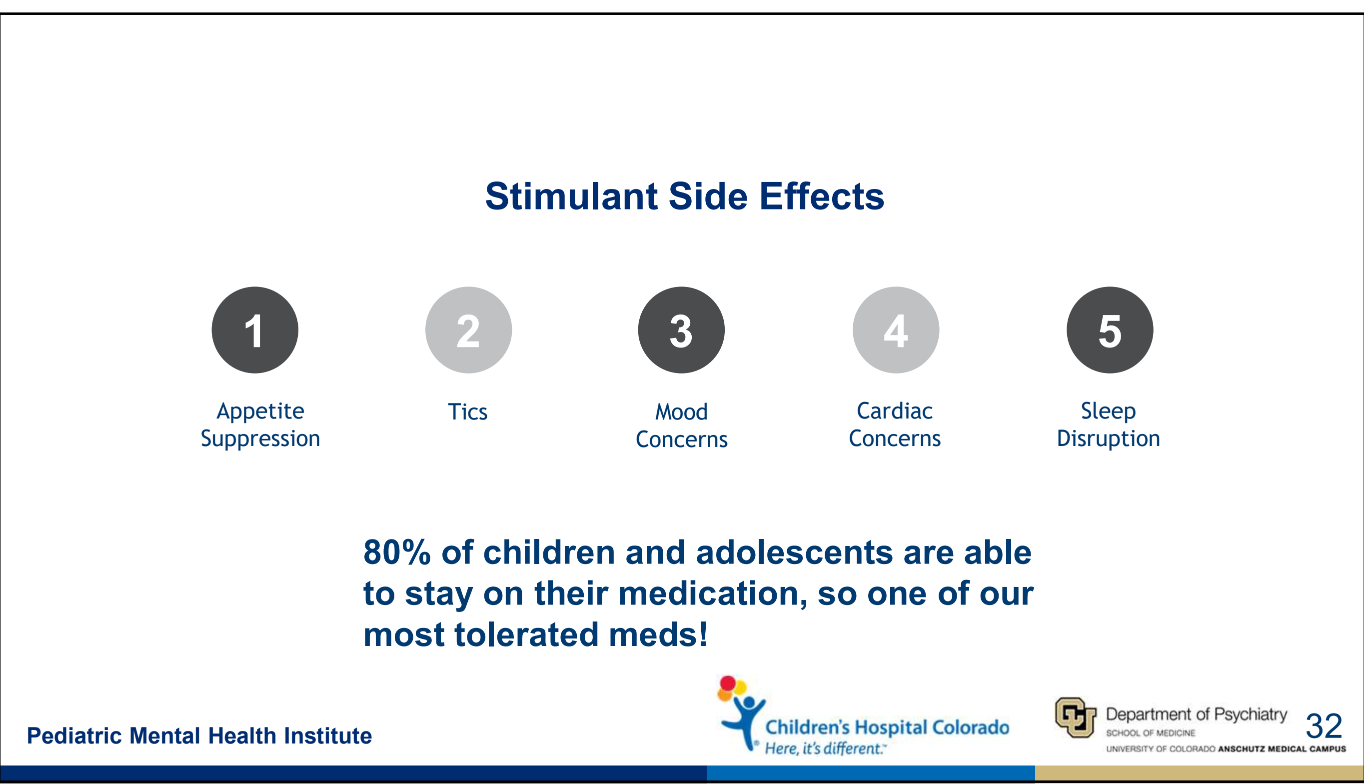

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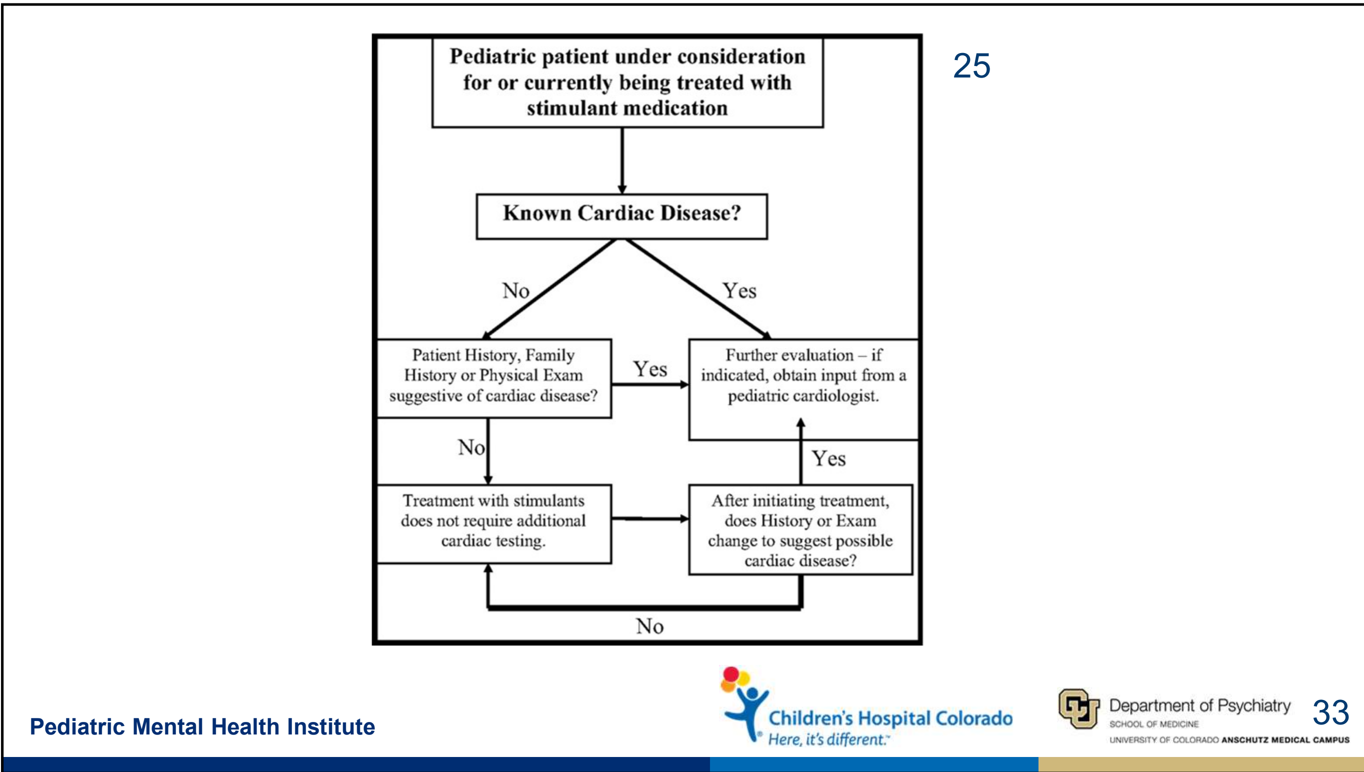

33

Atomoxetine

- Selective Norepinephrine Reuptake Inhibitor, a non-stimulant
- Approved for patients > 6 yo
- Dosing may be divided once or twice per day.
- Median time to response was 3.7 weeks
- Common SE's: somnolence, appetite suppression, GI, HA, BBW for SI

	Starting Dose	Target Dose	Maximum Dose (FDA)
Patients < 70 kg	0.5 mg/kg for at least 3 days	1.2 mg/kg	1.4 mg/kg
Patients > 70 kg and adults	40 mg for at least 3 days	80 mg	100 mg

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34

34

Viloxazine: FDA approval April 2021

- Selective Norepinephrine Reuptake Inhibitor, a non-stimulant
- Approved for patients > 6 yo – 17 yo
- Once daily, capsule can be sprinkled, may see benefits after a week
- Common SE's: somnolence, appetite suppression, HA, BBW for SI

	Starting Dose	Target Dose	Maximum Dose
6 – 11 yo	100 mg	Unclear, increase weekly by 100 mg	400 mg
11 – 17 yo	200 mg	Increase to 400 mg after a week	400 mg

Strong 1A2 inhibitor – check drug-drug interactions

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35

35

Clonidine and Clonidine ER

	Starting dosing & Titration	Maximum daily dose	Comments
Clonidine	< 45 kg: 0.05 mg qhs, Titrate by 0.05 mg q3-7 days in divided dosing, BID up to QID >45 kg: 0.1 mg qhs, Titrate by 0.1 mg q3-7 days in divided dosing, BID up to QID	27-40.5 kg: 0.2 mg* 40.5–45 kg: 0.3 mg* > 45 kg: 0.4 mg*	*Divided dosing
Clonidine ER	0.1 mg qhs May titrate weekly with BID dosing	0.4 mg	Monitor BP Do not crush/break pills

- Clonidine ER (Kapvay) side-effects (>5%): Somnolence, fatigue, upper respiratory tract infection (cough, rhinitis, sneezing), irritability, throat pain (sore throat), insomnia, nightmares, emotional disorder, constipation, nasal congestion, increased body temperature, dry mouth, and ear pain.
- Important to taper when discontinuing to avoid rebound hypertension

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36

36

Guanfacine and Guanfacine ER

	Starting dosing & Titration	Maximum daily dose	Comments
Guanfacine (Tenex)	<45 kg: 0.5 mg qhs >45 kg: 1 mg qhs May titrate after 3-4 days using divided dosing	<45 kg: 2 mg* 40.5-45 kg: 3 mg* >45 kg: 4 mg*	*Divided dosing BID to QID
Guanfacine ER	1 mg daily May titrate weekly	4 mg, ≤12 yo 7 mg, >12 (0.05-0.12 mg/kg)	Monitor BP Do not crush/break pills

- Guanfacine ER (Intuniv) side-effects: somnolence, fatigue, nausea, lethargy, and hypotension
- Important to taper when discontinuing to avoid rebound hypertension

Pharmacologic Management of Disruptive Behavior Disorders

- There are NO FDA-approved medications for Disruptive, Impulse Control, and Conduct Disorders
- Focus on medications for co-morbid disorders (mood, anxiety, ADHD)
  - Example: treating the ADHD in patients with DMDD + ADHD is the first-line strategy for irritability
- Off-label medications are sometimes used in emergent/urgent situations
- Consult with a child and adolescent psychiatrist (CoPPCAP)

Considerations for ASD Youth[30]

- Irritability and behavioral disruptions can be quite common
- Behavioral therapies are first-line treatments
- For medications, focus on true co-morbidities
  - For example, ADHD medications can be used if youth has ASD+ADHD, often with more careful dose titration
- There are two FDA-approved medications for ASD + Irritability
  - Risperidone and aripiprazole
  - We recommend careful dosing, careful monitoring of metabolic side effects, and with close consultation with CoPPCAP
  - And NEVER without concurrent behavioral treatment

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ADHD

• Attention Deficit Hyperactivity Disorder •

Attention Deficit Hyperactivity Disorder (ADHD) occurs in roughly 9.4% of children, with boys being more likely diagnosed (12.9%) than girls (5.6%)[1].

DSM-5 criteria for ADHD

≥5 symptoms per category **in adults**, ≥6 months; age of onset ≤12 years; noticeable in ≥2 settings; impact on social, academic or occupational functioning; not better accounted for by another mental disorder

Inattention

(a) Lack of attention to details / careless mistakes
(b) Difficulty sustaining attention
(c) Does not seem to listen
(d) Does not follow through on instructions (easily side-tracked)
(e) Difficulty organising tasks and activities
(f) Avoids sustained mental effort
(g) Loses and misplaces objects
(h) Easily distracted
(i) Forgetful in daily activities

Hyperactivity / Impulsivity

(a) Fidgetiness (hand or feet) / squirms in seat
(b) Leaves seat frequently
(c) Running about / feeling restless
(d) Excessively loud or noisy
(e) Always "on the go"
(f) Talks excessively
(g) Blurts out answers
(h) Difficulty waiting his or her turn
(i) Tends to act without thinking

Download a free ADHD medication guide!

Screening

CoPPCAP recommends pediatric providers consider use of multi-informant rating scales to, diagnose ADHD, track response to intervention 2-3 weeks after starting medication, to guide dose changes, and routinely every 6 months

even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
ADHD	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report Teacher Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.
ADHD	ADHD Rating Scale IV - Preschool Version 3-5 years Caregiver Report	ADHD Rating Scale IV - Preschool Version ⇒ English	The ADHD Rating Scale-IV obtains parent ratings regarding the frequency of each ADHD symptom based on DSM-IV criteria. Parents are asked to determine symptomatic frequency that describes the child's home behavior over the previous 6 months. The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.
ADHD	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV 3-5 years Caregiver Report Teacher Report	SNAP-IV ⇒ English ⇒ Spanish	The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992;Swanson et al., 1983). Items from the DSM-IV criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).
ADHD	Connors, 3rd Edition 6 – 18 years Caregiver Report Teacher Report Self-Report	Conners 3 ⇒ $$$	The Conners 3 assesses cognitive, behavioral, and emotional problems, with a focus on ADHD and comorbid disorders–providing teacher, parent, and student perspectives.
ADHD	Child Behavior Checklist 6 – 18 years Caregiver Report Teacher Report Self-Report	CBCL ⇒ $$$	The Child Behavior Checklist (CBCL) is a common tool for assessing depression in children, as well as ADHD, and other emotional and behavioral problems.

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ADHD	Behavior Assessment System for Children, 3rd Edition 2 – 21 years Caregiver Report Teacher Report Self-Report	BASC 3 ⇒ $$$	BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.

Diagnosis

- 314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.

- 314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.

- 314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity-impulsivity) is met but Criterion A1 (inattention) is not met over the past 6 months.

Specify if:

◊ In partial remission: When full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.

Specify current severity:

- Mild: Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in only minor functional impairments.
- Moderate: Symptoms or functional impairment between "mild" and "severe" are present.
- Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

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ADHD Algorithm

CoPPCAP | Colorado Care Guide

Diagnosis: preschoolers have some normal hyperactivity and impulsivity – skepticism is warranted for diagnosing ADHD in this age group (Note that Medicaid may require a medication review if prescribing & child age < 5).

If rapid onset symptoms, be wary of diagnosis, as this is not typical of ADHD.

Use DSM-5 criteria: Must have symptoms present in more than one setting
•Symptoms rating scale strongly recommended from both home and school
•If unremarkable medical history, neuro image and lab tests are not indicated.
•If significant concern for cognitive impairment, recommend neuropsychological testing

Broadband Social Emotional Screening

Concern for ADHD?

YES

NO

Continue with routine visit

ADHD Narrowband Screen

Symptom Tracking

Treat Substance Abuse
consider atomoxetine, alpha2 agonist, or buproprinen trial

Yes

Consider Differential Dx

No

ADHD Dx

Yes

Consider Recommendations for:
- Cognitive Behavioral Therapy
- Parent Management Training
- Social Skills Training
- Family Systems Therapy
- Executive Functioning Support
- Classroom Support

Active Substance Abuse?

No

but with significant ADHD impairment

Anxiety Disorder
Mood disorder
Trauma
Oppositional Defiant Disorder
Conduct Disorder
Substance Abuse
Language or Learning Disability
Intellectual Disability
Autism Spectrum Disorder

Symptom Tracking

ADHD Narrowband Screen

Monotherapy with stimulant medication
methylphenidate/amphetamine
•Titrate up every week until maximum benefit

If problem side effects or not improving, switch to the other stimulant class
methylphenidate/amphetamine

If problem side effects, or not improving, switch medication
atomoxetine/alpha2-agonist monotherapy

If no improvement, reconsider diagnosis
Medication combinations like alpha-2 agonist plus stimulant may be reasonable at this stage

Symptom Tracking

COPPCAP

click the algorithm above to enlarge

Treatment Modalities

Therapy: when ADHD symptoms are mild patients and families can consider therapy alone, otherwise evidence-based research supports use of intervention with both therapy and medication. When recommending therapy services, consider evidence-based therapies such as:

- Cognitive Behavioral Therapy (CBT)
- Parent Management Training
- Social Skills Training
- Family Systems Therapy
- Executive Function Coaching
- Video Games?
    - In 2020 the FDA approved EndeavorRx, a prescription-only, game-based treatment that is indicated to improve attention function as measured by computer-based testing. It is the first digital therapeutic intended to improve symptoms associated with attention deficit hyperactivity disorder (ADHD), as well as the first game-based therapeutic granted marketing authorization by the FDA for any type of condition.

Pharmacological: when ADHD symptoms are moderate or severe, treatments using an evidenced-based therapy and medication in combination provide the best efficacy.

- Medical workup recommended if medication will be used.
    - Obtain the patient's and patient's family's cardiovascular history (if patient or family has a cardiac history of sudden death, and/or cardiac symptoms patient should obtain more intensive cardiac workup before initiating stimulant treatment), risk of lead poisoning, history of sleep apnea, patient's height, weight, blood pressure, and substance use history. It is advisable to follow up every 2 weeks until appropriate dose achieved, then monitor all of the above every 3 months.
- Stimulants are first line treatment. All stimulants are based on two formulations…
    - Methylphenidate derivatives (includes Ritalin, Focalin, Concerta, etc): FDA approved starting at age 6yo.

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- Amphetamine derivatives (includes Adderall, Vyvanse, etc): some are FDA approved starting at age 3 yo (i.e. Adderall)
  - common side effects include decreased appetite, headache, insomnia, GI discomfort, increased anxiety, possibly worsens tics
  - less common side effects: anxiety, activation

- Non-stimulants (FDA approved starting at age 6yo):
  - Alpha-2 adrenergic agonists: Guanfacine, Clonidine
    - side effects include sedation, constipation, hypotension, dizziness, rebound hypertension if stopped suddenly
  - Selective NE reuptake inhibitor: Atomoxetine
    - side effects include suicidal ideation, severe liver injury, priapism
  - Viloxazine is a prescription medication that was approved by the FDA in 2021 to treat attention deficit hyperactivity disorder (ADHD) in children and adults. It is a noradrenergic reuptake inhibitor (NRI), which means that it works by increasing the levels of norepinephrine in the brain. Norepinephrine is a neurotransmitter that plays a role in attention, focus, and impulse control.
    - The most common side effects of viloxazine are: nausea, vomiting, diarrhea, stomach pain, headache, dizziness, sleepiness, dry mouth, blurred vision.
    - Viloxazine can also cause more serious side effects, such as: suicidal thoughts or actions, liver problems, seizures, heart problems, blood pressure problems

- Other medications to consider
  - note that **none** of the following are FDA approved for ADHD
    - Bupropion
    - Venlafaxine
    - TCAs
    - Modafinil
    - Natural Therapies (e.g. Omega3, attentional OTC "medications")

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ADHD Medication Guide*

Revised: October 1, 2022

Methylphenidate Formulations – Long Acting** (Capsules and tablets in this section are shown at actual size)

Medication	Dosing									
Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg; 13-17 Yrs: 18-72mg; SD: 18mg; ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	G 72mg		Methylphenidate ER 72mg (bioequivalent to 2 x 36 mg Concerta tablets)		
Aptensio® XR‡	6 Yrs-Adult: 10-60mg; SD: 10mg (biphasic – 40/60)	10mg	15mg	20mg	30mg	40mg	50mg	60mg		
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6-51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg		51.8mg		
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5-30mg; SD: 5mg; 18 Yrs-Adult: 5-30mg; SD: 5mg (biphasic – 50/50)	G 5mg		G 10mg	G 15mg	G 20mg	G 25mg	G 30mg	G 35mg	G 40mg
Quillivant XR® (5mg/5mL) (banana flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg	10mg 2mL; 1 Bottle: 300mg 60mL		20mg 4mL; 1 Bottle: 600mg 120mL	30mg 6mL; 1 Bottle: 900mg 180mL	40mg 8mL; 2 Bottles: 600mg 120mL	50mg 10mL; 2 Bottles: 750mg 150mL	60mg 12mL; 2 Bottles: 900mg 180mL		
Quillichew ER®§ (cherry flavor)	6 Yrs-Adult: 20-60mg; SD: 20mg			20mg	30mg	40mg				
Ritalin® LA‡	6-12 Yrs: 10-60mg; SD: 20mg (biphasic – 50/50)	G 10mg		G 20mg	G 30mg	G 40mg		G◆ 60mg		
Metadate® CD‡	6-17 Yrs: 10-60mg; SD: 20mg (biphasic – 30/70)	G◆ 10mg		G 20mg	G 30mg	G◆ 40mg	G 50mg	G◆ 60mg		
Metadate® ER†	6 Yrs-Adult: 20-60mg; SD: 20mg	G 10mg		G 20mg						
Daytrana® (patch)	6-17 Yrs: 10-30mg; SD: 10mg (The color border around each patch reflects the packaging color, not the patch itself.)	G 10mg 1.4"x1.4"	G 15mg 1.5"x1.9"	G 20mg 1.5"x2.6"	G 30mg 1.5"x3.9"					

Methylphenidate Pro-Drug Formulations - Long Acting** (Medications in this section are shown at actual size)

Medication	Dosing					
Azstarys®? (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	39.2mg SDX/ 7.8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH		

Methylphenidate Formulations – Long Acting/Delayed Onset** (Medications in this section are shown at actual size)

Medication	Dosing					
Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg

Methylphenidate Formulations – Short Acting** (Medications in this section are shown at actual size)

Medication	Dosing					
Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID; Adults: Daily: 10–60mg, divided BID or TID		G 5mg	G 10mg	G◆ 20mg	
Methylphenidate Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID; Adults: Daily: 10–60mg, divided BID or TID	G◆ 2.5mg	G◆ 5mg	G◆ 10mg		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID; Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Administration Key:

- ¶ Orally disintegrating tablet
- † Must be swallowed whole
- § Chewable
- ¥ Can be mixed with yogurt, orange juice, or water
- ‡ Can open capsule and sprinkle medication on apple sauce
- ? Can open capsule and sprinkle medication into water or onto apple sauce
- ‡ Can open capsule and mix with apple sauce or yogurt
- G Indicates a generic formulation is also available; generic products are not shown
- G Indicates a generic (but NOT a branded) formulation is available

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

****Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

◆**Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Ritalin LA capsule (60mg); Metadate CD capsules (40mg, 60mg); Metadate ER tablet (10mg); Ritalin SR tablets (20mg); Methylin Chewable tablets (2.5mg, 5mg, 10mg); Dexedrine Spansules (5mg, 10mg); Dexedrine tablets (5mg, 10mg); DextroStat tablets (5mg, 10mg); LiquADD solution (5mg/5mL), and Cylert (pemoline).

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ADHD Medication Guide*

Revised: October 1, 2022

Amphetamine Formulations – Long Acting** (Medications in this section are shown at actual size)

Medication	Dosing									
Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg	5mg	7.5mg	10mg	12.5mg	15mg	17.5mg	20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg; Adults: 12.5-50mg; SD: 12.5mg	12.5mg		25mg		37.5mg		50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg; 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg; Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adzenys ER® (d- & l-amphetamine) 1.25mg/mL (orange flavor)	6–12 Yrs: 6.3–18.8mg; SD: 6.3mg; 13–17 Yrs: 6.3–12.5mg; SD: 6.3mg; Adults: 12.5mg		3.1mg 2.5mL	6.3mg 5mL	9.4mg 7.5mL	12.5mg 10mL	15.7mg 12.5mL	18.8mg 15mL		
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg; Adults: 5-30mg; SD: 20mg (biphasic – 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G◆ 5mg	G◆ 10mg	G 15mg					

Amphetamine Pro-Drug Formulations – Long Acting** (Medications in this section are shown at actual size)

Medication	Dosing									
Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg	70mg		
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg			

Amphetamine Formulations – Short Acting** (Medications in this section are shown at actual size)

Medication	Dosing									
Evekeo® (d- & l- amphetamine sulfate)	3-5 Yrs: SD: 2.5mg 1x/day; 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		5mg		10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3-5 Yrs: SD: 2.5mg 1x/day; 6–16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		15mg	20mg	30mg	
Adderall® (mixed amphetamine salts)	3-5 Yrs: SD: 2.5mg 1x/day; 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3-5 Yrs: SD: 2.5mg 1x/day; 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Medication	Dosing									
Intuniv®† (guanfacine, extended release)	6-12 Yrs: 1-4mg; SD: 1mg; 13–17 Yrs: 1-7mg; SD: 1mg; Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg); >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxazine)	6-11 Yrs: 100-400mg; SD: 100mg; 12–17 Yrs: 200-400mg; SD: 200mg; Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg	+	400mg	+			

click the image above to enlarge

Educational Interventions: recommend families contact the child's school district to learn more about the availability and process to obtain the following educational interventions, or visit http://www.cde.state.co.us/cdesped/iep

- IEP: Federal law (i.e. it's federally funded) entitles children/teens with specific disabilities to obtain a free & appropriate public education which may include services including Psychological services, PT, OT, and Speech amongst others. ADHD falls under the "Other Health Impairment" classification. Obtaining an IEP is usually an involved process.
- 504 Plans: typically provide for classroom accommodations (i.e. extended testing time, student placement near teacher, etc) and may be easier to obtain than an IEP. 504 plans are managed by the school (principal, guidance counselor, teacher, etc) and need to be rewritten each year.

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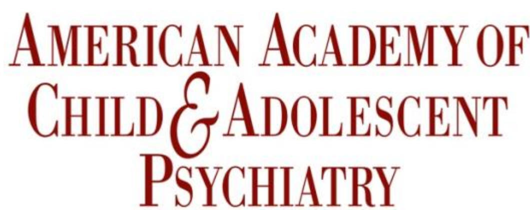
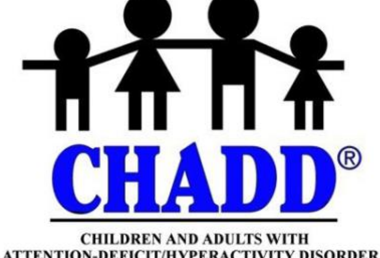
Free Resources:

- AACAP – ADHD: Parents' Medication Guide
- AAP – Caring for Children With ADHD: A Practical Resource Toolkit for Clinicians, 3rd Edition





ADHDchildhood

Acknowledgements: PMHCA sites across multiple states.

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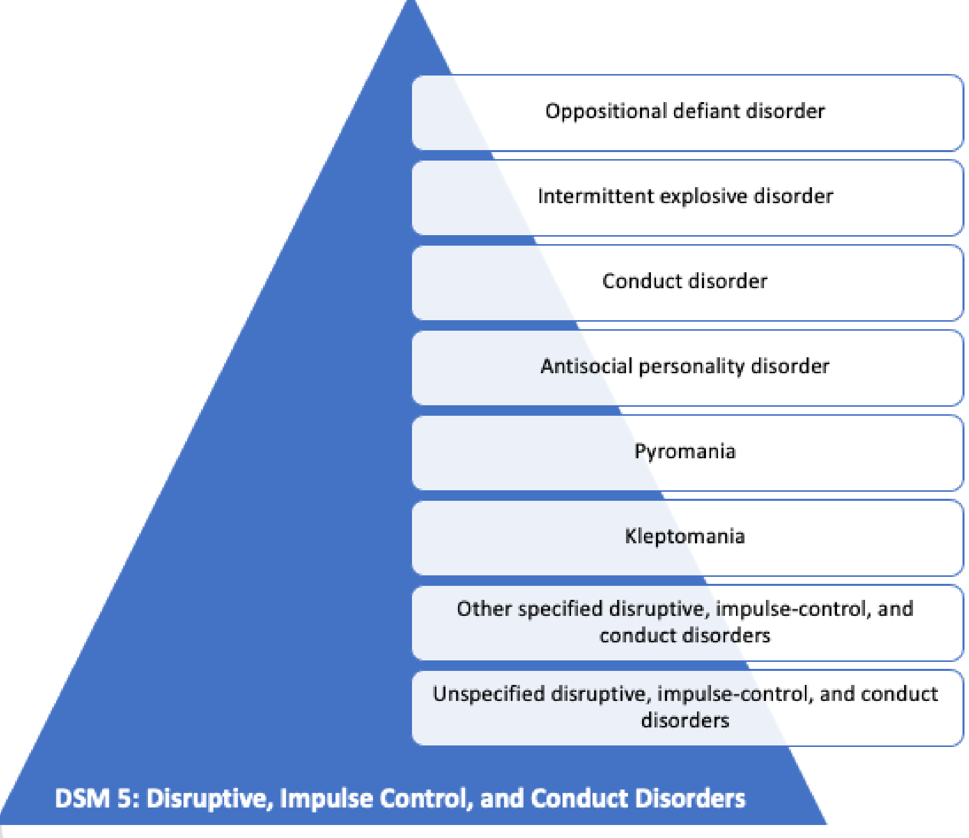
DISRUPTIVE BEHAVIORS

• Disruptive Behaviors •

Disruptive, Impulse-control, and Conduct Disorders involve problems in the self-control of emotions and behaviors which result in the violation of another one's rights and/or cause significant conflict with societal norms or authority figures.



Epidemiology[1]

Recent data collected as part of the National Survey of Children's Health (survey years: 2016 – 2019) reported an 8.9% prevalence rate of children and adolescents aged 3–17 years with a diagnosis of behavior problems, with a 7.0% point prevalence rate at the time of the survey. Children aged 6–11 years had higher rates of behavior problems than children who were less than 6 years or older than11 years. Similar to rates of ADHD, boys had more than twice the estimated prevalence of behavior problems compared with girls. When considering factors related to race, Black children had the highest estimated prevalence of behavior problems, followed by

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White and Hispanic children, with the lowest estimates among Asian children. Socioeconomic factors determined that the highest prevalence of behavior problems was among children in homes affected by poverty and among children with public health insurance; the prevalence of behavior problems was also higher among children of parents with a high school education (or less) as compared to those families with parents attaining more than a high school education. Additionally, it was found that the prevalence of behavior problems was higher among children living in rural areas than among those in urban or suburban areas.

Diagnostic Criteria

The revision of DSM-IV to DSM-5 added a chapter specifically categorizing disruptive, impulse-control, and conduct disorders. This revision brought together disorders that were previously included in the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" (i.e., oppositional defiant disorder; conduct disorder; and disruptive behavior disorder not otherwise specified, now categorized as other specified and unspecified disruptive, impulse-control, and conduct disorders) and the chapter "Impulse-Control Disorders Not Otherwise Specified" (i.e., intermittent explosive disorder, pyromania, and kleptomania). Evidenced based research supported the underpinnings of these disorders to all be characterized as problems in emotional and behavioral self-control.

Of note, ADHD is frequently comorbid with the disorders in this chapter but is now listed in DSM 5 within the chapter categorizing Neurodevelopmental Disorders. It had previously (DSM-IV TR) been considered within the Disruptive Behavior Disorders. Please review the ADHD Colorado Care Guide for further information on the assessment, diagnosis, and treatment of ADHD.

Click the links below to review diagnostic criteria for each of the DSM-5 categorized disruptive, Impulse control, and conduct disorders:

- Oppositional Defiant Disorder
- Intermittent Explosive Disorder
- Conduct Disorder
- Antisocial Personality Disorder
- Pyromania
- Kleptomania
- Other specified disruptive, impulse control, and conduct disorders
- Unspecified disruptive, impulse control, and conduct disorders

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Etiology

Several biological and environmental risk factors have been associated with the development of disruptive behaviors.

Biological Risk Factors

- Parent with a diagnosis of:
  - o Alcohol Dependence
  - o Antisocial Personality Disorder
  - o Attention Deficit/Hyperactivity Disorder
  - o Conduct Disorder
  - o Schizophrenia
- Sibling with a Disruptive Behavior Disorder
- ODD: Familial Pattern ODD is more common in families in which at least one parent has a history of Mood Disorder, ODD, CD, ADHD, ASPD, or a Substance Related Disorder. Some studies suggest a link between maternal depression and ODD; however, the direction of causality is suspect. ODD is more common in the families where there is serious marital discord
- CD: Familial Pattern Twin and adoption studies show genetic and environmental factors
- Maternal smoking during pregnancy

Environmental Risk Factors

- Parental rejection/neglect
- Harsh discipline
- Inconsistent parenting/multiple caregivers
- Lack of Supervision
- Large family size
- Single parent status
- Marital discord
- Abuse – emotional, physical or sexual
- Poverty
- Abuse and Neglect
- Parental criminality & psychopathology

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- Drug and alcohol use by parents/caregivers
- Exposure to violence

Screening

CoPPCAP recommends pediatric providers initially use an age-appropriate broadband screening measures to better understand the symptom profile. When clinically indicated, narrowband screening measures, especially ones that collect information from multiple reports and within multiple environments may be utilized to further detect symptoms of a disruptive behavior disorder. Consider the use of the following screening measures that include several open source options that are free for use:

Screener. DxCategory	Screener.Name	Screener.Acronynm	Screener.Description
Social-Emotional Development	The Survey of Well-being of Young Children 2-60 months Caregiver Report	SWYC ⇒ English ⇒ Spanish	The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines. The SWYC is copyright © 2010 Tufts Medical Center. Every SWYC form includes sections on developmental milestones, behavioral/emotional development, and family risk factors. At certain ages, a section for Autism-specific screening is also included. Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months.
Social-Emotional Development	Preschool Pediatric Symptom Checklist 18-60 months Caregiver Report	PPSC ⇒ English ⇒ Spanish	The Preschool Pediatric Symptom Checklist (PPSC) is a social/emotional screening instrument for children 18–60 months of age. The PPSC was created as one part of a comprehensive screening instrument designed for pediatric primary care and is modeled after the Pediatric Symptom Checklist.

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Social-Emotional Development	Brief Early Childhood Screening Assessment 18-60 months Caregiver Report	Brief ECSA* ⇒ English	The Brief ECSA screens children 18-60 months for signs of emotional and behavioral problems.
Social-Emotional Development	Pediatric Symptom Checklist – 17 item 4-18 years Caregiver Report	PSC-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist is a 17-item screening questionnaire listing a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing.
Social-Emotional Development	Pediatric Symptom Checklist – Youth – 17 item 11-18 years Self-Report	PSC-Y-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist - Youth - 17 is a 17 item screening questionnaire listing a broad range of behavioral and psychosocial problems in youth. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-Y-17 is used to screen for emotional and behavioral problems including those of attention, externalizing, internalizing, and suicidal ideation.
Social-Emotional Development	Ages & Stages Questionnaire: Social Emotional 1-72 months Caregiver Report	ASQ-SE $$$	SQ:SE- 2 is a set of questionnaires about behavior and social- emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

Screener.Dx Category	**Screener.Name**	**Screener.Acronynm**	**Screener.Description**
ADHD	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.

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	Teacher Report		
ADHD	ADHD Rating Scale IV - Preschool Version 3-5 years Caregiver Report	ADHD Rating Scale IV - Preschool Version ⇒ English	The ADHD Rating Scale-IV obtains parent ratings regarding the frequency of each ADHD symptom based on DSM-IV criteria. Parents are asked to determine symptomatic frequency that describes the child's home behavior over the previous 6 months. The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.
ADHD	Swanson, Nolan, and Pelham (SNAP) Questionnaire – IV 3-5 years Caregiver Report Teacher Report	SNAP-IV ⇒ English ⇒ Spanish	The SNAP-IV 18-item scale is an abbreviated version of the Swanson, Nolan, and Pelham (SNAP) Questionnaire (Swanson, 1992;Swanson et al., 1983). Items from the DSM-IV criteria for attention-deficit/hyperactivity disorder (ADHD) are included for the two subsets of symptoms: Inattention (items 1–9) and Hyperactivity/Impulsivity (items 10–18).
ADHD	Connors, 3rd Edition 6 – 18 years Caregiver Report Teacher Report Self-Report	Conners 3 ⇒ $$$	The Conners 3 assesses cognitive, behavioral, and emotional problems, with a focus on ADHD and comorbid disorders–providing teacher, parent, and student perspectives.
ADHD	Child Behavior Checklist 6 – 18 years Caregiver Report Teacher Report Self-Report	CBCL ⇒ $$$	The Child Behavior Checklist (CBCL) is a common tool for assessing depression in children, as well as ADHD, and other emotional and behavioral problems.
ADHD	Behavior Assessment System for Children, 3rd Edition 2 – 21 years Caregiver Report Teacher Report Self-Report	BASC 3 ⇒ $$$	BASC-3 applies a triangulation method for gathering information. It analyzes a child's behavior from three perspectives: self, teacher, and parent.

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Anxiety Algorithm

CoPPCAP | Colorado Care Guide

Use DSM-5 criteria for diagnosis

Pediatric Anxiety Disorders:
- Generalized Anxiety Disorder
- Separation Anxiety
- Panic Disorder
- Agoraphobia
- Specific Phobia
- Social Anxiety Disorder
- Selective Mutism

Broadband Social Emotional Screening

Concern for Anxiety?

YES

Anxiety Narrowband Screen

NO

CoPPCAP's Anxiety Management Plan provides action items to benefit all patients

Anxiety Management Plan

Continue with routine visit

Consider Differential Dx

No

Anxiety Dx

Mood disorder
ADHD
OCD
Trauma
Oppositional Defiant Disorder
Disruptive Mood Dysregulation Disorder
Adjustment Disorder
Substance Abuse
Language or Learning Disability
Vitamin D Deficiency
Autoimmune Disease
Medical Conditions

Mild

Recommend Psychotherapy
CBT
•Cognitive Behavioral Therapy (CBT) is recommended as a first-line treatment of children with an anxiety disorder of mild to moderate severity rather than an SSRI or other treatment.
•Exposure treatment is central to all efficacious CBT for pediatric anxiety disorders.

Moderate – Severe

Recommend Psychotherapy
CBT
• Combined CBT-SSRI treatment performed better than either modality individually in clinical trials of children with anxiety

Psychotherapy w/ medication is most effective treatment

First-line medication used in children and adolescents
SSRIs
•Titrate up every week until maximum benefit

Check in every 1-2 weeks for first month to assess for side effects and stop if worsening anxiety, agitation, or suicidal thoughts

If no improvement in 4-6 weeks at therapeutic dose, increase dose, and if no change in 12 weeks (with dose increases), switch medication and consider consulting CoPPCAP

click the algorithm above to enlarge

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Options for Treatment: Psychotherapy

Without intervention, it is likely that Disruptive Behavior Disorders may progress. There are several promising treatments that are available and if completed have enduring benefits. A thorough review of Boggs et. al. (2004) demonstrated that Parent-Child Interaction Therapy shows significant positive change after completing therapy, however this was not true for parents who discontinued treatment.

Streiner and Remsing (2007) identify the importance of skill training in problem-solving and family intervention that provides behavior management training

Eyberg, Nelson and Boggs (2008) have identified 16 evidence-based treatments for disruptive behaviors. Fifteen are identified as probably efficacious while one is evaluated as having well established treatment outcomes. Two examples are:

- **Parent Management Training** (PMT) is directed toward parents and teaches them to identify antecedents, resulting behaviors and the associated consequences for their children as well as themselves. Ultimately, the training focuses on reinforcing desired behaviors.
- **Parent-Child Interaction Therapy** (PCIT) emphasizes improvements in the relationship between the parent and child and offers tools to help manage behaviors that are disruptive

Early intervention during preschool years is imperative & offers promising results

Nixon (2002) has identified that effective parent management interventions may be offered via a number of modalities including face-to-face counseling, videotaped training and telephonic

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Options for Treatment: Pharmacotherapy

- **CBT is always indicated as a first line treatment of pediatric anxiety**
- Medications are indicated for more moderate – severe forms of anxiety or in anxiety that has not responded to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial

- SSRIs are typically the first-line pharmacologic treatment in children and adolescent's serotonin-norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants have also shown efficacy in the treatment of pediatric anxiety disorders. Because they are associated with less easily tolerated side effects compared with SSRIs, these drugs are generally used second- or third- line.
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases. Side effects experienced may be different based on individual medication.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
  - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
  - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in anxiety symptoms
  - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.
- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

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Anxiety Medications

Medications that may be used to treat anxiety disorders in children and adolescents

Class	Medication (Brand name)	Common dose range (mg/day)	Tablet size (mg)	Common side effects	Serious side effects	Uncommon, serious side effects
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5 – 40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100 – 300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25 – 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 – 60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10 – 50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5 – 225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30 – 120	20, 30, 40, 60			
	Atomoxetine (Strattera™)	10 – 100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75 – 250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	• Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5 – 1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	• Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
Atypical anxiolytic	Buspirone (Buspar™)	15 – 60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5 – 50	25, 50			
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50			

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Disruptive Behaviors Management Plan

CoPPCAP offers a Disruptive Behaviors Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.

Disruptive Behaviors Action Plan for Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: ____________ Date: ____________ Provider: ____________ Provider's Phone Number____________

No/Mild Disruptive Behavior Concerns (PPSC score 0 - 5)

- **Behavioral**: No behavioral concerns reported, or if so concerns only occur in one area or for limited durations
- **Physical**: No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive**: No new concentration/focus issues, able to enjoy usual activities.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:____________
□ Positive Parenting Strategies:____________
□ Increase Structure/Routine:____________
□ Relational/Family Dynamics:____________
□ Referral for Mental Health Services:____________

Moderate Disruptive Behavior Concerns (PPSC score 6 - 15)

- **Behavioral**: Occasional behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Occasional tantrums, erratic behavior, or consistent noncompliance.
- **Cognitive**: Occasional negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities)

My Disruptive Behavior Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:____________
□ Positive Parenting Strategies:____________
□ Increase Structure/Routine:____________
□ Relational/Family Dynamics:____________
□ Referral for Mental Health Services:____________

Significant Disruptive Behavior Concerns (PPSC score: 16 or higher)

- **Behavioral**: Pervasive behavioral concerns reported related to compliance, difficulty with transitions, emotionality, peer relationships, or aggression.
- **Physical**: Pervasive tantrums, erratic behavior, aggression, or consistent noncompliance
- **Cognitive**: Pervasive negative thoughts, difficulty with focus/concentration, or difficulty with appropriately expressing emotions.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities)

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of disruptive behavior:____________
□ Positive Parenting Strategies:____________
□ Increase Structure/Routine:____________
□ Relational/Family Dynamics:____________
□ Referral for Mental Health Services:____________

click the image above to access the full Disruptive Behaviors Management Plan

Resources:

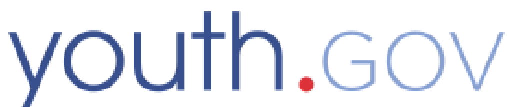
Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents

Mental Health App reviews

One Mind PsyberGuide is a non-profit project run by a team of experts in mental health, technology, and technology delivered care based out of the University of California, Irvine and Northwestern University. One Mind PsyberGuide is not an industry website; its goal is to provide accurate and reliable information free of preference, bias, or endorsement.



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1.

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NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: __________ Child's Name: ______________________________ Date of Birth: ____________

Parent's Name: ______________________________ Parent's Phone Number: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

DEDICATED TO THE HEALTH OF ALL CHILDREN™

National Initiative for Children's Healthcare Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: ___________ Child's Name: ____ Date of Birth: ________________

Parent's Name: ____ Parent's Phone Number: _____________________________

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ________________________

Total number of questions scored 2 or 3 in questions 10–18: ______________________

Total Symptom Score for questions 1–18: ______________________________________

Total number of questions scored 2 or 3 in questions 19–26: ______________________

Total number of questions scored 2 or 3 in questions 27–40: ______________________

Total number of questions scored 2 or 3 in questions 41–47: ______________________

Total number of questions scored 4 or 5 in questions 48–55: ______________________

Average Performance Score: ____

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: ____________

Today's Date: ________ Child's Name: ______________________ Grade Level: ______________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: ________.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Teacher's Name: ______________ Class Time: ______________ Class Name/Period: ______________

Today's Date: __________ Child's Name: ______________ Grade Level: ______________

Symptoms (continued)	**Never**	**Occasionally**	**Often**	**Very Often**
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance ***Academic Performance***	**Excellent**	**Above Average**	**Average**	**Somewhat of a Problem**	**Problematic**
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	**Excellent**	**Above Average**	**Average**	**Somewhat of a Problem**	**Problematic**
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: ______________

Mailing address: ______________

____

Fax number: ______________

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: ______________

Total number of questions scored 2 or 3 in questions 10–18: ______________

Total Symptom Score for questions 1–18: ______________

Total number of questions scored 2 or 3 in questions 19–28: ______________

Total number of questions scored 2 or 3 in questions 29–35: ______________

Total number of questions scored 4 or 5 in questions 36–43: ______________

Average Performance Score: ______________

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11-20/rev0303

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: ___________ Child's Name: ______________________________________ Date of Birth: ______________

Parent's Name: ______________________________________ Parent's Phone Number: ___________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: ___________ Child's Name: ____ Date of Birth: _______________

Parent's Name: ____ Parent's Phone Number: ____________________________

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: ________________________________

Average Performance Score for questions 19–26: __________________________

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: ______________________________ Class Time: ________________ Class Name/Period: ______________

Today's Date: __________ Child's Name: ______________________________ Grade Level: ______________________________

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: __________.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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Teacher's Name: ______________________ Class Time: ______________ Class Name/Period: __________

Today's Date: ________ Child's Name: ______________________ Grade Level: ______________________

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: ______________________

Average Performance Score: ______________________

Please return this form to: ______________________

Mailing address: ______________________

____

Fax number: ______________________

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity **Oppositional-Defiant Disorder Screen** ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55 **Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity **Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43 **Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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ADHD Medication Guide*

Revised: May 7, 2024

Methylphenidate Formulations – Long Acting, Oral**

(Capsules and tablets in this section are shown at actual size)

Medication	Dosing									
Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	Relexxii® (bioequivalent to corresponding Concerta dosing)		G 45mg	G 63mg	G 72mg
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 10–40mg; SD: 10mg (biphasic – 50/50)	G 5mg		G 10mg	G 15mg	G 20mg	G 25mg	G 30mg	G 35mg	G 40mg
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg (T2 + T2)		51.8mg (T3 + T3)		
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg (biphasic – 40/60)	G 10mg	G 15mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg		
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg	10mg 2mL — 1 Bottle: 300mg 60mL		20mg 4mL — 1 Bottle: 600mg 120mL	30mg 6mL — 1 Bottle: 900mg 180mL	40mg 8mL — 2 Bottles: 600mg 120mL	50mg 10mL — 2 Bottles: 750mg 150mL	60mg 12mL — 2 Bottles: 900mg 180mL		
QuilliChew ER®§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 30/70)			20mg	30mg	40mg				
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg (biphasic – 50/50)	G 10mg		G 20mg	G 30mg	G 40mg		G♦ 60mg		
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg (biphasic – 30/70)	G♦ 10mg		G♦ 20mg	G♦ 30mg	G♦ 40mg	G♦ 50mg	G♦ 60mg		
Metadate® ER†	6 Yrs-Adult: 20–60mg; SD: 20mg	G♦ 10mg		G♦ 20mg						

Methylphenidate Formulations - Long Acting, Transdermal

Daytrana® G

6-17 Yrs: 10–30mg; SD: 10mg

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

- 30mg / 9 hrs ~ 1.5"x 3.9"
- 20mg / 9 hrs ~ 1.5"x 2.6"
- 15mg / 9 hrs ~ 1.5"x 1.9"
- 10mg / 9 hrs ~ 1.4"x 1.4"

Methylphenidate Pro-Drug Formulations - Long Acting, Oral**

(Medications in this section are shown at actual size)

Medication	Dosing					
Azstarys®‽ (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	39.2mg SDX/ 7.8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH		

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral**

(Medications in this section are shown at actual size)

Medication	Dosing					
Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg

Methylphenidate Formulations – Short Acting, Oral**

(Medications in this section are shown at actual size)

Medication	Dosing					
Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg	G 10mg	G 20mg	
Methylin Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID	G♦ 2.5mg	G♦ 5mg	G♦ 10mg		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Administration Key:

- ¶ Orally disintegrating tablet
- † Must be swallowed whole
- § Chewable
- ¥ Can be mixed with yogurt, orange juice, or water
- ‡ Can open capsule and sprinkle medication on apple sauce
- ‽ Can open capsule and sprinkle medication into water or onto apple sauce
- Can open capsule and mix with apple sauce or yogurt
- G (blue) Indicates a generic formulation is also available; generic products are not shown
- G (red) Indicates a generic (but NOT a branded) formulation is available
- View the latest version of the ADHD Medication Guide at www.ADHDMedicationGuide.com

♦**Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Adzenys ER (liquid); Cylert (pemoline); Dexedrine Spansules (5mg, 15mg); Dexedrine tablets; DextroStat tablets; LiquADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylin Chewable tablets; Ritalin LA capsule (60mg); Ritalin SR tablets (20mg).

****Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

***Disclaimer:** The ADHD Medication Guide was created by Dr. Andrew Adesman of Northwell Health, Inc. Northwell Health is not affiliated with the owner nor is an owner of any of the medications or brands referenced in this Guide. No endorsement or affiliation exists between Northwell Heath and the owner of the medications or brands. The ADHD Medication Guide is a visual aid for professionals caring for individuals with ADHD. The Guide includes only medications indicated by the FDA for the treatment of ADHD. In clinical practice, this guide may be used to assist patients in identifying medications previously tried, and may allow clinicians to identify ADHD medication options for the future. Practitioners should refer to the FDA-approved product information to learn more about each medication. Although every effort has been made to depict the true size and color of each medication depicted, we cannot guarantee there are not minor distortions.

This Guide should not be used as an exclusive basis for decision-making. The user understands and accepts that if Northwell Health were to accept the risk of harm to the user from use of this Guide, it would not be able to make the Guide available because the cost to cover the risk of harm to all users would be too great. Thus, use of this ADHD Medication Guide is strictly voluntary and at the user's sole risk.

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ADHD Medication Guide*

Revised: May 7, 2024

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Medication	Dosing									
Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg		5mg		10mg		15mg		20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	G 12.5mg		G 25mg		G 37.5mg		G 50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5-30mg; SD: 20mg (biphasic – 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G♦ 5mg	G 10mg	G♦ 15mg					

Amphetamine Formulations- Long Acting, Transdermal

Xelstrym™ (d-amphetamine)

6-17 Yrs: 4.5–18mg; SD: 4.5mg
Adults: 9-18mg; SD: 9mg

- 18mg / 9hrs ~1.7"x 1.7"
- 13.5mg / 9hrs ~1.5"x 1.5"
- 9mg / 9hrs ~1.2"x 1.2"
- 4.5mg / 9hrs ~0.9"x 0.9"

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Medication	Dosing							
Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	G 70mg
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Medication	Dosing									
Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg		G 10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		G 15mg	G 20mg	G 30mg	
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Medication	Dosing									
Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1-4mg; SD: 1mg 13–17 Yrs: 1-7mg; SD: 1mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxazine)	6–11 Yrs: 100-400mg; SD: 100mg 12–17 Yrs: 200-400mg; SD: 200mg Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg (SPN 150)	+ (SPN 150)	400mg (SPN 200)	+ (SPN 200)			

Additional Resources for ADHD

1. ADHD Medication Guides for families
    a. English: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHD_Medication_Guide-web.pdf
    b. Spanish: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHDSpanishMedicationGuide-web.pdf
    c. ADHD and ASD: https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/ADHDwithASD_Web.pdf
2. https://www.cdc.gov/adhd/treatment/behavior-therapy.html
3. https://www.cdc.gov/adhd/communication-resources/index.html
4. https://www.cdc.gov/parenting-toddlers/site.html
5. https://www.cdc.gov/parenting-teens/about/index.html
6. https://www.cdc.gov/child-development/positive-parenting-tips/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html
7. FDA handout for atomexetine. http://www.accessdata.fda.gov/drugsatfda_docs/label/2009/021411s029s030lbl.pdf
8. FDA handout for viloxazine. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/211964s003lbl.pdf
9. FDA handout for clonidine. http://www.accessdata.fda.gov/drugsatfda_docs/label/2010/022331s001s002lbl.pdf
10. FDA handout for guanfacine ER. https://www.fda.gov/media/116457/download

Book Recommendations for Anxiety and OCD

Dr. Lee and Dr. Mullin

Title	Age	Author	Publisher	Year	Synopsis
A Perfectly Messed-Up Story	2-7	Patrick McDonnell	Little Brown Books for Young Readers	2014	A hilarious, delightful book with a story that breaks the "fourth wall" and talks directly to the audience. This book discusses perfectionism in a very non-threatening manner.
When My Worries Get Too Big! A Relaxation Book for Children Who Live with Anxiety	4-8	Kari Dr. Buron	Autism Asperger Publishing Company	2006	A book placing anxiety on a scale of 1 to 5, pushing children to think about what makes them anxious and what it feels like at different degrees.
Wilma Jean the Worry Machine	6-12	Julia Cook	National Center for Youth Issues	2011	Wilma Jean worries too much about everything. She worries so much that she feels sick. But when she goes to school, she discovers that the things that she worries about seem to work themselves out. Her teachers help her feel more in control and this allows her worries not to bother her so much.
What to Do When You Worry Too Much	6-12	Dawn Huebner	Magination Press	2005	Lively metaphors and humorous illustrations make concepts and strategies easy to understand, while clear how-to steps and prompts to draw and write help children to master new skills related to reducing anxiety.
What to Do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD	6-12	Dawn Huebner	Magination Press	2007	With engaging examples, activities, and step-by-step instructions, it helps children master the skills needed to break free from OCD's sticky thoughts and urges, and live happier lives.
What to Do When Good Enough Isn't Good Enough…	9-13	Thomas Greenspon	Free Spirit Publishing	2007	A self-help book for children and young adolescents whose perfectionism causes them to be their own worst enemies.

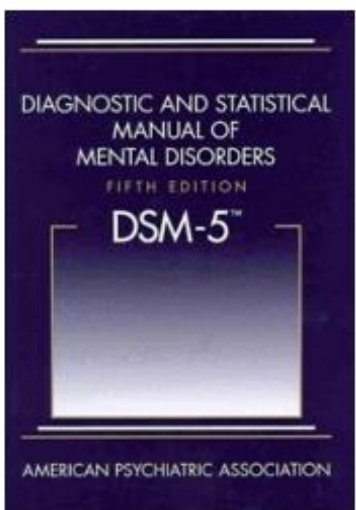
The Real Deal on Perfectionism					
Stuff that Sucks: A Teen's Guide to Accepting What You Can't Change and Committing to What You Can	13 and up	Ben Sedley	Instant Help	2017	Offers a compassionate and validating guide to accepting emotions, rather than struggling against them.
Stuff That's Loud: A Teen's Guide to Unspiraling When OCD Gets Noisy	13 and up	Ben Sedley Lisa W. Coyne	Instant Help	2017	While OCD can be difficult, you do not have to let it have power over you. Instead, you can live a life full of meaning, great relationships and joy.
Your Life, Your Way: Acceptance and Commitment Therapy Skills to Help Teens Manage Emotions and Build Resilience	13 and up	Joseph V. Ciarrochi Louise L. Hayes	Instant Help	2020	Readers will learn how to deal with all the changes and challenges of the tee years- and grow into the person that they want to be.
Getting Comfortable with Uncertainty for Teens: 10 Tips to Overcome Anxiety, Fear, and Worry	13 and up	Juliana Negreiros Katherine Martinez	Instant Help	2022	Learn to manage fears, live with confidence, and make a positive impact. Gain greater understanding of how uncertainty can trigger feelings of anxiety, worry, and self-doubt.
Breaking Free of Child Anxiety and OCD: A Scientifically Proven Program for Parents	Parents	Eli R. Lebowitz	Oxford University Press	2021	A completely parent-based treatment program for child and adolescent anxiety.

You and Your Anxious Child: Free Your Child from Fears and Worries and Create a Joyful Family Life	Parents	Anne Marie Albano Leslie Pepper	Avery	2013	Differentiates between separation anxiety, generalized anxiety, and social phobia, and guides parents on when and how to seek intervention.
Helping Your Anxious Child: A Step-by-Step Guide for Parents	Parents	Ronald Rapee Ann Wignall Susan Spence Vanessa Cobham Heidi Lyneham	New Harbinger Publications	2022	Includes the latest research and techniques for managing child anxiety and includes information on helping very young children and adolescents.

ANXIETY

• Anxiety Disorders •

Anxiety disorders are the most common psychiatric disorders diagnosed in childhood and adolescence. 7.1% of children aged 3-17 years (approximately 4.4 million) have diagnosed anxiety. For children aged 3-17 years with anxiety, more than 1 in 3 also have behavior problems (37.9%) and about 1 in 3 also have depression (32.3%).[1,2]



DSM-5 Anxiety Disorders

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder
- Panic Disorder/Panic Attack
- Generalized Anxiety Disorder
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition

Screening

CoPPCAP recommends pediatric providers use narrowband screening measures to further detect symptoms of anxiety if concerns arise from initial broadband screening. Narrowband anxiety screening forms can be utilized beyond initial screening efforts to track response to intervention 1-2 weeks after starting therapy/medication, to guide dose changes, and routinely every 6 months even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

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Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Anxiety	Screen for Child Anxiety Related Disorders 8 - 18 years Caregiver Report Self Report	SCARED ⇒ English ⇒ Spanish	The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias.
Anxiety	Spence Children's Anxiety Scale preschool version 2.5 - 6.5 years child version 8 – 15 years Self-Report Caregiver Report	SCAS ⇒ English ⇒ Spanish	The Spence Children's Anxiety Scale (SCAS) is a psychological questionnaire designed to identify symptoms of various anxiety disorders, specifically social phobia, obsessive-compulsive disorder, panic disorder/agoraphobia, and other forms of anxiety, in children and adolescents between ages 8 and 15. Developed by Susan H. Spence and available in various languages, the 45 question test can be filled out by the child or by the parent. There is also another 34 question version of the test specialized for children in preschool between ages 2.5 and 6.5. Any form of the test takes approximately 5 to 10 minutes to complete.
Anxiety	Generalised Anxiety Disorder Assessment 14+ years Self Report	GAD-7 ⇒ English ⇒ Spanish	The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.

Anxiety Disorders

According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the Anxiety Disorders category consists of nine separate diagnoses, with Obsessive-Compulsive Disorders and Trauma and Stressor-Related Disorders identified as distinct categories.

Anxiety Disorder	Brief Description	ICD Code
Generalized Anxiety Disorder	Generalized anxiety disorder involves persistent and excessive worry that interferes with daily activities. This ongoing worry and tension may be accompanied by physical symptoms, such as restlessness, feeling on edge or easily fatigued, difficulty concentrating, muscle tension or problems sleeping. Often the worries focus on everyday things such as job responsibilities, family health or minor matters such as chores, car repairs, or appointments.	F41. 1

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Separation Anxiety	A person with separation anxiety disorder is excessively fearful or anxious about separation from those with whom he or she is attached. The feeling is beyond what is appropriate for the person's age, persists (at least four weeks in children and six months in adults) and causes problems functioning. A person with separation anxiety disorder may be persistently worried about losing the person closest to him or her, may be reluctant or refuse to go out or sleep away from home or without that person, or may experience nightmares about separation.	F93.0
Panic Disorder	The core symptom of panic disorder is recurrent panic attacks, an overwhelming combination of physical and psychological distress. During an attack several of these symptoms occur in combination: Palpitations, pounding heart or rapid heart rate Sweating Trembling or shaking Feeling of shortness of breath or smothering sensations Chest pain Feeling dizzy, light-headed, or faint Feeling of choking Numbness or tingling Chills or hot flashes Nausea or abdominal pains Feeling detached Fear of losing control Fear of dying Sense of impending doom Because the symptoms are so severe, many people who experience a panic attack may believe they are having a heart attack or other life-threatening illness. They may go to a hospital emergency department. There may be identifiable triggers for panic attacks, including fear of subsequent panic attacks. The mean age for onset of panic disorder is 20-24. Panic attacks may occur with other mental disorders such as depression or PTSD.	F41.0
Agoraphobia	Agoraphobia is the fear of being in situations where escape may be difficult or embarrassing, or help might not be available in the event of panic symptoms. The fear is out of proportion to the actual situation and lasts generally six months or more and causes problems in functioning. A person with agoraphobia experiences this fear in two or more of the following situations: Using public transportation Being in open spaces Being in enclosed places Standing in line or being in a crowd Being outside the home alone The individual actively avoids the situation, requires a companion, or endures with intense fear or anxiety. Untreated agoraphobia can become so serious that a person may be unable to leave the house. A person can only be diagnosed with agoraphobia if the fear is intensely upsetting, or if it significantly interferes with normal daily activities.	F40.00

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Specific Phobia	A specific phobia is excessive and persistent fear of a specific object, situation or activity that is generally not harmful. Patients know their fear is excessive, but they can't overcome it. These fears cause such distress that some people go to extreme lengths to avoid what they fear. Examples are public speaking, fear of flying, or fear of spiders.	F40.2
Social Anxiety Disorder	A person with social anxiety disorder has significant anxiety and discomfort about being embarrassed, humiliated, rejected or looked down on in social interactions. People with this disorder will try to avoid the situation or endure it with great anxiety. Common examples are extreme fear of public speaking, meeting new people or eating/drinking in public. The fear or anxiety causes problems with daily functioning and lasts at least six months.	F40.11
Selective Mutism	Consistent failure to speak in social situations in which there is an expectation to speak even though the individual speaks in other situations.	F94.0

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Colorado Pediatric Psychiatry Consultation & Access Program

Anxiety Algorithm

CoPPCAP | Colorado Care Guide

Use DSM-5 criteria for diagnosis

Pediatric Anxiety Disorders:

- Generalized Anxiety Disorder
- Separation Anxiety
- Panic Disorder
- Agoraphobia
- Specific Phobia
- Social Anxiety Disorder
- Selective Mutism

Broadband Social Emotional Screening

Concern for Anxiety?

YES → Anxiety Narrowband Screen

NO → Continue with routine visit

CoPPCAP's Anxiety Management Plan provides action items to benefit all patients

Anxiety Management Plan

Anxiety Dx

No → Consider Differential Dx → Continue with routine visit

Mood disorder
ADHD
OCD
Trauma
Oppositional Defiant Disorder
Disruptive Mood Dysregulation Disorder
Adjustment Disorder
Substance Abuse
Language or Learning Disability
Vitamin D Deficiency
Autoimmune Disease
Medical Conditions

Mild

Recommend Psychotherapy
CBT
•Cognitive Behavioral Therapy (CBT) is recommended as a first-line treatment of children with an anxiety disorder of mild to moderate severity rather than an SSRI or other treatment.
•Exposure treatment is central to all efficacious CBT for pediatric anxiety disorders.

Moderate – Severe

Psychotherapy w/ medication is most effective treatment

Recommend Psychotherapy
CBT
• Combined CBT-SSRI treatment performed better than either modality individually in clinical trials of children with anxiety

First-line medication used in children and adolescents
SSRIs
•Titrate up every week until maximum benefit

Check in every 1-2 weeks for first month to assess for side effects and stop if worsening anxiety, agitation, or suicidal thoughts

If no improvement in 4-6 weeks at therapeutic dose, increase dose, and if no change in 12 weeks (with dose increases), switch medication and consider consulting CoPPCAP

click the algorithm above to enlarge

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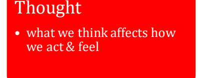
Options for Treatment: Psychotherapy

- Psychotherapy alone can be effective for mild to moderate anxiety. More severe anxiety is likely to require treatment with medication.
  - Consider importance of regulatory functioning with sleep, diet, and exercise when treating Anxiety

- If anxiety is not improving after six to twelve weeks of therapy, adding an adjunctive medication may be considered.

- **Cognitive Behavioral Therapy (CBT) is indicated for all the childhood anxiety disorders in children aged seven and older.[3,4,5]**

  - Exposure Therapy or Exposure Response Prevention (ERP) should be utilized as a CBT approach to effectively treat pediatric anxiety.
  - Children younger than seven may not possess the developmental abilities needed to understand and apply cognitive-behavioral strategies to their symptoms, but CBT has been adapted for delivery to parents of children with anxiety disorders, and for parents and children working together.[6]



- CBT conceptualizes anxiety as a tripartite construct that involves interaction between physiological, cognitive, and behavioral components. Change in one of these three components sets up a process of change in one or more of the other two. CBT includes several key treatment components. Each component targets mechanisms that are believed to maintain maladaptive anxiety:
  - Psychoeducation
  - somatic management skills
  - cognitive restructuring
  - exposure
    - exposure treatment is central to all efficacious CBT for pediatric anxiety disorders; this involves the child gradually but repeatedly experiencing the feared situation with the intent of reducing the associated anxiety, or learning to tolerate and manage normal, expected levels of anxiety.
  - relapse prevention
  - parental accommodation and family dynamics

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Options for Treatment: Pharmacotherapy

- **CBT is always indicated as a first line treatment of pediatric anxiety**
- Medications are indicated for more moderate – severe forms of anxiety or in anxiety that has not responded to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial
- SSRIs are typically the first-line pharmacologic treatment in children and adolescent's serotonin-norepinephrine reuptake inhibitors (SNRIs) and tricyclic antidepressants have also shown efficacy in the treatment of pediatric anxiety disorders. Because they are associated with less easily tolerated side effects compared with SSRIs, these drugs are generally used second- or third- line.
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases. Side effects experienced may be different based on individual medication.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
  - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
  - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in anxiety symptoms
  - If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.

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- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

Anxiety Medications

Medications that may be used to treat anxiety disorders in children and adolescents						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5 – 40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100 – 300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25 – 200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10 – 60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10 – 50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5 – 225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30 – 120	20, 30, 40, 60			
	Atomoxetine (Strattera™)	10 – 100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75 – 250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	• Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5 – 1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	• Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
Atypical anxiolytic	Buspirone (Buspar™)	15 – 60	5, 10, 15, 30	• Dizziness • Lightheadedness		

				• Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5 – 50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• symptoms. • Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5 – 50	25, 50			
	Hydroxyzine (Atarax™)	25 – 50	10, 25, 50			

Anxiety Management Plan

CoPPCAP offers an Anxiety Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.

Anxiety Action Plan For Primary Care Providers

For: ____________________Date: ______________ Provider: __________________ Provider's Phone Number________________

No Anxiety Concerns (SCARED Total score: less than 10)

- **Behavioral**: No avoidance of anxiety triggering situations; no fear or distress in these situations.
- **Physical**: No unexplained physical complaints (e.g., headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: No unrealistic thoughts of danger or threat; minimal worrying.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):
□ Learn the signs of anxiety: ____________________
□ Face your fears: ____________________
□ Change your thoughts: ____________________
□ Calm your body: ____________________

Moderate Anxiety Concerns (SCARED Total score: 10-15)

- **Behavioral**: Occasional (e.g., weekly or monthly) avoidance of anxiety triggering situations, some signs of fear and/or distress.
- **Physical**: Occasional unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Occasional unrealistic thoughts of danger or threat; some worry.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities); cannot do *all* usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):
□ Learn the signs of anxiety: ____________________
□ Face your fears: ____________________
□ Change your thoughts: ____________________
□ Calm your body: ____________________

Significant Anxiety Concerns (SCARED Total score: 15 or higher)

- **Behavioral**: Daily/weekly avoidance of anxiety-provoking situations, overt signs of fear, worry and/or distress.
- **Physical**: Daily/weekly unexplained somatic complaints (headaches, stomachaches, vomiting, fatigue).
- **Cognitive**: Daily/weekly unrealistic thoughts of danger or threat, significant worrying.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities); child cannot do many usual activities.

My Anxiety Action Plan (Provider: Check one or more strategies discussed and follow up plan):
□ Learn the signs of anxiety: ____________________
□ Face your fears: ____________________
□ Change your thoughts: ____________________
□ Calm your body: ____________________

click the image above to access the full Anxiety Management Plan
(used with permission from Gina Ginsburg, PhD)

AUTHORS:
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Safety Assessment and Planning in Anxious Adolescents

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of anxious adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
  - Expressing hopelessness
  - Expressing suicidal or self-harm thoughts
  - Behaving in an unusually impulsive or risky manner
  - Researching means of harming oneself
  - For young children, using death as a theme in play
  - Giving away possessions
  - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

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Resources:

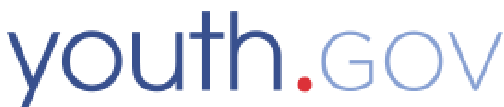
Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents

Mental Health App reviews

One Mind PsyberGuide is a non-profit project run by a team of experts in mental health, technology, and technology delivered care based out of the University of California, Irvine and Northwestern University. One Mind PsyberGuide is not an industry website; its goal is to provide accurate and reliable information free of preference, bias, or endorsement.



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CoPPCAP

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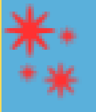


How to Help Your Child with Anxiety

When our children feel anxious, our natural instinct is to jump in and make them feel better

This can take many different forms:

- Talking for them in social situations
- Avoiding places or situations that your child finds anxiety provoking (e.g., crowds, restaurants)
- Providing a lot of reassurance to your child
- Sleeping in the same bed

These parenting behaviors are called *accommodations*.

Accommodations

Accommodations come from our love and care for our children. Unfortunately, research shows that they actually tend to promote and worsen anxiety in our children over time.

So...what can you do instead?

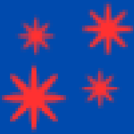
1. Let your child know that you understand that they feel anxious or fearful
2. Express confidence that your child can manage the situation on their own
3. Praise them for trying things that are hard and scary

Why do accommodations make anxiety worse?

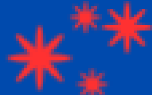
When we jump in and accommodate, our actions tell our child that we agree that a situation is unsafe, and that we think they couldn't have handled it without us.

Accommodations also prevent our child from being able to learn that the feared situation is *safe* and that they *can* manage their anxiety on their own.

"I know that sleeping in your room alone feels really tough. And I know you can do it! Let me walk you back to your room. I'm proud of you for giving this a try"



Families who want more information are encouraged to obtain the book "**Breaking Free from Childhood Anxiety and OCD**" by Eli Lebowitz.



Please also feel free to reach out to COAP at Children's Hospital of Colorado for therapy services. 720-777-6200

Colorado OCD and Anxiety Program (COAP) at ChIldren's Hospital colorado

Anxiety Disorders:

Parents' Medication Guide

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

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Table of Contents

Introduction....4

The Anxiety Disorders....6

Assessment and Treatment....8

Medication as a Tool for Treating Anxiety....9

Psychosocial Treatments for Anxiety....16

Resources....17

Introduction

The purpose of the *Anxiety Disorders: Parents' Medication Guide* is to provide parents with an easy-to-read and easy-to-understand resource on treating anxiety disorders in children. In this Guide, we discuss the most common forms of anxiety and related disorders, including the following:

- Specific phobia
- Separation anxiety disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Panic disorder
- Obsessive-compulsive disorder

What is anxiety?

Anxiety is a normal emotion that is critical for our survival and functioning. It can help us avoid potentially dangerous situations and prepare for challenges. Stressful life events, such as taking a test, starting a new school, or speaking in front of a group can trigger normal forms of childhood anxiety that are helpful in preparing a child for the challenge ahead. That said, sometimes there can be problems in expressing emotions that can negatively affect day-to-day living. Fear, anxiety, sadness, and even our capacity to enjoy ourselves can be a problem if these emotions become extreme and impair one's capacity to function.

How common are the anxiety disorders, and who is affected?

Anxiety disorders are common in children and adolescents, and typically begin during childhood and adolescence. In fact, some suggest that anxiety disorders may affect 1 in 8 children. The National Institute of Mental Health (NIMH) estimates that 25.1% of adolescents between the ages of 13 and 18 years will experience an anxiety disorder, and 5.9% will experience a severe anxiety disorder. Boys and girls are equally affected in childhood, and after puberty, girls appear to be more commonly affected than boys.

Both genetics and the environment play a role in the anxiety disorders. A genetic family history of anxiety disorder puts a young person at risk for developing an anxiety disorder. In addition, caregivers or relatives can respond to an anxious child in such a way as to make the child's anxiety even worse by unknowingly supporting avoidance instead of engagement and unintentionally reinforce fear and worry instead of good coping.

What is the difference between "normal" anxiety and an anxiety disorder?

Anxiety disorders are different from regular or typical anxiety, just like depression is different from everyday sadness or the way mania (elevated and expansive mood) is different from regular happiness and excitement.

Despite the different ways anxiety is expressed among children from different backgrounds and ethnicities, symptoms of anxiety disorders differ from those of normal anxiety in a number of important ways.

1. Normal anxiety occurs at all time points in life. Yet, the anxiety disorders **first affect children before puberty** and can begin or get worse unexpectedly "out of the blue."
2. Typical and developmentally appropriate activities that most children enjoy are **not manageable** for children with anxiety disorders. For a child with an anxiety disorder, going to school, participating in sleepovers or going to camp, making new friends at a party,

"showing off," and participating in new and potentially rewarding experiences (amusement parks) can be very anxiety provoking. As a matter of fact, the child's intense reaction is often surprising to their caregivers, as the triggering cause is often a routine and normal life event a child of a certain age is expected to be able to do.

3. Children with anxiety disorders often experience a number of **unexplained physical symptoms**, such as stomachaches, headaches, shortness of breath, chest pain, worrying about choking, and gagging or vomiting. They often worry about their overall health. Anxious children may pay too much attention to their body's sensations and mistakenly believe that these sensations are symptoms of an illness. As a result, these children are likely to appear as physically ill to their parents, and to visit the school nurse and/or pediatrician more often, potentially leading to missed school days and even unnecessary medical procedures.

4. The **persistence and consistency** of the anxiety symptom picture over time is key to diagnosing an anxiety disorder. That said, some anxious children can experience a sudden worsening of anxiety symptoms. For example, an 8-year-old child who has been mildly anxious as a younger child but enjoyed school may now suffer from separation anxiety and refuse to go to school.

5. Children with anxiety tend to cope by **avoiding situations** that make them anxious. If the triggering experiences are routine and necessary tasks of growing up, the child's everyday functioning and home or school life can be disrupted.

6. Children with anxiety disorders can **also have normal anxiety**. Trained professionals, such as child and adolescent psychiatrists, can recognize the symptom patterns of an anxiety disorder, in part because the types of symptoms are very similar among children with anxiety disorders.

Parents and caregivers often get into a pattern of anticipating a child's anxious behaviors and, in an effort to relieve their child's distress, will help their child avoid a potential anxiety trigger. Unfortunately, although the parents and caregivers have the best intentions, their actions may actually make the anxiety worse and prevent the child from coping with and adapting to typical and important developmental tasks. Avoidance, meltdowns, or other behaviors that continually keep a child from doing age-appropriate activities result in "functional" impairment. In addition, the physical and emotional distress of anxiety is "psychological" impairment. When a child with anxiety is experiencing *functional* and *psychological* impairment, they are suffering from an anxiety disorder.

The Anxiety Disorders

Anxiety disorders are categorized into different forms depending on the symptoms children display. **(Table 1)**

Common Symptoms Across All the Anxiety Disorders

Although there are specific symptoms associated with each of the anxiety disorders listed in Table 1, there are common symptoms among these disorders.

- Hypervigilance—continuous scanning of the environment for anything new and different.
- Reactivity—whereas most children are curious and interested in new things, children with anxiety often feel threatened by new or changing events or expectations and react accordingly.

- Physical complaints—headaches, fear of gagging, choking or vomiting, chest pain, shortness of breathing, poor appetite, stomachache, urgent bathroom trips, increased sweating, muscle tension, jitteriness, and difficulty falling asleep.
- Avoidance—the most common and easiest way for a child to cope with anxiety is to avoid. Instead of approaching a new situation with curiosity as most children do, children with anxiety disorders avoid their anxiety-triggering situations. Avoidance of important developmental tasks is a signal that the child's anxiety needs to be addressed.
- Behavioral issues—if the child cannot avoid an anxiety-triggering situation, he/she may demonstrate significant behavioral issues, often described as "meltdowns," such as refusing to participate, becoming oppositional, and having temper tantrums. Intense anxiety or meltdowns are very challenging for most caregivers and often leave them feeling powerless to help their child.

Table 1.

Anxiety and Related Disorders	
Specific Phobia	• Irrational or extreme fearful reactions to an object or situation (e.g., animals, heights, costume characters, and type of transportation) • Results in avoiding the objects or situations or in demonstrating distress when exposed to them in normal everyday life • Often the first sign of an anxiety disorder and can be associated with other anxiety disorders
Separation Anxiety	• Specific worry that something bad will happen to them or to their caregivers if they are apart (e.g., being in a different room in the house from their caregivers, falling asleep alone in their bed, going to school in the morning, attending a sleepover at a close friend's house, or worry when their caregivers are not home or late coming home) • They may be described as being clingy or easily homesick
Generalized Anxiety Disorder	• A variety of fears and worries about everyday life experiences (i.e., they often anticipate disaster [e.g., catastrophic thinking], worry about their health issues and financial status, as well as their families' health and finances, think about life and death, as well as family and interpersonal relationship problems, and feel intense academic pressures) • They may be described as being worriers, tense, uptight, inflexible, and perfectionistic • May feel as if "something bad will always happen," (if feelings of dread are extremely intense, may be misdiagnosed with depression) • May have problems falling asleep at night because of worry • Sometimes have problems focusing and concentrating in school because they are preoccupied with worry (if significant, may be misdiagnosed with attention-deficit/hyperactivity disorder)
Social Anxiety Disorder	• Fear or worry about their functioning in social interactions (i.e., they are extremely self-conscious and are afraid of being judged or humiliated in a social situation or doing something silly or embarrassing, frightened at the thought of becoming the focus of others' attention) • May be limited to specific settings (i.e., speaking in front of a group) or can be a global problem and affect them in 1:1 situations (i.e., ordering food in a restaurant and/or asking a safe stranger like a teacher a question or policeman for directions) • They are often considered to be shy, highly self-conscious, "slow to warm up," hesitant to talk in social settings, "soft spoken," and reluctant to ask others' questions, or may answer questions with short phrases and avoid making socially appropriate eye contact • Often have physical symptoms (i.e., blushing, sweating, trembling or shaking, or feeling nauseated or sick to their stomach) when they are confronting a social situation
Panic Disorder	• Experience panic attacks that are characterized by the sudden onset (within minutes) of intense fear that something bad is happening or going to happen or fear of losing control • The panic attack usually peaks in 10 minutes and lasts for approximately 15 to 30 minutes, but the effects of having had a panic attack can continue as the person worries about having another attack and what the attack could mean about their health, causing them to avoid situations associated with the feeling of panic • Physical symptoms of a panic attack may include shortness of breath, chest pain, sense of irregular heartbeat, heart beating too hard or too fast, increased breathing (hyperventilation) with tingling or numbness around the mouth and in the fingers, sweating, and shaking; although they feel life threatening, they are not dangerous
Obsessive Compulsive Disorder	• Characterized by obsessions, which are repeated and unwanted thoughts, urges, or mental images that cause anxiety, distress, and are linked to compulsive behaviors • Compulsive rituals seem to relieve the anxiety from these thoughts in the short run, but the child often spends a substantial amount of time obsessing or engaging in compulsions (more than 1 hour a day), which causes distress and daily dysfunction • Common obsessions include the following: fear of germs or contamination; unwanted, taboo thoughts about sex, religion, and harm to self or others; unwanted aggressive thoughts; and the need for things to be balanced, symmetrical, or in perfect order • Common compulsions include the following: excessive grooming and hand washing; ordering and arranging things in a particular and precise way; repeatedly checking on things such as whether the door is locked or whether the stove is off; and conducting mental rituals such as replacing a "bad thought" with a "good thought"

Assessment and Treatment

Regardless of the situation, when a child is having trouble handling their day-to-day life activities because of anxiety, they should be seen by a clinician for a complete assessment to see if treatment is recommended.

It is important that the clinician evaluating a child for an anxiety disorder is familiar with the diagnosis, life course, and treatment of anxiety disorders. Given the potential for the overlap of normal anxiety and anxiety disorders, some pediatricians, primary care doctors, school personnel, and mental health professionals may not understand what the anxiety disorders look like in children and may not fully recognize anxiety disorders as an important mental health problem.

Child and adolescent psychiatrists, physicians who specialize in the diagnosis and the treatment of mental health conditions in children and adolescents, are important members of your child's mental health care team, as they offer families the advantages of a medical education, the medical traditions of professional ethics, and medical responsibility for providing comprehensive care.

It is important to differentiate severe and ongoing anxious reactions to significant life events (i.e., "normal" anxious reactions to extreme life circumstance) from an anxiety disorder. Anxiety disorders require specific treatments and anxious reactions to extreme life circumstances are managed by providing children with safe, secure, and predictable environments and even treatment including psychological support. In both circumstances children having trouble handling their day-to-day life activities should be seen by a clinician for a complete assessment to see what kind of treatment is needed.

Because many of the symptoms of anxiety are experienced internally by a child (e.g., fear or worry), a caregiver may only recognize the functional impairment that the child is demonstrating; for example, difficulty falling asleep, not going to school, anxiety around performance situations, reluctance to engage in social activities and make friends, strong emotional reactions, and other avoidance behavior. A comprehensive evaluation by a clinician will likely include completing rating scales and interviewing the parent and child about the child's internal symptoms and functional impairment. The clinician will work to understand the child's pattern of anxiety symptoms, level of avoidance, and family readiness to engage in treatment. They will also determine whether the child has other problems that might make the treatment plan more challenging.

The clinician will consider many factors in deciding what treatment is needed for a child with an anxiety disorder. After the clinician has evaluated a child, he/she should communicate the results of the evaluation, specific treatment recommendations and the reason behind treatment recommendations. Treatment recommendations often include specific recommendations about how the family can best engage and support the child, essentially becoming "coaches" who work with the child to "take on" their fears and worries.

While it is a big decision to enter a child into treatment for an anxiety disorder, it is important to understand that it is also a big decision to not engage in treatment. Clinical studies suggest children with an anxiety disorder do not get better with just support and longer-term studies suggest anxiety, if not treated, is associated with a number of poor life outcomes including the risk for depression, substance misuse, suicidal thoughts and behaviors, and difficulties with adapting and coping.

Role of the Family in Assessment and Treatment

It is very important to have family involvement in the assessment and treatment of anxiety. Clinicians know about anxiety disorders in children, but they highly rely on the caregivers' active engagement in assessment and treatment to be able to do best by the child. The child's caregivers are the clinician's "eyes and ears." Treatment is much more effective when parents and clinicians work together to reduce the child's anxiety.

Medication as a Tool for Treating Anxiety

The United States Food and Drug Administration (FDA) oversees the approval process to show that a medication is safe and effective for a specific condition (e.g., generalized anxiety disorder). After a medication has been approved by the FDA, clinicians can use the medication for the specific condition (i.e., on-label prescribing) or for any other condition where studies have proven them effective or the physician believes the medication can be effective and safe (i.e., off-label prescribing).

It is important to recognize that clinicians who practice high quality "evidence-based" medication treatment for children and adolescents with anxiety disorders will often recommend and prescribe safe and effective medications "off label." This is not a bad thing, as the medications have been proven to be effective and safe, even though they have not gone through the FDA approval process.

For childhood anxiety disorders, only one medication, duloxetine, has received FDA approval and can be prescribed "on label" for children 7 years of age and older with generalized anxiety disorder. However, a number of other medications have been proven to be safe and effective for treating the childhood anxiety disorders but have not gone through the FDA approval process.

It is important to recognize that clinicians who practice high quality "evidence-based" medication treatment for children and adolescents with anxiety disorders often will recommend and prescribe safe and effective medications "off label."

The goal of treatment for a child is always remission (having few, if any symptoms) of the anxiety disorder.

What medications reduce anxiety and its symptoms consistently over time?

Antidepressant medications represent the foundation of medication treatment for youth with anxiety disorders and OCD. Many of the medications that benefit anxiety disorders and OCD were initially recognized as medications for depression and thus, called antidepressants. The most effective antidepressant medications, selective serotonin reuptake inhibitors (SSRIs), and selective norepinephrine reuptake inhibitors (SNRIs), increase the effects of serotonin and norepinephrine, chemical neurotransmitters in the human body that help regulate anxiety, mood, and social behavior.

Antidepressant medications that have proven to be effective for childhood anxiety disorders that can be prescribed "on label" include duloxetine (Cymbalta™) and "off label" include sertraline (Zoloft™), fluoxetine (Prozac™), fluvoxamine (Luvox™), paroxetine (Paxil™), and venlafaxine ER (Effexor XR™).

What is the goal of treatment in a child or teenager with anxiety?

The goal of treatment for a child is always remission (having few, if any symptoms) of the anxiety disorder. If remission is not achieved with either antidepressant treatment or antidepressant treatment combined with psychological treatment, the clinician may consider a variety of approaches, including medication changes or adding other psychological interventions. It is important to keep in mind that it is okay if a medication change is suggested to reach the goal of remission because a child may respond better to the second medication. Changing the treatment in youth who do not respond to initial medication treatment has been shown to be beneficial.

What have studies on antidepressant medication use in children and adolescents with anxiety disorders shown?

Nearly a dozen studies have evaluated antidepressant medications in children and adolescents with generalized, social, and separation anxiety disorders. **(Table 2)** In nearly all studies, youth who received antidepressant medication did better than those who received placebo (sugar pill). And those children who received a combination of medication and psychological treatment of anxiety did best. Likewise, in children with OCD, the SSRIs have been studied and are effective in reducing OCD symptoms. Studies that have compared SSRIs and psychotherapy in youth with OCD have generally shown that the combination of an antidepressant

medication and psychotherapy is far more effective than either psychotherapy or medication alone.

How are medications chosen?
A clinician will consider several factors in choosing whether to prescribe a specific medication for a child.

- Diagnosis
- Age of the child
- Medication effectiveness
- Side effects
- How quickly the medication works
- Interactions with other medications taken by the child
- Way in which the medication is taken (capsules, tablets, liquid)

How long does medication take to work?

Often, improvement from antidepressant medication begins in 2 to 4 weeks with additional improvement over 8 to 12 weeks. Some children show improvement at low doses of antidepressant medication very early in treatment, however, clinicians may increase the dose of the medication to ensure the child has the best chance for remission. In the clinical studies of medication, the best treatment dose is often identified in 8 to 12 weeks of treatment, with symptoms continuously improving even after that. Studies suggest the beneficial effects of SSRI treatment—regardless of whether it is given with cognitive-behavioral therapy (CBT)—reach maximum benefit at 6–9 months of treatment.

What medications are used occasionally for intense episodes of anxiety?

Clinicians often use medications from different classes to address a specific experience of anxiety such as flying on a plane, giving a speech, or other performance activity. Some of these medications come from the class of benzodiazepines, such as lorazepam (Ativan™) and clonazepam (Klonipin™). Benzodiazepines are generally used for short term treatment. When used for long periods of time, some patients have difficulty stopping the medication and experience withdrawal symptoms.

Some clinicians will also use antihistamines such as diphenhydramine (Benadryl™) or hydroxyzine (Atarax™, Vistaril™) to reduce anxiety for short periods of time. Also, medications from the class of beta-blockers such as propranolol (Inderal™) have been used for performance challenges such as public speaking events.

In the clinical studies of medication, the best treatment dose is often identified in 8 to 12 weeks of treatment, with symptoms continuously improving even after that.

Table 2.

Medications that may be used to treat anxiety disorders in children and adolescents.						
Class	**Medication (Brand name)**	**Common dose range (mg/day)**	**Tablet size (mg)**	**Common side effects**	**Serious side effects**	**Uncommon, serious side effects**
SSRI	Citalopram/escitalopram (Celexa/Lexapro™)	10/5–40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea • Decreased appetite • Hyperactivity/restlessness • Vomiting • Increased anger/irritability • Sexual dysfunction • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Potential for abnormal heart rhythm • Mania	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox™, Luvox CR™)	100–300	25, 50, 100, 150			
	Sertraline (Zoloft™)	25–200	25, 50, 100			
	Fluoxetine (Prozac™, Sarafem™)	10–60	10, 20, 40, 60			
	Paroxetine (Paxil™, Pexeva™)	10–50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor™)	37.5–225	37.5, 75, 150, 225	• Sleepiness • Insomnia • Restlessness • Sexual dysfunction • Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults • Mania	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta™)	30–120	20, 30, 40, 60			
Noradrenergic agent	Atomoxetine (Strattera™)	10–100	10, 18, 25, 40, 60, 80, 100			
Tricyclic antidepressant	Clomipramine (Anafranil™)	75–250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning–suicidal thinking and behavior in children, adolescents, and young adults • Heart rhythm problems; electrocardiogram and blood levels • Mania	Serotonin syndrome
	Imipramine (Trofanil™, Trofranil-PM™)		10, 25, 50			
Benzodiazepine	Alprazolam (Xanax™, Alprazolam Intensol™)	0.5–1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms. • Disinhibition • Memory impairment • Worsening depression	Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
	Clonazepam (Klonopin™)	0.5–3	0.5, 1, 2			
	Lorazepam (Ativan™, Lorazepam Intensol™)	1–2	1, 2			
Atypical anxiolytic	Buspirone (Buspar™)	15–60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl™, Banophen™, Diphenhist™)	12.5–50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• Abnormal heart rhythms • Agitation • Difficulty completely emptying the bladder • Harm to certain types of blood cells • Seizures	
	Doxylamine (Unisom™, WalSom™)	12.5–50	25, 50			
	Hydroxyzine (Atarax™)	25–50	10, 25, 50			

Adapted from Wilens, Hammerness. Straight Talk about Psychiatric Medications in Kids (Guilford Press, 2016).

What is the FDA warning?
The FDA added a "boxed warning" to all antidepressant medications to alert prescribing physicians and patients that special care should be taken when using antidepressant medications in children, adolescents, and young adults. The warning states that antidepressant medications are "associated with an increased risk of suicidal thinking and/or behavior in a small proportion of children and adolescents, especially during the early phases of treatment." Such "adverse events" (mostly suicidal thoughts) were reported by approximately 4% of all children and adolescents taking medication compared with 2% of those taking a placebo. More recent and larger studies suggest that the associated risk is even less. It is important to understand that it is not known why there is a small but somewhat greater risk for suicidal thoughts or behavior on medication than on placebo.

What medications are used for occasional sleep problems in youth with anxiety?

Sleep is often a significant problem in youth with anxiety. Treatment of the anxiety disorder with antidepressants and/or CBT is often beneficial in reducing anxiety and restoring normal sleep patterns. If the child's anxiety is under very good control and falling asleep is still a problem, behavioral approaches should be tried next. If behavioral approaches are not successful there are different medications that help children with anxiety sleep better. Clinicians often pick among medications such as melatonin, antihistamines, antidepressants that sedate like mirtazapine, and even some medications specifically marketed for insomnia in adults such as zolpidem (Ambien™) and zaleplon (Sonata™). While medicines used in adults for insomnia may be useful in children, they have not been studied extensively in children.

How is the medication dose selected and changed?

For the antidepressant medications, physicians select an initial dose based on studies that have evaluated the medication in children and adolescents. In general, children with anxiety are started on a low dose of medication, with incremental increases to reach the appropriate dose that offers the best chance for remission with minimal, if any side effects. Over the course of treatment, the caregiver and child will meet with the clinician regarding how the anxiety symptoms have changed and whether there are side effects. Some clinicians adjust doses more quickly (with more frequent check-in visits), and others may prefer a more gradual approach. "Going low and slow" is okay; however, it is important to understand that starting too low and going too slow may unnecessarily prolong a child's suffering. The common dose ranges for medications that are used to treat children with anxiety are shown in **Table 2**.

How are side effects managed?

Antidepressants such as SSRIs and SNRIs can have various side effects, as shown in **Table 2**. It is important to discuss medication side effects with your child's physician. Everyone worries about side effects but people and children with anxiety disorders are likely to worry more than others do. The presence of side effects is an important part of decision making for dose adjustments. Sometimes it is difficult to tell if the child is having a side effect or if it is the anxiety that is still impacting the child (e.g. stomachache).

Common side effects, which occur in approximately 10–20% of patients, include headaches, difficulty sleeping, appetite changes, abdominal pain, and diarrhea. Possible side effects, which may occur in 5% of patients, include weight gain, muscle pain, and common cold symptoms. Rare side effects, which occur much less frequently, include seizures, deliberate self-harm, abnormal heart rhythms, and mania. Suicidal thinking and behavior is discussed in the box to the left. It is important to know that this risk has not been shown in most studies of SSRIs in youth with anxiety disorders.

Perhaps of most concern to parents is whether the medication will change a child's behavior or personality in an unwanted way. In general, when SSRIs and SNRIs work well they reduce the child's anxiety greatly, and allow the child to function as they would if they were not anxious. It is important to know that the medications reduce anxiety, but don't solve all the problems a child might have.

Lastly, across all the SSRI and SNRI studies there is a common pattern of side effects that we call "activation syndrome"—an excessive and uncomfortable restlessness that occurs early in treatment or soon after a dose change. The activation may cause the child to be more irritable, impulsive, and overall more difficult to manage. Reducing the dose of medication or discontinuing it is the best management strategy until the activation symptoms go away. Since the activation symptoms most often occur early in treatment and at lower doses, it may be difficult to get a child to a full treatment dose if the medication seems to cause activation.

The usual strategy for managing side effects is to reduce the dose or discontinue the medication. However, adjusting the dose to minimize the side

effects may result in losing some of the benefit of the medication. It can be a delicate balance that a caregiver and the clinician have to manage together. If the clinician has to reduce the dose of the medication to reduce side effects and symptoms return, the clinician will review the treatment options with the caregiver so the child can have his/her best outcome. Switching medication is something that is commonly done when the first medication does not work or there are side effects.

How do I know the medication is working?

The question of whether treatment—medication, psychological treatment, or the combination of the two—is working is best answered by observing whether a child's anxiety decreases in frequency and severity and the child appears overall more comfortable and able to do things. Parents, caregivers, and clinicians may also answer this question by examining improvements in specific target symptoms, such as worrying excessively. In general, for kids with anxiety disorders, parents and caregivers will be able to observe that the child is able to do things now that they could not do before such as falling asleep quickly, spending the night at a friend's house, going to a party, attending school and camp, being around groups of people, going to malls or restaurants, etc. Anxiety-related physical symptoms (e.g., headaches, stomachaches, difficulty swallowing, etc.) will decrease or stop altogether.

How long should medication be continued?

As caregivers and the child consider when to stop antidepressant treatment, it is important to recall that the end goal of treatment is having few if any symptoms. The child has the best chance of discontinuing treatment if they have experienced remission and functional recovery. Any discussion regarding if

and when to discontinue treatment should only happen then. Children with ongoing symptoms of anxiety and associated impairment may not be the best candidates for stopping their medication. Increasing their medication or psychological treatment to achieve remission before considering stopping treatment may be best.

While a specific timeframe is not known, some experts recommend discontinuing medication 6–12 months after remission has been achieved. A child who has successfully worked with his/her family in psychotherapy along with medication treatment or a child with a faster response to treatment (more likely with antidepressant plus psychotherapy) might be ready to discontinue medication treatment more quickly. It is important to keep in mind that there is no evidence suggesting that long-term antidepressant treatment is unsafe when medication is overall well-tolerated.

A risk of discontinuing medication is the chance that anxiety symptoms will return even in children who have recovered. Families should only consider stopping antidepressant treatment during periods of low stress and specifically not when the child might be expected to be most anxious. For example, stopping medication before school starts in the fall in a child with separation anxiety who struggled to go to school is probably not a good idea. Also, for some children with anxiety, seemingly low stress periods like family vacations or holidays may seem like a good time to stop medication but may actually be stressful and the resulting anxiety be mistakenly blamed on the medication discontinuation.

If a child has successfully come off medication, it can be useful to monitor the child off medication to ensure that subtle anxiety symptoms do not return, and the child maintains their functional recovery.

Psychosocial Treatments for Anxiety

The clinician who assesses the child may recommend a specific psychological treatment such as cognitive-behavioral therapy (CBT), or a combination of CBT and medication, which are the evidence-based treatments for the childhood-onset anxiety disorders—specifically, separation, generalized and social anxiety disorders, and OCD.

The evidence-based psychological treatment (CBT) for the anxiety disorders and OCD begins with educating the child and family about the nature of the anxiety symptoms and how the symptoms may worsen over time, if not addressed effectively. For example, a child who is anxious, and copes by avoiding, may feel better in the short term but avoiding actually reinforces anxiety in the long term. After the child and family understand this important dynamic, the clinician should engage the child in a process called "exposure and response prevention." Exposure and response prevention treatment teaches the child two important things: 1) the fear or worry is not necessary for normal developmental tasks; and 2) with time, the fear or worry will go away or be better tolerated, and the child will learn how to cope without avoiding.

Although psychotherapy can be a very effective form of treatment for some children with anxiety disorders, this guide focuses on medication treatments. Other resources that discuss CBT in more detail are available. Also, psychotherapy may be used in combination with medication. Children who receive the combination of psychotherapy plus medication have fewer anxiety symptoms than children who receive medication only or psychotherapy only.

The evidence-based psychological treatment (CBT) for the anxiety disorders and OCD begins with educating the child and family about the nature of the anxiety symptoms and how the symptoms may worsen over time.

Resources

- American Academy of Child & Adolescent Psychiatry (AACAP)
  https://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx
- Anxiety and Depression Association of America
  https://adaa.org
- Centers for Disease Control and Prevention (CDC)
  https://www.cdc.gov/childrensmentalhealth/depression.html
- National Alliance on Mental Illness (NAMI)
  https://www.nami.org/Find-Support/Family-Members-and-Caregivers
- National Institute of Mental Health (NIMH)
  https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml
- https://www.nimh.nih.gov/health/publications/anxiety-disorders-listing.shtml

Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

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Co-Owner of a Copyrighted Diagnostic Questionnaire: Before School Functioning Questionnaire (BSFQ)

Licensing Agreement: Ironshore Pharmaceuticals Inc.

Research Funding: Lloyd Foundation; National Institute on Drug Abuse

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Supporting a Practice through a Behavioral Healthcare Model Change

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Pediatrics West

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Pediatric Mental Health Institute

1

Objectives

- Review levels of collaboration/integration
- Review benefits of collaborative/integrated care
- Outline steps for implementing a Behavioral Health Model Change

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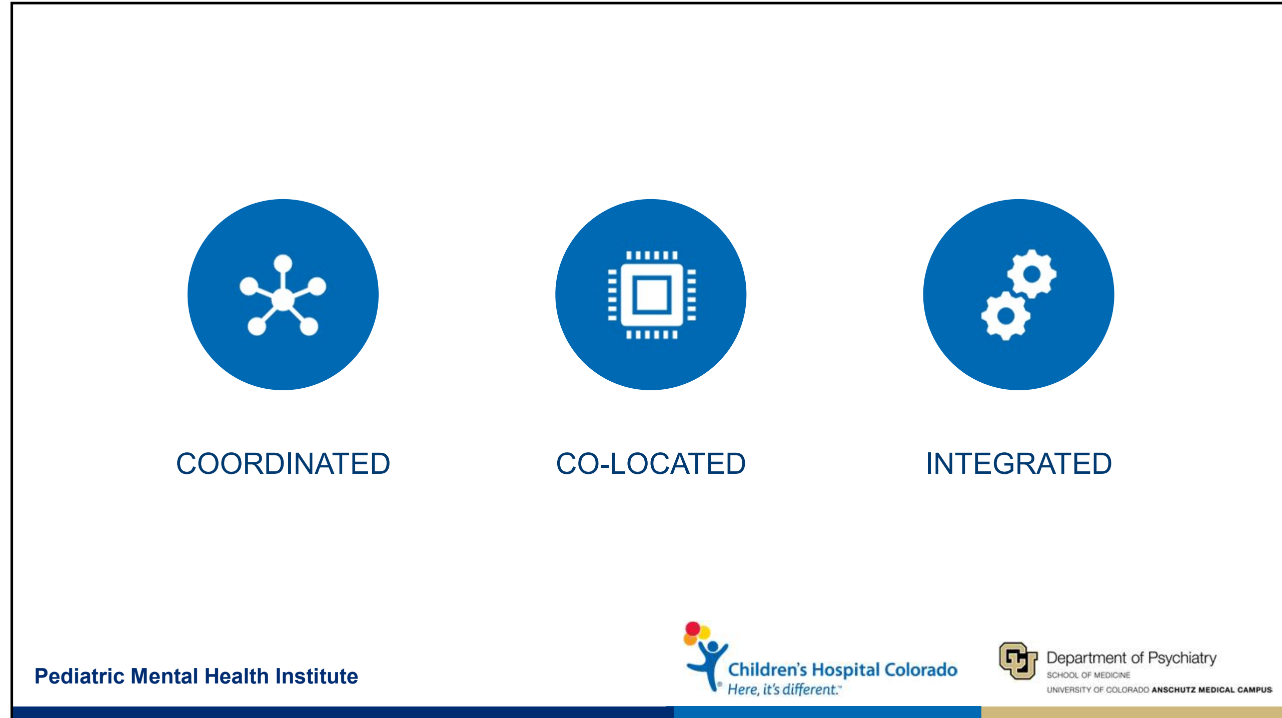
2



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Coordinated

Level 1: Minimal Collaboration

- Medical and BH providers in separate facilities
- Separate systems for scheduling, documenting, and communicating with patients
- Communication rare and driven by provider need or escalating circumstances
- No coordinated referrals process

Level 2: Basic Collaboration (Distance)

- Separate facilities and systems as with Level 1
- Periodic communication about shared patients via phone or secure e-mail
- Appreciation for each other's role as resources
- May have formal partnership for preferred referral process

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4

Co-Located

Level 3: Basic Collaboration (On-site)

- Medical and BH providers in same facility, but not necessarily same offices
- Separate systems for scheduling, documenting, and communicating with patients
- Communicate regularly about shared patients by phone or secure e-mail
- Formalized partnership for referral process

Level 4: Close Collaboration (On-site, some integration)

- In same space within same facility
- Some system sharing for scheduling and chart review
- In-person communication as needed
- Regular interaction about some patients
- Some warm-handoff availability

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Integrated

Level 5: Close Collaboration (Approaching integration)

- Shared space within same facility
- Shared system for scheduling and documentation
- Frequent in-person communication
- Regular team meetings to discuss patient care
- Warm-handoff capability

Level 6: Full Collaboration

- Functioning as one integrated system
- Communicate consistently at system, team and individual level
- Shared decision-making and treatment planning that is patient-centered
- Collaborate across continuum of care not just when a specific patient need identified

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6

Continuum of Care

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7

Benefits of Integration

Increase Access:
- Warm hand-off
- Crisis Management
- Augmenting anticipatory guidance
- Real-time parent training

Improve Coordination:
- Multiple lenses for viewing care
- Easier to identify and address holistic needs

Reduce Stigma:
- Meet patients where they are
- Normalize mental health is health
- "It's okay to talk about that here"

Practice Transformation:
- Changing approach to care
- Being present and available
- Increase capacity, reduce burnout

Enhanced Care:
- Whole-family care easier to provide
- Families feel seen and heard
- Addresses multiple determinants of health

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Behavioral Health Model Change:

1. Planning
2. Patience
3. Persistence

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9

Planning: Needs Assessment

Patients
- Prevalence and complexity
- Patient perceptions
- Age

Providers
- Comfort with screening/treatment
- Openness to collaboration

Support Staff
- Billing capabilities
- Crisis management training

Infrastructure
- Physical Space
- EHR capabilities

Resource Considerations
- Financial implications
- Reimbursement models
- Changes to payer contracts

Organizational Considerations
- Practice culture/adaptability
- Practice champion

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Planning: Identify a Champion

Who will lead the team?
Ideally, this is a *team* – “implementation team”
Team meets regularly
- Makes decisions
- Communicates to the whole clinic
- Makes plans for initial implementation
- Evaluates outcomes
- Engages in Continuous Quality Improvement

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11

Planning: Identify Current Work

Screening
- How do we identify patients in need?

Treatment
- What behavioral health services do we currently provide?

Follow-up
- What are our current follow up processes when a need is identified?

Prevention/Health Promotion
- How do we currently use health promotion or prevention techniques to support behavioral health?

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12

Planning: Set Goals, Strategize

Identify a strategy:
- Population
- Continuum of Care
- Evidence-based models

Goals should be SMART:
- Specific, Measurable, Achievable, Relevant, Time-bound

Long-term goal?
- Example – fully integrated care

Short-term goals?
- Examples – creating a routine screening process; standardizing referral processes; standardizing documentation

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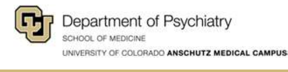

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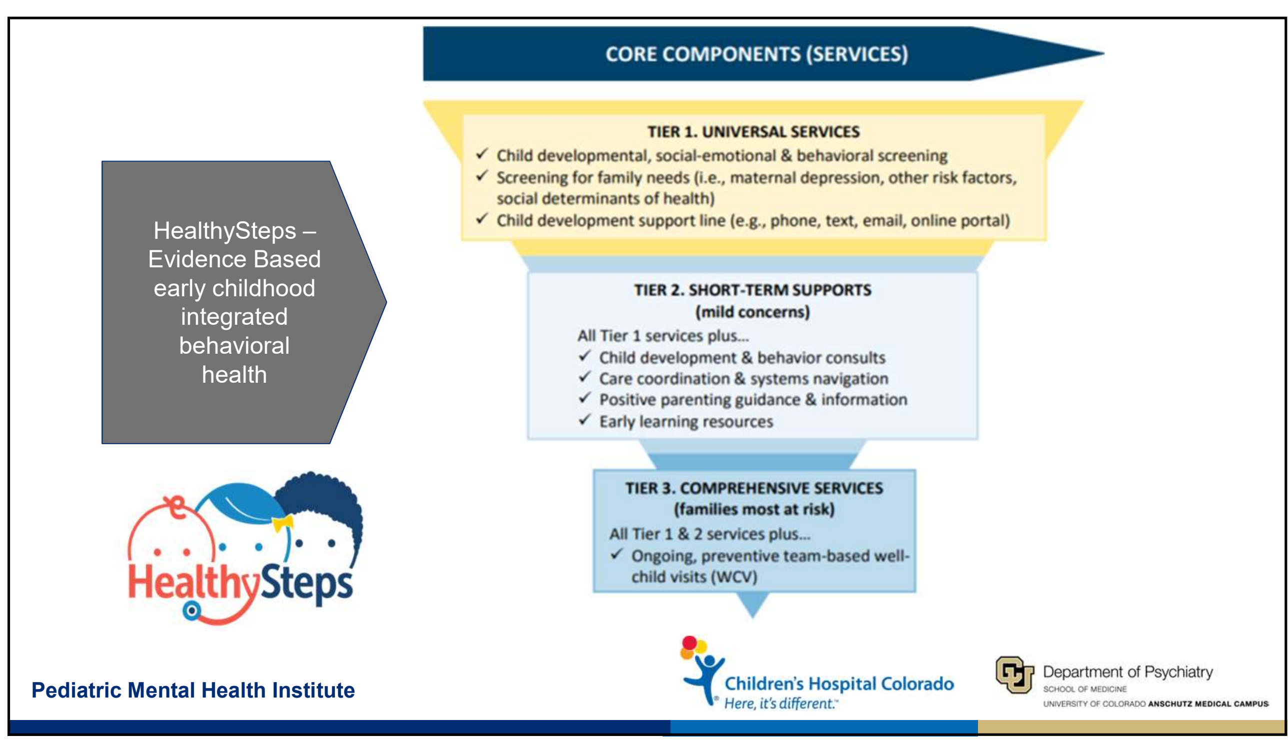

14

Who needs to be on the Team?

- Families and children
  - Families are the experts
  - Shared decision making and shared goals
  - Strengths-based
- Integrated professionals – onsite
  - Child development specialist
  - Behavioral health/social work
  - Lactation/nutrition
- Community Health Worker
  - Care coordinators
- Primary care provider
  - Foundational to the Medical home model
  - Coordination
  - Team leadership
- Other professionals – off site
  - Education/childcare
  - Specialists
  - Early Intervention

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Key ingredients for successful teams

Team Leadership

Family Centered

Team member buy-in

Role Clarity

Flexibility/Adaptability

Performance Monitoring

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16

Benefits of Team-Based Care

- Improves patient outcomes
  - Encourages different perspectives
  - Facilitates navigation of fragmented services
  - Division of labor allows professionals to work to the top of their degree

Increases Equity
- Focuses on promotion and prevention
- Maximizes system navigation

Provider satisfaction
- Reduces:
  - Burnout
  - Turnover
  - Compassion Fatigue and secondary trauma

Patient Satisfaction
- Amplifies family voice
- Empowers caregivers as experts and advocates

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17

Planning: Set Goals, Strategize

1) Maximizing Medicaid billing
2) Reviewing RAE contracts
3) Reviewing contracts with private payers
4) Grant funding
5) System/clinic investment

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18

Patience: Implement with Intention

1) Pilot implementation/start slowly
2) What is going well
3) What's not working
4) Expand as indicated

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19

Patience: Practice Transformation

- Changing the approach to care
- IBH present and available
- Broadening the focus of pediatric primary care
- Everyone in the practice has a role

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Persistence: Quality Improvement

Types of Data
- Clinical
- Process
- Qualitative

Data Collection
- Optimize EHR tools
- Minimize manual entry

Data Analysis
- Maximize reporting capabilities form EHR
- Level of sophistication

Next Steps
- Review data consistently
- Use data to drive additional improvements/changes

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21

Persistence: Quality Improvement

1) Comprehensive care for children and families
2) Increased access to behavioral health
3) Reduced burnout/increased provider satisfaction
4) Long-term health system savings

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22

Questions

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23

Thank You

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24

Table 1. Six Levels of Collaboration/Integration (Core Descriptions)

COORDINATED KEY ELEMENT: COMMUNICATION		CO LOCATED KEY ELEMENT: PHYSICAL PROXIMITY		INTEGRATED KEY ELEMENT: PRACTICE CHANGE	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
▸▸ Have separate systems ▸▸ Communicate about cases only rarely and under compelling circumstances ▸▸ Communicate, driven by provider need ▸▸ May never meet in person ▸▸ Have limited understand-ing of each other's roles	▸▸ Have separate systems ▸▸ Communicate periodically about shared patients ▸▸ Communicate, driven by specific patient issues ▸▸ May meet as part of larger community ▸▸ Appreciate each other's roles as resources	▸▸ Have separate systems ▸▸ Communicate regularly about shared patients, by phone or e-mail ▸▸ Collaborate, driven by need for each other's services and more reliable referral ▸▸ Meet occasionally to discuss cases due to close proximity ▸▸ Feel part of a larger yet non-formal team	▸▸ Share some systems, like scheduling or medical records ▸▸ Communicate in person as needed ▸▸ Collaborate, driven by need for consultation and coordinated plans for difficult patients ▸▸ Have regular face-to-face interactions about some patients ▸▸ Have a basic understanding of roles and culture	▸▸ Actively seek system solutions together or develop work-a-rounds ▸▸ Communicate frequently in person ▸▸ Collaborate, driven by desire to be a member of the care team ▸▸ Have regular team meetings to discuss overall patient care and specific patient issues ▸▸ Have an in-depth un-derstanding of roles and culture	▸▸ Have resolved most or all system issues, functioning as one integrated system ▸▸ Communicate consistently at the system, team and individual levels ▸▸ Collaborate, driven by shared concept of team care ▸▸ Have formal and informal meetings to support integrated model of care ▸▸ Have roles and cultures that blur or blend

Table 2A. Six Levels of Collaboration/Integration (Key Differentiators)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Clinical Delivery					
▸ Screening and assessment done according to separate practice models ▸ Separate treatment plans ▸ Evidenced-based practices (EBP) implemented separately	▸ Screening based on separate practices; information may be shared through formal requests or Health Information Exchanges ▸ Separate treatment plans shared based on established relationships between specific providers ▸ Separate responsibility for care/EBPs	▸ May agree on a specific screening or other criteria for more effective in-house referral ▸ Separate service plans with some shared information that informs them ▸ Some shared knowledge of each other's EBPs, especially for high utilizers	▸ Agree on specific screening, based on ability to respond to results ▸ Collaborative treatment planning for specific patients ▸ Some EBPs and some training shared, focused on interest or specific population needs	▸ Consistent set of agreed upon screenings across disciplines, which guide treatment interventions ▸ Collaborative treatment planning for all shared patients ▸ EBPs shared across system with some joint monitoring of health conditions for some patients	▸ Population-based medical and behavioral health screening is standard practice with results available to all and response protocols in place ▸ One treatment plan for all patients ▸ EBPs are team selected, trained and implemented across disciplines as standard practice
Key Differentiator: Patient Experience					
▸ Patient physical and behavioral health needs are treated as separate issues ▸ Patient must negotiate separate practices and sites on their own with varying degrees of success	▸ Patient health needs are treated separately, but records are shared, promoting better provider knowledge ▸ Patients may be referred, but a variety of barriers prevent many patients from accessing care	▸ Patient health needs are treated separately at the same location ▸ Close proximity allows referrals to be more successful and easier for patients, although who gets referred may vary by provider	▸ Patient needs are treated separately at the same site, collaboration might include warm hand-offs to other treatment providers ▸ Patients are internally referred with better follow-up, but collaboration may still be experienced as separate services	▸ Patient needs are treated as a team for shared patients (for those who screen positive on screening measures) and separately for others ▸ Care is responsive to identified patient needs by of a team of providers as needed, which feels like a one-stop shop	▸ All patient health needs are treated for all patients by a team, who function effectively together ▸ Patients experience a seamless response to all healthcare needs as they present, in a unified practice

Table 2B. Six Levels of Collaboration/Integration (Key Differentiators, continued)

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Key Differentiator: Practice/Organization					
▸▸ No coordination or management of collaborative efforts ▸▸ Little provider buy-in to integration or even collaboration, up to individual providers to initiate as time and practice limits allow	▸▸ Some practice leader-ship in more systematic information sharing ▸▸ Some provider buy-into collaboration and value placed on having needed information	▸▸ Organization leaders supportive but often colo-cation is viewed as a project or program ▸▸ Provider buy-in to making referrals work and appreciation of onsite availability	▸▸ Organization leaders support integration through mutual problem-solving of some system barriers ▸▸ More buy-in to concept of integration but not consistent across providers, not all providers using opportunities for integration or components	▸▸ Organization leaders support integration, if funding allows and efforts placed in solving as many system issues as possible, without chang-ing fundamentally how disciplines are practiced ▸▸ Nearly all providers engaged in integrated model. Buy-in may not include change in practice strategy for individual providers	▸▸ Organization leaders strongly support integration as practice model with expected change in service delivery, and resources provided for development ▸▸ Integrated care and all components embraced by all providers and active involvement in practice change
Key Differentiator: Business Model					
▸▸ Separate funding ▸▸ No sharing of resources ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share resources for single projects ▸▸ Separate billing practices	▸▸ Separate funding ▸▸ May share facility expenses ▸▸ Separate billing practices	▸▸ Separate funding, but may share grants ▸▸ May share office expenses, staffing costs, or infrastructure ▸▸ Separate billing due to system barriers	▸▸ Blended funding based on contracts, grants or agreements ▸▸ Variety of ways to structure the sharing of all expenses ▸▸ Billing function combined or agreed upon process	▸▸ Integrated funding, based on multiple sources of revenue ▸▸ Resources shared and allocated across whole practice ▸▸ Billing maximized for integrated model and single billing structure

Table 3. Advantages and Weaknesses at Each Level of Collaboration/Integration

COORDINATED		CO LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice
Advantages					
▸▸ Each practice can make timely and autonomous decisions about care ▸▸ Readily understood as a practice model by patients and providers	▸▸ Maintains each practice's basic operating structure, so change is not a disruptive factor ▸▸ Provides some coordination and information-sharing that is helpful to both patients and providers	▸▸ Colocation allows for more direct interaction and communication among professionals to impact patient care ▸▸ Referrals more successful due to proximity ▸▸ Opportunity to develop closer professional relationships	▸▸ Removal of some system barriers, like separate records, allows closer collaboration to occur ▸▸ Both behavioral health and medical providers can become more well-informed about what each can provide ▸▸ Patients are viewed as shared which facilitates more complete treatment plans	▸▸ High level of collaboration leads to more responsive patient care, increasing engagement and adherence to treatment plans ▸▸ Provider flexibility increases as system issues and barriers are resolved ▸▸ Both provider and patient satisfaction may increase	▸▸ Opportunity to truly treat whole person ▸▸ All or almost all system barriers resolved, allowing providers to practice as high functioning team ▸▸ All patient needs addressed as they occur ▸▸ Shared knowledge base of providers increases and allows each professional to respond more broadly and adequately to any issue
Weaknesses					
▸▸ Services may overlap, be duplicated or even work against each other ▸▸ Important aspects of care may not be addressed or take a long time to be diagnosed	▸▸ Sharing of information may not be systematic enough to effect overall patient care ▸▸ No guarantee that information will change plan or strategy of each provider ▸▸ Referrals may fail due to barriers, leading to patient and provider frustration	▸▸ Proximity may not lead to greater collaboration, limiting value ▸▸ Effort is required to develop relationships ▸▸ Limited flexibility, if traditional roles are maintained	▸▸ System issues may limit collaboration ▸▸ Potential for tension and conflicting agendas among providers as practice boundaries loosen	▸▸ Practice changes may create lack of fit for some established providers ▸▸ Time is needed to collaborate at this high level and may affect practice productivity or cadence of care	▸▸ Sustainability issues may stress the practice ▸▸ Few models at this level with enough experience to support value ▸▸ Outcome expectations not yet established

A QUICK START GUIDE TO BEHAVIORAL HEALTH INTEGRATION FOR SAFETY-NET PRIMARY CARE PROVIDERS

Integrating behavioral health (mental health and substance use) services into a primary care system involves changes across an organization's workforce, administration, clinical operations, and more. Providers adding behavioral health services as part of a developing integrated care system have many options to explore and paths to take.

Behavioral health integration encompasses the management and delivery of health services so that individuals receive a continuum of preventive and restorative mental health and addiction services, according to their needs over time, and across different levels of the health system.[1] Successful integration involves more than increasing access to behavioral health services through enhanced referral processes or co-location; the system of care delivery is transformed.

The following decision chart points health care providers wondering where to begin, or seeking more information about implementing a specific aspect of integrated care, to available resources.

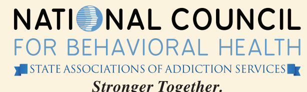
> Around the time that my bipolar condition was identified, I was diagnosed with kidney disease. Between the two disorders, it was a pretty upsetting time in my life... My doctors, dialysis clinic staff, and mental health case manager are well-connected. They take a team approach, and they each check on the status of my health... Today I have control over my health; it doesn't have control of me. The coordinated care allows me to feel like I can go out and be a part of the community.

Cassandra McCallister

Board Member, Washtenaw Community Health Organization, Ypsilanti, MI

SAMHSA-HRSA

Center for Integrated Health Solutions



www.integration.samhsa.gov

1. WHO definition of Integrated Care – http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

Section: ADMINISTRATION

Integration is more than providing mental health and substance use services. Building and sustaining integrated care means all facets of the organization must reflect the values of whole health, collaborative care, and the understanding that successful clinical outcomes are everyone's responsibility. It's developing an infrastructure that allows for the inclusion of the behavioral health system in your practice transformation; mapping out the financial costs and revenue sources for behavioral health integration.

Organizations offering integrated care need to be sure that behavioral health is fully embedded into the practice – including a ***mission statement*** and ***work plan*** that addresses these services. The answer to "How are we going to pay for this?" is a strong ***business plan.***

Start

Has your organization adopted a mission statement and a work plan for practice transformation that fully incorporates behavioral health?

NO

Well, you can start now. Taking time to define your organization's vision and goals will put you on the path towards developing a work plan for long-term success.

Check out the sample vision statement from the Institute for Family Health as a guide.

Is your organization ready to move ahead with integrated care?

Not sure. Check out CIHS' Organizational Assessment Toolkit for Integration (OATI) to assess your readiness.

Maybe. What exactly does integrated care look like, again? The Standard Framework for Integrated Care and AHRQ's Collaborative Care Lexicon can help jog your memory.

Yes, we're already working on getting recognition as a Patient-Centered Medical Home. Wow, way to go! While you're doing your homework on this process, you may want to explore our issue brief on this topic.

No, we still need to convince a few folks. Perhaps the Making the Business Case spreadsheets can help?

YES

Great! Your organization is on the way to ensuring that staff, patients, and behavioral health partners have a clear picture of what outcomes you want to achieve.

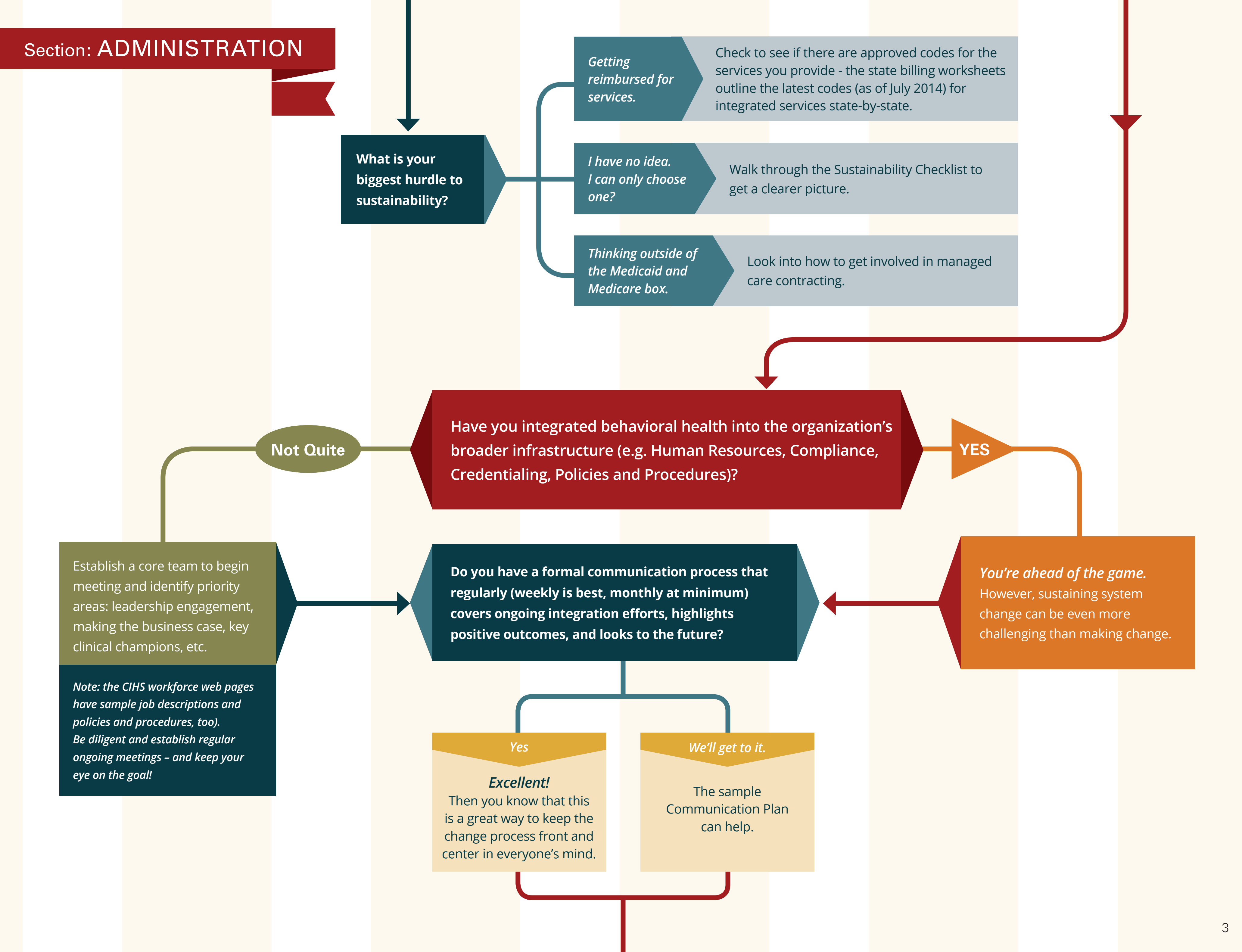
Do you have a business plan that incorporates the components needed to financially sustain behavioral health services?

NO

It can be tough to keep pace with new models, cope with structural barriers, or deal with a fragmented, complex reimbursement system. The good news is, there are tools to help.

YES

Congratulations! You may now explore opportunities to scale up your integration efforts by adding behavioral health services to additional sites, or expanding your array of mental health and substance use treatments.



Section: ADMINISTRATION
What is your biggest hurdle to sustainability?
Getting reimbursed for services.
Check to see if there are approved codes for the services you provide - the state billing worksheets outline the latest codes (as of July 2014) for integrated services state-by-state.
I have no idea. I can only choose one?
Walk through the Sustainability Checklist to get a clearer picture.
Thinking outside of the Medicaid and Medicare box.
Look into how to get involved in managed care contracting.
Have you integrated behavioral health into the organization's broader infrastructure (e.g. Human Resources, Compliance, Credentialing, Policies and Procedures)?
Not Quite
YES
Establish a core team to begin meeting and identify priority areas: leadership engagement, making the business case, key clinical champions, etc.
Note: the CIHS workforce web pages have sample job descriptions and policies and procedures, too). Be diligent and establish regular ongoing meetings – and keep your eye on the goal!
You're ahead of the game.
However, sustaining system change can be even more challenging than making change.
Do you have a formal communication process that regularly (weekly is best, monthly at minimum) covers ongoing integration efforts, highlights positive outcomes, and looks to the future?
Yes
Excellent!
Then you know that this is a great way to keep the change process front and center in everyone's mind.
We'll get to it.
The sample Communication Plan can help.

Section: WORKFORCE

Integrated care involves a ***patient-centered care team*** providing evidence-based treatments for a defined population using a measurement-based treat-to-target approach. In integrated settings, a behavioral health general practitioner works as part of the medical team to meet a wide range of needs. ***Behavioral Health generalists*** – such as psychologists, social workers, psychiatric nurses and peer support specialists – are trained to use evidenced-based strategies to promote behavior change across a broad range of populations, and behavioral and physical health conditions.[2] It's about finding the right person, setting the right expectations and providing the right support.

Does your primary care practice include at least one full-time licensed behavioral health provider (employed or contracted)?

I Wish!

Fear not, there are plenty of resources to support recruiting, training, and retaining behavioral health staff on the clinical team.

YES, of course!

Got everything worked out for your team, then?

Well, not everyone knows how to work with the provider yet.

You may want to further explore the role of the supervisor: from who should supervise behavioral health providers to what resources and support they need for success.

Sometimes these providers mention feeling a little out on their own...

Support your behavioral health providers in connecting with other professionals working in primary care settings – everything from local communities of practices, social media/listservs, professional guilds, and national associations.

We could use even more help, really.

Plan for additional behavioral health providers and paraprofessionals to support your expanding capacity to meet the behavioral health needs of your patients – the Productivity and Capacity Designing the Workflow resource can help.

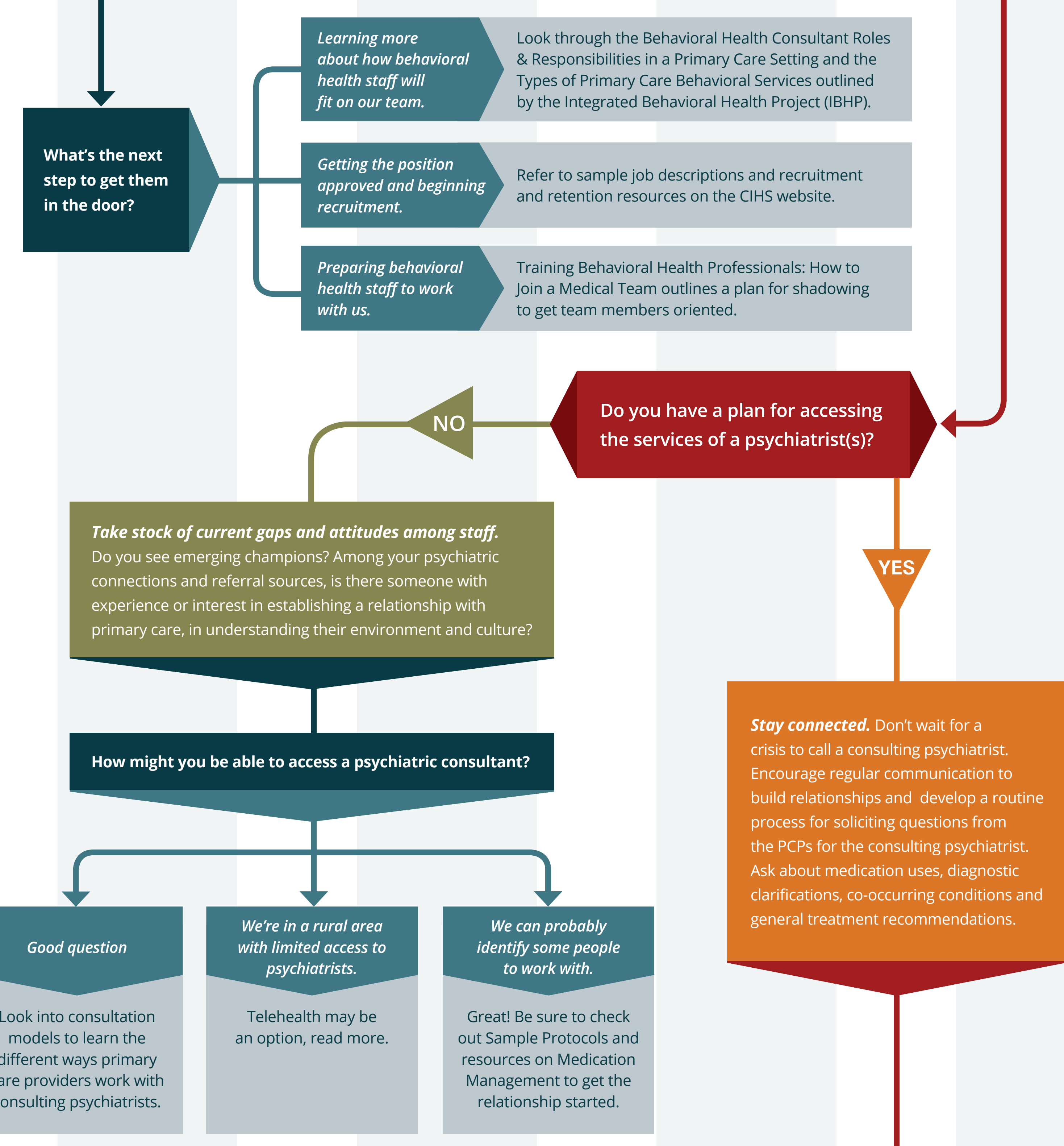
Yes, again!

Way to make the behavioral health provider an active member of your clinic's team-based care!

2. Hunter, C.L., Goodie, J.L., Oordt, M.S., & Dobmeyer A.C., (2009), Integrated behavioral health in primary care: Step-by-step guidance for assessment and intervention. Washington, DC: American Psychological Association.

Section: WORKFORCE

A common barrier to integrated care is a lack of knowledge and comfort with prescribing psychiatric medications. Many primary care physicians have gained foundational prescribing competence, yet PCPs are reluctant to proceed without input from a psychiatrist as more people turn to their PCPs for psychiatric medication. Good prescribing practices involve consistently building new knowledge and skills over time.

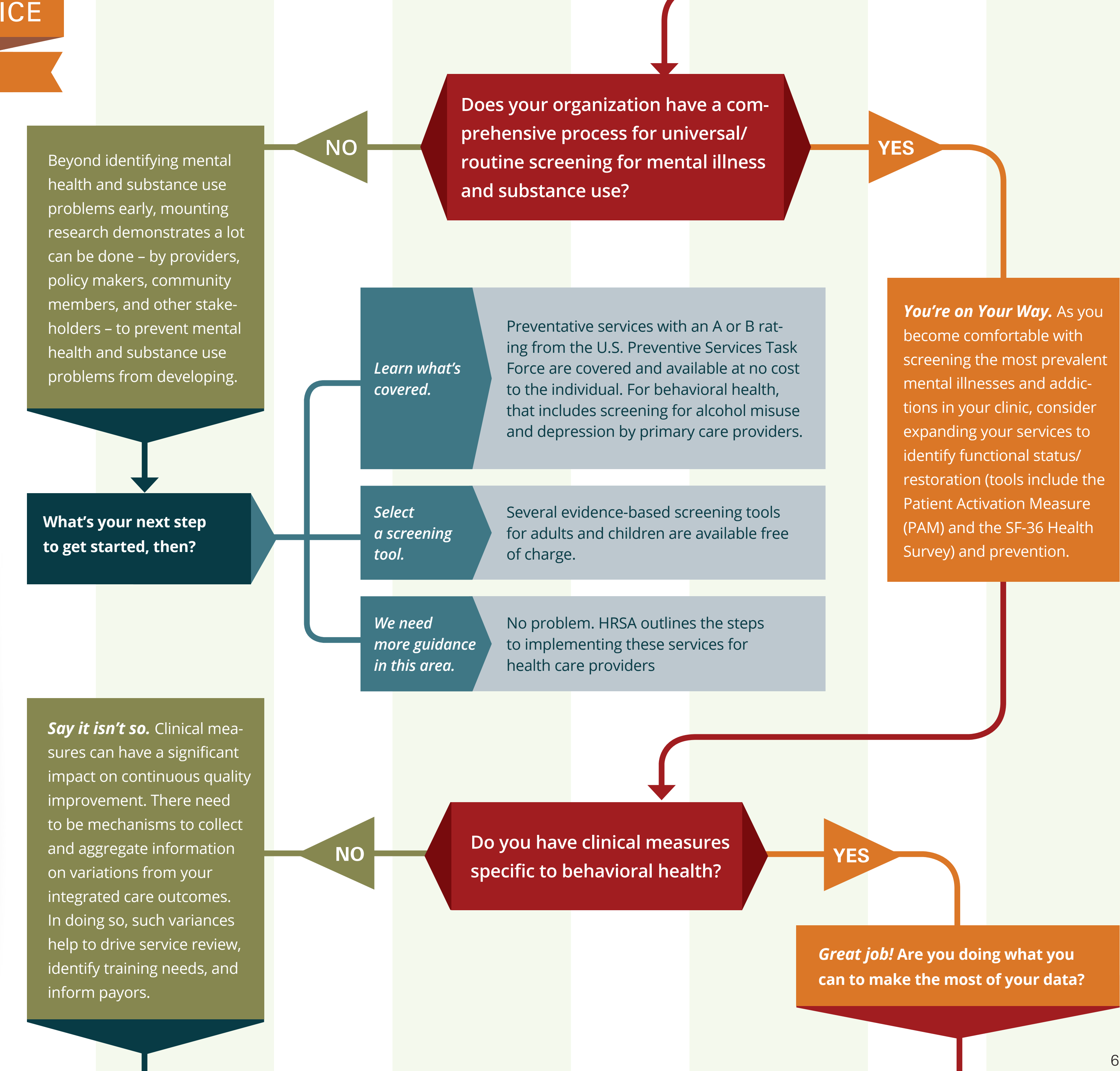


Section: CLINICAL PRACTICE

Integrated care begins with ***screening*** all patients for other health (including behavioral health) conditions in addition to the presenting problem. Similar to hypertension, behavioral health conditions can be "silent killers" in that the patient may not lead with this problem, but these conditions can drive and complicate other health concerns. If not proactively addressed, mental illness can quietly undermine efforts to improve health status. Routine screening leads to an organized collection of data.

Measuring the quality and outcomes of care are central components to all integration initiatives. Most health care providers have a performance improvement system in place that tracks the outcomes of core health indicators. These outcomes not only tell us whether our care is effective and efficient, this data can make the case for integrated care.

Care coordination is a function that supports information sharing across providers,



patients, types and levels of service, sites and time frames (NCQA).

Clinical pathways are one of the main decision-support and quality management tools used in healthcare settings. The implementation of clinical pathways helps to standardize care and to provide efficient, evidence-based treatment. Because more than 68 percent of adults with a mental disorder reported having at least one general medical disorder, and 29 percent of those with a medical disorder had a comorbid mental health condition,[3] it is critical that behavioral health consultation and treatment be incorporated into all clinical pathways for treating chronic medical conditions.

One of the most significant cultural shifts when providing integrated care is moving from a focus on individual patient outcomes to ***population-based care***. In primary care, the emphasis is on targeting populations (all people with diabetes, all people with depression), applying evidence-based

What's stopping you?

I'm not sure our EMR system would support it.

See how others have navigated this issue in A Resource Guide for Health Information Technology

I'm not sure what to measure.

There are plenty of resources to help. NQF outlines suggested clinical measures, as does AHRQ in their Atlas of Care Coordination Measures.

I'd like to find out what our patients think about our service.

AHRQ's Consumer Assessment of Healthcare Providers and Systems (CAHPS) clinician and group surveys ask patients to report on and evaluate their experiences with health care.

What do you suggest? Communicate your findings to all staff, patients, and to external stakeholders. Help staff make the connection between data and actions. Make sure you have a plan for regularly reviewing and discussing data findings in relation to successes and challenges and the role of team care in moving the integration process forward.

Does your organization's clinical pathway for chronic illness management include behavioral health?

NO

Using process mapping early on in the development of your integration work can support the development of clinical pathways. Process mapping helps to identify and examine existing journeys of care from the perspective of patients and staff. Teams can begin to see where changes or improvements need to be addressed.

Ready to move ahead?

I'll give it a try. — Wonderful, start with a process mapping exercise.

Can I have an example? — Of course! Resources include a sample workflow and a Clinical Pathway Example from Zero Suicide.

It'd be great to get my team trained, too. — A cross-training option for teams is behavioral activation. The AIMS Center has behavioral activation training materials and modules for building integrated care.

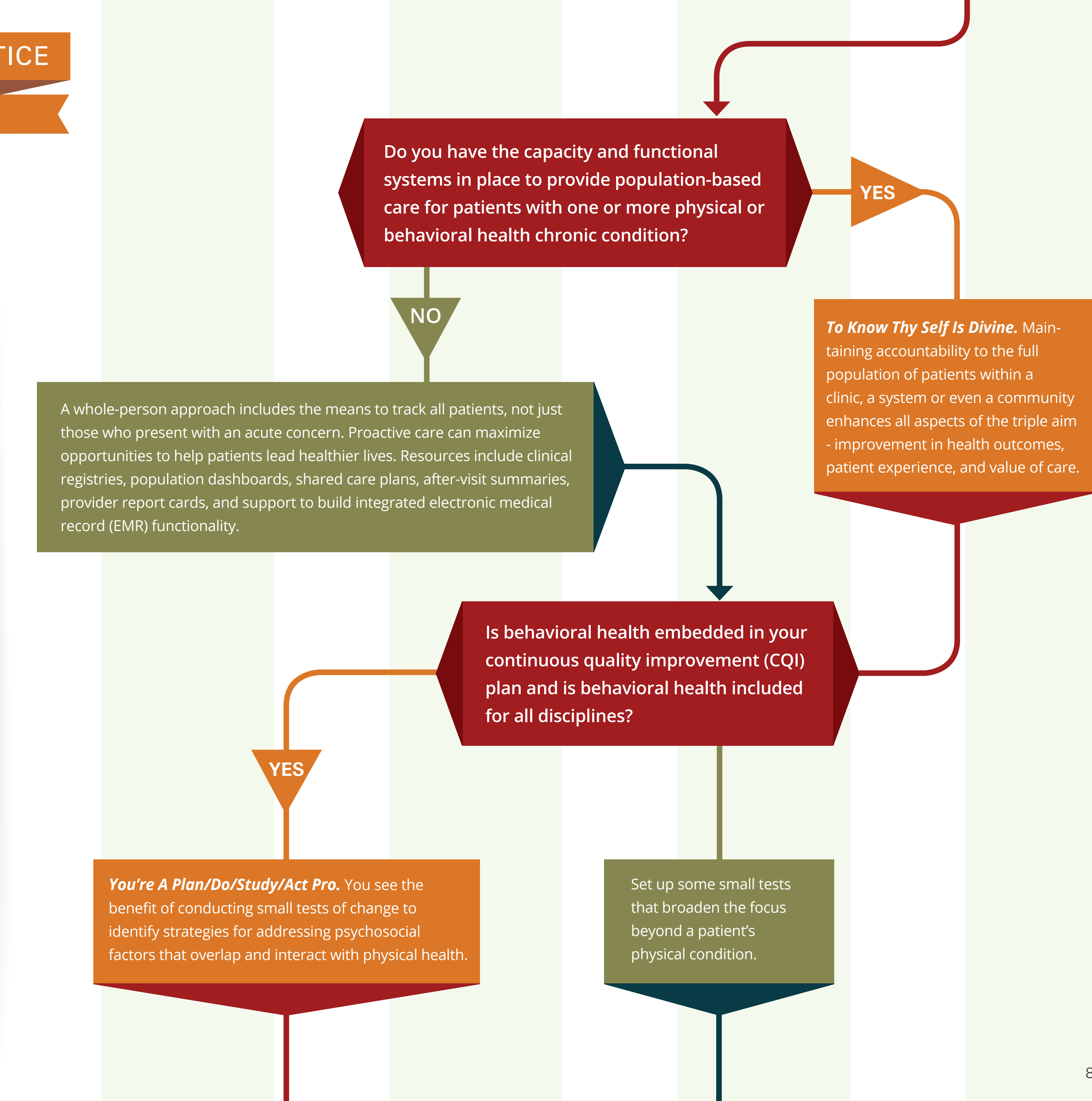
YES

Wow, You're Ahead of the Curve. Your next step might be to study which chronic diseases are most prevalent in the population you serve and what percent access behavioral health services. For example, what percentage of the population of people with diabetes has seen a behavioral health specialist in the last year? This could be the start of a great quality improvement project.

standards of care, and tracking the outcomes of these efforts using disease registries to collect, aggregate, and analyze results. This is a powerful way of holding providers accountable for standards of care and outcomes.

However, in behavioral health, because of the emphasis on the uniqueness of each individual's treatment plan, this can be a difficult concept to embrace and incorporate. Population-based care is tied directly to quality improvement (QI) efforts when targeted outcomes are not being met. Given that all chronic medical conditions have a behavioral health component (behaviors and conditions), it is important to ensure that QI projects are inclusive of behavioral health.

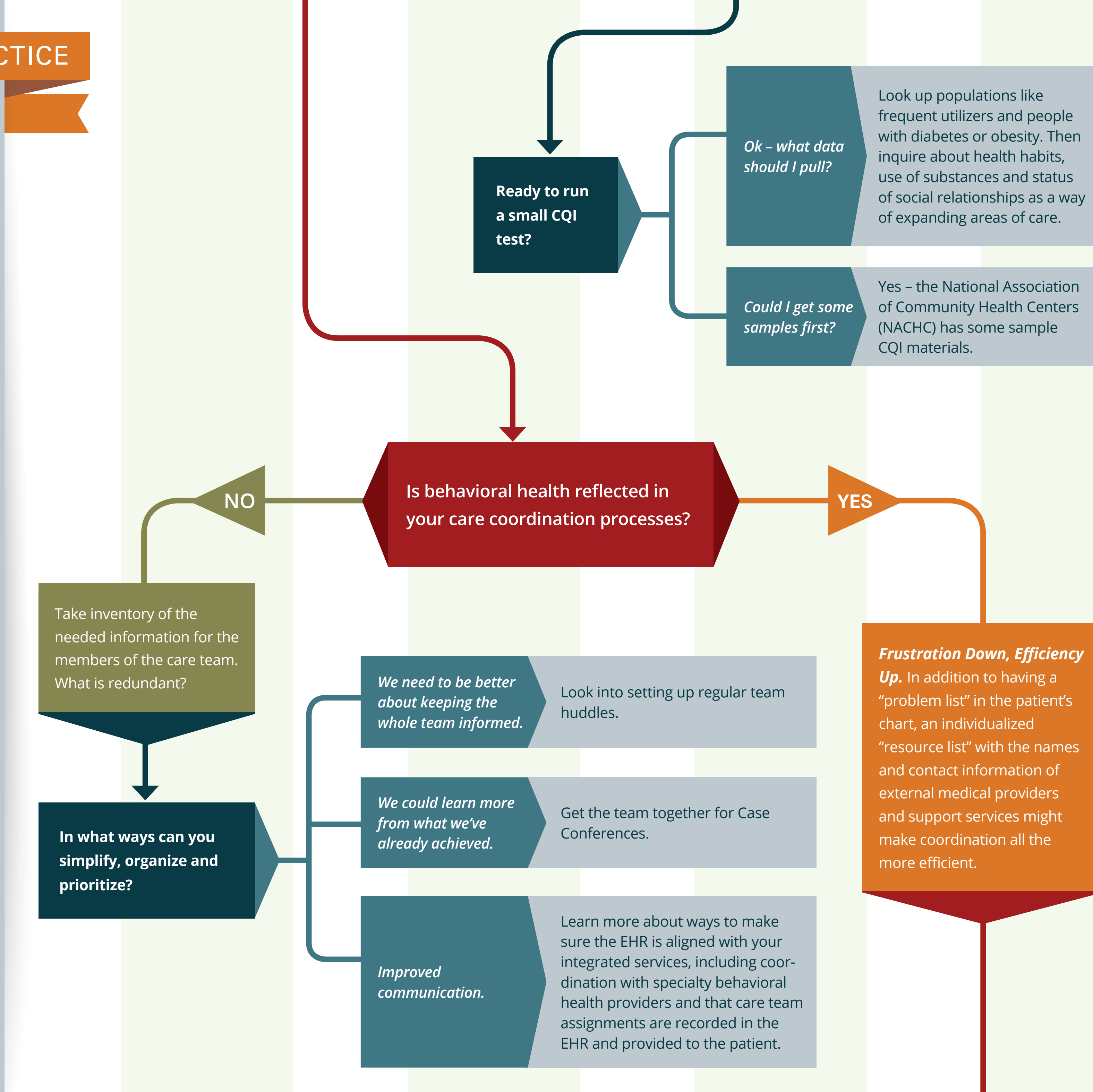
While population-based care is a critical component to integration, each patient is expected to carry out a care plan that is uniquely tailored to their needs, often involves multiple recommenda-tions (changes in diet, exercise, medication) and requires input from specialists. A ***coordinated plan*** of care and services,



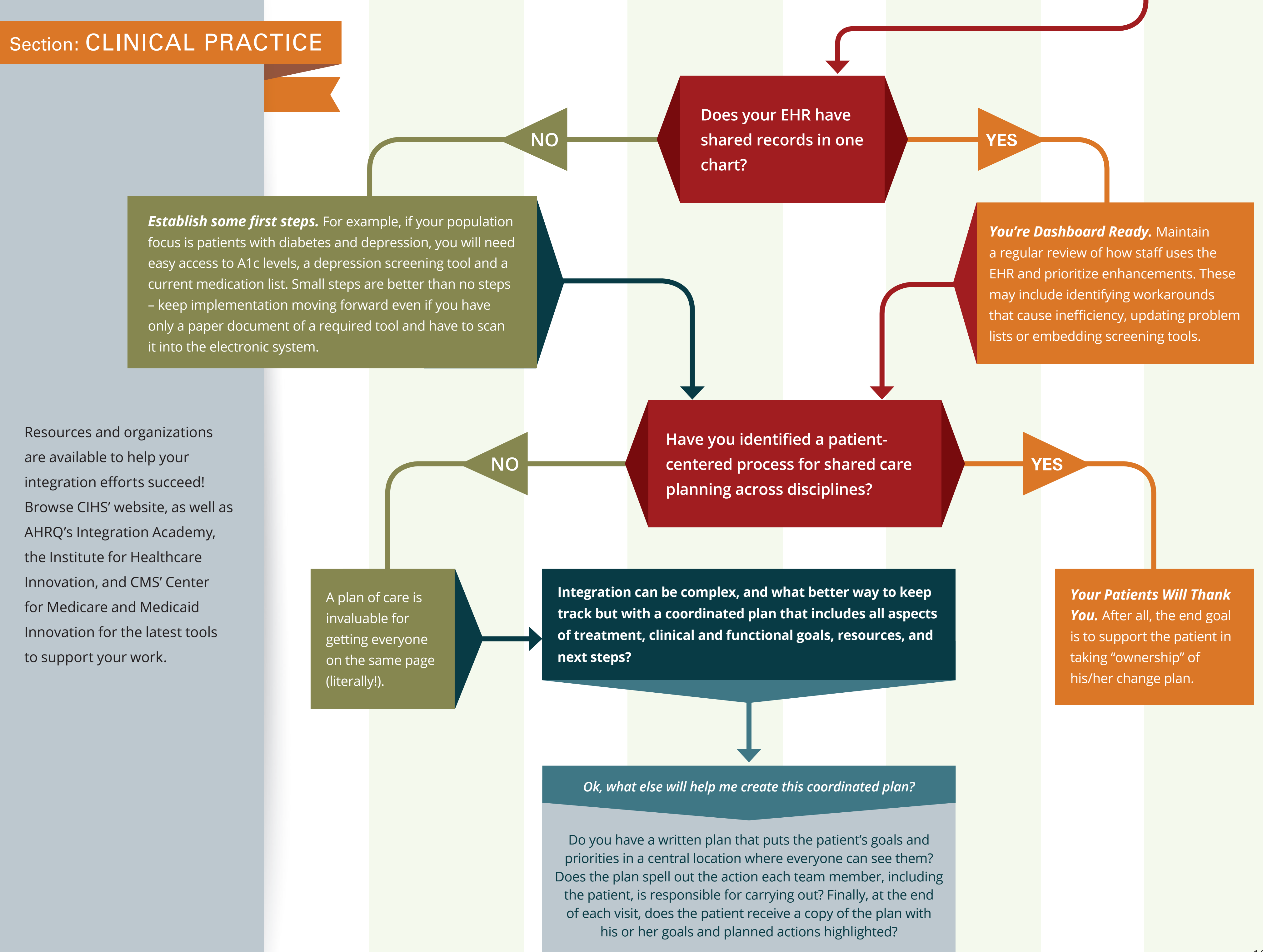
overseen by a member of the health care team, ensures support in following these recommendations. ***Self-care*** is at the center of chronic disease management, and a formal, interdisciplinary communication process and tool is needed to support follow through on short-term steps and long-term goals. The tool should promote patient engagement and be aimed at producing an informed and activated patient.

The ***medical record*** is the centerpiece for communicating findings and treatment recommendations. The behavioral health provider's assessment, plan and documentation of progress need to be easily accessible by the PCP, who is co-treating the patient and, in certain cases, may be the provider implementing and supporting behavioral health recommendations.

3. Kessler RC, Berglund P, Chiu WT, Demler O, Heeringa S, Hiripi E, Jin R, Pennell BE, Walters EE, Zaslavsky A, Zheng H. "The US National Comorbidity Survey Replication (NCS-R): Design and Field Procedures." International Journal of Methods in Psychiatric Research, vol. 13, no. 2, 2004



Resources and organizations are available to help your integration efforts succeed! Browse CIHS' website, as well as AHRQ's Integration Academy, the Institute for Healthcare Innovation, and CMS' Center for Medicare and Medicaid Innovation for the latest tools to support your work.



Integrated Behavioral Health Clinic Considerations and Needs Assessment

There are many different models for integrating behavioral health care into primary care and different practices can adopt or adapt to these models depending on their resources and needs.

Integration does not have to be all or nothing, a practice can start small and grow the program as factors like resources, staffing, training, and patient needs change. There are six levels of collaboration/integration for behavioral health in primary care (see attached charts from SAMHSA for further detail)

- Level 1: Minimal Collaboration
- Level 2: Basic Collaboration at a Distance
- Level 3: Basic Collaboration Onsite
- Level 4: Close Collaboration Onsite with Some System Integration
- Level 5: Close Collaboration Approaching Integrated Practice
- Level 6: Full Collaboration in a Transformed/Merged Integrated Practice

Before deciding which level and model of integrated care is right for your practice, it is important to conduct a **needs assessment** for: Patients, Providers, Support Staff, Clinic Infrastructure, Resource Considerations, and Organization Considerations (see table 1 for questions to consider). Use tools such as patient surveys, clinical data review, provider surveys/focus groups, and practice workflow analysis to identify your starting point for integration.

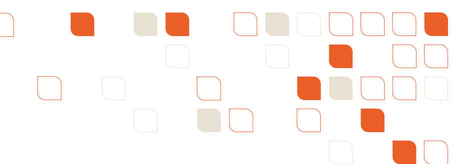
Next Steps (PDSA):

- Decide which level of integration and model for integrated care makes the most sense for your practice in this moment based on your needs assessment
  - Set an overall goal for full integration with smaller interim goals
- Talk with relevant stakeholders to gain buy-in
- Design an integration program that meets your needs
- Identify which outcomes you want to study to measure success
- Pick a start date and decide time interval for studying outcomes
- Celebrate successes and re-work opportunities for improvement until your final goal is achieved!

Table 1

Patients	Providers	Support Staff	Clinic Infrastructure	Resource Considerations	Organization Considerations
What is the prevalence of mental health conditions at your practice?	How comfortable are your providers in screening and assessing for developmental, behavioral, and mental health conditions?	Do you have the support staff capacity to increase screening, data entry, and care coordination to meet patients' behavioral health needs?	Is your EHR equipped to facilitate integrated behavioral health services? (Behavioral Health Registry, Data collection and reporting capabilities for monitoring outcomes, Internal vs. external referral pathways, Scheduling and templating for behavioral health visits)	Are there behavioral health providers in your area that can physically see patients, or do you need to rely on telehealth?	Is there a practice champion to lead the integration effort?
How many of these conditions are high-risk or complex, requiring specialty care?	How comfortable are your providers in treating these conditions?	Is your billing staff familiar with behavioral health CPT codes?	Is there physical space in your office where a behavioral health provider can see patients?	Will there be a need for additional staff roles such as a care coordinator?	What are your current policies and procedures related to behavioral health care?
How do your patients perceive access to mental health services? (Are there language or cultural barriers to consider?)	Are your providers willing to collaborate in real-time with behavioral health clinicians?	Does your support staff have the training to support clinicians and patients that are in crisis until they can be transferred to a higher level of care?	What are your current pathways for behavioral health referrals and how might these need to be adapted for integrated care?	What are the financial implications of hiring new staff?	How adaptable is your team to changes in workflows?
Are they okay with current wait times?			What are your other current workflows related to patient care and how might these need to change with integrated care?	Will you need to make any changes to your payer contracts or obtain credentialing with payers for any newly hired staff?	What is the culture at your practice regarding the role of primary care in addressing patients' behavioral health needs?
Would they prefer to see someone at your office?				What resources does your state/county/city have to facilitate hiring behavioral health staff?	How will you prioritize patients to see your integrated provider?
How do they feel about telehealth services?				What reimbursement model makes the most sense based off other needs?	Do you have process in place to protect behavioral health scheduling to prevent burnout and allow for warm hand-offs?
What are the SDOH needs of your patient population that might affect access (e.g. transportation, technology access, time of day for appointments)?				What onboarding processes are in place for newly hired staff? (Who supervises behavioral health providers? Who will train them on your EHR? What staff considerations will you need to train a new hire (e.g. blocking time on a provider schedule to onboard new hire)? How long should the onboarding process be?	

NATIONAL COUNCIL *for* Mental Wellbeing



Appendix 3:

The New Comprehensive Healthcare Integration Framework

NOTE: For BH settings, emphasis is on co-occurring PH, and for PH settings, emphasis is on co-occurring BH. Prioritized issues will vary based on age and other population variables.

KEY ELEMENTS of Integrated Care		**PROGRESSION to Greater Integration →**			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
1. Integrated Screening, referral to care and follow-up (f/u).	**1.1** Screening and follow-up for co-occurring behavioral health (MH, SUD, nicotine), PH conditions and preventive risk factors. **1.2** Facilitation of referrals and f/u.	Response to patient self-report of co-occurring behavioral health and/or PH complaints and/or chronic illness with f/u only when prompted. Referral to external BH or primary care provider(s) (PCP) and no systematic f/u.	Systematic screening for high prevalence BH and/or PH conditions and risk factors and proactive health/BH. Identify PCP and BH providers (if any) for all. Formal agreement between PH practice and BH providers to routinely facilitate referrals and share information about progress. Measurement of referrals to assess show rate and information exchange with the referral source.	Systematic screening and education for BH and/or PH conditions and risk factors PLUS systematic data collection and tracking of positive results to ensure engagement in appropriate services. Capacity for integrated teamwork, such as a nurse or care coordinator for a BH team, or a BHC for a primary care team, to ensure follow-up and coordination re positive screens, with access to well-coordinated referrals to internal or external PH and/or BH service providers.	Systematic screening and tracking for BH and/or PH conditions PLUS routine capacity for registries and analysis of patient population stratified by severity of PH/BH complexity and/or utilization and measuring the level of intensity of integrated care coordination. In addition to integrated teamwork, there is a systemic collaborative and consulting partnership with PH and BH services in one or more locations that can help meet population needs internally through both integrated service delivery and enhanced referral facilitation to both internal and external partners, with automated data sharing and accountability for engagement.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
2. Evidence-based (EB) care for prevention/ intervention for common PH and/or BH conditions.	**2.1** EB guidelines or protocols for preventive interventions such as health risk screenings, suicide risk screening, opioid risk screening, developmental screening. **2.2** EB guidelines or treatment protocols for common PH or BH conditions (as well as for addressing relevant health behaviors that affect the conditions being addressed). **2.3** Use of medications by prescribers for common PH and/ or BH conditions, including tobacco cessation. **2.4** EB or consensus approaches to addressing trauma and providing trauma-informed care.	Not used or minimal guidelines or protocols used for universal PH or BH preventive screenings. No/ minimal training for providers on recommended preventive screening frequency and response to results. Not used or with minimal guidelines or EB workflows for improving access to care for PH and/or BH conditions. None or limited use by prescribers of medications for co-occurring PH or BH conditions. Medications for co-occurring PH or BH conditions are primarily referred to other type of prescriber to treat. Staff have no or minimal awareness of effects of trauma on PH and BH care and do not have systematic application of person-centered trauma-informed practice.	Routine use of EB or consensus guidelines for performing or referring for risk factor screenings with basic training for providers on screening frequency and result interpretation. Coordination with outside providers for any preventive activities. Intermittent or limited use of EB/consensus guidelines and/or workflows for treatment of common PH and/or BH conditions with limited monitoring. Team receives basic training on PH and/or BH interventions. Prescribers routinely provide NRT or other medications for tobacco cessation and will continue to prescribe stable medications for co-occurring PH or BH conditions for a limited number of individuals. Coordinate referrals to outside providers otherwise. Basic education of provider team on impact of trauma on PH and BH and initiation of basic welcoming, person-centered, trauma-informed approaches to engaging people with complex needs. Coordinate referrals for trauma services.	Routine use of EB or consensus guidelines for universal and targeted preventive screenings with use of standard workflows for f/u on positive results. Provider team monitored on screening frequency and follow up on results. Demonstrated use of common preventive screening guidelines to screen for at least one BH or PH condition. Provider team, including embedded BH or PH consultant if any, routinely use EB/consensus guidelines or workflows for patients with PH and/ or BH conditions. Systematic measurement of symptoms completed for percentage of patients. In addition to Integration Construct 1: Prescribers will occasionally initiate medications for selected co-occurring conditions, including medication treatment for SUD, and will consult with "co-occurring" prescriber for assistance with ongoing management. Evidence of initiation of first line antidepressants, antianxiety and attention deficit disorder medications by most PCPs in a practice. Documentation or formal contract with psychiatric consultant. In addition to Integration Construct 1: Ongoing implementation of person-centered trauma-informed care models.	Prescribers more regularly initiate and manage a range of medications for common co-occurring PH or BH conditions, including medication treatment for SUD, with routine consultation and collaboration with "co-occurring" consultant. See Integration Construct 2 plus evidence of treating more than one condition (in collaboration with a consulting psychiatric or physical health provider). In addition to Integration Construct 2: Adoption of trauma-informed care strategies, treatment and protocols by treatment team at all levels. Routine use of validated trauma assessment tools.

KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
3. Ongoing Care Coordination and Care Management.	**3.1** Longitudinal clinical monitoring and engagement for addressing prevention and intervention for co-occurring PH and/or BH conditions.	None or minimal mechanisms for routine coordination and f/u of patients referred to PH or BH care.	Provider team has a basic mechanism for tracking f/u to appointments with PH or BH referrals, navigating or assisting with appointments and encouraging/ prompting adherence to medications and other co-occurring treatment recommendations.	Team members who can provide data analysis to guide care and plan. Assigned team member(s) who can provide routine care coordination and monitor routine proactive follow-up and tracking of patient engagement, adherence and progress in co-occurring PH and/or BH services, whether provided by the team or by referral. Availability of coaching by assigned care coordinator or others to ensure engagement and early response.	In addition to Integration Construct 2: Availability of a continuum of care coordination, involvement of consulting specialists like a BHC or RN care manager based on stratification of need across the full range of populations served. Use of tracking tool to monitor treatment response and outcomes over time at individual and group level, coaching and proactive f/u with appointment reminders.
4. Self-management support that is adapted to culture, socio-economic and life experiences of patients.	**4.1** Use of tools to promote patient activation and recovery from co-occurring PH and/ or BH conditions with adaptations for literacy, economic status, language, cultural norms.	None or minimal patient/ family education on PH and/ or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations.	Some availability of patient/ family education on PH and/ or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations. Includes materials/ handouts/web-based resources, with focus on referral to outside resources.	Routine brief patient/family education delivered in-person or technology application on selected PH and/or BH conditions, PH and/ or BH healthy behavior skills and PH and/or BH risk factor screening recommendations. Treatment plans include diet and exercise, with common but not routine use of self-management goal setting for both PH and BH conditions.	Routine and ongoing patient/family education on PH and/or BH conditions, PH and/or BH healthy behavior skills and PH and/or BH risk factor screening recommendations throughout the service continuum, with practical strategies for patient activation and healthy lifestyle habits. Self-management skills and goals routinely outlined and monitored in treatment plans. Advance directives discussed and documented when appropriate.
5. Multi-disciplinary team (including patients) with dedicated time to provide integrated PH/BH care.	**5.1** Care team. **5.2** Sharing of treatment information, case review, care plans and feedback. **5.3** Integrated care team training and competency development.	Provider team, patient, family caregiver (if appropriate). No or minimal routine sharing of treatment information and feedback between BH and PH providers in different settings. None or minimal training of all staff levels on integrated care approach and incorporation of PH/BHI concepts.	Provider team patient, family caregiver. Possibly care coordinator or manager. Routine release and exchange of info (phone, fax) between PH and BH referral providers on PH and BH issues, without regular chart documentation. Basic training of all staff levels on integrated care approach and incorporation of Integrated Care concepts and screening/referral workflows.	BH consultant(s) and care coordinators available to PH team. PH consultant (nurse/care manager) available to BH team. Should be access to a BH psychiatrist/NP or a PCP. Discussion of assessment and treatment plans in-person, virtual platform or by telephone when necessary and routine PH and BH notes visible for routine reviews. Routine training of all staff levels on integrated care approach and incorporation of Integrated Care activities into integrated teamwork, with role accountabilities defined for each team member.	PH/BH staff, with care managers, peers/CHWs, working as integrated teams throughout the continuum with patients/families. Regular in-person, phone, virtual or e-mail meetings to discuss complex cases and routine electronic sharing of information and care plans supported by an organizational culture of open communication. Routine integrated team processes like huddles and care meetings. Systematic annual and continuing training for all staff levels with learning materials that target areas for improvement with integrated teamwork for all categories of staff.

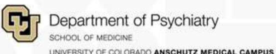
KEY ELEMENTS of Integrated Care		PROGRESSION to Greater Integration →			
DOMAINS	**SUBDOMAINS**	**HISTORICAL PRACTICE**	**SCREENING AND ENHANCED REFERRAL**	**CARE MANAGEMENT AND CONSULTATION**	**COMPREHENSIVE TREATMENT AND POPULATION MANAGEMENT**
6. Systematic quality improvement (QI).	**6.1** Use of quality metrics for PH/BH integration improvement and/or external reporting. Ability to measure baselines for processes and outcomes and apply QI activities to demonstrate improvements for one or more co-occurring PH and/or BH Domains.	None or minimal use of PH and/or BH quality metrics (limited use of data, anecdotes, case series).	Limited tracking of co-occurring PH and/or BH quality metrics for people served and/or for state or health plan reporting. Some ability to report and track improvement for group level issues. Include tracking of disparities in metrics as relates to marginalized and underserved populations.	Routine periodic QI monitoring of identified PH and/or BH quality process and outcome metrics, ability to regularly review performance against benchmarks and attempt to improve performance as needed. Include tracking of disparities in metrics as relates to marginalized populations with targeted efforts to address disparities as a key part of performance improvement.	Routine incorporation of PH/BH measurement into organizational QI with ongoing systematic monitoring of population level performance metrics, ability to respond to findings using formal improvement strategies and routine implementation of improvement projects by QI team/ champions, with demonstration of progress. Include tracking of disparities in metrics as relates to marginalized populations with routine implementation of QI efforts specifically targeted to address disparities.
7. Linkages with community and social services that improve BH and PH and/or mitigate environmental risk factors.	**7.1** Linkages to housing, employment, education, DD/ BI, child/adult protective, domestic violence, financial entitlement, home care, immigration, other social support services.	No or limited/informal screening of social determinants of health (SDOH) and linkages to social service agencies, no formal arrangements.	Routine SDOH screening and referrals made to social service agencies. Some referral and follow-up, but few if any formal interagency arrangements established.	Routine SDOH screening, with formal collaboration arrangements and contacts established with commonly used social service agencies. Some capacity for follow-up tracking and service monitoring as part of team-based care and care coordination functions.	Detailed psychosocial assessment incorporating broad range of SDOH needs. Patients and families routinely linked to collaborating social service organizations/resources to help improve appointment adherence, healthy food sources, with f/u to close the loop. Routine meetings with "complexity care" partners to continuously improve collaborative efforts.
8. Sustainability	**8.1** Build process for billing and – where applicable – process and outcome reporting to support financial sustainability of integration efforts. **8.2** Build process for expanding regulatory and/or licensure opportunities.	No or minimal attempts to bill for co-occurring PH and/or BH screening, prevention, intervention conducted on site. May have "special" services supported by grants or other non-sustainable funding. Licensed and/or regulated as a PH OR BH provider with no or limited understanding of how to provide or document integrated interventions for co-occurring diagnoses.	Billing for PH or BH screening and treatment services under fee-for-services with process in place for tracking reimbursements for PH and/or BH services. Established procedures for providing and documenting integrated screening and interventions, whether on-site or through collaboration, that support what is allowed within single license.	Revenue from payments for developing capacity or for improving processes through quality incentives related to PH or BH. Able to bill some bundled rates for specialized services such as COCM or MAT. Formalized ability to provide some level of integrated PH and BH services within a single license, as well as to coordinate and document internal or external service provision by a provider with the "other" license. Meets PCMH or BH Health Home standards.	In addition to Integration Construct 2: Receipt of value-based payments that reference achievement of BH and PH outcomes for the population served. Revenue helps support necessary staffing, services and infrastructure to support the continuum. Provides licensed PH and BH services in shared services settings throughout the continuum and regularly works to improve design and application of administrative or clinical licensure requirements and regulatory standards to meet evolving capacity to support integrated care for the population served.

NOVEMBER 8, 2024

Beyond the Questionnaire: The ART of Screening and Assessment

Behavioral Health in Pediatric Primary Care: Approaches for Supporting and Treating Children and Families

Dr. Brian Pitts, Assistant Professor, CU Anschutz and
Erica Gleason



2

Overview

The availability of screening tools for behavioral health conditions suggests there is a science to screening. This workshop will overview the evidence-based screening tools for depression, anxiety, suicide, and other conditions. We will weave in the art to this practice focusing on how practitioners (clinicians and others) enter conversations, ensure candid answers from patients and actionable next steps.

OBJECTIVES

- Providers will be able to describe the strengths and weaknesses of common mental health screening tools and apply them to their practice
- Providers will be able to use common screening tools to effectively start and frame conversations about mental and physical health with children and adolescents

Pediatric Mental Health Institute

3

Targeted vs. Universal Screening

Is one better than the other?

- Universal: Screens all patients, including those with other health concerns or who are seeking preventive care. This helps ensure that all patients are screened and feel less alone with their thoughts.
- Targeted: Only screens patients who are presenting with a mental and/or behavioral health concern.

4

National Mental Health Routine Screening Recommendations

AAP

- Developmental screening
  - 9, 18, 30 months
- Autism spectrum disorder
  - 18 and 24 months
- Behavioral/social/emotional health
  - Every well visit
- Depression:
  - Well visits starting at age 12
- Suicide risk
  - Well visits starting at age 12
- Substance use:
  - Well visits starting at age 11

USPSTF

- Anxiety
  - Starting at age 8
- Depression:
  - Starting at age 12
- Suicide risk, substance use, developmental disabilities, autism
  - Insufficient evidence

https://www.aap.org/periodicityschedule

5

5

Early Childhood and School Age Screening Tools

What is infant and early childhood mental health and how do we assess it?

- It is the "space between" the child and caregiver – dyadic relationship
- The ability of the child to form close and secure interpersonal relationships that shape development
- The developing capacity of the child from birth to five to experience, regulate, and express emotions
- Adversities happen & impact young children
- The foundations of life-long mental and physical health are laid in infancy & early childhood
- Prevention and repair are possible; the earlier the better; all within relationships

Abbreviated List of Screening Tools

- Ages and Stages Questionnaire (ASQ)
- The Modified Checklist for Autism in Toddlers (M-CHAT)
- The Survey of Well-being of Young Children (SWYC)
- Strengths and Difficulties Questionnaire (SDQ)
- The Preschool Feelings Checklist (PFC)
- Edinburgh Postnatal Depression Scale (EDPS) – Caregiver's mental health impacts infant and early childhood mental health and development
- Pediatric Symptom Checklist (PSC)

Pediatric Symptom Checklist

- 17 and 35 item versions available
- Validated for 4-18 year-olds
- Self-report version for older children
- Score of 30+ on the 35-item needs further evaluation
- Score of 15+ on the 17-item needs further evaluation
- 95% sensitivity and 68% specificity for mental health impairment
- Attention, Depression/Anxiety, Behavior subscales

Adolescent Screening Tools

The following screeners are some of the most common screens we use with our adolescent population in pediatric primary care. This list is not exhaustive.

Screening Tools

- Depression Screeners: PHQ-2, PHQ-9, PHQ-A
- Generalized Anxiety Screeners: GAD-2, GAD-7, SCARED
- Suicide Risk Screener: Ask Suicide Screening Questions (asQ), COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
- S2BI (substance use)
- Combined Screener: PHQ-4

8

Adolescent Screening Tools

The following screeners are some of the most common screens we use with our adolescent population in pediatric primary care. This list is not exhaustive.

Depression Screens

- PHQ-9 (13 yo+)
  - Sensitivity 89.5% and specificity of 77.5% for MDD (cutoff of 11)
  - Sensitivity 89.5% and specificity of 72.1% for MDD (cutoff of 10)
  - Item #9 problems
- PHQ-A
  - Added “irritable” to depressed mood item
  - Added “weight loss” to appetite item
  - Added “school work” and “reading” to concentration item
  - 1 Dysthymia question!
  - 2 suicide risk questions!
  - Not tested

9

Adolescent Screening Tools

The following screeners are some of the most common screens we use with our adolescent population in pediatric primary care. This list is not exhaustive.

Anxiety Screens

- SCARED (9 yo+)
  - Child and Parent versions
  - Anxiety vs Not-Anxiety: sensitivity of 71% and specificity of 67%
  - Detects panic/somatic, generalized anxiety, separation anxiety, social phobia, school phobia symptoms
- GAD-7
  - NOT validated/tested in children/adolescents
  - Anxiety vs Not-Anxiety (adults):
    - sensitivity of 68% and specificity of 88% (cutoff of 10)
    - sensitivity of 90% and specificity of 63% (cutoff of 5)
  - Detects generalized anxiety, PTSD better than SCARED
  - Detects social anxiety, panic slightly poorer than the SCARED
    - Optimal cutoff is maybe 6, 7, or 8

10

Adolescent Screening Tools

The following screeners are some of the most common screens we use with our adolescent population in pediatric primary care. This list is not exhaustive.

Brief Screens

- SCARED 5-item (9 yo+)
  - Anxiety vs Not-Anxiety: Sensitivity of 74% and specificity of 73%
- PHQ-2
  - First two items on PHQ-9 (depressed mood and anhedonia)
  - Sensitivity 73.7% and specificity of 75.2% for MDD (cutoff of 3)
  - Sensitivity of 89.5% and specificity of 56.7% for MDD (cutoff of 2)
- GAD-2
  - First two items on the GAD-7 (nervousness and unable to control worrying)
  - Anxiety vs Not-Anxiety (in Adults):
    - Sensitivity 65% and specificity of 88% (cutoff of 3)
    - Sensitivity of 86% and specificity of 70% (cutoff of 2)
- PHQ-4
  - PHQ-2 and GAD-2 combined

11

Adolescent Screening Tools

The following screeners are some of the most common screens we use with our adolescent population in pediatric primary care. This list is not exhaustive.

Suicide Risk Screens

- asQ
  - 97% sensitivity and 88% specificity for clinically significant suicidal ideation
  - Developed for children, adolescents, and young adults
- C-SSRS
  - Full assessment and screening versions available
  - Adult full assessment version is 95% sensitive and 95% specific for any current or recent suicidal ideation, intent, attempt
  - Screening version is not tested psychometrically

12

Managing Positive Mental Health Screens

Providers will be able to use common screening tools to effectively start and frame conversations about mental and physical health with adolescents

Symptoms vs. Diagnosis

- Pattern of symptoms
- Mental health symptoms vs disorder
- Pathology vs personality

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13

Managing Positive Mental Health Screens

Major Depressive Disorder Diagnosis

1. *Interests (decreased)**
2. *Depressed mood**
3. Sleep (insomnia/hypersomnia)
4. Energy (loss)
5. Appetite (increase/decrease)
6. Guilt (excessive/inappropriate)
7. Concentration (diminished)
8. Psychomotor (retardation/activation)
9. *Suicidal Ideation*

Requirements:

- 5/9 symptoms nearly every day for at least 2 weeks
- *Depressed mood or Anhedonia must be present

PHQ-9

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

14

Managing Positive Mental Health Screens

KB and EF

1. Score each depression screen
2. Are either screens positive for possible depressive disorder?
3. What is each patient's depressive symptom severity?
4. Is there anything about the screens pointing away from a major depressive disorder diagnosis?

15

Managing Positive Mental Health Screens

Approach to Management: EF

1. Score = 10
2. Moderate depression symptoms

   Depressed mood and anhedonia items are rated as mild

   Deceased sleep and **low energy** are themes
3. Management
   1. Sleep hygiene
   2. Sleep hygiene
   3. Sleep hygiene
   4. Melatonin 1-3 mg sublingual
   5. Diphenhydramine and hydroxyzine prn are also options

16

Managing Positive Mental Health Screens

Approach to KB

1. Score = 15
2. Moderately severe depression symptoms

   Not difficult at all

   Symptoms may not be causing decrease in functioning
3. Management
   1. Surveillance
   2. Therapy referral

17

Managing Positive Mental Health Screens

Starting Conversations

- "I noticed that you said on the intake questions that you said…
- you have been feeling down, sad, or hopeless recently."
- your sleep hasn't been good and you are tired a lot."
- your ability concentrate hasn't been great."
- you have been having thoughts about wishing you were dead."
- you have been having thoughts about hurting yourself or killing yourself."

- "Tell me about..."

18

18

Managing Positive Mental Health Screens

Normalizing Positive Screens

- "We ask all families/teens these questions" – for universal screeners
- Use the positive screen as an entry point to discuss problematic items (i.e., poor sleep, poor appetite, withdrawal, academic decline).
- "It looks like sleep has been really hard for you lately, why do you think this change has happened?"
- "It is ok to feel how you are feeling. You are not in trouble." – some children become nervous about how their caregivers will react when their screen is positive
- "Everyone gets sad and many teens experience depression. You are not alone and there are many ways we can talk about to help you to feel better. We will create a plan together."

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19

Managing Positive Mental Health Screens

Normalizing Positive Screens Continued

- "About one in five teenagers with deal with depression at some point in their lives."
- "About one in four teenagers will deal with anxiety at some point in their lives."
- "Most teenagers who are struggling with depression also struggle with anxiety."
- "About one third of teenagers will have thoughts of suicide at some point in their lives."
- "You are not weird."

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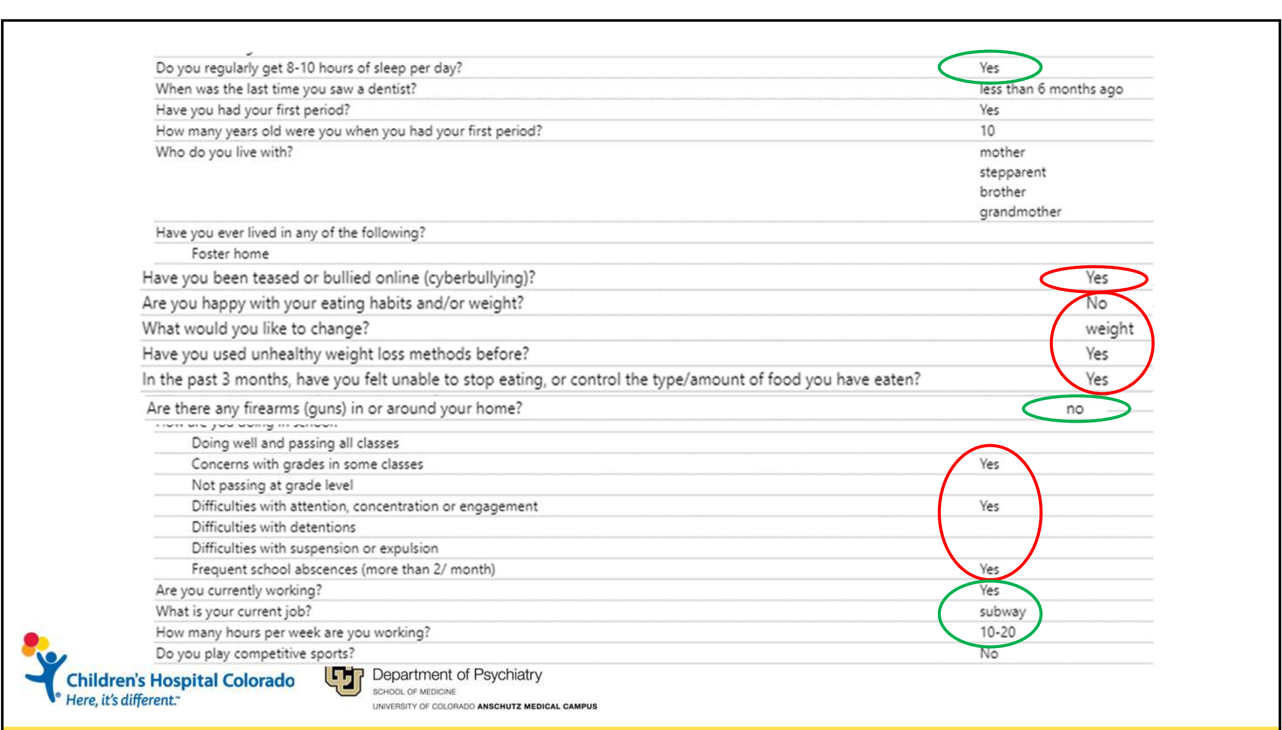
20



Question	Answer
Do you regularly get 8-10 hours of sleep per day?	Yes
When was the last time you saw a dentist?	less than 6 months ago
Have you had your first period?	Yes
How many years old were you when you had your first period?	10
Who do you live with?	mother stepparent brother grandmother
Have you ever lived in any of the following?	
Foster home	
Have you been teased or bullied online (cyberbullying)?	Yes
Are you happy with your eating habits and/or weight?	No
What would you like to change?	weight
Have you used unhealthy weight loss methods before?	Yes
In the past 3 months, have you felt unable to stop eating, or control the type/amount of food you have eaten?	Yes
Are there any firearms (guns) in or around your home?	no
Doing well and passing all classes	
Concerns with grades in some classes	Yes
Not passing at grade level	
Difficulties with attention, concentration or engagement	Yes
Difficulties with detentions	
Difficulties with suspension or expulsion	
Frequent school absences (more than 2/ month)	Yes
Are you currently working?	Yes
What is your current job?	subway
How many hours per week are you working?	10-20
Do you play competitive sports?	No

21

Managing Positive Mental Health Screens

Reflective Listening

- **Reflective listening helps to demonstrate understanding. Below are some example phrases.**
- "So, it sounds like you feel overwhelmed by school and that's impacting your sleep?"
- "You're saying that even small things can trigger your anxiety?"
- "It seems like you're concerned about how your mental health might affect your relationships?"

22

22

Managing Positive Mental Health Screens

Asking open-ended questions

- This leaves room for the child/adolescent to give you additional information
- Focus on their current feelings, experiences, and coping mechanisms, using phrases like: "How are you feeling lately?" or "When you feel stressed, what do you usually do to manage it?"
- "What's the hardest thing about being you right now?" This is a powerful, open-ended question that allows teens to speak about their own lives. They are the expert on their own life. This question honors that expertise and allows them to share whatever they'd like.

23

23

Managing Positive Mental Health Screens

Seeking to understand

- **Context is important! Interpret screening results in the context of the individual's overall circumstances and consider them as a starting point for further assessment, rather than as a definitive diagnosis.**
- **Curiosity vs. Judgement: Create a safe space by letting the teen know that they can share openly without judgment.**
- **Active listening: Pay close attention to their responses and ask follow-up questions to gain deeper insight.**
- **Use strengths-based questions as well – "What are you doing when you feel your happiest?"**
- **"Tell me about how school is going" as a proxy for wellbeing.**
- **Be mindful of language: Use terms that are age-appropriate and understandable**

24

24

Managing Positive Mental Health Screens

Seeking to understand

- Context is important! Interpret screening results in the context of the individual's overall circumstances and consider them as a starting point for further assessment, rather than as a definitive diagnosis.
- Curiosity vs. Judgement: Create a safe space by letting the teen know that they can share openly without judgment.
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- Use strengths-based questions as well – "What are you doing when you feel your happiest?"
- "Tell me about how school is going" as a proxy for wellbeing.
- Be mindful of language: Use terms that are age-appropriate and understandable

25

25

Managing Positive Mental Health Screens

Screening Positive and Motivational Interviewing

- It can be helpful to scale questions to gauge motivation and readiness for change:
- "On a scale of 1 to 10, how important is it to you to improve your mood right now?"
- "If you were to make changes to manage your mood, how confident are you that you could stick to them?“
- Eliciting change talk by asking about potential benefits:
- "What do you think might be different in your life if you were able to better manage your anxiety?"
- "How would improving your mental health benefit your relationships with others?"
- "What are some positive things that could happen if you started taking steps to feel better?“
- Focus on collaboration and shared decision making with the teen.
- Be patient and supportive by demonstrating you understand that change takes time and progress is not linear.

26

26

Managing Positive Mental Health Screens

Navigating Confidentiality

- Confidential histories are often important for accuracy
- Minor can consent to pregnancy, contraceptive care, STI diagnosis/treatment, psychotherapy for ages 12 and older
- If possible, be clear about what will be discussed privately with both patient and guardian
- Explain potential reasons for having to break confidentiality beforehand
- Encourage sharing between patient and guardian (if safe)

27

27

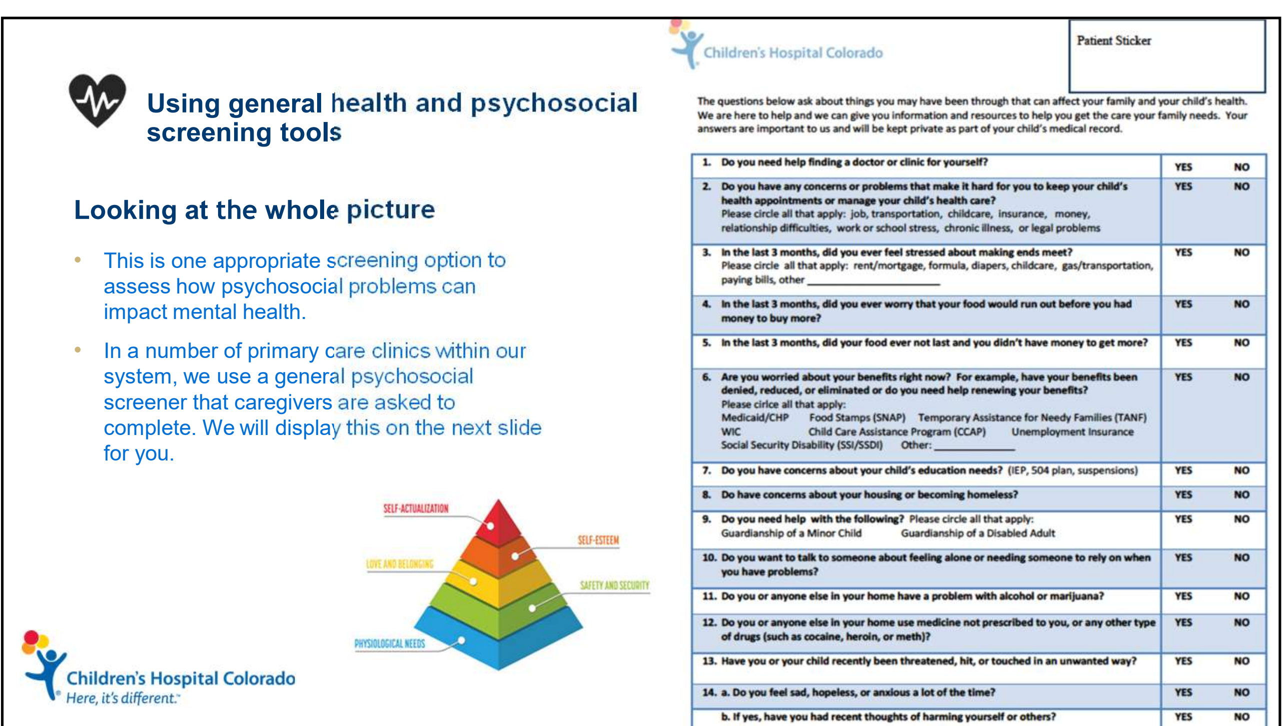
Managing Positive Mental Health Screens

Empowering Parents/Guardians

- “Teens who are struggling with mental health concerns typically do better if their parents/guardians are part of the team helping them.”
- “Because your safety is most important, we have to share this with your parents/guardian to help keep you safe”

28

28



Children's Hospital Colorado

Patient Sticker

The questions below ask about things you may have been through that can affect your family and your child's health. We are here to help and we can give you information and resources to help you get the care your family needs. Your answers are important to us and will be kept private as part of your child's medical record.

Question		
1. Do you need help finding a doctor or clinic for yourself?	YES	NO
2. Do you have any concerns or problems that make it hard for you to keep your child's health appointments or manage your child's health care? Please circle all that apply: job, transportation, childcare, insurance, money, relationship difficulties, work or school stress, chronic illness, or legal problems	YES	NO
3. In the last 3 months, did you ever feel stressed about making ends meet? Please circle all that apply: rent/mortgage, formula, diapers, childcare, gas/transportation, paying bills, other ________	YES	NO
4. In the last 3 months, did you ever worry that your food would run out before you had money to buy more?	YES	NO
5. In the last 3 months, did your food ever not last and you didn't have money to get more?	YES	NO
6. Are you worried about your benefits right now? For example, have your benefits been denied, reduced, or eliminated or do you need help renewing your benefits? Please cirlce all that apply: Medicaid/CHP Food Stamps (SNAP) Temporary Assistance for Needy Families (TANF) WIC Child Care Assistance Program (CCAP) Unemployment Insurance Social Security Disability (SSI/SSDI) Other: ________	YES	NO
7. Do you have concerns about your child's education needs? (IEP, 504 plan, suspensions)	YES	NO
8. Do have concerns about your housing or becoming homeless?	YES	NO
9. Do you need help with the following? Please circle all that apply: Guardianship of a Minor Child Guardianship of a Disabled Adult	YES	NO
10. Do you want to talk to someone about feeling alone or needing someone to rely on when you have problems?	YES	NO
11. Do you or anyone else in your home have a problem with alcohol or marijuana?	YES	NO
12. Do you or anyone else in your home use medicine not prescribed to you, or any other type of drugs (such as cocaine, heroin, or meth)?	YES	NO
13. Have you or your child recently been threatened, hit, or touched in an unwanted way?	YES	NO
14. a. Do you feel sad, hopeless, or anxious a lot of the time?	YES	NO
b. If yes, have you had recent thoughts of harming yourself or others?	YES	NO

29

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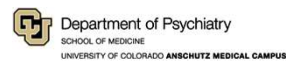

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Thank You

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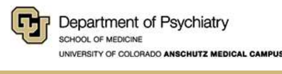

32

Colorado Pediatric Psychiatry Consultation and Access Program

Question: How do I assess and treat mental health concerns in primary care?

Answer: CoPPCAP! CoPPCAP aims to increase the ability and comfort of primary care clinicians to provide basic mental health assessment and treatment for their child and adolescent patients.

Core Components:

1) Telephone consultation (within 45 minutes of a request) with a child psychiatrist or e-consult answered within 24 hrs. **Toll-Free Number: 1-888-910-0153 (Monday - Friday 9:00 AM - 4:30 PM)**
2) Access to information about community resources through a clinical care coordinator/navigator.
3) Free education opportunities through different formats (see below)
4) A toolkit of screening tools and educational materials provided through website.
5) Direct face-to-face or telehealth consultation for patients with difficult diagnostic or treatment issues.
6) Payor blind, may seek consultation for any patient in practice up to age 25.
7) Community of Practice: monthly virtual gathering to discuss cases.

Sample of Free Educational Sessions			
ECHO Core Essentials (8 sessions, 3-4 times/year)	**ECHO Beyond Core Essentials (8 sessions, 3-4 times/year)**	**Learning Collaborative (September)**	**Lunch & Learn (as requested)**
Screening and Assessment	Treatment of Anxiety and Depression: Beyond 2 SSRIs	Motivational Interview	Screening Tools
What is Therapy?	Disruptive Behaviors in Preschoolers	Working with Parents of Preschoolers with Difficult Behaviors	Anxiety
ADHD	Disruptive Behaviors in School Age Children	Applying Acceptance and Commitment Therapy (ACT) in Primary Care	Suicide
Crisis and Chaos in the Primary Care Setting	Substance Use Disorder	Working with Interviewing Teens Around Mood (Depression) and Risk	Depression

What CoPPCAP participants have said:

- *Maura Capaul, FNP, Lafayette Pediatrics and Internal Medicine:* "I am so happy with your program. I take one piece of information from a consult and it's like a big cascade to apply with so many other patients!"
- *Michele Wallendal, MD, Pediatrics 5280:* "I want you to know that the last family you helped me find local resources for is extremely happy."
- *And always*: "Thanks so much; that was so very helpful."

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Xiaoshen Jin, PhD, Program Manager, 720-777-5443; Xiaoshen.Jin@cuanschutz.edu
Toll-Free Number: 1-888-910-0153; **Fax** Number: 720-777-7309; www.CoPPCAP.org

NOTE: Pediatric provider line; not intended for use by parents

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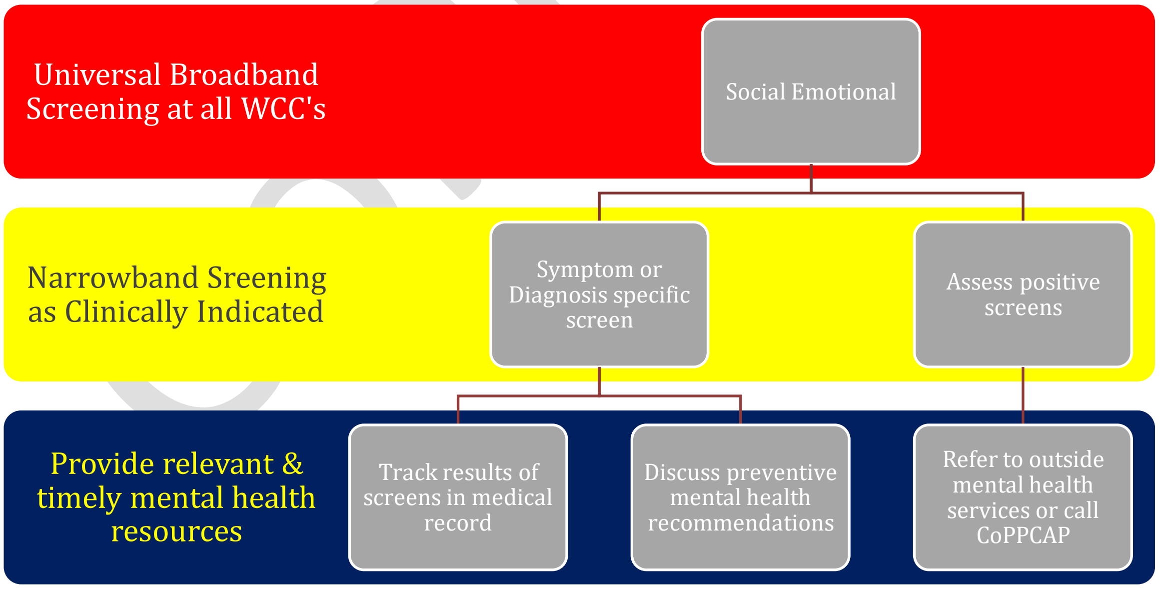
SCREENING & ASSESSMENT IN PEDIATRIC PRIMARY CARE

In primary care, CoPPCAP recommends providers consider the use of socioemotional screening “broadband” measures at annual well child visits. **Broadband screening** measures are meant to be used to assess multiple areas of functioning and quickly discern strengths and weaknesses in the general population. If concern is warranted, then a provider may consider the use of a **narrowband screening** form that further assesses symptomatology related to a particular disorder or condition. Taken together, the broadband and narrowband screening forms are complimentary to give primary care providers information about a child’s overall level of functioning and aid in collecting specific information to help to make a specific diagnosis or to assess the severity of symptoms.



AUTHORS: Ryan Asherin, PhD, David Keller, MD, & Sandra Fritsch, MD

CoPPCAP

UNIVERSAL BROADBAND SCREENING AT ALL WCC'S

Broadband screening for social-emotional problems is recommended by the American Academy of Pediatrics for all Well Child Checks (WCC). Selection of an appropriate social-emotional broadband screen may be based off a patient's age. Federal guidelines recommend (EPDST) social-emotional broadband screening at yearly Well Child Checks (WCC). Below, CoPPCAP lists information on validated broadband social-emotional screening forms that are open source and may be used at no cost to the provider:

Screener. DxCategory	Screener.Name	Screener.Acronynm	Screener.Description
Social-Emotional Development	The Survey of Well-being of Young Children 2-60 months Caregiver Report	SWYC ⇒ English ⇒ Spanish	The Survey of Well-being of Young Children (SWYC)™ is a freely-available, comprehensive screening instrument for children under 5 years of age. The SWYC was written to be simple to answer, short, and easy to read. The entire instrument requires 15 minutes or less to complete and is straightforward to score and interpret. The SWYC is approved by MassHealth for compliance with the Children's Behavioral Health Initiative screening guidelines. The SWYC is copyright © 2010 Tufts Medical Center. Every SWYC form includes sections on developmental milestones, behavioral/emotional development, and family risk factors. At certain ages, a section for Autism-specific screening is also included. Age-specific SWYC forms are available for each age on the pediatric periodicity schedule from 2 to 60 months.
Social-Emotional Development	Preschool Pediatric	PPSC ⇒ English	The Preschool Pediatric Symptom Checklist (PPSC) is a social/emotional screening instrument for children 18–60 months of age. The PPSC was created as one part of a comprehensive screening instrument

CoPPCAP

	Symptom Checklist 18-60 months Caregiver Report	⇒ Spanish	designed for pediatric primary care and is modeled after the Pediatric Symptom Checklist.
Social-Emotional Development	Brief Early Childhood Screening Assessment 18-60 months Caregiver Report	Brief ECSA* ⇒ English	The Brief ECSA screens children 18-60 months for signs of emotional and behavioral problems.
Social-Emotional Development	Pediatric Symptom Checklist – 17 item 4-18 years Caregiver Report	PSC-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist is a 17-item screening questionnaire listing a broad range of children's emotional and behavioral problems that reflects parents' impressions of their child's psychosocial functioning. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-17 is used to screen for childhood emotional and behavioral problems including those of attention, externalizing, and internalizing.
Social-Emotional Development	Pediatric Symptom Checklist – Youth – 17 item 11-18 years	PSC-Y-17 ⇒ English ⇒ Spanish	The Pediatric Symptom Checklist - Youth - 17 is a 17 item screening questionnaire listing a broad range of behavioral and psychosocial problems in youth. The screen is intended to facilitate the recognition of emotional and behavioral problems so that appropriate interventions can be initiated as early as possible. The PSC-Y-17 is used to screen for

COPPCAP

	Self-Report		emotional and behavioral problems including those of attention, externalizing, internalizing, and suicidal ideation.
Social-Emotional Development	Ages & Stages Questionnaire: Social Emotional 1-72 months Caregiver Report	ASQ-SE $$$	SQ:SE- 2 is a set of questionnaires about behavior and social- emotional development in young children. There are nine questionnaires for different ages to screen children from 1 month to 6 years old.

NARROWBAND SCREENING AS CLINICALLY INDICATED

Narrowband screening for mental health problems is recommended whenever broadband measures suggest additional screening may be warranted, or if clinical concern arises during the primary care appointment. Selection of an appropriate narrow screen may be based off symptom profile or diagnostic category. Below, CoPPCAP lists information on validated narrowband screening forms that are open source and free from copyright infringement:

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
ADHD*	NICHQ Vanderbilt Assessment Scale Diagnostic Rating Scale 6-12 years Caregiver Report	Vanderbilt ⇒ English ⇒ Spanish	The Vanderbilt Assessment Scale is a 55-question assessment tool that reviews symptoms of ADHD. It also looks for other conditions such as conduct disorder, oppositional-defiant disorder, anxiety, and depression.

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	Teacher Report		
Anxiety	Spence Children's Anxiety Scale 2.5 – 6.5 years (preschool) 8 – 15 years (child) Caregiver Report Self-Report	SCAS ⇒ English ⇒ Spanish	The Spence Children's Anxiety Scale (SCAS) is a psychological questionnaire designed to identify symptoms of various anxiety disorders, specifically social phobia, obsessive-compulsive disorder, panic disorder/agoraphobia, and other forms of anxiety, in children and adolescents between ages 8 and 15. Developed by Susan H. Spence and available in various languages, the 45 question test can be filled out by the child or by the parent. There is also another 34 question version of the test specialized for children in preschool between ages 2.5 and 6.5. Any form of the test takes approximately 5 to 10 minutes to complete.
Anxiety	Screen for Child Anxiety Related Disorders 8 – 18 years Caregiver Report Self-Report	SCARED ⇒ English ⇒ Spanish	The SCARED is a child and parent self-report instrument used to screen for childhood anxiety disorders including general anxiety disorder, separation anxiety disorder, panic disorder, and social phobia. In addition, it assesses symptoms related to school phobias.
Anxiety	Generalised Anxiety Disorder Assessment 13 – 18 years Self-Report	GAD-7 ⇒ English ⇒ Spanish	The Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to measure or assess the severity of generalised anxiety disorder (GAD). Each item asks the individual to rate the severity of his or her symptoms over the past two weeks.
Autism	Modified Checklist for Autism in Toddlers, Revised 16 – 30 months Caregiver Report	M-CHAT-R ⇒ English ⇒ Spanish	The M-CHAT-R, which stands for Modified Checklist for Autism in Toddlers, Revised with Follow-Up, is a screening tool for parents to assess their child's risk for Autism Spectrum Disorder (ASD).The M-CHAT-R/F is an autism screening tool designed to identify children 16 to 30 months of age who should receive a more thorough

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			assessment for possible early signs of autism spectrum disorder (ASD) or developmental delay.
Depression	Short Mood and Feelings Questionnaire 6 – 18 years Caregiver Report Self-Report	SMFQ ⇒ English ⇒ Spanish	The Short Mood and Feelings Questionnaire (SMFQ-short), child version, is an 13 item subscale from a longer 33-item questionnaire (the original MFQ). This instrument should be used an indicator of depressive symptoms and not as a diagnostic tool and therefore does not indicate whether a child or adolescent has a particular disorder. Diagnoses of mental disorder should only be made by a trained clinician after a thorough evaluation.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self-Report	PHQ-9A ⇒ English ⇒ Spanish	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9 item 12+ Self-Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
Depression	Edinburgh Postnatal Depression Scale 18+ Self-Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.

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Eating Disorders	Eating Attitudes Test 12 – 18+ Self-Report	EAT-26 ⇒ English	The Eating Attitudes Test (EAT, EAT-26), created by David Garner, is a widely used self-report questionnaire 26-item standardized self-report measure of symptoms and concerns characteristic of eating disorders. The EAT has been a particularly useful screening tool to assess "eating disorder risk" in high school, college and other special risk samples such as athletes. Screening for eating disorders is based on the assumption that early identification can lead to earlier treatment, thereby reducing serious physical and psychological complications or even death. Furthermore, EAT has been extremely effective in screening for anorexia nervosa in many populations.
Substance Abuse	CRAFFT 14 – 21+ years Self-Report	CRAFFT ⇒ English ⇒ Spanish	The CRAFFT Screening Test is a short clinical assessment tool designed to screen for substance-related risks and problems in adolescents. CRAFFT stands for the key words of the 6 items in the second section of the assessment - Car, Relax, Alone, Forget, Friends, Trouble.
Substance Abuse	Screening to Brief Intervention 12 – 17 years Self-Report	S2BI ⇒ English	The Screening to Brief Intervention (S2BI) tool consists of frequency of use questions to categorize substance use by adolescent patients ages 12-17 into different risk categories. The accompanying resources assist clinicians in providing patient feedback and resources for follow-up.
Suicide	Ask Suicide Screening Questions 10 – 24 years Self-Report	ASQ ⇒ English ⇒ Spanish	The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide.

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Suicide	Columbia Suicide Severity Rating Scale 5+ years Provider interview	C-SSRS ⇒ English ⇒ Spanish	The Columbia–Suicide Severity Rating Scale (C-SSRS) is an assessment tool that evaluates suicidal ideation and behavior.
Trauma	Child PTSD Symptom Scale 8 – 18 years Self-Report	CPSS ⇒ English	The CPSS is designed to assess PTSD diagnosis and symptom severity in children ages 8–18 who have experienced a traumatic event. It has 24-items, 17 of which correspond to the DSM-IV symptoms. Each of the 17 items is rated on a scale from 0 to 3 with total score ranging from 0 to 51.
Trauma	Primary Care PTSD Screen 13+ years Self-Report	PC-PTSD ⇒ English	The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD.
Trauma	Trauma History Screener – Youth 3 – 18 years Caregiver Report Self-Report	THS-Y ⇒ English ⇒ Spanish	A measure of PTSD and related symptoms, including those related to complex trauma disorders.
Trauma	Young Child PTSD Screen 3 – 6 years Caregiver Report	YC-PTSD ⇒ English	The YCPS is intended to quickly screen for PTSD in the acute aftermath of traumatic events (2-4 weeks after an event) and/or in settings where there would not be time for longer assessments or more in-depth mental health assessment is not available. The screen is not intended for a general assessment of PTSD or to make a diagnosis.

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PROVIDE RELEVANT & TIMELY MENTAL HEALTH RESOURCES

After providing recommended screening using broadband or narrowband efforts, as clinically indicated, it is important to document the results in the patient's medical record. Doing so allows the pediatric provider direct access to past screening results, recognition of increases/decreases in symptoms between visits, and encourages conversation around the patient's mental health. Additionally, after reviewing results of broadband or narrowband screening forms with patients, be sure to discuss relevant preventative mental health recommendations that may be effective in improving a patient's ability to function successfully and feel content. If results of screening forms or direct clinical questioning/observation warrant further mental health support, consider referring your patient to outside mental health services in your area or call CoPPCAP to discuss treatment options in Colorado.

Additionally, try to be mindful of the multiple factors (including social determinants of health) and adverse childhood experiences that can impact our mental health and optimal development. Social, biological and neurological sciences have provided insight into the role of risk and protective factors in the development of mental disorders. Biopsychosocial risk and protective factors have been identified across the lifespan from as early as fetal life. Many of these factors are modifiable and therefore potential targets for prevention and promotion efforts. High comorbidity among mental disorders and their interrelatedness with physical illnesses and social problems stress the need for integrated policies and access to resources.

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BILLING & REIMBURSEMENT

Some states in the US have ratified legislation mandating reimbursement via Medicaid or insurance providers. In Colorado, the EPDS and PHQ-9 are

reimbursable by Medicaid. The table below shows reimbursement codes that have been utilized by screener.

Examples (not comprehensive)	96110[1]	96127[2]	96160[3]	96161[4]
Acute Concussion Evaluation (ACE)			x	
Ages and Stages Questionnaire (ASQ)	x			
Ages and Stages Questionnaire: Social Emotional (ASQ:SE)		x		
Beck Depression Inventory (BDI)		x		
Beck Youth Inventory – Second Edition (BYI-II)		x		
Behavior Assessment Scale for Children – 2nd Ed. (BASC-2)		x		
Children's Depression Inventory (CDI)		x		
Conners Rating Scale		x		*
CRAFFT Screening Interview		x	x	
Edinburgh Postnatal Depression Scale (EPDS)		x		*
Modified Checklist for Autism in Toddlers – Revised (MCHAT-R)	x			
Patient Health Questionnaire (PHQ-2 or PHQ-9)		x		*
Parents' Evaluation of Developmental Status (PEDS)	x			
Screen for Child Anxiety Related Disorders (SCARED)		x		
Vanderbilt ADHD rating scales		x		*

When assessing caregiver, but billing under patient

[1] **96110 Developmental screening** (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

[2] **96127 Brief emotional/behavioral assessment** [e.g., depression inventory, attention-deficit/hyperactivity disorder (ADHD) scale], with scoring and documentation, per standardized instrument

[3] **96160 Administration of patient-focused health risk assessment instrument** (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument

[4] **96161 Administration of caregiver-focused health risk assessment instrument** (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

Further Resources:

Screening Technical Assistance & Resource Center

CHILD DEVELOPMENT ★ MATERNAL DEPRESSION ★ SOCIAL DETERMINANTS OF HEALTH

Acknowledgements: PMHCA sites across multiple states.

AUTHORS: Ryan Asherin, PhD, David Keller, MD, & Sandra Fritsch, MD

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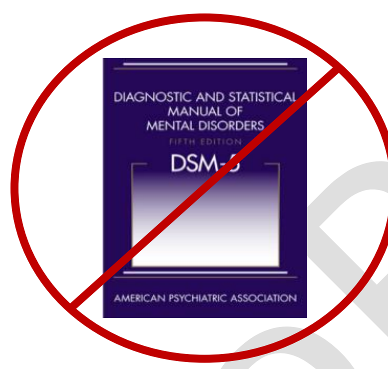
SUICIDE

• Suicide & Non-Suicidal Self Injury •

Suicide is a global pandemic with an estimated 1 million people dying from suicide per year worldwide. In the U.S. suicide is the second leading cause of death in youth aged 10yo-17yo, and in Colorado suicide is the leading cause of death in youth aged 10yo-24yo. Adolescent females are twice more likely to attempt suicide than males, and adolescent males are three times more likely to die by suicide. Adolescents are using increasingly lethal means to attempt suicide including firearms, hanging, jumping from heights, and medication overdose.



Diagnostic Criteria

Suicide and suicidal behaviors are not DSM-5 psychiatric diagnoses per se, however **suicide and suicidal behaviors are commonly seen in multiple psychiatric diagnoses** including:

- Depression
- anxiety
- disruptive behaviors
- substance use
- autism spectrum disorder

Depression is the most common diagnosis in youth who complete suicide in cases where there is a known psychiatric diagnosis. Children and adolescents that experience adversity and maltreatment including physical, sexual, emotional trauma, and neglect are at a higher risk for suicidality.

Terminology

Becoming comfortable with the following terminology facilitates improved communication between the clinician, the patient, patient's family, mental health providers, and others. The following is a list of frequently used terms:

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Suicidal ideation – thoughts of killing oneself, can be passive (wish to be dead or not be around but without intent or plan) or active (desire to die with actual intent and/or plan)

Suicide attempt – purposeful self-harm with intent to die

Interrupted suicide attempt – suicidal behavior that is interrupted by another person

Aborted suicide attempt – suicidal behavior that oneself stops before completion

Nonsuicidal Self-Injury (NSSI) – intentional self-harm without intent to die that's not socially sanctioned.

Safety Plan - a written set of instructions that you create for yourself as a contingency plan should you begin to experience thoughts about harming yourself

Safety Assessment

A safety assessment allows clinicians to identify patients at risk for self-harm and helps guide intervention and treatment. The table below offers general suicide screening questionnaires that can be used with individuals 10 years of age and older (these narrowband screening forms available to download for free at https://www.coppcap.org//screening-tools).

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Suicide	Ask Suicide Screening Questions 10 – 24 years Self-Report	ASQ ⇒ English ⇒ Spanish	The Ask Suicide-Screening Questions (ASQ) Toolkit is a free resource for medical settings (emergency department, inpatient medical/surgical units, outpatient clinics/primary care) that can help nurses or physicians successfully identify youth at risk for suicide.
Suicide	Columbia Suicide Severity Rating Scale 5+ years Caregiver Report Self-Report	C-SSRS ⇒ English ⇒ Spanish	The Columbia–Suicide Severity Rating Scale (C-SSRS) is an assessment tool that evaluates suicidal ideation and behavior.

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Depression	Edinburgh Postnatal Depression Scale 18+ years Adult Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self Report	PHQ-9A ⇒ English	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9 12+ years Self Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).

Once a patient has been identified as having a high risk for self-harm it is very important for the clinician to individualize a safety assessment for said patient and to continuously update this assessment during future appointments. The following is a list of items that should be considered and if possible, included in a safety assessment:

1. Identify Risk Factors including modifiable factors and non-modifiable factors: history of past suicide attempt, acute stressors (relationship losses, bullying, academic difficulties, family conflict, etc.), psychiatric diagnoses and chronic medical conditions (such as depression, chronic pain disorders, seizure disorders), substance use, insomnia and/or sleep disruption for other reasons, history of trauma, history of NSSI, access to means (such as guns and medications), male gender.

2. Identify Protective Factors including supportive family and peers, good problem-solving skills, engagement in mental health treatment, restricted access to lethal means (for example no guns in the home, medications in locked box controlled by parents)

3. Detailed suicide inquiry that includes existence of current active suicidal ideation, intent, and plan; recent and past history of suicidal

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behaviors including suicidal behavior (including attempts, aborted attempts, interrupted attempts, etc)

4. Recommend appropriate interventions and document recommendations this could be sending the patient to the ED if at imminent risk for self-harm, developing a safety plan with both the patient and the patient's family, referring the patient to a therapist, etc

Safety Plan

Safety plans can help decrease risk for self-harm. The term "contracting for safety" or "safety contracts" are no longer used, as it is more important to work together to identify steps to ensure safety. It is important to encourage collaboration between the clinician, the patient, the patient's caregivers, and other members of the treatment team (such as therapists, school counselors, etc.). The following is not an exhaustive list of safety plan items but rather a starting point:

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of depressed adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
    - Expressing hopelessness
    - Expressing suicidal or self-harm thoughts
    - Behaving in an unusually impulsive or risky manner
    - Researching means of harming oneself
    - For young children, using death as a theme in play
    - Giving away possessions
    - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical

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signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

Treatment Modalities

The goal of treatment for suicidal ideation or suicidal behaviors is to decrease risk and prevent suicide. Evidence based prevented treatments include:

- Psychotherapy:
    - Dialectical behavioral therapy (DBT) is a type of cognitive behavioral therapy. Cognitive behavioral therapy tries to identify and change negative thinking patterns and pushes for positive behavioral changes. DBT may be used to treat suicidal and other self-destructive behaviors.
    - Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP) was developed using a risk reduction, relapse prevention approach and theoretically grounded in principles of cognitive behavior therapy, dialectical behavioral therapy, and targeted therapies for suicidal, depressed youth. CBT-SP consists of acute and continuation phases, each lasting about 12 sessions, and includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

- Psychopharmacological:
    - The FDA has determined that the following points are appropriate for inclusion in the boxed warning:
        - Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD and other psychiatric disorders.
        - Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance the risk of increased suicidality with the clinical need.

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- Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior.
- Families and caregivers should be advised to closely observe the patient and to communicate with the prescriber.
- A statement regarding whether the particular drug is approved for any pediatric indication(s) and, if so, which one(s).

- Among the antidepressants, only Prozac is approved for use in treating MDD in pediatric patients. Prozac, Zoloft, Luvox, and Anafranil are approved for OCD in pediatric patients. None of the drugs is approved for other psychiatric indications in children.

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Resources:

Crisis Hotlines:

- National Suicide Prevention Lifeline - 1-800-273-8255
  - **988** has been designated as the new three-digit dialing code that will route callers to the National Suicide Prevention Lifeline. While some areas may be currently able to connect to the Lifeline by dialing 988, this dialing code will be available to everyone across the United States starting on July 16, 2022.
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

Books for Parents:

- Adolescent Depression: A Guide for Parents by Francis Mark Mondimore, MD and Patrick Kelly, MD
- The Childhood Depression Sourcebook by Jeffrey A. Miller, PhD

Helpful Apps:

- My3 – free app available in the Apple app store and Google app store that allows users to identify three contacts to have easy access to in a crisis, as well as update and review warning signs they are in a crisis and coping strategies they can use
- Mood Tools – free CBT-based app that provides information about depression, allows users to practice skills, and has places for documenting preferred coping skills and crisis plans for easy access in a crisis
- CBT Tools for Youth – CBT-based app developed specifically for youth to help them practice CBT skills and develop and record coping skills and safety plans. Has an associated cost.
- Safe2Tell Colorado provides:
  - An anonymous way for students, parents, school staff and community members to report concerns regarding their safety or the safety of others.
  - Resources and materials for schools and communities to educate and promote the Safe2Tell Colorado initiative.
  - Technical assistance to schools and communities before and after tragic events.
  - Expertise in creating safer schools and communities through prevention and early intervention.
  - Education, awareness, and outreach to encourage reporting and breaking the code of silence.

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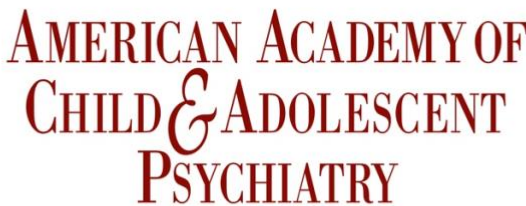

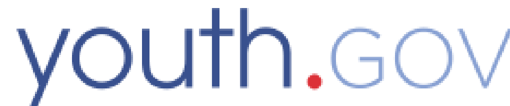

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Brief behavioral health interventions for pediatric depression in primary care settings

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Pediatric Mental Health Institute

1

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Conflict of Interest: Financial Disclosure

We have no relevant financial relationships with any commercial interests

Pediatric Mental Health Institute

2

Topics

1. Diagnostic considerations for major depressive disorder (MDD) in children and adolescents
2. Rule out bipolar disorder
3. Medication management of depression in the acute phase
4. Initial behavioral strategies for initial***

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3

Diagnostic Criteria

- No lab test for depression
- Must represent a change from normal baseline
  - May be helpful to ask the patient or caregiver when the last time they experienced a 2-month period symptom free

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4

Other Diagnostic Considerations

- Somatic complaints
- Behavior
- Role at this stage is to become more independent from caregivers
  - Decreased school performance
  - Social life suffering

Typical vs Atypical Adolescent Behavior

Typical	Cause for Concern
Increased Parent-Adolescent Conflict	Aggression; Self-injury or Suicidal Thoughts
Drug and Alcohol Experimentation/Knowledge	Substance Abuse, Using Substances to Manage Emotions
Increased Risk Taking and Sensation Seeking	Excessive Risk Taking and Recklessness
Increased Stress at School due to Workload or Transitions	Lack of Connection to School or Peers, Truancy, Decline in Perf.
Increased Focus on Body Image	Drastic Change in Appearance
Self-Consciousness	Excessive Restrictive Eating, Binging, Purging
Lying to Avoid Getting into Trouble	Not Knowing Friends, Activities, How They Spend Their Time
Many Hours of Screen Time Each Day	No Communication; Strange Thoughts or Unusual Behaviors

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Other Diagnostic Considerations

- Irritability more common than depressed mood
  - Be careful – this is a symptom of mania or hypomania

Rule Out Bipolar Disorder

- Many bipolar illnesses begin with 1 or more depressive episodes
- This is more likely in those who have:
  - Early onset of depression
  - A family hx of mania
  - Psychotic symptoms
  - Episodic mood lability
  - Subthreshold hypomania
  - ADHD +/- fluctuating mood

Jasper KH, et al, Prospective Evaluation of the Pharmacologic Management of Youth at Clinical and Genetic High Risk for Bipolar Disorder, Poster presented March 24, 2021

Screening for Bipolar Symptoms

- Mood Disorder Questionnaire-Adolescent Version (MDQ-A)
- Children's Affective Lability Scale (CALS)
  - 8+ years old
  - 20 questions

Appendix 1. Mood Disorder Questionnaire-Adolescent Version

Has there ever been a time for a week or more when your adolescent was not his/her usual self and…	Yes	No
…felt too good or excited?	❑	❑
…was so irritable that he/she started fights or arguments with people?	❑	❑
…felt he/she could do anything?	❑	❑
…needed much less sleep?	❑	❑
…couldn't slow his/her mind down or thoughts raced through his/her head?	❑	❑
…was so easily distracted by things?	❑	❑
…had much more energy than usual?	❑	❑
…was much more active or did more things than usual?	❑	❑
…had many boyfriends or girlfriends at the same time?	❑	❑
…was more interested in sex than usual?	❑	❑
…did many things that were foolish or risky?	❑	❑
…spent too much money?	❑	❑
…used more alcohol or drugs?	❑	❑
If you checked YES to more than one of the above, have several of these ever happened to your adolescent during the same period of time?	❑	❑

How much of problems did any of these cause your adolescent—like school problems, failing grades, problems with family and friends, legal troubles? Please circle one response only.

No problem   Minor problem   Moderate problem   Serious problem

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10. It is hard to tell what will set me off crying.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

11. I have bursts of silliness for little or no apparent reason.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

12. I do an activity and then suddenly stop because I am tired.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

13. You never know when I am going to blow up.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

14. I have periods of time when I talk about the same thing over and over.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

15. I suddenly start to laugh about something that most people do not think is funny.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

16. I suddenly appear sad, depressed, and down in the dumps for no apparent reason.
   ○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

Differential Diagnosis

- Medical Diagnoses
- Substances
  - Amphetamines (medication or recreational)
  - Alcohol
  - Steroids
  - Birth Control Pills or other hormonal treatments

Essentials of Good Treatment for MDD

- Psychoeducation
- Biopsychosocial Approach
- Multimodal Treatment

Adherence

Requires additional support

Current Knowledge of Depression

- Very common disorder with high rate of morbidity, mortality, recurrence
- Cause: most likely a psychosocial stressor precipitates depression in an individual with a genetic predisposition to develop depression
- Medications and psychotherapy are effective short-term in 40-50% of pts

--> When to refer?

-->Next – what to do.

Informed Consent

- Only fluoxetine and escitalopram have FDA-indication for pediatric MDD
- Discussion of black box warning

Black Box Warning

Suicidality and Antidepressant Drugs Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in **short-term studies** of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Zoloft or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. **Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older.** Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.

Combined Treatments Most Effective

- Medication alone rarely sufficient since there are frequently many social, school, legal, peer, neighborhood, and/or family problems
- Therefore, individual, family, group, and community-based treatments are frequently an important part of treatment plan

When do you consider medication?

- Psychotherapy ineffective
- Symptoms are significant or severe
- Patient and family prefer drug treatment
- Greater chance of compliance with med treatment

Treatment for Adolescents with Depression Study (TADS)

Multi-site, randomized, controlled trial

First 12 weeks

- CBT alone was less effective than combined treatment or fluoxetine

TADS Study: combined treatment

- Combined treatment
  - Speediest response
  - Better QOL
  - Better functioning
  - Remission
  - Overall safety

Texas Medication Algorithm Project (TMAP)

1st Line (Stage 1:)

- Fluoxetine - 1st
- Escitalopram
- Sertraline
- Citalopram

TMAP, 2007

Children's Hospital Colorado
Here, it's different.

23

Drug Selection

- When not to consider fluoxetine as initial medication
  - Previous poor response to fluoxetine
  - Previous poor response in family member
  - Drug-drug interactions
  - Concern about long half-life in patient who could have latent bipolar disorder

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23

24

Acute Phase of Treatment

- Up to 12 weeks
- Many patients don't respond for up to 12 weeks
- However, it is acceptable to consider a dose increase at 4-6 weeks
  - Partial or non-responders with significant symptoms

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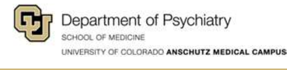
24

Dosage

- Start low
  - e.g. 10mg fluoxetine, less if sensitive to meds or fam hx of sensitivity



Activation

- Term with non-specific etiology
- Increase in activity level
- Seen soon after a dose change
- Dose dependent, can reduce dose or discontinue
- Likely not indicative of long-term risk for bipolar disorder
  - Distinct, paradoxical, reversible with dose adjustment

Walkup, J, Labellarte M. J Child Adol Psychopharmacol. 2001;11(1): 1-4.

Bipolar Switching

- Much more rare
- Much more specific
  - Euphoria and Grandiosity
  - Not just Irritability
- Greater prognostic significance
  - Bipolar disorder
- Not as reversible
- Critical to differentiate from 'Activation'
  - Patients cannot be prescribed antidepressants if bipolar switching

Walkup, J, Labellarte M. J Child Adol Psychopharmacol. 2001;11(1): 1-4.

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27

Monitoring

- Monitor for suicidality
  - ASQ
- Check in with multiple informants
  - Caregivers, other adults in the patient's life
  - Therapists, caseworker, school counselor, teachers, probation officer
- Use objective measures
  - PHQ-A, age 11-17
  - PHQ-9, age 12 and up
  - CES-DC, age 6-17

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28

Responding to patient needs related to pediatric depression.

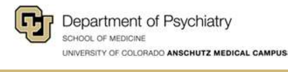
29

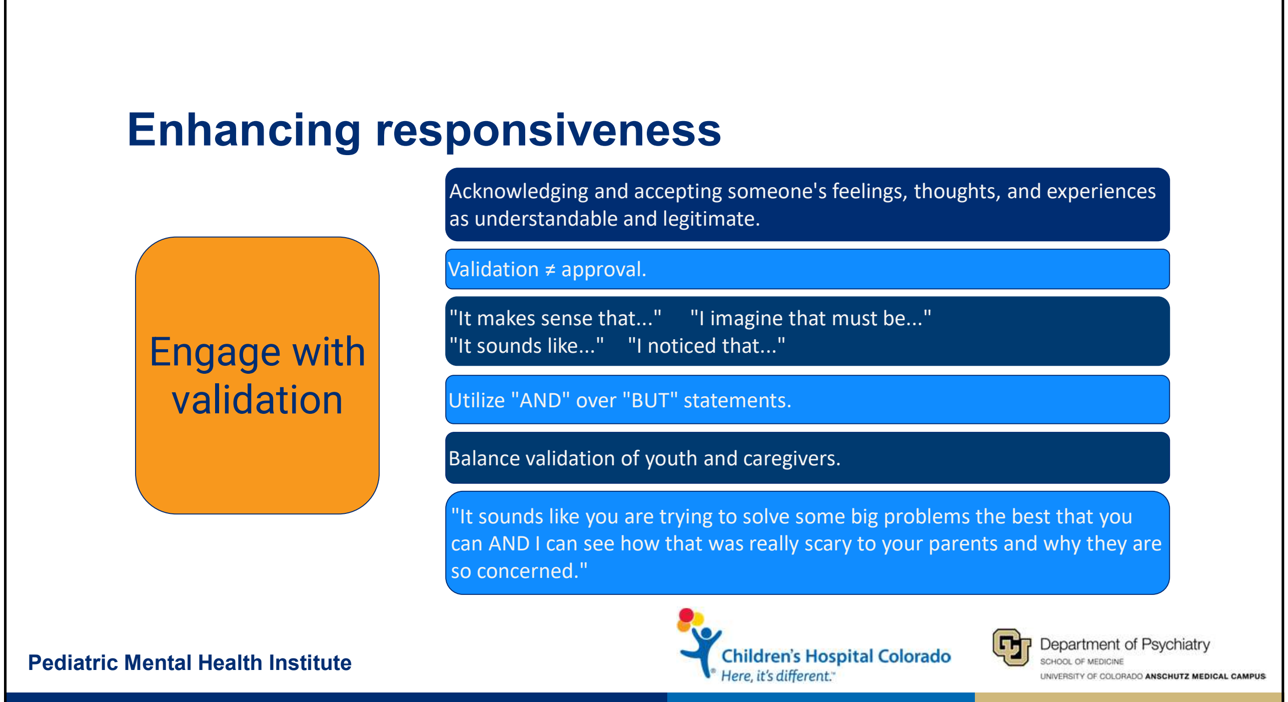
What difficult situations are you encountering around pediatric depression?

30

16-year-old

Emily is a 16-year-old, White, cisgender female who struggles with depression and social anxiety, leading her to withdraw from in-person interactions and primarily engage with others online. She doesn't have close relationships and feels overwhelmed by school, exacerbated by her perfectionist tendencies. Emily is strong-willed and finds it challenging to adjust her plans, often feeling paralyzed by the fear of making mistakes. Despite her nervousness around people, she deeply desires to feel happy, make in-person friends, and share her interests with someone who understands her. This internal conflict leaves her feeling isolated and yearning for genuine connections. She states she just doesn't really like therapy and isn't interested.





Weighing decisions

Benefits of NOT Changing What is good about things staying the same?	**Benefits of Changing** What is good about things changing?
Cost of NOT Changing What is difficult about things staying the same?	**Cost of Changing** What is difficult about changing?

Ehrenreich-May et al., 2018

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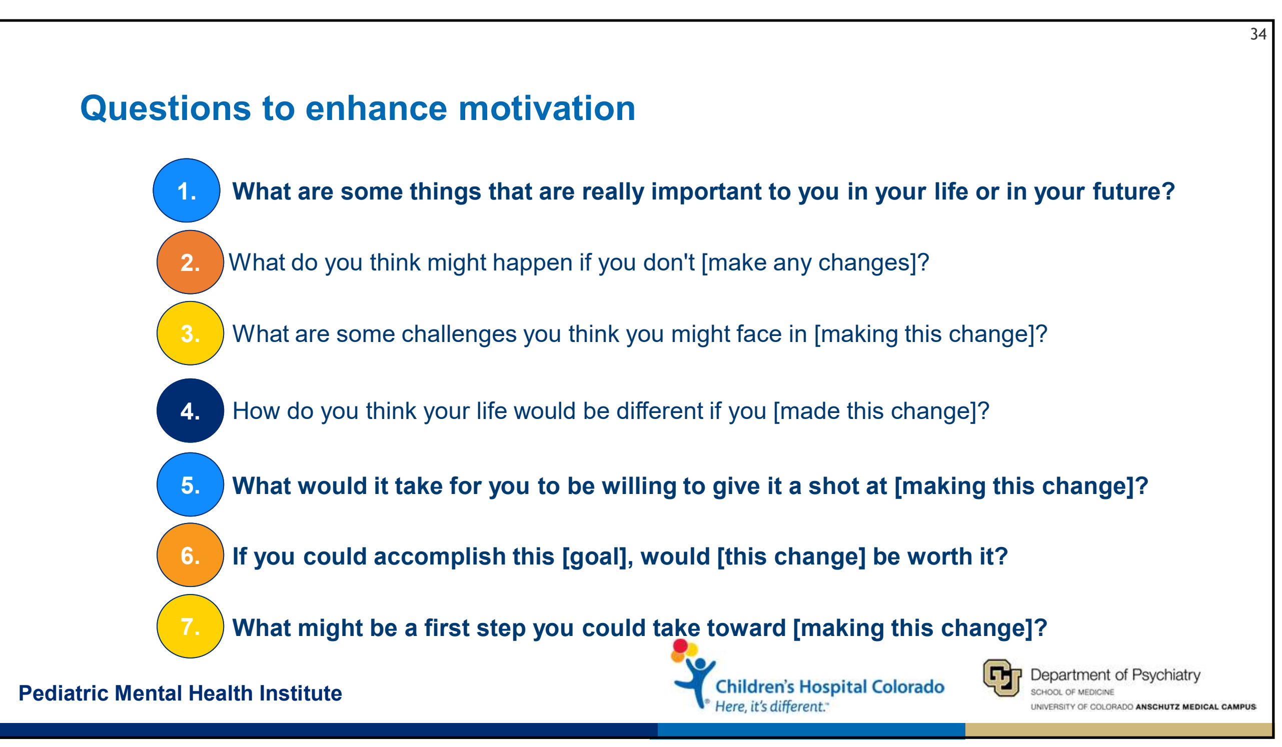

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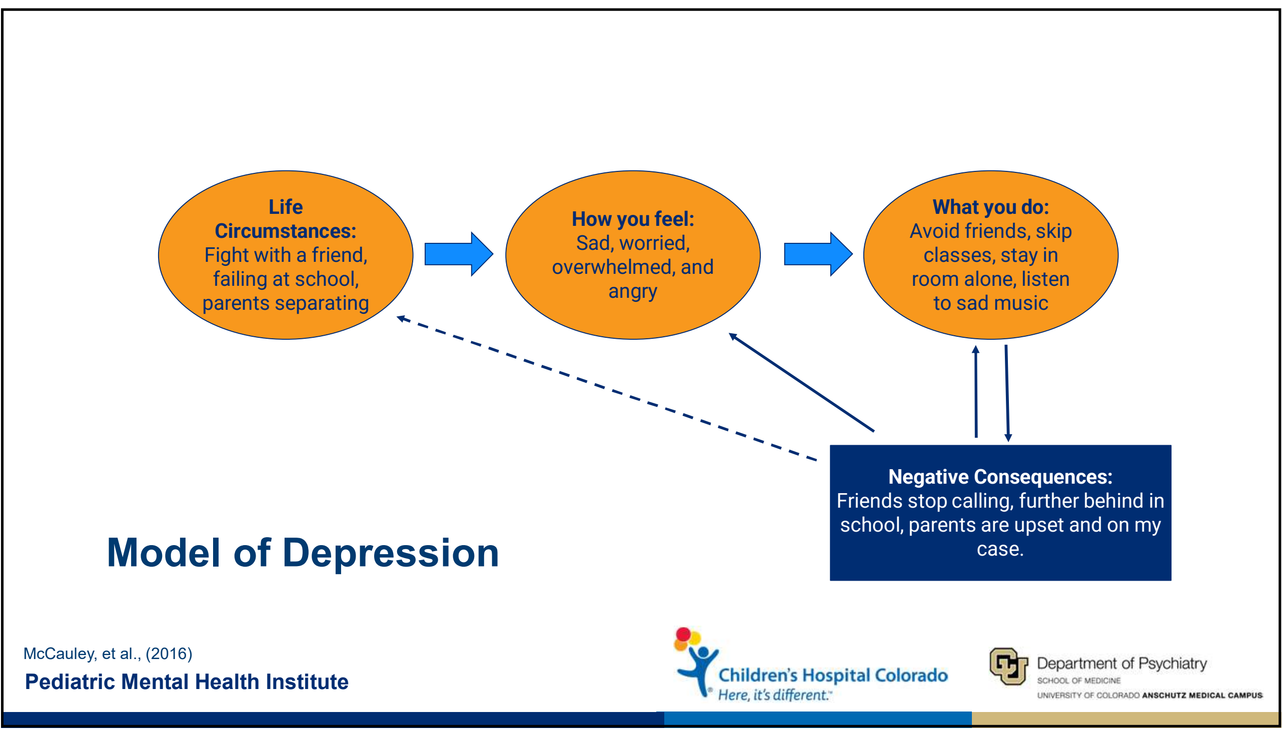

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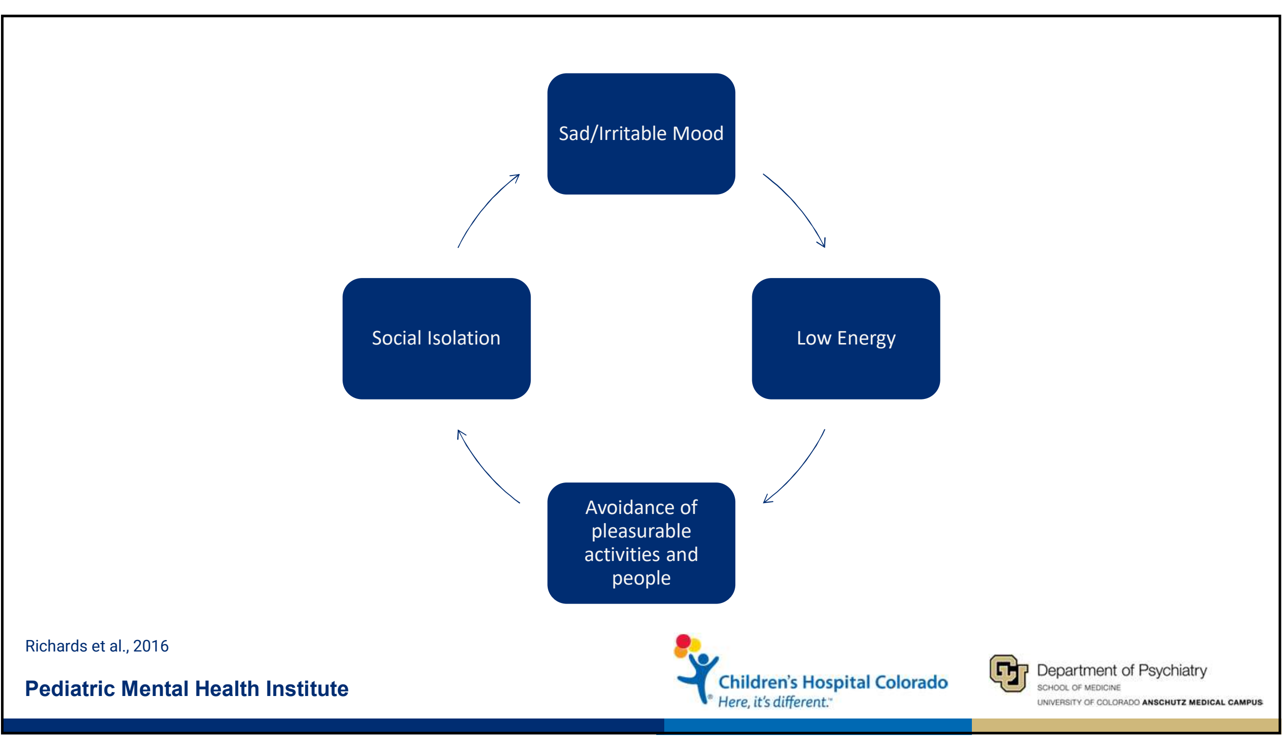

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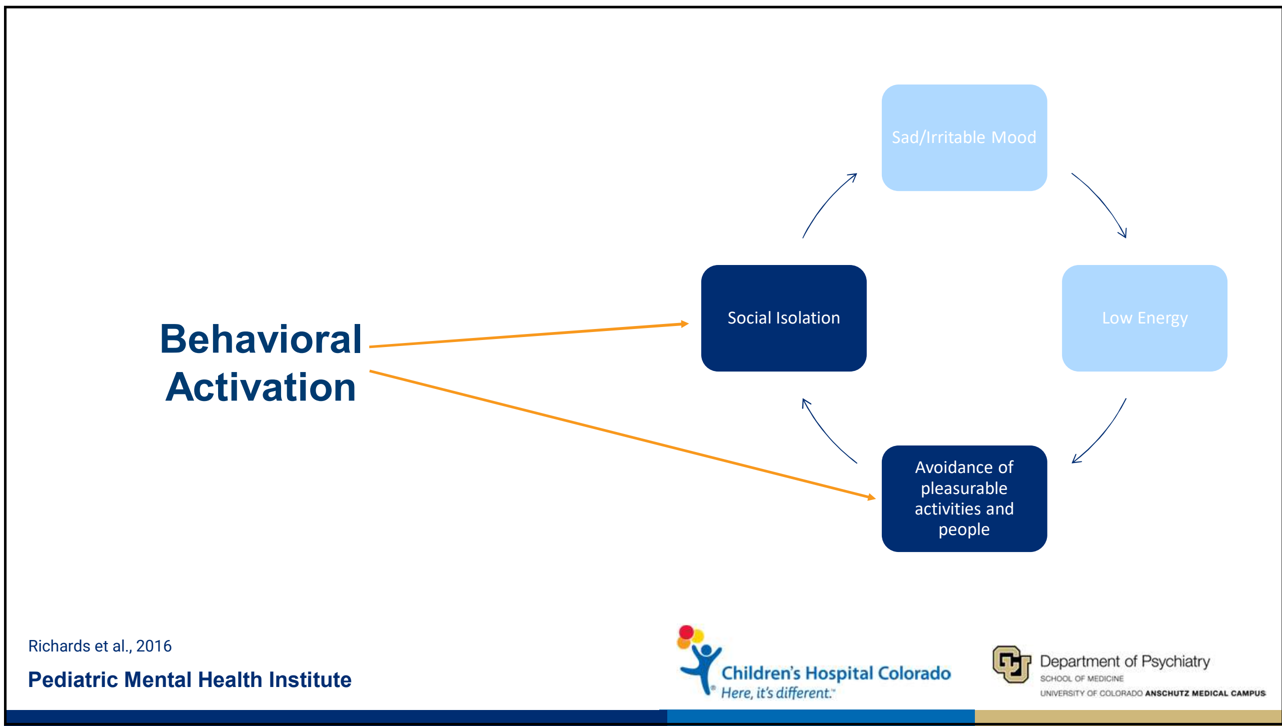

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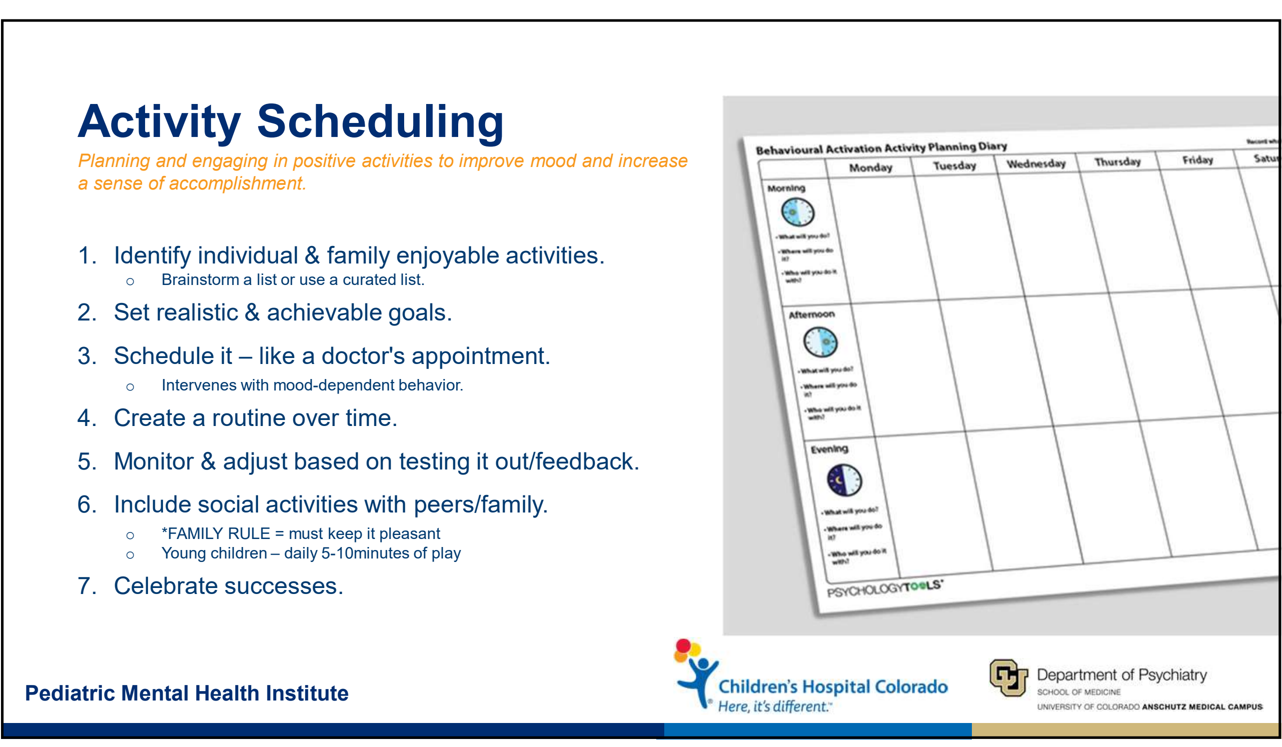

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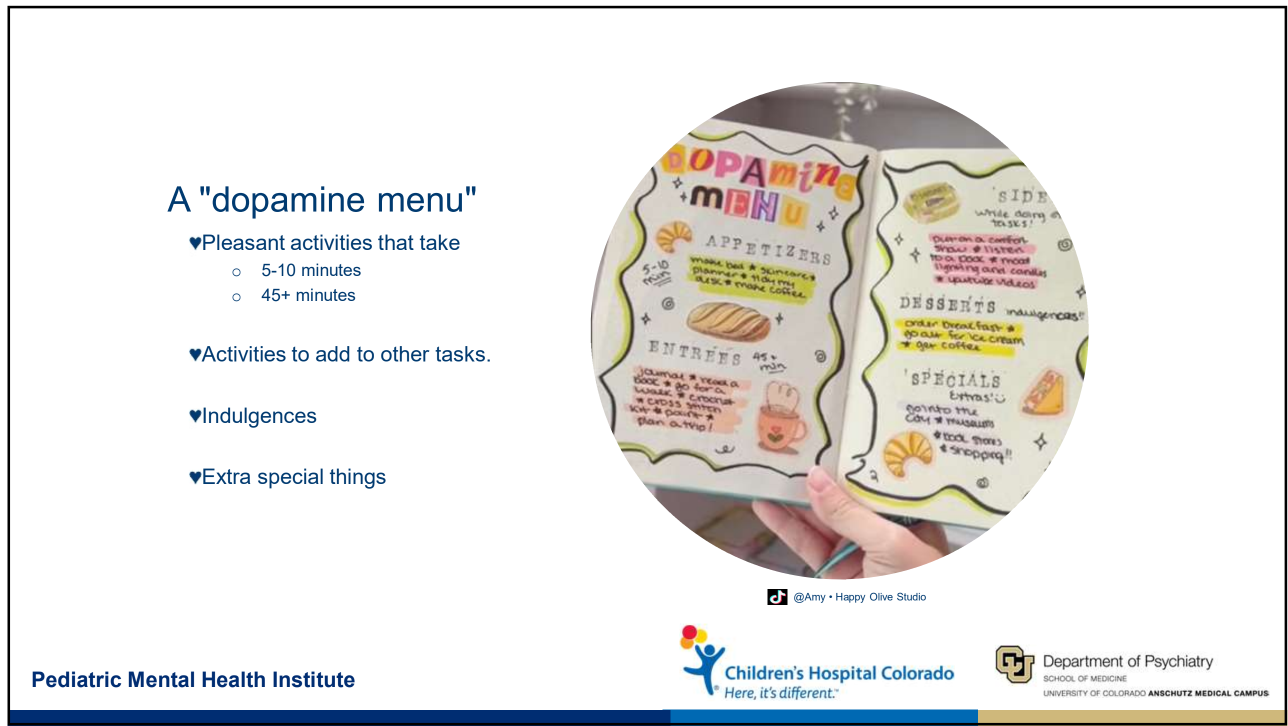

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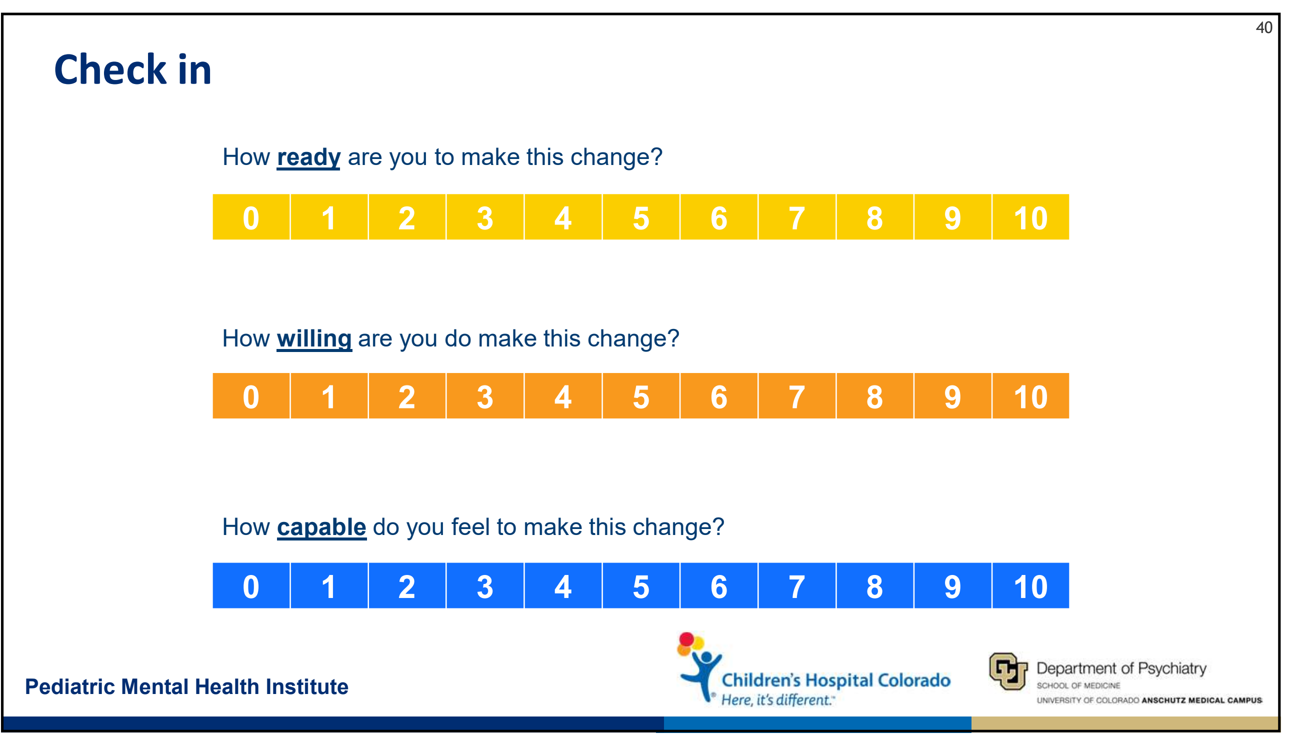

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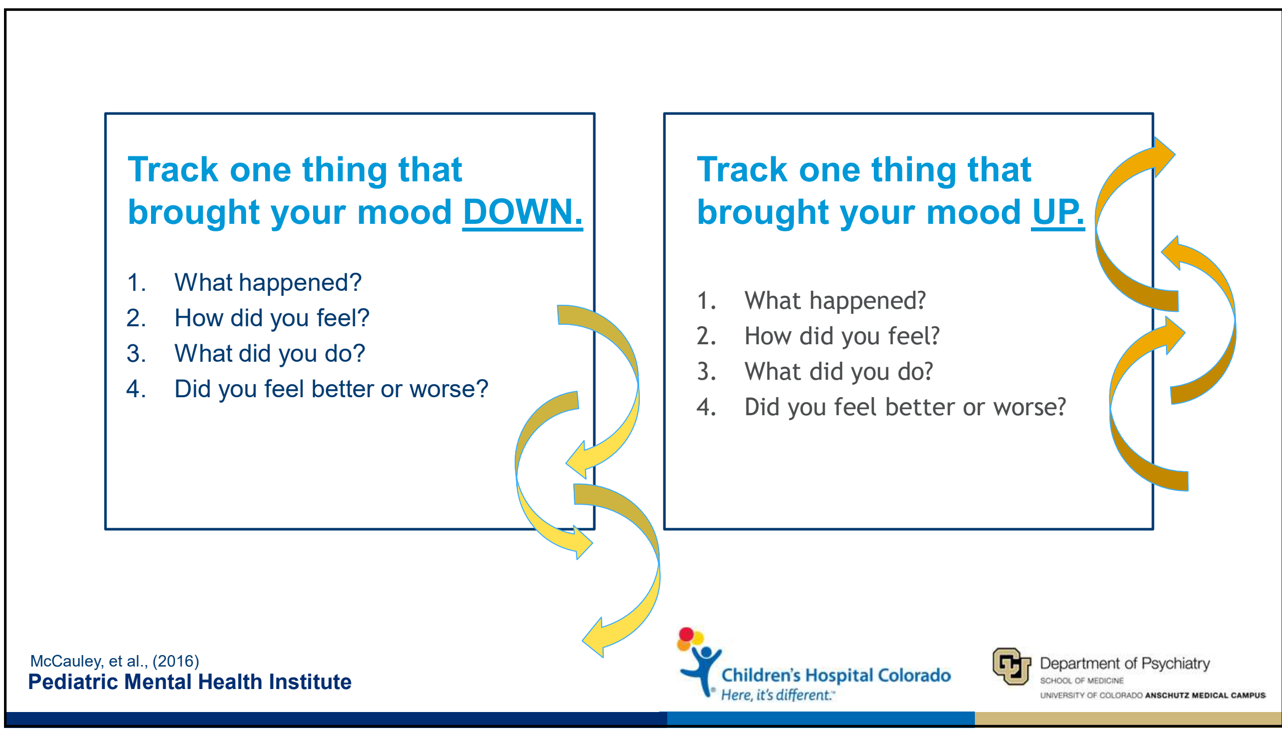

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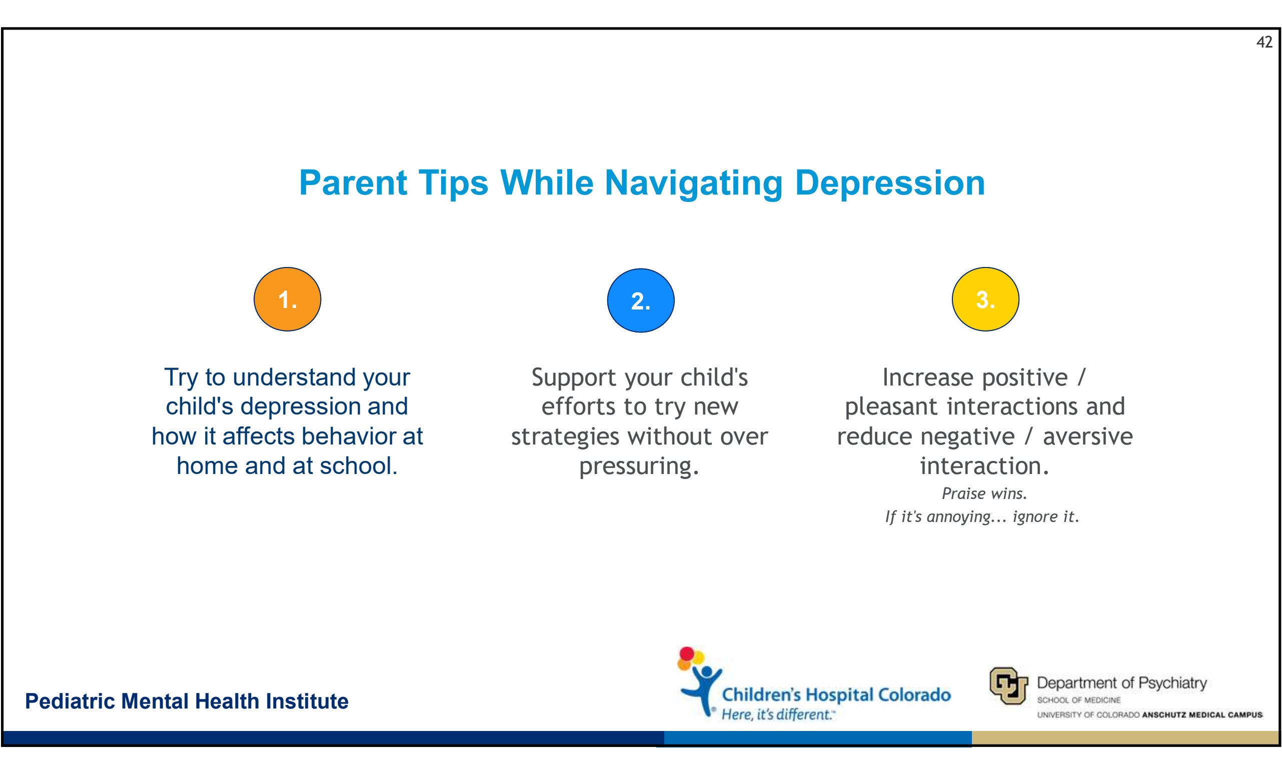

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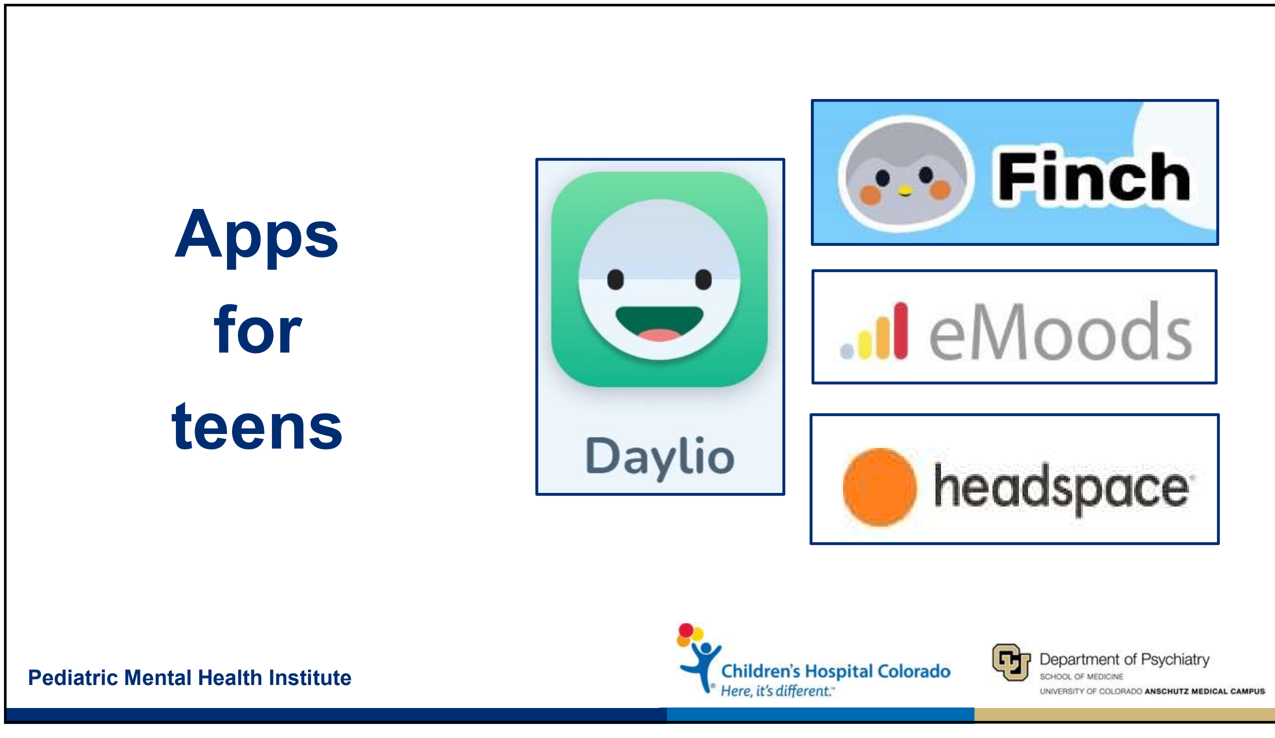

43

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44

Thank You

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45

BIOS
11/03

CHILDREN'S AFFECTIVE LABILITY SCALE (CALS)
Child Form for children 8 years and older

DIRECTIONS: Fill in the circle on the scale below each question that best describes your mood.

1. I suddenly start to cry for little or no apparent reason.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

2. It is hard to tell what will set me off into a temper or a fit.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

3. I suddenly become tense or anxious.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

4. I have bursts of being overly affectionate for little reason, hugging or kissing more than people than I would expect.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

5. I suddenly lose interest in what I am doing.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

6. It is hard to tell what mood I will be in (how I will feel; happy, sad, excited, mad).

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

7. I suddenly lose my temper (yell, curse, or throw something) when others would not expect it.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

8. I have bursts or increased talking.

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

9. I have short periods when I feel shaky or my heart is pounding, or I have difficulty breathing (not due to asthma or another medical problem).

○	○	○	○	○
Never or rarely occurs	1-3 times during the month	1-3 times a week	4-6 times a week	1 or more times a day

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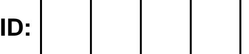

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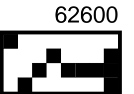

10. It is hard to tell what will set me off crying.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

11. I have bursts of silliness for little or no apparent reason.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

12. I do an activity and then suddenly stop because I am tired.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

13. You never know when I am going to blow up.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

14. I have periods of time when I talk about the same thing over and over.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

15. I suddenly start to laugh about something that most people do not think is funny.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

16. I suddenly appear sad, depressed, and down in the dumps for no apparent reason.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

17. I have bursts of being nervous or fidgety.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

18. I have bursts of crabbiness or irritability.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

19. I suddenly act overly familiar with people I barely know.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

20. I appear very angry (yell, curse) in response to a simple request.

○ Never or rarely occurs ○ 1-3 times during the month ○ 1-3 times a week ○ 4-6 times a week ○ 1 or more times a day

DEPRESSION

• Major Depressive Disorder •

3.2% of children aged 3-17 years (approximately 1.9 million) have diagnosed depression. Diagnoses of depression are more common with increased age.

Major Depressive Disorder

DSM-5 (2013)

5+ Symptoms Over 2 Weeks

- Depressed Mood
  and/or
- Diminished Interest
- Weight Loss
- Insomnia or Hypersomnia
- Psychomotor Agitation or Retardation
- Loss of Energy or Fatigue
- Worthlessness or Guilt
- Inability to Concentrate or Indecisiveness
- Thoughts of Death or Suicide

Screening

CoPPCAP recommends pediatric providers consider rating scales to identify depression symptoms, track response to intervention 1-2 weeks after starting medication, to guide dose changes, and routinely every 6 months even when stable medication dose is achieved to monitor symptoms. Additionally, when tracking response to treatment intervention, consider use of the same screening form used at baseline prior to diagnosis.

AUTHORS:
McNitt, Cassidy, MD, Ryan Asherin, PhD, & Sandra Fritsch, MD

Screener.Dx Category	Screener.Name	Screener.Acronynm	Screener.Description
Depression	Edinburgh Postnatal Depression Scale 18+ years Adult Report	EPDS ⇒ English ⇒ Spanish	The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child.
Depression	Patient Health Questionnaire - 9A (modified for teens) 13 – 18 years Self Report	PHQ-9A ⇒ English	The PHQ-9 is the nine item depression scale of the patient health questionnaire.* It is one of the most validated tools in mental health and can be a powerful tool to assist clinicians with diagnosing depression and monitoring treatment response. The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM 5.
Depression	Patient Health Questionnaire - 9A 12+ years Self Report	PHQ-9 ⇒ English ⇒ Spanish	The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria as "0" (not at all) to "3" (nearly every day).
Depression	Short Mood and Feelings Questionnaire 6 – 18 years Caregiver Report Self-Report	SMFQ ⇒ English ⇒ Spanish	The Short Mood and Feelings Questionnaire (SMFQ-short), child version, is an 13 item subscale from a longer 33-item questionnaire (the original MFQ). This instrument should be used an indicator of depressive symptoms and not as a diagnostic tool and therefore does not indicate whether a child or adolescent has a particular disorder. Diagnoses of mental disorder should only be made by a trained clinician after a thorough evaluation.
Depression	Center for Epidemiological Studies Depression Scale for Children 6 – 17 years Self-Report	CES-DC ⇒ English ⇒ Spanish	The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20 item self-report questionnaire for young people between the ages of 6 and 17. It asks young people to rate how many depressive symptoms they have experienced in the last week.
Depression	Quick Inventory of Depressive Symptomatology – Adolescent – (17 Item) – Clinician Rated 12 – 18 years Clinician Report	QIDS-A17-C ⇒ English ⇒ Spanish	The QIDS-A17-C is a 17-item clinician-reported depression measure, where a score of 6–10 indicates mild depression; 10–15, moderate depression; 16–20, severe depression; and ≥21, very severe depression

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AUTHORS:
McNitt, Cassidy, MD, Ryan Asherin, PhD, & Sandra Fritsch, MD

Diagnosis of Major Depressive Disorder

According to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), five or more of the symptoms listed below must be present during the same 2-week time period that represents changes in functioning. At least one symptom is either a depressed mood or loss of interest.

- Depressed mood most of the day, nearly every day, as indicated in the subjective report or in observation made by others
- Markedly diminished interest in pleasure in all, or almost all, activities most of the day and nearly every day
- Significant weight loss when not dieting or weight gain, for example, more than 5 percent of body weight in a month or changes in appetite nearly every day
- Insomnia or hypersomnia nearly every day
- Psychomotor agitation or retardation nearly every day
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness nearly every day
- Recurrent thoughts of death

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The ICD-10 classification of Mental and Behavioral Disorders developed in part by the American Psychiatric Association classifies depression by code. In typical, mild, moderate, or severe depressive episodes the patient suffers from lowering of mood, reduction of energy and decrease in activities. Their capacity for enjoyment, interest, and concentration is reduced and is marked by tiredness after even a minimum of effort is common. Sleep patterns are usually disturbed and appetite diminished along with reduced self-confidence and self-esteem. Final code selection should use specifiers based on severity (mild, moderate, severe) and status. Depending on the number and severity of the symptoms, a depressive episode may be specified as mild, moderate, or severe.

For **mild** depressive episodes two or three symptoms from the list above are usually present.

For **moderate** depressive episodes four or more of the symptoms noted above are usually present and the patient is likely to have great difficulty in continuing with ordinary activities.

For a classification of **in remission** the patient has had two or more depressive episodes in the past but has been free from depressive symptoms for several months. This category can still be used if the patient is receiving treatment to reduce the risk of further episodes. It will be based on the provider's clinical determination and documentation.

Coding for Major Depressive Disorder, single episode

- F32.0 Major depressive disorder, single episode, mild
- F32.1 Major depressive disorder, single episode, moderate
- F32.2 Major depressive disorder, single episode, severe without psychotic features
- F32.3 Major depressive disorder, single episode, severe with psychotic features
- F32.4 Major depressive disorder, single episode, in partial remission
- F32.5 Major depressive disorder, single episode, in full remission
- F33Major depressive disorder, recurrent

Coding for Major Depressive Disorder, recurrent

A recurrent depressive disorder is characterized by repeated episodes of depression without any history of independent episodes of mood elevation and increased energy or mania. There has been at least one previous episode lasting a minimum of two weeks and separated by the current episode of at least two months. At no time in the past has there been any hypomanic or manic episodes.

- F33.0 Major depressive disorder, recurrent, mild
- F33.1 Major depressive disorder, recurrent, moderate
- F33.2 Major depressive disorder, recurrent, severe without psychotic features
- F33.3 Major depressive disorder, recurrent, severe with psychotic features
- F33.4Major depressive disorder, recurrent, in remission
- F33.40 Major depressive disorder, recurrent, in remission, unspecified
- F33.41 Major depressive disorder, recurrent, in partial remission
- F33.42 Major depressive disorder, recurrent, in full remission

COPPCAP

CoPPCAP
Colorado Pediatric Psychiatry Consultation & Access Program

Depression Algorithm

CoPPCAP | Colorado Care Guide

Use DSM-5 criteria for diagnosis
• Irritability symptom acceptable & anhedonia as hallmark feature

Must have five or more of these symptoms in a two-week period -
• Depressed mood (can present as irritability in kids)
• Decreased interest or pleasure in usual activities
• Unintentional weight loss or weight gain
• Fatigue or decreased energy
• Slowed thoughts or physical movements
• Feelings of guilt or worthlessness
• Decreased concentration or indecisiveness
• Recurrent thoughts of death or suicide

Broadband Social Emotional Screening

Concern for Depression?

YES → Depression Narrowband Screen → Depression Management Plan → Depression Dx

NO → Continue with routine visit

Depression Dx: No → Consider Differential Dx → Continue with routine visit

Consider Differential Dx:
Anxiety Disorder
Mood disorder
ADHD
Trauma
Oppositional Defiant Disorder
Disruptive Mood Dysregulation Disorder
Adjustment Disorder
Substance Abuse
Language or Learning Disability
Anemia
Hypothyroidism
Vitamin D Deficiency
Autoimmue Disease

Mild:
• Educate parent and child
• Recommend lifestyle changes as indicatedncreased peer interactions, improved sleep hygiene, behavioral activation, exercise
• Reduce stressors as able
• Offer further resources for reading and education
• Follow up in 2-4 weeks to assess for improvement
• Consider referral for psychotherapy if not improving

Moderate or Severe:

Consider Psychotherapy
CBT or IPT
•Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) have strongest evidence base

First-line antidepressant used in children and adolescents
SSRIs
•Titrate up every week until maximum benefit

Check in every 1-2 weeks for first month to assess for side effects and stop if worsening anxiety, agitation, or suicidal thoughts

If no improvement in 4-6 weeks at therapeutic dose, increase dose, and if no change in 12 weeks (with dose increases), switch medication and consider consulting CoPPCAP

click the algorithm above to enlarge

AUTHORS:
McNitt, Cassidy, MD, Ryan Asherin, PhD, & Sandra Fritsch, MD

Options for Treatment: Psychotherapy

- Psychotherapy alone can be effective for mild to moderate depression. More severe depression is likely to require treatment with medication.
- If depression is not improving after six to twelve weeks of therapy, adding a medication should be considered.
- Consider regulatory functioning with sleep, diet, and exercise
- The two types of therapy shown to be most effective in treating depression in children and adolescents are **cognitive behavioral therapy (CBT)** and **interpersonal therapy (IPT)**
    - CBT is based on the idea that thoughts, feelings, and behaviors impact one another. Negative thoughts are believed to contribute to negative behaviors and depressed mood, which can contribute to more negative thoughts. CBT works by targeting patients' thoughts and behaviors to improve mood. Key components of CBT including increasing positive activities (behavioral activation), identifying and challenging negative thoughts (cognitive restructuring), and improving coping and problem-solving skills.
    - IPT is based on the idea that interpersonal problems can contribute to depressed mood. The goal of treatment is to address interpersonal problems that may be contributing to depressed mood by identifying problem areas in relationships and improving problem-solving and communication skills to build social supports.
- Other non-pharmacologic treatments that may be helpful in treating depression include:
    - DBT (dialectical behavioral therapy) – DBT is a manualized therapy originally developed for adults and more recently adapted for adolescents. DBT focuses on teaching mindfulness skills, emotional regulation, distress tolerance, and interpersonal effectiveness and has been shown to be effective in treating moderate to severe depression and self-harm and suicidal behaviors.
    - Family-based treatments, particularly attachment-based family therapy, which is a manualized treatment that focuses on promoting family connections and building on family strengths while also working to improve a child's success outside the home.
    - Promoting general wellness including encouraging exercise, which has shown to be effective by itself in reducing depression, engagement in prosocial activities, good sleep hygiene, and healthy eating

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Options for Treatment: Pharmacotherapy

- Medications are indicated for more severe depression or in depression that has not been responsive to psychotherapy alone
- Approximately 55-65% of children and adolescents will respond to an initial antidepressant trial
- SSRIs are typically the first-line pharmacologic treatment in children and adolescents
- Fluoxetine (Prozac) and Escitalopram (Lexapro) are the only FDA approved medications for use for depression in children and adolescents, though other antidepressant medications have been FDA approved for other indications and in common use for depression
- The most common side effects of SSRIs are gastrointestinal symptoms, headaches, agitation, sleep changes, irritability, motor restlessness (need to constantly move), and behavioral activation. These side effects are most likely to occur in the first 1-2 weeks after starting the medication, or when making dosage increases.
- Concerning side effects of SSRIs include serotonin syndrome and increased suicidal thoughts.
    - When discussing antidepressant medications with families, always provide education about the FDA black box warning for increased suicidal thoughts when used in children and adolescents. This warning is based upon a 2004 review 24 clinical trials of children and adolescents who had been prescribed antidepressants. No suicides occurred in any of these studies, but 4 out of 100 children taking antidepressants reported suicidal thoughts or behaviors while 2 out of 100 children not on medication reported suicidal thoughts or behaviors. As a result, the FDA applied the black box warning for increased suicidal thoughts to all antidepressant medications.
- Frequent check ins are recommended during the first month to monitor for development of side effects or suicidal thoughts. Medication should be stopped if patient develops intolerable side effects or suicidal thoughts during this period.
    - Consider phone calls directly or via support staff to monitor mood and functioning weekly when first starting medication
- SSRIs can be titrated weekly, as tolerated, to a therapeutic dose (see depression medication chart below)
- Patients may have to take SSRIs for 4-6 weeks at an effective dose before experiencing any reduction in depression symptoms

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- If no benefit after 4-6 weeks, increase dose. If no benefit after 12 weeks, switch to a different medication.

- Patients should continue medication for 6-12 months following resolution of symptoms
- When discontinuing antidepressant medications, taper slowly to minimize side effects (going down by the lowest titration increment every 1-2 weeks)

Depression Medications

SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRI'S)						
Drug Name	Dose Form	Usual Starting Dose	Increase Increment	RCT Evidence in Kids	FDA approved in kids?	Things to know
Citalopram (Celexa)	Tablet: 10/20/40mg Suspension: 10mg/5ml	10 mg daily	10 – 20 mg (40 mg max daily dose)	Yes	No	Risk for QT prolongation at doses above 40 mg
Escitalopram (Lexapro)	Tablet: 5/10/20mg Suspension: 1mg/1ml	5 mg daily	5 - 10 mg (20 mg max daily dose)	Yes	Yes (for 12 years and up)	**Second line,** lower risk for GI side effects and med interactions
Fluoxetine (Prozac)	Tablet: 10/20/40/60mg Suspension: 20mg/5ml	10 mg daily	10 – 20 mg (60 mg max daily dose)	Yes	Yes (for 8 years and up)	**First line**, long half-life
Fluxoxamine (Luvox)	Tablet: 25/50/100mg	25mg daily	50 – 200 mg			
Paroxetine (Paxil)	Tablet: 10/20/30/40mg Tablet CR: 12.5/25/37.5mg Suspension: 10mg/5ml		10 – 50 mg			
Sertraline (Zoloft)	25, 50, 100 mg 20 mg/mL	25 mg daily	25 – 50 mg (200 mg max daily dose)	Yes	No (FDA approved for use in kids with anxiety)	**Second line,** prone to GI side effects
NON-SSRI ANTIDEPRESSANTS						
Drug Name	Dose Form	Usual Starting Dose	Increase Increment	RCT Evidence in Kids	FDA approved in kids?	Things to know
Bupropion, Bupropion SR (Wellbutrin)	IR form: 75/100mg	37.5 – 75 mg daily	75 – 100 mg (typically BID or TID dosing, max dose 450	No	No	Can be activating. Avoid in eating disorders due to risk of

COPY

	SR form: 100/150/200mg XL form: 150/300/450mg	150 mg daily	mg daily for IR or 400 mg daily for ER) 150 mg (450 mg max daily dose)			lowering seizure threshold. Can have some benefit for ADHD symptoms
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100mg	25 – 50 mg daily	50 – 100 mg daily			
Duloxetine (Cymbalta)	Tablet: 20/30/40/60mg	20mg daily	40 – 60 mg daily			
Mirtazapine (Remeron)	7.5, 15, 30, 45 mg	7.5 mg daily	7.5 – 15 mg (45 mg max daily dose)	No	No	Sedating, stimulates appetite
Trazodone (Desyrel)	Tablet: 50/100/150/300mg	25 – 50 mg daily	100 – 150 mg daily			
Venlafaxine (Effexor)	IR form: 25/37.5/50/75/100mg ER form: 37.5/75/150/225mg	37.5 mg daily	37.5 – 75 mg (225 mg max daily dose)	No	No	Risk for withdrawal syndrome due to short half-life

CoPPCAP

Depression Management Plan

CoPPCAP developed a Depression Management Plan for use in Primary Care settings to help provide psychoeducation & actionable items providers, caregivers, and patients can take after depression screening.

Depression Action Plan For Primary Care Providers

Fill out this plan in collaboration with patients and their families, and keep for follow up. Give the pages that follow to patients and families to keep.

For: ________________________ Date: _______________ Provider: _____________________ Provider's Phone Number____________________

No/Mild Depression Concerns (PHQ-9 score 0 - 10)

- **Behavioral**: No new social withdrawal, new irritability,
- **Physical**: No poor appetite, fatigue, poor energy, sleep normal.
- **Cognitive**: No new concentration/focus issues, able to enjoy usual activities, hopes for future.
- **Impairment:** No disruptions to daily life (home, school, sports, other activities); can do *all* usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:______________________________

□ Get Active: ______________________________

□ Change your thoughts: ______________________________

□ Coping Strategies: ______________________________

□ Calm Your Body: ______________________________

Moderate Depression Concerns (PHQ-9 score 11- 15)

- **Behavioral**: Occasional social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical**: Occasional fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Occasional negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Some disruption to daily life (home, school, sports, other activities); cannot do *all* usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:______________________________

□ Get Active: ______________________________

□ Change your thoughts: ______________________________

□ Coping Strategies: ______________________________

□ Calm Your Body: ______________________________

Significant Depression Concerns (PHQ-9 score: 16 or higher)

- **Behavioral**: Pervasive social withdrawal, apathy, irritability, some signs of fear and/or distress.
- **Physical**: Pervasive fatigue, low energy, too much or too little sleep, unexplained physical complaints (headaches, stomach aches, vomiting, fatigue).
- **Cognitive**: Pervasive negative thoughts, difficulty with focus/concentration, loss of pleasure, beginning to have question of hope for the future.
- **Impairment:** Significant disruption in daily life (home, school, sports, other activities); child cannot do many usual activities.

My Depression Action Plan (Provider: Check one or more strategies discussed and follow up plan):

□ Learn the signs of depression:______________________________

□ Get Active: ______________________________

□ Change your thoughts: ______________________________

□ Coping Strategies: ______________________________

□ Calm Your Body: ______________________________

click the image above to access the full Depression Management Plan

Safety Assessment and Planning in Depressed Adolescents

- **Ask.** Providers and families should regularly ask about suicidal thoughts and behaviors.
- **Restrict means.** Providers should ask all families of depressed adolescents about access to potentially harmful items including firearms, other weapons, medications (prescription and over the counter), sharps objects like knives and razors, and items that could be used for strangulation like ropes and belts and recommend removing these items from the home or locking them up.
- **Monitor for risky or suicidal behaviors.** Watch for behaviors such as:
    - Expressing hopelessness
    - Expressing suicidal or self-harm thoughts
    - Behaving in an unusually impulsive or risky manner
    - Researching means of harming one's self
    - For young children, using death as a theme in play
    - Giving away possessions
    - Talking about being a burden to others
- **Watch for substance use.** Using substances including alcohol and drugs can make it more likely that a person with suicidal thoughts acts on those thoughts, so parents so closely monitor for substance use and remove any substances from their home.
- **Develop a crisis plan or safety plan.** Develop a plan with adolescents and their parents for what to do if they are in crisis or develop suicidal thoughts. This plan should include triggers that cause distress for the child, physical signs or behaviors that occur when they are in distress, ways parents or others can help them calm down or cope with the distress, ways they can help themselves cope, and other supports they can contact or utilize in a crisis including positive peers, supportive adults, and therapists. Local and national crisis lines and 911 can also be included.

CoPPCAP

Resources:

Crisis Hotlines:

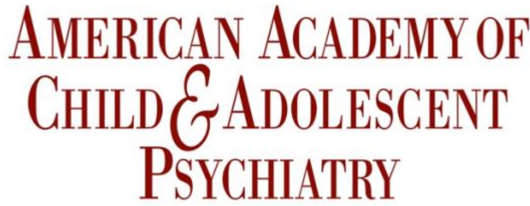
- National Suicide Prevention Lifeline - 1-800-273-8255
- National Suicide Hotline – 1-800-784-2433
- Colorado Crisis Services – 1-844-493-8255 (or text "Talk" to 38255)

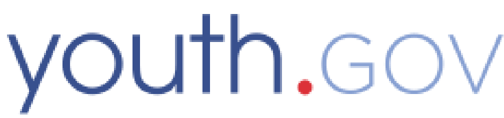
Books for Parents:

- Adolescent Depression: A Guide for Parents by Francis Mark Mondimore, MD and Patrick Kelly, MD
- The Childhood Depression Sourcebook by Jeffrey A. Miller, PhD

Helpful Apps:

- My3 – free app available in the apple app store and google app store that allows users to identify three contacts to have easy access to in a crisis, as well as update and review warning signs they are in a crisis and coping strategies they can use
- Mood Tools – free CBT-based app that provides information about depression, allows users to practice skills, and has places for documenting preferred coping skills and crisis plans for easy access in a crisis
- CBT Tools for Youth – CBT-based app developed specifically for youth to help them practice CBT skills and develop and record coping skills and safety plans. Has an associated cost.





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COPPCAP

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

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SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

ACKNOWLEDGEMENT: This instrument was developed by a committee composed of the following individuals: Chairman, Robert M.A. Hirschfeld, MD – University of Texas Medical Branch; Joseph R. Calabrese, MD – Case Western Reserve School of Medicine; Laurie Flynn – National Alliance for the Mentally Ill; Paul E. Keck, Jr., MD – University of Cincinnati College of Medicine; Lydia Lewis – National Depressive and Manic-Depressive Association; Robert M. Post, MD – National Institute of Mental Health; Gary S. Sachs, MD – Harvard University School of Medicine; Robert L. Spitzer, MD – Columbia University; Janet Williams, DSW – Columbia University and John M. Zajecka, MD – Rush Presbyterian-St. Luke's Medical Center.

[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.

Depression:
Parents' Medication Guide

American Academy of Child & Adolescent Psychiatry

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Table of Contents

Introduction 4

Causes and Symptoms 5

Diagnosing Depression in Children and Adolescents 6

Suicide and Youth with Depression 7

Treating Depression 8

Taking Medication for Depression 9

Psychosocial Treatments for Depression 13

Other and/or Unproven Treatments for Depression 14

Helping the Depressed Child 15

Introduction

The original Parents Medical Guide on treating depression was published in 2005, and a revision was published in 2010, through collaboration by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA). The current revision has been updated to include new research on effective treatments for child and adolescent depression. The goal of this guide is to help parents make informed decisions about getting the best care for a child or adolescent with depression.

What is depression?

Depression is a serious illness that can affect almost every part of a young person's life and significantly impact his or her family. Depression is a type of mood disorder that can damage relationships among family members and friends, harm school performance, and limit other educational opportunities. Depression can negatively affect eating, sleeping, and physical activity. Because it can result in so many health problems, it is important to recognize the signs of depression and get the right treatment. When depression is treated successfully, most children can get back on track with their lives.

Although depression can occur in young children, it is much more common in adolescents (youth ages 12–18 years). Depression before children reach puberty occurs equally in boys and girls. After puberty, depression is more common in girls.

Causes and Symptoms

Why does my child have depression?

We don't fully understand all the causes of depression; we think it's a combination of genetics (inherited traits) and environmental factors (events and surroundings). There is no single cause. Stressors or events that cause a stressful response and genetic factors can cause depression. Stressors can be triggers that result from pediatric illnesses and diseases, such as viral infections; diseases of the thyroid and endocrine system; head injury; epilepsy; and heart, kidney, and lung diseases. A family history of depression is a major genetic factor; a child can be more prone to becoming depressed if a parent or sibling has been diagnosed with depression. Stressors in everyday life also contribute to the development of depression, for example, the loss of a close loved one; parents frequently arguing, separating, or divorcing; school changes; and family financial problems. Finally, developmental factors, such as learning and language disabilities, are sometimes overlooked. Other mental illnesses and symptoms, such as attention-deficit/hyperactivity disorder (ADHD), anxiety, fears, and excessive shyness, in addition to not having opportunities to develop interests and show strengths and talents, can add to depression.

What are the symptoms of depression?

- Depressed, sad, or irritable mood
- Significant loss of interest or pleasure in activities
- Significant weight loss, weight gain, or appetite changes
- Difficulty falling asleep and/or staying asleep or sleeping too much
- Restlessness, unable to sit still (referred to as psychomotor agitation), or being slowed down (referred to as psychomotor slowing)
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate feelings of guilt
- Difficulties in concentrating or making decisions
- Constant thoughts of death, suicidal thinking, or a suicide attempt

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, an episode of major depression is characterized by 5 or more of these symptoms (with at least one of the symptoms noted as a depressed and/or irritable mood or having reduced interests or little pleasure) that have lasted for at least 2 weeks and affected a child's performance at school, at work, with family, or with friends. These symptoms are not caused by medication, drug abuse, or alcohol and are not the result of another medical or mental illness.

The symptoms of major depressive disorder (MDD) in youth and adults are the same. However, the symptoms of depression may look differently in children and adolescents than in adults. For example, children may have difficulty expressing their sad mood and may complain of headaches or stomachaches instead. Listed below are other ways that depression may look differently in youth:

- Irritable or cranky mood
- Boredom, giving up favorite activities, toys, and interests
- Failure to gain weight as expected
- Delays in going to sleep, refusal to wake up for school or get out of bed
- Difficulty sitting still or very slowed movements
- Tired all the time, feeling "lazy"
- Self-critical or blaming self for everything
- Decline in school performance, failing grades or classes
- Frequent thoughts and discussion about death, giving away favorite belongings

How do the symptoms of depression differ from typical sadness?

It is normal for children and adolescents to feel sad sometimes or be irritated in response to stressors. Depression is different from occasional sadness. A child or adolescent with depression has a significant **change** in their typical mood and interest level and is persistent (ie, most of the time for several weeks). Youth with depression show symptoms that are significant enough to cause them problems at home, at school, and/or with friends and family. Youth with depression may report that their symptoms are in response to a stressful or upsetting event, or they may not know what caused them to feel this way.

Diagnosing Depression in Children and Adolescents

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor.

How is depression in children and adolescents diagnosed?

If you are concerned that your child is depressed, it's important to discuss this with your child's doctor. Your child's doctor may recommend a thorough assessment. A thorough assessment includes getting information about the degree and severity of symptoms, psychosocial stressors and functioning from the child, parent, caregiver and/or guardian who lives with the child and reports from the school.

This assessment should be done by someone with experience in evaluating children for mental illness, such as a child and adolescent psychiatrist. A child and adolescent psychiatrist is a doctor who specializes in the diagnosis and treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents and their families. Child and adolescent psychiatry training requires four years of medical school, at least three years of residency training in general psychiatry with adults, and two years of additional specialized training in treating children, adolescents and families.

A medical history and physical exam, as well as a detailed history of biologically related family members, are also recommended to rule out or identify other co-existing medical and mental health conditions that may require treatment.

What other conditions can accompany depression?

Up to 50% of children and adolescents diagnosed with depression may have other mental health disorders, including bipolar disorder. Children and adolescents with depression may also have anxiety, ADHD, and learning differences or be at risk of abusing drugs or alcohol.

Suicide and Youth with Depression

Youth with depression are at increased risk for suicide attempts and suicide. It is important to ask your child whether they are having thoughts about hurting themselves. If your child expresses suicidal thoughts, this is an opportunity to discuss taking precautions to make the child's environment safe. Talking with your child about suicide does not cause suicide, but it does let your child know that you are concerned and that you want to know whether they have any thoughts about it.

How common are suicidal thoughts, behaviors, and death by suicide in youth?

Among students in grades 9–12 in the United States in 2015, 18% reported seriously considering attempting suicide in the previous 12 months, whereas 15% actually made a suicide plan. Nine percent of students attempted suicide one or more times, and 3% made an attempt that resulted in an injury, poisoning, or an overdose that required medical attention.

In 2015, suicide was the third leading cause of death among youth between the ages of 10 and 14 years and the second leading cause of death among individuals between the ages of 15 and 34 years. Suicide claims more lives than many diseases in children and adolescents. More adolescents and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

What factors other than depression may increase suicide risk?

Additional risk factors for suicide include having a family member who died by suicide or knowing someone else who died by suicide. Other factors include family conflict, sleep problems, substance use, school problems, impulsivity, other mental illnesses, not feeling connected to others, and easy access to lethal means of self-harm.

Do antidepressant medications increase the risk of suicide?

Determining whether antidepressant medications increase the risk for suicide is quite hard, particularly because children and adolescents with depression are more likely to think about suicide and attempt it than other children. With this concern, the FDA (US Food and Drug Administration) reviewed all published and unpublished clinical trials of antidepressants in children and adolescents, and in 2004, it issued a black box warning about an increased risk of suicidal thoughts and/or behaviors in youth who take antidepressants. There was no record of completed suicides in their review of over 2,000 youth who were treated with antidepressant medications, but the rate of suicidal thinking/behavior (including actual suicide attempts) was twice as high in youth taking medications (4%) than those taking placebo or sugar pills (2%).

Treating underlying depression in youth who are thinking about suicide is an important strategy, because antidepressant medications improve depressive symptoms, which is the best way to treat suicidal thoughts and behavior. Antidepressant medication may increase the risk for suicidal thoughts and/or behaviors in a small percentage of youth. If a doctor determines that medication is appropriate for your child, it is important to weigh the pros and cons of antidepressants. If your child has moderate to severe depression, the benefit of reducing depressive symptoms may outweigh the risks of medication side effects. Maintaining regular follow-ups and monitoring throughout treatment helps manage any uncertainty. It is important that your child be monitored closely for all side effects, including suicidal thinking and behavior, particularly in the first few weeks after beginning treatment with an antidepressant and after adjusting the antidepressant dose.

Treating Depression

A single episode of depression, if left untreated, often lasts from 6 to 9 months, which can be an entire school year for most children.

The first step to treatment is a thorough assessment. Once your child has been diagnosed with depression, there are several important factors to consider before moving forward with treatment. It is important to get as much information as possible from your child's doctor on effective treatment options, potential side effects, and treatment expectations. You and your child should have the opportunity to ask questions about treatment options before you make a decision about your child's care.

It is important to share with your child's doctor your understanding of depression and related treatment options. Family values and norms—which can be heavily influenced by ethnicity and culture—may play a role in decision making regarding your child's wellness.

If your child's depression is not so severe or does not significantly impair his or her functioning and they do not have suicidal thoughts or psychosis, your child's doctor may recommend active support and monitoring. During a period of active support and monitoring, it is important for your child to have positive interactions with peers, to exercise, to follow a healthy diet, and to practice good sleep patterns. It is also important to reduce stressors, if possible. If your child's depressive symptoms get worse or do not improve, his or her doctor may recommend that you consider specific treatment, such as psychotherapy and/or antidepressant medications for your child.

The primary goals of treatment are as follows: 1) to shorten the duration of your child's depressive episode; 2) to provide treatment until your child's symptoms are in remission (having minimal or no depressive symptoms); and 3) to prevent relapse or recurrence (a return of depressive symptoms).

Will my child's depression pass without treatment?

A single episode of depression, if left untreated, often lasts from 6 to 9 months, which can be an entire school year for most children. When left untreated, the consequences can be serious, including a high risk for substance abuse, eating disorders, teenage pregnancy, and/or suicidal thinking and behaviors. Suicide attempts and completed suicide are risks of untreated depression. Children with untreated depression are also likely to have ongoing problems in school, at home, and with their friends; it can also lead to a higher risk of developing a more chronic, difficult-to-treat form of depression.

Taking Medication for Depression

Are medications effective for depression in youth?

Antidepressant medications can be effective in relieving depressive symptoms in children and adolescents. Approximately 55–65% of children and adolescents will respond to initial treatment with antidepressant medication. Of those who don't respond to the first treatment, a high number will respond to another medication and/or a different form of therapy, such as cognitive-behavioral therapy (CBT) or dialectical behavior therapy (DBT).

What types of medications are available to treat my child's depression?

To date, fluoxetine [a selective serotonin reuptake inhibitor (SSRI), also known as Prozac] is the only antidepressant approved by the FDA for the treatment of depression in both children and adolescents (ages 8 years and older). Escitalopram (an SSRI also known as Lexapro) is approved by the FDA for the treatment of depression in adolescents (ages 12 years and older). No other antidepressants have been approved by the FDA for the treatment of depression in youth, although some have been approved for the treatment of other mental health conditions. Your child's doctor may prescribe other antidepressant medications that are not FDA approved based on available data. You should know that prescribing an antidepressant that has not been approved by the FDA for use in children and adolescents (referred to as off-label use or prescribing) is common and is consistent with accepted clinical practice.

Factors that might influence a doctor's choice(s) of medication include, but are not limited to, specific characteristics of the patient, comorbid or coexisting mental or medical conditions, and patient or parent/caregiver's preference for treatment with medication, psychotherapy, or combined psychotherapy and medication treatment.

Selective Serotonin Reuptake Inhibitors (SSRIs)

Medications called SSRIs are the first-line treatment for youth with depression.

SSRIs work by increasing the levels of serotonin in the brain. Serotonin is a neurotransmitter that sends signals between brain cells. It is common to experience side effects from SSRIs right after beginning treatment; it can take up to 4 to 6 weeks of taking an SSRI regularly for the medication levels in the brain to be steady enough to decrease the symptoms of depression. SSRIs are also used for treating conditions other than depression, such as anxiety disorders.

The table on page 10 includes the most commonly used SSRIs for youth with depression.

Other Antidepressants

Although SSRIs are usually the first choice of medication for children and adolescents with depression, your doctor may recommend different types of medications if in certain circumstances, such as your child does not improve with an SSRI. These medications have unique qualities that make them effective, some of which involve serotonin and other neurotransmitters. The table on page 10 includes non–SSRI antidepressants that are approved by the FDA for adults with depression and are often prescribed for youth with depression in clinical practice.

Other prescribed antidepressant medications, such as tricyclic antidepressants (TCAs, eg, imipramine and amitriptyline) and older monoamine oxidase inhibitors [MAOIs, eg,

Medications called SSRIs are the first-line treatment for youth with depression.

SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Medication	Formulations	Daily Dose Range
Citalopram (Celexa)	Tablet: 10/20/40 mg Suspension: 10 mg/5 ml	10–40 mg
Escitalopram (Lexapro)*	Tablet: 5/10/20 mg Suspension: 1 mg/1 ml	10–20 mg (initial dose may be 2.5–5 mg)
Fluoxetine (Prozac)**	Tablet and capsule: 10/20/40/60 mg Suspension: 20 mg/5 ml	20–60 mg (initial dose may be 10 mg)
Fluvoxamine (Luvox)	Tablet: 25/50/100 mg	50–200 mg (initial dose may be 25 mg)
Paroxetine (Paxil)	Tablet: 10/20/30/40 mg Tablet CR: 12.5/25/37.5 mg Suspension: 10 mg/5 ml	10–50 mg
Sertraline (Zoloft)	Tablet: 25/50/100 mg Suspension: 20 mg/ml	50–200 mg (initial dose may be 12.5–25 mg)

Note: CR = controlled release
**FDA approved for children age 12 and up.*
***FDA approved for children age 8 and up.*

NON–SSRI ANTIDEPRESSANTS

Medication	Formulations	Daily Dose Range
Bupropion, Bupropion SR (Wellbutrin)	Tablet: 75/100 mg Tablet ER 12 hour: 100/150/200 mg	150–300 mg (first dose may be 37.5–75 mg)
Bupropion XL (Wellbutrin)	Tablet ER 24 hour: 150/300/450 mg	150–450 mg
Desvenlafaxine (Pristiq)	Tablet ER 24 hour: 25/50/100 mg	50–100 mg (first dose may be 25–50 mg)
Duloxetine (Cymbalta)	Tablet: 20/30/40/60 mg	40–60 mg (first dose may be 20 mg)
Levomilnacipran (Fetzima)	Capsule ER 24 hour: 20/40/80/120 mg	40–120 mg (first dose may be 20 mg)
Mirtazapine (Remeron)	Tablet: 7.5/15/30/45 mg Tablet disintegrating: 15/30/45 mg	15–45 mg (first dose may be 7.5–15 mg)
Trazodone (Desyrel)	Tablet: 50/100/150/300 mg	100–150 mg (first dose may be 25–50 mg)
Venlafaxine XR (Effexor)	Tablet: 25/37.5/50/75/100 mg Capsule and Tablet ER 24 hour: 37.5/75/150/225 mg	150–300 mg (first dose may be 37.5 mg)
Vilazodone (Viibryd)	Tablet: 10/20/40 mg	15–40 mg (first dose may be 10 mg)
Vortioxetine (Trintellix)	Tablet: 5/10/20 mg	20 mg (first dose may be 10 mg)

Note: SR = sustained release, ER = extended release, XL = extended release, XR = extended release

phenelzine (Nardil) and tranylcypromine (Parnate)], are not recommended as a first-line treatment for youth with depression because they have not been proven to be effective and have negative side effects. A newer MAOI called selegiline (Emsam) appears to be as good as other antidepressants in treating adults with depression, with few negative side effects. Although selegiline was not shown to be effective in treating adolescents with depression, it was safe and well tolerated in a recent study.

Sometimes more than one antidepressant medication may be prescribed for a youth who has shown only partial response to initial treatment, has lingering symptoms, or has not responded to treatment. Other types or classes of medications, particularly mood stabilizers and atypical antipsychotic medications, may also improve the effects of antidepressant medications, but they are not used as often because of the risk of more serious side effects like weight gain, obesity, and metabolic syndrome.

Side Effects

The most common side effects of SSRIs are as follows:

- gastrointestinal symptoms (nausea, stomachaches, and/or diarrhea)
- headaches
- agitation
- sleep disturbance
- irritability
- activation

Sexual side effects, increased bruising and/or bleeding, and mania are also possible, although they are less common side effects of SSRIs. The most common side effects of non–SSRI antidepressants vary quite a bit among the individual medications. If your child has been prescribed a non–SSRI antidepressant, you should ask your child's doctor about the side effects that are specific to that medication.

Some side effects may be managed easily. For example, if your child experiences the side effect of sleepiness throughout the day, it may be wise to take the antidepressant at bedtime, or if your child experiences nausea as a side effect, it might be helpful to take the antidepressant with meals. If your child experiences side effects from one SSRI, they will not necessarily experience the same side effects from all SSRIs, so it is important for you and your child to discuss all of their side effects with their doctor. It is important to contact your child's doctor immediately if your child experiences any unusual change in behavior at any time after starting treatment with an antidepressant.

Serotonin syndrome is a rare but serious potential side effect of SSRIs. Serotonin

syndrome occurs when high levels of serotonin accumulate in the body, and it most often happens when a person is taking more than one medication that affects the serotonin level. Symptoms of serotonin syndrome may include fever, confusion, tremor, restlessness, sweating, and increased reflexes.

Other medications, in addition to those that affect serotonin, can interact with SSRIs and other antidepressants and cause problems. Therefore, it is very important that you tell your child's doctor about all the medications and supplements that your child takes. It is also important to discuss with your child's doctor any new supplements or over-the-counter medications or medications prescribed to your child by other doctors before taking those medications.

How can I help monitor my child during treatment?

Because some youth have adverse physical and/or emotional reactions to antidepressants, parents should pay attention to any signs of increased anxiety, agitation, aggression, or impulsivity. Parents should also check their children for involuntary restlessness or unexplained happiness or energy accompanied by fast, driven speech, and unrealistic plans or goals. These reactions are more common at the start of treatment, but they can occur at any time during treatment. If your child shows any of these symptoms or any other concerning changes in behavior, consult your child's doctor immediately, because it may be necessary to adjust the dose, change to a different medication, or stop using the medication.

The following precautions for suicide prevention should be put into place if a child or any other family member has depression:

- Dangerous means of suicide, such as guns, should be removed from the home, and potentially dangerous medications, including over-the-counter drugs like acetaminophen (Tylenol) should be locked away.
- You should work with your child's doctor or other mental health provider to develop an emergency safety plan, which consists of a planned set of actions for you, your child, and your child's doctor to take if your child has more thoughts of suicide. This should include access to a 24-hour crisis phone number available to deal with such crises.
- If your child expresses new or more frequent thoughts of wanting to die or self-harm or takes steps to do so, you should implement the safety plan and contact your child's doctor immediately.

How do I know if my child's medication is working?

You may notice that your child's medication is working if your child's depressive symptoms (mood, interest, appetite, sleep, concentration, or suicidal thinking/behavior) improve or if they are functioning better at school, at home, or with peers. Your child's doctor will know whether your child's medication is working by collecting information from

you, your child's school team, and your child through clinical assessments and self-reports and parent questionnaires and other reports.

It is important for your child to have more frequent visits with their doctor soon after they start their treatment with an antidepressant. More frequent visits early in treatment and during times of antidepressant medication dose adjustments will allow your child's treatment provider to address any concerns about treatment response or side effects and to monitor your child for suicidal thinking and behavior.

What can be done if my child's depression is not improving on medication?

Depending on the specific antidepressant that your child is taking, it may take 4–6 weeks of treatment before your child's depressive symptoms begin to show improvement. This may be the case, even if your child started to have side effects shortly after taking an antidepressant for the first time. If your child's depressive symptoms have not improved after taking an antidepressant regularly for 4–6 weeks, their doctor may consider increasing the antidepressant dose. An appropriate trial of an antidepressant may last up to 12 weeks. If your child's depressive symptoms have not responded to an adequate trial of an antidepressant or if your child experiences unacceptable side effects from an antidepressant, their doctor may recommend switching to a different antidepressant or adding an additional antidepressant.

When a child or adolescent fails to respond to treatment with an SSRI, it is extremely important to understand why and address the cause. In addition to problems with finding the right dose or the duration of medication therapy, nonresponse may be the result of a number of other factors, including wrong diagnosis, another medical illness, extreme stress, poor management of comorbid mental conditions, or not properly following the instructions on taking the medication. If your child does not respond to a first SSRI, your child's doctor might recommend a second SSRI. Research has shown that approximately half of youth who don't respond to one SSRI will still respond to a second SSRI. If your child does not respond to a second SSRI, non–SSRI antidepressants are then considered.

Once my child is well, how long do they need to continue taking medication?

If your child responds to treatment with an antidepressant, which is when depressive symptoms are reduced by 50% or more, it is recommended that they continue taking antidepressants for 6–12 months after achieving this response. Youth who don't continue treatment, especially if they still have leftover symptoms, are at increased risk of sinking back into depression.

Six to 12 months after responding to treatment, stopping antidepressants medication may be the right choice for some youth. Stopping antidepressant treatment should be done only under the care and monitoring of your child's doctor. Youth who stop taking antidepressants should be reassessed by their doctor within 1–2 weeks to check for any withdrawal effects and/or return of depressive symptoms.

Psychosocial Treatments for Depression

What treatments other than medication are available to help my child's depression?

There is a great deal of scientific support showing the effectiveness of psychosocial treatments for youth with depression. Cognitive-behavioral therapy (CBT), interpersonal therapy (IPT), and attachment-based family therapy are several examples.

Cognitive-behavioral Therapy

CBT is the most widely studied psychotherapy for the treatment of youth with depression. CBT is a form of psychotherapy that targets thoughts and behaviors that are related to mood. The individual is taught to identify patterns of thinking and behavior that add to their depressed mood. CBT may be used as a form of treatment by itself, or it can be combined with antidepressant medication. There is some evidence that CBT is most effective when combined with antidepressant therapy, particularly for adolescents with more severe depression or in those with treatment-resistant depression. Pediatric guidelines say that CBT alone may be an appropriate first-line treatment for those with mild depression.

Interpersonal Psychotherapy

Although there are fewer clinical trials of IPT compared with CBT, IPT is a well-established intervention in adolescents. IPT works by focusing on improving relationships with friends and family, increasing social support, and improving problem-solving skills.

Family-based Treatment

Studies involving family therapy are more difficult to evaluate because of the diversity of interventions. However, one treatment model—attachment-based family therapy—has been manualized, meaning that therapists follow the same process, and it has been shown to be effective in studies. This intervention, which promotes family alliances and connection, builds on family strengths and also improves the adolescent's success outside of the home.

Dialectical Behavior Therapy

DBT, originally developed in adults, has recently been adapted for adolescents. It has been proven to be effective in treating moderate to severe depression and co-occurring disorders, along with self-harm and suicidal behaviors. It was originally based on CBT but it also includes strategies for controlling emotions and handling stressful situations.

Supplementary Interventions

Other work has focused on using high-dose exercise programs to reduce depressive symptoms, improve mood, and reduce relapse into depression. Studies have shown that exercise can be an effective way to treat depression. Furthermore, interventions that improve sleep can also be used to improve depressive symptoms. Motivational interviewing strategies can be used to improve adolescents' participation with all interventions and improve their desire to stick with the treatment program.

Although there is little research to support its use to treat depression in children and adolescents, psychodynamic psychotherapy may be a helpful part of an individualized treatment plan for some youth.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health. Strategies focus on youth participating in activities that develop self-confidence or a sense of purpose, increase feeling connected with other people, and foster gratitude or willingness to help others.

Promoting wellness and emotional resilience, not just reducing depressive symptoms, is an overall goal of positive mental health.

Other and/or Unproven Treatments for Depression

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression. In addition, these supplements are not regulated by the FDA or any other agency. If you are considering giving your child herbal supplements, always check with the doctor as supplements may interact with prescribed medications.

There are treatments for MDD in youth that are currently being studied under the oversight of the FDA, including esketamine and transcranial magnetic stimulation (TMS). These treatments may or may not be available in your area. Youth who do not improve clinically during other stages of treatment may be candidates for such interventions. Before starting new or investigational treatment, your child's doctor may consider conducting a reassessment to determine whether the initial diagnosis was correct, evaluate whether there are ongoing or unrecognized comorbid disorders, and assess how well psychosocial interventions are being implemented.

Several herbal supplements on the market (eg, St John's Wort, etc.) may claim to treat symptoms of depression; however, it is important to understand that there is little scientific research showing that these supplements work in treating depression.

Helping the Depressed Child

What is my role in my child's treatment?

Provide Support and Reduce Stress

It is important to remember that depression is an illness, and you will need to provide support, avoid blame, and reduce as much stress as possible for your child. It will be necessary to work with your child to review their current schedule and/or activities to determine what might need to be adjusted. It may be necessary to modify your expectations for your child, at least until symptoms improve. When disciplining or punishing your child, don't deny them access to things that make them happy or help them cope (eg, don't take away access to friends or extracurricular activities, if possible). As needed, work with and involve school professionals to adjust academic workloads, pace, and expectations. Communicate to the teachers and other school staff that your child suffers from mental health challenges and that from time to time they may require special accommodations for learning and/or interaction with peers. Assumptions about what your child can manage in school, based only on periods of good moods (also known as euthymia), should be strongly avoided.

Help Teenagers Practice New Skills and New Ways of Thinking

It is important to be involved in your child's treatment. This includes knowing the new skills/strategies that your child is learning in treatment. Parents can help to model these skills at home and point out opportunities to practice and apply them in the home setting. Some therapists envision the parents' role as serving as a "coach" to help with learning these strategies and extending them to other settings.

Reduce Negative Emotion in the Home (Sarcasm, Criticism)

Having family members in the home who suffer from depression can be challenging. It is important to avoid criticism and blame. While your child is depressed you may consider calling a truce on "hot topics" or subjects that can lead to high conflict and disagreement. Finding activities that the family can do together to promote positive emotions and increase activity level can be helpful. Parents may seek out parent psychoeducation or couples therapy, and you may check to see whether parent coaching is available in the community. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Because childhood or adolescent depression affects the whole household, all family members can benefit from supportive treatment.

Develop Communication Strategies

When there is conflict and when emotions are high, developing a solid communication plan is recommended. An "exit and wait" strategy to allow family members to gain control of their emotions can help to manage difficult communication and conflict.

Participate in Safety Plan; Keep Environment Safe

A safety plan that includes strategies for managing mood, getting support, and knowing when to get professional help is important. In addition, making the environment safe by removing all access to dangerous tools, such as medications, knives or other blades, weapons, and firearms, is an essential part of treating youth with depression.

Monitoring Social Media, Peer Influence, Social Stress

Youth who are depressed can be especially vulnerable to social media and conflict with peers. Teenagers may see others as having more friends or more fun than themselves, which may make them feel even more excluded or not liked by others. Constantly checking social media sites to make sure that they haven't been left out can be a source of stress for youth. Parents need to be vigilant and aware of the impact of social media and peers on their child. Protective monitoring, such as having guidelines and rules for using technology, is important. Technological tools, such as parental control software, to control and monitor use of media are more and more available and may be needed for youth who are negatively affected by social media and/or cyberaggression or cyberbullying by their peers.

Is there anything else that I can do to help my child?

It's important for parents and caregivers to practice self-care. Find support and learn more about what's going on with your child so that you can be as effective as possible in helping them get the care they need. The National Alliance on Mental Illness (NAMI), Depression and Bipolar Support Alliance (DBSA), and other mental health organizations offer a variety of options for support and information. Depression tends to run in families, so it's important to know that if anyone else in the family is experiencing symptoms of depression, they need to also seek treatment.

Resources

- American Academy of Child & Adolescent Psychiatry (AACAP) https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx
- National Alliance on Mental Illness (NAMI) https://www.nami.org/Find-Support/Family-Members-and-Caregivers
- Depression and Bipolar Support Alliance (DBSA) http://www.dbsalliance.org/site/PageServer?pagename=home
- National Institute of Mental Health (NIMH) https://www.nimh.nih.gov/health/publications/teen-depression/index.shtml

  https://www.nimh.nih.gov/health/publications/depression-what-you-need-to-know/index.shtml
- Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/childrensmentalhealth/depression.html

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Books/Intellectual Property: Guilford Press; Cambridge University Press; Elsevier

Co-owner of a copyrighted diagnostic questionnaire: Before School Functioning Questionnaire (BSFQ)

Licensing agreement: Ironshore Pharmaceuticals Inc.

Research Funding: National Institute on Drug Abuse

Medication Tracking Form

Use this form to track your child's medication history. Bring this form to appointments with your provider and update changes in medications, doses, side effects and results.

Date	Medication	Dose	Side Effects	Reason for keeping/stopping

AMERICAN ACADEMY OF
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PSYCHIATRY

WWW.AACAP.ORG

3615 Wisconsin Avenue, NW | Washington, DC 20016-3007 | www.aacap.org

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Additional Resources for Depression

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Bipolar-Disorder-In-Children-And-Teens-038.aspx

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/The-Depressed-Child-004.aspx

Collaborative Care Implementation and Delivery

Lessons Learned from Across the Nation

November 8, 2024

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MENTAL HEALTH
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Our Team Presenting Today

Roshni L. Koli, MD

Chief of Staff

Sulamita Camargo

Senior Director of Finance
Health Systems Integration

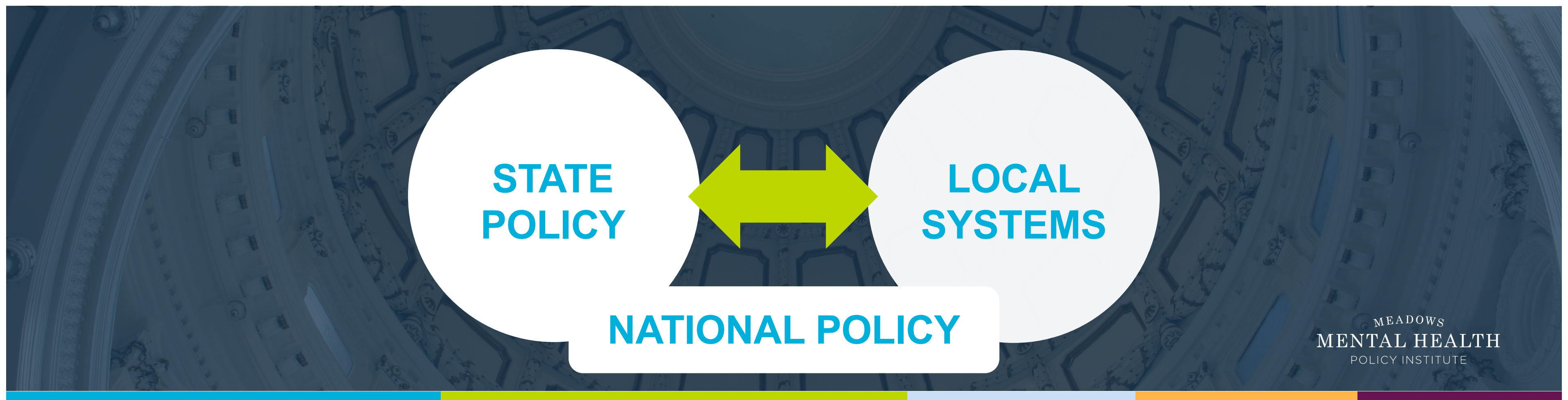
Agenda

- **MMHPI Background**
- Overview of the Collaborative Care Model
- Roshni’s Section Continued
- Understanding Coverage and Reimbursement
- Barriers and Challenges to Implementation and Delivery
- Policy Advocacy and Other Recommendations
- **Practice Transformation Outcomes**

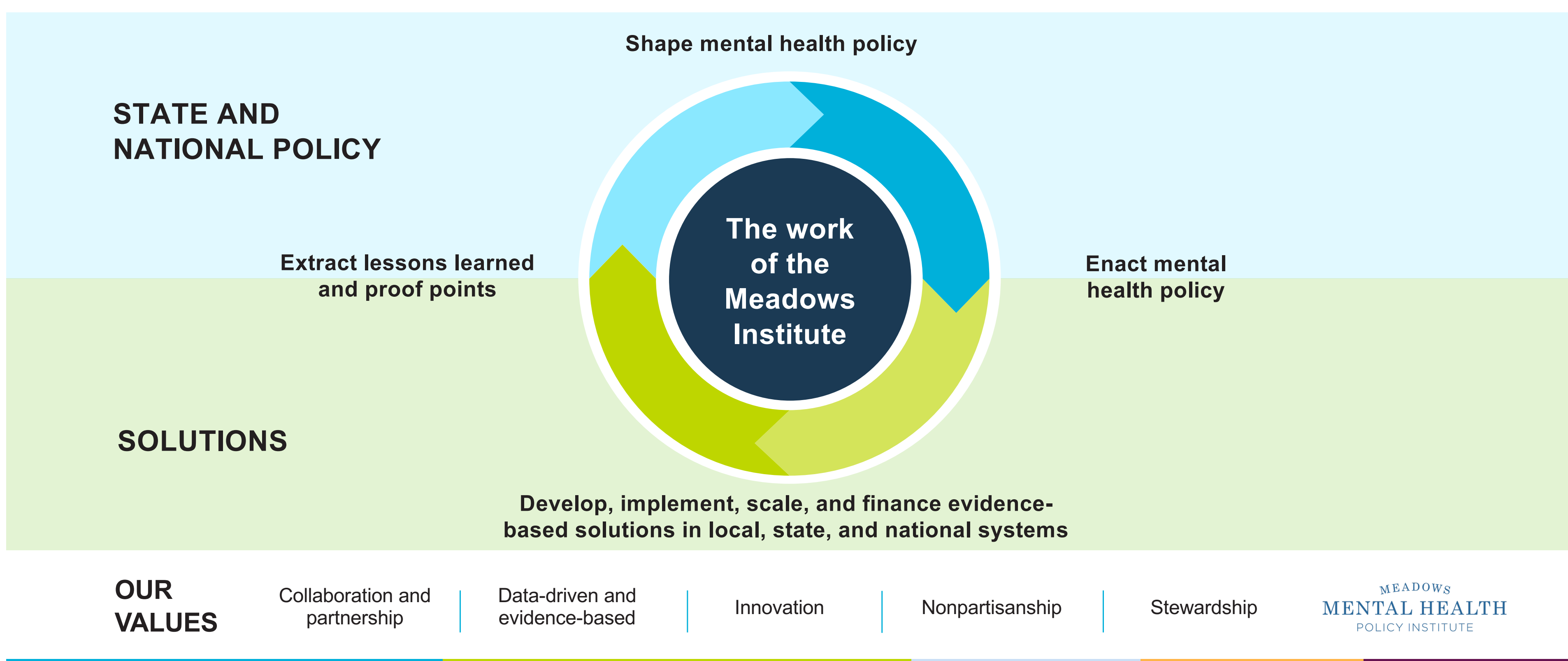
Vision, Mission, Core Change Strategy

Vision: We envision Texas to be the national leader in treating people with mental health needs.

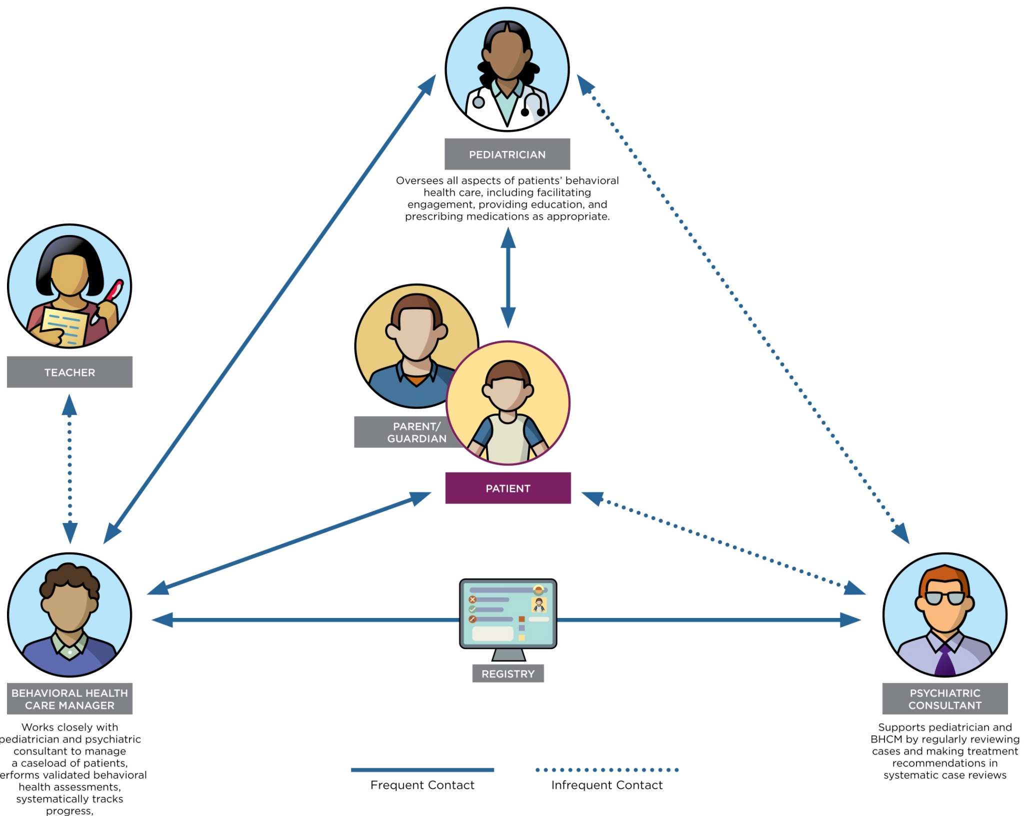
Mission Statement: Independent and nonpartisan, the Meadows Mental Health Policy Institute works at the intersection of policy and programs to create equitable systemic changes so all people in Texas, the nation, and the world can obtain the health care they need.



Our Unique Value: Intersection of Policy & Programs



Collaborative Care Model



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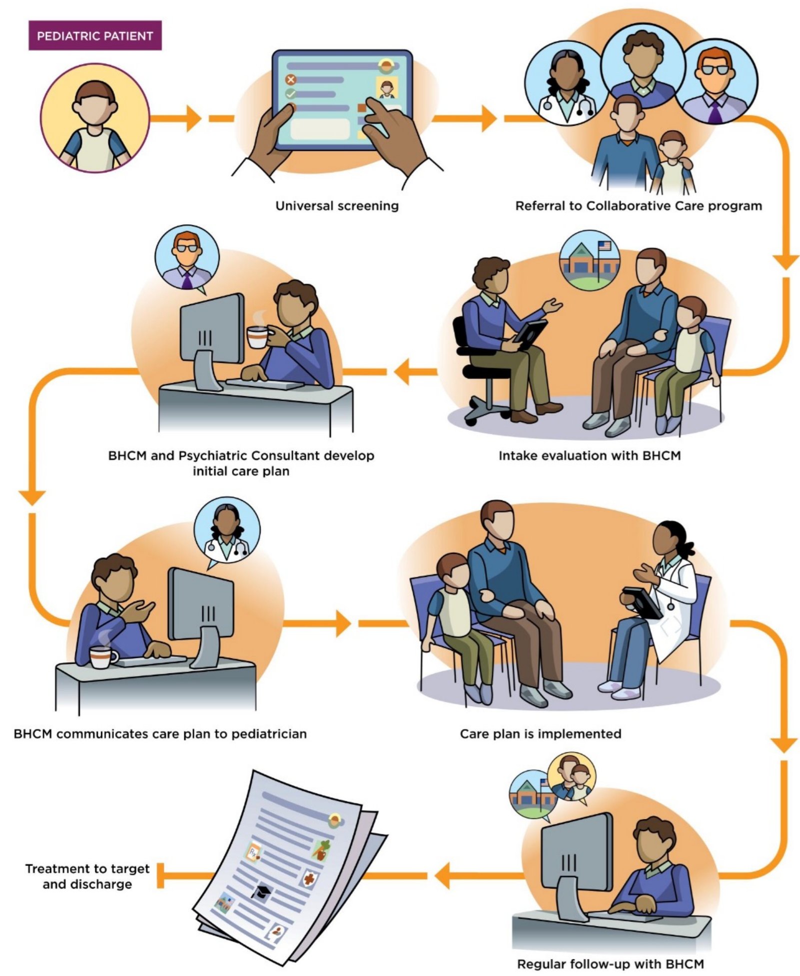
Collaborative Care Workflow



Pediatric CoCM Supporting Evidence

Depression

- Richardson et al, 2014
- RCT
- Ages 13-17
- Comparison group - usual care (test results + follow-up info to parents + pediatrician)
- CoCM group with greater improvement in depression symptoms at 12 months

Research

Original Investigation

Collaborative Care for Adolescents With Depression in Primary Care

A Randomized Clinical Trial

Laura P. Richardson, MD, MPH; Evette Ludman, PhD; Elizabeth McCauley, PhD; Jeff Lindenbaum, MD; Cindy Larison, MA; Chuan Zhou, PhD; Greg Clarke, PhD; David Brent, MD; Wayne Katon, MD

IMPORTANCE Up to 20% of adolescents experience an episode of major depression by age 18 years yet few receive evidence-based treatments for their depression.

OBJECTIVE To determine whether a collaborative care intervention for adolescents with depression improves depressive outcomes compared with usual care.

Editoria

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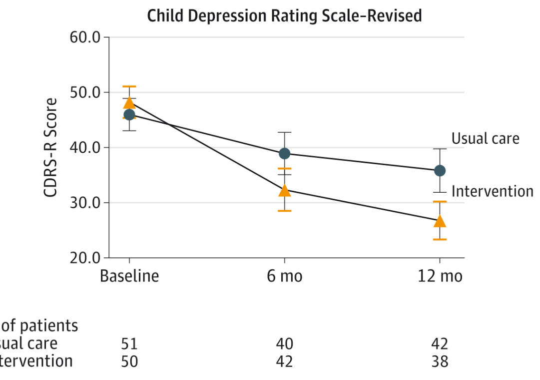
Figure 2. Mean CDRS-R and CIS Scores Over Time in Intervention vs Control Youth



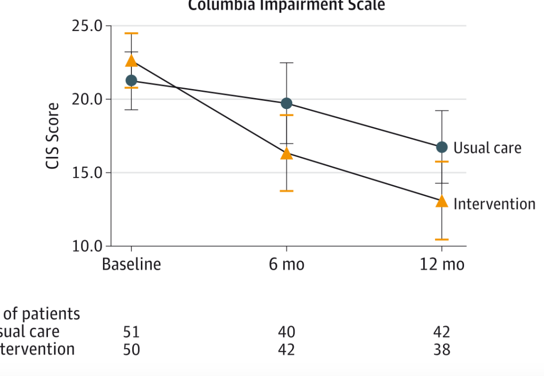


Table 2. Intervention vs Control Differences in Depressive Symptoms and Functional Impairment on 20 Multiple Imputation Samples (N=101)

	CDRS-R Score		CIS Score	
	β (95% CI)	*P* Value	β (95% CI)	*P* Value
Group				
Usual care	1 [Reference]		1 [Reference]	
Intervention	2.2 (−1.7 to 6.2)	.27	1.4 (−1.3 to 4.0)	.30
Time				
Baseline	1 [Reference]		1 [Reference]	
6 mo	−7.1 (−10.4 to −3.9)	<.001	−1.7 (−4.6 to 1.2)	.24
12 mo	−11.4 (−15.2 to −7.5)	<.001	−5.0 (−7.8 to −2.1)	.001
Group × month				
Intervention × 6 mo	−8.5 (−13.4 to −3.6)	.001	−4.4 (−8.4 to −0.5)	.03
Intervention × 12 mo	−9.4 (−15.0 to −3.8)	.001	−4.3 (−8.3 to −0.3)	.04

ADHD

- Silverstein et al, 2015
- Randomized comparative effectiveness
- Ages 6-12
- Compared basic versus enhanced CoCM – enhanced BHCMs had additional training on refractory ADHD sx
- Children in the enhanced care arm experienced better symptom trajectories

Collaborative Care for Children With ADHD Symptoms: A Randomized Comparative Effectiveness Trial

Michael Silverstein, MD, MPH[a], L. Kari Hironaka, MD, MPH[a], Heather J. Walter, MD, MPH[b], Emily Feinberg, ScD[a,c], Jenna Sandler, MPH[a], Michelle Pellicer, MPH[a], Ning Chen, MA[a], Howard Cabral, PhD, MPH[d]

abstract

OBJECTIVES: Although many attention-deficit/hyperactivity disorder (ADHD) care mod been studied, few have demonstrated individual-level symptom improvement. We s test whether complementing basic collaborative care with interventions that address reasons for symptom persistence improves outcomes for children with inattention hyperactivity/impulsivity.

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TABLE 4 Multivariable Symptom Change Models

Outcome	Difference in Symptom Score Between Enhanced and Basic Collaborative Care Groups			
	6 mo n = 146		12 mo n = 142	
	Mean Difference (95% CI)	Effect Size	Mean Difference (95% CI)	Effect Size
Main effects				
SNAP inattention score	0.00 (–0.21 to 0.20)	0.00	−0.14 (–0.34 to 0.07)	0.21
SNAP hyperactivity/impulsivity score	0.09 (–0.09 to 0.27)	−0.17	−0.13 (–0.31 to 0.05)	0.20
SNAP ODD score	0.05 (–0.13 to 0.23)	−0.09	−0.09 (–0.28 to 0.11)	0.17
Social skills score	0.59 (–2.98 to 4.16)	−0.06	3.30 (–1.23 to 7.82)	0.23
ADHD consistent presentation				
SNAP inattention score	−0.05 (–0.37 to 0.27)	0.08	−0.16 (–0.50 to 0.18)	0.24
SNAP hyperactivity/impulsivity score	−0.22 (–0.48 to 0.04)	0.49	−0.36 (–0.69 to –0.03)	0.57
SNAP ODD score	−0.10 (–0.42 to 0.23)	0.18	−0.40 (–0.75 to –0.05)	0.55
Social skills score	1.68 (–4.49 to 7.85)	0.13	9.57 (1.85 to 17.28)	0.69
ADHD inconsistent presentation				
SNAP inattention score	0.02 (–0.25 to 0.28)	−0.05	−0.15 (–0.41 to 0.10)	0.19
SNAP hyperactivity/impulsivity score	0.31 (0.08 to 0.54)	−0.58	0.03 (–0.18 to 0.24)	−0.08
SNAP ODD score	0.14 (–0.06 to 0.34)	−0.31	0.09 (–0.13 to 0.31)	−0.11
Social skills score	−0.01 (–4.35 to 4.32)	0.00	−1.14 (–6.46 to 4.17)	−0.10

All models are adjusted for parental education and study site. Negative mean differences favor the enhanced care arm for all SNAP-IV measures; positive mean differences favor the enhanced care arm for social skills. Positive effect sizes favor the enhanced care arm; negative effect sizes favor the basic care arm.

Multi-Diagnosis

- Kolko et al, 2014
- Cluster RCT
- Ages 5-12
- Behavior problems, ADHD, Anxiety
- Compared CoCM to enhanced usual care (referral or pediatrician tx)
- CoCM associated with improved access, child/parent outcomes, consumer satisfaction, and clinician skill

Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial

AUTHORS: David J. Kolko, PhD,[a,b,c,d] John Campo, MD,[e] Amy M. Kilbourne, PhD,[f] Jonathan Hart, MS,[c] Dara Sakolsky, MD,[a] and Stephen Wisniewski, PhD[g]

Departments of [a]Psychiatry, [b]Psychology, and Pediatrics, School of Medicine, [c]Special Services Unit, Western Psychiatric Institute and Clinic, [d]Clinical and Translational Science Institute, [g]Graduate School of Public Health, University of Pittsburgh, Pittsburgh, Pennsylvania; [e]Department of Psychiatry, Ohio State University, Columbus, Ohio; and [f]VA Ann Arbor Center for Clinical Management Research and Department of Psychiatry, University of Michigan, Ann Arbor, Michigan

WHAT'S KNOWN ON THIS SUBJECT: Integrated or collaborative care intervention models have revealed gains in provider care processes and outcomes in adult, child, and adolescent populations with mental health disorders. However optimistic, conclusions are not definitive due to methodologic limitations and a dearth of studies.

WHAT THIS STUDY ADDS: This randomized trial provides further evidence for the efficacy of an on-site intervention (Doctor Office Collaborative Care) coordinated by care managers for children's

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- CoCM was associated with:
  - Higher rates of treatment initiation (99.4% vs 54.2%; P < .001)
  - Higher rates of treatment completion (76.6% vs 11.6%, P < .001)
  - Higher rates of improvement in behavior problems, hyperactivity, and internalizing problems (P < .05 to .01)
  - Higher rates of improvement in parental stress (P < .05–.001)
  - Higher rates of remission in behavior and internalizing problems (P < .01, .05)
  - Higher rates of goal improvement (P < .05 to .001)
  - Higher rates of treatment response (P < .05)
  - Higher rates of consumer satisfaction (P < .05).
- CoCM pediatricians reported greater perceived practice change, efficacy, and skill use to treat ADHD (P < .05 to .01).

Multi-Diagnosis

- Parkhurst et al, 2021
- Non-randomized, non-controlled
- Ages 6-18
- Anxiety, depression, ADHD
- Patients experienced significant improvement in ADHD and Anxiety symptoms and pediatrician attitudes and access to care substantially improved.

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Extending Collaborative Care to Independent Primary Care Practices: A Chronic Care Model

John T. Parkhurst[1, 2], Rachel R. Ballard[1, 2], John V. Lavigne[1, 2], Tara Von Mach[1], Courtney Romba[1, 2], Marisa Perez-Reisler[1, 2], and John T. Walkup[1, 2]

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[2] Department of Psychiatry and Behavioral Sciences, Feinberg School of Medicine, Northwestern University

Objective: Collaborative approaches to pediatric primary care are increasingly recognized as a way to improve access to mental health care, but certain collaborative care models are not well suited for smaller, independent pediatric practices. We describe the

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Table 5

MAACC Population Measurement-based Care Change

Outcome		Baseline	6-weeks				Baseline	12-weeks				Baseline	18-weeks		
	n	*M*	*M*	M_{diff}	*p*	*n*	*M*	*M*	M_{diff}	*p*	*n*	*M*	*M*	M*diff*	*p*
Vanderbilt															
ADHD-I [a]	26	17.23 (1.1)	16.38 (1.1)	0.85 (1.2)	0.48	13	15.85 (1.5)	11.15 (0.9)	4.69 (1.3)	0.003**					
ADHD-H [b]	26	12.96 (1.4)	11 (1.2)	1.96 (1.1)	0.09	13	11.38 (2.1)	10.62 (2.0)	0.77 (1.1)	0.49					
ADHD-C [c]	26	30.19 (1.9)	27.38 (1.9)	2.81 (2.0)	0.18	13	27.23 (3.1)	21.77 (2.6)	5.46 (1.9)	0.01*					
ODD	5	16 (2.3)	14 (2.2)	2 (2.2)	0.41	3	15.33 (0.9)	16.67 (1.33)	-1.33 (2.2)	0.60					
PROMIS Depression															
Youth	23	27.30 (2.0)	20.48 (1.7)	6.83 (2.1)	0.004**	10	30.7 (3.1)	23.8 (2.7)	6.9 (3.9)	0.11	7	34.57 (2.7)	16.57 (3.2)	18 (3.1)	0.001**
Parent	23	15.96 (1.2)	13.8 (1.2)	2.13 (1.1)	0.07	11	17.27 (1.8)	17.82 (1.1)	-0.55 (1.6)	0.73	7	18 (2.4)	14.57 (2.1)	3.43 (4.1)	0.43
PROMIS Anxiety															
Youth	55	21.05 (1.1)	19.11 (0.8)	1.95 (0.9)	0.03*	39	21.90 (1.3)	18.71 (1.3)	3.18 (1.1)	0.007**	20	21 (1.4)	15.5 (1.3)	5.5 (1.5)	0.002**
Parent	61	19.57 (0.9)	18.46 (0.7)	1.11 (0.7)	0.13	39	20.31 (1.1)	16.87 (0.9)	3.43 (0.9)	<0.001***	22	20.09 (1.0)	15.04 (1.7)	5.0 (1.7)	0.008**

Collaborative Care Training

First Approach Skill Training (FAST) Programs

What are FAST programs?

FAST programs are designed to provide **brief, evidence-based behavioral therapy** for youth and families with common mental health concerns. They are ideal for delivery in **primary care clinics and schools**, and are designed to address **gaps in mental health care**.

- Online training videos are free for **any providers**.
- Workbooks and handouts can be used in primary care or behavioral health sessions
- New self-guided patient videos can help patients get started on skills while they wait for care, or serve as examples in behavioral health sessions

FAST-A (Anxiety)

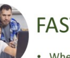
- When: Ages 3-18
- Who: Children with anxiety
- How: Exposure based therapy (a key part of Cognitive Behavioral Therapy, aka CBT)
- Includes youth & caregiver self-guided video version!

FAST-E (Early Childhood)

- When: Ages 1-4
- Who: Young children and families struggling with connection, development or behaviors
- How: Developmental parent coaching skills

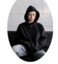
FAST-B (Behavior)

- When: Ages 4-11
- Who: Children with disruptive behaviors, ADHD
- How: Parent behavior management training
- Includes parent self-guided video version!



FAST-P (Parenting Teens)

- When: Ages 11–18
- Who: Teens and parents with challenges with communication and behavior
- How: Parent training and emotion coaching



FAST-D (Depression)

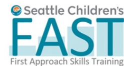
- When: Ages 12-18
- Who: Teens with depression
- How: Behavioral activation therapy

FAST-T (Trauma)

- When: Ages 7-18
- Who: Children with history of trauma and related mental health symptoms
- How: Cognitive Behavioral Therapy (CBT) methods specific for trauma

HOW DO I GET FAST?

Connect with your primary care behavioral health team about options for FAST-based therapy sessions
Download workbooks, handouts and videos at www.seattlechildrens.org/FAST
Reach out for questions at FAST@seattlechildrens.org!



APA offers free* training in the Collaborative Care Model (CoCM) for primary care providers (PCPs). PCPs will learn how to improve access to mental health and substance use services.

Applying the Integrated Care Approach: Skills for the Primary Care Physician

2 *AMA PRA Category 1 Credit™*

Integrated care programs, in which mental health care is delivered in primary care settings, exist as a promising solution to common, disabling and costly behavioral health problems, such as depression, anxiety and substance use disorders.

Collaborative Care for Primary Care Providers

1 *AMA PRA Category 1 Credit™*

This presentation will educate primary care providers on the Collaborative Care Model as a solution to access issues. Primary Care providers will also learn how to connect with a psychiatrist trained in the model.

FAQs for Primary Care Physicians

View answers to frequently asked questions for primary care physicians to clarify

Collaborative Care Practice Transformation

Plan	Build	Maintain
Identify needs & goals: What resources are required? What impact do we hope to have at the individual and population health level?	***Build the CoCM system:*** Identify clinical and operations teams, design workflows, and build IT infrastructure	***Launch and maintain:*** The clinical team begins treating patients, measuring clinical impact, to continuously monitor and improve workflows

Transformation Team

Plan	Build	Maintain
• Clinic or Health System Leadership • Finance Team Leader • Clinical Change Leader • Clinical Operations Leader	• Clinical Operations Leader • Information Technology (IT) • Health Care Informatics/Data Analyst • Revenue Cycle and Billing Team • Compliance Representative • Human Resources	• Clinical Operations Leader • Pediatrician • Behavioral Health Care Manager (BHCM) • Psychiatric Consultant

PLAN

- Clinic/Health System Leadership
  - CEO, CMO, Service Line Leader, Clinic Owner
  - Works closely with leadership team to implement and sustain CoCM (funding, overall directives)
  - Program Champion
- Finance Team Leader
  - CFO, Finance Lead, Operations Lead for Service Line
- Clinical Change Leader
  - Commits to learning, teaching, and practicing CoCM to fidelity
  - Primary care champion
- Clinical Operations Leader
  - Assembles key team leaders, creates operational infrastructure for success
  - Communicates bidirectionally, monitors progress

BUILD

- Informational Technology / EMR Build Team
- Healthcare Informatics / Data Analyst
- Revenue Cycle and Billing
- Compliance Representative
- Human Resources

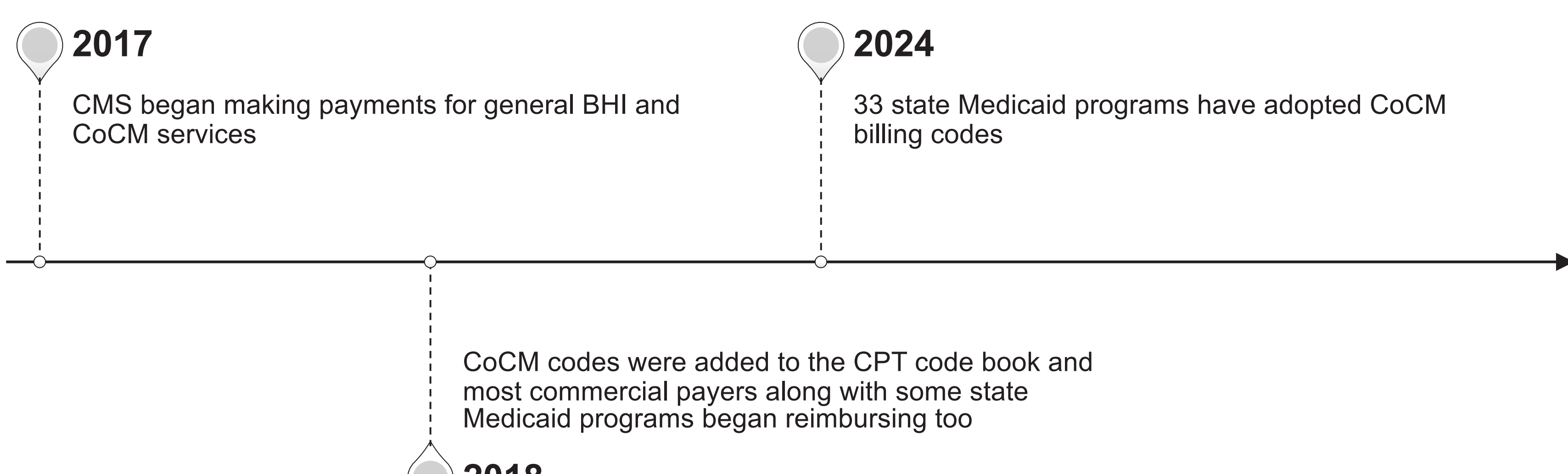
SUSTAIN

- Pediatrician
  - Oversees all aspects of patients' behavioral health care from initial screening and referral to maintenance care and post treatment
- BHCM
  - Acts as the primary behavioral health support for patients, and maintains direct contact with patients, pediatrician, and psychiatric consultant
- Psychiatric Consultant
  - Provides psychiatric expertise through direct and regular contact with BHCM and occasional contact with pediatrician, but has no direct contact with patient

CoCM Coverage and Reimbursement

DANGER

History of CoCM Financing



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CoCM Billing Codes

Code	Description	Minimum Time Threshold *
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99493	First **60 minutes** of CoCM services rendered in any **subsequent** month	31 Mins
99494	Each **additional 30 minutes** of CoCM services rendered in **any** calendar month after the total time for the primary code has been met As of 7/1/24, Medicare reimburses up to **4 units** per month	16 Mins
G2214	**30 minutes** of CoCM services rendered in **any** calendar month	16 Mins
G0512	**minimum 70 minutes** during initial month and **minimum 60 minutes** during subsequent months of CoCM services in **FQHC/RHC**	N/A

**** APPLIES IF PAYER FOLLOWS CPT "TIME RULE"***

Potential Barriers and Challenges

Attestation

- Some state Medicaid programs require providers / practices to apply and attest that they are providing all the evidence-based elements of CoCM prior to billing, **delaying** the start of services.

BHCM Licensure

- Some state Medicaid programs have minimum requirements for BHCMs to be individually licensed practitioners, further **limiting** the pool of BH professionals who can serve as BHCMs.

Billing Variability

- When it comes to state Medicaid programs, they have the authority to create their own rules around coverage and reimbursement for services. This is where we find the most **variability** and, at times, the most **complexity**.

Diagnosis

- Some state Medicaid programs limit eligible diagnosis to a certain set of codes, **restricting** the patients that can be served.

Payer Responsiveness

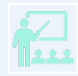
- Some states Medicaid programs are currently working on developing and implementing additional guidelines, yet not being responsive to inquiries and requests for clarifying information, causing **confusion and frustration**.

Prior Authorization

- Some state Medicaid programs require prior authorization for services over 6 months, adding administrative **burden** to staff.

Recommendations

Policy Advocacy: Advocate for policy reform to improve standardization and reimbursement rates for integrated behavioral health service.



Technical Assistance: Access expert technical assistance and implementation support to determine billing strategies, workflow adjustments, registry builds, and evaluation plans.

Workforce Development and Retention: Invest in training programs to increase the number of behavioral health professionals who are trained to work in integrated behavioral health models and promote interdisciplinary collaboration.

Cultural Competency Training: Develop and provide cultural competency training programs, allowing them to better serve the mental health needs of diverse patient populations.

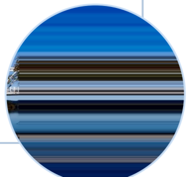
Research and Evaluation: Support research initiatives to assess best practices and cost-effectiveness of integrated behavioral health models, thus informing evidence-based practices and policy decisions.

Building a Financial Model

Financial sustainability is dependent on the use of the collaborative care codes and fidelity of implementation.

- Health system specific payer mix and reimbursement rates
- Implementation costs
- Direct and indirect operating costs

Geographic Factors



- Percent of patients screened / eligible / engaged
- Case manager hiring / case load ramp up
- Fidelity of model implementation

Performance Factors

Practice Transformation Outcomes

Clinical

- Better patient engagement
- Improved patient outcomes
- Increased provider satisfaction

Financial

- Enhance administrative efficiency
- Financial sustainability
- Reduced costs

Coming Up Tomorrow

5 STEPS to CoCM Billing Success

- **S** — SET PATIENT RESPONSIBILITY
- **T** — TRACK TIME
- **E** — ENTER CHARGES AND SUBMIT CLAIMS
- **P** — POST PAYMENTS
- **S** — SETTLE OUTSTANDING BALANCES

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Questions

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Thank You!

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Five Steps
For Collaborative Care Billing Success

November 9, 2024

Agenda

Describe CoCM billing codes

- *And the requirements for using them*

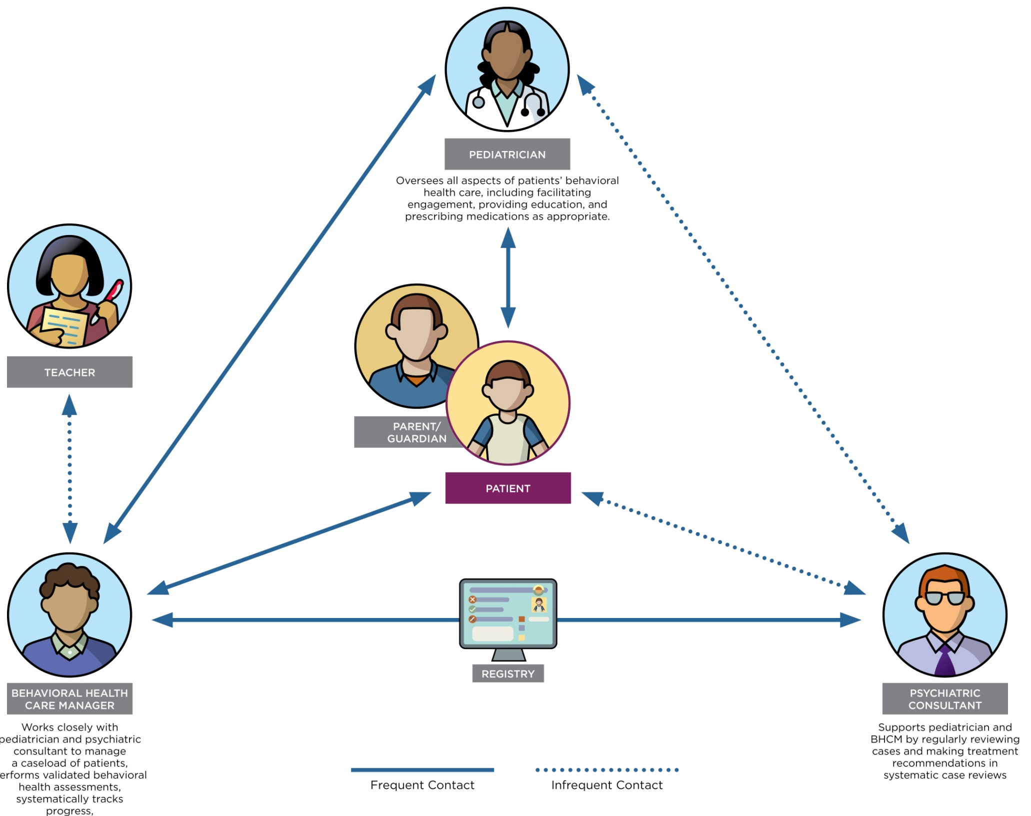
Understand CoCM cost-sharing

- *And how to discuss eligibility with patients*

Identify common reasons for claim denial

- *And how to address them*

Collaborative Care Model



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G2214	**30 minutes** of CoCM services rendered in **any** calendar month	16 Mins
G0512	**minimum 70 minutes** during initial month and **minimum 60 minutes** during subsequent months of CoCM services in **FQHC/RHC**	N/A

****APPLIES IF PAYER FOLLOWS CPT "TIME RULE"***

5 STEPS to CoCM Billing Success

- **S** SET PATIENT RESPONSIBILITY
- **T** TRACK TIME
- **E** ENTER CHARGES AND SUBMIT CLAIMS
- **P** POST PAYMENTS
- **S** SETTLE OUTSTANDING BALANCES

Set Patient Responsibility

- Prior to the initiation of CoCM services, the PCP must **obtain consent, inform the patient that cost-sharing** may apply, and document this in the patient chart.
- Most payers follow similar cost-sharing to other non-preventive PCP services and, if a copay applies, **only one monthly charge is due**.
- CoCM billing codes are paid under the **medical benefits**, not the behavioral health carve-out, despite using behavioral health diagnostics.

Track Time

- CoCM billing codes are time-based and reported as the total amount of time the **BHCM** spends engaging in clinical activities over the course of a **calendar month.**
- **Direct and indirect services** including (face-to-face and non-face-to-face):
    - Preparing and engaging in clinical work.
    - Patient warm connections, phone calls, and texting.
    - Care coordination with CoCM team and other providers.
    - Time spent with the psychiatric consultant on the weekly case reviews.
    - Registry management and updates.
- Services are billed monthly, once the time threshold has been met.

Enter Charges and Submit Claims

- CoCM billing codes are billed by the **treating provider** (also known as the **PCP/referring provider**) who takes the role of the **billing provider**.
- All services delivered by the behavioral health care manager working in collaboration with the psychiatric consultant are billed **incident to** under general supervision.
- **Separate and distinct** E/M and psychotherapy services can be billed as well – as long as the minutes are not counted twice.

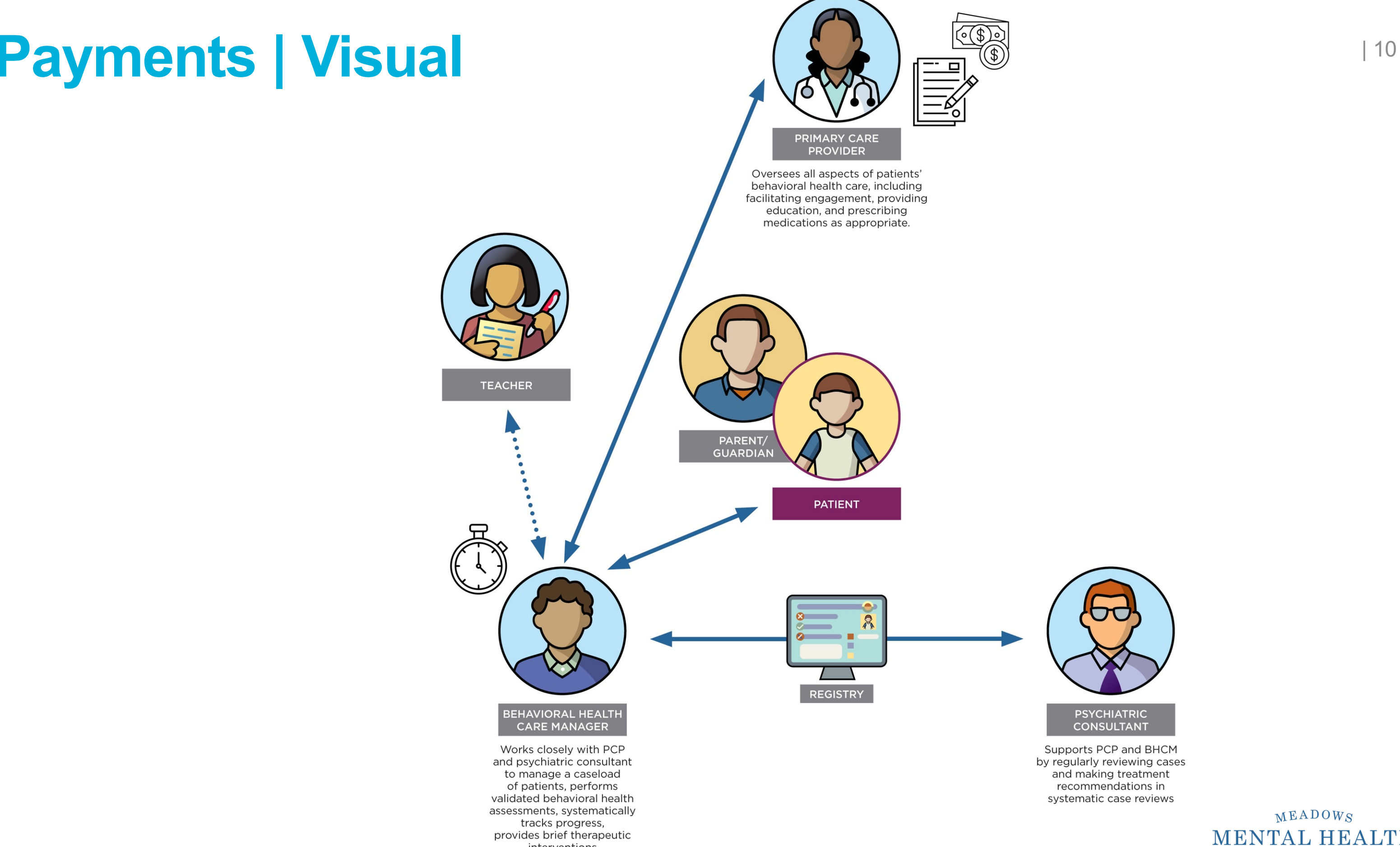
Post Payments

- CoCM services are reimbursed by Medicare, many state Medicaid agencies, and major private payers.

Code	Description	Non-Facility	Facility
99492	70 Mins, Initial Month	$157.52	$94.08
99493	60 Mins, Subsequent Month	$143.09	$102.78
99494	30 Additional Mins, Any Month	$60.79	$41.16
G2214	30 Mins, Any Month	$58.76	$38.43

- Contracted rates for private payers vary by region, practice size, provider type, contract type (individual vs. group and non-facility vs. facility), how successfully the practice negotiated at the time of contracting, and payer mix.
- Rates across payers may vary +/- 20% to 50% of Medicare.

Post Payments | Visual



Icons made by artist on The Noun Project (Adiba, Creative Mania, HNTRY)

Settle Outstanding Balances

- Common reasons why CoCM billing codes are not paid include:
    - Codes need to be added to the fee schedule.
    - Patient cost-sharing.
    - Gaps in episode of care.
    - Prior authorization beyond 6 months.
    - Claim was forwarded to the behavioral health carve-out in error.
    - Other services provided on the same DOS.

5 STEPS to CoCM Billing Success

- **S** — SET PATIENT RESPONSIBILITY
- **T** — TRACK TIME
- **E** — ENTER CHARGES AND SUBMIT CLAIMS
- **P** — POST PAYMENTS
- **S** — SETTLE OUTSTANDING BALANCES

Test Your Knowledge

1. There is no patient cost-sharing associated with CoCM services as they are considered preventative care.
2. Consent from the patient/parent must be obtained in writing.
3. CoCM services are billed under the treating provider (also known as the PCP/referring provider) as incident-to.
4. CoCM codes are time based and account for the total number of minutes spent by the behavioral health care manager (BHCM) over the course of a calendar month.
5. Colorado Medicaid reimburses for CoCM codes.

Test Your Knowledge

1. There is no patient cost-sharing associated with CoCM services as they are considered preventative care?

FALSE. *Cost-sharing applies to CoCM and the patient must be informed of such at the time of obtaining consent.*

2. Consent from the patient/parent must be obtained in writing.

FALSE. *Consent may be verbal and must be documented in the patient's chart.*

3. CoCM services are billed under the treating provider (also known as the PCP/referring provider) as incident-to.

TRUE

4. CoCM codes are time based and account for the total number of minutes spent by the behavioral health care manager (BHCM) over the course of a calendar month.

TRUE

5. Colorado Medicaid reimburses for CoCM codes.

FALSE. *Colorado Medicaid does not currently reimburse for CoCM codes.*

Additional Resources

Meadows Mental Health Policy Institute
**CoCM TA Tools*

Centers for Medicare & Medicaid Services (CMS)
**Can use the fee lookup tool*

American Psychiatric Association (APA)
**Includes an updated list of payers covering CoCM*

Advancing Integrated Mental Health Solutions (AIMS)

References

Behavioral Health Integration Services (No. MLN909432). (2022). CMS, Medicare Learning Network. Retrieve from: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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Collaborative Care Model

Billing Basics

The Collaborative Care Model (CoCM) is the only integrated behavioral health model to have designated billing codes. CoCM billing codes are time-based and reported as the total amount of time the Behavioral Health Care Manager (BHCM), in collaboration with the Psychiatric Consultant (PC), working under the direction of the Primary Care Physician (PCP), spends engaging in clinical activities over the course of a calendar month.

Code	Description
99492	First 70 minutes of CoCM services rendered in the first calendar month (36–85 minutes).
99493	First 60 minutes of CoCM services rendered in any subsequent month (31-75 minutes).
99494	Each additional 30 minutes of CoCM services rendered in any calendar month (16–30 minutes), after the total time for the primary code has been met. *Typically no more than 2 units per month are paid.*
G2214	30 minutes of CoCM services rendered in any calendar month (16–30 minutes).
G0512	Minimum 70 minutes during initial month and minimum 60 minutes during subsequent months of CoCM services in FQHC/RHC settings.

CoCM services are reimbursed by Medicare, more than half state Medicaid agencies, and most private payers.

CoCM billing codes are paid under the medical benefits, not the behavioral health carve-out, despite using behavioral health diagnosis. Prior to CoCM services starting, the PCP must obtain consent and inform the patient that cost-sharing may apply. Most payers follow similar cost sharing to other non-preventive PCP services, and if a copay applies, only one monthly charge is due.

CoCM services are billed monthly once the time threshold has been met. CoCM billing codes are billed with the PCP (treating provider) as the billing provider. All services delivered by the BHCM working in collaboration with the PC are billed incident to. Other separate and distinct Evaluation and Management (E/M) and psychotherapy services may be billed in addition to CoCM.

Some common reasons why CoCM codes are not paid include codes are not included in the provider fee schedule, prior authorization requirement, or the claim was forwarded to the behavioral health carve-out in error.

Additionally, if CoCM criteria is not met, **99484** for 20 minutes of general Behavioral Health Integration (BHI) services may be billed.

Coding and billing stipulations and limitations vary by payer, state agency, and place of service, and may change over time. As such, this information is only meant to be used as a general guideline. For additional details, each practice should check with their internal billing and compliance department for specific guidelines on documentation, coding, and billing.

Resources: Medicare Learning Center (2022). Behavioral Health Integration Services. Retrieved from: https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf.

Independent and nonpartisan, the Meadows Mental Health Policy Institute works at the intersection of policy and programs to create equitable systemic changes so all people in Texas, the nation, and the world can obtain the health care they need.

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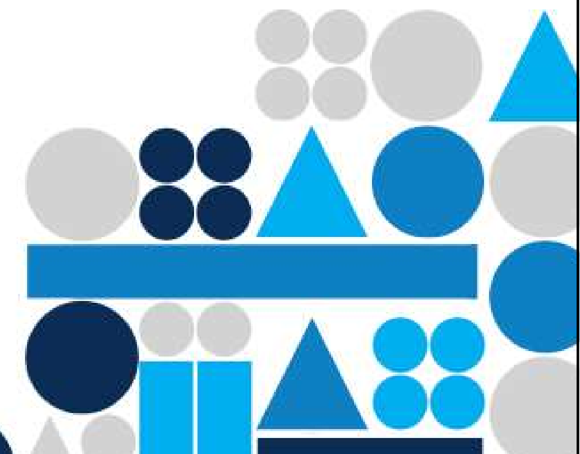
Financial Challenges – Lessons from Across the Country and Colorado
Additional Resources

Collaborative Care Technical Assistance Tools

Roles and Scopes of Team Members

Bethany Ashby, PsyD
Associate Professor, CU Anschutz

Allyson Gottsman
Research Instructor, Family Medicine, CU Anschutz



1

Our Perspective

Allyson:
Practice Innovation Program
School of Medicine, Dept of Family Medicine
- Convene and support Practice Transformation Organizations
- Observed hundreds of practices addressing BH Integration
  - State Innovation Model (SIM)
  - HB 22- 1302 – BH Integration award program

Bethany:
Psychologist
Associate Professor of Psychiatry and Ob/Gyn, School of Medicine
Director of integrated behavioral health programs in pediatrics and obstetrics

Pediatric Mental Health Institute

2

Steps for success

- What is your why?
  - Engaged leadership
  - Team must understand and have buy-in **before** implementation
- Whole team training and education
  - Culture that supports new initiatives
  - Role-specific training
- Anticipate challenges and pain points
  - You don't have to know what they are, but know that you will encounter problems
  - Commitment is critical

Pediatric Mental Health Institute

3

Counseling

"At its center, counseling is deep, skillful listening; creating a sphere of non-judgment and empathy; focusing on strengths, and working shoulder to shoulder with another, to help find the best path forward.

These skills and strategies are not degree or license-dependent."

Elizabeth Morrison, PhD, LCSW, MAC

Pediatric Mental Health Institute

4

Why Team-Based Care?

We have a mental health crisis

There are not enough licensed therapists to meet the need

There is good evidence that trained non-licensed staff provide comparable services

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5

Some of the Benefits of Using a Team

Provides more timely access to support for patients and family

Increases “touches” from practice to patients and families

Increased “touches” improves trust and strengthens the bond between the family and practice

Enrich and elevate your most dedicated, skillful employees

Improves staff morale, job satisfaction and retention

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6

Why Team-Based Care?
Because it works! …and it's efficient.

Staff with "the right stuff" can be trained to support Behavioral needs of patients and families

Key attributes needed

Empathy
"People Skills"
Ability to Maintaining connection
Ability to Build Trust
"people skills"
Reliable follow through – Do what you say you will do, when you say you will do it

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7

Who can be "trained up" to provide counseling?

It's not the role, it's people with the "the right Stuff"

Could be:

Medical Assistants
Community Health Workers
Care Navigators
Outreach workers
Health coaches
Front Desk Staff
Licensed Practice Nurses

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8

With training, staff can

- Communicate empathy
- Develop and maintain a therapeutic relationship
- Acknowledge feelings
- Affirm and amplify strengths
- Engage in Motivational Interviewing
- Adopt trauma-informed practices
- Counter and Mitigate stigma and bias
- Know ethics and boundaries
- Avoid advice

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Acknowledge Realities of Providing Integrated Care

- Some visits may take longer
- Distressed patients and parents = more phone calls and Mychart messages
- Increased refill requests
- Additional training and support needed for care team

AND

- Reduction of symptoms and improvement in function
- Fewer mental health crises
- Improved outcomes
- Increased trust in you and in the medical system
- ??

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Staff Roles and Responsibilities

- Schedulers and front desk staff
  - Be able to describe behavioral health services
  - Give mental health screenings and rationale for mental health screening as part of check-in
  - Have protocol for how to respond to distressed patients
- Medical Assistants
  - Review and score screening tools
  - Initial check in with family

11

Nursing Roles and Responsibilities

- Review and score screening tools
  - Ask follow up questions about responses
- Return patient phone calls and MyChart messages
- Use algorithm for refills
- Assist with referrals

12

Medical Provider Roles and Responsibilities

- *Provider champion*
- Discuss screening results
- Identify mental health symptoms and *current psychosocial stressors and social determinants of health*
- Warm handoffs/coordination with behavioral health clinicians (BHCs), health or community navigators, social workers
- Coordination of care with BHCs

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13

BHC Role and Responsibilities

Practices without a BHC	Co-located services	Integrated services
Brief interventions	Schedule appointment with BHC at time of visit	Warm hand offs at visit
If referring to specific provider, parents sign ROI	Develop protocols for responses to urgent needs	Consultation
Frequent follow up and care coordination	Protocol for BHC absences	Therapy
Develop protocols for responses to urgent needs		**Education and prevention*
		Protocol for BHC absences

14

Social Work Roles and Responsibilities

- Some settings may have separate roles for social workers and BHCs
  - Roles must be delineated
- Assessment of child protection concerns including interpersonal violence
- Assessment of substance use and referrals for treatment
- Address social determinants of health
- Care coordination for medically and psychosocially complex patients

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Community Navigators

- Intermediary between medical setting and community support
- Facilitate access to needed resources including insurance, housing, education
- Provide direction and support to meet specific patient needs
- Can be specialized based on clinic needs

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Ongoing efforts…

- Provide regular team updates about behavioral health services
- Continuous evaluation of program
- Share QI information with the team
- Include information about behavioral health services in employee orientation and training

17

Resources for training staff

Free training for Community Health Workers

Training information

****

Training to lead: Circle of Parents, or Circle of Kids

info@circleofparentsco.org

****

The Lay Counselor Academy

Lay Counselor Academy

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18

Our contact information

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303-915-7701

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19

TRAINING CHECKLIST

COMMUNITY HEALTH WORKER TRAINING PROGRAM

You can choose a training plan that works for you. Level 1: Health Navigation Fundamentals must be completed before Level 2: Care Coordination. CHW Fundamentals has required self-paced modules before the instructor-led course. Otherwise, courses can be completed any time.

INSTRUCTOR-LED COURSES

- ○ Level 1: Health Navigation Fundamentals
  3 days in person with online prework or 8 weeks online
- ○ Basic Motivational Interviewing
  4 weeks online or included in Level 1 Health Navigation Fundamentals in person
- ○ Level 2: Care Coordination
  1.5 days in person or 4 weeks online
- ○ Community Health Worker Fundamentals
  3 days in person with online prework or 8 weeks online
  Required self-paced modules:
  - ○ Intro to the CHW Role
  - ○ Ethical Guidelines for CHWs
  - ○ CHW Scope of Practice
  - ○ Duty of Self-Awareness
  - ○ Community Education and Facilitation
  - ○ Inreach and Outreach

SELF-PACED COURSES/MODULES

Can be completed any time during program:

- ○ Preventive Healthcare 101
- ○ Intro to Chronic Disease
- ○ Intro to the Healthcare System
- ○ Intro to Emergency Preparedness
- ○ CLAS Standards & Social Determinants of Health
- ○ Trauma-Informed Care
- ○ Health Insurance Basics
- ○ Cross-Cultural Communication
- ○ Situational Awareness
- ○ MI + Vaccine Hesitancy
- ○ Public Health 101

COMMUNITY HEALTH WORKER TRAINING PATHWAYS

CHW APPRENTICESHIP

- One year, full-time commitment
- Living allowance provided
- Includes 100 hours of CHW training and placement at health organization
- For students and entry-level professionals
- Ideal for someone who is not employed
- Apprentices will be eligible for state credentialing exam

CHW TRAINEE

- Part time commitment
- About 100 hours of coursework
- Flexible training plans
- Internship provided for those not working in a CHW role
- $2,000 stipend included
- For entry-level professionals
- Trainees will be eligible for state credentialing exam

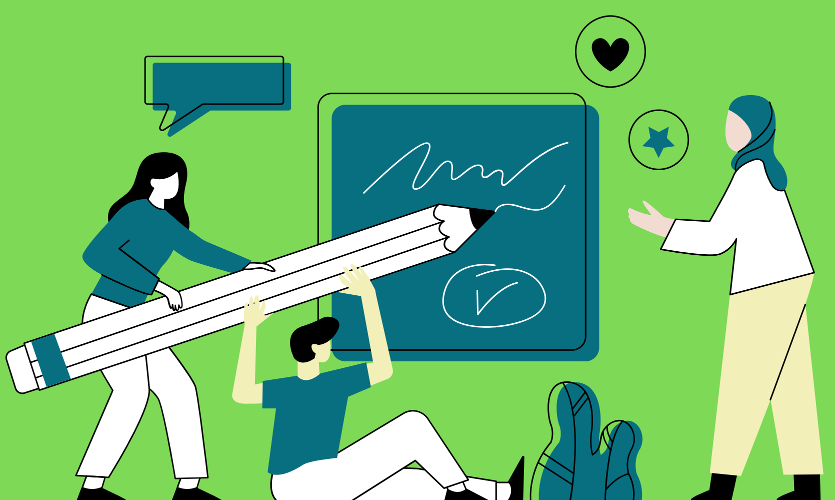
UPSKILLING TRAINING

- Shorter experience in a specific focus area
- Ideal for those already working in a CHW role
- Flexible training plans
- No stipend provided
- Can obtain eligibility for state credentialing exam

Learn More:
patientnavigatortraining.org/
help-your-community

Help people get the care they need by becoming a Community Health Worker

- Free training to jump start your career in community health work ($5,500 value)
- Flexible training plans
- Internship and job placement assistance included



What does a CHW do?

- Connects people to community resources
- Helps with addressing health challenges
- Assist individuals with eligibility and enrollment in health insurance and other social services programs

Learn more about what it takes to become a CHW

Scan the QR code for more details and to view a sample training plan.

Community Health Worker

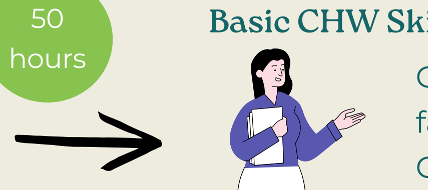
Training Opportunity

Training is available at no cost for those who participate in the full training plan of CHW + Health Navigator Courses, with funding from the Health Resources and Services Administration (HRSA).

CHW Courses

- CHW Fundamentals (3 days in person or 8 weeks online)
- Self-paced online courses
  - Situational Awareness
  - Health Insurance Basics
  - And more

50 hours



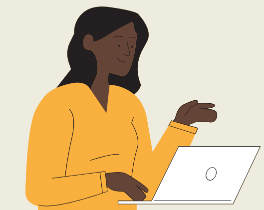
Basic CHW Skills for community engagement

Community assessment, facilitation skills, outreach, CHW ethics and values, cultural mediation skills

Health Navigator Courses

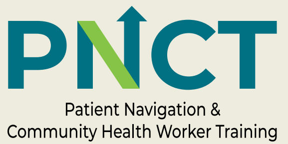
- Level 1: Health Navigation Fundamentals (3 days in person or 8 weeks online)
- Level 2: Care Coordination (4 weeks online)
- Basic Motivational Interviewing (4 weeks online or part of Fundamentals in person)
- Self-paced courses
  - Chronic Disease
  - Preventive Healthcare
  - Healthcare Systems

Navigation skills for reducing barriers to care



Connecting clients to resources, professional boundaries, helping with behavior change, communication skills, team-based care coordination

- Participants are eligible if they live in Colorado, are at least 18 years old, are a U.S. Citizen/ permanent resident and have not received prior CHW or navigation training.
- Trainees who agree to complete the full training program (~100 hours) receive a $2,000 stipend.
- Trainees will be asked to provide de-identified data for grant reporting.
- Training value is approximately $5,500 per person.
- Training schedule is flexible (in person and online options).
- Estimated time to complete is 5-8 months; trainees may take up to a year to complete.
- Trainees are required to complete an internship. This can be at their workplace if they are employed or volunteering as a CHW or related role.

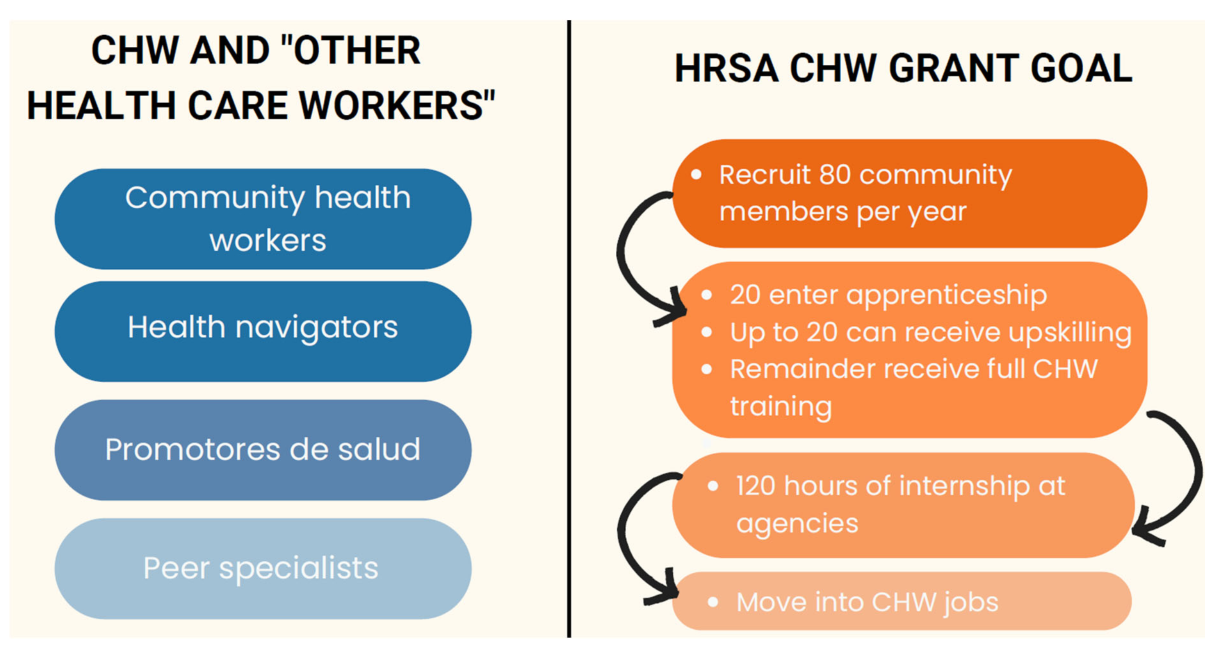


OPPORTUNITIES TO BUILD THE COLORADO COMMUNITY HEALTH WORKER (CHW) WORKFORCE AS A TRAINEE OR EMPLOYER

The Health Resources & Services Administration (HRSA) has awarded Colorado organizations **nearly $3 million in funding to implement a training and apprenticeship/internship program to support Colorado's workforce in community health work and related positions.**

We are recruiting individuals and local employers across Colorado for exciting career building opportunities in community health work.

Community Health Worker (CHW): trusted messengers who connect individuals to health care and other services. CHWs work to address health disparities, particularly in communities most impacted by social, economic, and environmental injustice.



Help Your Community, Become a Community Health Worker

Interested in a career helping your community address their healthcare needs and access to other services? Receive comprehensive training at no cost to you to become a community health worker or health navigator plus placement in an internship or apprenticeship with a local organization.

Trainees will receive:

- Training focused on building your skills in areas such as community outreach and engagement, communication and cultural responsiveness.
- Flexible training plans to fit your schedule, with in-person, online, and self-paced options.
- Funds available to offset costs while in training. Participants who enroll in the full training program will be eligible to receive a $1,000 stipend to offset costs while in training.
- Assistance with finding the internship, apprenticeship, or job placement opportunity that is right for you.

Employers: Help Grow This Vital Workforce by Hosting an Internship or Apprenticeship

Sites across Colorado are needed to host and mentor CHW trainees for on-the-job learning.

Host sites will:

- Host a short-term (approximately 120 hour) internship or one-year paid apprenticeship, with additional opportunities to offer job placement.
- Support your agency's work by hosting trained CHWs who will have the opportunity to support the implementation of projects and services relevant to the CHW role.
- Provide leadership opportunities to current employees as they mentor trainee CHWs.
- Receive basic guidance on mentoring, supervising, and utilizing CHWs within the scope of practice.
- Diversify your workforce to better serve your clients or patients.

Want more information about these opportunities or have a question?
Contact us using the QR code or links below

Trainee Interest Form English | Trainee Interest Form Spanish | Host Site Interest Form

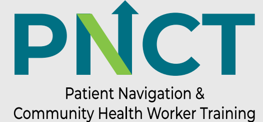
HRSA CHW Training Program – Newsletter Blurb

Training Opportunity for Community Health Workers

Colorado has been awarded funding from the Health Resources and Services Administration (HRSA) to offer free training in community health work and health navigation. Training plans are flexible and have in-person, online and self-paced options. Pathways include:

- Full training program including a stipend to offset costs, internship and job placement assistance
- Upskilling program for those currently employed as a CHW or health navigator
- Apprenticeships for those looking for a paid, 1-year placement

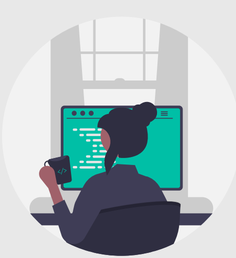
Community health workers (CHWs) are trusted messengers who connect individuals to health care and other services. Join this exciting workforce helping people live healthier lives! For more information or to fill out an interest form, visit https://patientnavigatortraining.org/help-your-community



SAMPLE LEARNING PLAN

COMMUNITY HEALTH WORKER TRAINING PROGRAM

This is just an example. You can choose a learning plan that works for you and it may be longer or shorter. Self-paced courses are done online and typically take 2 hours or less. Instructor led courses can be done online with live Zoom sessions or in-person.

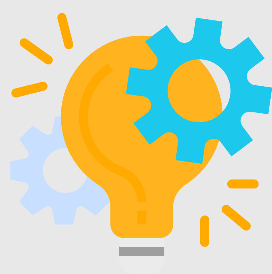


MONTH 1 *Dive in with self-paced online courses*

- Intro to the Healthcare System (self-paced)
- Intro to Chronic Disease (self-paced)
- Preventive Healthcare 101 (self-paced)
- Health Insurance Basics (self-paced)
- Cross-Cultural Communication (self-paced)
- Public Health 101 (self-paced)

MONTHS 2-3 *Connect with instructors and peers*

- Health Navigation Fundamentals (8 week online course)
- Digital Health Literacy (self-paced)



MONTH 3 *Continue your learning journey*

- Basic Motivational Interviewing Online (4 weeks)
- Intro to the CHW Role (self-paced)
- CLAS Standards (self-paced)
- CHW Scope of Practice (self-paced)
- Duty of Self-Awareness (self-paced)
- Ethical Guidelines for CHWs (self-paced)

MONTH 4 *Learn community-based skills*

- Community Education and Facilitation (self-paced)
- Inreach and Outreach
- CHW Fundamentals (3 days in person + homework)

MONTH 5 *Finish up your online coursework*

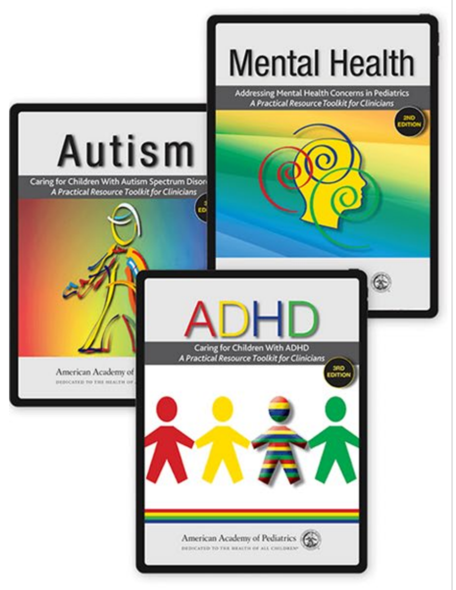
- Situational Awareness (self-paced)
- Intro to Emergency Preparedness (self-paced)
- MI + Vaccine Hesitancy (self-paced)
- Trauma-Informed Care (self-paced)

MONTH 6 *Build on your skills with this advanced course*

- Care Coordination Online (4 weeks)

MONTHES 7-8 *On-the-job experience*

- Internship (if not already employed as a CHW or related role)



AAP Toolkits Package

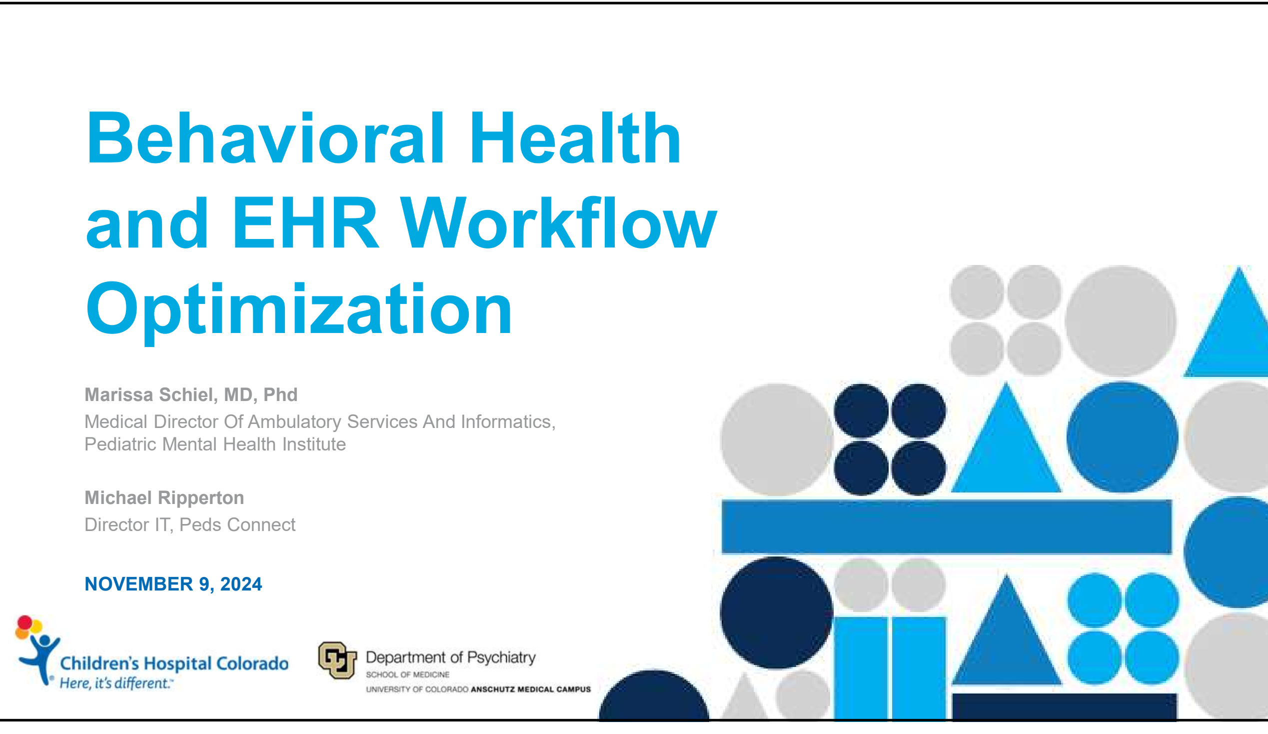
Price: **$390.00**

Member Price: **$300.00**

Log in to see pricing

Add to Cart

https://www.aap.org/AAP-Toolkits-Package?srsltid=AfmBOoroV4Fbxnba3br5p8H47ehuS_fkgo33BpCuqLFROErxZTxRKhy4



2

Introduction

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Pediatric Mental Health Institute

Michael Ripperton
Director IT,
Peds Connect

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Disclosures

- Dr. Schiel serves on the Epic Behavioral Health Steering Board

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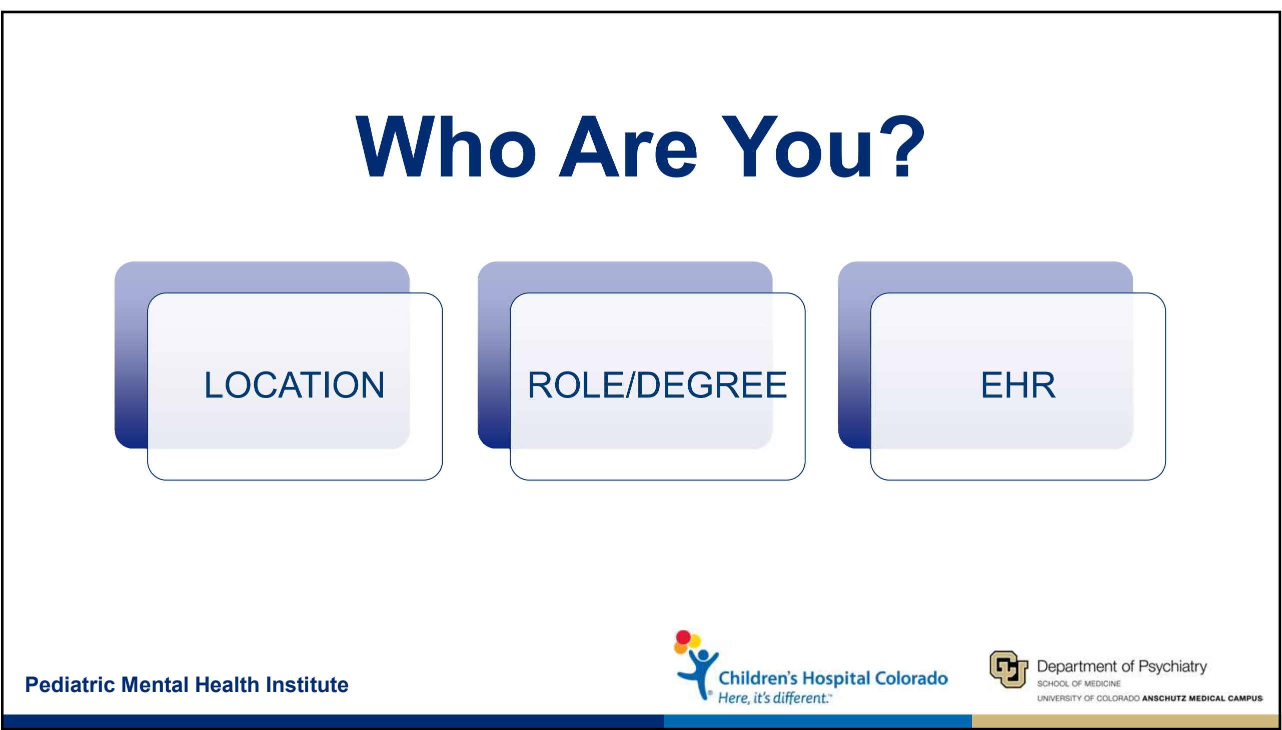

5

Patient Confidentiality

- **Who is Involved in Care?**
- **Who has access to records?**
  - Patient
  - Guardians
  - Providers
- **Additional Considerations:**
  - 21st Century Cures – Federal law
  - Minor Rights – Colorado law
  - Documentation
  - Billing

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Minor Consent Note

This minor patient consented to the treatment documented in this section. This minor must authorize its release. Please contact HIM to process any requests for release of this information.

- **Considerations:**
  - When to use it
  - PedsConnect – Epic
  - Release of Patient Notes

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Questionnaires

- **Public Access vs Proprietary**
- **Workflows for administration**
  - Paper with data entered later
  - RN or Provider administered in the EHR
  - Completed by patient and/or guardian in at portal
- **How and where is the data documented?**
  - Discrete data (ex/flowsheet) vs in a note or both
- **Additional Considerations**
  - Safety
  - Confidentiality
  - Authorship
  - Number of questions
  - What to do with the results?

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Examples of Questionnaires

Suicide screening: Ask Suicide-Screening Questions (ASQ), Columbia-Suicide Severity Rating Scale (C-SSRS)

Depression: PHQ-A, PHQ-9, PROMIS Depression self and proxy

Anxiety: GAD-7, SCARED, PROMIS Anxiety self and proxy

ADHD: Vanderbilt

Eating Disorders: EAT-26

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PCP Documentation

- Templates can be used to document key behavioral health information in your medical charting system
- Documentation for visits may differ based on visit type:
  - Anticipated new evaluation for behavioral health concern
  - Unanticipated report of new behavioral health concern
  - Planned follow-up for behavioral health concern
- Documentation for orders may also be important
  - Ex: routine labs
- Medication List maintenance
- Problem List maintenance
  - Risk Adjusted Patient
  - Medicaid Complex patients

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Minor Consent Note

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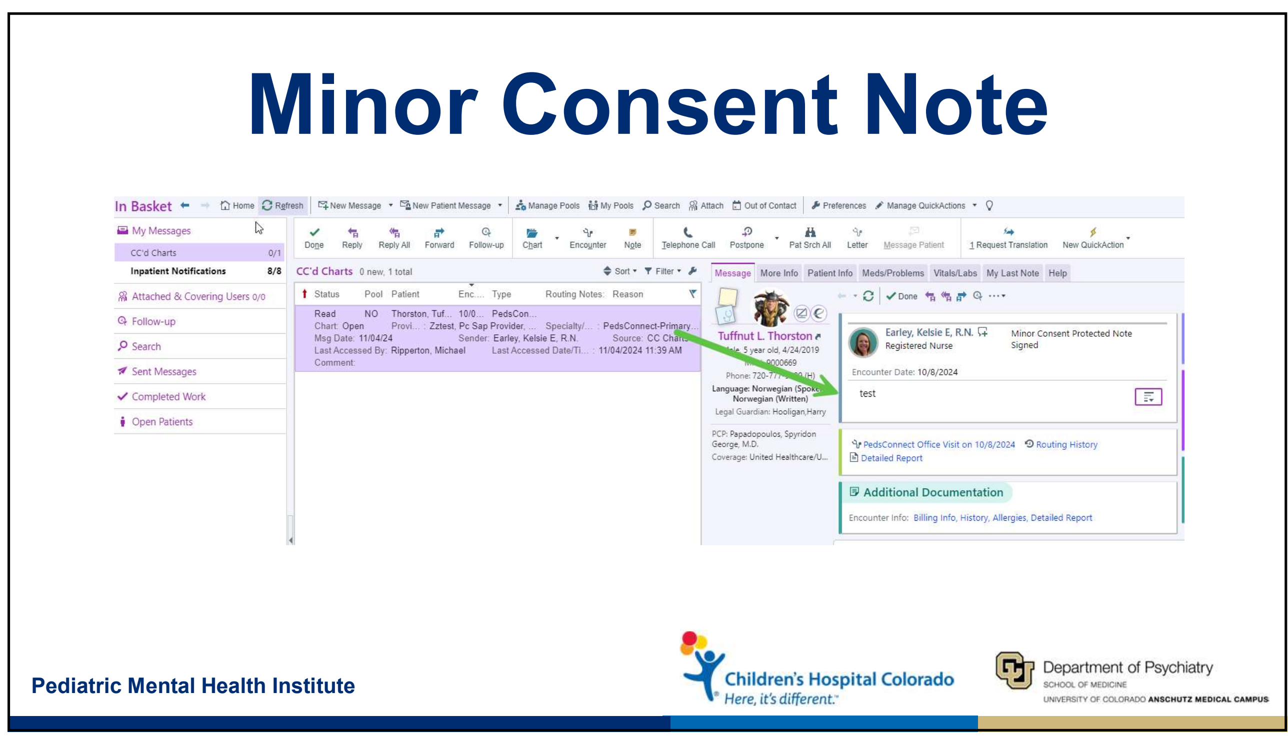

12

Safety Plan

- Who is completing safety planning?
- How are you completing safety planning?
- How it is available to the patient/guardian?

MY SAFETY PLAN

Name: *Sigmund Zztest*
Created Date: 8/17/2023
Revised Date: 11/3/2024
Supporting Adult(s) taking part in the Plan: *mom and aunt*

STEP 1: My warning signs

Signs that I am having strong feelings or I am not feeling safe:
1. *crying*
2. *yelling*
3. *shutting down*

Signs my supporting adult(s) may notice:
1. *shutting down*

STEP 2: Things I can do to help myself
1. *read*
2. *color*
3. *talk to mom*
4. *text a friend*

Step 3: Reasons to be safe
1. *siblings*
2. *pets*

STEP 4: Things others can do to help me
1. *play games with me*
2. *sit with me*

STEP 5: People who can help me

Name	Phone
Mom	

STEP 6: Health care workers and agencies to call

Name	Phone
PMHI	*303-555-5555*

Colorado Crisis Services: 1-844-493-TALK (8255) or text TALK to 38255
www.ColoradoCrisisServices.org
Call 911 or go to the nearest Emergency Department for immediate safety concerns

STEP 7: Ways to make your environment safer
1. *Mom to monitor mediacations*

Tips for keeping your environment safe
- Remove or safely secure sharps and weapons.
- Remove or safely secure over the counter and prescription medicines.
- Secure any unique items in your environment that could be used for harm.
- Increase supervision from supportive adult(s).

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Resources on Suicide and Depression

Resource Links

Patient and Family/Caregiver Resources

- In Care of Kids Resource Sheet (English)
- In Care of Kids Resource Sheet (Spanish)
- Patient Handouts - Psychiatric/Mental Health
- Suicide Safety: Precautions at Home (AACAP Facts for Families)
- Suicide in Children & Teens(AACAP Facts for Families)
- Depression in Children & Teens (AACAP Facts for Families)

Provider Resources

- AACAP Resource Center: Suicide
- American Academy for Pediatrics - Blueprint for Youth Suicide Prevention
- CoPPCAP Colorado Care Guide: Suicide

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Reports From Providers

Notes

- Discharge summaries from higher levels of care are auto-routed to PCPs

Letters

- Sent with Assessment and Plan from PMHI Outpatient Psychiatrist/APP Encounters

What are you doing with this information?

- Fax
- EpicCare Link
- PedsConnect inbasket/patient record

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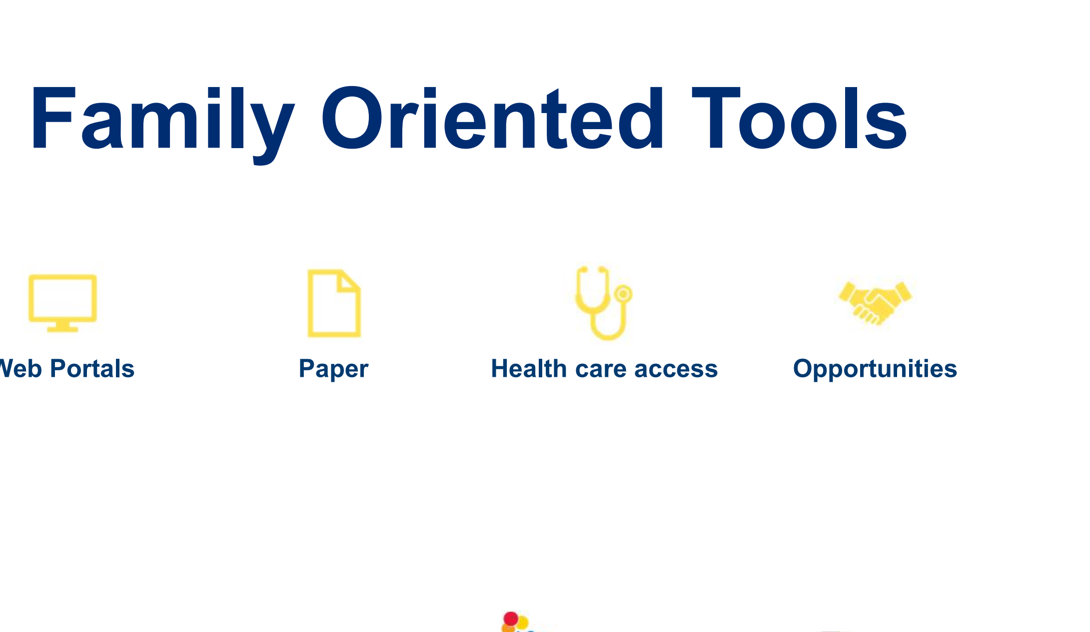
Family Oriented Tools



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Thank You

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NOVEMBER 8, 2024

Collaborative Foundations: Promoting Behavioral Health Integration in Primary Care

Maya Bunik MD MPH
Kelly Galloway RN
Ayelet Talmi PhD

Pediatric Mental Health Institute

2

Disclosures

This work is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

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3

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Circa 2019

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4

Child Health Clinic

Project CLIMB: Consultation Liaison in Mental Health & Behavior

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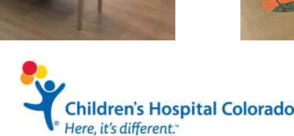

5

CLIMB…how we started

- Partnership of Psychiatry and Pediatrics
- Initial Health Foundation funding

Started with:

- Developmental screening (>85% rates)
- Added pregnancy-related depression screening
- Built foundation of collaboration and co-management of two disciplines
- Planned for sustainability
  with funds from ASQ &
  of Dept. Peds making it whole

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6

And How Are You Doing?

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________ Address: ______________

Your Date of Birth: ______________ ______________

Baby's Date of Birth: ______________ Phone: ______________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

7

PRD data

- 89% of mothers seen for well child visits < 4 months of age get screened
- 10% of mothers scored ≥10 on at least one visit.
- 60 % by CLIMB provider only, 4% (21/508) social worker only (SW), 11 % both
- Those mothers who score high have more clinic visits as part of their treatment compared to those that do not (means 2.6 (1.1 sd), median 3.0 and 2.3 (1.1 sd), median 2.0, respectively

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8

Collaboration, Investments, and Sustainability

- Department of Pediatrics
- Pediatric Mental Health Institute
- Children's Hospital Colorado
- American Academy of Child and Adolescent Psychiatry
- Rose Community Foundation & Roots & Branches
- The Colorado Health Foundation
  - Pediatric Resident Education
- Caring for Colorado
- Walton Family Foundation
- Liberty Mutual
- Denver Post Season to Share
- Community First Foundation
- ZOMA Foundation
- Piton/Gary Community Investments
- UPL
- HRSA

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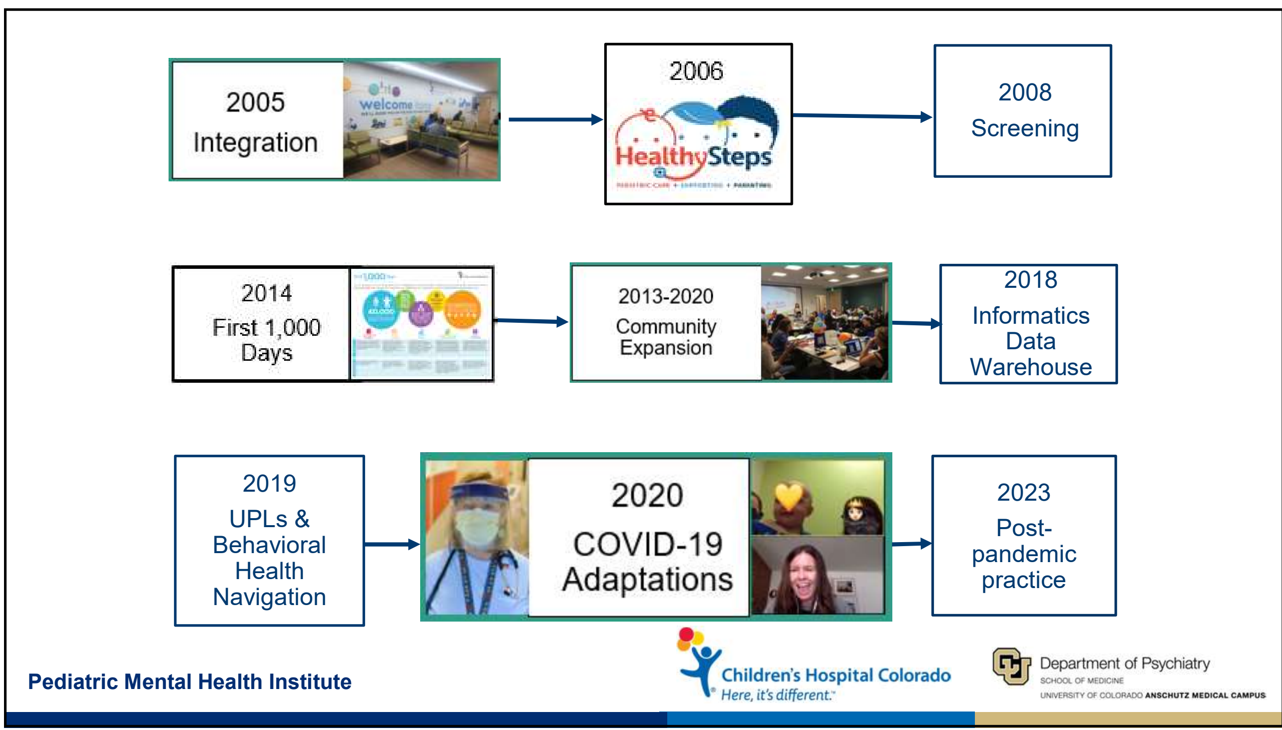

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CLIMB Services Provided

- Pregnancy related depression screening (EPDS)
- Developmental screening (ASQ, ASQ-SE, MCHAT)
- Adolescent mood screening (PHQ-9A)
- Caregiver behavioral health, safety, resource needs (Psychosocial screener)
- HealthySteps for young children (0-3 years old)
- Baby and Me (1 month-12 months)
- Trifecta Approach for Breastfeeding Management
- Fussy Baby Colorado
- Motivational Interviewing (SHS)
- Short-term behavioral health therapy
- Psychopharmacology consultations with child psychiatrists
- Behavioral health navigation
- Social work
- Case-based consultation, coordination, triage, referral
- Training and education
  - Formal didactics
  - Clinical precepting of trainees

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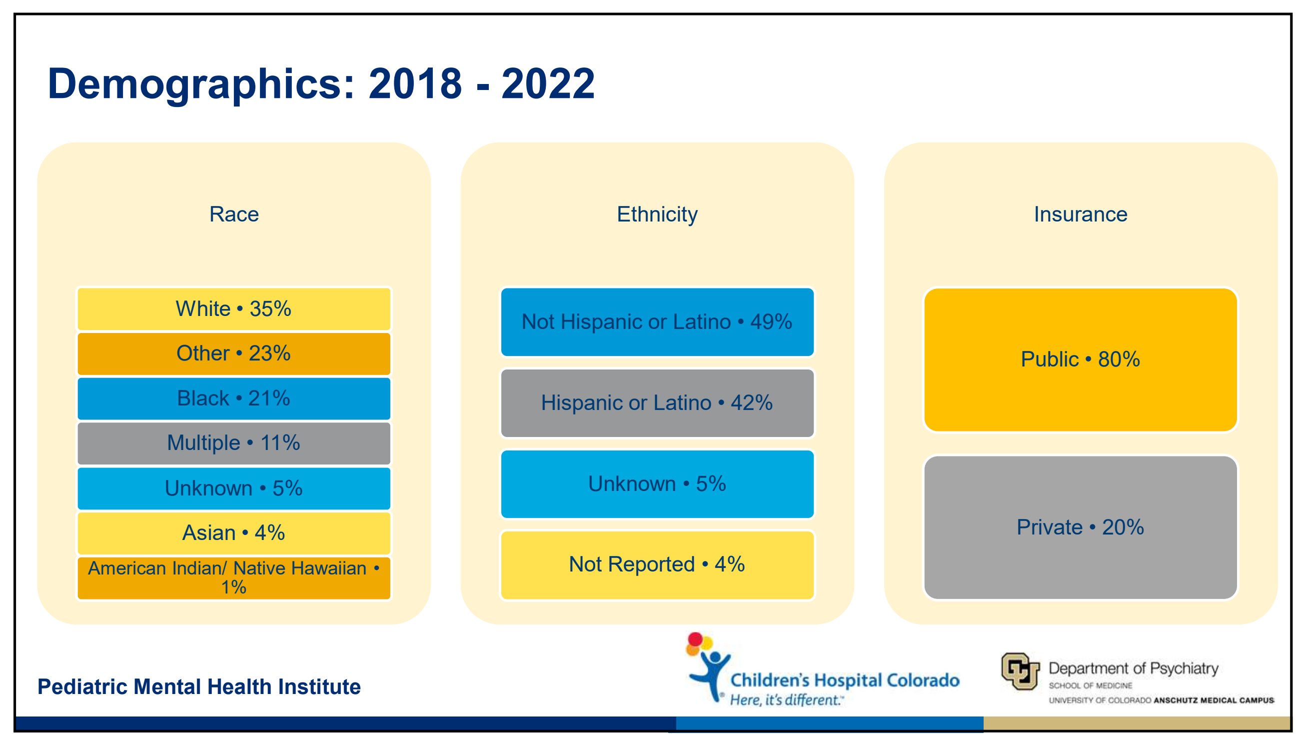

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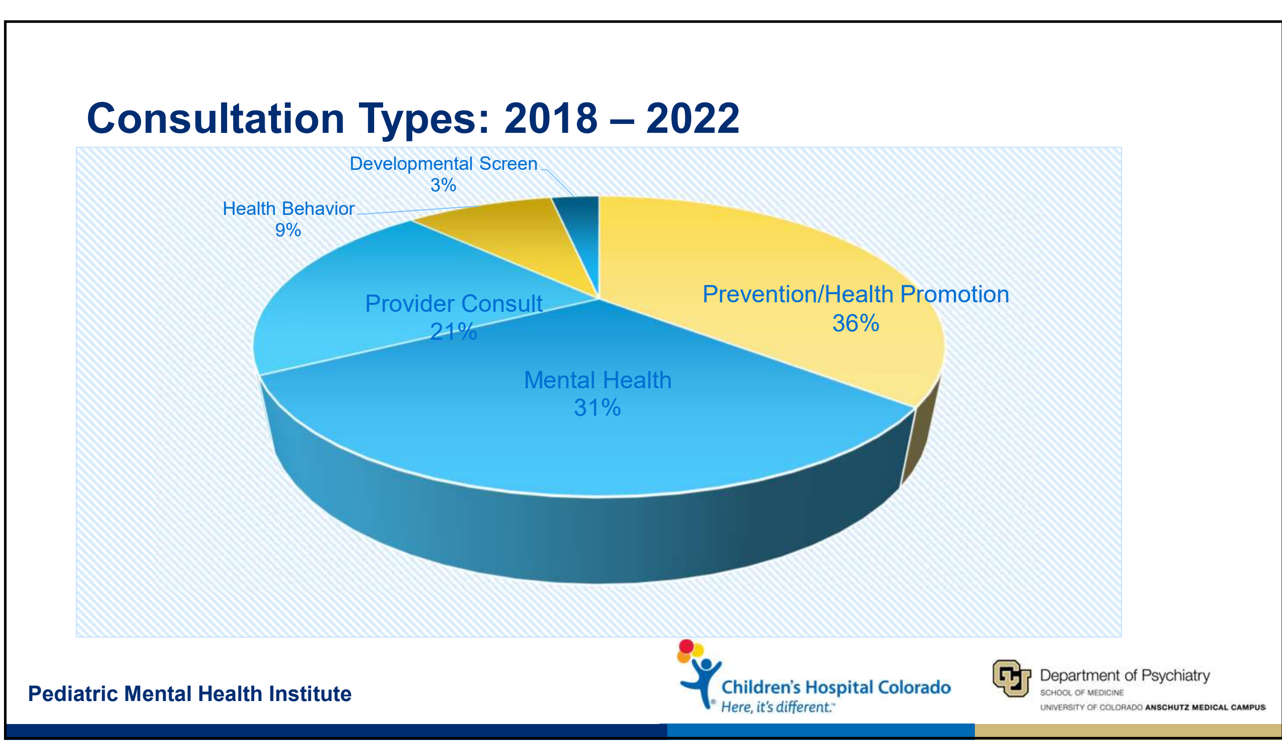

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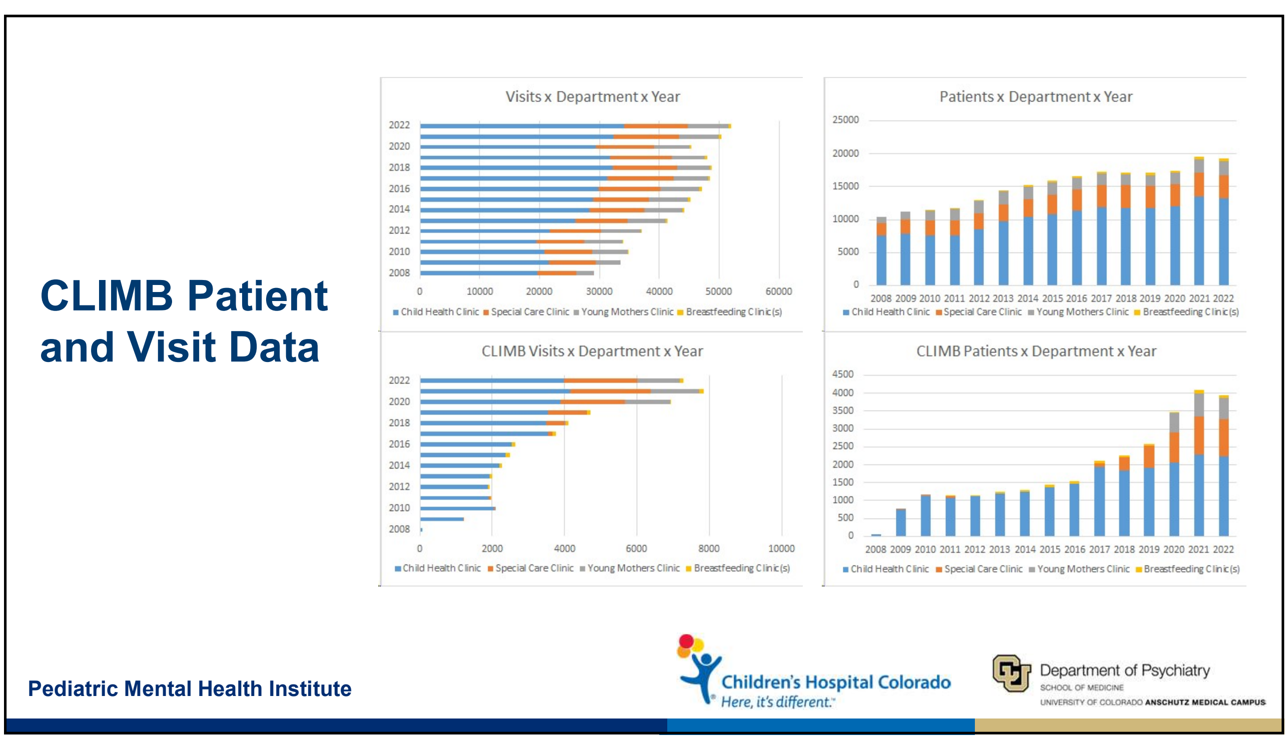

15

	EPDS	ASQ-3	M-CHAT-R	PHQ-9	Psychosocial
Ages we give the screener	0-4 months	2 month 5 years Adjust for Prematurity up to Age 2 years!	18, 24 months	11 years+ Except ASD, ID	Birth+
Visits when we screen	ALL	WCC/Physicals	WCC	ALL	WCC/Physicals
Who responds to + Screen	Provider CLIMB	Provider CLIMB, FN, CWS, NCC as needed	Provider Dev Peds CLIMB, FN, CWS, NCC as needed	Provider CLIMB	Provider FN, CHWS, SW, CLIMB NCC as needed
Scan Into Epic?	NO	Yes	Yes	Yes	NO, except the ROI for Food/resources

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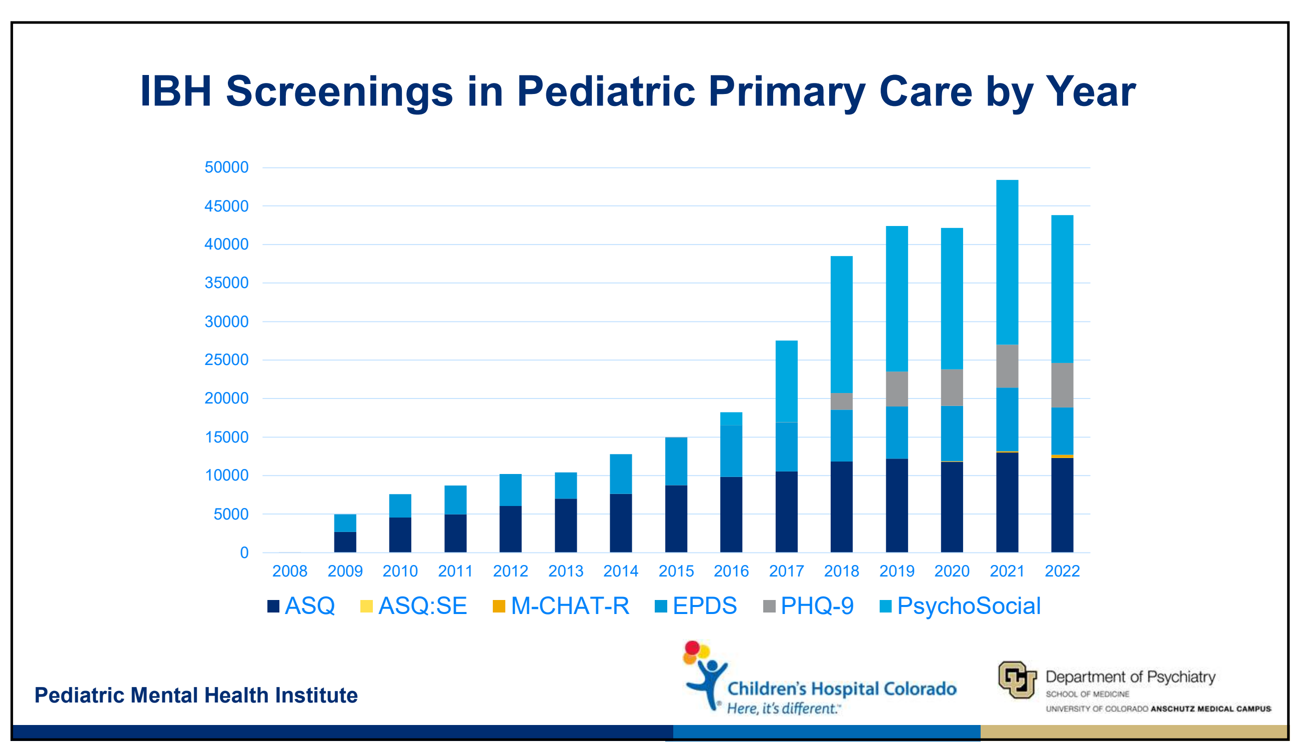
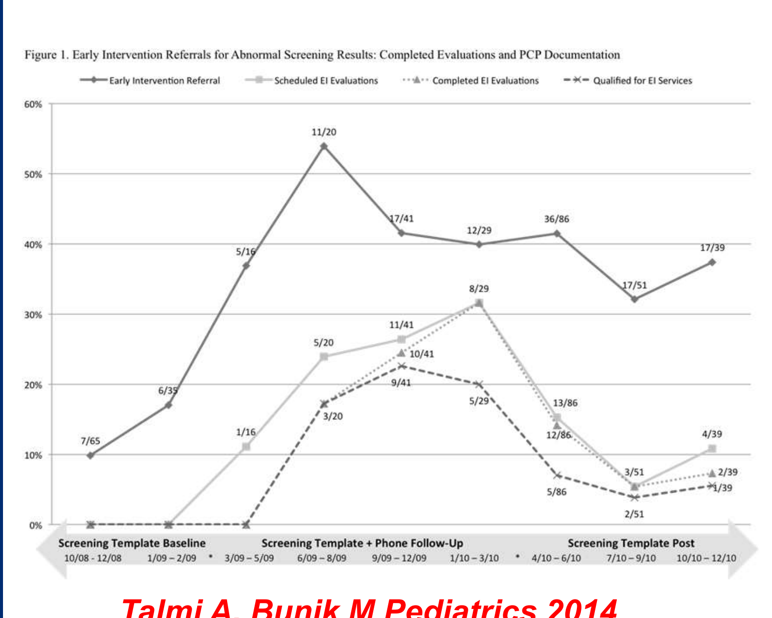
16



17

Developmental Screening and Closing the Referral Loop



Talmi A, Bunik M Pediatrics 2014

18

Healthy Steps

- Provide enhanced developmental services in pediatric primary care settings
- Focus on developing a close relationship between the clinician and the family in order to address the physical, socio-emotional, and cognitive development of babies and young children
- Baby & Me at the CHC

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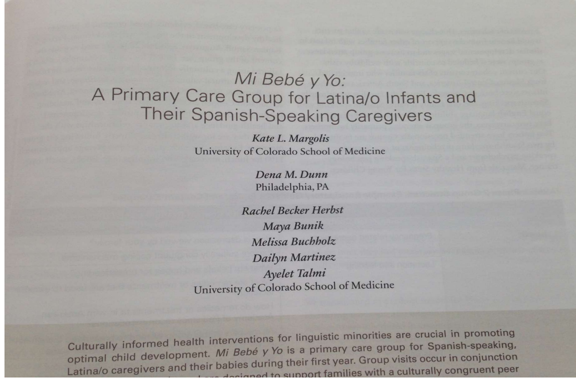
19

Baby & Me at the CHC



Mi Bebé y Yo:
A Primary Care Group for Latina/o Infants and Their Spanish-Speaking Caregivers

Kate L. Margolis
University of Colorado School of Medicine

Dena M. Dunn
Philadelphia, PA

Rachel Becker Herbst
Maya Bunik
Melissa Buchholz
Dailyn Martinez
Ayelet Talmi
University of Colorado School of Medicine

Culturally informed health interventions for linguistic minorities are crucial in promoting optimal child development. *Mi Bebé y Yo* is a primary care group for Spanish-speaking, Latina/o caregivers and their babies during their first year. Group visits occur in conjunction

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Breastfeeding Management

Evaluation earlier is better and support from an infant mental health specialist is crucial

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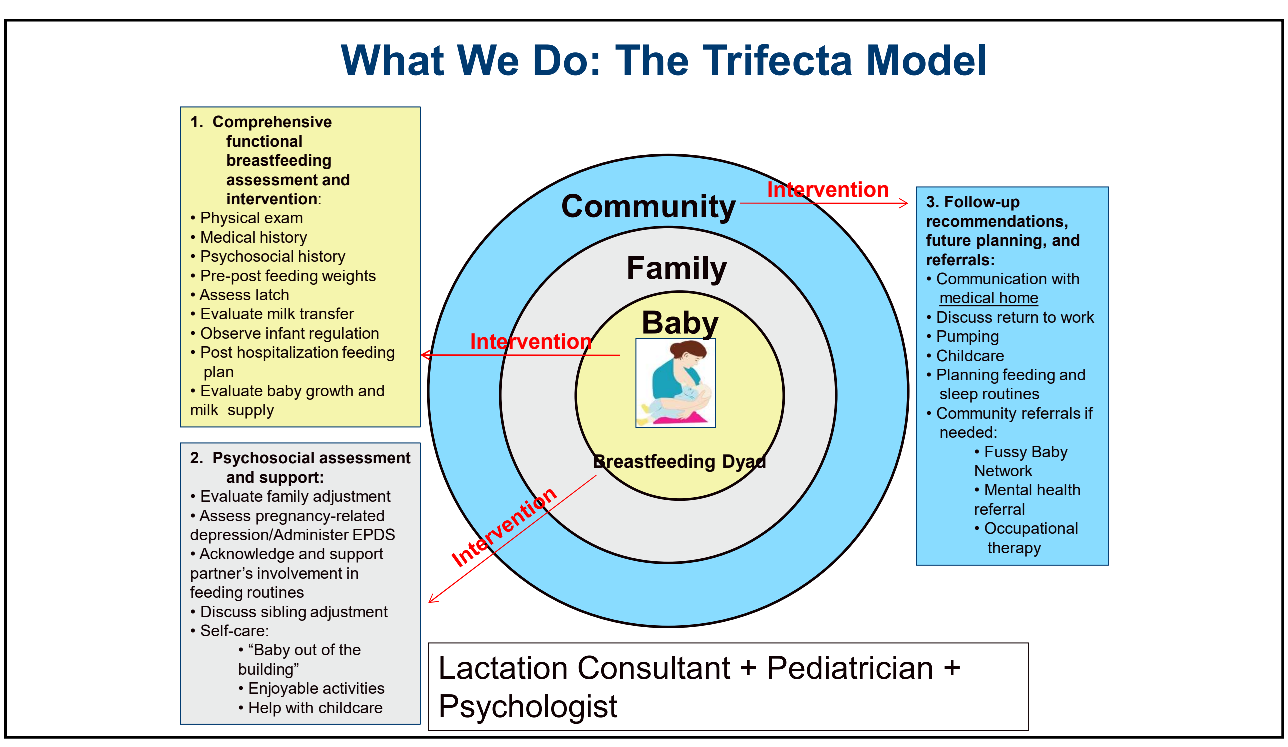
21

It's Complicated

- Pregnancy-related depression
- Paternal depression
- Sleep expectations/deprivation
- Sibling adjustment
- Financial stress
- Other family stressors
- Transition to parenthood
- Previous fertility or loss issues

22



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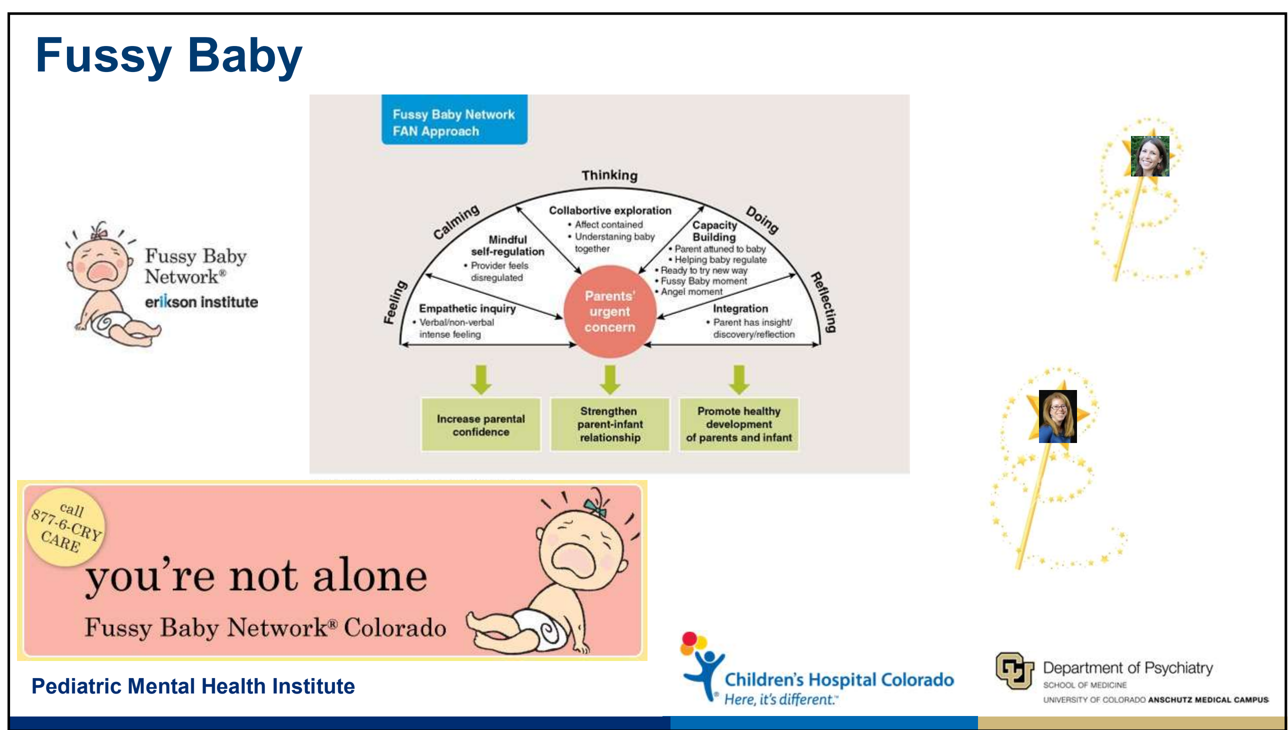

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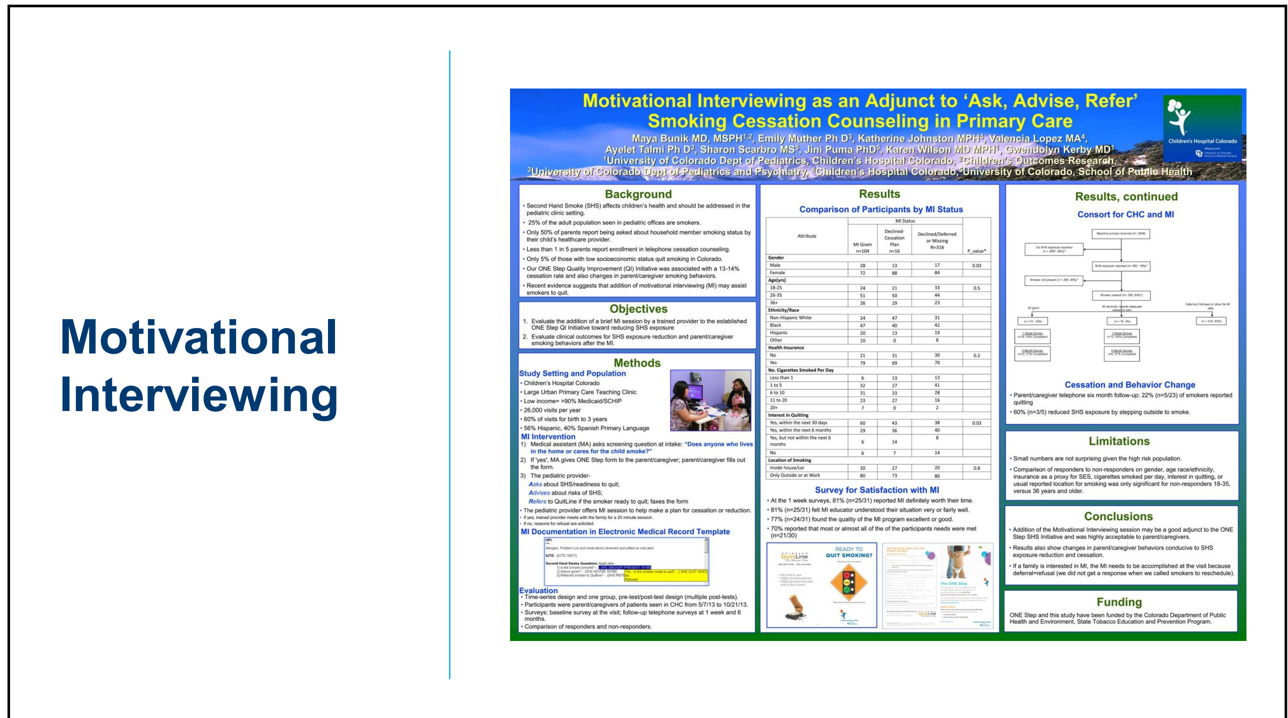

25

PHQ-9A

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

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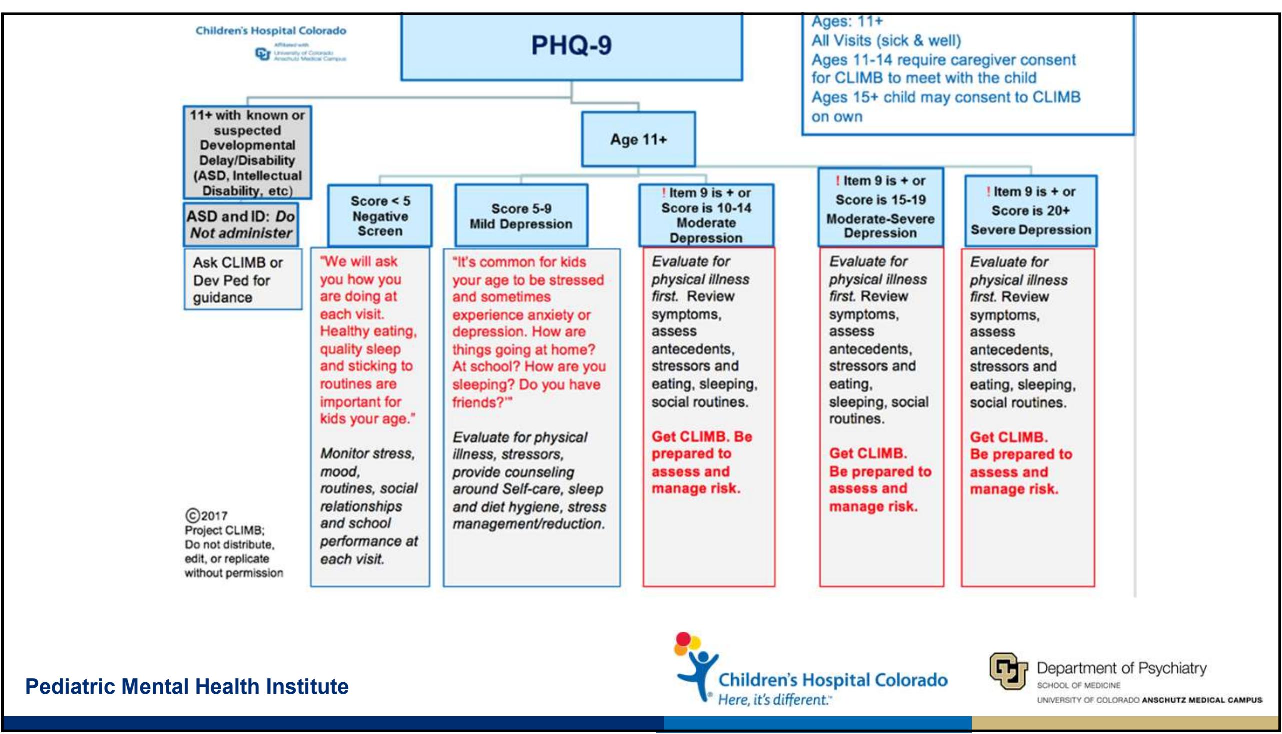
26



27

Risk Assessments in the CHC

- Typically identified by the PHQ-A (question #9) and EPDS (question #10)
- Can get consulted on children younger than 11 with SI

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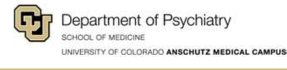


28

Children's Hospital Colorado

Do Not Scan

Patient Sticker

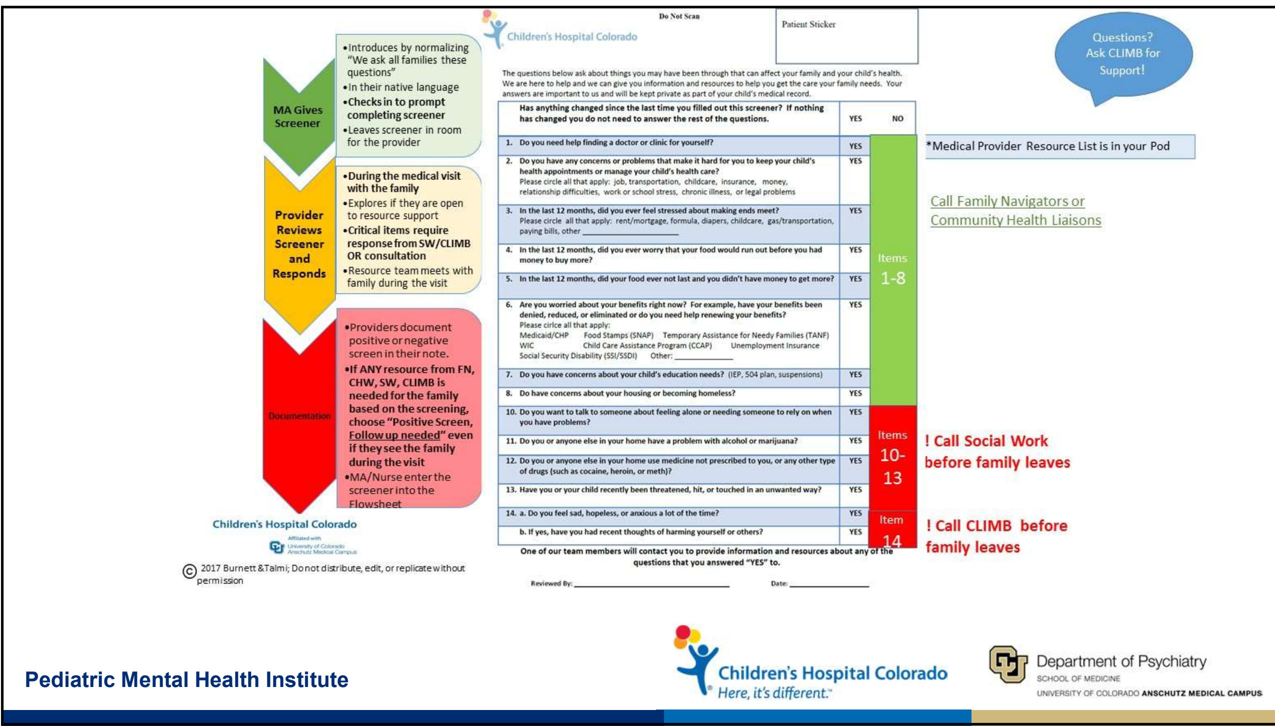
The questions below ask about things you may have been through that can affect your family and your child's health. We are here to help and we can give you information and resources to help you get the care your family needs. Your answers are important to us and will be kept private as part of your child's medical record.

Question		
Has anything changed since the last time you filled out this screener? If nothing has changed you do not need to answer the rest of the questions.	YES	NO
1. Do you need help finding a doctor or clinic for yourself?	YES	NO
2. Do you have any concerns or problems that make it hard for you to keep your child's health appointments or manage your child's health care? Please circle all that apply: job, transportation, childcare, insurance, money, relationship difficulties, work or school stress, chronic illness, or legal problems	YES	NO
3. In the last 12 months, did you ever feel stressed about making ends meet? Please circle all that apply: rent/mortgage, formula, diapers, childcare, gas/transportation, paying bills, other ______________	YES	NO
4. In the last 12 months, did you ever worry that your food would run out before you had money to buy more?	YES	NO
5. In the last 12 months, did your food ever not last and you didn't have money to get more?	YES	NO
6. Are you worried about your benefits right now? For example, have your benefits been denied, reduced, or eliminated or do you need help renewing your benefits? Please cirlce all that apply: Medicaid/CHP Food Stamps (SNAP) Temporary Assistance for Needy Families (TANF) WIC Child Care Assistance Program (CCAP) Unemployment Insurance Social Security Disability (SSI/SSDI) Other: ____________	YES	NO
7. Do you have concerns about your child's education needs? (IEP, 504 plan, suspensions)	YES	NO
8. Do have concerns about your housing or becoming homeless?	YES	NO
10. Do you want to talk to someone about feeling alone or needing someone to rely on when you have problems?	YES	NO
11. Do you or anyone else in your home have a problem with alcohol or marijuana?	YES	NO
12. Do you or anyone else in your home use medicine not prescribed to you, or any other type of drugs (such as cocaine, heroin, or meth)?	YES	NO
13. Have you or your child recently been threatened, hit, or touched in an unwanted way?	YES	NO
14. a. Do you feel sad, hopeless, or anxious a lot of the time?	YES	NO
b. If yes, have you had recent thoughts of harming yourself or others?	YES	NO

One of our team members will contact you to provide information and resources about any of the questions that you answered "YES" to.

Reviewed By: ______________________ Date: ______________

29



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	YES	NO
Has anything changed since the last time you filled out this screener? If nothing has changed you do not need to answer the rest of the questions.	YES	NO
1. Do you need help finding a doctor or clinic for yourself?	YES	
2. Do you have any concerns or problems that make it hard for you to keep your child's health appointments or manage your child's health care? Please circle all that apply: job, transportation, childcare, insurance, money, relationship difficulties, work or school stress, chronic illness, or legal problems	YES	
3. In the last 12 months, did you ever feel stressed about making ends meet? Please circle all that apply: rent/mortgage, formula, diapers, childcare, gas/transportation, paying bills, other ___	YES	
4. In the last 12 months, did you ever worry that your food would run out before you had money to buy more?	YES	
5. In the last 12 months, did your food ever not last and you didn't have money to get more?	YES	
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7. Do you have concerns about your child's education needs? (IEP, 504 plan, suspensions)	YES	
8. Do have concerns about your housing or becoming homeless?	YES	
10. Do you want to talk to someone about feeling alone or needing someone to rely on when you have problems?	YES	
11. Do you or anyone else in your home have a problem with alcohol or marijuana?	YES	
12. Do you or anyone else in your home use medicine not prescribed to you, or any other type of drugs (such as cocaine, heroin, or meth)?	YES	
13. Have you or your child recently been threatened, hit, or touched in an unwanted way?	YES	
14. a. Do you feel sad, hopeless, or anxious a lot of the time?	YES	
b. If yes, have you had recent thoughts of harming yourself or others?	YES	

One of our team members will contact you to provide information and resources about any of the questions that you answered "YES" to.

Reviewed By: ___ Date: ___

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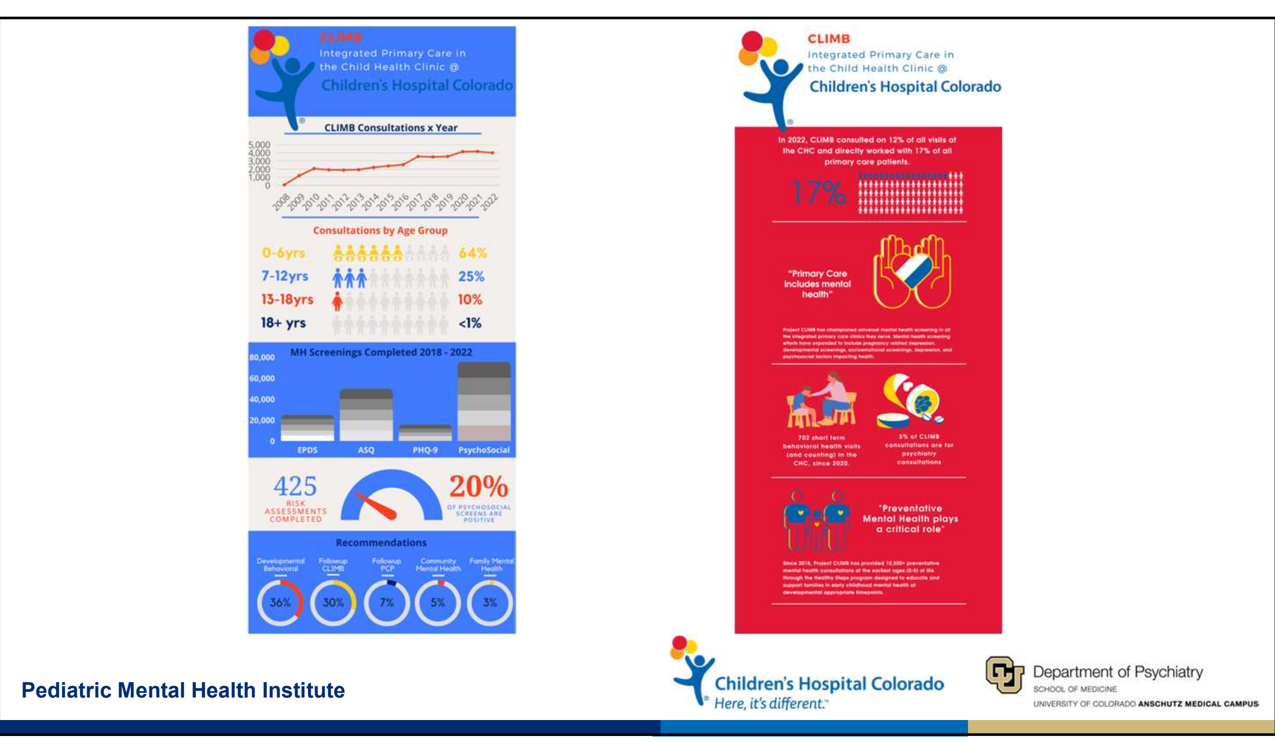

31

The Scope of Behavioral Health Integration in a Pediatric Primary Care Setting

Ayelet Talmi, PhD, Emily F. Muther, PhD, Kate Margolis, PhD, Melissa Buchholz, PsyD, Ryan Asherin, MA, and Maya Bunik, MD, MSPH

19
Integrated Behavioral Health in Pediatric Primary Care Settings
Using Screening Processes as Ports of Entry for Children and Families

Ayelet Talmi, Bridget Burnett and Melissa Buchholz

Sustaining Integrated Behavioral Health Practice Without Sacrificing the Continuum of Care

Rachel Becker Herbst, Kathryn L. Margolis, Brigitte B. McClellan, Jason L. Herndon, Amanda M. Millar, and Ayelet Talmi
University of Colorado School of Medicine

All Hands on Deck: Addressing Adolescent Depression in Pediatric Primary Care

Jessica Kenny, PhD, Lisa Costello, PhD, Kim Kelsay, MD, Maya Bunik, MD, MPH, Shengh Xiong, BS, Lauren Chiaravalloti, PsyD, Amanda Millar, MSS, and Ayelet Talmi, PhD

Chapter 9
Funding, Financing, and Investing in Integrated Early Childhood Mental Health Services in Primary Care Settings

Ayelet Talmi, Melissa Buchholz, and Emily F. Muther

Postdoctoral Fellows' Developmental Trajectories in Becoming Pediatric Primary Care Psychologists

Ayelet Talmi and Jennifer L. Lovell, University of Colorado School of Medicine; Rachel Becker Herbst, Children's Hospital Colorado, Aurora, Colorado; Kathryn L. Margolis, Emily F. Muther, and Melissa Buchholz, University of Colorado School of Medicine

Mi Bebé y Yo: A Primary Care Group for Latina/o Infants and Their Spanish-Speaking Caregivers

Young Minds Matter: Supporting Children's Mental Health Through Policy Change
August 2015
CCHAP
Colorado Children's Campaign

Increased behavioral health needs and continued psychosocial stress among children with medical complexity and their families during the COVID-19 pandemic

Jonna von Schulz | Verena Serrano | Melissa Buchholz | Crystal Natvig | Ayelet Talmi

Early Childhood Integrated Behavioral Health: A Promoter of Equity in Pediatric Care

Kathryn L. Margolis, Melissa Buchholz, Dominique Charlot-Swilley, Verena Serrano, Rachel Herbst, Elizabeth Meiselman, and Ayelet Talmi

BHIPP:0-5: Primary Care Practice Transformation in Early Childhood Behavioral Health Integration

Ayelet Talmi, Amanda Millar, Melissa Buchholz, Bridget Burnett, and Catherine Wolcott
Online First Publication, December 17, 2020. http://dx.doi.org/10.1037/cpp0000380

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32

Comradery: Main Lessons Learned

- Consultation extends beyond clinic for family and friends and self
- Mindful self-regulation
- What's in a baby name?
- "We all just want to know we are held in mind"
- I am a better pediatrician because I work along side you—I get extra credit
- The need to debrief saves us all from taking it all home

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33

Acknowledgements & Gratitude

- The children, families, staff, and providers in the primary care clinics at CHCO and statewide
- Child Health Clinic, Children's Hospital Colorado
- Project CLIMB Team
- University of Colorado School of Medicine, Departments of Psychiatry and Pediatrics
- Harris Program in Child Development and Infant Mental Health
- Children's Hospital Colorado, Pediatric Mental Health Institute

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34

35

Integrating Behavioral Health in the Outpatient Setting Resources

https://www.healthysteps.org

https://www.nctsn.org

https://www.samhsa.gov/resource-search/ebp

https://www.samhsa.gov/resource/ebp/integrated-models-behavioral-health-primary-care

NOVEMBER 8, 2024

Lessons from Primary Care: Strategies for Behavioral Health Clinic Culture Shift.

A conversation with Drs. Cecile Fraley & Sarah Humphrey

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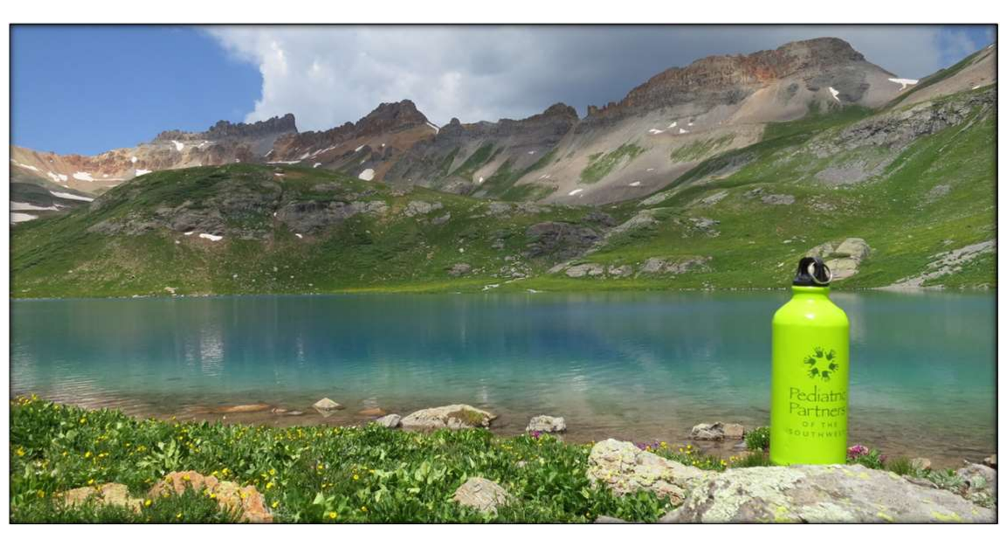

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2

INTEGRATED BEHAVIORAL HEALTH

M. CECILE FRALEY MD, CEO PPSW

Pediatric Mental Health Institute

3

PPSW: A LITTLE ABOUT US....

- Pediatrician-owned & mission driven
- Pediatric medical home established in 2005
- ~11,200 patients ages 0-22 years
- 35% Medicaid, 8% CHP+, 55% Private Pay
- 2 CDPHE funded School Based Health Centers in Durango & Bayfield
- 9 Pediatricians & 5 APP's
- Regional Hospitalists (next closest admitting pediatricians are about ~ 3 hours away)
- Largest sub-specialty and tele-medicine clinics partnership with CHCO, now entering our 11th year (344 miles away)
- Integrated Behavioral Health Program began in 2012; 4 FTE BH Consultants (BHC's) & 1 FTE BH Care Coordinator. HCPF: "Fire House Model". Also called the Primary Care BH Model (PCBH).
- Innovation paired with "No margin, No Mission"

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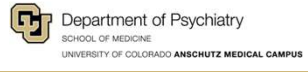

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History of PPSW's Integrated Behavioral Health Team (IBH)

- 2012: Our integrated behavioral health program began as a Behavioral Health Medical Home with up to 10% of office visits consisting of behavioral health needs and with a focus on prevention. We realized that our approach would need to have both breadth and depth.
- 2014: Rocky Mountain Health Plans also sees this need and we receive money for an Integrated Behavioral Health Program, thus giving wings to the program. Hmmm--- accountability and data?!!
- 2015: We created and modeled our program after the CLIMB program at CHCO with modifications for specific needs of a rural community. Thank you to CHCO Steve Poole for training support.
- 2015 Telepsychiatry: We established a co-managed relationship with Dr. Kimberly Kelsay of CHCO psychiatry who provides telepsychiatry visits twice a month. This has allowed for great specialty care and consultative support for our providers.
- 2019: Started incorporating HCPF "6-visit coding" to allow our behavioral health counselors to see patients with Medicaid for regularly scheduled visits.
- Current Model: 4 full time BHC employees and 1 FTE BH Care Coordinator who are an integral part of the team providing hot spotting, toolkit visits, resiliency visits, care coordination with therapists/schools/mental health center, screenings, early intervention referrals, 504 letters, therapist referrals, 6-visit counseling (capped 6 clients /PPSW BHC) staffing with local psychiatric providers, and supportive population mangement for high-risk individuals (SDoH, CWH3, Autism, and Psych NP Medical Homes). Funding: RAE $ + SBHC $ + HCPF 1302 Grant + CPT charges.

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5

A Day in the Life of a BHC: Intervention

Hot spotting: unplanned visit to address a newly identified need such as somatic symptoms, school difficulties, grief, parental concerns, case management/community referrals, big feelings, safety planning, therapist referrals, sleep challenges

Early intervention referrals: send in & provide handouts for activities for speech and language, gross motor, fine motor, problem solving

504 letters: physician's letter of support for ADHD, Anxiety, Depression, Concussion

Therapist referrals: ongoing list of those accepting referrals that we update quarterly so we can identify who might be a good fit and circle these for families to have a more specialized referral and more likely follow through (we can assist with a warm handoff as needed)

Care coordination: with outside providers based on immediate needs community mental health center, schools, early intervention, therapists, psychiatrists, health department, community resources

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A day in the life of a BHC: Prevention

- Toolkit visits: visit for a known challenge such as anxiety, depression, potty training, ADHD, behavioral challenges
- Resiliency visits: preventative visit at scheduled intervals such as new baby, 1 month, toddler, Kindergarten, middle school, high school, adulting
- Care coordination: monthly meetings to keep lines of communication open with community mental health centers, early intervention, psychiatrists, health department, and community resources
- Screenings:
  PHQ9s, SCAARED, Vanderbilt, ASQ, MCHAT
- Supportive population mangement:
  CWH2+3, Autism Medical Home, Psych NP

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7

PPSW IBH Team Resiliency Focus

- Preventative visits
- Medical trauma prevention through procedure support
- Mental health care access in the moment
- Referrals for appropriate care
- Time to create trusting relationships
- Same support offered to a variety of families
- Supports BHC's bandwidth and employment joy

From the California Surgeon General's Playbook at COVID19.CA.gov

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WYS WESTERN YOUTH SERVICES

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aces aware
GRANTEE

8

Population Managed Medical Homes: IBH Team Role

- Provider, Nurse Champion or BHC with protected time to support patients and families
- Shared focus on supports, up to date Well Visits, and portal access
- Problem list entry with standardized information
- Data pulled monthly by clinical champion for partner meeting
- Asthma Medical Home: patients with persistent asthma requiring maintenance medicines
- Diabetes Medical Home: patients with type 1 diabetes mellitus
- Complex Care Medical Home: multiple or complex medical issues
- Autism Medical Home: ABA, school supports, care coordination, IEPs/504s
- Child Wellness Home 3: SDoH supports, monthly check ins, 95% Medicaid, 75% WCC rate
- Psychiatric NP Wellness Home: care coordination (therapists, nutritionists, schools, etc.), 504s

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9

Risk Stratification Model at PPSW

Risk Level	Definition	ACEs score	Level of Support
CWH-3	Extremely high risk for crisis or in Crisis	High ACES* (>4) with *significant* sxs / Resiliency factors limited	Supported in the **Child wellness home** with a detailed care plan and monthly check ins
CWH-2	Moderate Risk	ACES > 1 with sxs/ Resiliency factors slightly outweighed by risk factors	Supported in the **Child wellness home** with a detailed care plan
CWH-1	Low Risk	ACES 1-4 without sxs/Resiliency factors outweigh risk factors	**May benefit from** BHC involvement for brief intervention, referrals, secondary assessments, care coordination, and/or family education
CWH-0	Very Low Risk	ACES 0/ Resiliency factors present	**Continue to promote and support resiliency factors**

*ACES: adverse childhood experiences

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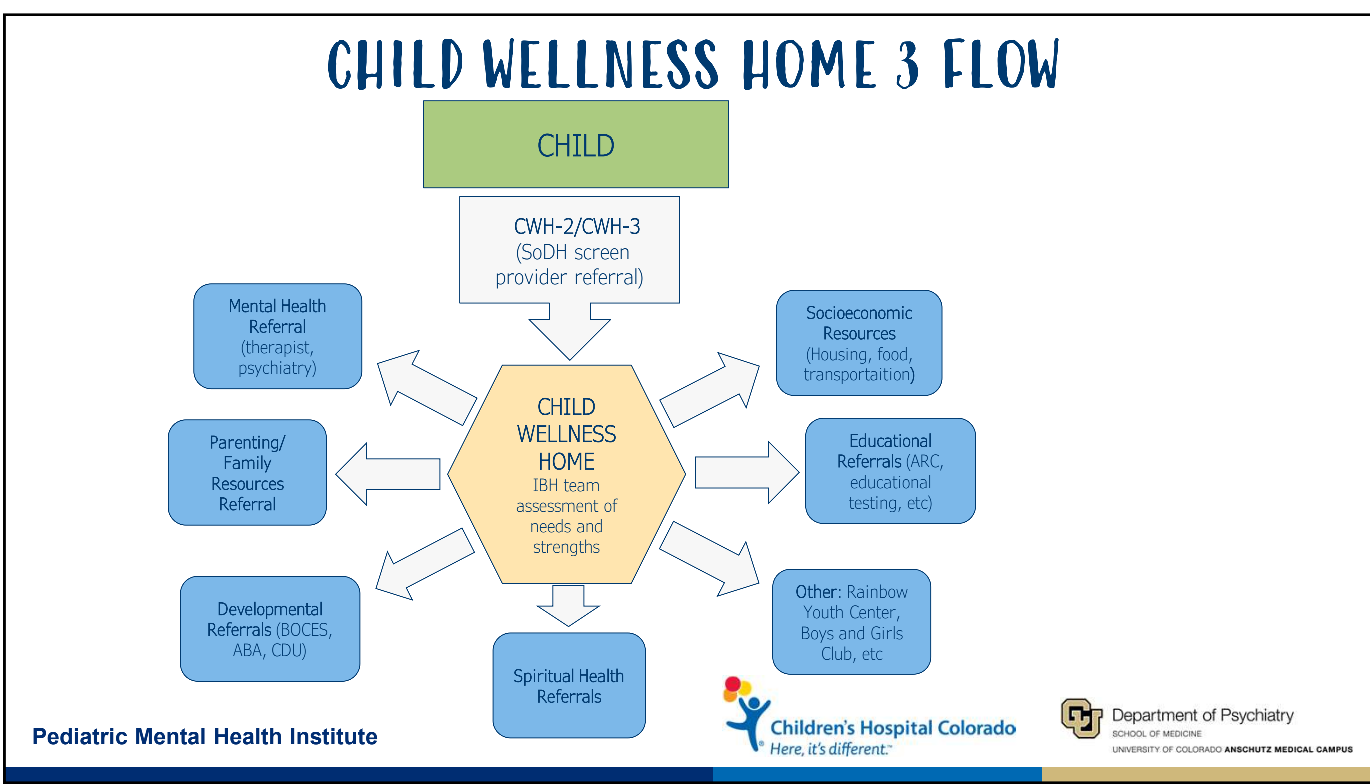

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Billing :

- We bill Medicaid & CHP+ for our IBH Team interventions
- Our primary CPT codes are psychotherapy and care coordination codes (T1017 & T1026)
- Psychotherapy codes includes hot-spotting and HCPF "6-visit" counseling
- We cap each BHC at six "6-visit"* clients to maintain Fire House Model accessibility.*Medicaid/CHP+ only
- Care Coordination T-codes may need to be contracted through your RAE

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Data: Finances with billed sessions

2022 BHC 6 Session CPT			Q1 2022						Q2 2022					
CPT	CPT Fee	BHC 6 Session CPT Description	January	February	March	Billed Charges	Collected	% Collected	April	May	June	Billed Charges	Collected	% Collected
90791	$ 200.00	**Diagnostic Evaluation**	3	3	2			70.29%	0	3	0			74.50%
90832	$ 105.00	**Psychotherapy- 30 Minutes**	26	22	28			53.15%	28	22	20			54.65%
90834	$ 135.00	**Psychotherapy- 45 Minutes**	4	2	0			52.36%	2	0	0			22.67%
90837	$ 190.00	**Psychotherapy- 60 Minutes**	21	31	32			42.11%	23	22	22			46.03%
90846	$ 112.00	**Family Psychotherapy without patient**	1	3	0			66.50%	1	2	1			72.50%
90847	$ 118.00	**Family Psychotherapy with Patient**	2	4	6			0.00%	1	5	1			75.89%
			Total 6 Visit:					47.47%	**Total 6 Visit:**					51.01%
			Total 6 Vist and Care Coordination:					45.31%	**Total 6 Vist and Care Coordination:**					41.97%

2022 6 Visit and Care Coordination Total	January	February	March	April	May	June	July	August	September	October	November	December
Total 6 Session Visits	57	65	68	55	54	44						
Care Coordination Provider Billed	1	7	3	2	0	3						
Care Coordination BHC Billed	43	66	61	33	52	48						
2022 6 Visit Appointments By Provider	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
LeAnn Shaw	10	12	8	5	8	12						
Shayla Walker	9	12	8	7	9	6						
Anne Holmes	11	16	14	11	10	4						
2022 Insurance 6 Session	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
RMHP CHP+	1	4	1	0	0	0						
Medicaid	28	35	29	23	26	22						
Other	1	1	0	0	1	0						

2022 Care Coordination			Q1 2022						Q2 2022					
CPT	CPT Charges	Care Coordination CPT Description	January	February	March	Billed Charges	Collected	% Collected	April	May	June	Billed Charges	Collected	% Collected
T1017		**Targeted Case Management**	41	62	58			17.39%	31	52	47			15.22%
T1026		**Care Coordination (Per Hour)**	3	11	6			83.92%	4	0	4			62.88%
			Total Care Coordination Visit:					42.15%	Total Care Coordination Visit:					26.04%
			Total 6 Vist and Care Coordination:					45.31%	Total 6 Vist and Care Coordination:					0.00%

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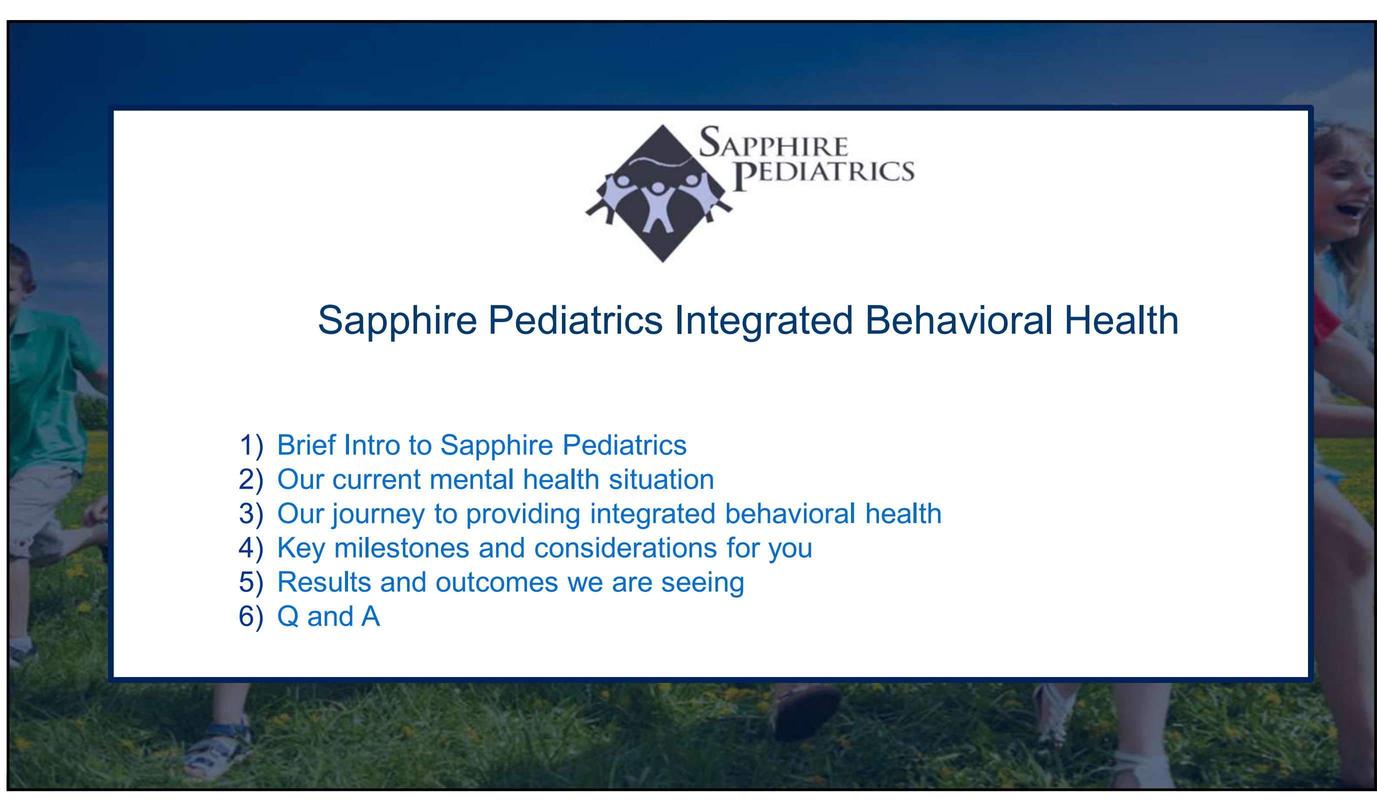

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ABOUT US

- Have been in business for 20+ years!
- Located in central Denver
- Co-located with Health One/Rose Medical Center

- Seven Doctors
- Two Behavioral Health Providers

- 5000 patients and growing!

- 28% on Medicaid

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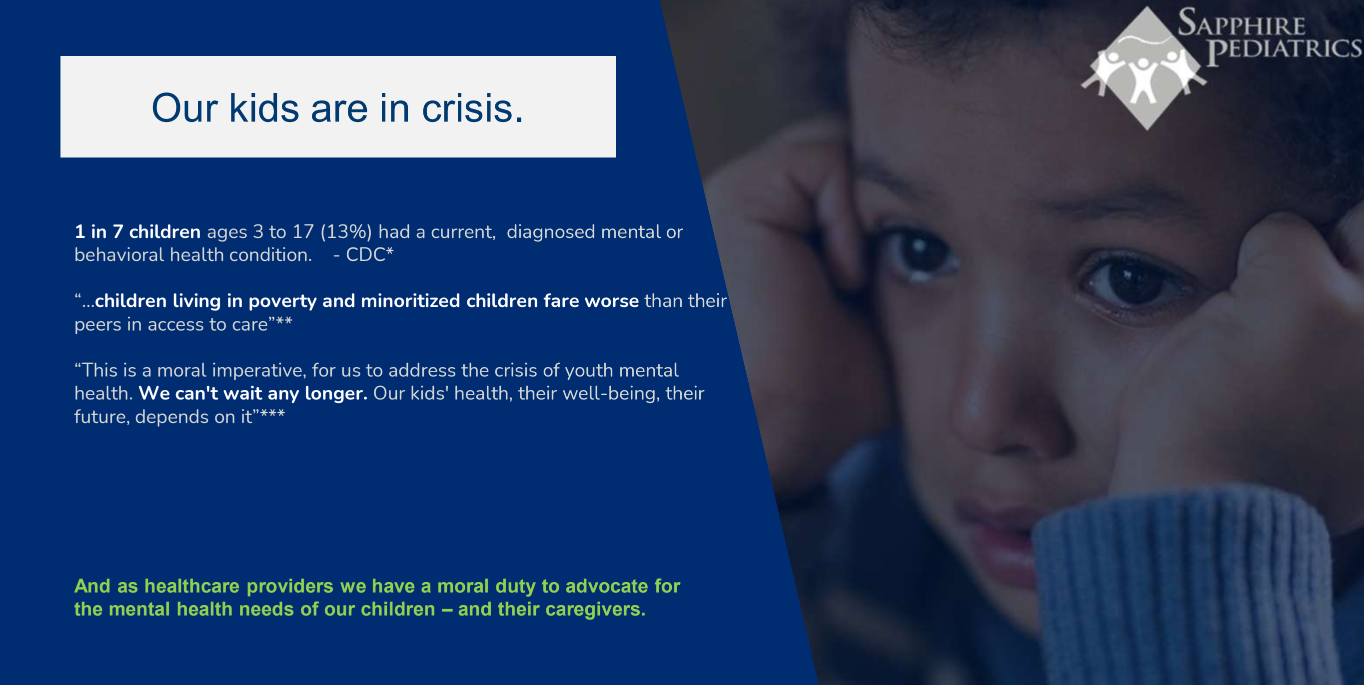

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We knew there was a need to provide more mental health support for our patients

Prior to Investment	Today
• If a need presented itself, we provided families with a list of mental health professionals • Many mental health providers were above capacity • Need and diagnoses went un-answered or deferred It was often the families with resources to pay for expensive diagnostic procedures and support who could care appropriately for their children's mental health care needs.	• Today we can see patients in house • Can provide initial assessment and advise families on path forward • Not only do we prescribe next steps, but have the capacity to ensure that the right level of help is found • Can provide visits with the BHP and MD together as a shared visit or separately but in coordination

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17

SAPPHIRE PEDIATRICS

How we were able to secure the support we needed

What we did

Some ideas/resources for you

- Early 2018 — Applied for grant – SIM
- October 2018 — First Mental Health Professional started
- April 2023 — Applied for grant #2 – Health Steps
- Sept 2024 — Tara, provider #2 started, birth to early childhood 14 tier 3 families, 20+ tier 2, just getting started!

There are many grants out there, suggest starting your search

There are grant programs that can help with implementation of these programs. Most recent grant was HB 1302, but there are others.

The goal, of course, is to make these programs financially sustainable

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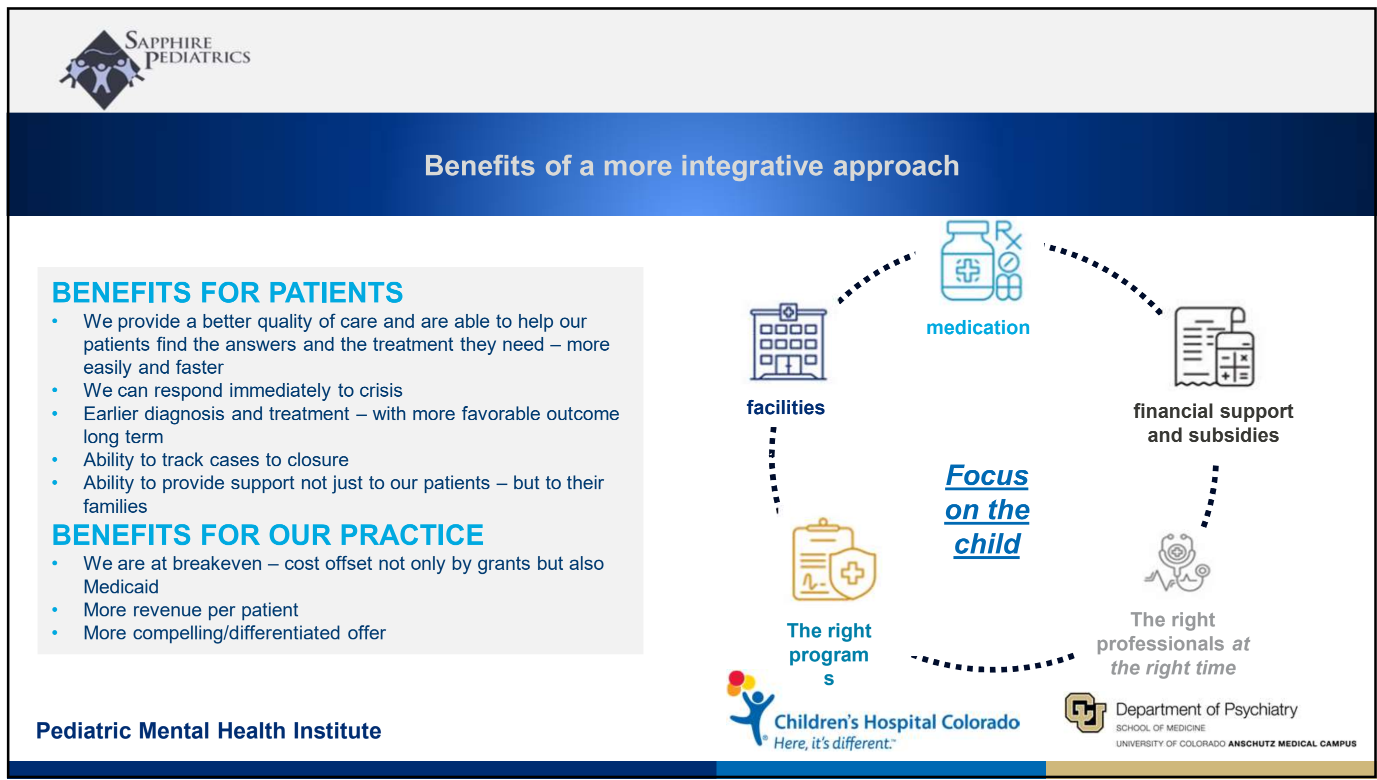

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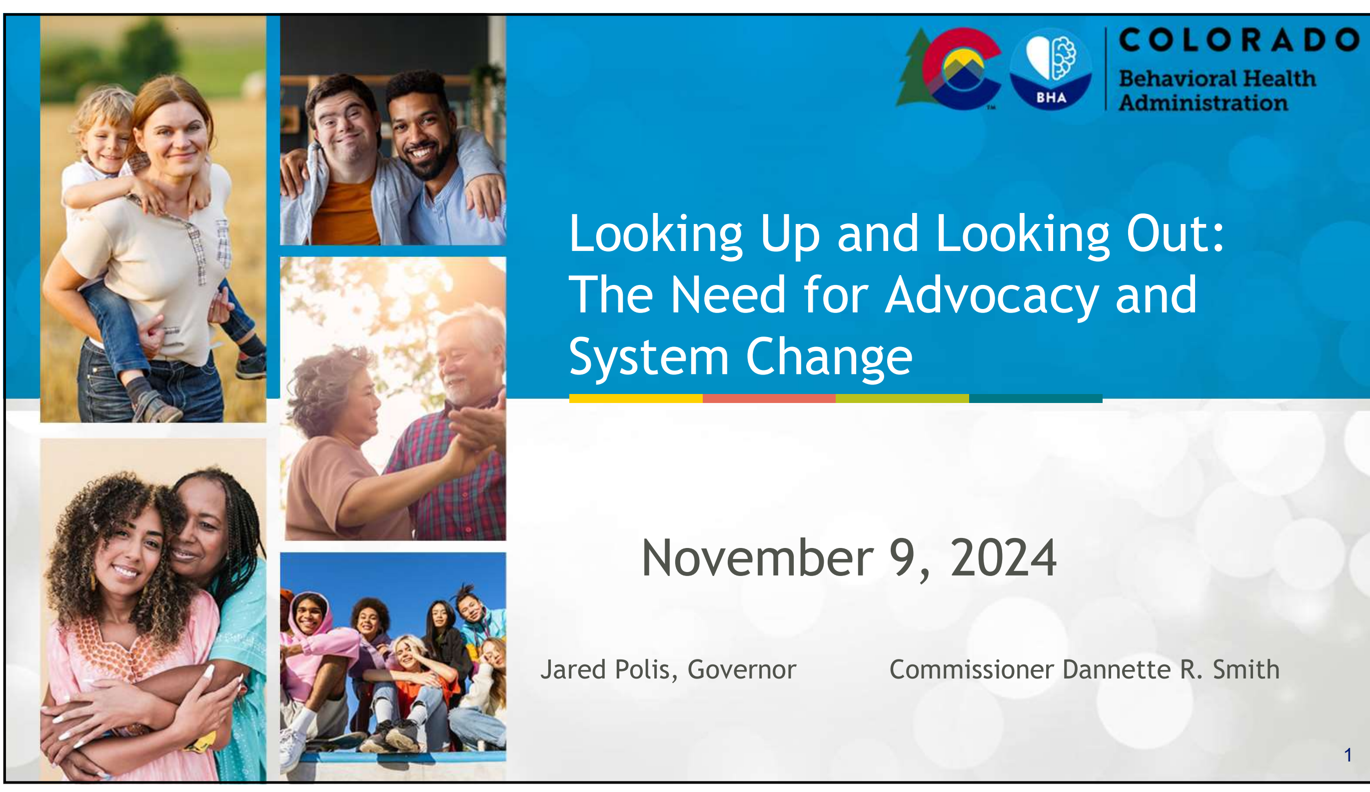

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BHA Vision

Behavioral health services in Colorado are accessible, meaningful, and trusted

BHA Mission

Co-create a people-first behavioral health system that meets the needs of all people in Colorado

3

3

BHA Corporate Goals

1. Establish a "Solid Foundation" for the behavioral health continuum through thoughtful legislation, internal policies and procedures.
2. Solidify a strong and robust workforce within BHA that is innovative, groundbreaking and trailblazing as we work with communities around the state.
3. Seek opportunities to be creative, and co-create behavioral health strategies that enhance and embellish the services delivery system across Colorado.
4. Ensure that BHA has developed a behavioral health care system that is sustainable and can be implemented across the state, and yet has the flexibility to address specific needs of the state's unique and diverse communities.

4

4

BHA 5 Priorities

Launched July 1, 2024

- **Behavioral Health Safety Net System:** Reforming and Strengthening with Public Input
- **Behavioral Health Care Coordination System:** Coordinating Support
- **BHA Performance Hub:** Launching Colorado's Behavioral Health Data Bank
- **Behavioral Health Care Grievance and Complaint Process:** Increasing Transparency & Improving Timelines
- **Children and Youth Behavioral Health Implementation Plan:** Delivering Improved Access

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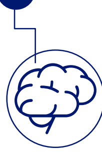
Children and Youth Implementation Plan: Envisioning a Continuum of Care

In October, BHA's organizational chart shifted to reflect our focus on establishing a continuum of care truly dedicated to serving children and youth with their unique needs in mind



Early Childhood

A robust continuum means that behavioral health services are woven into every system that takes care of our kids:

- Healthcare system (including hospitals)
- Child welfare system
- Juvenile justice system
- Education system

This will allow us to create a better prevention and behavioral health recovery model that allows children and youth to transition back into the community and to have successful adult lives..

6

6

Integration: Our Critical Work Together

- As hospitals and pediatric primary care providers, you are community connectors - critical lifelines to our behavioral health system.
- Close collaboration between pediatric primary care and behavioral health care providers will increase integration of services to expand to a solid behavioral health foundation for children and youth.

7

7

Expanding on the Children and Youth Behavioral Health Implementation Plan

Reaching All Youth

Connection

BHA is committed to reaching youth in our most rural and frontier communities. We can do this through our partnership with the RAE's and BHASO's, along with continuing to publicly engage community partners in our efforts

Inter-Agency Effort

Collaboration

We have worked with the Governor's office and many state agencies to align the work occurring throughout the state. This work will continue with the creation of a landing page for all youth behavioral health efforts housed by BHA.

Defining Our Model

Expertise

BHA has contracted with a national partner, the Technical Assistance Collaborative (TAC), to help define the behavioral health service model for children, youth, and families through the care continuum. TAC will also help identify the necessary infrastructure, which will guide the data team's evaluation and development of KPIs.

8

8

BHASO Implementation Road Map

Implementation road map for the Behavioral Health Administrative Service Organizations (BHASOs) in Colorado.

1. **AUGUST 2023** Request for Information
2. **SPRING 2024** Request for Proposals
3. **FALL 2024** Vendors selected
4. **JANUARY 2025** Network development begins
5. **JULY 1, 2025** Launch!

9

10

Managing a Behavioral Health Crisis in Primary Care & Escalation Pathways

Beau A. Carubia, M.D.

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Associate Medical Director, Pediatric Mental Health Institute, Children's Hospital Colorado

Medical Director Consultative Division, Pediatric Mental Health Institute, Children's Hospital Colorado

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Questions:

1. Examples of a behavioral health crisis you have been asked to manage in your practice?
2. When is it in my scope to manage?
3. When should I refer to BH provider?
4. When should I send to the ED?

4

Learning Objectives

Review data driving pediatric mental health crisis and identify evidenced-based tools available for use in pediatric ambulatory settings for evaluation of suicide risk

Demystify the Emergency Room Process. What is a Crisis Evaluation?

When to send to an ED? Review available routes of escalation of care

5

National State of Emergency in Child and Adolescent Mental Health

CHILDREN'S HEALTH

Pediatricians say the mental health crisis among kids has become a national emergency

OCTOBER 20, 2021 · 3:50 PM ET

- Joint declaration in Oct 2021 by:
  - American Academy of Pediatrics (AAP)
  - American Academy of Child & Adolescent Psychiatry (AACAP)
  - Children's Hospital Association (CHA)

6

Behavioral Health in Community Practice

Volume 152, Issue 3
September 2023

FROM THE AMERICAN ACADEMY OF PEDIATRICS | POLICY STATEMENT | AUGUST 16 2023

The Management of Children and Youth With Pediatric Mental and Behavioral Health Emergencies FREE

Mohsen Saidinejad, MD, MS, MBA, FAAP, FACEP; Susan Duffy, MD, MPH, FAAP; Dina Wallin, MD; Jennifer A. Hoffmann, MD, FAAP; Madeline M. Joseph, MD, FAAP, FACEP; Jennifer Schieferle Uhlenbrock, DNP, MBA, RN, TCRN; Kathleen Brown, MD, FAAP; Muhammad Waseem, MD, MS, FAAP, FACEP, CHSE-A; Sally Snow, BSN, RN, CPEN, FAEN; Madeline Andrew, MD; Alice A. Kuo, MD, PhD, MBA, FAAP; Carmen Sulton, MD, FAAP; Thomas Chun, MD, MPH, FAAP; Lois K. Lee, MD, MPH, FAAP, FACEP; AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine; AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee; EMERGENCY NURSES ASSOCIATION Pediatric Committee

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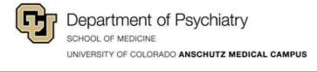
https://doi.org/10.1542/peds.2023-063255 **Article history**



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Bright Futures Recommendations; 2022

- American Academy of Pediatric s (AAP)/Bright Futures Recommendations for Preventative Pediatric Care recommends screening for suicide risk for all youth ages 12 and above.
    - Age Recommendations:
        1. Youth ages 12+: Universal screening
        2. Youth ages 8-11: Screen when clinically indicated
        3. Youth age < 8: Screening not indicated.
            a. Assess for suicidal thoughts/behaviors if warning signs present

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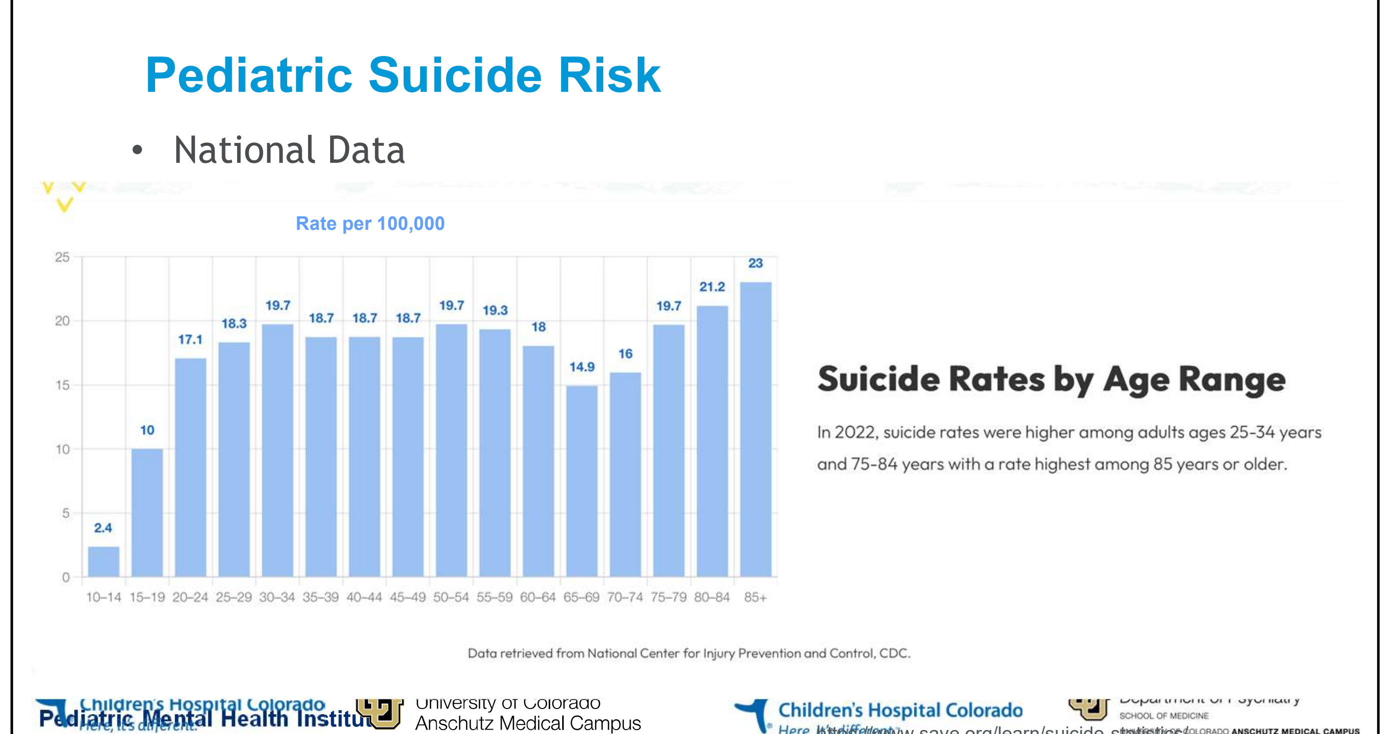
Pediatric Suicide Risk

- National Data



https://www.save.org/learn/suicide-statistics/

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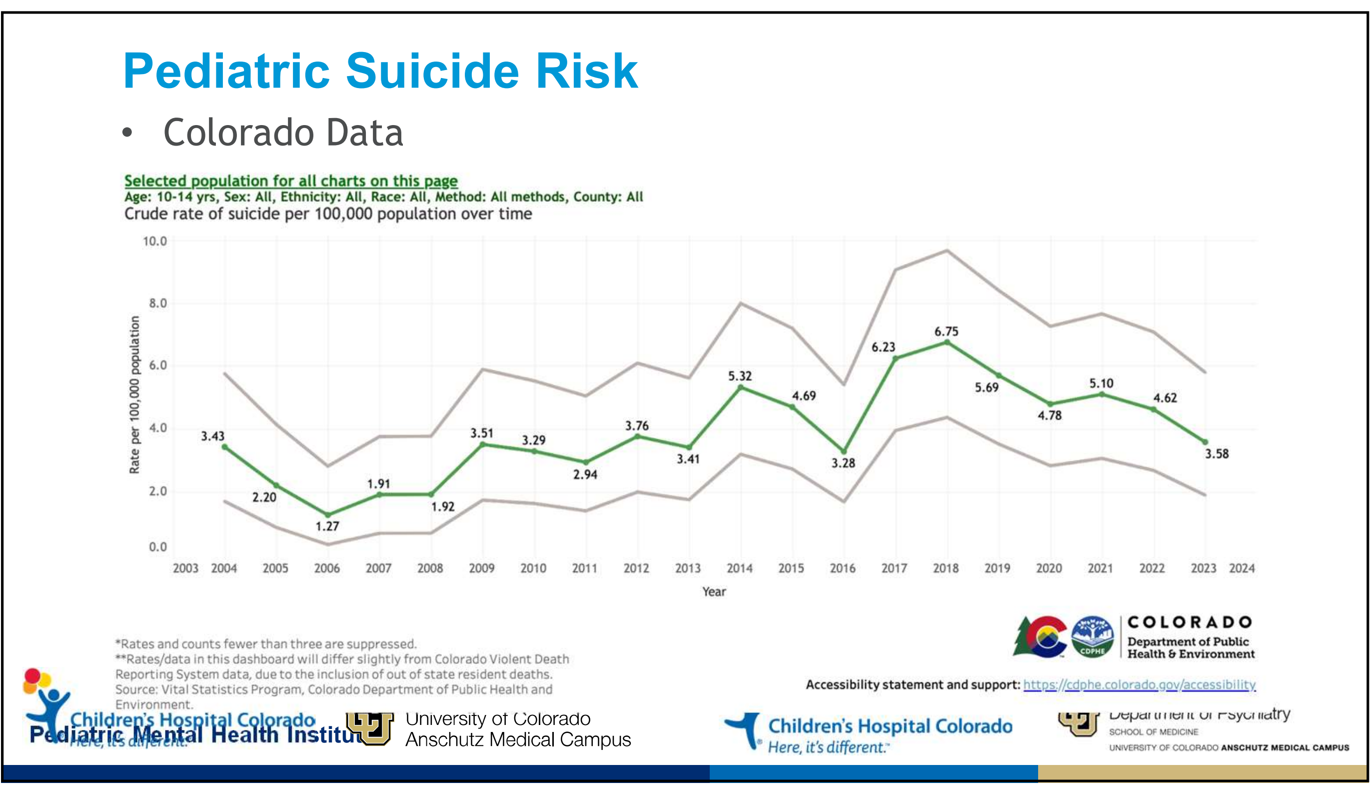

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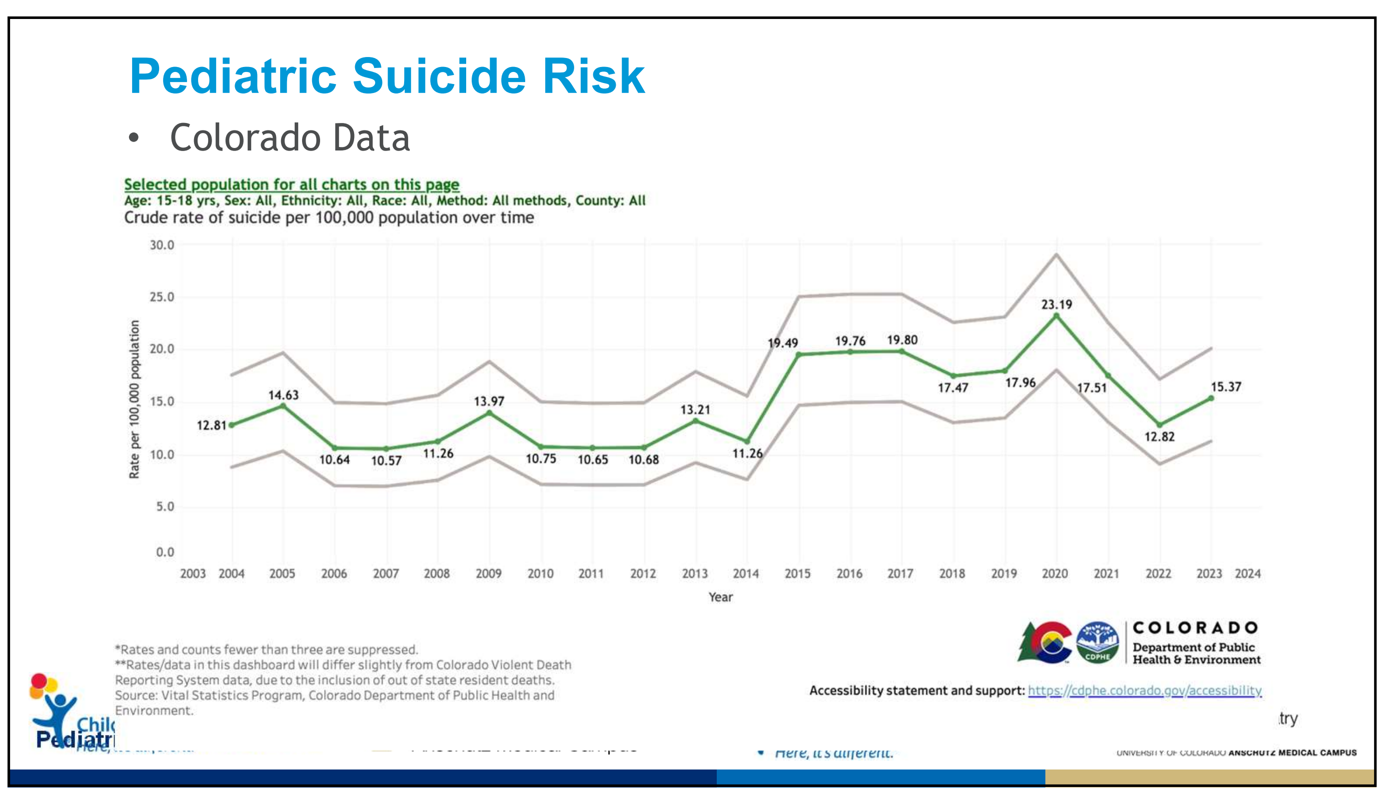

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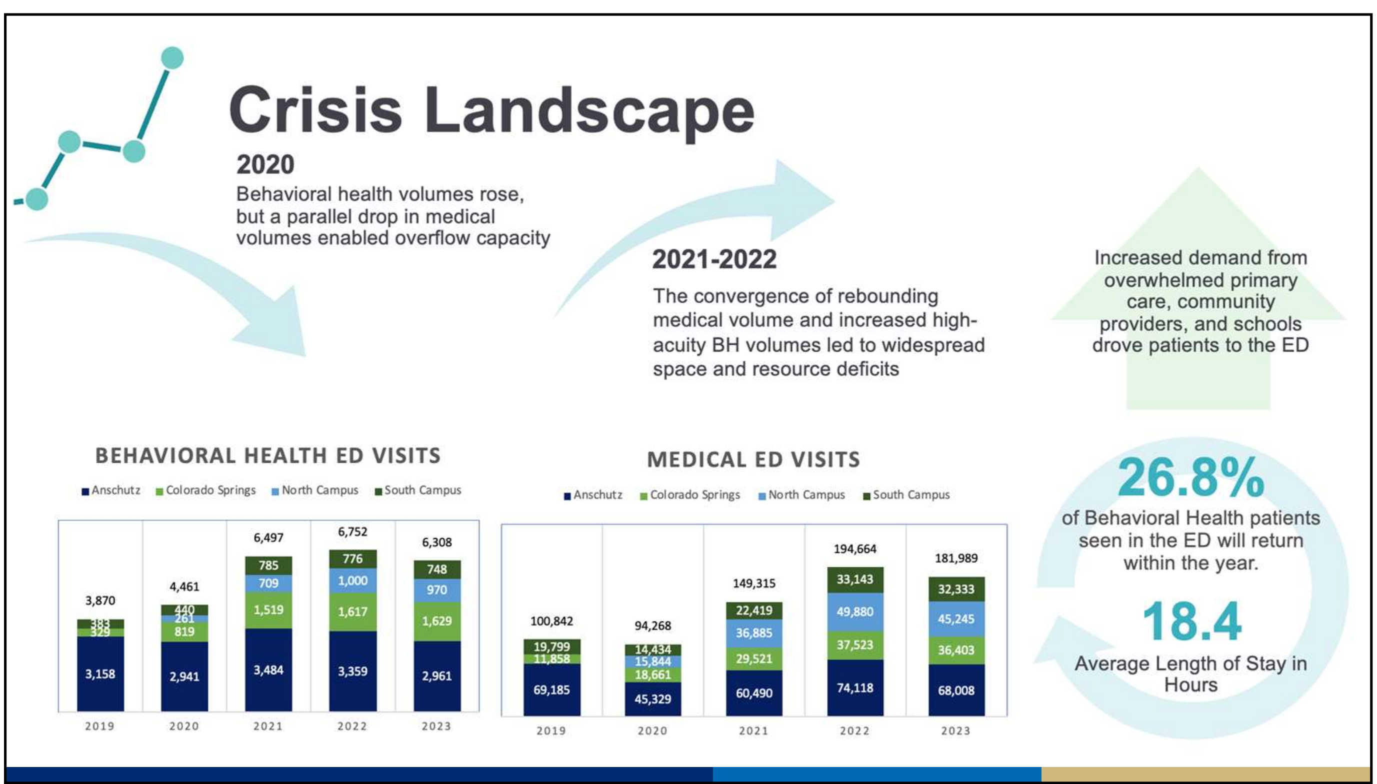

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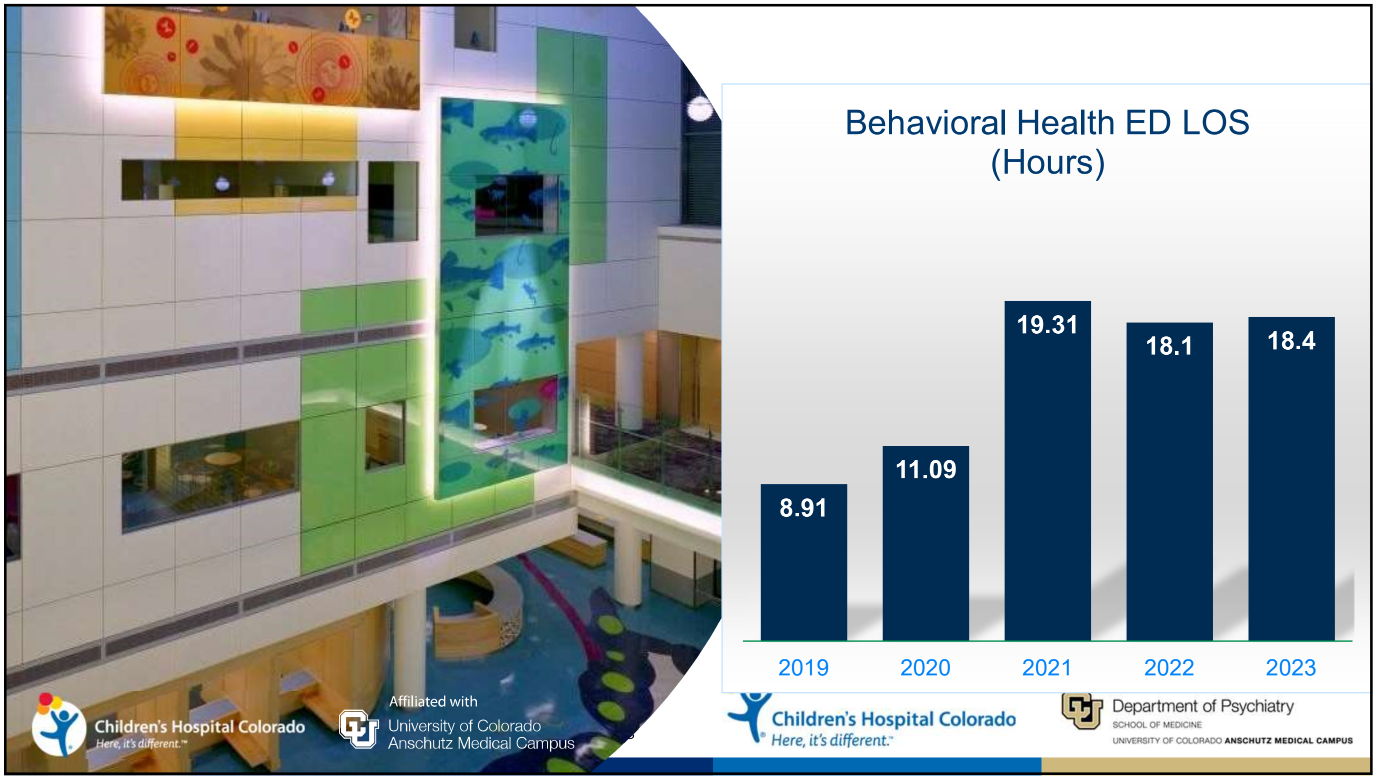

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Clinical Pathway Resources for Primary Care

1. AAP Screening for Suicide Risk in Clinical Practice

Screening Tools

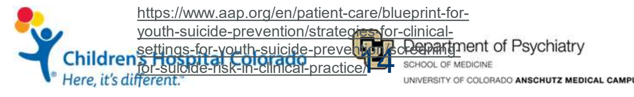
Evidence-based, publicly available, validated tools for suicide risk screening in medical settings that can be used to detect suicidal ideation or behaviors:

- Ask Suicide-Screening Questions (ASQ)
- Suicide Behavior Questionnaire-Revised (SBQ-R)

Other publicly available tools that are commonly used in primary care settings:

- Columbia Suicide Severity Rating Scale (C-SSRS) – Triage Version
- Patient Health Questionnaire – 9 Adolescent Version (PHQ-9A)
- Patient Safety Screener – 3 (PSS-3)

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/



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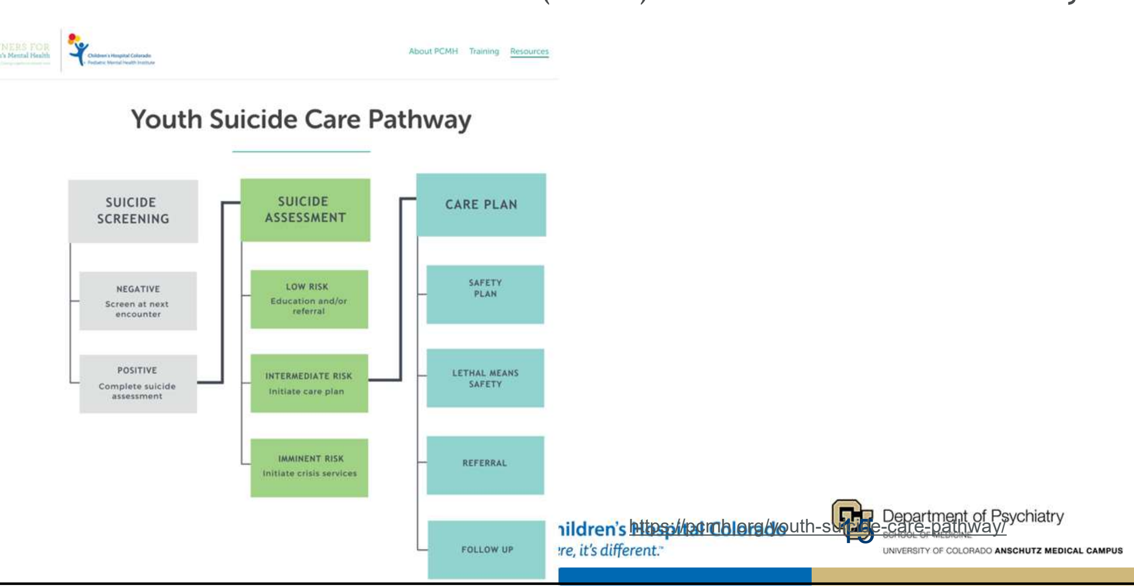
Clinical Pathway Resources for Primary Care

2. Partners For Children's Metal Health (PCMH) Youth Suicide Care Pathway



https://pcmh.org/youth-suicide-care-pathway/

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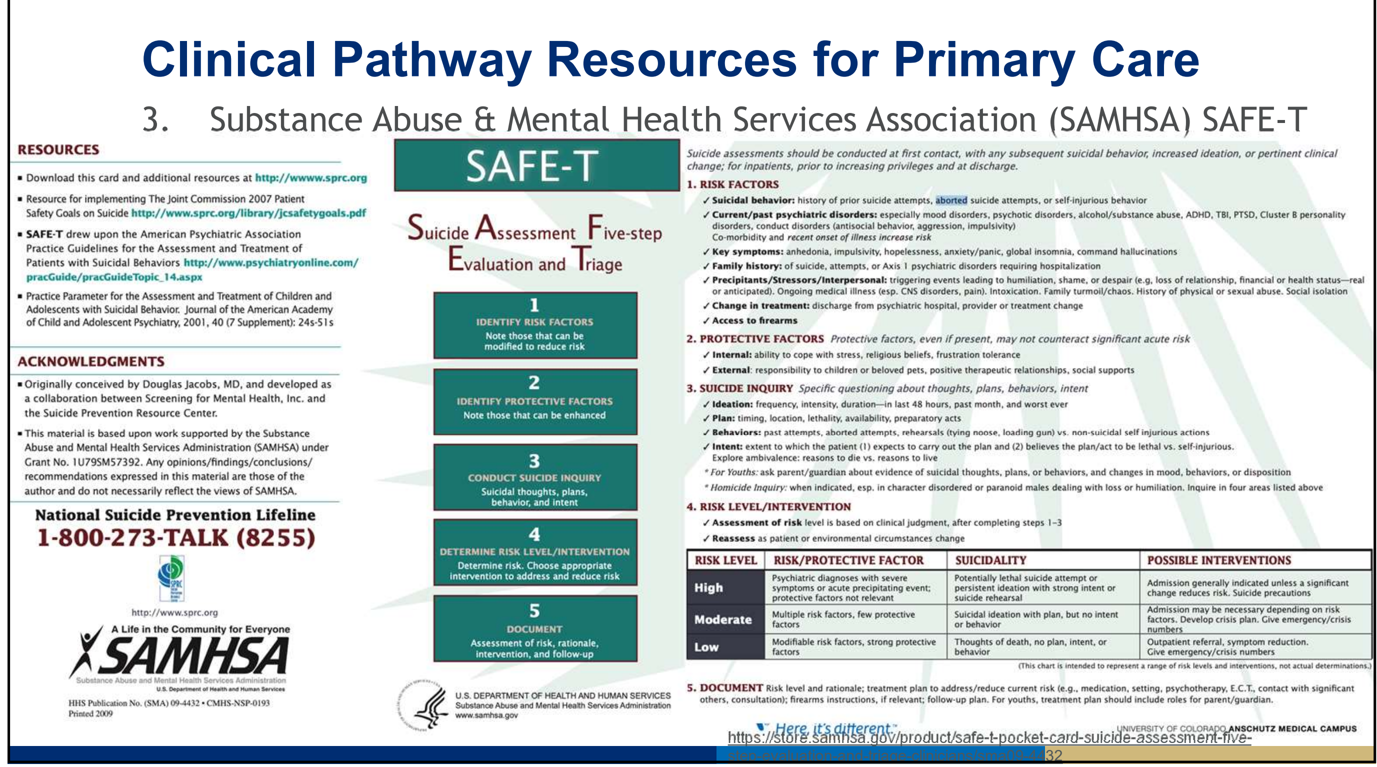

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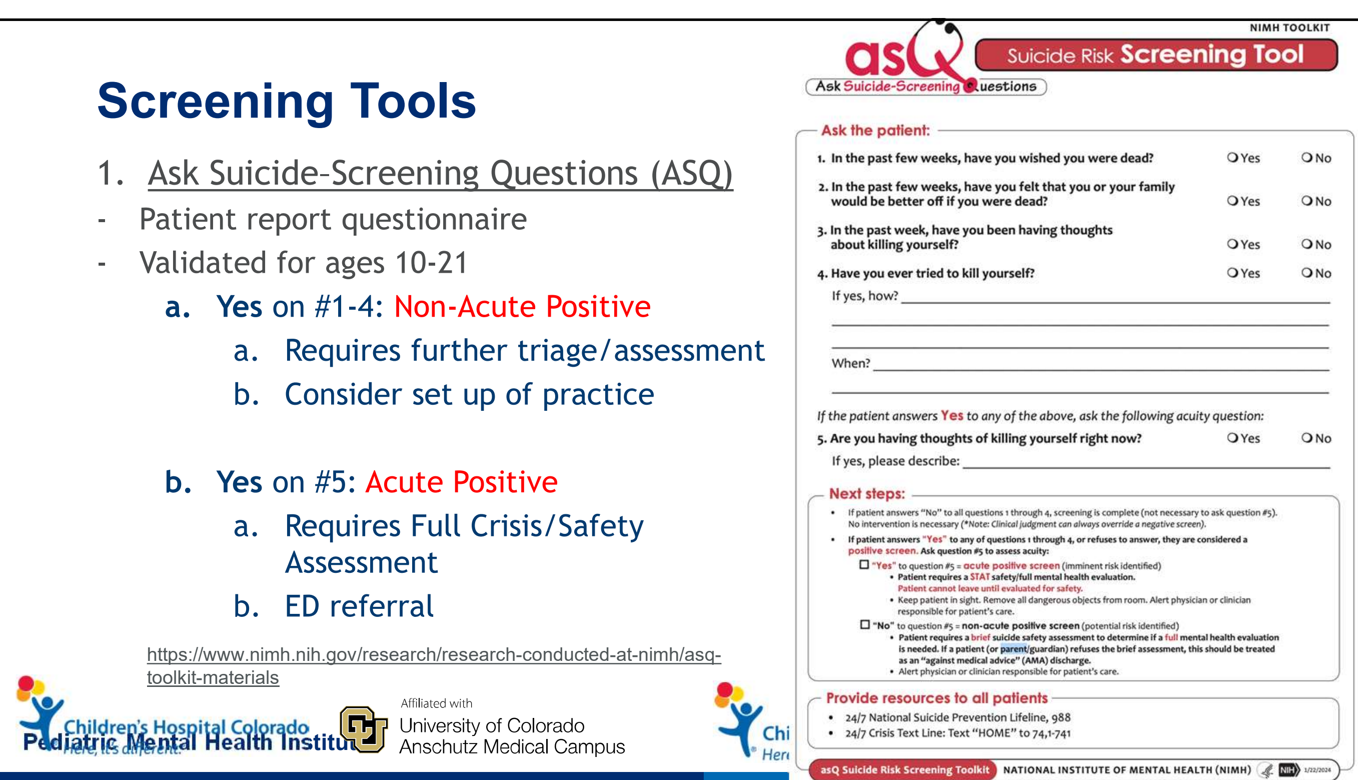

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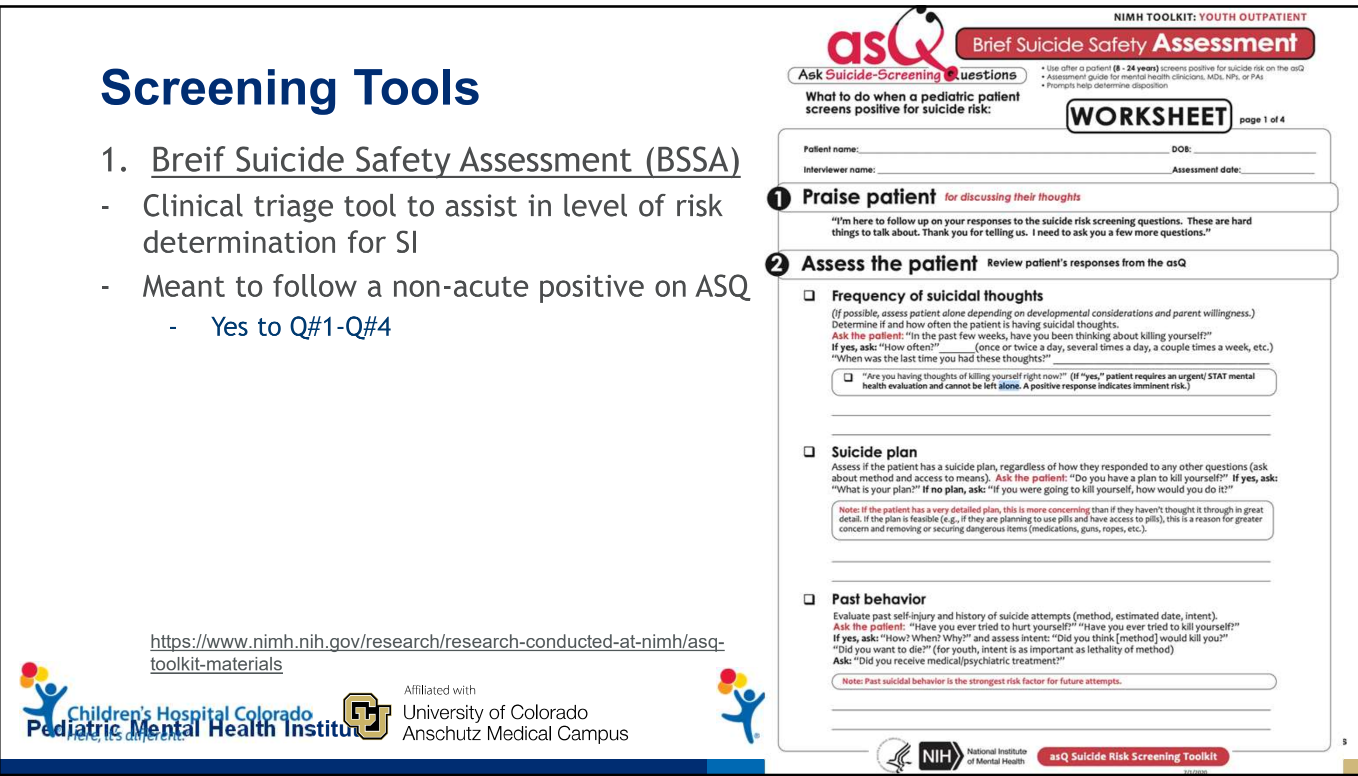


NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions — Brief Suicide Safety **Assessment**

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk:

WORKSHEET page 1 of 4

Patient name: ______ DOB: ______

Interviewer name: ______ Assessment date: ______

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient **Review patient's responses from the asQ**

☐ **Frequency of suicidal thoughts**

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"______(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" ______

☐ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

☐ **Suicide plan**

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

☐ **Past behavior**

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit

18

NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions — Brief Suicide Safety **Assessment**

WORKSHEET page 2 of 4

2 Assess the patient **Review patient's responses from the asQ**

☐ **Symptoms** Ask the patient about:

- ☐ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ☐ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ☐ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ☐ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ☐ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ☐ **Isolation:** "Have you been keeping to yourself more than usual?"
- ☐ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ☐ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- ☐ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ☐ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ☐ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

☐ **Social Support & Stressors** *(For all questions below, if patient answers yes, ask them to describe.)*

- ☐ **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/ counselor?" **If yes, ask:** "When?"
- ☐ **Family situation:** "Are there any conflicts at home that are hard to handle?"
- ☐ **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- ☐ **Bullying:** "Are you being bullied or picked on?"
- ☐ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ☐ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit — 7/1/2020

NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions — Brief Suicide Safety **Assessment**

WORKSHEET page 3 of 4

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:
- ☐ Sad or depressed?" ☐ Anxious?" ☐ Impulsive? ☐ Reckless?" ☐ Hopeless?" ☐ Irritable?"
- ☐ Unable to enjoy the things that usually bring him/her pleasure?"
- ☐ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ☐ Sleeping pattern?" ☐ Appetite?"

"Does your child use drugs or alcohol?" ☐ Yes ☐ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ☐ Yes ☐ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ☐ Yes ☐ No

"Are you comfortable keeping your child safe at home?" ☐ Yes ☐ No

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient Include the parent/guardian, if possible.

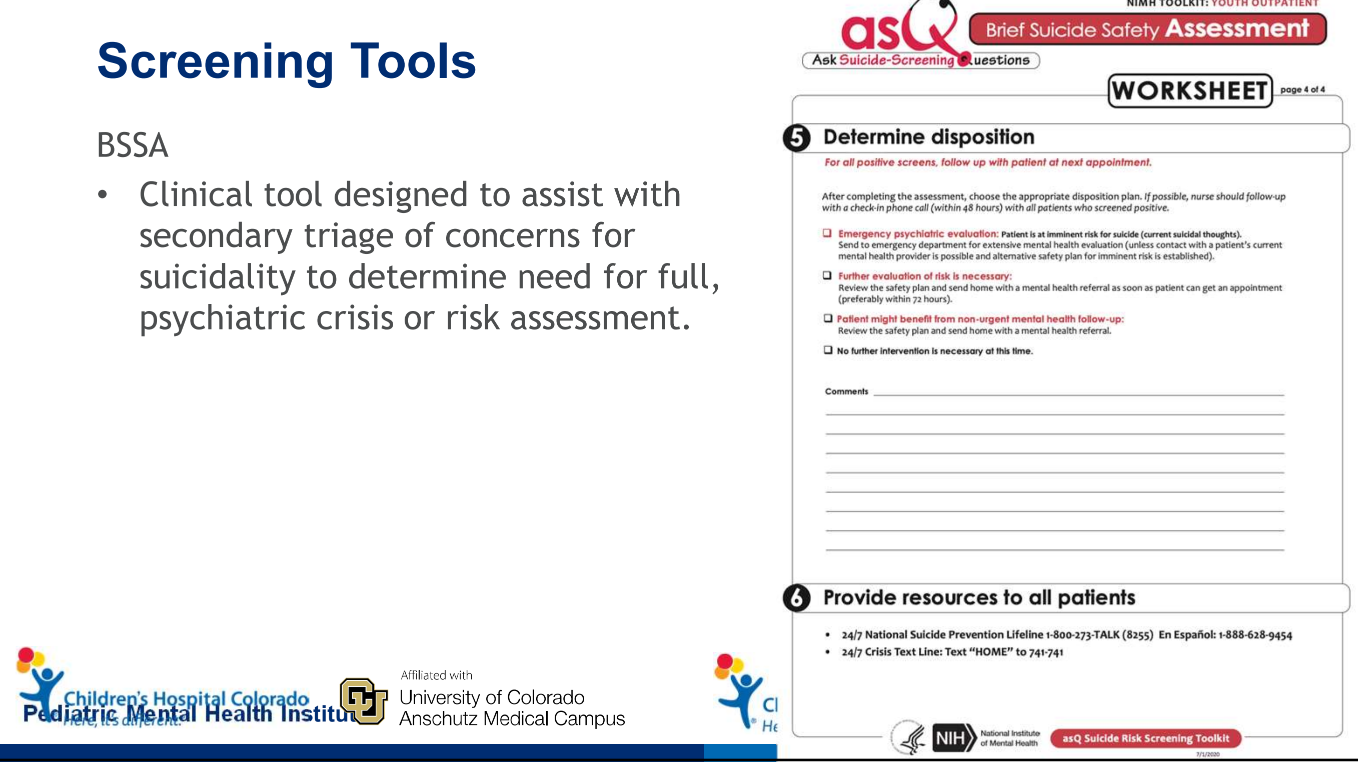
Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call ______."

- ☐ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- ☐ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
- ☐ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

Comments ______

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit — 7/1/2020

19



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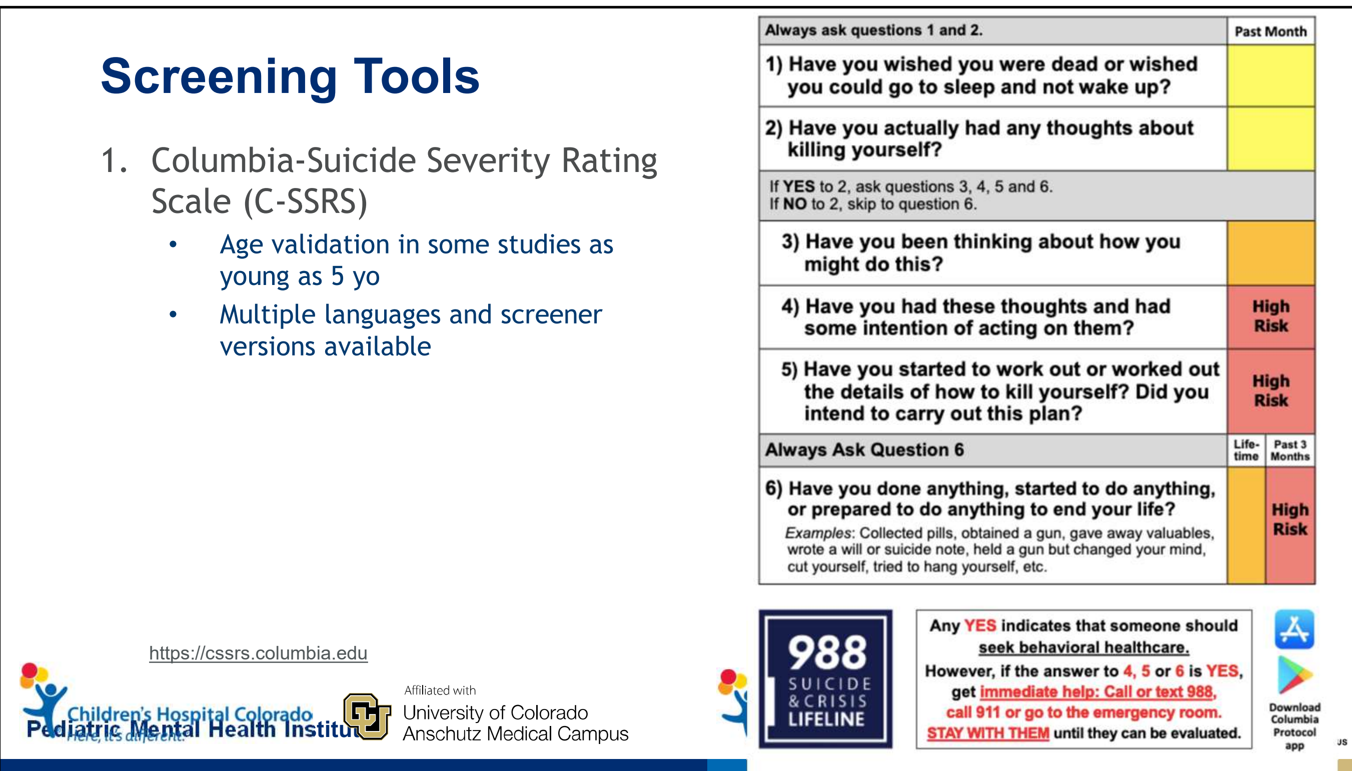


21

Screening Tools

- Less Commonly Used
  1. Suicide-Questions Behaviors-Revised (SBQ-R)
  2. PHQ's (next slide)

Affiliated with University of Colorado Anschutz Medical Campus

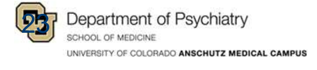
22

Screening Tools

- Depression Screening Tools (PHQ-2, PHQ-9, PHQ-A)

Suicide Screening

- Considerations for screening, triage, assessment in Primary Care
  - Make up of practice (Independent, Integrated, Co-Located, E-consult)
  - Available time
  - Scope and comfort of providers and or clinicians in practice



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Review data driving pediatric mental health crisis and identify evidenced-based tools available for use in pediatric ambulatory settings for evaluation of suicide risk

Demystify the Emergency Room Process. What is a Crisis Evaluation?

When to send to an ED? Review available routes of escalation of care

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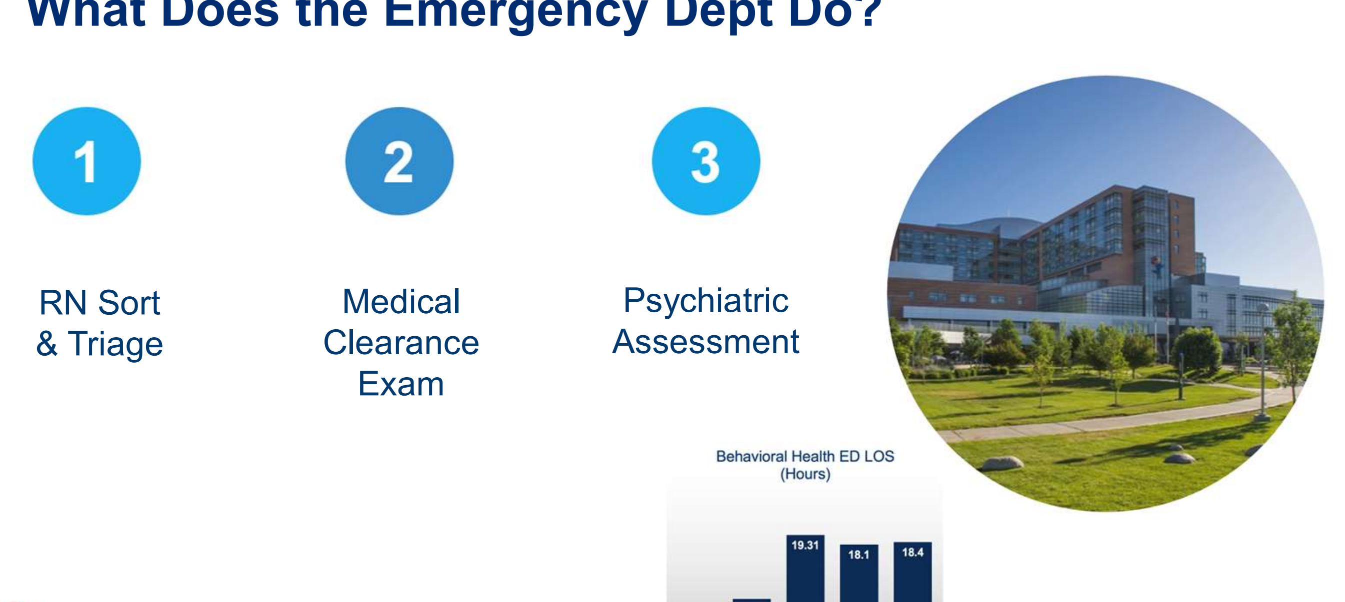

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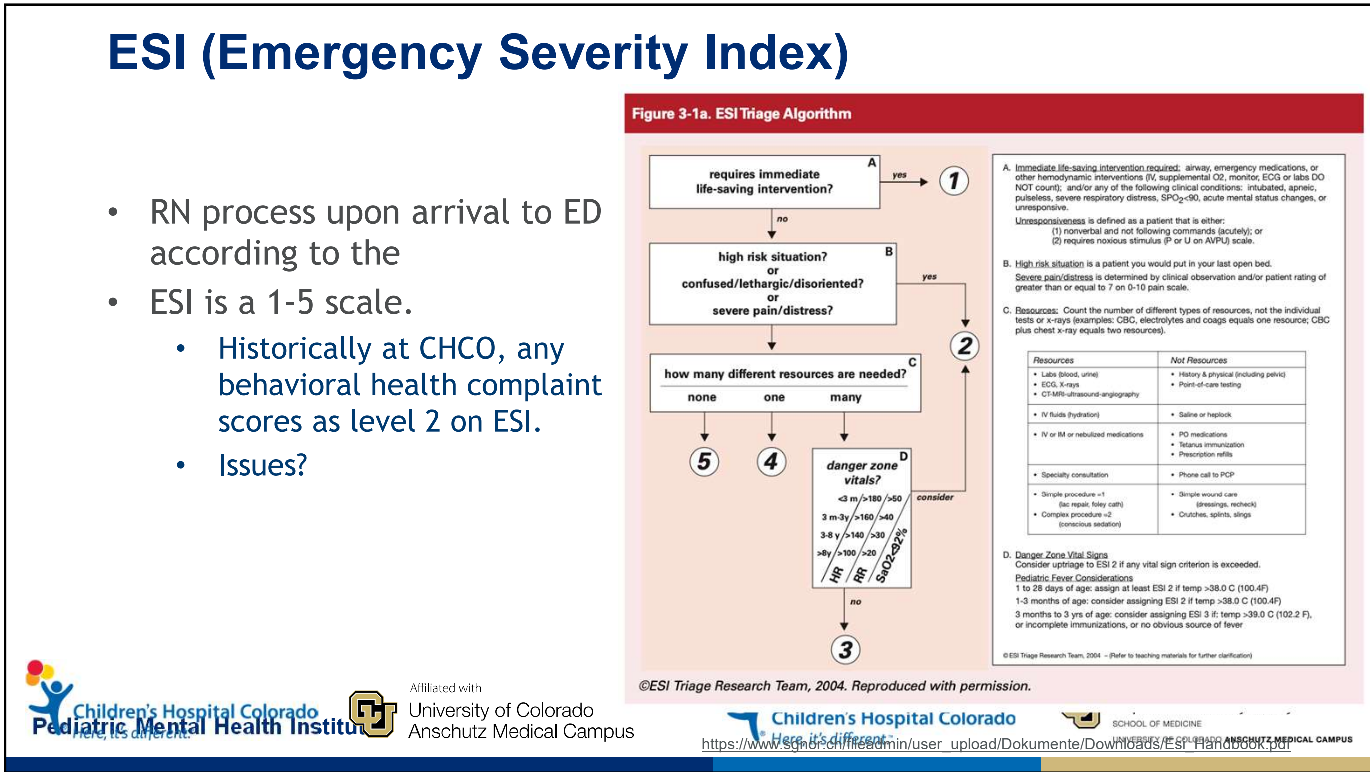

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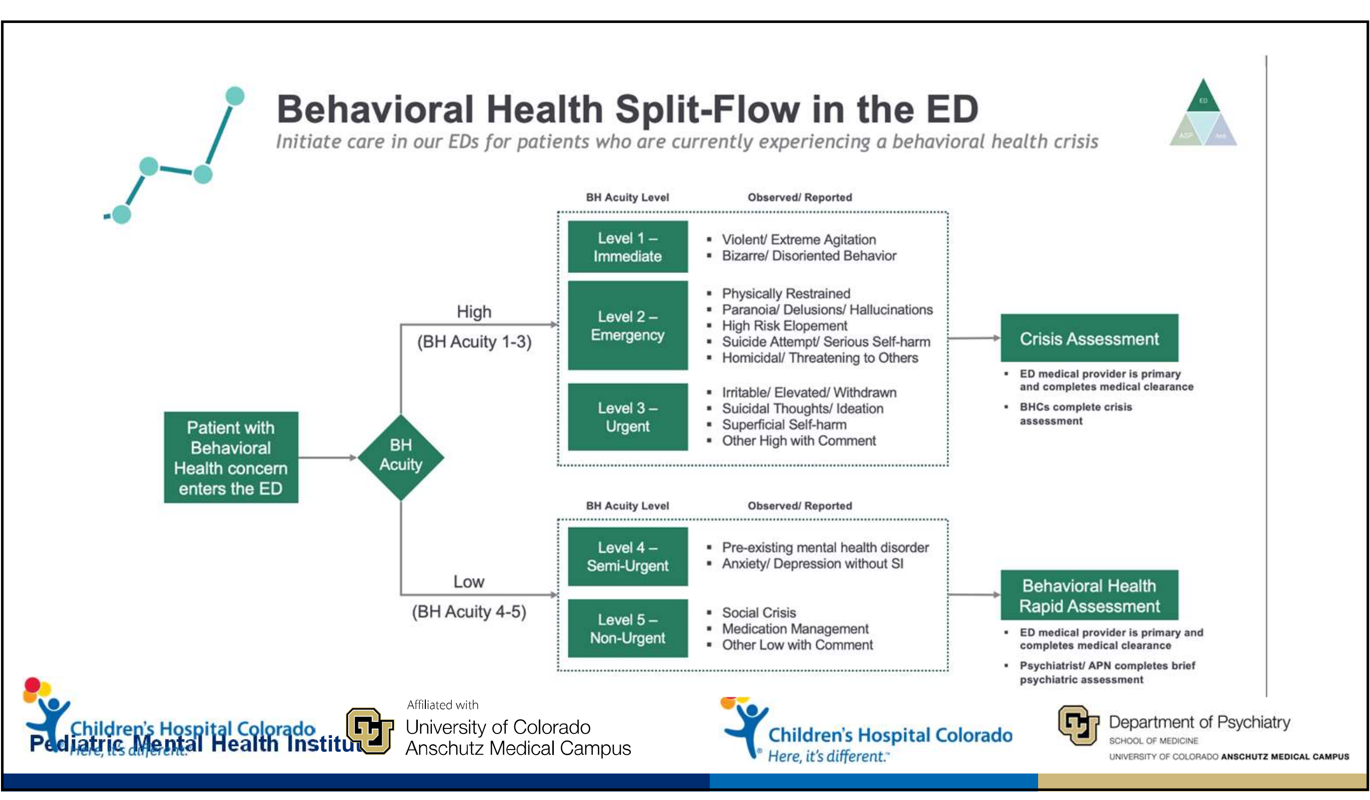

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Psychiatric Crisis Assessment

- High Acuity Track (1-3's)
  - Physical search, gowned, moved to psych safe suite in ED, 1:1 staffed
  - Medical Clearance Exam conducted by PEM provider or pediatric provider
  - Psychiatric Crisis Assessment conducted by LCSW, LPC and then staffed with a child psychiatrist
    - <u>Evaluation includes</u>: HPI, Psych Hx, trauma/abuse screen, substance use screen, Psych ROS, MSE, Full Columbia, Risk/Protective factors, child & guardian interview, collateral when available
    - <u>Determination of</u>: Imminent risk to self or others or grave disability
      - Essentially level of care eval: discharge vs inpatient admission

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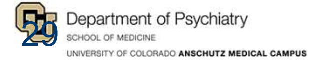
Psychiatric Crisis Assessment

- Low Acuity Track (4-5's)
  - No physical search, not gowned, moved to consult room, no 1:1
  - Medical Clearance Exam conducted by PEM provider or pediatric provider
  - Brief/Rapid BH Assessment conducted by APP, child psychiatrist
    - <u>Evaluation includes</u>: Brief HPI, brief review of history, ASQ, PHQ-9, MSE, care coordination referral
    - <u>Determination of</u>: Ambulatory resources/supports needed



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Learning Objectives

Review data driving pediatric mental health crisis and identify evidenced-based tools available for use in pediatric ambulatory settings for evaluation of suicide risk

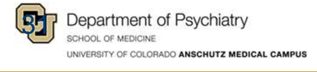
Demystify the Emergency Room Process. What is a Crisis Evaluation?

When to send to an ED? Review available routes of escalation of care

30

Escalation Pathways: What is Available in the Community

- Emergency Departments
- Urgent Cares
- Crisis Walk-in Centers
- Community Mental Health Centers (CMHC's)
- PCP E-Consult models (CoPPCAP)
  - Colorado Pediatric Psychiatry Consultation & Access Program
- Established outpatient BH provider, therapist
  - Insurance matters: Commercial vs Medicaid vs Uninsured
  - Private Practice: largely fee-for-service models



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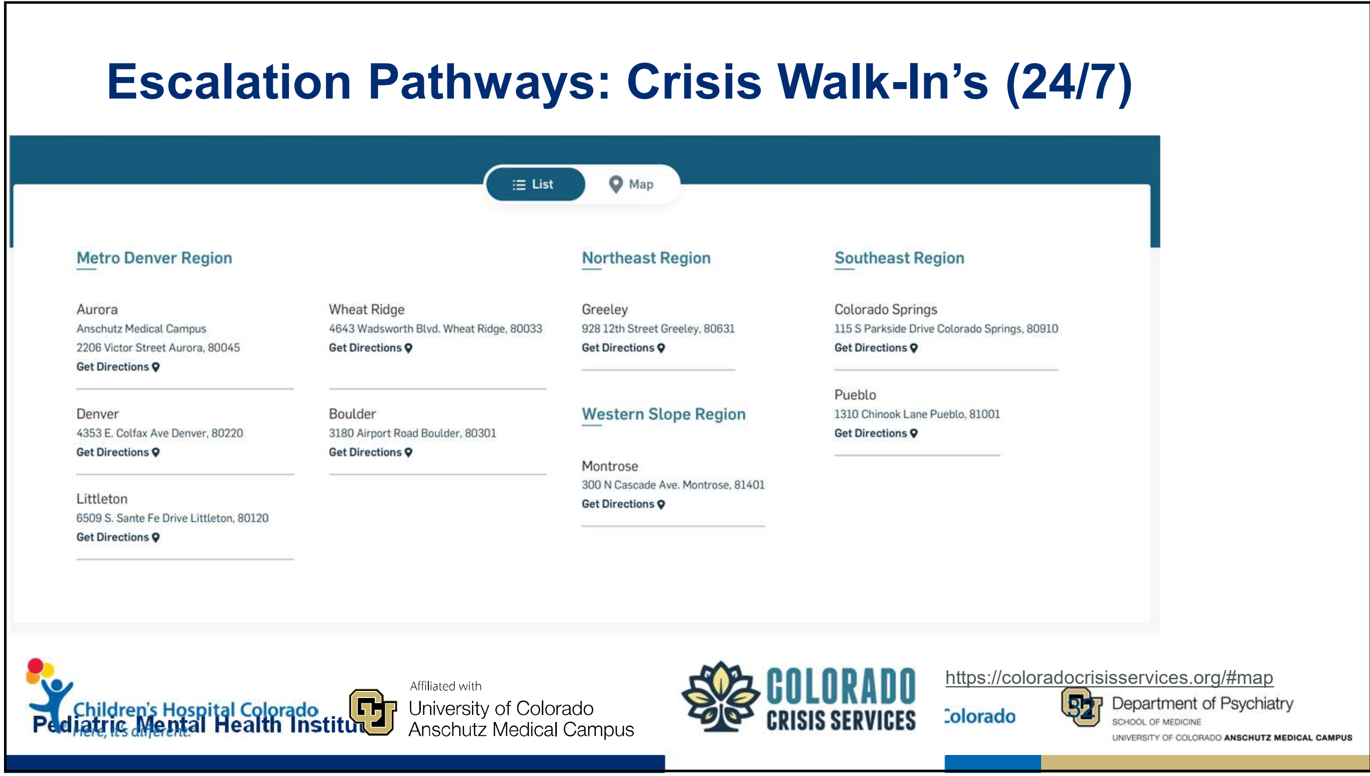

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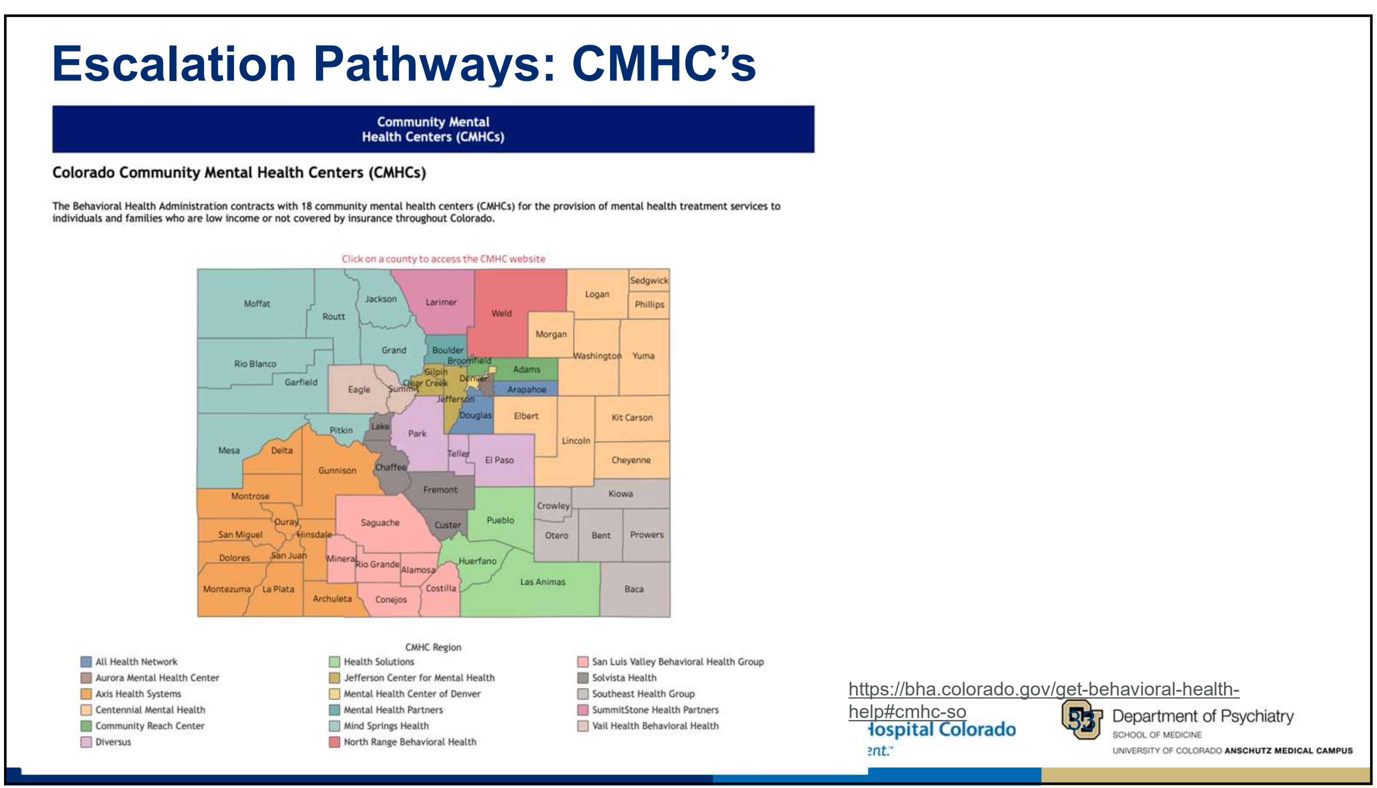

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Escalation Pathways: E-Consults (ie. CoPPCAP)

- Colorado Pediatric Psychiatry Consultation & Access Program

CoPPCAP SERVICES

- Telephone consultation (within 45 minutes of a request) with a child psychiatrist or e-consult answered within 24 hrs.
- Payor blind, all providers may seek consultation for any patient in their Colorado practice up to age 25.
- Access to information about community resources through a clinical care coordinator/navigator.
- Education on Mental Health matters unique to your practices & your communities via "Lunch & Learns", ECHO, & learning collaboratives.
- Direct face-to-face or telehealth consultation for patients with difficult diagnostic or treatment issues.
- FREE toolkit of screening tools and educational materials provided through our website.

https://www.coppcap.org

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Escalation Pathways: Outpatient

- Established outpatient BH provider, therapist
  - Insurance matters: Commercial vs Medicaid vs Uninsured
  - Private Practice: largely fee-for-service models

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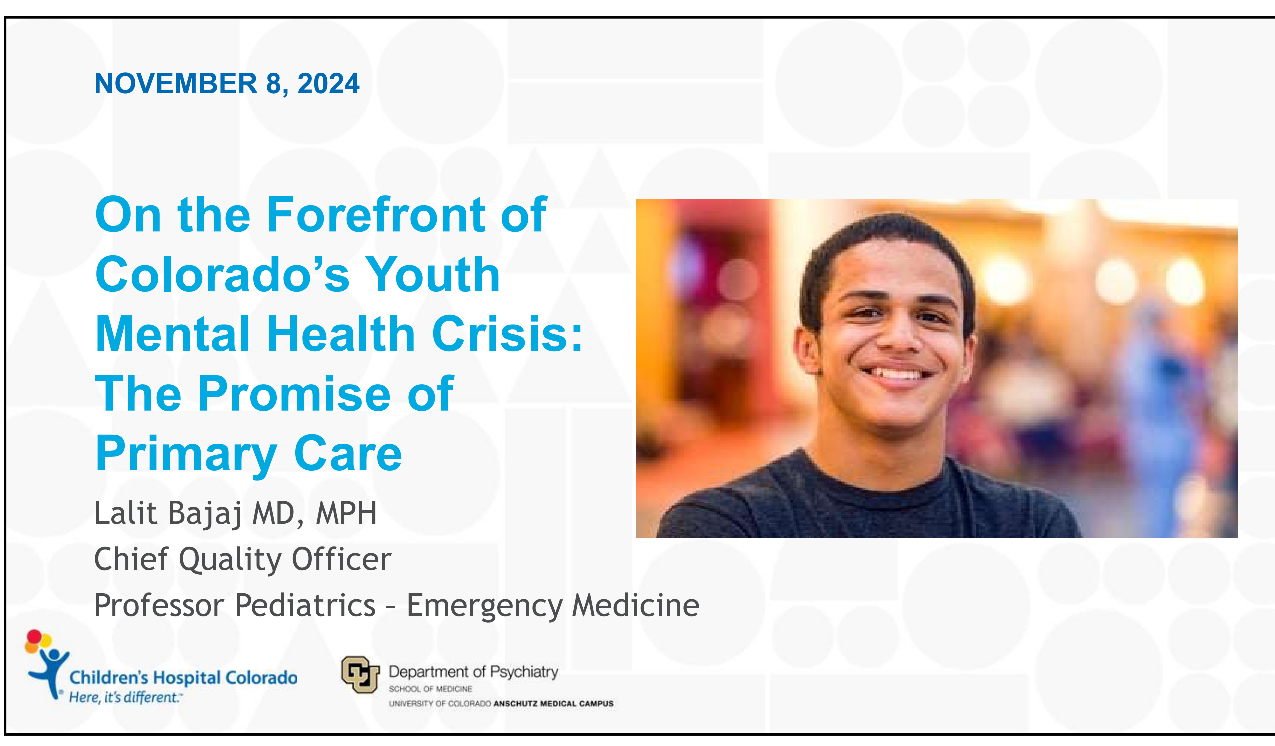

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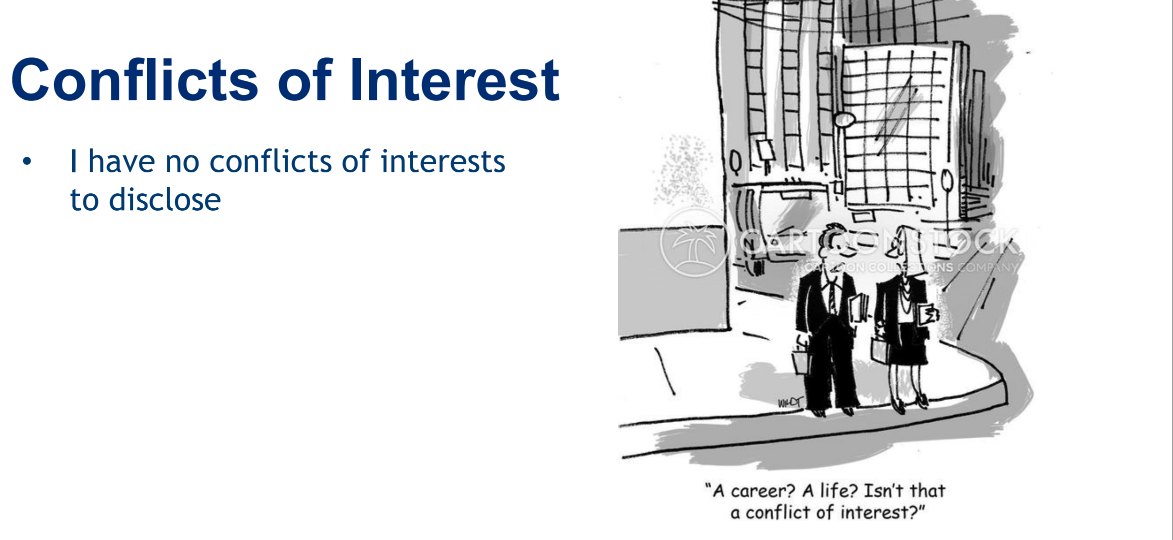

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Enough about you, let's talk about me

- 1991-1996: Medical school/Public Health School – UCSF/UC Berkeley
- 1996-1999: Pediatrics Residency – University of Colorado
- 1999-2000: Chief Residency – University of Colorado
- 2000-2003: Pediatric Emergency Medicine Fellowship – University of Colorado
- 2003 – present: Faculty – University of Colorado
- Roles:
  - ED Research Director
  - Director of Evidence Based Practice
  - Medical Director: Research Institute
  - Medical Director: Clinical Effectiveness
  - Chief Quality Officer

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How did I get involved in Primary Care Quality?

- 2005 – CFO (Len Dryer) has me join him for a meeting at a company called Physician Health Partners. They were managing a group of pediatricians called Colorado Pediatric Partners (CPP).
- Began my journey in Quality Improvement. Immunization program, Asthma program
- Building data structures and initiating process improvement in a pediatric network
- Learned health care financing, Lean Six Sigma, Project Management, Leadership
- Helped write a grant to the Colorado Health Foundation to start Colorado Pediatric Collaborative (CPC) – CHCO/CPP
- Gil Peri and Tyler Leishman began engaging the pediatric community about building a CIN…

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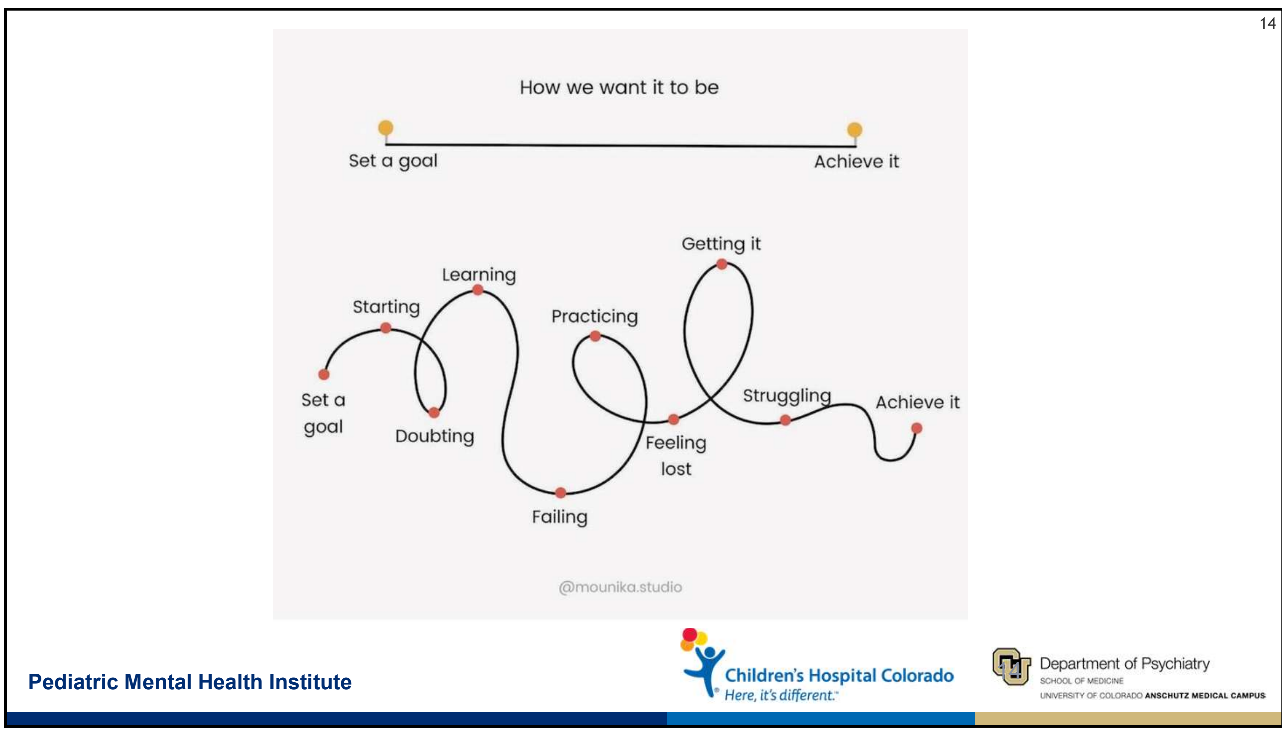

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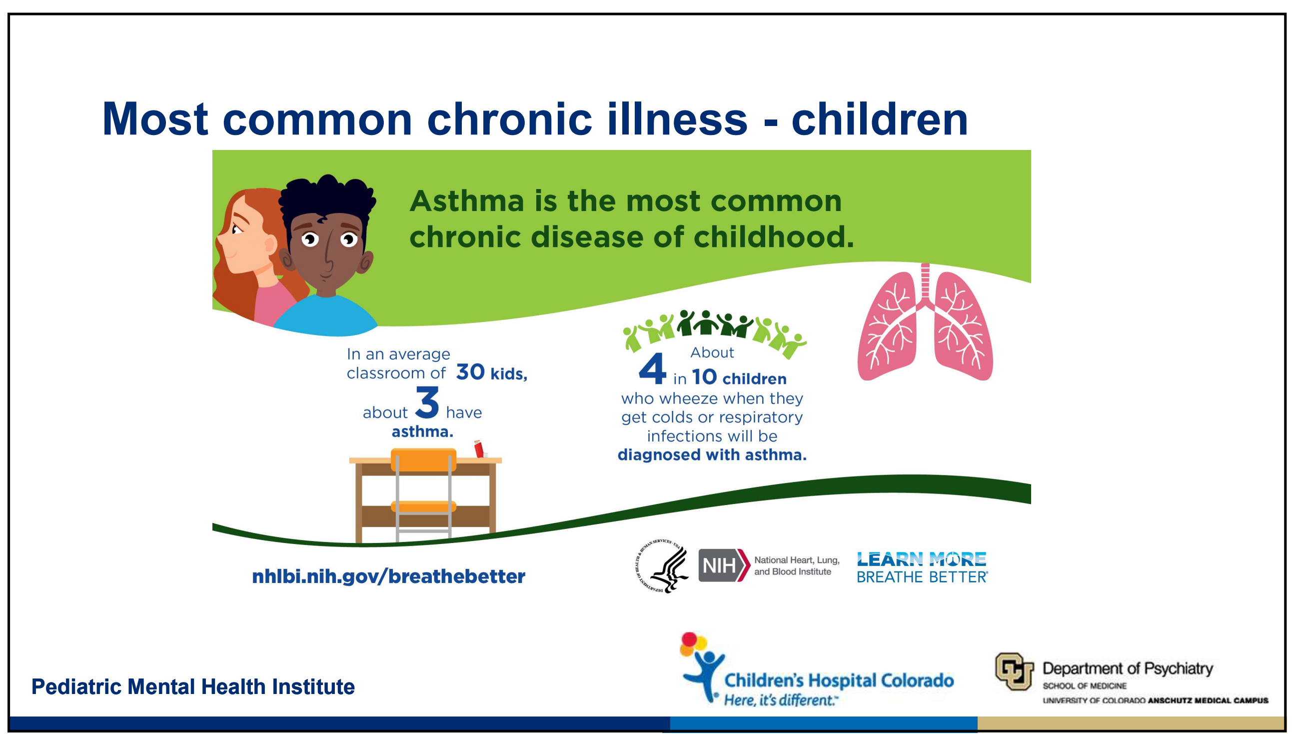

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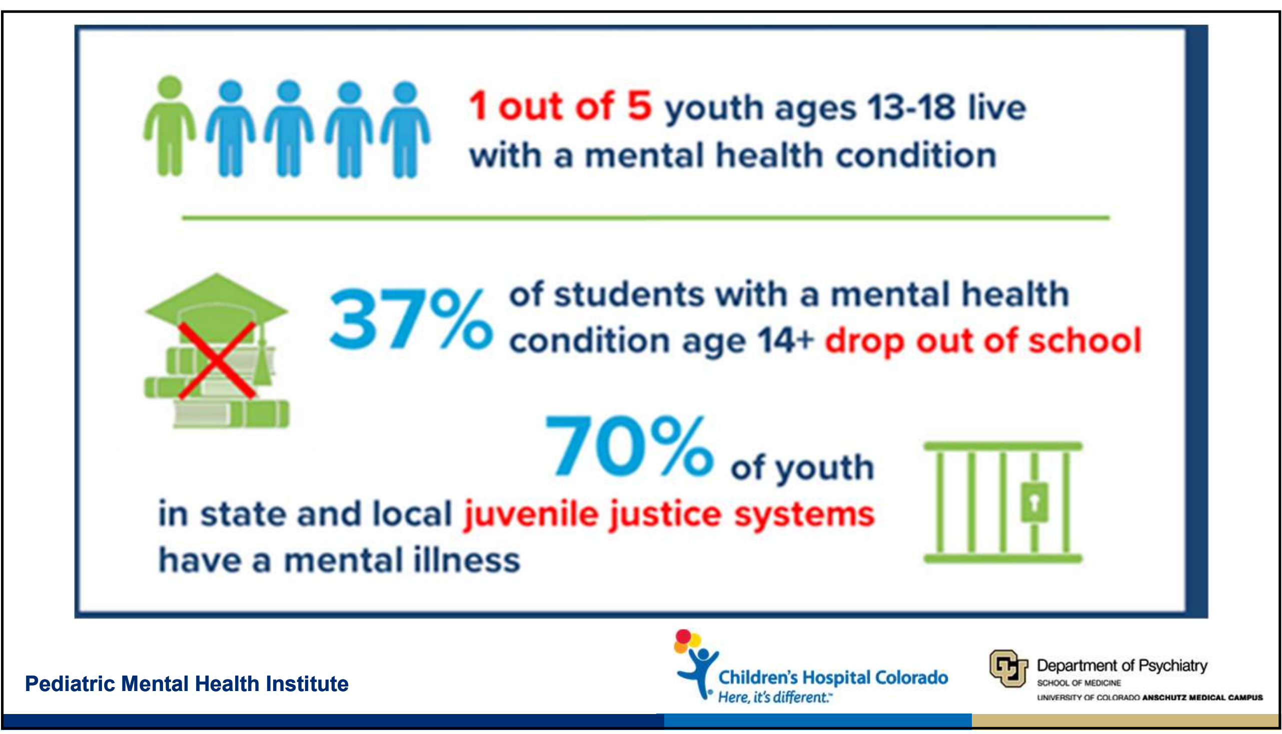

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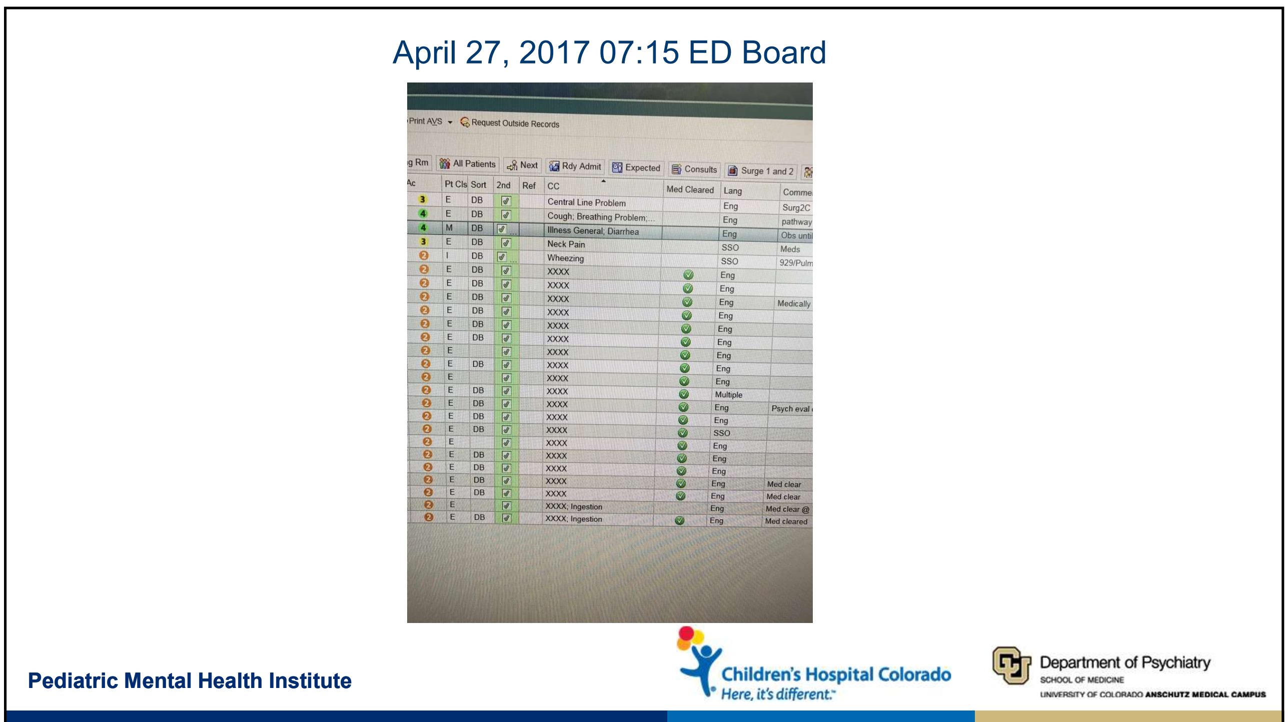

Ac	Pt Cls	Sort	2nd	Ref	CC	Med Cleared	Lang	Comme
3	E	DB	✓		Central Line Problem		Eng	Surg2C
4	E	DB	✓		Cough; Breathing Problem;...		Eng	pathway
4	M	DB	✓		Illness General; Diarrhea		Eng	Obs until
3	E	DB	✓		Neck Pain		SSO	Meds
2	I	DB	✓		Wheezing		SSO	929/Pulm
2	E	DB	✓		XXXX	✓	Eng	
2	E	DB	✓		XXXX	✓	Eng	
2	E	DB	✓		XXXX	✓	Eng	Medically
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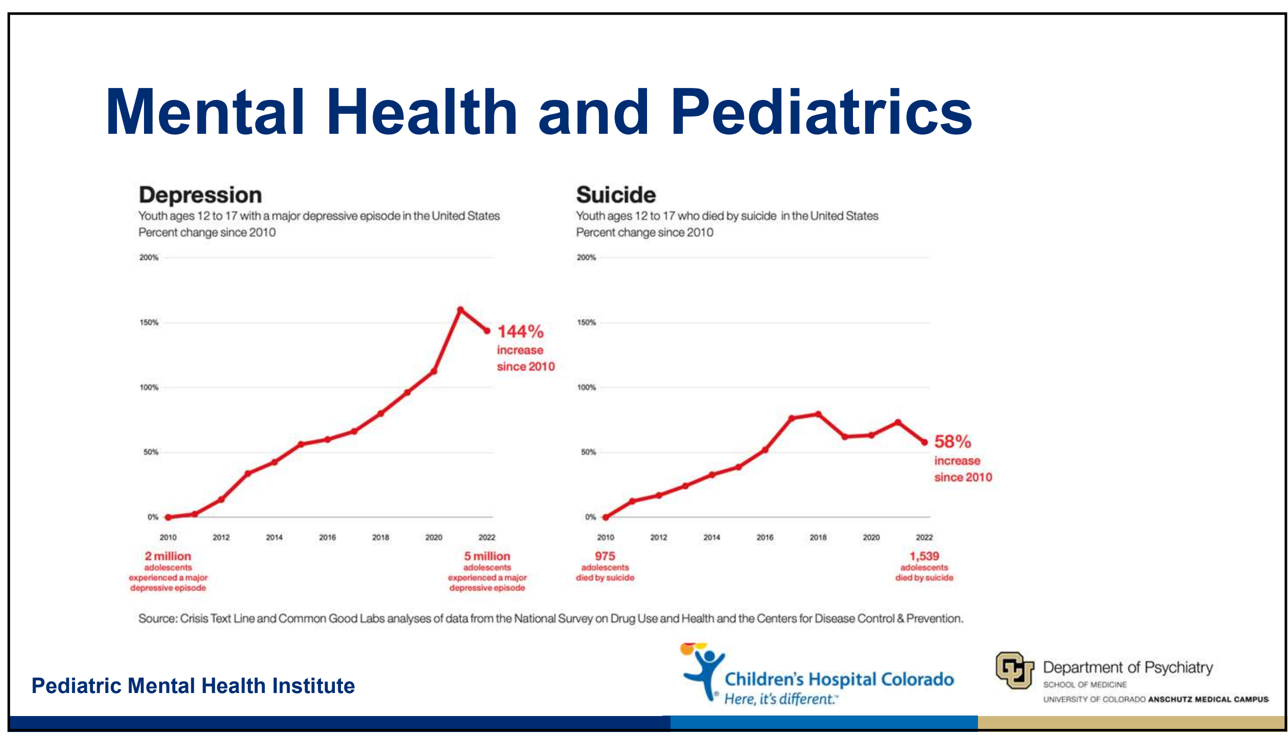

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I am an Academic, therefore I Pubmed

Did you mean ***geriatrics and mental health*** (16,765 results)?

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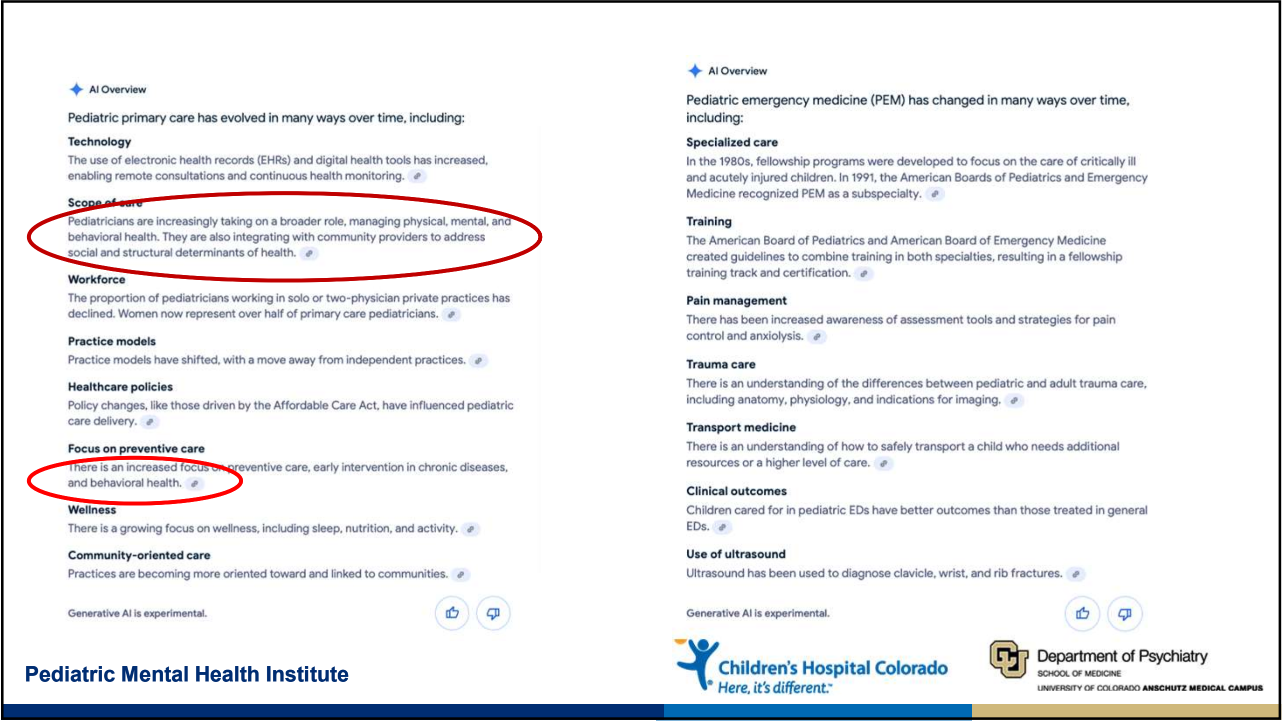

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I know this is a Busy slide

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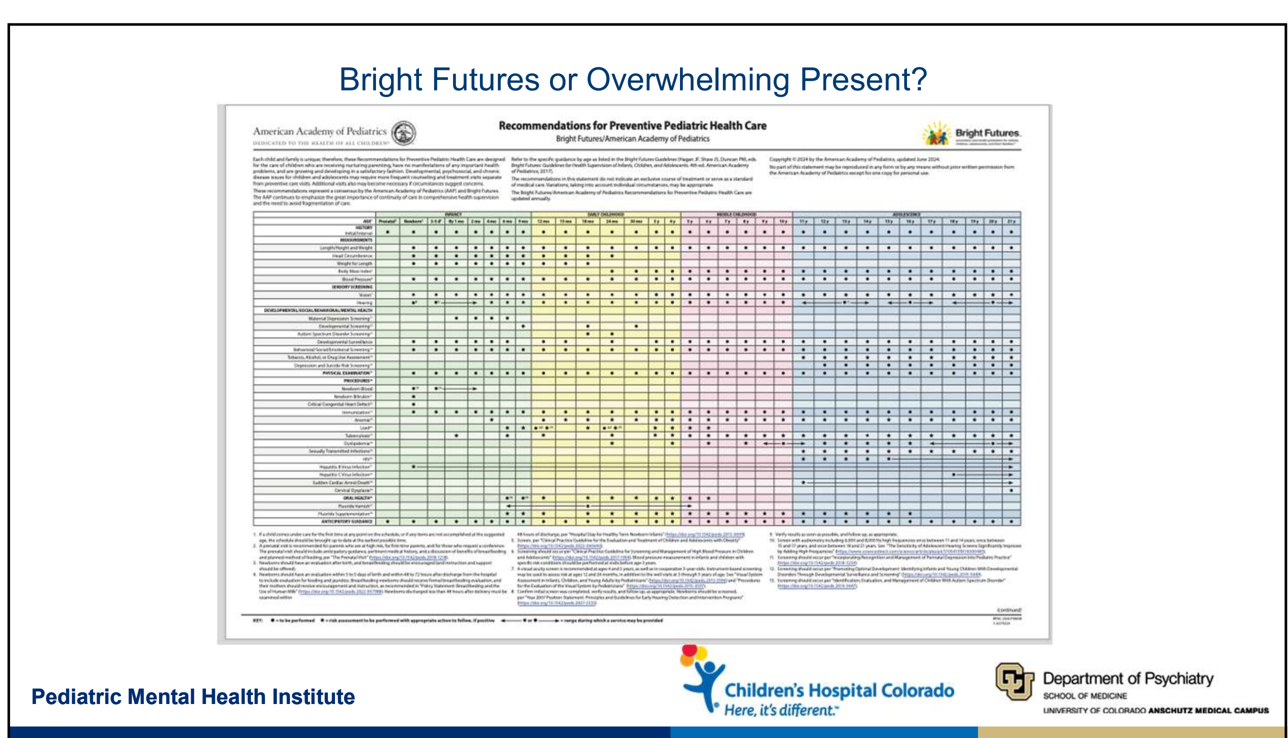
Bright Futures or Overwhelming Present?



American Academy of Pediatrics

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures

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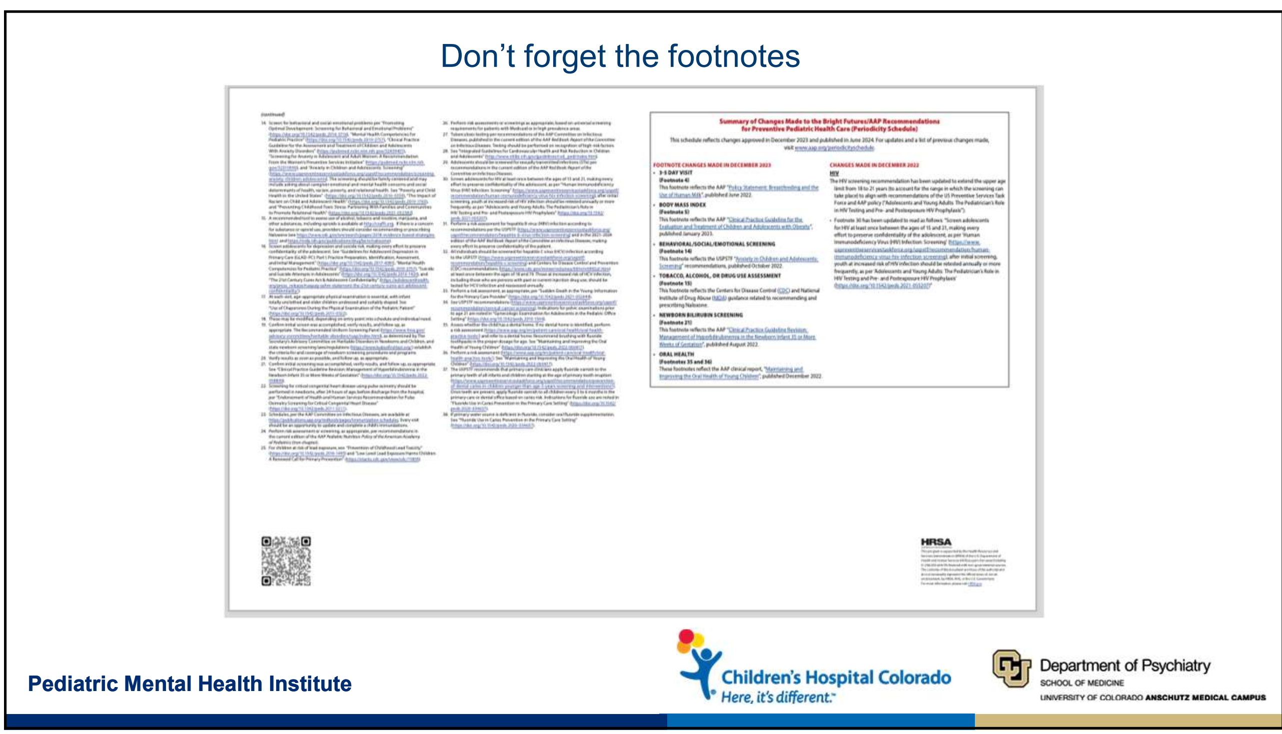

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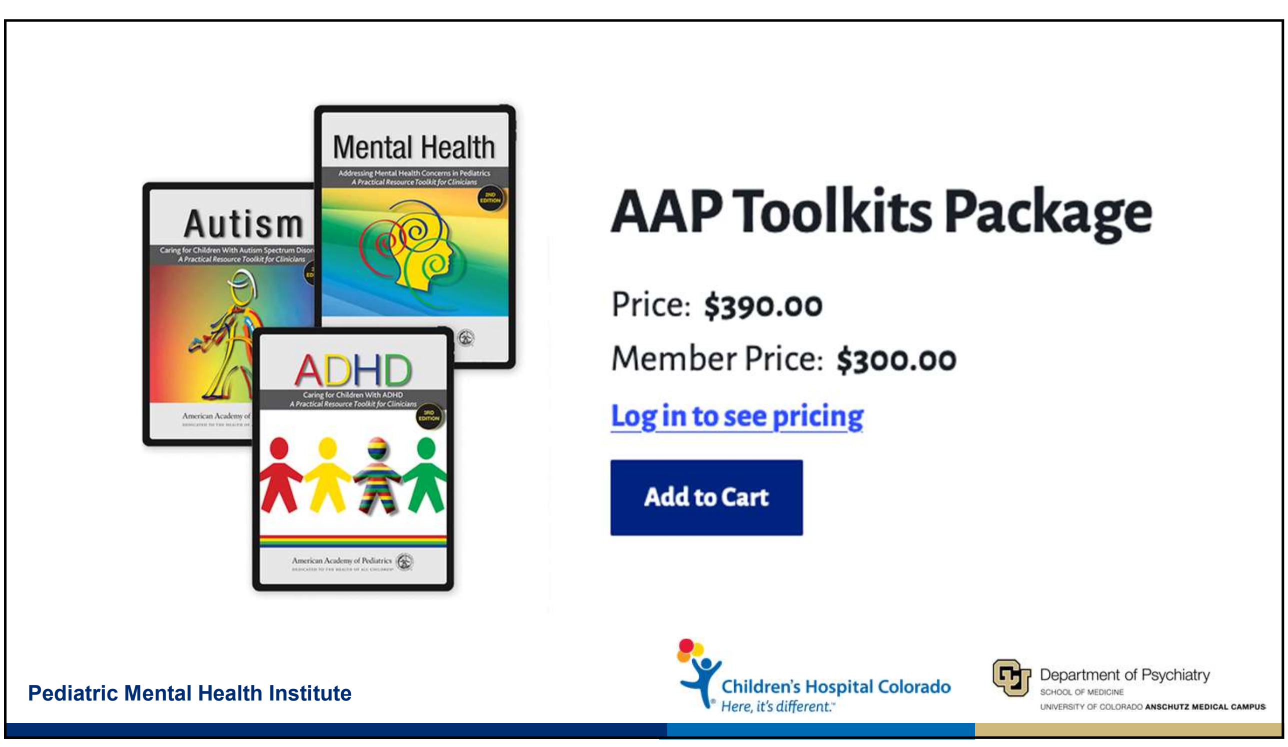

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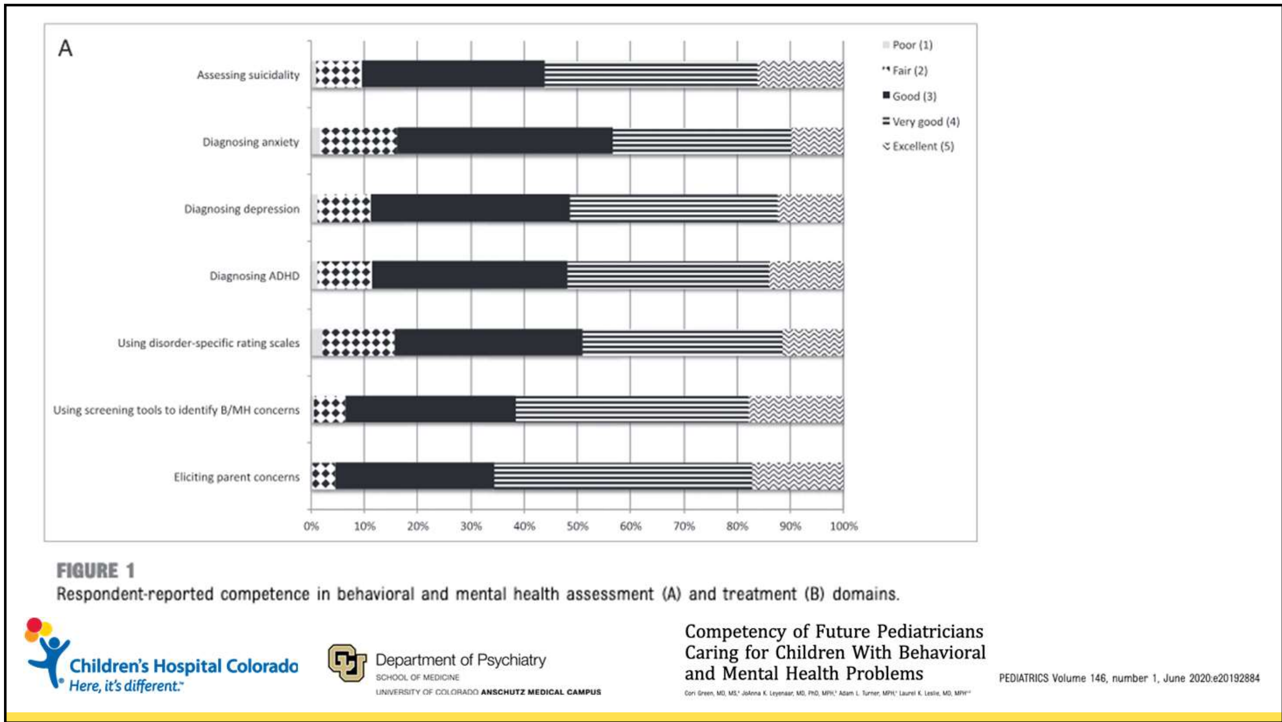

FIGURE 1
Respondent-reported competence in behavioral and mental health assessment (A) and treatment (B) domains.

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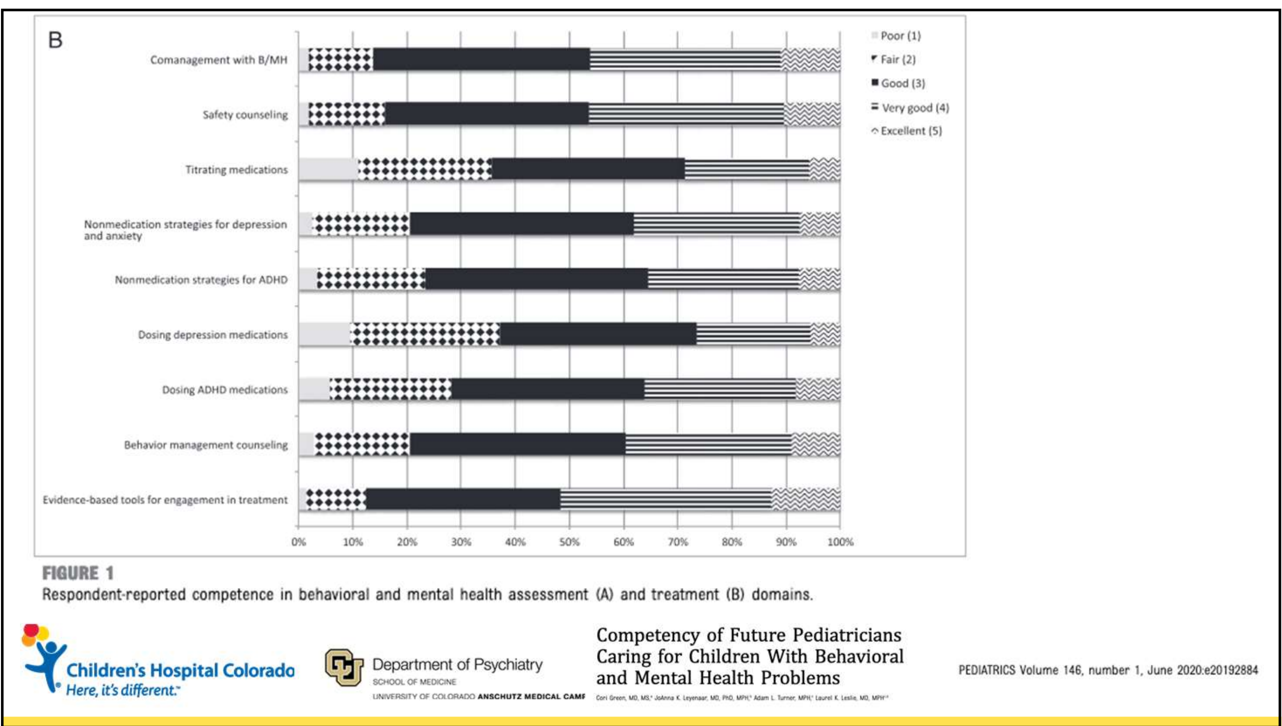

FIGURE 1
Respondent-reported competence in behavioral and mental health assessment (A) and treatment (B) domains.

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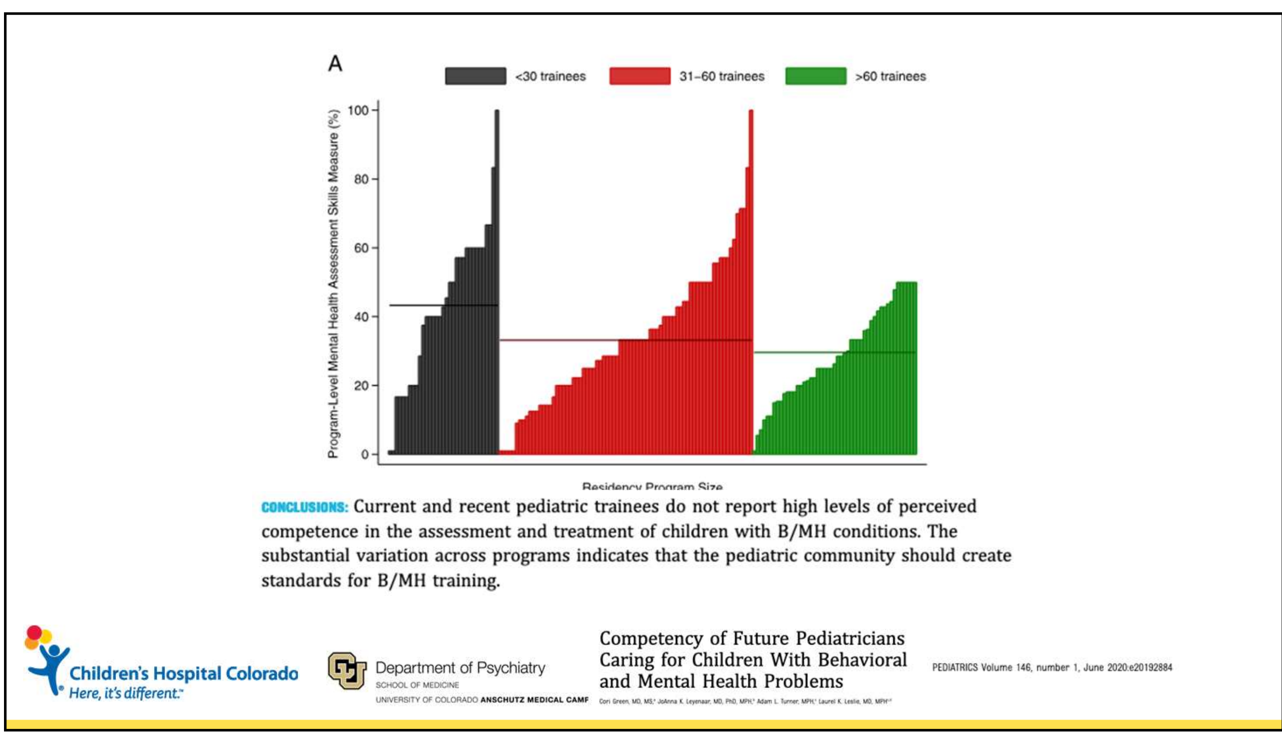

28

Addressing the Behavioral and Mental Health Educational Gap in Pediatric Residency Training

Sue E. Poynter, MD, MEd,[a] Kenya McNeal-Trice, MD,[b] Javier Gonzalez del Rey, MD, MEd[a]

PEDIATRICS Volume 146, number 1, July 2020:e20200805

Incorporating best practices learned from community pediatricians will also be key to success.[9] Although

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Preparing Future Pediatricians to Meet the Behavioral and Mental Health Needs of Children

Julia A. McMillan, MD, FAAP,[a] Marshall Land, Jr, MD, FAAP,[b,c] Ashley E. Tucker, MPH,[c] Laurel K. Leslie, MD, MPH, FAAP[c,d]

PEDIATRICS Volume 145, number 1, January 2020:e20183796

Theme 1: There Is an Urgent Need for Pediatricians to Increase Their Role in Improving the B/MH of Children

Theme 2: Parent, Patient, and Trainee Perspectives Are Necessary for Enhancing Training

Theme 3: Regulatory Efforts May Be Necessary To Promote Needed Change

Theme 4: Curricular Changes and Faculty Engagement and Development Are Key Components for Training Programs

Theme 5: Addressing B/MH Training Will Require a Collaborative Effort

Theme 6: There Will Be Challenges

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Theme 5: Addressing B/MH Training Will Require a Collaborative Effort

You all are the Medical Home and Anchor the Medical Neighborhood

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We are in this together

- What does the crisis look like in your practice?
- What can be managed locally?
- What can we learn from one another?
- What works well?
- What doesn't work?
- How do you all as small business owners make this work?
- Etc…..

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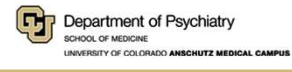

32

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How to Partner More Effectively with Schools

Lauren Henry, PhD
Lauren Eckhart, PsyD
November 9, 2024

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Today's Discussion

1. Benefits of collaboration between primary care and schools
2. Definitions, roles, and other alphabet soup
3. Common intersections for schools and pediatrics
4. Resources

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The Benefits and Barriers of School Collaboration

School Identified Barriers:

- Too much medical and psychological jargon
- Difficulty initiating/ maintaining communication
- Limited understanding of the school culture
- Inappropriate or ill-feasible recommendations

Henry el al, 2023, Bradley-Klug, 2013

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3

Initiating School Collaboration

Who to Contact

- School Psychologists and School Counselors

How to Connect

- Letters AND verbal follow up
- Release of information (HIPPA/FERPA)

School Preferred Contact Persons

Other 8%
Administration 3%
Gen Education Teacher 10%
Counselor 22%
Special Education Professional 14%
School Psychologist 27%
School Social Worker 16%

Henry el al, 2023

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Heath Insurance Portability and Accountability Act & Family Educational Rights and Privacy Act

HIPAA	FERPA
Protects medical records and health information. Applies to healthcare providers, insurers, and related entities.	Safeguards educational records. Applies to schools receiving federal funding. Includes health records maintained by schools.

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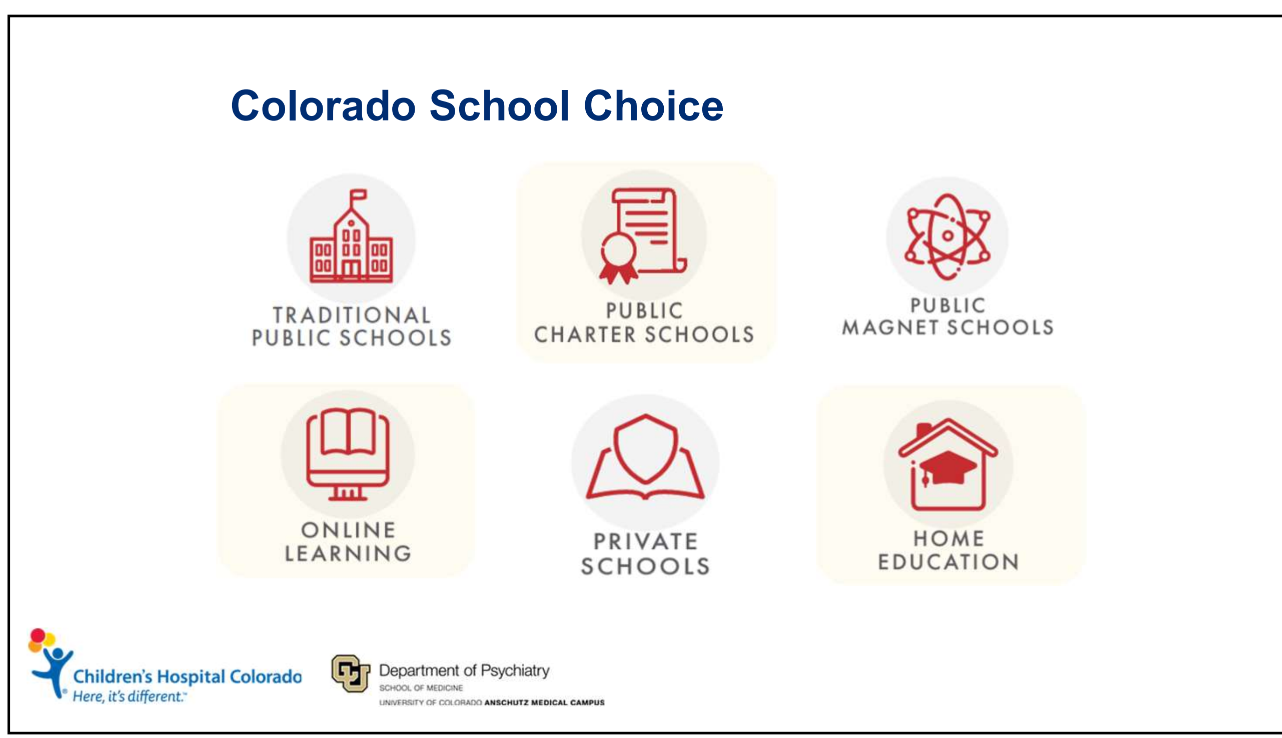
Colorado School Choice



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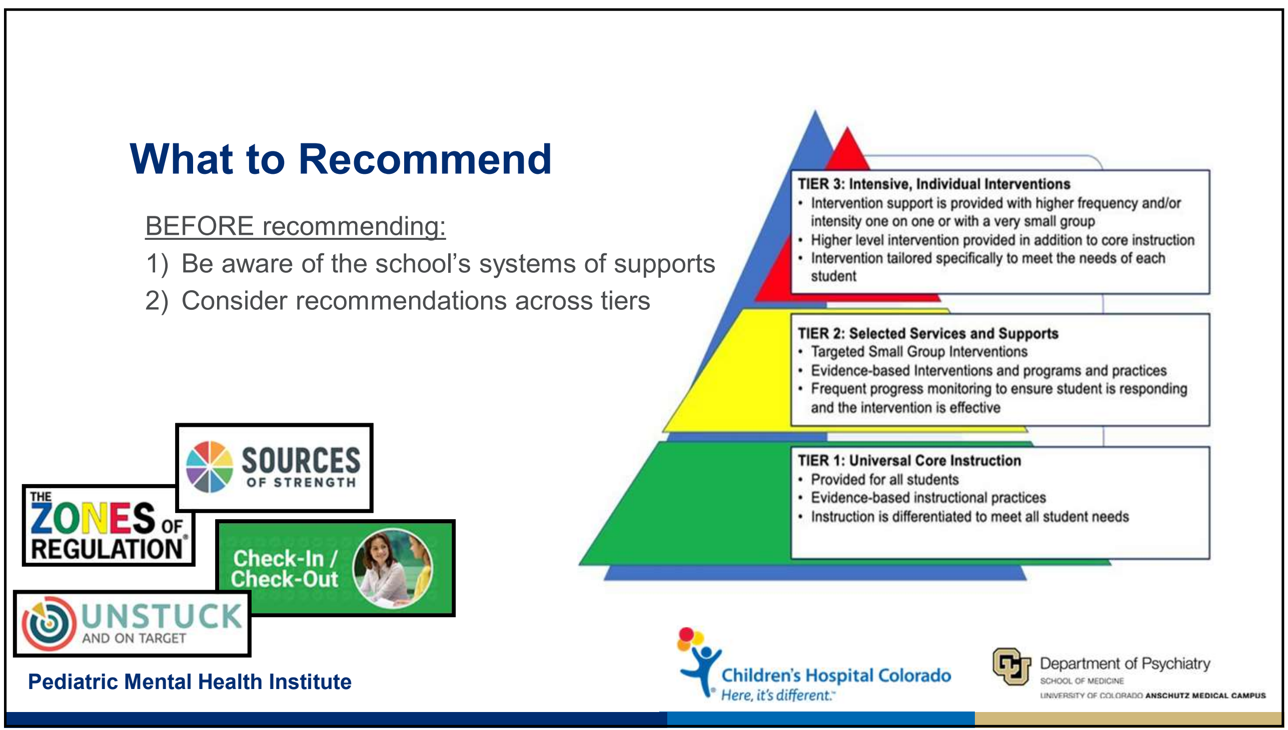

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Supporting Parents in Requesting Special Supports

Educating Parents in the Process

- 504s and IEPs
- Parental Rights
- Navigating Requests

Advocate with Parents

- Provide written and verbal communication of concern

Unique to IEP	Common Characteristics	Unique to 504
• Required under IDEA • Qualification based on 13 disability categories • Describes accommodations and modifications • Formal written learning goals & objectives • Mechanisms for conflict resolution • State receives funding for eligible students	• Mandated by laws • Accommodations at no cost • Parent engagement throughout processes • Reviewed yearly • Reassessment of student every 3 years • Parents can resolve disputes via mediation or lawsuit	• Required under rehabilitation Act • Qualification based on a record of impairment • Describes services that alter learning environments • Parents pay for an outside evaluation • No formal written plan is required • States do NOT receive additional funding for eligible students

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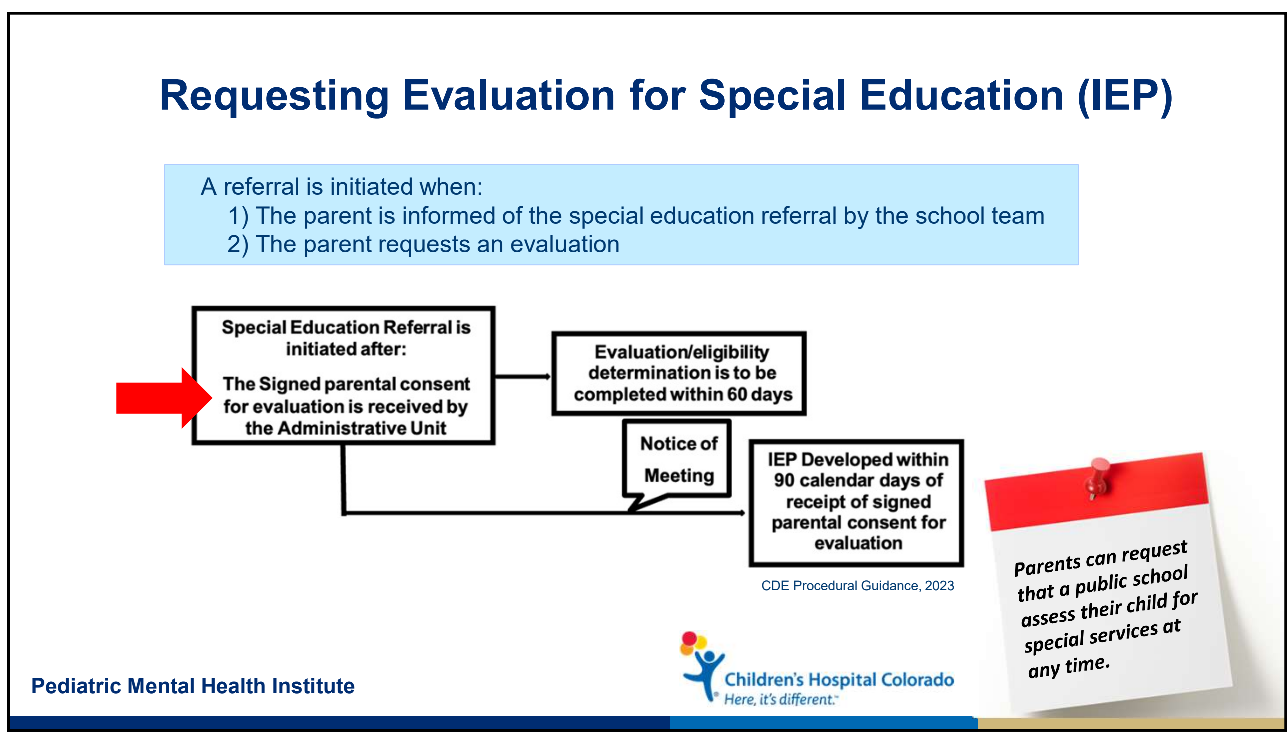

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Common Intersections

- Attention-Deficit/Hyperactivity Disorder
- Prescribing medications for school use
- Somatic Symptom and Related Disorders
- Bullying
- Social media
- School refusal
- Suicide/Self-harm

SCHOOL

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Attention-Deficit Hyperactivity Disorder

- Parents present reporting that school is concerned about possible ADHD
- Often in response to challenging behaviors or poor academic performance
- Often have requests
  - Formal diagnosis
  - Medications
  - Information about accommodations
- Review AAP Clinical Practice Guidelines:
  Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents | Pediatrics | American Academy of Pediatrics (aap.org)

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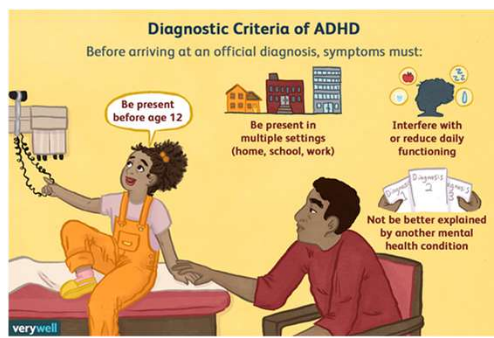
12

ADHD Assessment and Diagnosis Considerations

- Consider use of standardized scales
  - NICHQ Vanderbilt Assessment Scales: NICHQ Vanderbilt Assessment Scales
  - Conners Rating Scale, ADHD Rating Scale
  - Behavior Assessment System for Children, Child Behavior Checklist
- Consider atypical presentations, gender differences, and co-morbidities
- Be aware of resources available to you and refer if needed
  - CoPPCAP



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Prescribing Medications to be Taken at School

- Encourage caregivers to talk to the school
- Original, properly labeled pharmacy container
  - Considerations for medications that require multiple doses per day and/or mail order
- Prescriptions need to be as specific as possible!
  - Drug name, dose, route, time, and/or frequency/length of treatment
  - "3 times daily" vs "at lunchtime" vs. "at 12:00pm"

Medication Guidelines for Colorado School and Child Care Settings | CDE (state.co.us)

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Somatic Symptom and Related Disorders

Non-Epileptic Seizures (NES) & Functional Neurological Disorder (FND)

- FNSD vs Avoidance vs Factitious
- Comprehensive medical workup
- PCP medical home
- Collaboration of medical team and school

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Language Matters

Term	Example of use	Reason why the child finds the term offensive	Alternate language options
Psycho	Psychogenic, as in psychogenic non-epileptic seizures, psychogenic tremor, and so on	In everyday slang, *psycho* means crazy or mentally ill, and the child interprets the clinicians to be telling her that she is crazy or mentally ill.	Non-epileptic seizures (without the "psychogenic" prefix) Functional seizures Functional tremor
Pseudo	Pseudoseizures	The child may interpret the clinician's use of *pseudo* as communicating that her that her seizures are "fake" and that she is "faking" the seizures.	Functional seizures Non-epileptic seizures (without the "psychogenic" prefix)
Behavioral	The FND symptom is described as being "behavioral"	In everyday slang, *behavioral* means naughty or bad behavior, and the child interprets the clinician as telling her that she is naughty or bad or that she is doing it on purpose.	The symptom can be described as functional: reflecting dysregulation within the nervous system—rather than a problem with structure—and requiring mind–body interventions that restore regulation and normal function. The symptom can be described as functional: reflecting activation of the stress-system and disruption of normal motor function, as a result of physical, emotional, or cognitive stress.

Kozlowska, 2021

15

Bullying

In 2021-22, about 20% of students ages 12-18 reported being bullied during school

Three Steps Healthcare Providers Can Take to Prevent and Protect Children from Bullying

1. *Recognize (notice changes)*
2. *Screen (ask questions)*
3. *Refer (appropriate interventions)*

The 2019 Youth Behavior Surveillance System

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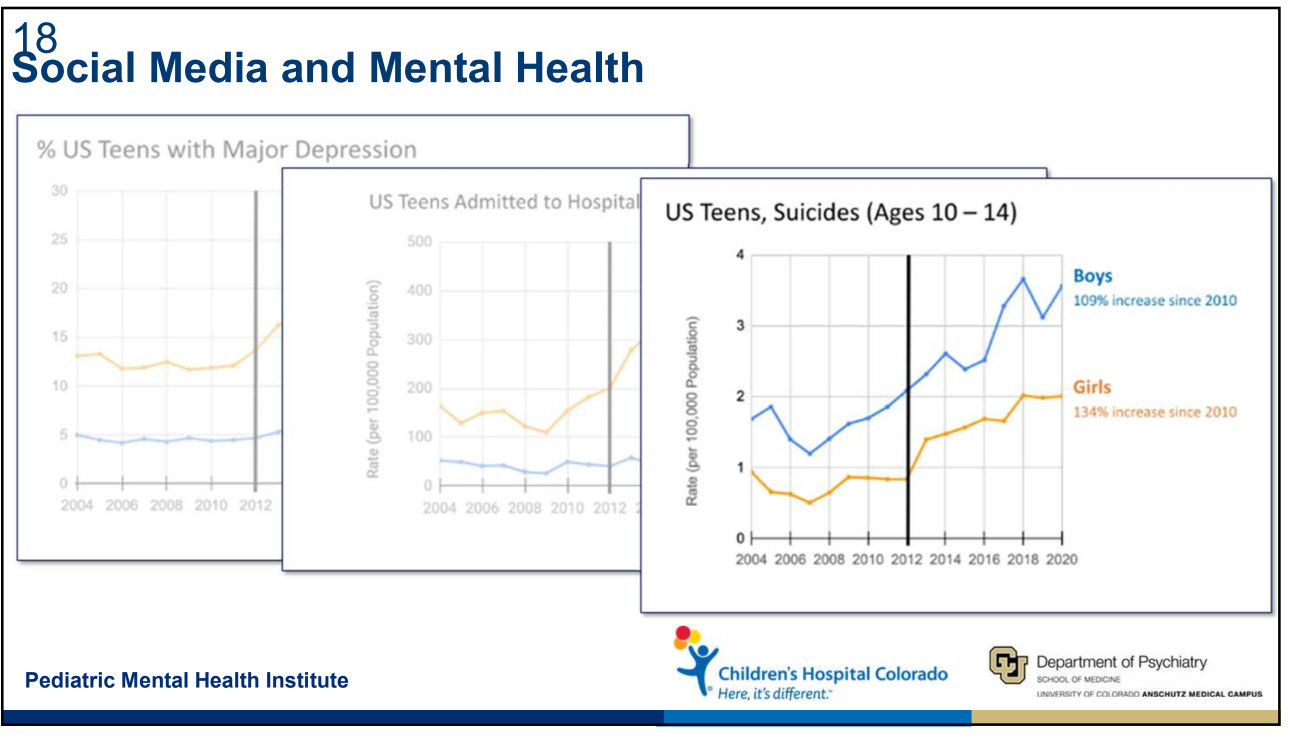

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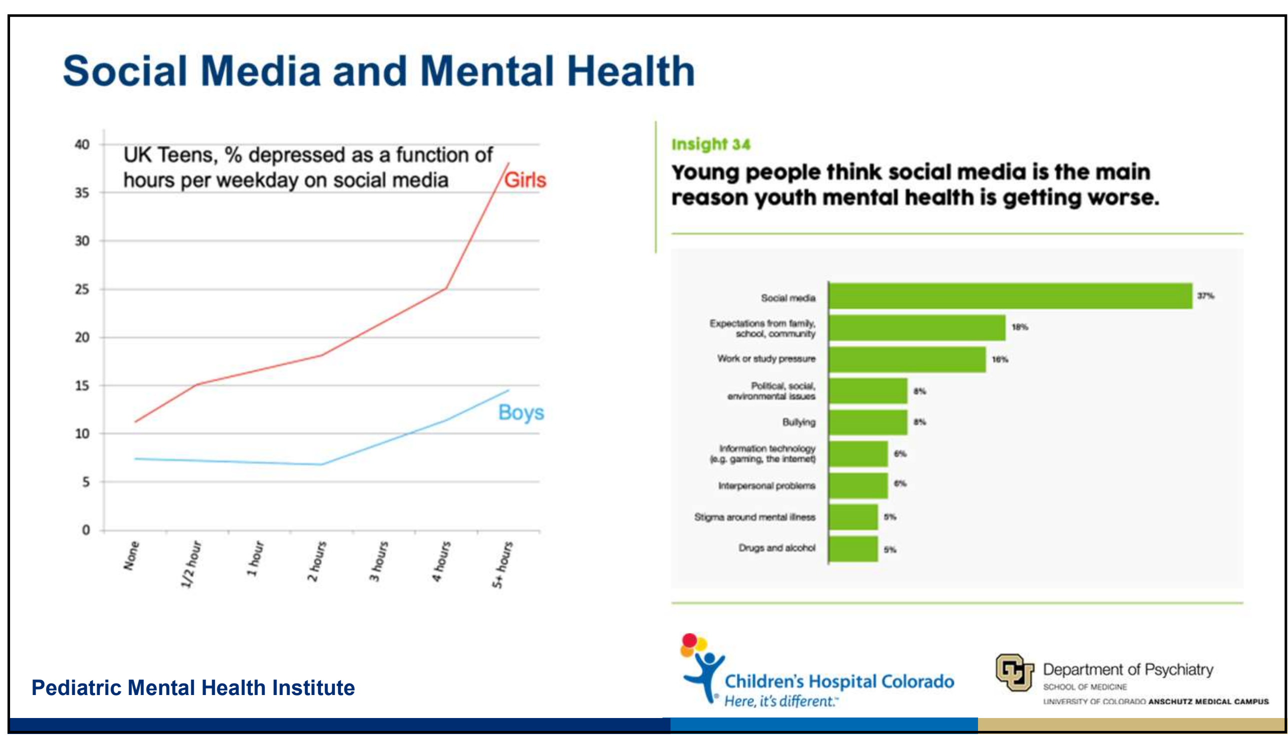

19

Coaching Parents on Media Use

- Carefully consider when to start
- Encourage families to create a Family Media Plan (AAP Media Plan)
- Consider tech free times/spaces
- Model responsible social media use
- Consider parental control apps
- Consider digital detox
- Report concerning behavior!

Impacts of digital social media detox for mental health: A systematic review and meta-analysis

Roy N. Ramadhan[1], Derren D. Rampengan[2], Defin A. Yumnanisha[3], Sabrina BV. Setiono[2], Kevin C. Tjandra[4], Melissa V. Ariyanto[1], Bulat Idrisov[5], and Maulana A. Empitu[1,6*]

[1]Faculty of Medicine, Universitas Airlangga, Surabaya, Indonesia; [2]Faculty of Medicine, Universitas Sam Ratulangi, Manado, Indonesia; [3]Faculty of Medicine, Universitas Indonesia, Depok, Indonesia; [4]Faculty of Medicine, Universitas Diponegoro, Semarang, Indonesia; [5]Health Services Research Department of Health Systems and Population Health, University of Washington, Seattle, USA; [6]Faculty of Health, Medicine and Natural Sciences, Universitas Airlangga, Banyuwangi, Indonesia

Taking a One-Week Break from Social Media Improves Well-Being, Depression, and Anxiety: A Randomized Controlled Trial

Authors: Jeffrey Lambert, George Barnstable, Eleanor Minter, Jemima Cooper, and Desmond McEwan | AUTHORS INFO & AFFILIATIONS

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No More FOMO: Limiting Social Media Decreases Loneliness and Depression

Melissa G. Hunt, Rachel Marx, Courtney Lipson and Jordyn Young

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20

School Avoidance and Refusal

Assessment

School Support

Mental Health Resources

Upwards of 25% of children are going to have some type of school refusal behavior at some point during their lives.

Kearney, 2014

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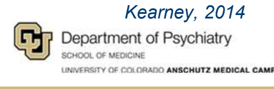

21

Suicide

- Child, parent, and/or school may express concern
  - School may be requesting evaluation or documentation that student is "safe" to return
- Consider universal screening
  - American Academy of Child and Adolescent Psychiatry: Recommend screening for depression in in primary care starting at age 8 AND assessing for symptoms in children ages 3+ who are referred for emotional/behavioral problems
  - Plan for how to respond to positive screens
- Ask directly
  - Consider does your team need additional training
- Safety planning (vs. no suicide contracts)
- Suicide vs self-harm

Depression Screening (aacap.org)
Home - Stanley-Brown Safety Planning Intervention (suicidesafetyplan.com)

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23

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. ______
2. ______
3. ______

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. ______
2. ______
3. ______

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: ______ Contact: ______
2. Name: ______ Contact: ______
3. Place: ______ 4. Place: ______

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: ______ Contact: ______
2. Name: ______ Contact: ______
3. Name: ______ Contact: ______

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: ______ Phone: ______
Emergency Contact : ______
2. Clinician/Agency Name: ______ Phone: ______
Emergency Contact : ______
3. Local Emergency Department: ______
Emergency Department Address: ______
Emergency Department Phone : ______
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. ______
2. ______

The Stanley-Brown Safety Plan is copyrighted by Barbara Stanley, PhD & Gregory K. Brown, PhD (2008, 2021). Individual use of the Stanley-Brown Safety Plan form is permitted. Written permission from the authors is required for any changes to this form or use of this form in the electronic medical record. Additional resources are available from www.suicidesafetyplan.com.

Stanley-Brown
Safety Planning Intervention

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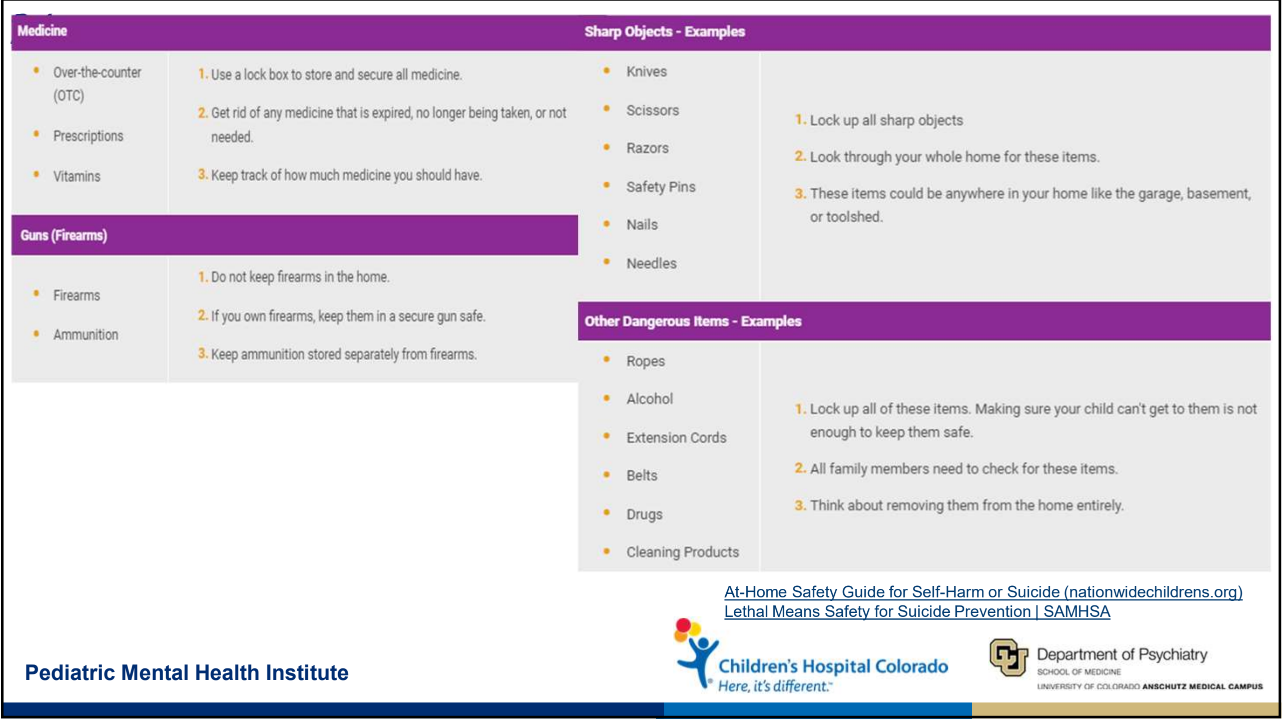
Department of Psychiatry
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS



Medicine	
• Over-the-counter (OTC) • Prescriptions • Vitamins	1. Use a lock box to store and secure all medicine. 2. Get rid of any medicine that is expired, no longer being taken, or not needed. 3. Keep track of how much medicine you should have.

Guns (Firearms)	
• Firearms • Ammunition	1. Do not keep firearms in the home. 2. If you own firearms, keep them in a secure gun safe. 3. Keep ammunition stored separately from firearms.

Sharp Objects - Examples	
• Knives • Scissors • Razors • Safety Pins • Nails • Needles	1. Lock up all sharp objects 2. Look through your whole home for these items. 3. These items could be anywhere in your home like the garage, basement, or toolshed.

Other Dangerous Items - Examples	
• Ropes • Alcohol • Extension Cords • Belts • Drugs • Cleaning Products	1. Lock up all of these items. Making sure your child can't get to them is not enough to keep them safe. 2. All family members need to check for these items. 3. Think about removing them from the home entirely.

At-Home Safety Guide for Self-Harm or Suicide (nationwidechildrens.org)
Lethal Means Safety for Suicide Prevention | SAMHSA

Resources

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25

Safe2tell Colorado

- Established in 2004 as a non-profit organization
- "Youth-centered harm prevention and intervention resource"
- Enables youth to make a report "when a trusted adult isn't available"
- Able to engage schools, law enforcement, and mental health resources

"If you see something harmful, say something helpful"

A student reported that another student was threatening to harm students at their school. Local teams investigated and found the student to have possession of guns. The student was arrested, and the Crisis Response Team conducted a threat assessment.

A person reported seeing a written message on the bleachers at a school, which included threats of a planned school attack. Local teams investigated and identified the student who wrote the message. The student's parents were notified, school disciplinary action was taken, a threat assessment was conducted, and the student is receiving counseling services.

A person reported that a student took an excessive number of pills because they were depressed. Local teams notified the parents, conducted a welfare check, and transported the student to the hospital.

A person reported that a student was selling illegal drugs to other students at school. The school investigated and found drugs in the student's backpack. School disciplinary action was taken, the student's parents were notified, and the student was arrested.

A person reported that a student was inappropriately touching other students at their school. School teams investigated and the allegations were confirmed, leading to school disciplinary action, the student's parents being notified, and counseling services being offered to the student.

A person reported that their peer expressed concerns about a stalker. School teams investigated and contacted the student's parent, who is working with the Sheriff's Office.

9

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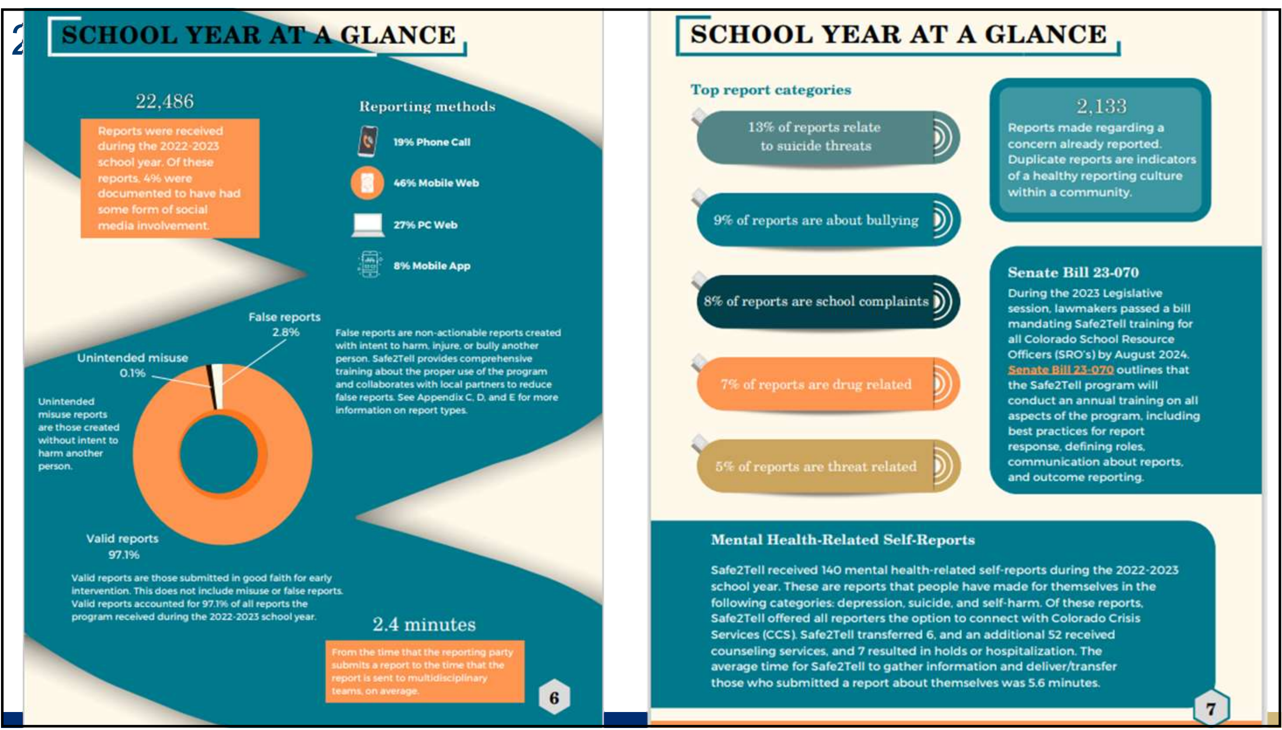
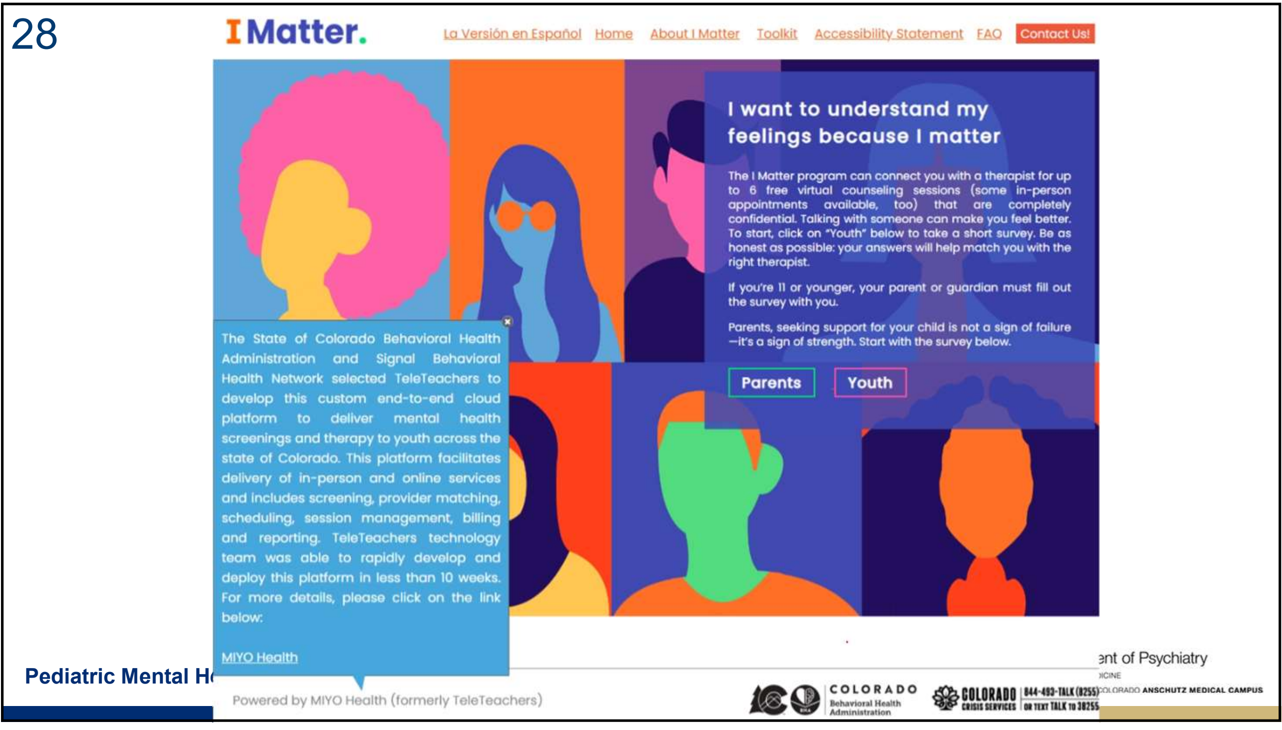
Home - Safe2Tell

26



27



28

29

Crisis Resources

988 | SUICIDE & CRISIS LIFELINE

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29

30

Takeaways

- Collaboration and consultation with schools can enhance access and treatment of youth mental health concerns.
- There are common intersections where PCPs can lead and support families in navigating mental health in the home and school setting.
- Adding behavioral health assessment and psychoeducation into well-child visits can help identify and prevent mental health concerns early.

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30

Thank You

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31