AAP’s Mental Health Toolkit: The Building Blocks for Addressing Mental Health Concerns in Primary Care

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Kristine Hobbs, LMSW
CATCH Meeting, January 26, 2013
Disclosures

This is what my living room looks like most days.

I would say I have a financial relationship with LEGOS! But they in no way have supported this project...
For this presentation, we are going to show you snapshots of what is found in the mental health toolkit
Overview of Presentation

• Opening the AAP’s Mental Health Toolkit
  – Different approaches
• AAP’s MHPRI – Snapshots of Resources for...
  – Community Resources
  – Health Care Financing
  – Support for Children and Families
  – Clinical Information Systems/ Redesign
  – Decision Support for Clinicians
• Protocols for Anxiety and Aggression/Disruptive Behavior
• Closing
Mental Health Toolkit:
“Mental” encompasses:

- Behavioral
- Neurodevelopmental
- Psychiatric
- Psychological
- Social-emotional
- Substance Abuse
- Adjustment to stressors
- Somatic manifestations
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June 2010, VOLUME 125 / ISSUE Supplement 3

- Introduction
  Jane Meschia Foy and for the American Academy of Pediatrics Task Force on Mental Health
  Pediatrics 2010; 125:S69–S74
  » Extract  » Full Text  » Full Text (PDF)  » Request Permissions

- Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community
  Jane Meschia Foy, James Perrin, and for the American Academy of Pediatrics Task Force on Mental Health
  Pediatrics 2010; 125:S75–S86
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- Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice
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Mental Health Toolkit:
Acknowledgments

Introduction to Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit

Using the Toolkit

Glossary of Mental Health and Substance Abuse Terms

Mental Health Practice Readiness Inventory

Algorithm A: Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care
Interactive Version | Printable PDF

Algorithm B: Assessment and Care of Children with Identified Social-Emotional, Mental Health (MH) or Substance Abuse (SA) Concerns, Ages 0-21
Interactive Version | Printable PDF

Competencies for the Mental Health Algorithm Steps
ADDRESSING MENTAL HEALTH CONCERNS IN PRIMARY CARE
A CLINICIAN’S TOOLKIT
“Science is built of facts the way a house of build of bricks; but an accumulation of facts is no more science than a pile of bricks is a house.”

~Henri Poincare
# Mental Health Practice Readiness Inventory

<table>
<thead>
<tr>
<th>Community Resources</th>
<th>Health Care Financing</th>
<th>Support for Children and Families</th>
<th>Clinical Info Systems/Delivery Systems Redesign</th>
<th>Decision Support for Clinicians</th>
</tr>
</thead>
</table>
| • Inventory of available providers  
• Knowledge needed to access cores services  
• Collaborative relationships with key providers | • 3rd party payors – providers, authorizations, payors  
• Coding – to capture payment | • First contact – feel welcome  
• Culturally effective MH care  
• Mental health promotion  
• Confidentiality  
• Adolescents – MH/SA  
• Engage patient in MH dialogue  
• Self and family management – self-care  
• Referral assistance  
• Care coordination for MH needs  
• Special populations  
• Family centeredness  
• QI – for kids with MH needs | • Registry to id kids with MH/SA issues  
• Recall and reminder for kids on the registry  
• Med Management  
• Emergency – plan in place for handling psychiatric emergencies  
• Information exchange related to community resources  
• Tracking systems to monitor progress  
• Care plans – interdisciplinary  
• Collaborative models of care for kids with MH needs  
• Interactive web-based tools  
• Screening and assessment | • Functional assessment – how does the MH /SA issue affect functioning  
• Clinical Guidance – training areas  
• Protocols for kids with MH issues and to help foster self-mgmt  
• Psychiatric Consultation – access to psychiatrist  
• Screening and surveillance – to elicit MH/SA problems and identify family strengths and risks |
**Introduction**

**Mental Health Practice Readiness Inventory**

**Practice name:** [Input Field]

**Date:** 11-20-2012

**Instructions:** The purpose of this tool is to help primary care clinicians assess the extent to which their office systems promote and support mental health practice. It is recommended that the entire practice team complete this tool together, select priority areas (building on strengths), and stage practice improvements incrementally. The practice team may include clinicians, nurses, office administrators, receptionists, and specialists caring for children with mental health problems and their families. To learn more about the specific competencies primary care clinicians need to provide mental health care, see *The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care* (Pediatrics. 2009;124:410–421).

Use the following rating system to evaluate your practice.

1 = We do this well—substantial improvement is not currently needed.
2 = We do this to some extent—improvement is needed.
3 = We do not do this well—significant practice change is needed.

Click the radio button next to one.

<table>
<thead>
<tr>
<th>Community Resources</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inventory</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care practice has an up-to-date inventory of accessible developmental-behavioral pediatricians, adolescent medicine specialists, community- and school-based mental health and substance abuse professionals, Early Intervention program(s), special education program(s), child protection agencies, youth recreational programs, family and peer support programs, and mental health care coordinators.</td>
<td></td>
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</tr>
<tr>
<td><strong>Core Services</strong></td>
<td></td>
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</tr>
<tr>
<td>Primary care practice team is knowledgeable about eligibility requirements, contact points, and services of the programs and providers listed above and the type(s) of payment they accept.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Collaborative Relationships</strong></td>
<td></td>
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</tr>
<tr>
<td>Primary care practice team has collaborative relationships with school- and community-based mental health programs, and professionals, and readily available and accessible to clients.</td>
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</tr>
</tbody>
</table>

**PDF Version**
“Architecture starts when you carefully put two bricks together. There it begins.”

~ Ludwig Mies van der Rohe
Introduction

Building resilience and promoting mental health in children and adolescents will require the participation of many organizations and individuals throughout the community. (See “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community” for a full discussion). Treatment of children with social-emotional problems and mental health disorders will require strong collaborative relationships between primary care clinicians and the various individuals and systems that provide services to children and families. These collaborations will function in ways that will make practice better for both groups and care better for patients.

Resources in the Community Resources section of Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit will enable you to

- Create a resource guide of community mental health and substance abuse resources (and the types of payment accepted). This might include developmental and behavioral pediatricians, adolescent medicine specialists, family support groups, Early Intervention (EI) services, human services agencies, child care consultants, parenting education programs, key school contacts, youth organizations, recreation programs, and others involved in supporting or serving children and families.
- Become knowledgeable about the available community resources.
- Develop collaborative relationships with providers of key services.

Use the following rating system to determine the starting point for your practice:

1 = We do this well—substantial improvement is not currently needed.
2 = We do this fairly well—some improvement is needed.
3 = We do not do this well—signficant practice change is needed.
4 = We do not do this at all—significant practice change is needed.
## Inventory

### Educational Terminology/Abbreviations/Acronyms

<table>
<thead>
<tr>
<th>Mentioned Terms/Abbreviations/Acronyms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health/Substance Abuse</td>
</tr>
<tr>
<td>Abuse, Neglect, and Foster Care</td>
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<tr>
<td>Environmental Health</td>
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<tr>
<td>Chronic Disease/Terminal Illness/Respite Care</td>
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<tr>
<td>Dental</td>
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</tbody>
</table>

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### Sample Pocket Guide to Community Resources for Children and Families

**Month/Year**

**Best Places to Start!**

### Addressing Mental Health Concerns in Primary Care

A Clinician's Toolkit

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### Basic Needs

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Emergency Assistance</td>
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<tr>
<td>Food/Nutrition</td>
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<tr>
<td>Housing/Homelessness</td>
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<tr>
<td>Income Assistance</td>
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<tr>
<td>Insurance Coverage/Medical</td>
</tr>
<tr>
<td>Safety/Smoke Detectors</td>
</tr>
<tr>
<td>Transportation</td>
</tr>
<tr>
<td>Health Care Access for Uninsured</td>
</tr>
<tr>
<td>Perinatal</td>
</tr>
</tbody>
</table>

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### Sociocultural/Educational Issues

<table>
<thead>
<tr>
<th>Item</th>
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</thead>
<tbody>
<tr>
<td>Child Care/Day Care</td>
</tr>
<tr>
<td>Parent Education, Support, and Counseling</td>
</tr>
<tr>
<td>Literacy</td>
</tr>
<tr>
<td>School System/Training/Employment</td>
</tr>
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</table>

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### Financial Counseling

<table>
<thead>
<tr>
<th>Item</th>
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</thead>
<tbody>
<tr>
<td>Latino Issues</td>
</tr>
<tr>
<td>Special Needs Children/Developmental Disabilities</td>
</tr>
<tr>
<td>School Aged/Adolescents, at Risk Youth</td>
</tr>
</tbody>
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### Legal Issues

<table>
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<tr>
<th>Item</th>
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<tbody>
<tr>
<td>Medicaid</td>
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### Literature

<table>
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<th>Item</th>
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### Special Needs Children/Developmental Disabilities

<table>
<thead>
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<tbody>
<tr>
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<td>Dental</td>
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### Health Care Access for Uninsured

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### Literature

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### Website

[Website](http://www.sampleguide.com)
Sample Mental Health Professional Survey

Name of Professional ____________________________________________
Professional Degrees and Licensure ____________________________________________
Name of Practice ____________________________________________
Address ____________________________________________

Ages Served
- Birth to 5 Years  
- 6 to 12 Years  
- 13 to 19 Years  
- Adult

Specialty Areas ____________________________________________
Therapy Types Offered ____________________________________________

Office Hours ____________________________________________
Types of Insurance Accepted ____________________________________________
Types of Payment Accepted ____________________________________________
Office Contact for Referrals
Name ____________________________________________
Phone ____________________________________________
Fax ____________________________________________

Please Fax to Name of practice
Attn: Name of primary care clinician
Fax number

If interested in further conversation about collaborative opportunities, please provide contact information here.

__________________________________________
__________________________________________
“The [LEGO] brick is a universal language. If a kid from China were to meet a kid from Chicago, they don’t have to speak the same language but they could build something together.”

~Richard Stollery, British LEGO executive
Health Care Financing

Introduction

Primary care clinicians cannot provide or sustain specialty services without appropriate payment. This will likely require advocacy with public and private insurance payers and purchasers, using strategies such as those suggested in *Strategies for System Change in Children’s Mental Health: A Chapter Action Kit*. At the practice level, it will require preparations to ensure that clinicians effectively access third-party payment for the mental health services they provide.

Resources in the Health Care Financing section of *Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit* will enable you to:

- Provide a realistic business framework for mental health services.
- Gain access to specialty provider lists and authorization procedures of major public and private health insurers.
- Prepare the practice to code and bill effectively to ensure payment for mental health services.

Use the following rating system to determine the starting point for your practice:

1 = We do this well—substantial improvement is not currently needed.
2 = We do this to some extent—improvement is needed.
3 = We do not do this well—significant practice change is needed.

Rate practice. Check link for tools and resources.

Health Care Financing
Coding Sheets

Coding for the Mental Health Algorithm Steps
This resource provides a direct link between each step in the clinical algorithms and the codes to be used for payment.

American Academy of Pediatrics Care Plan Oversight Encounter Worksheet
This sample care plan worksheet from the Coding for Pediatrics manual is an example of a form for documenting time for services rendered.

Developmental Screening and Testing Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance to primary care clinicians on coding for developmental screening and testing for children.

Anxiety Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance for primary care clinicians to use in coding for services for children with symptoms of anxiety.

Bereavement Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance for primary care clinicians to use in coding for services for bereaved children.

Depression Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance for primary care clinicians to use in coding for services for children with depression.

Inattention, Impulsivity, Disruptive Behavior, and Aggression Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance for primary care clinicians to use in coding for services for children with inattention, impulsivity, disruptive behavior, and aggression.

Post-traumatic Stress Disorder Coding Fact Sheet for Primary Care Clinicians
This fact sheet provides guidance for primary care clinicians to use in coding for services for children with post-traumatic stress disorder.
ANXIETY CODING FACT SHEET FOR PRIMARY CARE CLINICIANS


Initial assessment usually involves a lot of time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most pediatricians will report either an office or outpatient evaluation and management (E/M) code using time as the key factor or a consultation code for the initial assessment.

Physician Evaluation and Management Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit, new patient; self limited or minor problem, 10 min.</td>
</tr>
<tr>
<td>99202</td>
<td>Low to moderate severity problem, 20 min.</td>
</tr>
<tr>
<td>99203</td>
<td>Moderate severity problem, 30 min.</td>
</tr>
<tr>
<td>99204</td>
<td>Moderate to high severity problem, 45 min.</td>
</tr>
<tr>
<td>99205</td>
<td>High severity problem, 60 min.</td>
</tr>
<tr>
<td>99211</td>
<td>Office or other outpatient visit, established patient; minimal problem, 5 min.</td>
</tr>
<tr>
<td>99212</td>
<td>Self limited or minor problem, 10 min.</td>
</tr>
</tbody>
</table>

+99354 Prolonged physician services in office or other outpatient setting, with direct patient contact; first hour (use in conjunction with time-based codes 99201–99215, 99241–99245, 99301–99350)

+99355 Each additional 30 min. (use in conjunction with 99354)

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- Time spent does not have to be continuous.
- Codes are add-on codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, 99201–99215).
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Physician Non-Face-to-Face Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99339</td>
<td>Care Plan Oversight—Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (e.g., assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plan, written report sent to patient</td>
</tr>
</tbody>
</table>
“Bricks may make a house, but the laughter of children makes a home.”

~ Irish Proverb
Support for Children and Families

Introduction

Pediatric primary care practices are typically child- and family-friendly places and can readily take additional steps to normalize and destigmatize mental health concerns. Engagement of children and their families in their own care is one of the best correlates of successful outcomes. Such efforts may focus on child and family motivation, education, skill building, or emotional support. When specialty care is needed, children and families need support in the referral process.

Resources in the Support for Children and Families section of Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit will enable you to

- Ensure children and families with mental health concerns have a positive first contact with the practice.
- Address stigma.
- Promote the concept of mental health as integral to the care of children in the medical home.
- Assure children and families about confidentiality.
- Prepare to address the mental health and substance abuse needs of adolescents.
- Focus effort on engagement of the child and family in help-seeking.
- Offer self-help interventions.
- Support families in the referral process.
- Identify children involved in the specialty system and provide them with a medical home.
- Prepare to address the mental health and substance abuse needs of special populations within the practice.
- Ensure the family friendliness of the practice.
Culturally Effective Care

PARENTS’ GUIDE: A STRENGTHS-BASED APPROACH

The following guidance is based on the Vermont Child Health Improvement Program.

When a child or youth is diagnosed with any illness or health condition, it is important for the parent and youth to focus on understanding the plan for treatment. There are often questions that cannot be answered right away and depend on what happens in the next few weeks or months. There are some things, however, that are not in question—your child’s and family’s strengths. It’s important to remember, as Nan Henderson says, “What’s right with you is more powerful than what’s wrong with you.” Use the following ideas, which were taken from many sources, to help you identify these strengths.

Your love and support, along with your child’s strengths, are what will help your child manage her illness and become a successful adult. There are simple things you can do to support your child’s development of strengths.²

Offer Guidance: Actively guide your child toward the values and skills you want for him.

- Regularly discuss what you expect from him.
- Suggest ways he can pursue his interests and enhance his strengths.
- Discuss your values, what you do and do not believe.
- Model positive behavior. Let your kids see you learning, working, contributing to your community, and trying new
Mental Health Promotion

The Office of Minority Health
This resource center develops health policies and programs in an effort to eliminate health disparities.

Mental Health Promotion

Sample Welcome Letter
This sample welcome letter to children, adolescents, and families provides a template for primary care clinicians to use when welcoming new children and families to their practice and encouraging them to share psychosocial as well as medical concerns. Practices can adapt the form as necessary.

Brochures
The following are educational brochures or handouts that primary care clinicians can provide to parents as a resource.

- Welcome to the World of Parenting
- Your Child's Growth: Developmental Milestones
- Teaching Good Behavior: Tips on How to Discipline
- Discipline and Your Child
- Guidelines for Special Time
- Your Family's Mental Health: 10 Ways to Improve Mood Naturally

Promoting Mental Health
This section of Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition, highlights opportunities for promoting mental health in every child, outlining suggestions for each visit.

Zero to Three: Free Parent Brochures and Guides
This website provides a number of parent resources based on age in English and Spanish.

Age-Specific Checklists
The following age-specific checklists from the National Center for Education in Maternal and Child Health Bright Futures guide discuss mental health during the office visit:
"Know what's weird? Day by day, nothing seems to change, but pretty soon...everything's different."

~Calvin from Calvin and Hobbes
Clinical information systems ensure that information about patients is accessible to clinicians across settings and time. Effective information systems foster collaboration among primary care clinicians and the many others important to children’s mental health—specialists caring for children with mental health concerns and their family, school and child care personnel, social and juvenile justice agencies, care managers, and of course, families. Collaboration may take many forms. Family preferences, local resources, clinical circumstances, and business realities will dictate the specific model(s) of collaboration and the design of delivery systems to support them.

Resources in the Clinical Information Systems/Delivery System Redesign section of Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit will enable you to:

- Create registries of children with mental health problems.
- Use monitoring, prescribing, and tracking systems for psychosocial therapy and psychotropic drugs.
- Put into place a plan for managing psychiatric and social emergencies.
- Put into place office systems to support screening, assessment, and collaboration.
- Collaboratively develop care plans.
- Prepare for participation in the full range of collaborative models.
RECALL/REMINDER SYSTEMS FOR USE IN TRACKING CHILDREN WITH MENTAL HEALTH CONCERNS

Recall/reminder systems used for preventive services and management of chronic medical conditions can be adapted for use in ensuring that children with mental health problems receive needed services and follow-up.

The recall/reminder system begins with identifying children in the practice who have a mental health problem. This should include children whose families are not yet ready to take action, those in treatment within the medical home, and those referred elsewhere for consultation or treatment. For assistance in the process of identifying children with special healthcare needs and developing a registry, click here. Once identified, each child's record should be marked or noted in such a way as to communicate his or her special status.

The system then requires agreement on a practice protocol for the care of children with each specific condition such as attention-deficit/hyperactivity disorder (ADHD) or depression, e.g., frequency of visits or contacts, collateral information collected prior to each visit or contact, laboratory tests and their periodicity, elements of a follow-up visit (e.g., vital signs, mental status examination, components of history and physical assessment, functional assessment scale), assurance of preventive services, communications sent to other providers.

Whenever possible, the recall/reminder system should be automated. Almost all electronic health records (EHRs) have such a capacity and some offer administrative systems can manage such systems. Call your computer vendor directly to determine if you can use your computer system to help you with recall/reminder tasks. Following are some questions you may want to ask your EHR representative, your administrative computer vendor, or your information technology staff:

- Does the system maintain information on diagnoses or types of visits? Can it generate a list of children with certain conditions or follow-up requirements?
- Does the computer system have a built-in tracking system it is possible to purchase a tracking system as an add-on?
- Can the system be programmed to generate reminder notices prior to scheduled visits for designated patients? If so, can it be programmed to request information from collateral sources such as schools and specialists, notify a case manager, or remind the patient and family?
- Can the system be programmed to track referral completion and adherence to a treatment schedule?

If the system will be manual, it is important to mark records in a visible, yet confidential, way and establish a labeling system—a calendar-based file—marking designated staff members on a certain date they should request collateral information, notify a case manager, or remind the family of an upcoming visit, contact, or compliance. If an appointment is missed, there should be clear responsibility for notifying the clinician and rescheduling the family. If a child is referred for assessment or care by a specialist in the child's school or community, the system should remind a designated staff member to make contact, ensure that the referral was completed, and periodically request updates. When children do not adhere to planned follow-ups or referrals, there should be a process to match the child to the family in an effort to identify barriers and assist in problem solving.

Periodically, the practice should review a sample of records to ensure that office protocols are being followed. Assessment programs like the American Academy of Pediatrics Education in Quality Improvement for Pediatric Practice on ADHD are ideal for such reviews. At the time of new scientific developments, publication of new clinical guidelines, or medication alerts, the practice should review the relevant protocols and review records of children affected by changes.

References
Recall

Questions for EMR Vendor...

• Does the system contain information on diagnosis or type of visit? Can it generate a list of children with certain conditions or follow-up requirements?
• Does the computer system have a built-in tracking system? Is it possible to purchase a tracking system as an add-on?
• Can the system be programmed to generate reminder notices prior to scheduled visits for designated patients? If so, can it be programmed to request information from collateral sources such as schools and specialists, notify a case manager, or remind the patient and family?
• Can the system be programmed to track referral completion and adherence to a treatment schedule?
Tracking Systems and Care Plans

It is appropriate to seek a referral or consultation with a child and adolescent psychiatrist.

Forms for Documenting Mental Health Assessment and Tracking Progress in Care
This set of interrelated forms is designed to gather mental health-related information that complements, without replicating, information gathered elsewhere in the pediatric health record. The forms were developed to document steps in Algorithms A and B, Algorithms to Guide Primary Care Clinicians in Promoting Mental Health, Identifying and Addressing Mental Health and Substance Use Concerns in Pediatric Primary Care. Clinicians have the option to use the forms as is or customize to reflect their own record-keeping practices. The set includes the following contents:

- How to Use Forms and Resources
- Primary Care Mental Health Assessment [PDF] | [Customizable doc]
- Mental Health Monitoring Tool [PDF] | [Customizable doc]
- Interim Mental Health Visit Form [PDF] | [Customizable doc]
- Family Care Plan: Generic Template [PDF] | [Customizable doc]
- Family Care Plan: Generic Template/No Prompts [PDF] | [Customizable doc]
- Family Care Plan: Externalizing Template [PDF] | [Customizable doc] (for a child who is experiencing externalizing behaviors such as inattention or impulsivity, or disruptive behavior or aggression)
- Family Care Plan: Internalizing Template [PDF] | [Customizable doc] (for a child who is experiencing internalizing behaviors such as depression or anxiety)
- Family Care Plan Sample: Anxiety/Depression Template [PDF] | [Customizable doc] (sample of how the Family Care Plan: Internalizing Template can be completed for a child who is experiencing anxiety)
- Family Care Plan Sample: Grief/Loss Template [PDF] | [Customizable doc] (sample of how the Family Care Plan: Initial History Questionnaire Visit Documentation Form can be completed for a child who is experiencing grief or loss)

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Tracking Systems and Care Plans...
(from AAP MH Toolkit)

- ...interrelated forms is designed to gather mental health–related ...The forms were
developed to document steps in Algorithms A and B, *Algorithms to Guide Primary
Care Clinicians in Promoting Mental Health, Identifying and Addressing Mental Health
and Substance Use Concerns in Pediatric Primary Care.*

**How to Use Forms and Resources**
- available in PDF or Customizable documents:
  - Primary Care Mental Health Assessment [PDF](#) | [Customizable doc](#)
  - Mental Health Monitoring Tool [PDF](#) | [Customizable doc](#)
  - Interim Mental Health Visit Form [PDF](#) | [Customizable doc](#)
  - Family Care Plan: Generic Template [PDF](#) | [Customizable doc](#)
  - Family Care Plan: Generic Template/No Prompts [PDF](#) | [Customizable doc](#)
  - Family Care Plan: Externalizing Template [PDF](#) | [Customizable doc](#)
  - Family Care Plan: Internalizing Template [PDF](#) | [Customizable doc](#)
  - Family Care Plan Sample: Anxiety/Depression Template [PDF](#) | [Customizable doc](#)
  - Family Care Plan Sample: Grief/Loss Template [PDF](#) | [Customizable doc](#)
  - *Initial History Questionnaire Visit Documentation Form*

...Not all about forms...but ideas...
Algorithm A
Promoting Social-Emotional Health, Identifying Mental Health and Substance Use Concerns, Engaging the Family, and Providing Early Intervention in Primary Care

Click on a step to view details and supplementary material.
Algorithm B
Assessment and Care of Children with Identified Social-Emotional, Mental Health (MH) or Substance Abuse (SA) Concerns, Ages 0-21

Click on a step to view details and supplementary material.
Referring and Feedback Form

PRIMARY CARE REFERRAL AND FEEDBACK FORM

Date: __________________________

Referring Physician Name: __________________________

Address: __________________________

City: __________________________
State: ____________
Zip: __________________________

Patient's Name: __________________________

Parent's Name: __________________________

Date of Patient Seen: __________________________

Reasons for Referral:

Any Specific Questions or Requests:

Referring Physician’s Printed Name/Signature:

Thank you for evaluating this patient. To facilitate communication and treatment, please make copies of this form to retain in the patient’s record; complete a form after initial assessment; complete additional forms periodically during treatment (as indicated) and when treatment is terminated; and mail or fax completed form(s) to the physician listed above. This is not a request for copies of psychotherapy notes, which require a signed consent to release. Thank you for your collaboration.
“A successful man is one who can lay a firm foundation with the bricks others have thrown at him.”

~ David Brinkley
**Introduction**

Tools that inform diagnosis and management at various stages and for diverse conditions will assist primary care practices in enhancing their mental health care.

Resources in the Decision Support for Clinicians section of *Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit* will enable you to:

- Select validated functional assessment tool(s) for use in identifying mental health problems and in monitoring a child and family’s progress toward therapeutic goals.

- Select instruments for the assessment of children whose screening results or clinical finding suggest the presence of a mental health or substance abuse problem.

- Identify reliable, current sources of information concerning diagnostic classification of mental health problems and evidence about the safety and efficacy of treatment.

- Develop and implement evidence-based protocols.

- Establish a relationship with a psychiatrist who has expertise in children and adolescents.

- Routinely screen for mental health and substance abuse problems in the child and family.

- Use acute care visits to elicit mental health concerns.
Functional Assessment | Clinical Guidance | Protocols | Psychiatric Consultation
Screening and Surveillance

Introduction
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- Develop and implement evidence-based protocols.
- Establish a relationship with a psychiatrist who has expertise in children and adolescents.
- Routinely screen for mental health and substance abuse problems in the child and family.
- Use acute care visits to elicit mental health concerns.

Use the following rating system to determine the starting point for your practice:
Clinical Guidance

Descriptions of DSM-IV, DSM-PC Child and Adolescent Version, and DC:0-3R
This document provides a description of Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV), the Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version, and the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3R), including the organizational structure, clinical uses, and limitations.

Evidence-Based Child and Adolescent Psychosocial Interventions
This matrix outlines evidence-based child and adolescent psychosocial interventions. Check www.aap.org/mentalhealth for updates.

Evidence-Based Child and Adolescent Psychopharmacology
This matrix outlines evidence-based child and adolescent psychopharmacologic interventions in an effort to facilitate intervention strategies for families with children suffering from mental health disorders. Check www.aap.org/mentalhealth for updates.

Stages of Change and Goals of Intervention
This matrix provides the stages of change, goals of intervention, and discussion points.

Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents
The American Academy of Child & Adolescent Psychiatry Practice Parameters describe generally accepted practices. The parameters are designed to assist clinicians in providing high-quality assessment and treatment for children and adolescents that are consistent with the best available scientific evidence and clinical consensus.

National Guideline Clearinghouse
The National Guideline Clearinghouse contains summaries of select guidelines that cover similar topic areas. Key elements of each summary include the scope of the guidelines, interventions and practices considered, major recommendations and corresponding rating schemes and strength of evidence, areas of agreement, and areas of disagreement.
## EVIDENCE-BASED CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTIONS

This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period April 2010 - September 2010 using the PracticeWise Evidence-Based Services (PWES) Database, available at www.practicewise.com. If this is not the most current version, please check the American Academy of Pediatrics mental health Web site (www.aap.org/mentalhealth) for updates.

### Table of Evidence-Based Interventions

<table>
<thead>
<tr>
<th>Problem Area</th>
<th>Level 1 - BEST SUPPORT</th>
<th>Level 2 - GOOD SUPPORT</th>
<th>Level 3 - MODERATE SUPPORT</th>
<th>Level 4 - MINIMAL SUPPORT</th>
<th>Level 5 - NO SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arousal or Avoidant Behavior</td>
<td>Cognitive Behavior Therapy (CBT), CBT and Medication, Education, Exposure, Modeling</td>
<td>Assertiveness Training, CBT for Child and Parent, CBT with Parents, Family Psychoeducation, Hypnosis, Relaxation</td>
<td>Contingency Management, Group Therapy</td>
<td>Biofeedback, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy</td>
<td>Attachment Therapy, Client Centered Therapy, CBT with Parents Only, Eye Movement Desensitization and Reprocessing (EMDR), Relationship Counseling, Teacher Psychoeducation</td>
</tr>
<tr>
<td>Attention and Hyperactivity Behavior</td>
<td>Behavior Therapy and Medication, Self-Verbalization</td>
<td>Biofeedback, Contingency Management, Education, Parent Management Training (alone, with Problem Solving, or with Teacher Psychoeducation), Physical Exercise, Relaxation and Physical Exercise, Social Skills and Medication, Working Memory Training</td>
<td>None</td>
<td>None</td>
<td>Parent Management Training and Social Skills, Relaxation, Self-Verbalization and Contingency Management, Social Skills</td>
</tr>
<tr>
<td>Autism Spectrum Disorders</td>
<td>Intensive Behavior Therapy, Intensive Communication Training</td>
<td>None</td>
<td>None</td>
<td>CBT, Parent Management Training, Peer Coaching</td>
<td>Auditory Integration Training, Hyperbaric Treatment</td>
</tr>
<tr>
<td>Delinquency and Disruptive Behavior</td>
<td>Assertiveness Training, CBT, Multisystemic Therapy, Parent Management Training, Parent Management Training and Problem Solving, Social Skills</td>
<td>Anger Control, Communication Skills, Contingency Management, Functional Family Therapy, Parent Management Training and Classroom Contingency Management, Problem Solving, Rational Emotive Therapy, Relaxation, Therapeutic Foster Care, Transactional Analysis</td>
<td>Attention, Outreach Counseling, Peer Coaching, Parent Management Training and Self-Verbalization, Physical Exercise, Stress Inoculation</td>
<td>None</td>
<td>Catharsis, CBT and Anger Control, CBT with Parents, Client Centered Therapy, Collaborative Problem Solving, Education, Exposure, Family Empowerment, Family Systems Therapy, Group Therapy (f), Life Skills, Play Therapy, Project CARE (f), Psychodynamic Therapy, Self-Verbalization, Skill Development, Wraparound</td>
</tr>
<tr>
<td>Depressive or Withdrawn Behavior</td>
<td>CBT, CBT and Medication, CBT with Parents, Family Therapy</td>
<td>Client Centered Therapy, Expressive Writing/Journaling/Diary, Interpersonal Therapy, Relaxation</td>
<td>None</td>
<td>None</td>
<td>Life Skills, Problem Solving, Psychodynamic Therapy, Social Skills</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>None</td>
<td>CBT, Family Systems Therapy, Family Therapy</td>
<td>None</td>
<td>None</td>
<td>Client Centered Therapy, Education, Goal Setting</td>
</tr>
<tr>
<td>Mania</td>
<td>None</td>
<td>CBT</td>
<td>None</td>
<td>CBT</td>
<td>Family-Focused Therapy, Psychoeducation</td>
</tr>
<tr>
<td>Substance Use</td>
<td>Family Therapy</td>
<td>CBT, Contingency Management, Family Systems Therapy, Goal Setting/monitoring, Meditational Interviewing/Engagement, Purdue Brief Family Therapy</td>
<td>None</td>
<td>None</td>
<td>Client Centered Therapy, Education, Group Therapy (f), Project CARE (f), Twelve Step Program</td>
</tr>
<tr>
<td>Suicidality</td>
<td>None</td>
<td>Multisystemic Therapy, Social Support</td>
<td>None</td>
<td>None</td>
<td>Accelerated Hospitalization, Counselors Care, Counselling Care and Anger Management</td>
</tr>
<tr>
<td>Traumatic Stress</td>
<td>CBT with Parents</td>
<td>CBT</td>
<td>None</td>
<td>Play Therapy, Psychodrama</td>
<td>Client Centered Therapy, CBT and Medication, CBT with Parents Only, EMDR, Interpersonal Therapy</td>
</tr>
</tbody>
</table>

*Note: Level 5 refers to treatments whose tests were unsuccessful or inconclusive. The symbol (f) indicates that at least one study found negative effects on the main outcome measures. The risk of using treatments so designated should be weighed against potential benefits. This report updates and replaces the "Blue Book" originally distributed by the Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence-Based Services Committee from 2003 - 2008.*
### Symptoms and Signs Suggestive of Mental Health and Substance Abuse Concerns

#### Table 1. Symptoms of Emotional Disturbance by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Symptoms</th>
</tr>
</thead>
</table>
| Infants and Young Children | *Excessive crying*  
                   | *Feeding problems or poor weight gain*  
                   | *Dysregulation (difficulty organizing feelings and emotions, difficulty being soothed or comforted, difficulty falling or staying asleep)*  
                   | *Irritability*  
                   | *Excessive clinginess for developmental stage*  
                   | *Excessive fearfulness for developmental stage*  
                   | *Poor eye contact or engagement with caregiver* |
| School-aged Children | *Anger*  
                   | *Fluctuating moods*  
                   | *Bullying*  
                   | *Sleep disturbance* |
Evidence-Based Child and Adolescent Psychopharmacology
This matrix outlines evidence-based child and adolescent psychopharmacologic interventions in order to facilitate intervention strategies for families with children suffering from mental health disorders. Check [this link](http://www.mentalhealth.org) for updates.

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This matrix provides the stages of change, goals of intervention, and discussion points.

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The National Guideline Clearinghouse contains summaries of selected guidelines that cover similar topic areas. Key elements of each summary include the scope of the guidelines, interventions and practices considered, major recommendations and corresponding rating schemes and strength of evidence, areas of agreement, and areas of disagreement.

**Adverse Effects Associated With Psychiatric Medications**
This chart provides a list of the adverse side effects of commonly used psychiatric medications for mental health disorders.

**ParentsMedGuide.org**
The American Psychiatric Association and the American Academy of Child & Adolescent Psychiatry have developed 2 medication guides posted on this Web site—**ADHD Parents Medication Guide** and **The Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families**. The guides are designed to help patients, families, and physicians make informed decisions about obtaining and administering the most appropriate care for a child with ADHD or depression.

**A Guide to Evidence-Based Practices (EBPs) on the Web**
This Substance Abuse & Mental Health Services Administration Web guide was designed to assist the public with simple and direct connections to Web sites that contain information about interventions to prevent or treat mental health or substance abuse disorders. This Web guide also contains resources that will better inform the public about these...
<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Adverse Effects</th>
<th>Withdrawal Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stimulants</td>
<td>Insomnia, appetite suppression, headache, stomachache. Also dizziness or sedation, irritability, exacerbation of tics (controversial), hallucinations (usually visual or tactile, not auditory; can show up at any time in course of treatment, usually decrease in response to lowering of dose), possibly cardiac arrhythmia in children with preexisting cardiac disease. <strong>MONITOR:</strong> BP, pulse, BMI.</td>
<td>Rebound (phenomenon in which ADHD symptoms “worsen” at end of day when medication wears off).</td>
</tr>
<tr>
<td>Tricyclics</td>
<td>Drowsiness, dizziness, autonomic symptoms. Also excitement, headache, somnolence, tremor, slurred speech, gastrointestinal symptoms. <strong>MONITOR:</strong> BP, pulse, BMI, initial and follow-up EKG.</td>
<td>Nausea, vomiting, abdominal pain, anxiety, headache malaise.</td>
</tr>
<tr>
<td>SSRI</td>
<td>Activation (restlessness, insomnia, impulsiveness, talkativeness—occurs early in treatment) without mood elevation. Also Autonomic: eg, diaphoresis, mydriasis, hypertension. Cardiovascular: eg, flushing, sinus tachycardia, hypertension; Serotonergic syndrome (potentiated by drug interaction with other pro-serotonergic agents); eg, MAOIs, trazodone, lithium, opioids, amphetamine/stimulants, cocaine, St John’s Wort, ginseng); agitation, ataxia, diaphoresis, diarrhea, hyperreflexia, mental status changes, myoclonus, shivering, tremor, hyperthermia. <strong>NMS</strong> (associated with dopamine antagonists).</td>
<td>Especially shorter half-life SSRIs such as sertraline and paroxetine: flu-like syndrome; dizziness (most common); nausea or emesis, fatigue, headache, gait instability, insomnia, mood changes, myalgia; akathisia (difficulty remaining still, feeling of restlessness, anxiety).</td>
</tr>
</tbody>
</table>
American Academy of Pediatrics Policy Web Site
This site was developed by the AAP to provide policy statements, clinical reports, technical reports, clinical practice guidelines, and pages designed for parents and clinicians.

Protocols: back to top

Generic or Common Factors Interventions: HELP
This tool provides a concise description of the generic—so-called “common factors”—techniques primary care clinicians can use to engage with children and families, addressing any barriers to their seeking or accepting mental health or substance abuse care, and reach agreement about steps to address the problem. These techniques, central to the process of care outlined by the AAP Task Force on Mental Health, have been shown effective in reducing parental distress and increasing the child’s functioning across a range of mental health problems.

Guidance for Primary Care Clinicians: Managing Common Mental Health Symptoms in Children and Adolescents
This series of tools provides a clinical framework and primary-care–specific guidance for the assessment and care of children and adolescents with commonly presenting symptom clusters. It is cross-linked to other resources, forms, and tools in this toolkit. This guidance can assist primary care practices in developing their protocols for the care of children with commonly presenting mental health problems.

Background
Social-Emotional Problems in Children, Birth to Age 5
Anxiety
Depression
Inattention and Impulsivity
Disruptive Behavior and Aggression
Substance Use and Abuse
Learning Difficulties

Psychiatric Consultation: back to top

Enhancing Pediatric Mental Health Care: Strategies for Preparing a Community
This report from the AAP Task Force on Mental Health outlines strategies that primary care clinicians can use to work with their partners at the community level, collectively, to foster resilience in children, to address factors that increase their risk of developing mental health problems, and to facilitate systemic changes that foster collaboration between primary care clinicians and other specialists important to children’s mental health and care.

When to Seek Referral or Consultation with a Child Adolescent Psychiatrist: Recommendations for
Protocols

H – Hope
E – Empathy
L2 – Language & Loyalty
P3 - Permission, Partnership, Plan

“Clearly, in many instances the clinician can relieve parental distress and decrease the child’s discomfort without knowing exactly what is causing the child’s symptoms. Similarly, in the absence of an emergent need, clinicians presented with a child’s mental health problem can often take steps to address parents’ distress and children’s symptoms without knowing the specific diagnosis.”

Disruptive and aggressive behaviors are common among children from toddlerhood through adolescence. They may be transient, influenced by temperament and environmental factors, or they may be persistent, rising to the level of oppositional-defiant disorder (ODD) or conduct disorder (CD) and causing significant impairment in the child’s and family’s functioning. ODD affects 1% to 16% of children, depending on the population studied; CD affects 1.5% to 3.4%. Male-female ratio varies with age and diagnosis from 3.2:1 to 5:1. Many children progress from ODD to CD. They can be extremely challenging to manage and, if untreated, experience an increased risk of school failure, underemployment, difficulty with legal authorities, 

Symptoms and Clinical Findings Suggesting Disruptive Behavior or Aggression

- In younger children, marked tantrums, defiance, fighting, and bullying.
- In older children and adolescents, inappropriate behavior such as stealing, damage to property, or fighting.
- Repetitive, persistent, excessive behaviors out of keeping with level, norms of peer group behavior indicating a disorder rather than a disruption.
DISRUPTIVE BEHAVIOR AND AGGRESSION

Please note: This guidance is based on the work of the World Health Organization (www.who.int) and may be updated annually. Check “Feedback & Updates” periodically.

Disruptive and aggressive behaviors are common among children from toddlerhood through adolescence. They may be transient, influenced by temperament and environmental factors, or they may be persistent, rising to the level of oppositional-defiant disorder (ODD) or conduct disorder (CD) and causing significant impairment in the child’s and family’s functioning. ODD affects 1% to 16% of children, depending on the population studied; CD affects 1.5% to 3.4%. Male-female ratio varies with age and diagnosis from 3:2:1 to 5:1. Many children progress from ODD to CD. They can be extremely challenging to manage.

Symptoms and Clinical Findings Suggesting Disruptive Behavior or Aggression

- In younger children, marked tantrums, defiance, fighting, and bullying.
- In older children and adolescents, serious law breaking such as stealing, damage to property, or assault.
- Repetitive, persistent, excessive aggression or defiance; behaviors out of keeping with the child’s development level, norms of peer group behavior, and cultural context.
common behaviors

• Can be:
  • Transient - influenced by temperament and environmental factors, or
  • Persistent - such as oppositional-defiant disorder (ODD) or conduct disorder
    • ODD affects 1% to 16% of children, depending on the population studied;
    • Conduct Disorder affects 1.5% to 3.4%.
    • Many children progress from ODD to CD.

• They are difficult to manage

• If untreated will increased risk of school failure, underemployment, difficulty with legal authorities
Screening Results

**Pediatric Symptom Checklist (PSC)-35:**
- Total score ≥24 for children 5 years and younger;
- ≥28 for those 6 to 16 years; and ≥30 for those 17 years and older
- AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**PSC-17:**
- Externalizing subscale is ≥7
- AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**Strengths and Difficulties Questionnaire (SDQ):**
- Total symptom score of >19;
- conduct problem score of 5 to 10 (see instructions at www.sdqinfo.com/ScoreSheets/e2.pdf);
- impact scale (back of form) score ≥2 indicates some degree of impairment;
- AND further discussion of items related to disruptive behavior and aggression confirms a concern
Symptoms and Clinical Findings

- Marked tantrums, defiance, fighting, and bullying.
- Repetitive, persistent, excessive aggression or defiance; behaviors out of keeping with the child’s development disruption.
- Aggression may be impulsive and associated with intense emotional states, or it may be predatory and premeditated.
- Behaviors characteristic of ODD: angry outbursts, loss of temper, refusal to obey commands and rules, destructiveness, hitting, and intentional annoyance of others,
- Behaviors characteristic of CD: vandalism, cruelty to people and animals (including sexual and physical violence), bullying, lying, stealing, truancy, drug and alcohol misuse, and criminal acts, plus all the features of ODD
- In older kids: serious law breaking such as stealing, damage to property
Conditions That May Mimic or Co-occur

- Attention Deficit Disorder
- Sleep deprivation
- Learning problems or disabilities
- Developmental problems
- Exposure to Adverse Childhood Experiences (ACEs)
- Bereavement
- Anxiety
- Depression or Bipolar disease
- Substance abuse
- Autism spectrum disorder
Tools for Further Assessment

✓ **Vanderbilt ADHD Rating Scale** (teacher and parent scales): This tool has been developed for children 6 to 12 years of age.

✓ **Modified Overt Aggression Scale (MOAS)**: This tool was developed for adults but has been used with adolescents.
Evidence-Based/ Informed Interventions
Updates are available at www.aap.org/mentalhealth

Psychosocial Interventions

- **Level 1 (best support):** assertiveness training, cognitive behavior therapy (CBT), multi-systemic therapy, parent management training, problem solving, social skills
- **Level 2 (good support):** anger control, communication skills, contingency management, functional family therapy, parent management training and classroom contingency management, problem solving, rational emotive therapy, relaxation, therapeutic foster care, transactional analysis

Psychopharmacologic Interventions

- (FDA) approved indications for aggression in children and adolescents, apart from irritability-associated aggression in children with autism.
- In other populations, recent federally supported evidence-based reviews suggest efficacy for some psychotherapeutic agents.
- Primary care clinicians are urged to consult with mental health specialists before prescribing medications for aggression
Selected Informational Links

• American Academy of Pediatrics Children’s Mental Health in Primary Care Web site (www.aap.org/mentalhealth )

• American Academy of Child & Adolescent Psychiatry (www.aacap.org )

• US FDA Web site (www.fda.gov )
Engaging Children and Families in Mental Health Care: A Process for Pediatric Primary Care Clinicians

Reinforce family strengths

- Build trust and optimism.
- Reach agreement on incremental next steps and ultimately, therapeutic goals.
- Develop plan of care (see the following clinical guidance)

- Collaboratively determine role of primary care clinician, eg, provide intervention(s); provide initial intervention while awaiting family’s readiness for access to specialty care; coordinate with specialist(s), child care, school, or agencies; monitor progress;
- Encourage child and family’s positive view of treatment.

*Without engagement, most families will not seek treatment. May require multiple visits*
Plan of Care for Children

- Encourage healthy habits
- Reduce Stress: consider the environment
- Offer initial intervention
  - Catch them being good
  - Praise and reward
    - Ignore unwanted behaviors when possible
- Encourage prevention
  - Reduce + reinforcement of negative behaviors
  - If possible re-organize child’s day to avoid confrontations
  - Keep track of adolescents
  - Partner with schools
- Encourage parents to stay calm and consistent
  - Clear Rules
  - Consistent consequences
  - Don’t argue
  - Parenting classes
Plan of Care for Children

Create a safety and emergency plan
• Care plan developed jointly with family should include listing of telephone numbers to call
• Remove weapons from the home
• Monitor for situations that trigger outbursts
• Mental health hotline crisis numbers

Resources to assist self-management
• Brochures
  – Your Child’s Mental Health: When to Seek Help and Where
  – to Get Help
  – How to Handle Anger
  – Parent’s Role in Teaching Respect

• Web Sites
  – The Incredible Years (www.incredibleyears.com)
Monitor child’s progress toward goals

- Child care, preschool, or school reports can be helpful in monitoring progress.

- SDQ (parent, teacher) and PSC can be helpful in monitoring progress with symptoms and functioning.

- Provide contact numbers and resources in case of emergency (see “Create a safety and emergency plan”).

See report “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice” for monitoring methods.
Plan of Care for Children With Anxiety

Engage child and family in care.

Engaging Children and Families in Mental Health Care: A Process for Pediatric Primary Care Clinicians®
Reinforce strengths of child and family. Follow the mnemonic HELP to
- Build trust and optimism.
- Reach agreement on incremental next steps and, ultimately, therapeutic goals.
- Develop plan of care (see the following clinical guidance).
- Collaboratively determine role of primary care clinician, e.g., provide intervention(s); provide initial intervention while awaiting family’s readiness for or access to specialty care; coordinate with specialist(s), child care, school, or agencies; monitor progress; encourage child and family’s positive view of treatment.

Is the parent anxious or depressed or impaired because of substance abuse? Has the parent suffered trauma or loss? Anxious children very often have an anxious or a depressed parent. Advise parents to minimize their own displays of fear or worry when the child is present. A referral to adult mental health services might also be appropriate.

Acknowledge and reinforce relationships with at least one pro-social peer, concerns a connection to positive organization.

Offer initial intervention

Guide parents in managing
- Identify the child’s fear(s) child and family on the ground.
- Teach the child and parents strategies to improve cognitive response, muscle relaxation, positive thinking of a safe place.

SIGH

%20Files/American%20Academy%20of%20Pediatrics/Addre...
ANXIETY

Please note: This guidance is based on the work of the World Health Organization (www.who.int) and may be updated annually. Check “Feedback & Updates” periodically.

Anxiety disorders (overanxious anxiety disorder, generalized anxiety disorder, panic disorder, separation anxiety disorder, agoraphobia, social phobia, avoidant disorder, post-traumatic stress disorder [PTSD], obsessive-compulsive disorder [OCD], specific phobias) are among the most common mental health disorders in children and adolescents. From 6% to 20% of youth meet the diagnostic criteria for any of the anxiety disorders,1 approximately half experiencing impairment of daily functioning.2 Anxiety disorders often occur concomitantly with chronic medical conditions3 and with other psychiatric disorders—especially depression.4 Because of the prevalence and clinical significance of anxiety among children and the potential effectiveness of primary care interventions, the American Academy of Pediatrics recommends that pediatric primary care clinicians achieve competence in the care of children experiencing anxiety.3

- Fears are keeping child from developmentally appropriate experiences (eg, school refusal, extreme shyness or clinging, refusal to sleep alone).
- Tantrum, tearfulness, acting-out behavior, or another display of distress occurs when child is asked to engage in feared activity.
- Child worries about harm coming to self or loved ones or fears something bad is going to happen.
- Behavior changes such as the following4 followed a traumatic experience such as abuse, witness to violence, loss of a loved one, or medical trauma:
  - Infants and toddlers: Crying, clinging, change in sleep or eating habits, regression to earlier behavior (eg, bed-wetting, thumb sucking), repetitive play or talk
  - 3- to 5-year-olds: Separation fears, clinging, tantrums, fighting, crying, withdrawal, regression to earlier behavior (eg, bed-wetting, thumb sucking), sleep difficulty

Screening Results Suggesting Anxiety
Pediatric Symptom Checklist (PSC)-35: Total score ≥24 those 6 to 16
Anxiety Disorders are Common

- 6% to 20% of youth meet criteria for an anxiety disorder,
  - About half of these experience impaired daily functioning.
- Anxiety disorders often occur with...
  - chronic medical conditions and
  - other psychiatric disorders—especially depression.
Anxiety Disorders are Common

• Examples:
  – overanxious anxiety disorder,
  – generalized anxiety disorder,
  – panic disorder,
  – Separation anxiety disorder,
  – agoraphobia,
  – social phobia,
  – avoidant disorder,
  – post-traumatic stress disorder [PTSD], obsessive compulsive disorder [OCD],
  – specific phobias
Anxiety Disorders Differ From Age-Appropriate Behaviors

Moderate anxiety is normal and predictable at certain ages:

- **8 to 9 months:**
  Peak of stranger anxiety (children are usually able to separate easily by 3 years).

- **5 to 8 years:**
  May have increase in worry about harm to parents or attachment figures.

- **School-aged children of any age:**
  Anxiety and distress at the time of high-stakes testing; initial reluctance to socialize in new situations.

Children with anxiety disorders have excessive fear and distress in response to everyday situations.
Competencies

Because of the prevalence and clinical significance of anxiety among children and the potential effectiveness of primary care interventions, the American Academy of Pediatrics recommends that pediatric primary care clinicians achieve competence in the care of children experiencing anxiety.
Screening Results Suggesting Anxiety

• **Pediatric Symptom Checklist (PSC)-35:**
  – Total score $\geq 24$ for children 5 years and younger;
  – $\geq 28$ for those 6 to 16 years; and
  – $\geq 30$ for those 17 years and older
  – AND further discussion of items related to anxiety confirms a concern in that area.

• **PSC-17:**
  – Internalizing subscale is $\geq 5$
  – AND further discussion of items related to anxiety confirms a concern in that area.

• **Strengths and Difficulties Questionnaire (SDQ):**
  – Total symptom score of $>19$;
  – emotional symptom score of 7 to 10 and
  – impact scale (back of form) score $\geq 2$ indicates some degree of impairment;
  – AND further discussion of items related to anxiety confirms a concern in that area.
MORE Tools for Further Assessment of Anxiety

Screening Tools:

- **SCARED** (Screen for Child Anxiety Related Disorders 2)  
  Best for generalized anxiety, panic disorder, significant somatic symptoms, separation anxiety, social anxiety, or significant school avoidance

- **Spence Children’s Anxiety Scale**: Tool designed for children 2½ to 6½ years

In all cases, ALSO Consider:

- **OCD** in the presence of marked rituals or compulsive behaviors

- **PTSD** if the onset of anxiety was preceded by an extremely distressing experience(s)
Clinical Findings Suggesting Anxiety

History from youth or parent suggests:

• Normal fears exaggerated /persistent *(dev extremes)*
  – strangers, dark, separation, new social situations or objects

• Fears are keeping child from developmentally appropriate experiences *(functional impairment?)*
  – eg, school refusal, won’t sleep alone

• Tantrum, tearfulness, acting-out behavior when child is asked to engage in feared activity *(surprise?)*

• Child worries about harm coming to self or loved ones or fears something bad is going to happen

• Behavior changes **following** a traumatic experience
Panic Attacks

- Unexpected and repeated periods of intense fear, dread, or discomfort along with physical symptoms such as racing heartbeat, shortness of breath, dizziness, lightheadedness, feeling smothered, trembling,

- Sense of unreality, fear of dying, losing control, or losing one’s mind.

*Panic attacks frequently develop without warning and last minutes to hours.*
Conditions That May Mimic or Co-occur With Anxiety

- Learning difficulties
- Somatic Complaints
- Depression
- Bereavement
- Autism Spectrum Disorders
- Exposure to ACEs (Adverse Childhood Experiences)
- Psychosis
- Physical Illness
- Selective mutism
Treatment of Anxiety

Psychotherapy

• Cognitive behavior therapy (CBT), CBT and medication, education Level 1 (best support)

• Psychosocial Interventions for Traumatic Stress (Level 1)

Pharmaceuticals

• OCD: selective serotonin reuptake inhibitor (SSRI) (sertraline, fluvoxamine), clomipramine

• Other anxiety disorders: none FDA-approved for Children

Panic Attacks: Early treatment, including psychosocial and psychopharmacologic therapy useful, may prevent progression to other problems such as depression and substance abuse
First Line Care

- **Reinforce strengths** of child and family.
  - Follow the mnemonic HELP to Build trust and optimism.
- Reach agreement on **incremental next steps** and, ultimately, therapeutic goals.
- Develop **plan of care** (see the following clinical guidance).
- **Collaboratively determine role** of primary care clinician, eg, provide intervention(s);
- **provide initial intervention** while awaiting family’s readiness for or access to specialty care;
- **coordinate** with specialist(s), child care, school, or agencies; monitor progress;
- **encourage** child and family’s positive view of
- **Encourage** healthy habits
- **Reduce stress** (consider the environment *Is the parent anxious or depressed or impaired because of substance abuse? Has the parent suffered trauma or loss?*)
- **Acknowledge and reinforce protective factors**, eg, good relationships with at least one parent or important adult, pro-social peers, concerned or caring family, help-seeking, connection to positive organization(s).

*Help them make the most of their mosts!*
Initial Interventions

Guide parents in managing child’s fears.

• Identify the child’s fear(s) and reach consensus with child and family on the goal of reducing symptoms.
• Teach the child and parent cognitive behavioral strategies to improve coping skills
  – deep breathing, muscle relaxation, positive self-talk, thought stopping, thinking of a safe place
• Use reading material or Web course as appropriate to literacy level.
• One of the best-validated approaches to anxiety and phobias is to gradually increase exposure to feared objects or experiences.

The eventual goal is to master rather than avoid feared things.
Increasing Exposure

- Start out with brief exposure to the feared object or activity and gradually make it longer.
- Imagine or talk about the feared object or activity or look at pictures.
- Learn to tolerate a short exposure.
- Tolerate a longer exposure in a group or with a coach.
- Tolerate the feared activity alone but with a chance to get help in needed
So what now?
Instructions are for the weak!
I hope you step on a LEGO.

Nothing personal, though.
Mental Health Toolkit...

Community Resources; Health care financing; Support for children and families; clinical system redesign; Decision support....
To invent, you need a good imagination and a pile of stuff.

Thomas Edison
Children’s Mental Health Awareness Week
May 1-7, 2011

1 in 5 Children In South Carolina Experiences a Mental Health Disorder