Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Fitting Mental Health into Pediatric Practice

BEST CHILDREN'S HOSPITALS
U.S.News & WORLD REPORT
RANKED IN 10 SPECIALTIES 2019-20

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Disclosures

- Rachel Ballard, MD
- I receive royalties from American Psychiatric Publishing, Inc

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Rachel Ballard, MD

I attended medical school at UT Health Science Center at San Antonio, did my pediatric residency at Children's National Medical Center in their primary care track, then went back to Texas where I practiced urgent care and public health pediatrics.

I went back to UTSHCSA for an adult psychiatry residency and child and adolescent psychiatry fellowship, then worked at a large Texas FQHC as a pediatrician and child psychiatrist for 5 years.

I came to Lurie Children's 7 years ago and have worked as a child psychiatrist and been given the role of director of collaborative care. I have developed an online curriculum called Mental Health Care in the Pediatric Clinic available for CME credit, and now developing a web page on the Lurie site with all that content and more.

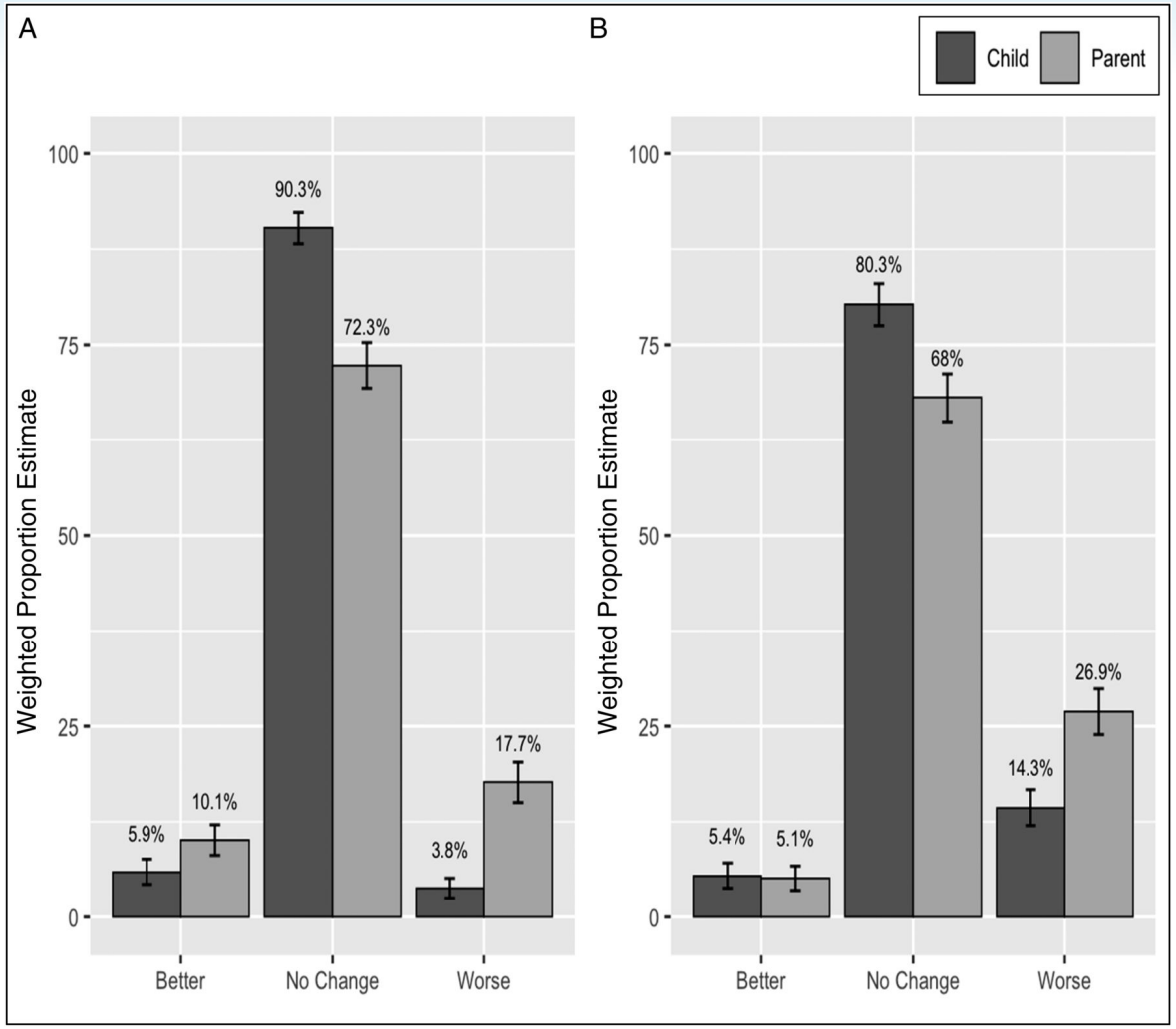
Objectives

- 1. Describe pediatric mental health challenges associated with the pandemic
- 2. List commonalities between general pediatrics skills and mental health skills
- 3. Identify strategies to expand mental health skills in the areas of assessment, treatment and screening

Pediatric Mental Health in the Pandemic

- Some did better, some did worse

Parental physical and mental health and child physical and behavioral health changes since March 2020.



Stephen W. Patrick et al. Pediatrics 2020;146:e2020016824

PEDIATRICS®

From: **Caregiver Perceptions of Children's Psychological Well-being During the COVID-19 Pandemic**

JAMA Netw Open. 2021;4(4):e2111103. doi:10.1001/jamanetworkopen.2021.11103

32 217 caregivers, (39.3%) White, (30.2%) Latinx, (22.4%) Black, and (8.1%) multiple or other races/ethnicities reported on 40 723 to 40 852 children.

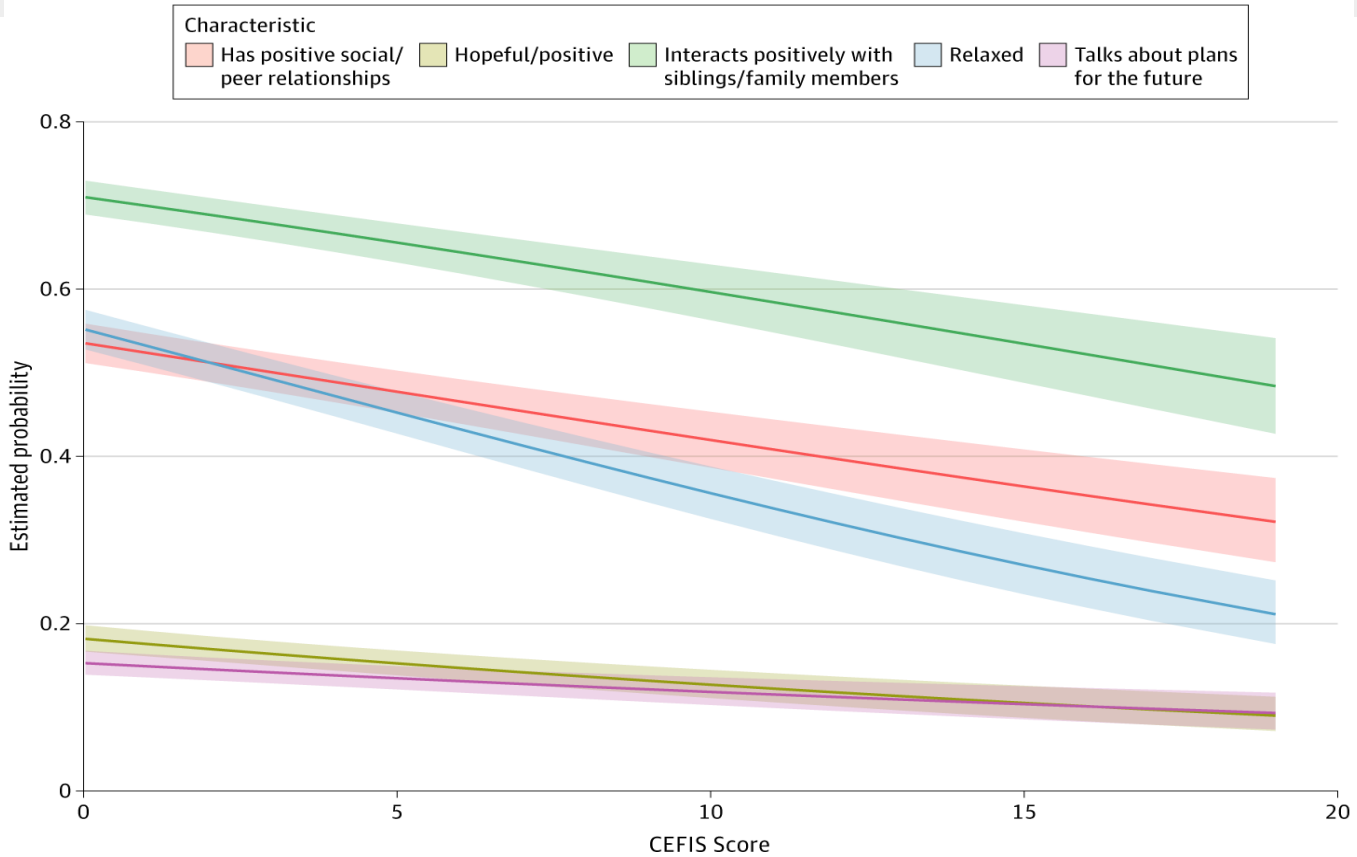


Figure Legend:

Adjusted Probabilities of Positive Adjustment Characteristics After the End of In-Person InstructionCEFIS indicates COVID-19 Exposure and Family Impact Scale.

From: **Caregiver Perceptions of Children's Psychological Well-being During the COVID-19 Pandemic**

JAMA Netw Open. 2021;4(4):e2111103. doi:10.1001/jamanetworkopen.2021.11103

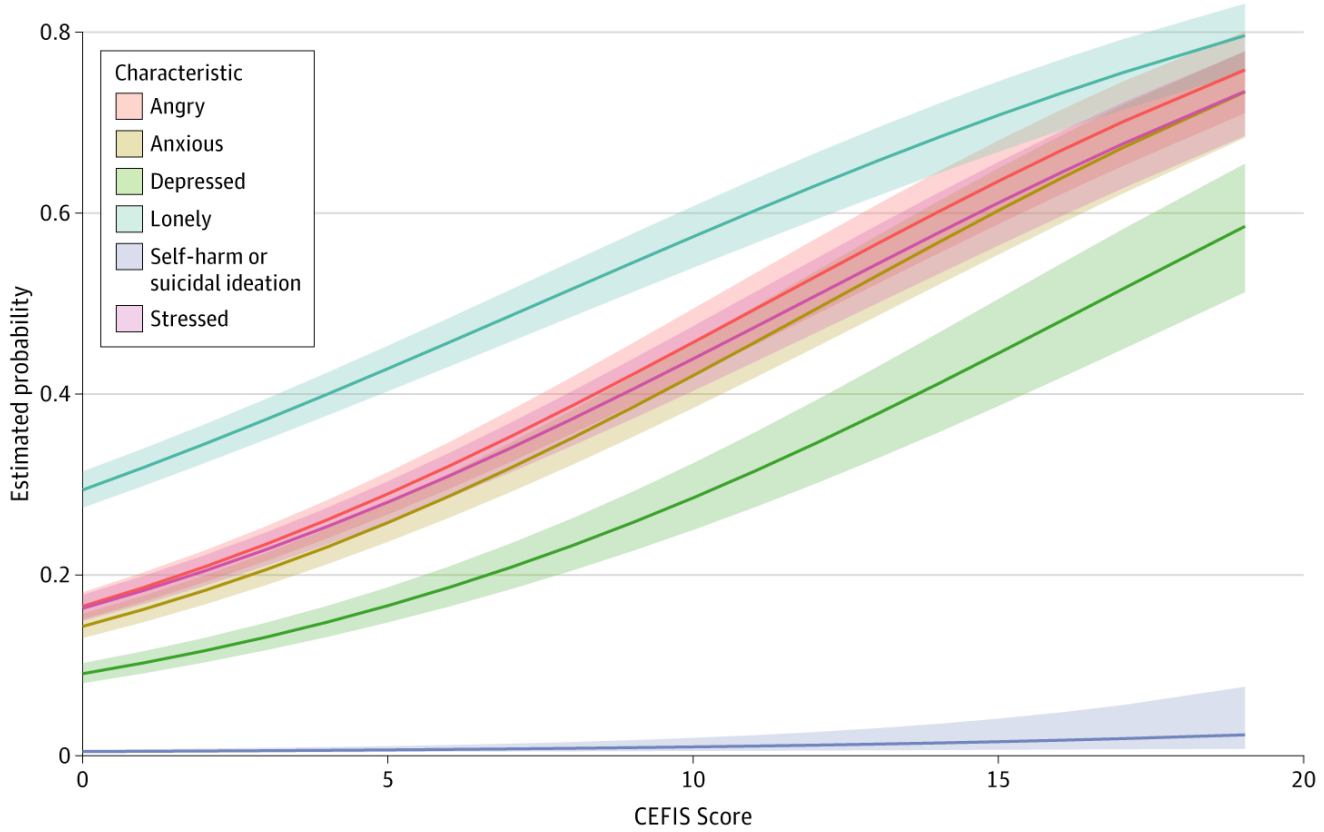


Figure Legend:

Adjusted Probabilities of Child Mental Health Concerns After the End of In-Person InstructionCEFIS indicates COVID-19 Exposure and Family Impact Scale.

JAMA Network™

From: **Caregiver Perceptions of Children's Psychological Well-being During the COVID-19 Pandemic**

JAMA Netw Open. 2021;4(4):e2111103. doi:10.1001/jamanetworkopen.2021.11103

Table 2. Caregiver Reports of Child Mental Health and Positive Adjustment Characteristics for All Participants and by Race/Ethnicity

Characteristic	No. (%)							
			Race/ethnicity					
	All participants		Black		Hispanic/Latinx		White	
	Before[a]	Since[b]	Before[a]	Since[b]	Before[a]	Since[b]	Before[a]	Since[b]
Agitated or angry	1712 (4.2)	9752 (23.9)	393 (5.3)	1107 (14.9)	494 (4.5)	1720 (15.8)	486 (3.5)	4913 (35.8)
Anxious	5137 (12.6)	9497 (23.3)	648 (8.7)	1132 (15.2)	1157 (10.6)	1939 (17.8)	2324 (16.9)	4478 (32.6)
Depressed or low mood	1387 (3.4)	5715 (14.0)	272 (3.7)	612 (8.2)	359 (3.3)	906 (8.3)	460 (3.4)	3006 (21.9)
Lonely	1452 (3.6)	13 019 (31.9)	255 (3.4)	1708 (22.9)	380 (3.5)	1959 (17.9)	470 (3.4)	6637 (48.4)
Stressed	4773 (11.7)	9957 (24.4)	734 (9.9)	1265 (17.0)	1281 (11.7)	2106 (19.3)	1707 (12.4)	4479 (32.6)
Self-harm or thoughts of suicide	191 (0.5)	246 (0.6)	33 (0.5)	29 (0.4)	47 (0.4)	32 (0.3)	25 (0.9)	30 (1.0)
Had positive social or peer relationships	26 995 (66.1)	14 386 (35.2)	4667 (62.7)	2838 (38.1)	5770 (52.8)	3377 (30.9)	10 861 (79.1)	5250 (38.3)
Hopeful or positive	20 052 (49.1)	12 012 (29.4)	3709 (49.8)	2712 (36.4)	4393 (40.2)	3357 (30.7)	7638 (55.7)	3383 (24.6)
Interacted positively with siblings or family	24 666 (60.4)	19 130 (46.8)	4100 (55.0)	3550 (47.7)	5473 (50.1)	4552 (41.7)	9896 (72.1)	7035 (51.3)
Relaxed	21 414 (52.4)	15 056 (36.9)	3987 (53.5)	3276 (44)	5887 (53.9)	4644 (42.5)	6973 (50.8)	3829 (27.9)
Talks about plans for the future	18 114 (44.3)	12 601 (30.9)	3169 (42.5)	2628 (35.3)	3814 (34.9)	2956 (27.1)	7392 (53.9)	4440 (32.3)

[a] Before the end of in-person instruction on March 17, 2020.

[b] Since the end of in-person instruction on March 17, 2020.

Table 3. COVID-19 Exposure and Family Impacts for All Participants and by Race/Ethnicity

COVID-19 family exposure	No. (%)			
		Race/ethnicity		
	All participants	Black	Hispanic/Latinx	White
Stopped working temporarily	6074 (18.9)	1205 (19.5)	2115 (25.4)	1487 (13.7)
Permanently lost job	2688 (8.3)	570 (9.2)	803 (9.7)	742 (6.9)
Kept working outside of home	14 208 (44.1)	2886 (46.8)	4606 (55.4)	3785 (35.0)
Health care practitioner	4052 (12.6)	896 (14.5)	835 (10.0)	1264 (11.7)
Cut back hours	7313 (22.7)	1114 (18.1)	2222 (26.7)	2389 (22.1)
Moved out of home	184 (0.6)	48 (0.8)	60 (0.7)	30 (0.3)
Lost health insurance	634 (2.0)	133 (2.2)	200 (2.4)	145 (1.3)
Family income decreased	10 577 (32.8)	1647 (26.7)	3257 (39.1)	3360 (31.0)
Difficulty				
Getting other essentials	4308 (13.4)	1296 (21.0)	1475 (17.7)	628 (5.8)
Getting medicine	1102 (3.4)	369 (6.0)	335 (4.0)	128 (1.2)
Getting health care	1728 (5.4)	450 (7.3)	497 (6.0)	326 (3.0)
Getting food	1881 (5.8)	571 (9.3)	661 (7.9)	239 (2.2)
Getting face masks, sanitizer, or other products	9461 (29.4)	2197 (35.6)	3268 (39.3)	2079 (19.2)
Could not pay				
Rent	1840 (5.7)	433 (7.0)	800 (9.6)	256 (2.4)
Bills	2496 (7.7)	694 (11.3)	988 (11.9)	325 (3.0)
Children took on job outside of home	275 (0.9)	57 (0.9)	101 (1.2)	44 (0.4)
Children assumed childcare responsibilities	1983 (6.2)	422 (6.8)	605 (7.3)	487 (4.5)
Someone in family				
Was exposed to COVID-19	4746 (14.7)	949 (15.4)	1469 (17.7)	1378 (12.7)
Had COVID-19 symptoms or was diagnosed	3407 (10.6)	829 (13.4)	1268 (15.2)	715 (6.6)
Died of COVID-19	1403 (4.4)	521 (8.4)	481 (5.8)	175 (1.6)
Overall CEFIS score, mean (SD)[a]	2.5 (2.2)	2.8 (2.4)	3.1 (2.3)	1.8 (1.8)

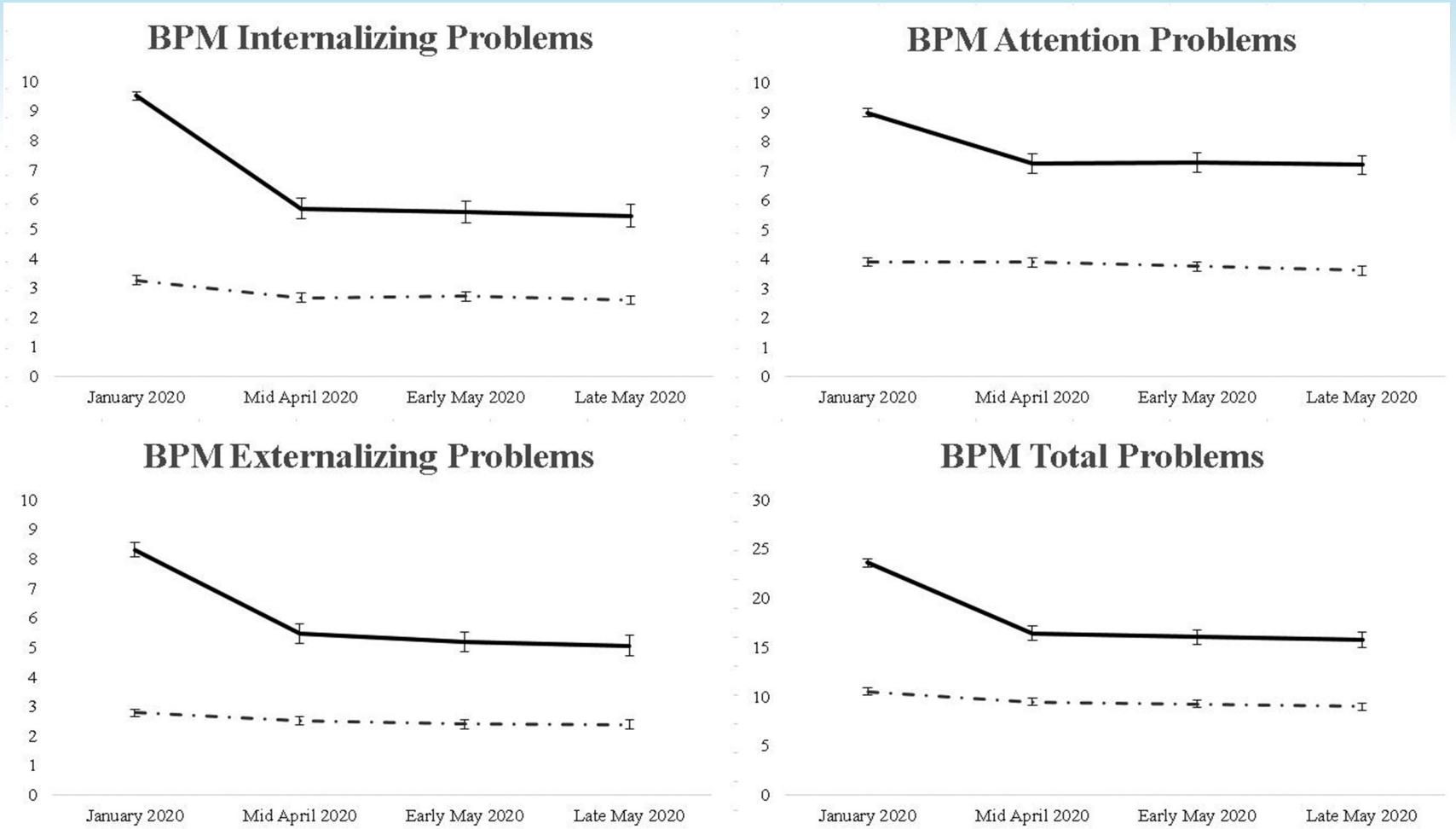
Abbreviation: CEFIS, COVID-19 Exposure and Family Impact Scale.

[a] Range, 0 to 20, with higher scores indicating more exposure.

From: **Caregiver Perceptions of Children's Psychological Well-being During the COVID-19 Pandemic**
JAMA Netw Open. 2021;4(4):e2111103. doi:10.1001/jamanetworkopen.2021.11103

Figure 1

322 subjects (mean age = 11.9 years, 55% female 72.7% Hispanic/Latinx, 9.3% Black or African American, 5.9% multiple races, 5.0% Asian, 1.6% White, and 1.2% American Indian, completed a mental health screening measure prior to the COVID-19 pandemic and at 3 time-points after COVID-19 stay-at-home measures.



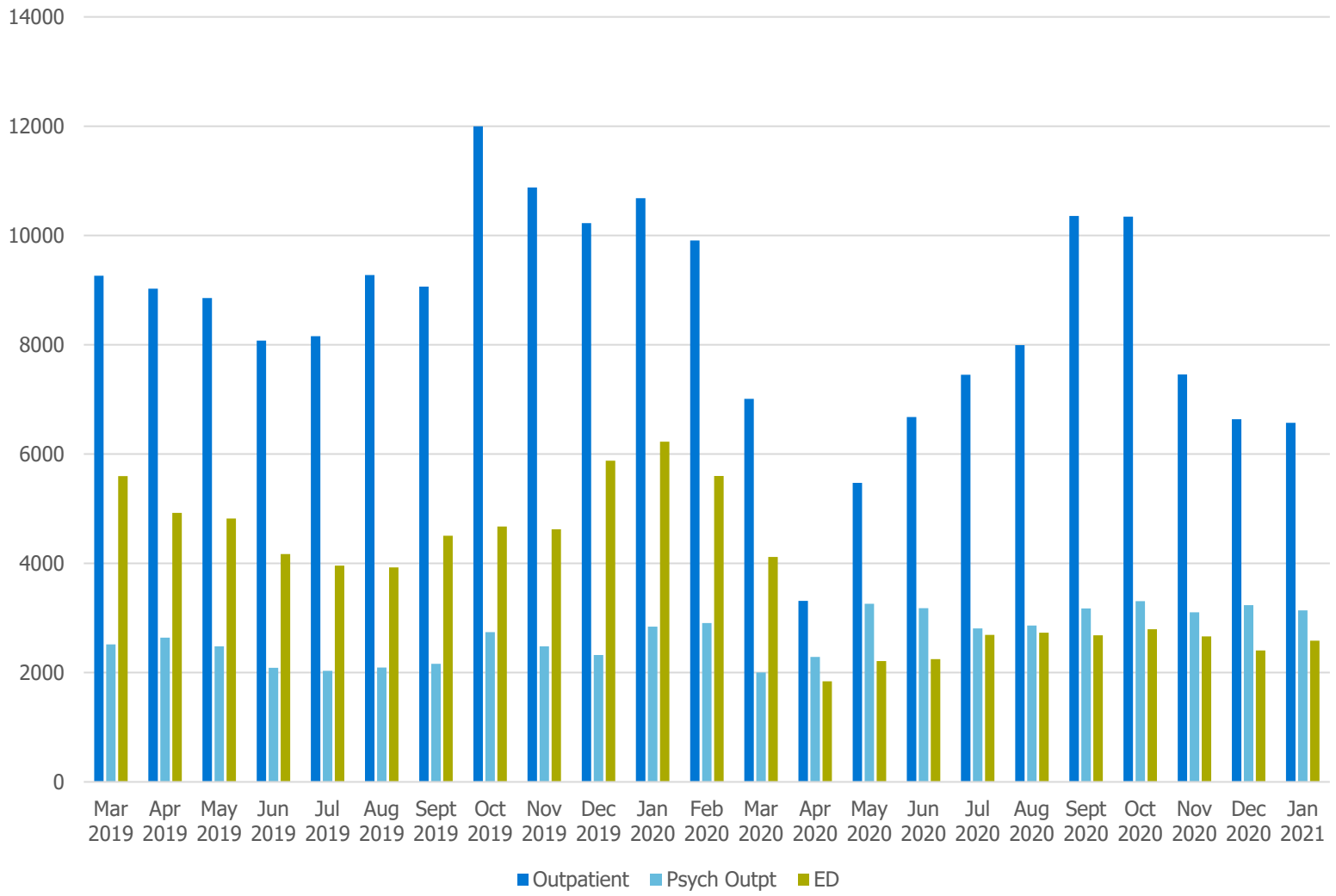
Change in Youth Mental Health During the COVID-19 Pandemic in a Majority Hispanic/Latinx US Sample
Francesca Penner, MA, Jessica Hernandez Ortiz, BS, Carla Sharp, PhD
Journal of the American Academy of Child & Adolescent Psychiatry
Volume 60 Issue 4 Pages 513-523 (April 2021)
DOI: 10.1016/j.jaac.2020.12.027

Ann & Robert H. Lurie Children's Hospital of Chicago®
Pritzker Department of Psychiatry and Behavioral Health

The view from Lurie Children's

Pediatric outpatient visits declined by 28.3% ($p < .001$) and emergency department visits by 45.6% ($p < .001$).

Outpatient child psychiatry visits increased by 23% ($p = .002$).



The longer view

Mental Health Competencies for Pediatric Practice

Jane Meschan Foy, Cori M. Green, Marian F. Earls, COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, MENTAL HEALTH LEADERSHIP WORK GROUP

Pediatrics Nov 2019, 144 (5) e20192757; **DOI:** 10.1542/peds.2019-2757

Proposed mental health competencies

- foundational communication skills
- capacity to incorporate mental health content and tools into health promotion and primary and secondary preventive care
- skills in the psychosocial assessment and care of children with ADHD, anxiety disorders, depression and substance use disorders
- knowledge and skills of evidence-based psychosocial therapy and psychopharmacologic therapy
- skills to function as a team member and comanager with mental health specialists
- commitment to embrace mental health practice as integral to pediatric care.

That seems like a lot.

What can you do?

Lurie
of Chicago
ent of
oral Health

Practicing medicine

Pediatrics

- Chief complaint
  - Differential diagnosis
- History and physical
  - Further refine differential diagnosis
- Labs, imaging
  - Further refine differential diagnosis
- Treatment decisions
- Assess response to treatment

Mental Health

Feelings
Problems
Angst
Self-Harm
Talking
Conflict
Suicide

Things that make mental health care scary

- Might take a lot of time
- Vague, open-ended, life-story type issues
- Someone might be in a sort of danger which is hard to assess
- Not having the words to talk about these things
- Unsure what to do with information given
- Sense that there are no resources to help if you uncover a problem
- It's uncomfortable if there is family conflict in front of you
- Fear that people with mental health problems are difficult, unpredictable, and dangerous

- Mental health problems fall into categories, just like all health problems.
- Mental health symptoms can be assessed like all symptoms: severity, frequency, duration, impact on functioning, what makes them better, worse.
- Mental health disorders emerge in a predictable way, based on family history and age of onset risk.
- Certain skills are effective for addressing all kinds of mental health problems.

- Assessment
- Treatment
  - Common factors
  - Specific disorders – how to start
- Screening

Assessment

Grafting mental health skills onto existing skills

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

- Chief complaint
  - Differential diagnosis
- History and physical
  - Further refine differential diagnosis
- Labs, imaging
  - Further refine differential diagnosis
- Treatment decisions
- Assess response to treatment

Simultaneously:

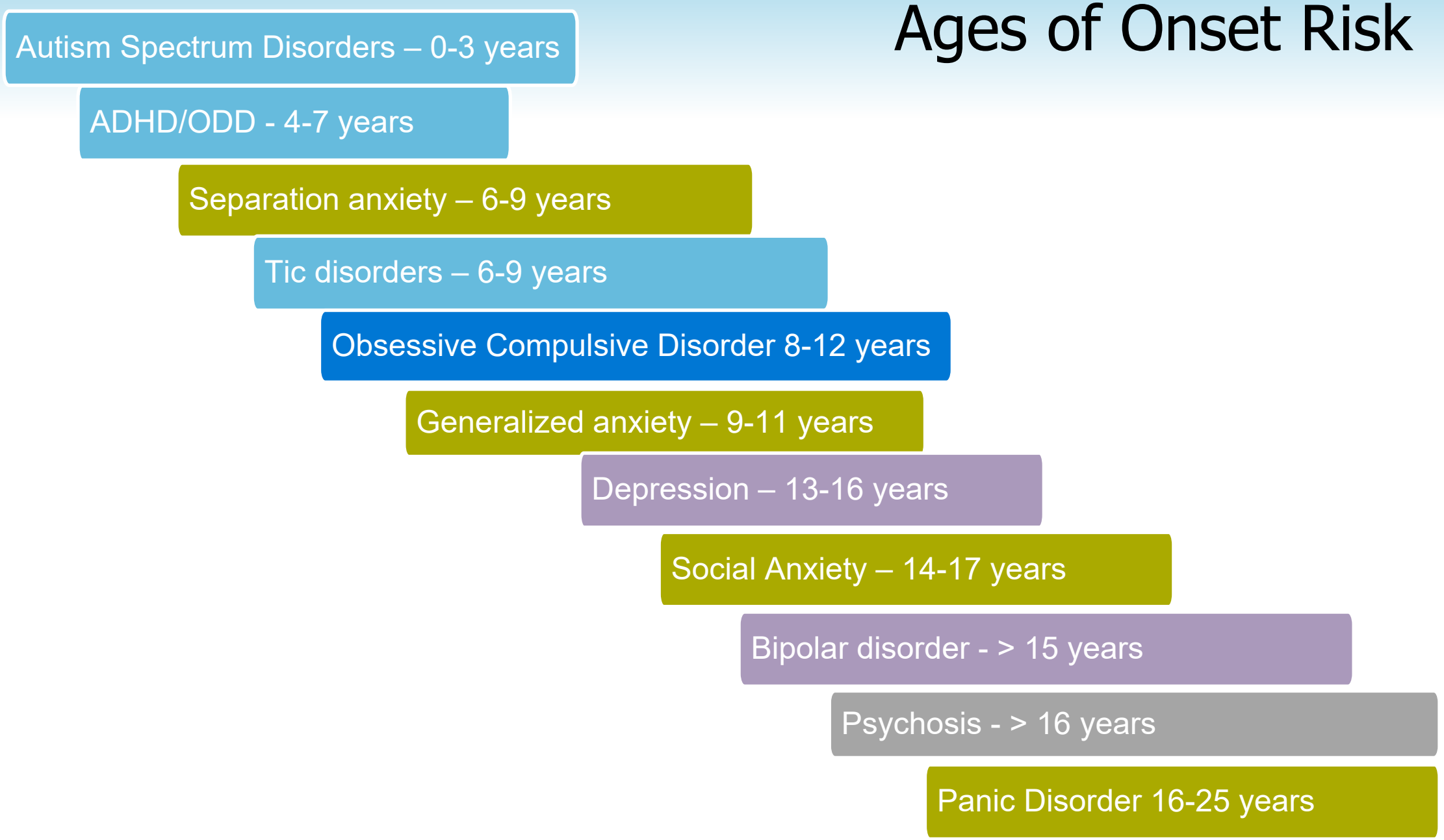
- Is this an emergency?
- How bad are the symptoms?
- Are they impairing functioning?
- Is this a disorder or a reaction to a stressor?
- Who is this a problem for, the child or the parent?
- Do I have to solve this all today?
- What is appropriate anticipatory guidance at this time?

Assessment

Age, demographics, chief complaint

Development knowledge guides differential diagnosis

Ages of Onset Risk



Assessment Tools

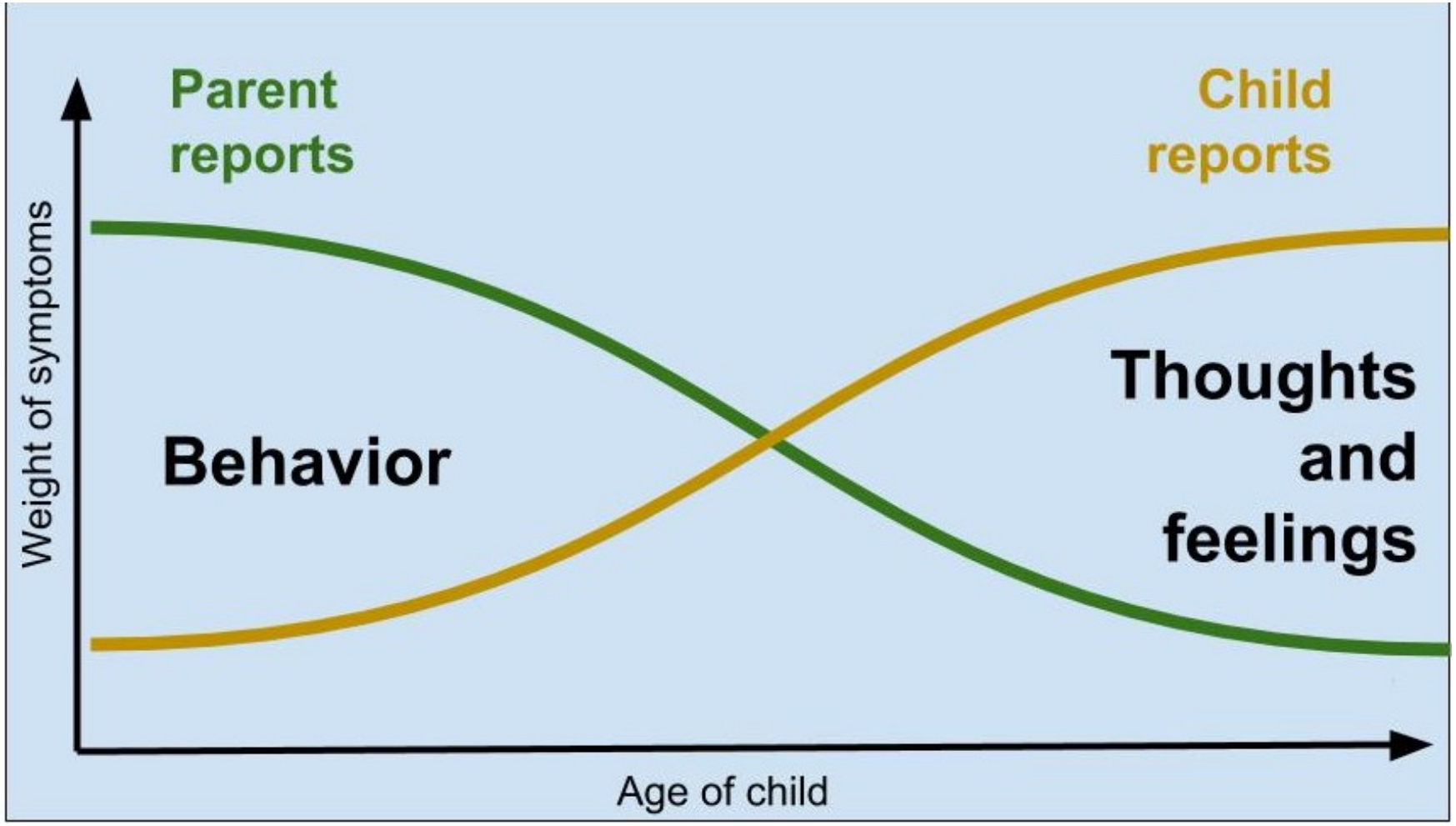
Pediatrics

- Demographics
- Vitals
- Chief complaint
- HPI
- family and social history
- Physical
- Labs/imaging
- Parent perspective
- Child perspective

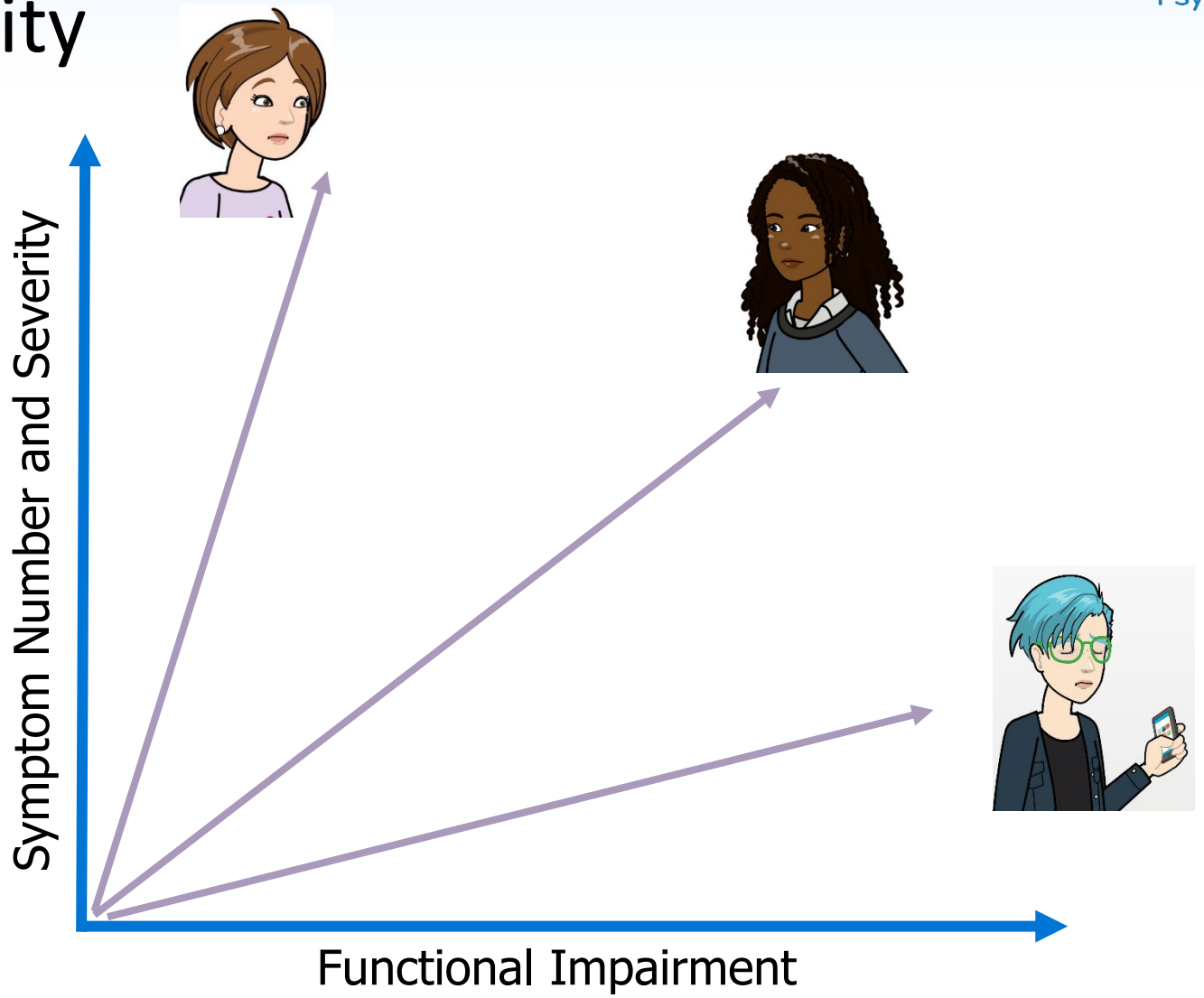
Mental Health

- Demographics
- Vitals
- Chief complaint
- HPI
- family and social history
- Mental status exam
- Assessment instruments
- Parent perspective
- Child perspective

Input from parents and children



Assessing severity



Symptom Number and Severity

- How bad is it?
- How often do you feel that way?
- What makes it better or worse?

- Symptom checklists – how many pertinent positives are present?
- How many pertinent negatives are present?

- Symptom scales – how often, how much?

Functional impact

Functional impact varies by disorder

Separation Anxiety
- Acts out when separation likely

Oppositional Defiant Disorder
- Tantrums
- Aggression/arguing

ADHD
- Doesn't listen when spoken to
- Forgets things
- Can't sit still
- Impulsive actions

Tic Disorders
- Social impact

Depression
- Decreased activity/engagement
- Self-harm

Generalized Anxiety Disorder
- Mostly internal but may be irritable

Social Phobia
- Can't ask/answer questions
- Can't socialize/ work with others

Whom does the disorder impact?

Separation Anxiety
- Acts out when separation likely

Oppositional Defiant Disorder
- Tantrums
- Aggression/arguing

ADHD
- Doesn't listen when spoken to
- Forgets things
- Can't sit still
- Impulsive actions

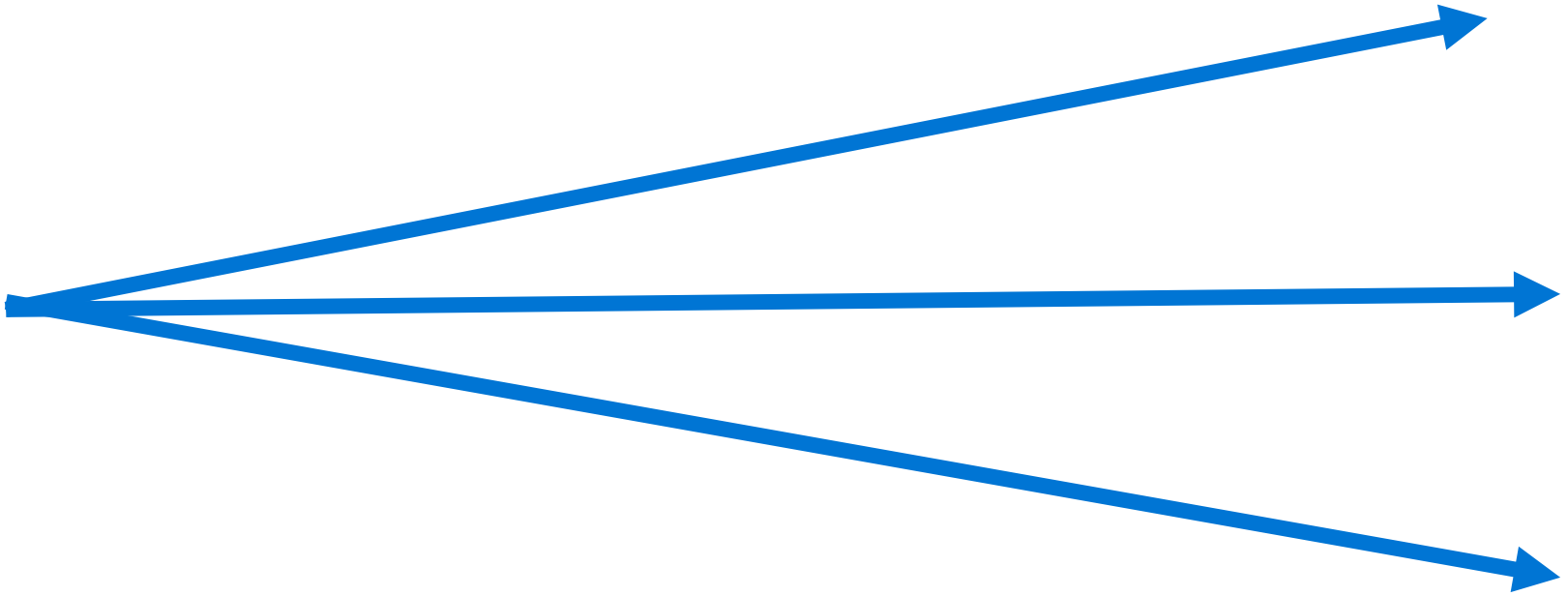
Tic Disorders
- Social impact

Depression
- Decreased activity/engagement
- Self-harm

Generalized Anxiety Disorder
- Mostly internal but may be irritable

Social Phobia
- Can't ask/answer questions
- Can't socialize/ work with others

Time is an excellent tool



Treatment

Common factors approach

Elements of treatment that affect:

- Patient-provider relationship
  - Bond between patient and provider
  - Agreement on problem and direction of treatment
- Changes in patient behaviors
  - Optimism about outcomes
  - Engagement in treatment
  - Maintaining focus on achievable goals
- Evidence base for being as effective as condition-specific treatments

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

HEL^2P^3

HEL^2P^3

- **H = Hope**

  Increase hopefulness by describing your realistic expectations for improvement and reinforcing the strengths and assets you see in the child and family.

- **E = Empathy**

  Communicate empathy by listening attentively, acknowledging struggles and distress, and sharing happiness experienced by the family.

"Depression is painful, but it is treatable."

"People in your family really support each other."

"You have been through so much this year! I am amazed you are doing as well as you are."

HEL^2P^3

- **L 2 = Language, Loyalty**
  - Use the child and family's own **language** (not a clinical label) to reflect your understanding of the problem as they see it and to give the child and family an opportunity to correct any misperceptions.
  - Communicate **loyalty** to the family by expressing your support and your commitment to help now and in the future.

"What I hear you both saying is..."
"Tell me if I have this right..."
"This may take time but I will work with you until it's better"

HEL^2P^3

P^3= Permission, Partnership, Plan

Ask the family's **permission** for you to ask more in-depth and potentially sensitive questions or to make suggestions for further evaluation or management.

"How can I be helpful in this?"
"What solutions have you looked at?"
"Do you want to work on this with me or do you have someone else helping you with it?"

HEL^2P^3

P 3 = Permission, Partnership, Plan

Partner with the child and family to

- identify any barriers or resistance to addressing the problem,
- find strategies to bypass or overcome barriers, and
- find agreement on achievable steps that are aligned with the family's motivation.

"How important does it feel to work on this now?"

"What is going to make it hard to work on it?"

"What do you think you can do about that?"

HEL^2P^3

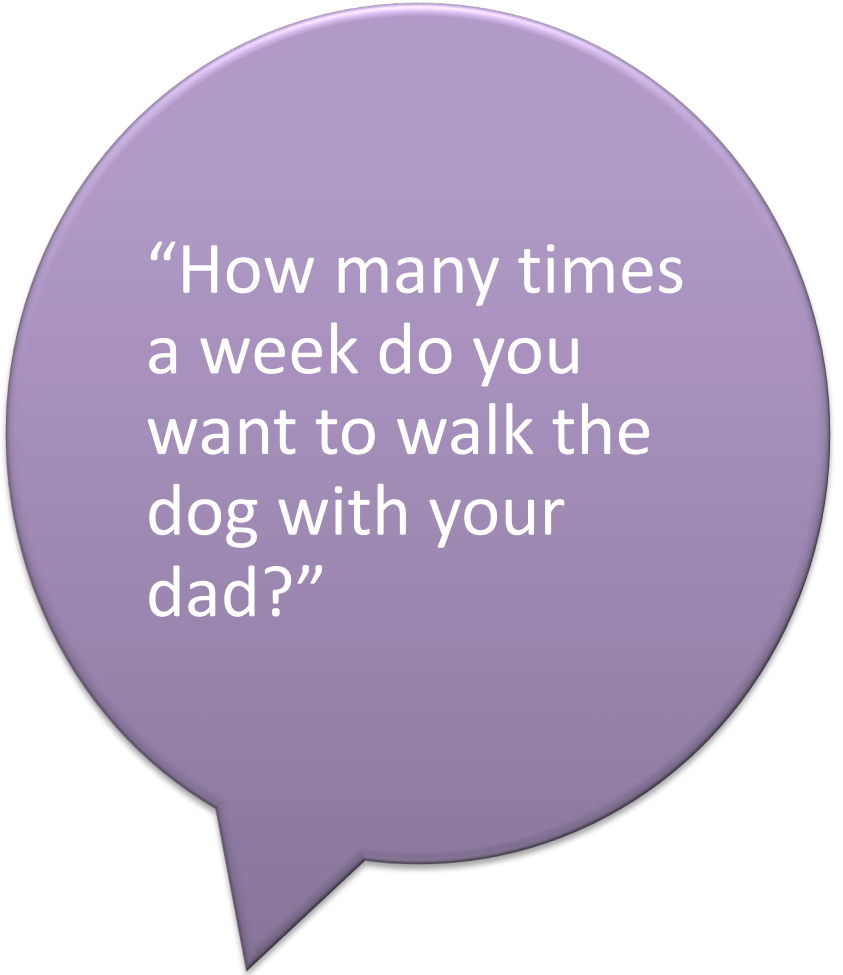
P 3 = Permission, Partnership, Plan

On the basis of the child and family's preferences and sense of urgency, establish a **plan** to

- expand the assessment,
- change a behavior or family routine,
- seek help from others,
- work toward greater readiness to take one or more of these actions,
- or monitor the problem and follow up with you.

Plans should include SMARRT goals

- Encourage setting of goals that are:
  - Specific
  - Measurable
  - Attainable (start small)
  - Related to behavior rather than feelings or attitudes
  - Related to doing something rather than not doing something
  - Related to people in the room, or factors over which people in the room have control



Treatment – specific disorders

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Where to start

- Pick a disorder
- Read up
- Pick a treatment
- Look out for a straightforward case in patient you have known for a few years
- Treat
- Learn
- Have a friend you can call
- Look out for another straightforward case
- Use the same treatment
- Learn

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

ADHD

What's a straightforward case?

A 6-10 year-old who has always been hyperactive, inattentive, mostly cheerful, a little challenging behaviorally, no chronic health concerns, no family cardiac history, ideally a family history of ADHD.

ADHD

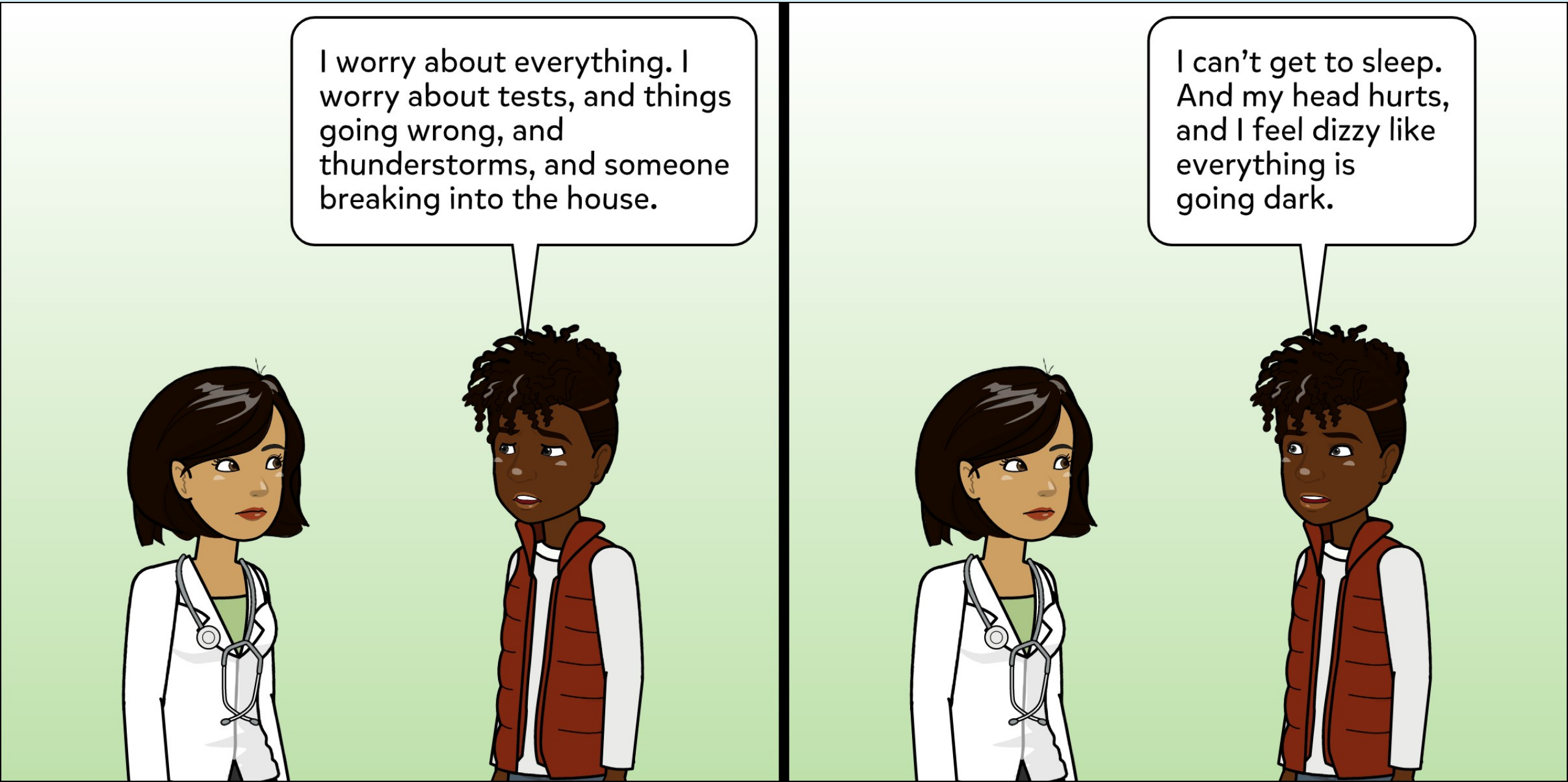
- Do your eval, get Vanderbilt scales from a parent and a teacher, confirm diagnosis
- Start methylphenidate 5 mg morning and noon or equivalent extended release (methylphenidate CD 10 mg, methylphenidate ER 18 mg)
- Assess, titrate
- Watch the child's attention, learning and behavior improve

- Find another case.

Anxiety

What's a straightforward case?

A 8-12 year-old who has always been a little nervous and hesitant but healthy, who presents with separation, generalized or social anxiety disorder interfering with functioning.


I worry about everything. I worry about tests, and things going wrong, and thunderstorms, and someone breaking into the house.
I can't get to sleep. And my head hurts, and I feel dizzy like everything is going dark.

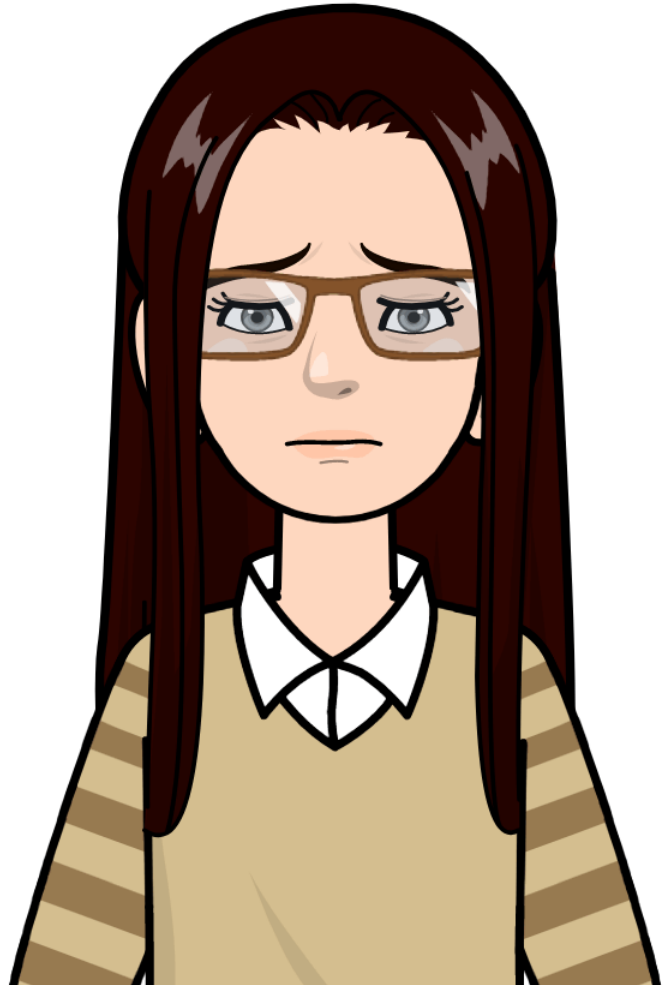
Anxiety

- Do your eval, get SCARED from parent and child, confirm diagnosis
- Refer for individual or group cognitive behavioral therapy
- Start SSRI of your choice (fluoxetine, sertraline or escitalopram) at the starting dose
- Assess, titrate
- Watch the child's anxiety improve
- Find another case. Start with the same SSRI every time until you are comfortable with it, then consider trying another.

Depression

What's a straightforward case?

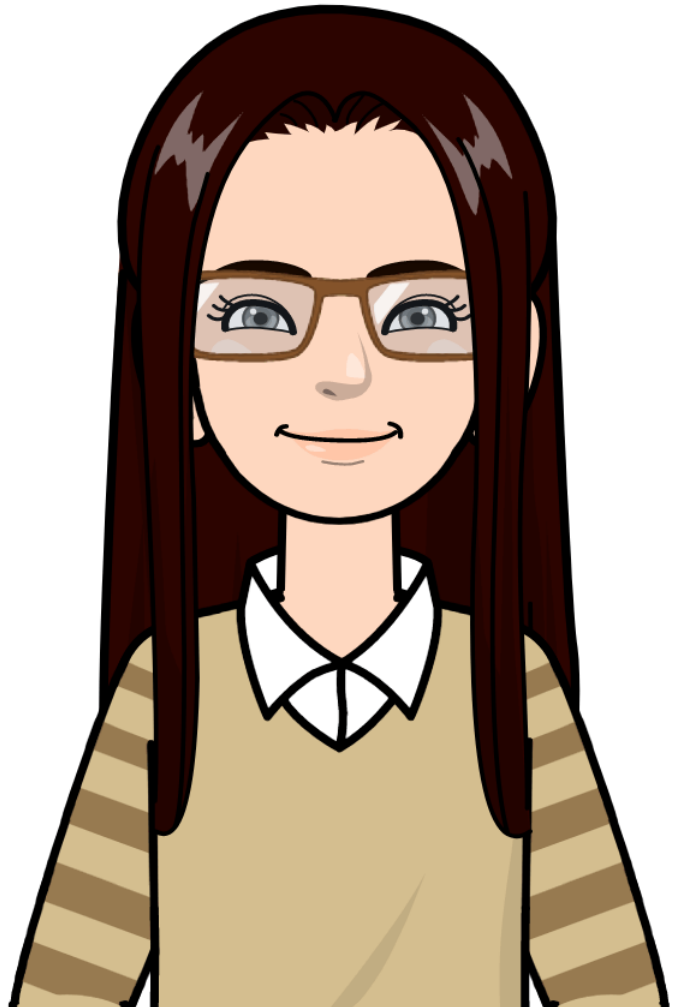
- A 12-18 year-old who has become withdrawn, sad, with low motivation and energy, poor sleep, and negative thoughts but without suicidal ideation or plan.



Depression

- Do your eval, get PHQ9 or MFQ from (parent) and child, confirm diagnosis
- Do safety assessment and plan
- Refer for individual or group cognitive behavioral therapy
- Encourage behavioral activation (get out of bed, walk for 10 minutes, etc)
- Start fluoxetine 10 mg x 2 weeks then increase to 20 mg
- Assess, titrate

- Find another case. Start with fluoxetine if patient has depression without anxiety.



Treatment – informed decisions

- Having your spiel
- Shaping expectations
  - Benefits
  - Likely outcomes
  - Duration oreatmenf tt
  - Amount of work involved
  - Side effects

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Screening

Screening: formal and systematic – Why?

- When screening is
  - universal (normalized)
  - confidential
  - acknowledged and addressed during the visit

patients and parents are more likely to disclose mental health concerns.

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Screening normalizes and sets a tone

Thank you for completing this screen. It looks like you don't have any concerns about your child's feelings or behaviors right now. Is that correct? We will continue to check on that in the future, because mental health and physical health are both important.

From your answers to the PHQ-2 and GAD-2 it sounds like you haven't been feeling depressed or anxious lately. I will be checking with you about this regularly because it's an important part of your health. If you have concerns, you can let me know about them. This can be confidential as long as you are not in any sort of danger.

Factors to consider in selecting instruments

- What conditions do we want to screen for?
- If we start with a broad-based screen, do we have a plan to follow up with appropriate narrower screens?
- How will patients or caregivers fill out screens?
  - In the waiting room?
  - In the exam room?
  - At home, through a portal?
  - On paper, or on an electronic device?
- Who will score the screen?
- Who will put the screen and/or results into the medical record?
- Where will the screen go in the medical record, especially if it will be used as part of the baseline assessment for needed treatment?
- Do we want to pay for screening instruments?

Multiple condition instruments

Instrument	Age range (years)	Who fills it in	# items	free
Patient Symptom Checklist -17 (PSC-17)	8-17	parent child	17 17	yes
Strengths and Difficulties Questionnaire	3-17 11-17	parent teacher child	25	yes

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

Patient Symptom Checklist-17

Please mark under the heading that best describes your child: (0) NEVER (1) SOMETIMES (2) OFTEN

1. Feels sad, unhappy
2. Feels hopeless
3. Is down on self
4. Worries a lot
5. Seems to be having less fun
6. Fidgety, unable to sit still
7. Daydreams too much
8. Distracted easily
9. Has trouble concentrating
10. Acts as if driven by a motor
11. Fights with other children
12. Does not listen to rules
13. Does not understand other people's feelings
14. Teases others
15. Blames others for his/her troubles
16. Refuses to share
17. Takes things that do not belong to him/her

Patient Symptom Checklist 17-scoring

- Total score of 15 or greater: indicates need for further assessment.
  - Internalizing Subscale (Cutoff >=5 items)
  - Attention Subscale (Cutoff >=7 items
  - Externalizing Subscale (Cutoff >=7 items)

Follow up on screening

- If screen indicates no significant concerns, be sure to address this with family.
- Follow up instruments may include
  - ADHD: Vanderbilt, Connors
  - Depression: PHQ-9, Mood and Feeling Questionnaire, Beck Depression Inventory, PROMIS-depression
  - Anxiety: SCARED, Generalized Anxiety Disorder-7, PROMIS-anxiety, Beck Anxiety

ADHD-specific instruments

Instrument	Age range (years)	Parent/child/ teacher	# items	free
Vanderbilt Scales (inattention, hyperactivity, oppositional behavior)	6-12	parent teacher	55 43	yes
SNAP-IV-C	6-18	parent teacher	90 90	yes

Depression-specific instruments

Instrument	Age range (years)	Parent/child	# items	free
Patient Health Questionnaire-Adolescent (PHQ-A)	11+	child	2 or 9	yes
Patient-Reported Outcomes Measurement Information System (PROMIS)	8-17 6-17	child parent	14 11	yes
Mood and Feeling Questionnaire (MFQ) – short form	8-18	both	11	yes

Anxiety-specific instruments

Instrument	Age range (years)	Parent/ child	# item s	free
Screen for Anxiety Related Disorders (SCARED)	8+	both	41	yes
Patient-Reported Outcomes Measurement Information System (PROMIS) – Anxiety-	8-17 5-17	child parent	13 10	yes
Generalized Anxiety Disorder -7 (GAD-7)	12+	child	7	yes
Spence Children's Anxiety Scale	8-12	both	34-45	yes

A few things to remember about screening instruments

Ann & Robert H. Lurie
Children's Hospital of Chicago®
Pritzker Department of
Psychiatry and Behavioral Health

None is diagnostic. All must be followed up with clinical assessment.

Each has its own scoring instructions and recommended cut-off points. These may vary by population.

Who fills out the screen?

The older the patient, the reliable self-report, especially for internalizing conditions (anxiety, depression).

Looking at parent + child screens can be useful.

The AAP has a great resource on screening.

Like any test applied to a population, screening instruments will generate false positives and false negatives. The specificity and sensitivity of most instruments listed here is 70-90%.

Remember, you can bill a 96127 code for up to 4 mental health screeners per year.

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/mental-health/documents/mh_screeningchart.pdf

Good questions, always

- What do you think this is?
- What are you afraid this might be?
- Of everything we have talked about, what is most important for us to address today?
- How can I help with this?

In all areas of medicine your attention can be therapeutic as well as diagnostic.