Objectives

- Describe the potential impacts of children’s behavioral health as a public health issue
- Understand the factors limiting detection, and the barriers to screening, in a primary care setting
- Identify reasons to screen, how to select measures, and tips for screening successfully in primary care
- Identify areas for future attention
- Understand what a “referral in action” might look like for common referral issues
QUESTIONS 1 & 2
Childhood cancers, childhood cardiac problems and renal problems combined are more common than pediatric behavioral, developmental and mental health issues?

A) TRUE

B) FALSE
Approximately 75% of kids with psychiatric concerns are seen by the mental health professionals?

A) TRUE

B) FALSE
Effects of Children’s Behavioral Health

- Approximately 11-20% of children in the U.S. with a behavioral or emotional disorder at any given time
- Estimated $247 billion spent annually on treatment and management of childhood mental health disorders

- Pediatric behavioral, developmental, and MH issues are more common than childhood cancers, cardiac problems, and renal problems combined
- Developmental and behavioral health disorders are now the top 5 chronic pediatric conditions causing functional impairment
Epidemiology

25-40% will have at least 1 additional diagnosis

Most commonly ADHD + ODD

Also anxiety + depression

37-39% diagnosed by 16 years old

Impulse control/disruptive behaviors

Anxiety

Mood disorders

~50% adults with MH problems report emergence in early adolescence

Earliest: anxiety, ADHD (preschool, early school-age)

Latest: substance abuse
What Are Some Risk Factors?

- Biological and genetic influences
- Gender
- Parental mental health
- Parenting practices
- Parental substance abuse
- DV/partner conflict
- Family grief/illness

- Socioeconomic status
- Financial hardship
- Environmental, neighborhood, and community factors
- Stressful life events
- Abuse or maltreatment
- Parent-child relationship
- Toddlers and preschoolers can exhibit “mental health” symptoms
  - Behavior problems, inattention, difficulties interacting with peers, anxiety

- Symptoms can be accurately assessed and may persist, but needs are often unmet
  - Parents may believe the problem is normative or transient
  - Parents may have fewer contexts (school) to evaluate their child’s functioning, fewer points of referral
Pediatric primary care settings are conceptually ideal for detecting and addressing behavioral health concerns:

- Up to 50% of visits address some behavioral, psychosocial, or educational concerns
- Approximately 75% of kids with psychiatric concerns are seen within primary care settings
- Providers meet with families at regular intervals
- More available than access to specific MH services
Factors Limiting Detection

Rates of detection range from 14-40%...But pediatricians surveyed overwhelmingly endorse that they should be responsible for identifying kids with ADHD, eating disorders, depression, substance abuse, and behavior problems.

- Necessary brevity of appointment
- Stigma associated with MH
- Parents don’t consistently discuss concerns with PCP
  - Detection increased substantially when parents reported concerns during visit
- Detection rates lowest when PCP used no standardized screening
  - DSM criteria + standardized measure used most with ADHD
  - Sensitivity of clinical judgment alone is about 14-54% (low), and less likely to identify problems in minority or non-English speakers
Despite AAP’s recommendations, many providers do not administer a standardized screening tool or provide a referral when concerns arise about possible delays.

- 13% pediatricians report lack of confidence in training/ability to successfully manage behavioral/emotional problems
- Staffing and time limitations
- Reimbursement issues
- Lack of disclosure by parent
- Reluctance to “label” young children
- Limited referral options, access to services, long wait lists
- Limited knowledge of resources
- Lack of office strategies to integrate screening into well-child visits
Support for Psychosocial Screening

- Healthy People 2010 (US health goals, Surgeon General):
  - Increase the number of persons seen in primary care who receive MH screening and assessment
  - Increase the proportion of children with MH problems who receive treatment
- President’s 2003 New Freedom Commission on MH
  - Prevention/recognition of childhood emotional and behavioral problems through early MH and developmental screening
- Affordable Care Act 2010
  - Requiring health care plans to provide preventive services, including AAP’s *Bright Futures*, calling for assessment of psychosocial and behavioral health at all well-child visits
- AAP Task Force on MH (guidelines and tools)
WHY SCREEN?
QUESTIONS 3 & 4
3. Which of the following is not a benefit of screening in mental health field?

A. Screening improves long-term outcome for patients and families
B. Screening provides a diagnosis for mental illness
C. Screening can predict risk and indicate severity of symptoms within a time period
D. Screening done early creates an acceptance of mental health treatment by families
E. Screening creates an avenue for conversation about mental health issues
4. Which of the following is a Screening Success Tip?

A. Physician “champion” is needed to maintain the initiative
B. Identification of community partners and referrals needed for the initiative
C. Regular staff meetings should be put in place to monitor and review progress
D. Mapping of practice workflow
E. All of the above are correct
Why Screen?

- Does not provide a diagnosis, but can predict risk and indicate severity of symptoms within a time period
- Provides a way to begin conversation about MH issues, which can lead to education, referral, and/or treatment
- When referral is brought up early, acceptance of MH treatment may be better for some families
- Intervention improves long-term outcomes for patients and families (e.g., parent stress, employment)
- Minimal delay between onset of illness and treatment likely leads to best outcome
Screening Success Tips

- Physician ‘champion’ to maintain the initiative
- Map practice workflow, collect data to improve it
- Train and prepare all office staff
- Identify community partners and referrals
- Consult parents at regular intervals
- Regular staff meetings to review progress
- Pilot screening first
- Consider office resource guide
  - Community support info, screening how-tos, educational materials, handouts, CMEs, etc.
Selecting Screeners

- Global (broadband) or domain-specific?
- How does it measure the problem?
- Who will administer it? Is it paper-and-pencil or computerized?
- How long does it take?
- Who is answering the questions? Parent-, self-, teacher-report forms?
- Literacy level for the respondent? What about health literacy level?
- Is it computer- or hand-scored? Who will score it?
- Age range of the child in question?
- Cost of the measure and scoring (if any)?
- Psychometrics: Reliability, validity, sensitivity, specificity?
- Cultural considerations? Language of administration?
<table>
<thead>
<tr>
<th>Developmental:</th>
<th>Behavioral/Emotional:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Expressive and receptive language</td>
<td>- Social-emotional regulation</td>
</tr>
<tr>
<td>- Fine and gross motor</td>
<td>- Mood and affect</td>
</tr>
<tr>
<td>- Self-help skills</td>
<td>- Attention</td>
</tr>
<tr>
<td>- Cognitive milestones</td>
<td>- Interpersonal skills</td>
</tr>
<tr>
<td>- Ages &amp; Stages</td>
<td></td>
</tr>
</tbody>
</table>
# Behavioral/Emotional Screening

<table>
<thead>
<tr>
<th>Public Domain:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4-16</strong></td>
</tr>
<tr>
<td>- Pediatric Symptom Checklist (PSC)</td>
</tr>
<tr>
<td><strong>3-17</strong></td>
</tr>
<tr>
<td>- Strengths and Difficulties Questionnaire</td>
</tr>
<tr>
<td><strong>6-12</strong></td>
</tr>
<tr>
<td>- NICHQ Vanderbilt Scales</td>
</tr>
<tr>
<td><strong>6-18</strong></td>
</tr>
<tr>
<td>- SNAP-IV for ADHD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proprietary:</th>
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<tbody>
<tr>
<td><strong>2-16</strong></td>
</tr>
<tr>
<td>- Eyberg Child Behavior Checklist (ECBI)</td>
</tr>
<tr>
<td><strong>2-21</strong></td>
</tr>
<tr>
<td>- Behavior Assessment System for Children (BASC-3)</td>
</tr>
<tr>
<td><strong>1.5-18</strong></td>
</tr>
<tr>
<td>- Child Behavior Checklist (CBCL)</td>
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</tbody>
</table>
### Other Screening Areas

<table>
<thead>
<tr>
<th>Category</th>
<th>Tools/Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Functioning</td>
<td>• Interpersonal relationships, school/work, self-care, leisure time</td>
</tr>
<tr>
<td>Autism &amp; DD</td>
<td>• Modified Checklist for Autism in Toddlers (MCHAT)</td>
</tr>
<tr>
<td>Substance Use</td>
<td>• CRAFFT Screening Interview for ages 11-21</td>
</tr>
<tr>
<td>Trauma</td>
<td>• Trauma Symptom Checklist (TSCC/TSCYC)</td>
</tr>
<tr>
<td>Depression/Suicide</td>
<td>• Mood and Feelings Questionnaire, as young as 7</td>
</tr>
<tr>
<td></td>
<td>• Patient Health Questionnaire (PHQ-9)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>• Screen for Child Anxiety Related Disorders (SCARED)</td>
</tr>
<tr>
<td>Environmental and Family Factors</td>
<td>• Parent depression, substance use, history of abuse; DV; social support; parent-child relationship problems/stress</td>
</tr>
</tbody>
</table>
## Pediatric Symptom Checklist (PSC-17)

Please mark under the heading that best describes your child:

<table>
<thead>
<tr>
<th></th>
<th>(0) NEVER</th>
<th>(1) SOMETIMES</th>
<th>(2) OFTEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feels sad, unhappy</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>2. Feels hopeless</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>3. Is down on self</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>4. Worries a lot</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>5. Seems to be having less fun</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>6. Fidgety, unable to sit still</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>7. Daydreams too much</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>8. Distracted easily</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>9. Has trouble concentrating</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>10. Acts as if driven by a motor</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>11. Fights with other children</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>12. Does not listen to rules</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>13. Does not understand other people’s feelings</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>14. Teases others</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>15. Blames others for his/her troubles</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>16. Refuses to share</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>17. Takes things that do not belong to him/her</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Does your child have any emotional or behavioral problems for which she/he needs help?  **No**  **Yes**
Tracking Referrals

- A means to an end!
  - Some studies show as little as 16% children screening positive for behavioral health problem are given referral for follow-up
  - Those referred do not always follow-through

- Identify ➔ Connect ➔ Monitor and Support
  - Were referrals completed and services obtained?
  - What barriers did the family face and how can they be overcome?
  - With release, obtain info from the referral source about effectiveness of services, symptom reduction, and progress
Ongoing Issues & Future Directions

- NIH funding directed toward this area is insufficient
- More info needed on how to develop effective collaborations with MH providers
- More info needed on how to interpret screens to make the best use of their results
- More support needed on how to receive adequate financial reimbursement for screens
- Screening instruments will need formatted for EMR
- Paper/pencil screeners will need transformed to web-based, smartphone apps, and waiting room tablets
A “Perfect World”

- **Integrated care models**
  - Mental health consultants located within pediatric practices
  - Fewer barriers, in-person introductions, “warm hand-offs,” consultation with the family

- **Consultative models**
  - Massachusetts Child Psychiatry Access Project
  - National Network of Child Psychiatry Access Programs
  - 30 states have similar programs...AL still a work in progress

- **But....limited research and variable findings**
  - Especially in serving the needs of very young children who are at increased risk of having unmet mental health needs
Your Referral in Action

- **Emotional and behavioral disorders:**
  - Behavior Disorders
  - Mood and Anxiety Disorders
  - Substance Use Disorders

- **ADHD is one of the most common neurobehavioral disorder diagnoses**
  - AAP recommends as first-line treatment:
    - Preschoolers: evidence-based behavioral therapy
    - School-age: behavioral therapy + meds
    - Especially behavioral parenting interventions!
ADHD Treatments
For Preschoolers (ages 4–5)
Be sure they get what’s best!

Where we have been:
(Treatment practices, 2009-2010)
Almost 1 in 2 preschool children with ADHD got no behavioral therapy.
About 1 in 4 were treated only with medication.

Where we need to go:
(Treatment guidance, 2011)
Provide behavioral therapy first, before medication.

What can you do?

Parents:
Talk to your doctor about behavioral therapy for your preschool child’s treatment.

Healthcare professionals:
Be aware of the psychological resources in your community and be prepared to refer children, particularly preschoolers, for behavioral therapy as recommended by the American Academy of Pediatrics (AAP).

FOR MORE INFORMATION:
www.cdc.gov/adhd
Twitter: @CDC_NCBDDD
Your Referral in Action: Preschoolers

- Important group where there is growing awareness of significant behavioral health issues
  - Estimated 7-24% prevalence of behavioral health problems
  - Behavioral health disorders (e.g., ADHD, anxiety)
  - Relational disturbances (e.g., parent-child difficulties, attachment problems)
  - Regulatory problems (e.g., eating and sleeping disturbances)

- Opportunity to reduce early behavior problems before they become exacerbated by school and peer risk factors

- Reduce negative parent-child interactions that may contribute to development of child disruptive behaviors
QUESTION 5
5. Which of these is not a component of Parent-Child Interaction Therapy (PCIT)

A. It is an empirically supported and evidence-based practice used in mental health treatment
B. PCIT is beneficial for treating disruptive behavior disorder and developmental disabilities
C. Live coaching and hands-on training for parents are required occasionally
D. The age range for therapy is between 2 and 7 y old
E. It is a two-stage treatment process
Parent-Child Interaction Therapy (PCIT)

- Empirically supported, evidence-based practice
  - US Dept of Justice
  - Kaufman Best Practices Project
  - National Child Traumatic Stress Network
- Children ages 2-7 with disruptive behavior disorders
  - Additional benefits and adaptations for developmental disabilities, Autism, anxiety, abuse history, etc.
  - Group and abbreviated adaptations
- 12-20 sessions, usually weekly
- Live coaching, hands-on training for the parent
## Two-Stage Treatment Process

<table>
<thead>
<tr>
<th>Child-Directed Interaction</th>
<th>Parent-Directed Interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Relationship enhancement</td>
<td>• Discipline and compliance</td>
</tr>
<tr>
<td>• Child-directed interaction affecting:</td>
<td></td>
</tr>
<tr>
<td>• Parent-child attachment</td>
<td>• Clear directives</td>
</tr>
<tr>
<td>• Positive parenting</td>
<td>• Consistent follow-through</td>
</tr>
<tr>
<td>• Child social skills</td>
<td>• Reduces child noncompliance, aggression, and behavior problems</td>
</tr>
<tr>
<td>• “Special Time”</td>
<td>• “Time-out”</td>
</tr>
</tbody>
</table>
PCIT @ Children’s

- (205) 638-9193
- Children’s Behavioral Health (CBH) – Ireland Center, 4th Floor Dearth Tower
- Also offered by a PhD at our Lakeshore location
- Referred patients call intake and are screened by phone for appropriateness and fit for the program
- crystal.dillard@childrensral.org
References & Resources

- Bright Futures Guidelines, American Academy of Pediatrics
  - [https://brightfutures.aap.org](https://brightfutures.aap.org)
- Centers for Disease Control and Prevention
  - [www.cdc.gov](http://www.cdc.gov)
- National Child Traumatic Stress Network
  - [www.nctsnet.org](http://www.nctsnet.org)
- National Network of Child Psychiatry Access Programs
  - [www.nncpap.org](http://www.nncpap.org)
- Office of Disease Prevention and Health Promotion
  - [www.healthypeople.gov](http://www.healthypeople.gov)
- PCIT International
  - [www.pcit.org](http://www.pcit.org)
- Substance Abuse and Mental Health Services Administration
  - [www.samhsa.gov](http://www.samhsa.gov)
• American Academy of Pediatrics (2010).

• American Academy of Pediatrics (2010).

• Berkovits, MD, O'Brien, KA, Carter, CG, Eyberg, SM (2010).


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B) FALSE
QUESTION 2

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