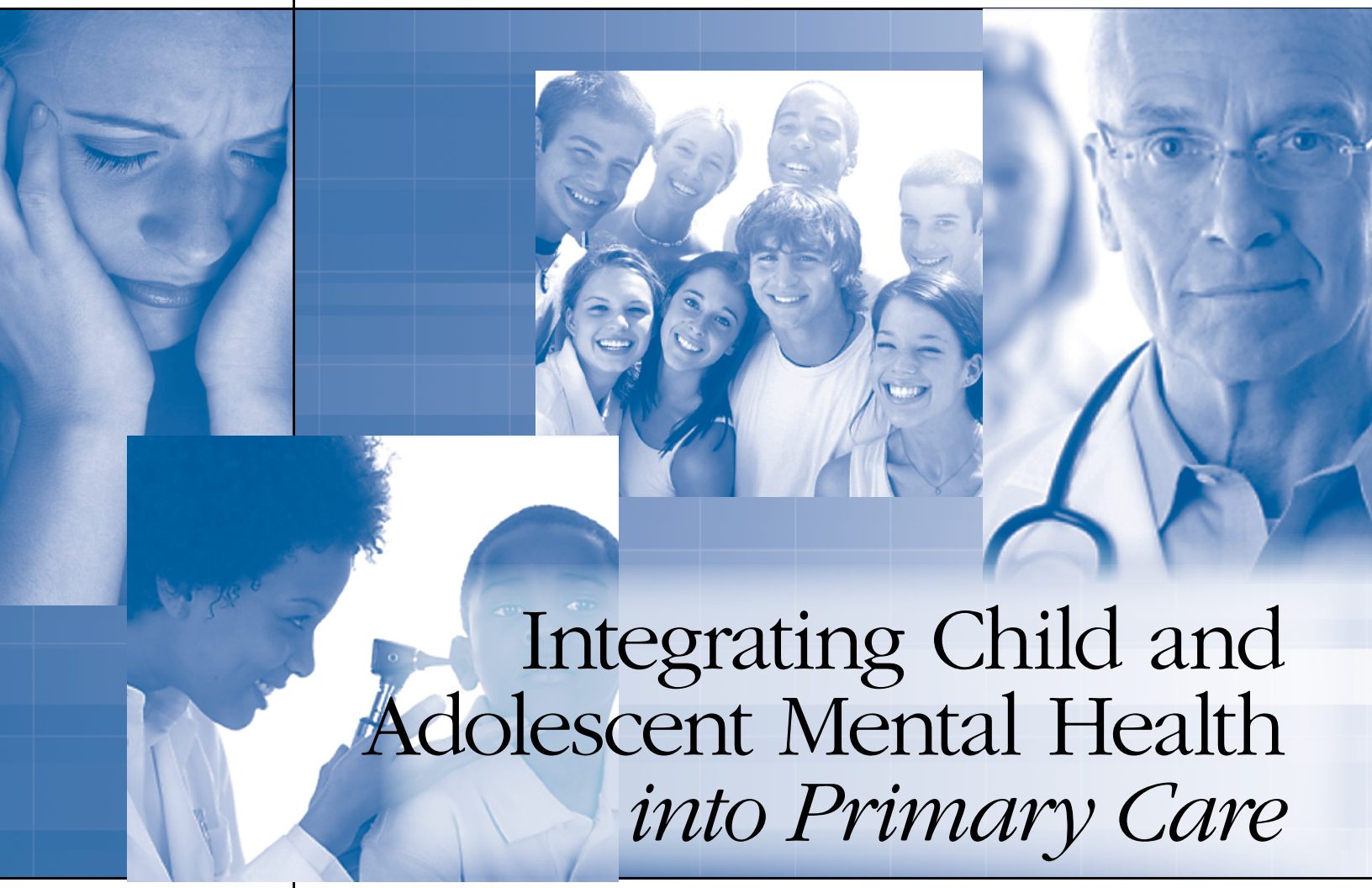
A Resource Guide for **Physicians**



# Integrating Child and Adolescent Mental Health *into Primary Care*

"The feeling of being valuable — 'I am a valuable person'— is essential to mental health and is a cornerstone of self-discipline."

M. Scott Peck


Texas Medical Association

Physicians Caring for Texans

# Integrating Child and Adolescent Mental Health *into Primary Care*

## A Resource Guide for **Physicians**

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### Disclaimer

This resource guide is not intended to be construed or to serve as a standard of medical care.

Standards of medical care are determined on the basis of all of the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. This report reflects the views of scientific literature as of April 2008.

### For Copies or Reprints

Visit the TMA Web site at www.texmed.org, or contact the TMA Public Health Department at (800) 880-1300, ext. 1396.

### Dedication

This edition is dedicated to my friend Wendy, a San Francisco artist, who has spent most of her life struggling successfully with mental illness. Her courage is inspiring; may she continue to find peace, love, vision, and success with her beautiful work.

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# Introduction

In 1999, the TMA Committee on Child and Adolescent Health made as its priority mission improving children's mental health. (See Appendix E for original authors.) This guide is a second edition of the resultant work that followed. It offers primary care physicians practical information on the prevention, early diagnosis, and treatment of mental illness in young patients.

Because mental and behavioral health issues among children and youth are so pervasive, primary care physicians may become frustrated and bewildered in trying to address them. Barriers often seem more evident than solutions. With one in five children having some form of mental health problem, the fact is that primary care physicians are seeing these troubled children every day, whether or not the problems are recognized or managed.[1] Fortunately, there are many constructive interventions primary care physicians can implement to help these children and adolescents. Often, structured and supportive counseling with three to four follow-up visits will get these patients and their families back on the right track.[2,3]

In this guide, the term "mental health problem" can refer to a range of issues from mild conduct problems to serious disturbances such as schizophrenia. With that in mind, any approach to dealing with mental illness should include steps toward overall mental and emotional wellness, not just addressing the problem at hand. The advantage of being a primary care physician working with children and adolescents is that by following a patient's developmental progression, you can observe changes in mental health and well-being as part of your ongoing developmental surveillance. It's extremely important that these issues are recognized early before they become full-blown mental health problems or diagnoses.

**Important Messages**

Mental health is as important as physical health for *all* children.

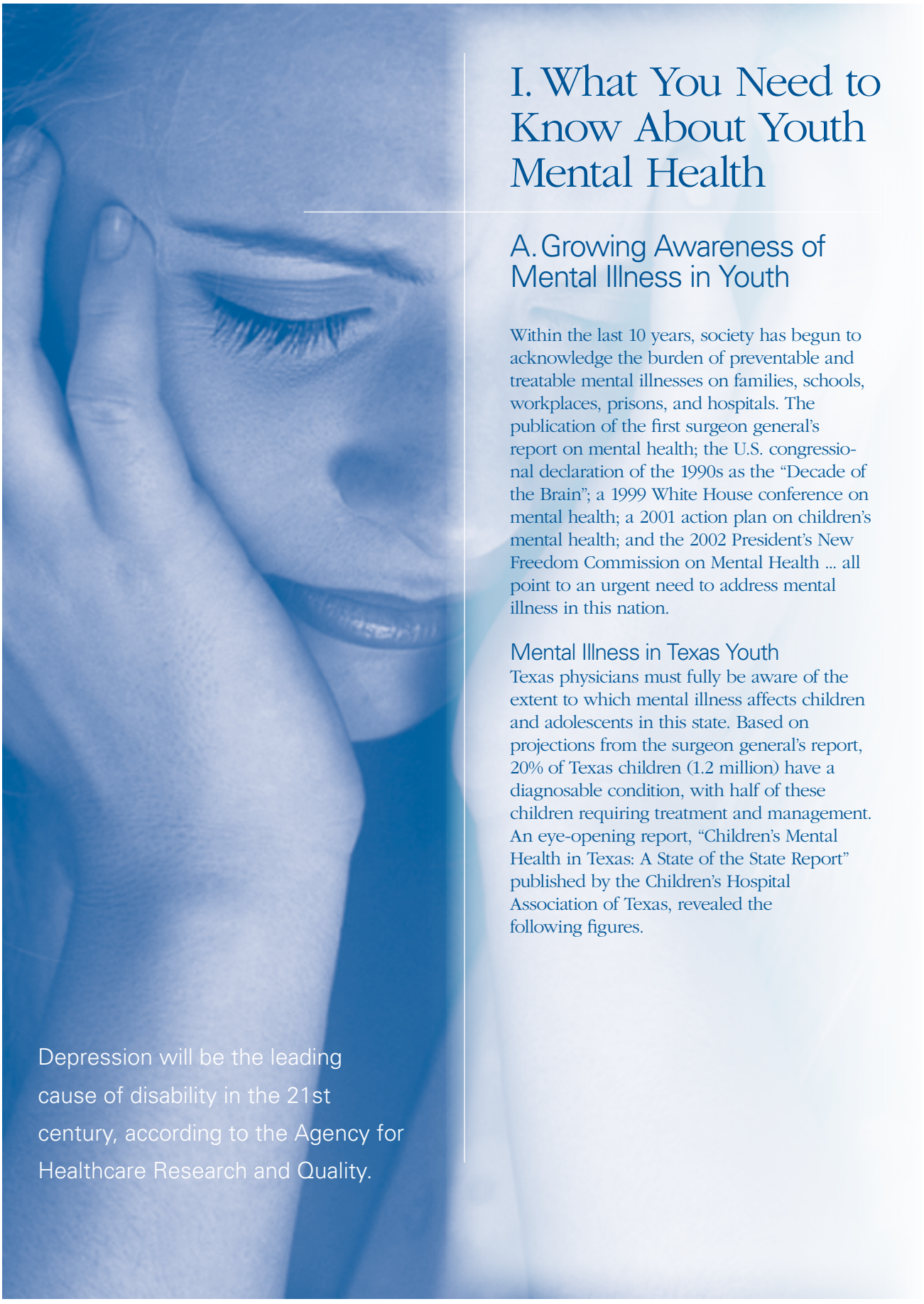
- Many children (one in five) have mental health problems.
- Children's strengths and assets are the foundation of their mental health.
- Mental health problems can be recognized and treated: the earlier, the better.
- Caring families and communities working together can help you, your patients, and your practice.

To help you begin to incorporate more mental health care into your practice, we have included in this guide new information and data on trends; tips on prevention; screening, especially structured screens; descriptions of the most common disorders; guidance on coding; and lists of resources throughout the state and nation. It's about what you can do in your office and in your community. In your practice, you can start by acknowledging that mental health is as important as physical health. And you can learn to build on a child's strengths and resources for achieving and maintaining good mental health.

In short, you will find answers and resources for yourself as well as your patients and their families, and you will learn approaches to tapping into the mental health resources in your community.

We have suggested steps to help you get started. Copy and use the practice tools and key contacts in the Appendices. Pass along the information to your colleagues, patients, and families. Get involved in making our communities healthier, safer, and more productive places in which children can grow and mature into strong, mentally healthy, contributing members of society.

1 U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon Genera*l. Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General, 1999.
2 Schmitt BD. "Pediatric Counseling" in *Developmental-Behavioral Pediatrics*, Third Edition. Levine MD, Carey WB, Crocker AC, eds. (1999) Philadelphia: W.B. Saunders Company.
3 Coleman WL. *Family-focused Behavioral Pediatrics*. Philadelphia: Lippincott, Williams, & Wilkins. 2001.



# I. What You Need to Know About Youth Mental Health

## A. Growing Awareness of Mental Illness in Youth

Within the last 10 years, society has begun to acknowledge the burden of preventable and treatable mental illnesses on families, schools, workplaces, prisons, and hospitals. The publication of the first surgeon general's report on mental health; the U.S. congressional declaration of the 1990s as the "Decade of the Brain"; a 1999 White House conference on mental health; a 2001 action plan on children's mental health; and the 2002 President's New Freedom Commission on Mental Health ... all point to an urgent need to address mental illness in this nation.

### Mental Illness in Texas Youth

Texas physicians must fully be aware of the extent to which mental illness affects children and adolescents in this state. Based on projections from the surgeon general's report, 20% of Texas children (1.2 million) have a diagnosable condition, with half of these children requiring treatment and management. An eye-opening report, "Children's Mental Health in Texas: A State of the State Report" published by the Children's Hospital Association of Texas, revealed the following figures.

Depression will be the leading cause of disability in the 21st century, according to the Agency for Healthcare Research and Quality.

## Rising Risk Factors Associated With Mental Illness in Children — 2005[4]

**(Poverty, Trauma, and Alcohol/Drug Abuse)**

- 21.3% of Texas children lived in poverty, 1/5 higher than the national average.
- 32,000 children were in foster care, almost double the number in the early 1990s.
- 61,000 children were confirmed victims of abuse/neglect, up 50% from the previous decade.

Yet, there's a reduction in mental health services[5]:

- Since 2003, there has been a decline in public mental health expenditures in Texas.
- Since 2003, the number of children served has decreased by 28%.
- In 2001, only 25% of the priority population received services; this has fallen to 18% in 2007.
- In 2005, only 2.6% of child psychiatrists practiced in rural areas — 172 rural counties have no access to child psychiatrists.
- Less than 40% of psychiatrists participate in Medicaid.

According to a recent report from the Hogg Foundation for Mental Health, "The Mental Health Workforce in Texas," the situation is only getting worse. The supply ratio of general and child psychiatrists has fallen 18% over the past 15 years. Because of the aging of the practitioner population (average 53 years), the rising demand for services, and the expense and duration needed for training, it is unlikely that the situation will improve.[6] Increasingly, primary care practitioners on the front line will be forced to manage many of these mental health problems.

As reported in the findings of the 2002 President's New Freedom Commission on Mental Health Report, in any given year, about 5% to 9% of the nation's children have a serious emotional disturbance.[7] This translates into some 13.7 million American children experiencing a diagnosable disorder each year.

## Prevalence Study of Psychiatric Disorders in 9-17 Year Olds — 1996[8]

| Disorder | Prevalence |
|---|---|
| Anxiety Disorders | 13 % |
| Mood Disorders | 6.2 % |
| Disruptive Disorders | 10.3 % |
| Substance Abuse Disorders | 2 % |
| Any Disorder | 20.9% |

## Prevalence Study of Psychiatric Disorders by Age Group — 1998[9]

| Age Groupings | Prevalence |
|---|---|
| Preschoolers (1-5 years) | 10.2 % |
| Pre-adolescents (6-12 years) | 13.2 % |
| Adolescents (13+ years) | 16.5 % |
| Overall | 15.8 % |

## Prevalence Study Psychiatric Disorders of Preschoolers — 1996[10]

| Disorder | Prevalence |
|---|---|
| Psychiatric Disorder | 21 % |
| Severe Disorder | 9 % |
| Oppositional Defiant Disorder | 51 % |
| Parent-Child Problem | 10 % |
| ADHD | 9 % |
| Depression | 3 % |
| Separation Anxiety | 2 % |
| Adjustment Disorder | 2 % |
| Over Anxious Disorder | 2 % |

The Texas Education Agency reports the percentage of students retained in kindergarten, first and second grade were 3.7%, 6.4%, and 3.7%, respectively during the 2003-04 school year. Additionally, child care/preschool centers reported a 20+% expulsion rate for disordered behavior.[11]

4 Children's Hospital Association of Texas. "Children's Mental Health Services in Texas: A State of the State Report." May 2006.
5 Berndt D, Hogg Foundation for Mental Health. *The Mental Health Workforce in Texas: A Snapshot of the Issues*. May 2007.
6 Ibid.
7 President's New Freedom Commission on Mental Health. "Achieving the Promise: Transforming Mental Health Care in America, Final Report." July 2003.
8 Shaffer D, Fisher P, Dulcan M, et al. "The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC 2.3): Description, Acceptability, Prevalence Rates, and Performance in the MECA Study," *Journal of the American Academy of Child and Adolescent Psychiatry*, 35;7 (1996):865-877.
9 Roberts R, Attkisson C, Rosenbaltt A. "Prevalence of Psychopathology Among Children and Adolescents," *The American Journal of Psychiatry*, 155 (1998):715-725.
10 Lavigne J, Gibbons R, Christoffel K, et al. "Prevalence Rates and Correlates of Psychiatric Disorders Among Preschool Children," *Journal of the American Academy of Child and Adolescent Psychiatry*, 35;2 (1996):204-214.
11 Gilliam WS. *Prekindergarteners Left Behind: Expulsion Rates in State Prekindergarten Systems*. New Haven, CT: Yale University Child Study Center. 2005.

According to Texas Department of Mental Health and Mental Retardation, mental illness affects approximately 680,000 of the 5.7 million children and adolescents (11.9%) in the state; however, fewer than 116,000 were eligible to receive services in 2002, and the number is almost half the expected national prevalence rates for treatment. [12]

Statistics on youth suicide, child abuse and neglect, and juvenile crime further illustrate the mental and behavioral problems facing Texas youth and their families:

- Suicide is the third leading cause of death among Texas youth aged 10 to 24.[13]
- In 2004, there were 4.56 suicides per 100,000 youth aged 10 to19 in Texas. [14]
- In 2006, Texas students were more likely to report lifetime use of cigarettes, alcohol, cocaine/crack, and ecstasy than their peers nationally.[15]
- In 2004, more than 50,000 Texas children were confirmed victims of abuse or neglect.[16]
- Of all juvenile offenders referred to Texas Juvenile Probation Commission in 2002, 47.5% had at least one mental health or addictive disorder.[17]

## Youth Risk Behavior Survey

For years, the public health system has been documenting indicators of health behaviors and well-being among youth. The Centers for Disease Control and Prevention, in partnership with state health departments through annual surveys of youth, collect these behavioral health data. The surveys focus on a variety of health risks including alcohol and drug use, symptoms of depression and suicide, and exposure to violence. Of most interest in the context of mental health issues are the results that point to emotional distress in our youth, as shown to the right.

## Youth Risk Behavior Surveillance Findings

The Centers for Disease Control obtained 13,953 questionnaires from 40 states and 21 localities (overall response rate 67%) in 2005 to assess general health behaviors and risks of ninth to 12th graders as part of an ongoing national surveillance project.

| Texas | U.S. | Responses |
|---|---|---|
| 31.4 % | 28.5 % | Felt sad or hopeless every day for at least two weeks |
| 15.9 % | 16.9 % | Had seriously considered committing suicide |
| 12.2 % | 13 % | Had specifically planned to commit suicide |
| 9.4 % | 8.4 % | Had attempted suicide |
| 2.5 % | 2.3 % | Had injured themselves in a suicide attempt |
| 37 % | 27 % | Rode in a vehicle when driver had consumed alcohol and drugs |
| 47.3 % | 43.3 % | Current alcohol use |
| 29.6 % | 25.5 % | Heavy alcohol use |
| 7.3 % | 6.2 % | Methamphetamine use |
| 21.7 % | 20.2 % | Marijuana use |
| 29.7 % | 25.6 % | Alcohol use, less than 13 years of age |
| 10.3 % | 8.7 % | Marijuana use, less than 13 years of age |
| 19.3 % | 18.4 % | Carried a weapon |
| 34 % | 30.3 % | Had a fight with an injury |
| 14.5 % | 11.4 % | Physically hurt at school |

"Youth Risk Behavior Surveillance — United States, 2005." *Morbidity and Mortality Weekly Report*, Vol. 55 (June 9, 2006): SS-5. www.cdc.gov/yrbss

12 Children's Hospital Association of Texas. "Children's Mental Health Services in Texas: A State of the State Report." May 2006.
13 Mental Health America of Texas, 2006. www.texassuicideprevention.org
14 Lubell KM, Kegler SR, Crosby AE, Karch, D. "Suicide Trends Among Youths and Young Adults Aged 10-24 Years — United States, 1990-2004," *Morbidity and Mortality Weekly Report*, 56;35 (Sept. 7, 2007):905-908. www.cdc.gov/mmwr/preview/mmwrhtml/mm5635a2.htm
15 Texas Department of State Health Services. "Monitoring the Future Survey." 2006. www.dshs.state.tx.us//sa/research/survey/2006/adolescentsubstabuse_2006.pdf
16 Texas Attorney General. "What Can We Do About Child Abuse?" May 6, 2005. www.oag.state.tx.us/AG_Publications/txts/child_abuse.shtml
17 Texas Department of State Health Services, Health Professions Resource Center. *Highlights: The Supply of Mental Health Professionals in Texas — 2005*. February 2006. Publication No. 25-12347; E-Publication No. E25-12347, p. 4. www.dshs.state.tx.us/chs/hprc/MHhigh05.pdf

## National Agenda for Child and Adolescent Mental Health

In response to a growing awareness of the problem, in January 2001, U.S. Surgeon General David Satcher, MD, PhD, released a comprehensive report calling for national action on "the public crisis in mental health for children and adolescents." The report, prepared by the Department of Health and Human Services in collaboration with the Department of Education and the Department of Justice, is available at www.surgeongeneral.gov.

The agenda set forth in that document is summarized below.

### Four-Point Vision

1. Promoting the recognition of mental health as an essential part of child health;
2. Integrating family-, child-, and youth-centered mental health services into all systems serving children and youth;
3. Engaging families and incorporating their perspectives on children and youth in the development of all mental health care planning; and
4. Developing and enhancing a public-private health infrastructure to support these efforts to the fullest extent possible.

### Goals and Action Steps

- Promote public awareness of children's mental health issues and reduce the stigma associated with mental illness;
- Continue to develop, disseminate, and implement scientifically proven prevention and treatment services in the field of children's mental health;
- Improve the assessment and recognition of mental health needs in children;
- Eliminate racial/ethnic and socioeconomic disparities in access to mental health care;
- Improve the infrastructure for children's mental health services, including support for scientifically proven interventions across professions;
- Increase access to and coordination of quality mental health care services;
- Train frontline care providers to recognize and manage mental health issues, and educate mental health care practitioners in scientifically proven prevention and treatment services;[18] and
- Monitor access to and coordination of quality mental health care services.

## President's New Freedom Commission on Mental Health, April 2002

The final report of the President's New Freedom Commission on Mental Health (www.mentalhealthcommission.gov) states that mental illnesses come with a devastatingly high financial cost. In the United States, the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount — approximately $63 billion — reflects the loss of productivity as a result of illnesses. But indirect costs also include almost $12 billion in mortality costs (lost productivity resulting from premature death) and almost $4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care.

The President's New Freedom Commission has as the following goals:

1. Americans understand that mental health is essential to overall health.
2. Mental health care is consumer and family driven.
3. Disparities in mental health services are eliminated.
4. Early mental health screening, assessment, and referral to services are common practice.
5. Excellent mental health care is delivered and research is accelerated.
6. Technology is used to access mental health care and information.

## Mental Health Transformation in Texas[19]

The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded $92.5 million to seven states over five years for Mental Health Transformation State Incentive Grants, including Texas. Texas was selected to receive $2,730,000 per year from Sept. 30, 2005, to Sept. 29, 2010. Texas is charged with building a solid foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the multiple needs of mental health consumers across the life span. Such a system is radically different from the system that exists today in which access to care is limited, quality of care is uneven, and coordination and continuity of care across agencies and providers are, for the most part, disjointed.

18 This is Texas Medical Association's rationale for creating this manual, especially for primary care practitioners, as they are best positioned to address prevention, health promotion, and early diagnosis/treatment.
19 Texas Mental Health Transformation Initiative. www.mhtransformation.org

## Transformation Objectives

| Current | | Transformed System |
|---|---|---|
| Persons receiving services | → | Population-based; early intervention |
| Agency "silos" | → | Coordinated care; "no wrong door" |
| Piecemeal, fragmented training | → | Well-defined workforce development/training infrastructure |
| Data compartments | → | Data sharing and coordination |
| Consumer and family member involvement | → | Consumer- and family-driven system |
| Persons falling through agency "cracks" | → | Seamless continuity of care |

The overall Mental Health Transformation Initiative (MHT) is governed by the Transformation Work Group (TWG). The TWG is composed of top leadership from 14 state agencies, and representatives from the Governor's Office, Texas Senate, Texas House of Representatives, Veterans Affairs, and consumer and family members. Additionally, six workgroups have been formed to address specific priority issues, including adult services, children and adolescents, workforce, housing, consumer voice, and data and technology.

Seven local community collaboratives have been funded to demonstrate and inform state and national mental health transformation efforts by serving as models of how to implement transformation at the local level. (See Appendix D: Community Resources for a list of the MHT community collaboratives and their contact information.)

### Systems of Care[20]

A system of care is a coordinated network of community-based services and supports that are organized to meet the challenges of children and youth with serious mental health needs and their families. Families and youth work in partnership with public and private organizations to design mental health services and supports that are effective, that build on the strengths of individuals, and that address each person's cultural and linguistic needs. A system of care helps children, youth, and families function better at home, in school, in the community, and throughout life.

"Systems of Care" is not a program — it is a philosophy of how care should be delivered. Systems of Care is an approach to services that recognizes the importance of family, school, and community, and seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, and social needs. Systems of Care serves as the ideal model for mental health transformation efforts.

## B. Role of the Primary Care Physician


As a primary care physician treating children, adolescents, and their families, you have the best opportunity to promote mental health and identify early psychosocial and behavioral problems in your practice, and it can be done with a quality approach in a timely manner and with rewarding success! This is particularly true in early childhood. [21,22,23]

Following recommendations from an Institute of Medicine (IOM) report addressing the science of early brain growth and development,[24] the American Academy of Pediatrics (AAP) is now recommending for well-child care at least three structured developmental screenings in infancy, emphasizing socio-emotional development.[25]

20 Substance Abuse and Mental Health Services Administration's Systems of Care. www.systemsofcare.samhsa.gov

21 Zero to Three, The DC:0-3R Revision Task Force. *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, Revised (DC:0-3R)*. Washington, D.C.: Zero to Three Press. 2005.

22 Willis D. "The Emerging Role of Pediatricians in Children's Mental Health: Implications from the Epidemiology." Presentation at the Section on Community Pediatrics, American Academy of Pediatrics Conference. New Orleans (Nov. 3, 2003). dwwillis@nweci.org

23 National Technical Assistance Center for Children's Mental Health. Georgetown University Center for Child and Human Development. http://gucchd.georgetown.edu/programs/ta_center/index.html

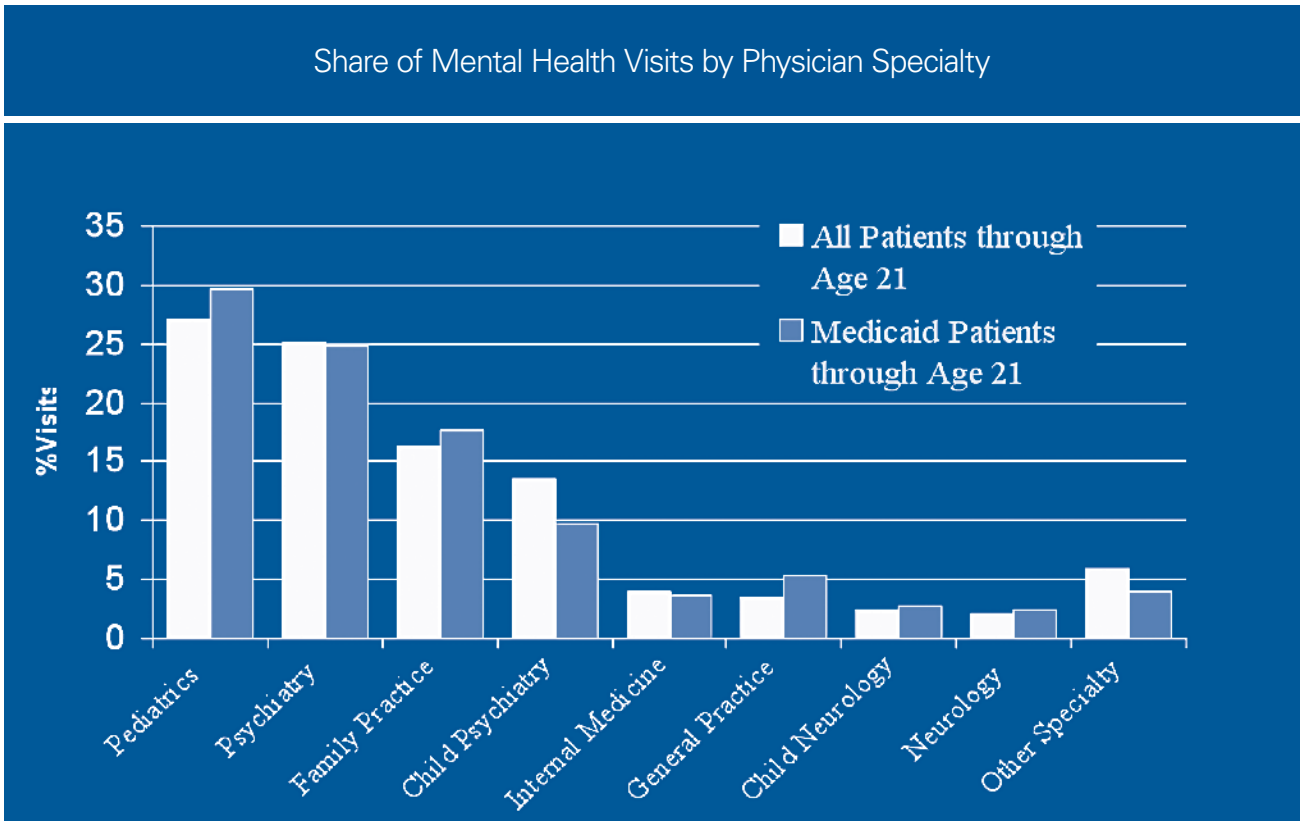
24 Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families. *From Neurons to Neighborhoods: The Science of Early Childhood Development*. JP Shonkoff and DA Phillips, eds., National Academy of Sciences. 2000. www.nap.edu.

25 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening," *Pediatrics*, 118;1 (July 2006):405-420. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405

According to a study published in the June 2000 issue of *Pediatrics,* from 1979 to 1996, clinician-identified psychosocial problems increased from 6.8 to 18.7% of all pediatric visits among 4- to 15-year-olds.[26] This clinical study basically confirmed the epidemiologic studies quoted by the surgeon general. Additional validated screens are available for maternal depression, autistic spectrum disorders, school-age socio-emotional problems, alcohol abuse, and depression/suicide.

The American Academy of Family Physicians (AAFP) produced a strong position paper, "The Provision of Mental Health Care Services by Family Physicians" in 2001. While recognizing that many patients with mental illness are in denial or just do not want to address the problem, this position paper indicated that 32% of patients will go to their family physician, while only 4% would approach a psychiatric professional.[27] Additionally, the paper states that 40+% of psycho-pharmacologic prescriptions are written by generalists, but stresses that there is a definite need to improve the follow-up management of these patients. Family physicians see up to 26% of pediatric visits and a disproportionally larger share in rural areas. Screening tools greatly facilitate the assessment of mental and behavioral problems in a busy practice.[28] Therefore, the family physician role in meeting the increasing demand for mental health services is critically important for the mental health of Texas children.[29]

Primary care physicians have multiple strengths to offer in addressing mental health issues. In addition to prevention and screening, you can develop skills to handle mild to moderate cases of youth mental illness and be able to recognize the serious cases that need to be referred.[30,31] **That is the purpose of this manual**. Even when a psychiatric referral occurs, you will still need to provide the infrastructure of a medical home for that patient during his or her treatment, which may involve multiple health care systems and providers and may last three to 12 months or more. Because recurrence rates of childhood disorders are frequent, the primary care physician may need to reinstitute treatment. Primary care physicians have more success with their patients initiating and keeping needed follow-up visits.[32]




***SOURCE:*** *American Academy of Pediatrics analysis of 1991-2000 National Ambulatory Medical Care Survey*

26 Kelleher K, et al. "Increasing Identification of Psychosocial Problems: 1979-1996," *Pediatrics*, 105;6 (June 2000):1313-1321.
27 American Academy of Family Physicians. "The Provision of Mental Health Care Services by Family Physicians." Position Paper. Fall 2001.
28 Carlat DJ. "The Psychiatric Review of Symptoms: A Screening Tool for Family Physicians," *American Family Physician*, 58;7 (Nov. 1, 1998). www.aafp.org/afp/981101ap/carlat.html
29 Phillips RL, et al. "Family Physicians in the Child Health Care Workforce: Opportunities for Collaboration in Improving the Health of Children," *Pediatrics*, 118;3 (September 2006):1200-1206.
30 Schmitt BD. "Pediatric Counseling" in *Developmental-Behavioral Pediatrics*, Third Edition. Levine MD, Carey WB, Crocker AC, eds. (1999). Philadelphia: W.B. Saunders Company.
31 Coleman, WL. *Family-focused Behavioral Pediatrics*. Philadelphia: Lippincott, Williams, & Wilkins. 2001.
32 American Academy of Family Physicians. "The Provision of Mental Health Care Services by Family Physicians." Position Paper. Fall 2001.

Because you provide your patients with continuity of care, you have the unique opportunity to observe them as they grow and develop over time. This is particularly important with mental health, where disorders are defined by a series of symptoms rather than a specific lab or radiologic exam. For example, as you observe a child developing from infancy to toddler years, you might see behavior consistent with ADHD during the preschool years that requires treatment. While seeing the same patient in follow-up during school years and still on medication, there may be signs of a new mental health problem emerging with agitation and acting out that often masks a depressive reaction. This is a common response to teasing peers and having to "take medicine," especially in the preteen years.

Your ongoing relationship with the patient and your attention to his or her earlier diagnosis significantly improve clinical management because of the continuity of care you uniquely provide. While psychiatrists or psychologists may come and go in the case depending on their availability, you will be there as a constant observer who is familiar with the patient's developmental history.

As a pediatrician or family physician, you are likely to know the child's family and care for his siblings and/or parents. Managing mental illness is always a family affair. You also can be proactive regarding family history in dealing with problems like alcoholism, atopic disease, and obesity. Most chronic disease results in mental and behavioral problems that complicate management. Successfully addressing those issues in your office can have a major impact on the outcomes of disorders like asthma, diabetes, epilepsy, and hypertension.

Despite these strengths offered by primary care, a number of studies suggest that more than half of all psychiatric disorders in pediatric settings go unrecognized and untreated. In a 1999 National Alliance for the Mentally Ill (NAMI) survey of parents, only 34% reported that primary care physicians routinely evaluated mental, emotional, and behavioral issues; 56% said their children's primary care physician failed to recognize mental illness.[33] Clearly, if your practice includes children and adolescents, a number of those patients, maybe more than you realize, have mental or behavioral conditions that need attention. The good news is that with preparation and planning, you can begin to address these mental health needs in your office.

33 National Alliance for the Mentally Ill. *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers.* July 1999.

## C. Tips for Getting Started

Before moving on to the next section, consider the following tips for getting started on integrating mental health care in your practice.

One way you could begin to test the waters with the emotional health of your patients is to pick one or two days each week to ask each school-age child or adolescent a particular question about his or her feelings.

Ask the same question of each child or adolescent. Just keep a tally of positive responses and the total number seen over the next month or two to get a sense of the prevalence of these issues in your practice.

Simple questions/observations can allow you to pick up information from your patient's visit that you previously may not have recognized. If the child or adolescent tells you he or she is feeling distressed, ask her or him to come back in a short time for a follow-up visit when you can talk more about what is going on.

### Questions to Ask School-Age or Adolescent Patients

- Are you feeling stressed?
- Are you having trouble sleeping?
- Are you worrying about anything?
- Are you doing well in school?
- Are you getting along with your friends/other students?
- Are you getting along with you parents?

### Observations During Well-Child Exams on Infants and Toddlers

**Note/Write down how the patient reacts or relates to you:**

- Appropriately fearful?
- Indifferent?
- Calm?
- Frightened?

**Note/Write down how the patient reacts or relates to the parent:**

- Comforted?
- Attached?
- Anxious?
- Poor eye contact?

Again, tally the number of abnormal observations and the total number of patients seen to look at the prevalence of such issues during your well-child exams.

With infant observations, simply comment to the parent what you have observed and ask the parent's thoughts on the observations. These experiences will give you a chance to become comfortable with what are "normal" or "typical" answers and what are more unusual or worrisome answers.

These activities should take less than one to two minutes. Most primary care physicians have an awareness of the signs and symptoms of mental and behavioral problems, but have not addressed them because of time limitations, lack of an office protocol to deal with the newly recognized issues, and discomfort from a lack of knowledge or familiarity in managing these psychosocial problems.

The American Medical Association has identified fetal alcohol syndrome as the leading cause of preventable mental retardation in the Western world.

# II. What You Can Do in Your Office

As we discussed in the previous chapter, your role as a primary care physician begins with accepting the problem of mental illness in children and realizing its frequency, severity, and impact. The problems facing your patients and their families may seem overwhelming at first, but with an informed approach, you can make a difference by expanding your office capabilities in addressing mental and behavioral problems

## A. Tips for Prevention and Counseling

From anticipatory guidance to identifying risk factors early and conducting brief screenings, you can do a number of things to promote and maintain the mental well-being of your young patients. There are many resources, including those highlighted in this chapter, to help you, your patients, and their parents address mental healthiness.

### Addressing Prevention and Prenatal Care

Preventive intervention for mental health begins when the mother first considers pregnancy, or is at risk for pregnancy (i.e., unintended), and with prenatal visits. For example, if a mother or potential mother is drinking alcohol or smoking on a regular basis, you should counsel her about the risks to the fetus. All women who might get pregnant should be taking folic acid 1 mg. daily to prevent neural tube defects and other potential malformations. You also should inform prospective mothers about medications that may counteract oral contraceptives. This information can be passed out to mothers of children you are seeing for health checks.

### Discuss Mom's Future Pregnancy

- **Folate:** Prescribe 1 mg. daily
- **Tobacco:** Refer to smoking cessation; prescribe replacement therapy
- **Alcohol:** Screen with CAGE and/or CRAFFT; refer to AA
- **Substance abuse:** Refer to NA
- **Structured screen:** Beaufort Stress Index

## Preparing Parents for Life With a Newborn

Much of your attention will be spent on fostering parents to develop healthy habits as they deal with the challenges and rewards of their child's infancy. By providing expectant parents with prenatal visits and preparatory counseling, you can help them anticipate challenges and develop coping skills before the baby is born. Assist your parents-to-be by discussing what to expect in terms of the difficulties of parenting a newborn.

Parents should be counseled about understanding one another's reactions and not having unrealistic expectations of each other and their new baby when the stress of sleep deprivation and 24/7 responsibility sinks in.

### Prenatal Visits

- **Early/Regular prenatal care**
- **Child development** (Reference: I Am Your Child developmental calendar from Texans Care For Children)
- **Medical home**
- **Health care for infants and children** (Reference: *Your Child's Health* by Bart Schmitt)
- **Structured screen:** Beaufort Stress Index

Potential messages include:

- Expect moderate to severe stress leading to anger and depression and how you will cope together (e.g., sharing duties, not personalizing spouse reactions, extra supportive measures.) Screening for maternal depression is encouraged.[34]
- Discuss with one another your parenting styles, spousal expectations, and how you will respond to your baby's emotions and actions.
- Address potential disagreements about your child's behavior.

### Questions to Ask Parents About How They Are Dealing With Parenthood

- Are you having trouble sleeping?
- Are you more tearful or very angry in certain situations lately?
- Are you making time for yourself?
- Are you still connected with friends?
- Are you setting time aside together as a couple without the baby?

## Providing Anticipatory Guidance for Childhood Development

During a child's early years, parental self-care is a key issue, and you should discuss with parents how they are dealing with parenthood.

**If you understand how the parents are doing affectively, you can determine their availability for their child emotionally.**

## Infant/Toddler Visits

When you discuss development during each well-child visit — often during the physical exam in order to demonstrate milestones — you also can offer anticipatory guidance and parenting techniques for problems areas the parents are experiencing and want to discuss.

### Infant/Toddler Visits

- **Structured screens:** *ASQ-SE*, PEDS-DM
- **Family status:** Beaufort Stress Index
- **PE: Child behavior/language:** Attention, response, connectiveness
- **Parent-Child interaction:** Responsiveness, comforting style

"Timely Topics" for each periodic visit identify three to four socio-emotional issues appropriate for that visit. They can be raised in one to three minutes and thus easily included in your usual approach.

34 Olson AL, et al. "Brief Maternal Depression Screening at Well-Child Visits," *Pediatrics*, 118;1 (July 2006):207-216. http://pediatrics.aappublications.org/cgi/content/abstract/118/1/207

## Infant/Toddler Visits — Timely Topics

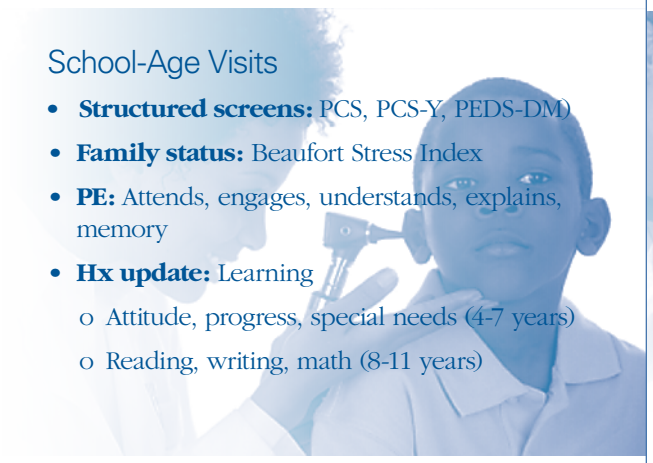
| | |
|---|---|
| **Newborn-1 week** | Prepare for stress/exhaustion; 24 hours a day; bonding |
| **2 weeks** | Crying; exhaustion/stress; mutual support |
| **2 months** | "Spoiling"; verbal /physical stimulation; time away |
| **4 months** | Back to work and child care; quality time; stimulation; loving |
| **6 months** | Individuation (anxieties); parent team; reading/language stimulation |
| **9 months** | Response to affect; discipline — save voice, use environmental control |
| **12 months** | Vocal/Physical affectation; praise (+) behavior; reading; parent time away/working together |
| **15 months** | Begin rules; negative (verbal) or zero (time out); not spanking; consistency; one at a time; caretakers; future toilet training |
| **18 months** | Watch interactions and listen care fully; consistent discipline; verbal/ physical praise; other children/ sharing |
| **2 years** | Prioritize discipline/violence; verbal/physical reinforcement and rewards; active reading; sexual differences; toilet |
| **3 years** | Sex differences/toilet; active learning (careful TV/video); encourage choices; discipline consistent/fair |

Your goal in providing preparatory counseling to parents is to help them develop skills so they are able to support their child's growth and development in the healthiest way possible. For example,

- Begin talking with parents about how to approach oppositional behavior around nine months and how to initiate rules and discipline between 15 and 18 months.
- Give each family a developmental calendar ($1/ copy) produced by Texans Care for Children (www.texanscareforchildren.org) and funded by the Texas Health and Human Services Commission from the *Frew v. Hawkins* settlement.[35]
- Provide parents with information about how to interact with children at various ages, such as discussing feelings associated with the activities of early school-age children instead of just addressing daily events.
- Prepare school-age children for significant emotional losses (e.g., a pet, a family member) and the grieving process (suggest appropriate story books: *The Red Pony* and *The Yearling*).
- In early school years, emphasize the importance of honesty and trust in order to build regular and lasting communication into the teen years.
- Work to keep parents engaged with the child, especially during preadolescence, around 8 or 9 years old. This will help usher the child into and through the tween/teen years; it will lay the foundation of the child's relationship with the parents and determine the real value of parental authority
- Often the physician's time is very limited! Two time-tested books are very helpful for parents having frequent child-rearing challenges: Bart Schmitt's, *Your Child's Health*[36] and T.B. Brazelton's *Touchpoints: Your Child's Emotional and Behavioral Development*.[37] For non-readers, refer to such programs as Parents as Teachers, a program of Mental Health America of Texas. (See Appendix D: Community Resources.)

35 Texans Care for Children. www.texanscareforchildren.org
36 Schmitt BD. *Your Child's Health*. New York: Bantam Books. 2005.
37 Brazelton TB. *Touchpoints: Your Child's Emotional and Behavioral Development*. New York: Addison-Wesley. 1992.

## School-Age Visits




## School-Age Visits — Timely Topics

| | |
|---|---|
| **4 years** | Identify feelings: self and others; impulse control; rules/safety; discipline consistent; choices; privacy/masturbation/touching |
| **5 years** | Discuss feelings, not just events about self/others; attitude/values; +/- interaction behavior (courtesy, listening, queuing, fighting, interrupting); privacy/space |
| **6-7 years** | Evaluate choices; parental role modeling; values (honesty, helping others); sexual humor; healthy behaviors (diet, exercise, dental, discuss feelings) |
| **8-9 years** | Role-modeling healthy behaviors (honesty, empathy, dealing with losses); sexual humor; tobacco, alcohol, and other drug (TAOD) pressure; safe from violence/abuse; problem solving |
| **10-11 years** | Healthy behaviors; fitness/self-esteem/TAOD-refusal skills; sexual development; discipline/consequences; conflict resolution/violence |

## Adolescent Visits


# B. Guidelines for Preventive Care

The next section discusses recognized guidelines for preventive care of children and adolescents. While these guidelines will help you address child development and mental health during periodic well exams, the efficacy of the guidelines has not been carefully evaluated. However, they have been developed by panels of practitioners and clinicians with years of experience. The American Academy of Pediatrics' 2007 edition is designed to better accommodate the busy schedules of primary care practitioners, but remains a challenge. Data from a survey of pediatricians found the average length of a preventive care visit, including all care by all personnel, ranges from 28 to 30 minutes, depending on the age of the patient. Pediatricians personally spend an average of 17 to 20 minutes with patients/parents depending on the patient's age.[38] Using Timely Topics (noted above) may be an approach that complements your practice operation.

Regular attention to child development can help in the detection and prevention of mental health problems, but additionally, we are learning that it is not just risk reduction but also asset acquisition that we would like to accomplish with anticipatory guidance.[39] Children who acquire socio-emotional, cognitive, and communication skills have been shown to avoid risky behaviors and poor outcomes, and find success in their relationships and schooling.[40,41]

38 American Academy of Pediatrics, Division of Health Policy Research, Periodic Survey of Fellows #56. Executive Summary. Pediatricians' Provision of Preventive Care and Use of Health Supervision Guidelines. Elk Grove Village, IL: American Academy of Pediatrics, 2004.
39 Hagan JF, Shaw JS, Duncan PM, eds. (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics.
40 Benson PL, Leffert N, Scales PC, Blyth DA. "Beyond the 'Village' Rhetoric: Creating Healthy Communities for Children and Adolescents," *Applied Developmental Science*, 2;3 (1998):138-159.
41 Leffert N, Benson PL, Scales PC, Sharma AR, Drake DR, Blyth DA. "Developmental Assets: Measurement and Prediction or Risk Behaviors of Risk Behaviors Among Adolescents," *Applied Developmental Science*, 2;4 (1998):209-230.

As a primary care physician, you have a golden opportunity to educate parents and future parents about the impact of their parenting on their child's development and mental health from the beginning of life through the teen and early adult years. This can be accomplished in the context of a busy practice.[42]

### American Academy of Pediatrics (AAP): Recommendations for Preventive Pediatric Health Care

The new, third edition of *Bright Futures*, a joint effort of AAP and the Maternal and Child Health Bureau (MCHB), provides a detailed list of organized, periodic wellness checks and screenings starting with prenatal visits through age 21. Additional "inter-periodic" visits are usually necessary if parents identify problems or concerns during the well exam. The physician should present only brief solutions during the well exam; identified developmental and psychosocial issues for children and adolescents usually require separate counseling and treatment visits or referrals. The physician should schedule follow-up visits soon after the initial visit (less than one week). You may need to adjust your calendar to allow your patients better access to you for their mental health follow-up visits. Parents often need an additional referral visit to ensure they really understand why their child needs the referral; otherwise, families have poor follow-up rates to the referred practitioner.

AAP emphasizes the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care whenever possible. Thus, it is best that these exams only be done in a medical home where all the patient's care is integrated and appropriate follow-up care is monitored.

### Medical Home

Here in Texas, the Texas Medical Association strongly supports the patient-centered medical home (PCMH) concept. The TMA Select Committee on Medicaid, CHIP, and the Uninsured recently has developed several legislative recommendations to promote the PCMH model, including physician payment for after-hours care and grants to help physicians implement e-prescribing and electronic medical records. The Texas Health and Human Services Commission — at the behest of TMA, the Texas Pediatric Society, and the Texas Academy of Family Physicians — formed a Texas Health Steps (THSteps) Process Improvement workgroup. The workgroup's charge was to evaluate ways to modernize the clinical requirements of the THSteps exam, as well as identify barriers that prevent physicians from serving as a medical home, such as excessive paperwork and prior authorization requirements.

### American Medical Association (AMA): Guidelines for Adolescent Preventive Services (GAPS)

GAPS recommendations outline an ideal preventive services package for annual health visits for adolescents between the ages of 11 and 21. Annual visits afford you the opportunity to provide health promotion messages for both adolescents and their parents. You also can identify adolescents who have begun to take health risks or who are at early stages of physical or emotional disorders. Most important, these regular visits will allow you to develop relationships with the adolescents in your practice that will foster open disclosure of health information.

GAPS provides reproducible forms that organize patient data collection, track preventive service visits, measure body mass index, graph blood pressure, and prompt providers to perform screening and health guidance activities. GAPS also offers handouts you can give to your parents on topics such as raising a teenager, dealing with teens and violence, and other areas of risky behaviors. GAPS has a parent/guardian questionnaire that screens for parent concerns, and an adolescent questionnaire is available for collecting health-risk behavior information. Some forms are available in Spanish. For GAPS implementation forms, call (312) 464-5315, e-mail gaps@ama-assn.org, or visit www.ama-assn.org.

## C. Tools for Early Identification and Screening

As patients grow into early childhood, your best chance for recognizing mental or behavioral problems will be through structured, standardized screening questionnaires during regular health promotion visits.[43] At a minimum, early childhood screens should be at the 9-, 18-, and 30-month visits.[44] You also should use structured screens when you or the parents have concerns or doubts. Examples of structured developmental screens

42 Earls MF, Shackelford Hay S. "Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice — The North Carolina Assuring Better Child Health and Development (ABCD) Project," *Pediatrics*, 118;1 (July 2006):e183-e188. http://pediatrics.aappublications.org/cgi/content/abstract/118/1/e183

43 American Academy of Pediatrics, Committee on Children With Disabilities. "Developmental Surveillance and Screening of Infants and Young Children," *Pediatrics*, 108;1 (July 2001):192-196. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192

44 American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening," *Pediatrics*, 118;1 (July 2006):405-420. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405

addressing socio-emotional development are the *Ages & Stages Questionnaires®: Social-Emotional (ASQ:SE)* and the Parents' Evaluation of Developmental Status — Developmental Milestones (PEDS:DM)©. (See Appendix A: Tools for Your Practice.)

Strategies on how to integrate structured screens into your office practice are reviewed in Chapter IV. Common Childhood Mental/Behavioral Disorders

It is vitally important that parents be encouraged to maintain the recommended schedule of health maintenance visits. Later, when children start school (after 2 to 3 years of age), they should have a thorough annual checkup involving an assessment of mental health, and social and cognitive skills, not just a physical exam or "sports exam."

During adolescence (after the age of 11 and possibly earlier, depending on individual development), children should be interviewed alone with confidentiality assured to accurately assess their social, academic, and familial relationships and their feelings about friends, school, and parents. Additional standardized screens are available when concerns arise about depression, suicide, and substance use/abuse.

Remember that in many families, socio-emotional, behavioral, and especially mental health issues are still stigmatizing and result in parental fear, denial, and angry reactions. If the physician has raised socio-emotional issues from the beginning of the patient-physician relationship, this helps to ameliorate these reactions, but not completely.

# D. Strategies for Change: The Practice/Internal Team

## Health Team Development

After sampling some behavioral health strategies as suggested earlier, you hopefully will decide you would like to better address these issues in your practice. Published experience suggests that to undertake this challenge, it is best to identify a team within the practice to handle this task and select a team leader/champion to lead the endeavor.[45,46,47] Health team development is not a simple or obvious task.[48] The following steps outline the basics of the process; helpful articles and references detail the process.[49,50,51]

## Internal Health Team Development

1. **Involve each area of the office**
- Reception: Schedule new time block for screening implementation
- Billing: Use new diagnoses codes
- Nurse/Practitioner Staff: Manage patient education, set follow-up routines, coordinate with external partners, establish referral protocols

2. **Identify goals the practice is to address**
- Screenings
- Changes in health checkups
- Conditions that will be diagnosed, referred, or treated

3. **Write objectives the practice is to address**
- Select and purchase screens
- Identify and select treatment algorithms
- Monitor treatment

4. **Define and negotiate roles and responsibilities**
5. **Monitor progress.**

Most of the literature strongly suggests that each of these elements of integrating mental health into primary care should be undertaken in very small doses with plenty of time for the practice to accommodate and assimilate these changes. If the process gets bogged down, you may want to consider a practice change consultant or coach.

**At the very outset, the chief administrator must sign off on time allotments on a weekly basis for the team to accomplish this task and how team members will be rewarded for their efforts.**[52]

45 North Carolina ABCD Project. "Getting Started with Developmental Screening and Surveillance." www.dbpeds.org/articles/detail.cfm?TextID=98.
46 Commonwealth Fund. *A Practical Guide for Improving Child Development.* May 8, 2006. www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=372065
47 Commonwealth Fund. *A Practical Guide for Healthy Development.* April 1, 2006. www.commonwealthfund.org/General/General_show.htm?doc_id=335599
48 Rubin IM, Plovnick MS, Fry RE. *Improving the Coordination of Care: A Program for Health Team Development.* Cambridge MA: Ballinger Publishing Company. 1975.
49 Earls MF, Shackelford Hay S. "Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice — The North Carolina Assuring Better Child Health and Development (ABCD) Project," *Pediatrics*, 118;1 (July 2006):e183-e188. http://pediatrics.aappublications.org/cgi/content/abstract/118/1/e183
50 Glascoe FP. "Organizing Offices for Detecting and Addressing Developmental Behavioral Problems," in *Collaborating with Parents.* Nashville, TN: Ellsworth & Vandermeer Press, Ltd. Nov. 3, 2004. www.dbpeds.org/articles/detail.cfm?TextID=284
51 Ploof D, Hamel S. "Developmental Screening Is an Important Part of Well Care: How Can We Really Make It Happen? Basic Principles for Practice Change in The Real World," *American Academy of Pediatrics' Section on Developmental and Behavioral Pediatrics' Newsletter.* June 2002.
52 Rubin IM, Plovnick MS, Fry RE. *Improving the Coordination of Care: A Program for Health Team Development.* Cambridge MA: Ballinger Publishing Company. 1975.

### Integrated Mental Health

The concept of blended primary care practice and behavioral health practice is not new, but neither is it very prevalent. Nor has the concept been carefully evaluated for efficacy and costs, especially in pediatric populations. However, with the enormous increased pressure on primary care practitioners to address mental health issues that show up in their practices,[53] there has been a recent surge to develop a broad and intimate relationship between the two practices.[54]

Once the primary care practitioner accepts the role of promoting mental health and providing screening, early diagnosis, treatment, and referral for those problems, co-locating and/or integrating the practice with a mental health practitioner to help manage these patients becomes very attractive for both practices.

Co-location offers superior benefits, as it allows for deeper integration and involvement with the practice.[55,56] Even distance integration of a psychiatrist into a primary care practice with regularly scheduled case review, consultation, and mentoring as they help manage new and challenging cases offers the primary care physician substantial support and backup for the quality of care the physician is providing.[57,58] In either case, the mental health practitioner would become an invaluable member of the practice team. Of course the primary care physician may want to combine both approaches, using a licensed therapist in the office and regularly scheduled mentoring sessions with a psychiatrist. A list of the many types of mental health practitioners and their backgrounds is given below.

Child psychiatrists and clinical psychologists are in short supply.[59] Further, the success of these models will depend on adequate reimbursement by both private and public health insurance — not only for face-to-face visits, but also for telephone consultation for both the primary care physician and psychiatrist. It is hoped that these issues will be addressed adequately for Medicaid and SCHIP patients through the *Frew v. Hawkins* settlement and with private insurance carriers.

## E. Overview of Mental Health Professionals

The following is an overview of allied mental health professionals and common abbreviated credentials for each profession in Texas.

### Licensed Professional Counselor (LPC)

Licensed professional counselors help people deal with problems or conflicts they are unable to solve alone, including substance abuse; family, parenting, and marriage conflicts; stress management; depression; suicidal thoughts; career concerns; and problems with self-esteem. Mental health counselors collect information through interviews, observations, and tests, then decide how best to treat patients. The counselor may work with individuals, couples, families, or in group sessions of people with similar problems. They work closely with other mental health professionals, such as psychiatrists, psychologists, and social workers, to care for patients.

### Social Worker (LMSW-ACP: Licensed Master of Social Worker-Advanced Clinical Practitioner)

Social workers assist individuals and groups with problems such as poverty; illness; substance abuse; child, spouse, or elder abuse; lack of financial management skills; emotional and mental health disorders; and inadequate housing. There are five types of certified/licensed social workers: social work associate, licensed social worker, advanced practice social worker, licensed master's social worker, and advanced clinical practice social worker.

### Chemical Dependency Counselor (LCDC: Licensed Chemical Dependency Counselor)

Chemical dependency counselors help assess and treat drug and alcohol addiction. They provide intervention services, family counseling, and prevention. They also speak to individuals and groups about the dangers of such addictions.

53 Kelleher K, et al. "Increasing Identification of Psychosocial Problems: 1979-1996," *Pediatrics*, 105;6 (June 2000):1313-1321.
54 Hogg Foundation for Mental Health. Integrated Health Care. www.hogg.utexas.edu/programs_ihc.html
55 Williams J, et al. "Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models," *Clinical Pediatrics*, 45;6 (July 2006):537-543. http://cpj.sagepub.com/cgi/content/abstract/45/6/537
56 Ginsburg S. "Colocating Health Services: A Way to Improve Coordination of Children's Health Care?" Commonwealth Fund Issue Brief. Vol. 41 (July 9, 2008).
57 Massachusetts Child Psychiatry Access Project. www.mcpap.org
58 American Academy of Pediatrics, Illinois Chapter. Screening Tools & Education for Pediatric Providers (STEPPS): Developmental Screening and Referral Program. Resource & Referral Kit. Contact: Kathryn Hawley, Project Manager, Illinois Chapter, American Academy of Pediatrics. Phone: (312) 733-6207, khawley@illinoisaap.net.
59 Berndt D, Hogg Foundation for Mental Health. *The Mental Health Workforce in Texas: A Snapshot of the Issues*. May 2007. www.hogg.utexas.edu/PDF/MH%20Workforce%20in%20Texas_%20A%20Snapshot.pdf

### Marriage and Family Therapist (LMFT: Licensed Marriage and Family Therapist)

These therapists deal with an array of issues, including those that stem from couple relationships, children, stepfamilies, and caring for elderly parents. They also treat and help families cope with specific disorders such as substance abuse, eating disorders, prolonged underachieving, depression, and other mental and emotional problems. The marriage and family therapist consults with all those involved in the problem, including parents, spouses, children, friends, school personnel, social services, community agencies, and the courts.

### Psychiatric Aide or Technician (QMHP: Qualified Mental Health Professional)

Psychiatric aides and technicians observe and record patient behavior and present their findings to counselors, nurses, and other professional staff. They also assist with feeding, moving, and dressing patients. QMHPs can be referred to as therapist technicians, mental health aides, and other terms. To be a QMHP, the individual has to have a bachelor's degree in human services and experience in direct care and implementing treatment plans. A non-degreed technician may be referred to as a QMHPP, or qualified mental health paraprofessional. Marriage and family therapists address a wide array of relationship issues and diagnose and treat individuals, couples, families, and groups to achieve more adequate, satisfying, and productive marriage, family, and social adjustment.

## F. Reimbursement Challenges

Managing the business aspect of your practice, including reimbursement issues, is key to ensuring your time and energies can be devoted to the health and mental health of your patients. Following are discussions about reimbursement challenges for physicians, insurance coverage and benefits, and suggested coding for primary care outpatient services for mental and behavioral health.

Historically, inadequate reimbursement levels have led to a decrease in physician participation in Medicaid. Between 1996 and 1999, many physicians stopped participating in the program, including 40 to 60% of psychiatrists, according to surveys by the Texas Society of Psychiatric Physicians. There was concern that the Children's Health Insurance Program (CHIP) suffered the same problem as Medicaid in that inadequate payments were preventing primary care physicians and subspecialists such as psychiatrists from participating in the program. As a result, patients enrolled in Medicaid or CHIP found referrals to mental health professionals difficult to impossible to obtain.

In 2000, however, the problem began to receive attention. Responding to mounting concerns about a declining and insufficient Medicaid provider base, the 77th Texas Legislature allocated $197 million in state funds to update reimbursement rates for physicians, allied health professionals, dentists, hospitals, and Medicaid health plans.

Fifty million dollars in state funds were earmarked for physicians and allied health practitioners. Over the biennium, these funds were matched with another $75.4 million in federal monies, creating a total increase of $125.4 million. The Texas Health and Human Services Commission was charged with implementing the fee increase; however, the appropriations rider established specific parameters for use of the new monies. The monies allocated for physicians and professional services were appropriated for children's health care and targeted toward the following:

- Texas Health Steps (THSteps, the Early and Periodic Screening, Diagnostic, and Treatment program in Texas), including a "bonus" payment for practitioners who provide care within the recommended time frames;
- Office-based evaluation and management codes, with the goal of promoting preventive care and rewarding high-volume Medicaid practitioners; and
- Other primary care codes.

In developing parameters for distributing the new monies, legislative budget writers consulted with TMA on the best approach given limited dollars. The legislature and TMA agreed that what was ultimately adopted was enough to retain existing Medicaid physicians and other health care providers, but not enough to *recruit* new Medicaid providers or those who already have left the program. That being said, the new monies could substantially improve reimbursement for selected services, particularly THSteps.

For over a dozen years, there was a lawsuit pending against the State of Texas for its failure to implement the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program (called THSteps in Texas), a component of Medicaid. As a result of the *Frew vs. Hawkins* lawsuit agreement in 2007, reimbursement has been restructured to more appropriately pay practitioners for their Medicaid services. Payment for THSteps exams are now paid 92% of Medicare for new patients and 100% of Medicare for established patients. Funding for mental health-related services also increased. TMA, in collaboration with the Texas Pediatric Society and Texas Academy of Family Physicians, will continue to monitor and make recommendations on these guidelines and reimbursement. For more information, contact TMA Council on Socioeconomics staff at (512) 370-1300.

Additionally, as part of the *Frew* agreement, the state allocated $150 million to fund "medical and dental strategic initiatives" to improve the availability and quality

of care for children. Since September 2007, an advisory committee of physicians, consumers, hospital administrators, and health researchers has recommended several innovative initiatives be funded, including payment for physician-to-physician phone consultations and a pilot to test the co-location of primary care physicians and mental health professionals to improve mental health screening, diagnosis, and treatment.

## G. Insurance Coverage and Benefits

According to Texas Community Services, a provider-sponsored organization representing community mental health organizations, the following is an overview of the mental health benefits provided by commercial managed care plans and public assistance programs.

### Managed Care Organizations

Managed care plans provide a range of benefits but typically limit outpatient visits, inpatient care, and substance abuse treatment.

- Outpatient care (counseling and medication management) is covered for a limited number of visits per year for most disorders, e.g., depression, ADHD, anxiety, and the like.
- Inpatient care (if covered) is managed very tightly with a limited number of days per year. Covered disorders are generally only those that result in possible physical harm to self or others.
- Substance abuse is treated on an outpatient basis for the most part; inpatient services are provided for detoxification, are very closely scrutinized, and generally have to be from active abuse of alcohol or benzodiazapines.
- Major depression is not hospitalized, generally, unless there is an active suicidal or homicidal threat.

### Medicaid

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, known in Texas as Texas Health Steps (THSteps), is the largest and most comprehensive medical and dental prevention and treatment program in the United States. Available to Medicaid-eligible youth from birth to age 21, the THSteps program provides comprehensive and periodic evaluation of a child's health, development, and nutritional status; vision, dental, and hearing care; and a mental health assessment.

- Traditional fee-for-service Medicaid benefits are similar to managed care benefits in terms of limiting the number of visits.
- Rehabilitative services are only allowed to be used by community MHMR centers and are geared toward providing "wrap-around" services that support children in their environments, involve parents and caregivers, and work toward developing skills such as anger management, peer relations, and learning behaviors.
- Medicaid covers outpatient counseling services for **chemically dependent** children 13 to 17 years of age (younger and older children require special justification). Group counseling is limited to 135 hours per calendar year and 26 hours for individual counseling.
- Federal Medicaid law specifies that states cover all medically necessary services for children under age 21. Thus, if additional services are needed beyond those described in the Medicaid manual, additional services may be prior authorized as part of the Texas Health Steps Comprehensive Care Program (THS-CCP), so long as the physician documents medical necessity.

### Children's Health Insurance Program (CHIP)

TMA convened a panel of physician specialists to work closely with state agencies and patient advocacy groups to collaborate on the design of mental health benefits, and to review and comment on benefit package proposals. TMA's Select Committee on Medicaid, CHIP, and the Uninsured provides ongoing interaction with the agencies overseeing CHIP.

TMA's participation and leadership helped in the development of a rich mental health benefits package for children, which includes:

- 60 outpatient visits per year for most disorders. (Medication management visits do not count toward this.)
- 60 days of rehabilitative day treatment as needed for ongoing care.
- 45 inpatient days per year for debilitating disorders such as major depression.
- Outpatient and inpatient services for substance abuse.

For more information on the mental health benefits of CHIP, contact (800) 647-6558, or visit www.hhsc.state.tx.us/chip/chip_prov_info.html.

### Social Security for Seriously Ill Children

Children who are disabled due to mental illness may qualify for Social Security and Supplemental Income (SSI). These young people have "marked and severe functional limitations" expected to last at least 12 months or be life-threatening. For SSI information, call (800) 772-1213, or go to www.ssa.gov/disability. To find local Social Security Administration offices, visit www.ssa.gov/reach.htm.

Children receiving SSI are eligible for Medicaid and Children With Special Health Care Needs benefits, which is administered by the Texas Department of State Health Services' (DSHS') Chronically Ill and Disabled Children (CIDC) program. For local CIDC resources, call the DSHS main office at (512) 458-7355 or (800) 252-8023.

The National Dissemination Center for Children with Disabilities provides information on disabilities and disability-related issues for families, educators, and other professionals. Call (800) 695-0285, or visit www.nichcy.org.


# III. Billing and Coding

## A. Suggested Coding for Primary Care Outpatient Services

Coding behavioral health services to receive optimal reimbursement is complex. Some guidelines to assist you with this type of coding follow.

*The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care* (*DSM-PC*) [Child and Adolescent Version] by the American Academy of Pediatrics (AAP) is a reference book offering comprehensive guidance for diagnosing and coding behavioral problems and situations. It is available from AAP for $39.95 at http://www.aap.org/.

Zero to Three publishes *DC:0-3R*, which addresses the need for a systematic, developmentally based approach to the classification of mental health and developmental disorders in the first three years of life.[60] *DC:0-3R* is a complement to *The Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (*DSM-III-R*) and the *International Classification of Diseases of the World Health Organization* (*ICD-9*). *DC:0-3R* is available from Zero to Three for $32.95.

### Preventive and/or Acute Care Services

For Medicaid/CHIP, use the appropriate Texas Health Steps codes (based on child's age and follow-up) per the *Texas Medicaid Provider Procedures Manual*, available at www.tmhp.com/Providers/default.aspx. In the 2007 edition, see pages 43-7 through 43-9. Or use the appropriate evaluation and management codes (shown below) per the *American Medical Association Current Procedural Terminology* (*CPT*), published yearly.

Below you will find the reimbursement rates from the 2007 Medicaid Physician Fee Schedule for children's services; you can access the Medicaid Fee Schedule at www.tmhp.com. Check this source annually, as the reimbursement rates may change.

60 Zero to Three. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (*DC:0-3R*). 2005.

The rates listed below apply only to traditional Medicaid and the Primary Care Case Management (PCCM) program. While Medicaid HMOs frequently use the Medicaid Fee Schedule to determine their rates, they may negotiate different amounts. Contact the HMOs operating in your service area for additional information. You can find a complete list of Medicaid HMOs at www.hhsc.state.tx.us.

**New Patient**

- 99201: "problem focused …" $28.87
- 99202: "expanded problem …" $45.56
- 99203: "detailed history …" $61.56
- 99204: "comprehensive … moderate" $90.07
- 99205: "… high complexity" $111.98

**Established Patient**

- 99211: "… minimal" $14.96
- 99212: "problem focused …" $25.04
- 99213: "expanded problem …" $37.64
- 99214: "detailed history … moderate" $52.86
- 99215: "… high complexity" $81.38

**Note:** *1) The physician should use the appropriate diagnostic code, i.e., well-child or acute condition, with these procedure codes; 2) THSteps codes must be billed under the provider's THSteps number; while 3) the CPT codes must be billed under the provider's Medicaid number. These services should be billed on separate CMS 1500 forms.*

## Consultative Services for Mental or Physical Health

These evaluation and management codes for consultative services for mental or physical health are from the *American Medical Association Current Procedural Terminology* (*CPT*), published yearly.

**New or Established Patients**

- 99241: "problem focused …" $44.87
- 99242: "expanded problem …" $70.25
- 99243: "detailed history …" $90.77
- 99244: "comprehensive … moderate" $127.28
- 99245: "… high complexity" $169.01

**Note:** *The physician should use a diagnostic code for a mental or behavioral health condition with these procedure codes. These services should be billed under the provider's Medicaid number on separate CMS 1500 forms.*

## Numbers at Glance for Providers

Following are key contact numbers for providers dealing with health care financing agencies or programs in Texas.

- Medicaid (TMHP): (800) 925-9126
- Medicare (Trailblazer): (877) 392-9865
- Texas Department of State Health Services: (512) 338-6569
- Texas Department of Insurance: (800) 252-3439
- Independent Review Organization (TDI): (888) 834-2476

## Common ICD-9 Codes

Based on the *DSM-IV* that psychiatrists and psychologists use, ICD-9 codes are provided for situations and manifestations. Below are the codes used for common mental health disorders seen in children and adolescents.

| Diagnosis | ICD-9 Code |
|---|---|
| Anxiety States, Unspecified | 300.00 |
| Other Mental Problems | V40.2 |
| Other Specified Counseling | V65.49 |
| Separation Anxiety Disorder | 309.21 |
| Attention-Deficit/Hyperactivity Disorder, Combined Type | 314.01 |
| Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type | 314.01 |
| Attention Deficit Disorder, Predominantly Inattentive Type | 314.00 |
| Unspecified Hyperkinetic Syndrome | 314.9 |
| Conduct Disorder, Adolescent Onset | 312.82 |
| Conduct Disorder, Childhood Onset | 312.81 |
| Depressive Disorder, Not Elsewhere Classified | 311 |
| Major Depressive Disorder, Single Episode | 296.2x |
| Major Depressive Disorder, Recurrent Episode | 296.3x |
| Educational Circumstances | V62.3 |
| Other Behavior Problems | V40.3 |
| Unspecified Delay in Development | 315.9 |
| Problems With Learning | V40.0 |
| Oppositional Disorder | 313.81 |
| Non-Dependent Abuse of Drugs | 305.xx |
| Alcohol Dependence Syndrome | 303.xx |
| Drug Dependence | 304.xx |
| Other Suspected Mental Condition | V71.09 |

## CPT Codes for Assessments and Tests

The following CPT codes are used for central nervous system assessments and tests.

| Activity | CPT Code* |
|---|---|
| Psychological testing with interpretation and report, per hour | 96100 |
| Assessment of aphasia with interpretation and report, per hour | 96105 |
| Limited developmental testing with interpretation and report | 96110 |
| Extended developmental testing (includes motor, language, social, adaptive, and/or cognitive functioning) with interpretation and report | 96111 |
| Neurobehavioral (clinical assessment of thinking, reasoning, and judgment, e.g., acquired knowledge, attention, memory, visual spatial abilities, language, planning) status exam with interpretation and report, per hour | 96116 |
| Neuropsychological testing with interpretation and report, per hour | 96118 |
| Neuropsychological testing with qualified health care professional interpretation and report, administered by technician, per hour | 96119 |
| Neuropsychological testing administered by a computer, with qualified health care professional interpretation and report | 96120 |

**Codes listed are based on the AMA's* CPT 2007*, a manual that is updated each Jan. 1.*

See Appendix F for clinical examples from the American Academy of Pediatrics' Developmental Screening/Testing Coding Fact Sheet for Primary Care Pediatricians.

# B. Reimbursement of Mental Health Services in Primary Care

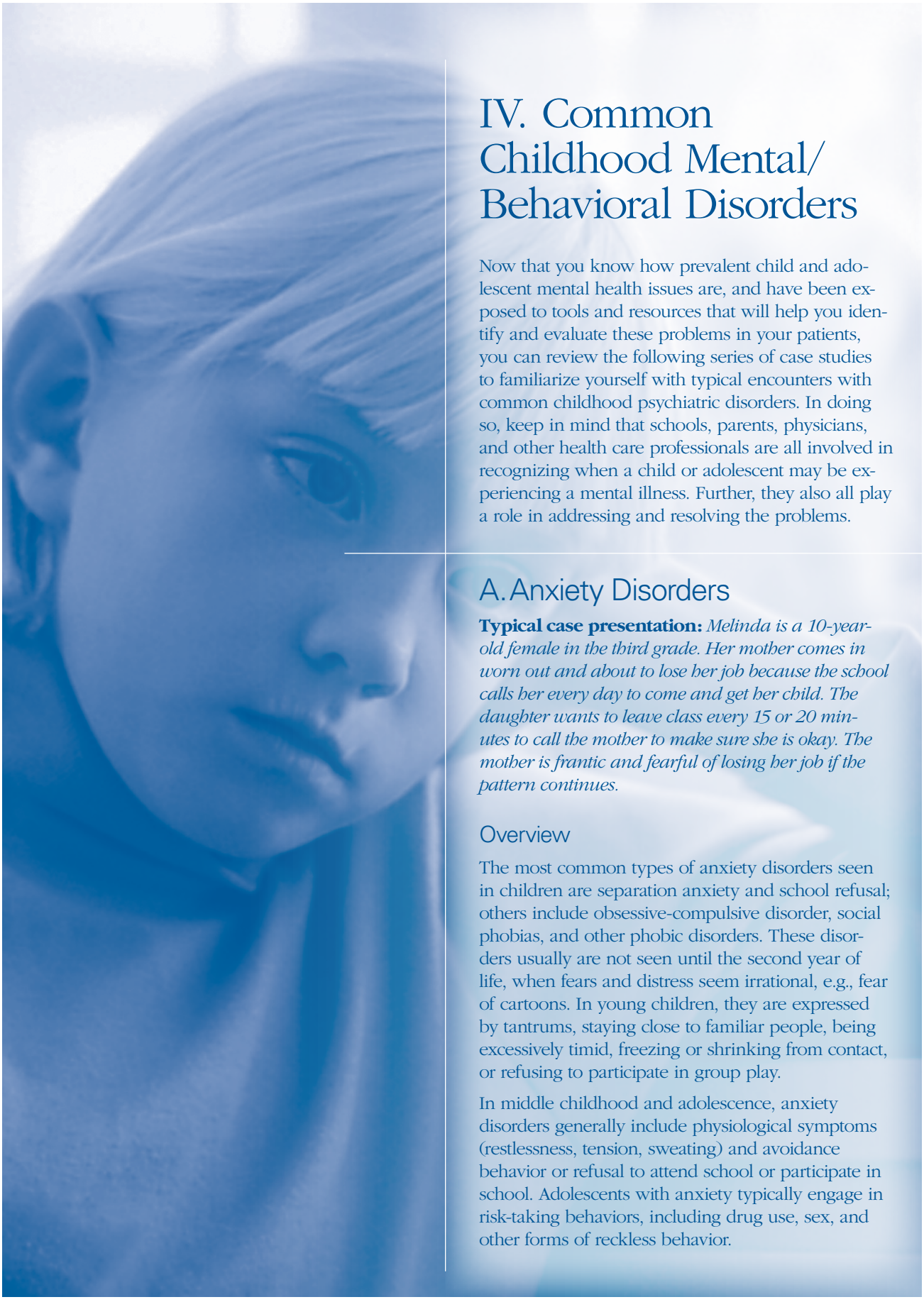
A number of mental health products recently have been developed under the joint federal response to the 2002 President's New Freedom Commission on Mental Health Report. This work was completed by a team composed of the Centers for Medicare & Medicaid Services, Health Resources and Services Administration (HRSA), and SAMHSA under the Federal Partners Mental Health Financing Issues Workgroup.

"Reimbursement of Mental Health Services in Primary Care Settings" highlights key action steps that help reduce existing barriers to reimbursement for mental health services in primary care settings. Recommendations focus on a variety of stakeholders, including primary care providers, state Medicaid officials, and others billing for mental health services in the public sector. The report was funded jointly by SAMHSA and HRSA, with the technical expertise of CMS. The report is available at http://download.ncadi.samhsa.gov/ken/pdf/SMA08-4324/SMA08-4324.pdf.

## Examples of State Billing Codes for Mental Health Services

SAMHSA has posted on its Web site a set of tools on mental health billing codes and Medicaid-by-provider type. This information should be of interest to safety net providers who want to work with their state Medicaid agencies to consider billing for specific mental health services by specific provider types. On the Web site you will find:

- Mental Health Codes and Payers, a summary table of which codes may be used by different providers of mental health services under both Medicare and Medicaid. You can find the table at http://hipaa.samhsa.gov/pdf/Table_MH_Codes_Payers.pdf.
- A document explaining how specific codes are used by different mental health providers to bill under Medicaid, including a table with the most frequent codes used to bill state Medicaid for mental health services, and a table listing billing codes used to bill state Medicaid by provider type. For more information, visit http://hipaa.samhsa.gov/hipaacodes2.htm.
- CMS has developed a Web site devoted to Medicaid and mental health services. See http://www.cms.hhs.gov/MHS/. HRSA also is developing a site.



# IV. Common Childhood Mental/ Behavioral Disorders

Now that you know how prevalent child and adolescent mental health issues are, and have been exposed to tools and resources that will help you identify and evaluate these problems in your patients, you can review the following series of case studies to familiarize yourself with typical encounters with common childhood psychiatric disorders. In doing so, keep in mind that schools, parents, physicians, and other health care professionals are all involved in recognizing when a child or adolescent may be experiencing a mental illness. Further, they also all play a role in addressing and resolving the problems.

## A. Anxiety Disorders

**Typical case presentation:** *Melinda is a 10-year-old female in the third grade. Her mother comes in worn out and about to lose her job because the school calls her every day to come and get her child. The daughter wants to leave class every 15 or 20 minutes to call the mother to make sure she is okay. The mother is frantic and fearful of losing her job if the pattern continues.*

### Overview

The most common types of anxiety disorders seen in children are separation anxiety and school refusal; others include obsessive-compulsive disorder, social phobias, and other phobic disorders. These disorders usually are not seen until the second year of life, when fears and distress seem irrational, e.g., fear of cartoons. In young children, they are expressed by tantrums, staying close to familiar people, being excessively timid, freezing or shrinking from contact, or refusing to participate in group play.

In middle childhood and adolescence, anxiety disorders generally include physiological symptoms (restlessness, tension, sweating) and avoidance behavior or refusal to attend school or participate in school. Adolescents with anxiety typically engage in risk-taking behaviors, including drug use, sex, and other forms of reckless behavior.

- "Mental Health: A Report of the Surgeon General" in 1999 indicates that some 13% of children and adolescents between the ages of 9 and 17 suffer from anxiety disorders.
- According to the Texas Department of Mental Health and Mental Retardation, anxiety disorders as a group are the most common disorders present in children and adolescents ... and the least diagnosed and treated.
- Anxiety disorders are often undiagnosed in children yet can cause great disability. Adults with these disorders frequently manifested the condition in childhood.
- Social phobia is common yet treatable. Often ignored in children, social phobia causes substantial disruption in school.

### History and Behaviors to Look For

1. Generalized anxiety disorder, 300.02: At least six months of persistent worry and anxiety across a multitude of domains/situations, including school, work, sports, and social performance. The child is over- or under-stimulated, unable to focus, and fluctuates between worry and anger or crying.
2. Separation anxiety, 309.21: Excessive worry about separation from home or caregivers; may include somatic symptoms (i.e., headache, vomiting, abdominal pain); lasting more than one month.
3. School refusal, 300.02: The child doesn't want to go to school because of excessive worry.
5. Panic disorder, 307.80, 300.01: Quite rare in elementary school-age children; seen more commonly in adolescents. A feeling of panic or doom is accompanied by a variety of somatic complaints, e.g., lightheadedness, sweating, palpitations.
6. Post-traumatic stress disorder following an overwhelming trauma, 309.81: Manifests as anxiety/panic; in infants — disordered sleep, excessive startle, and separation reaction.
7. Anxiety state, unspecified, 300.00: Similar to generalized; less than six months.
8. Social phobia, 300.23: Situational; strong adverse reactions; lasts more than four months.
9. Other isolated or simple phobias, 300.29.

### Diagnosis

Tools are available to assist you with evaluating for anxiety disorder. The Revised Children's Manifest Anxiety Scale (RCMAS) is a 37-item self-report questionnaire designed to be used with children in grades 1 through 12. There are norms for children at each age 6 to 17+, and separate norms for males and females. The instrument should take all but the youngest children well under 10 minutes to complete; scoring takes a minute or two. The scale is available through Western Psychological Services at (800) 648-8857 or www.wpspublish.com, under Products.

### Treatment or Referral

Counseling, education, and reassurance can be helpful for patients and parents, and anti-anxiety medications can help them deal with the problem. SSRI's have been found effective with some phobias. Cognitive behavioral therapy also may be useful in treatment as well. If there is no progress after three to four visits, consultation or referral may be needed.

## B. Attention-Deficit/Hyperactivity Disorder (ADHD)

**Typical case presentation:** *In kindergarten, 5-year-old Leroy is constantly squirming or getting out of his seat, interrupting, or talking in class. Other children consider him bossy and try to ignore him so they don't get in trouble. Teachers report that despite being very bright, his grades are lower because he frequently forgets to turn in homework or complete it. It turns out, Leroy was dismissed from his child care center because of disruptive behavior. Teachers and parents report much frustration as re-direction and the usual discipline techniques (time-out, removing privileges, etc.) seem to be ineffective.*

### Overview

With disorders such as ADHD, cases run a continuum from mild to severe. Two distinct sets of symptoms are involved: hyperactivity/impulsivity and inattention. They usually occur together, but one set can be present to qualify for a diagnosis (*DSM-IV-TR*).

In addition to being very fidgety and having a difficult time listening and following instructions, these children are easily distracted, frequently lose things, make careless mistakes, and/or forget to turn in homework. Eventually, impairment can be seen in all aspects of a child's life: academic, health, family life, and peers.

- ADHD is the most common psychiatric condition in children.
- About 5% of children are affected, with 3:1 prevalence in male to female.
- Boys commonly present with hyperactivity, while girls may be quiet daydreamers who are distracted easily.
- Hyperactivity becomes more fidgetiness and an internal restlessness as a child develops into a teenager/young adult.

- Approximately half of all children and adolescents with ADHD continue to manifest symptoms into adulthood that they have learned to manage.
- Despite an increase in stimulant use over the last 30+ years, the U.S. Surgeon General's 1999 report on mental health states that 56% of those diagnosed with ADHD receive no or inadequate treatment.

## History and Behaviors to Look For

The symptoms of hyperactivity typically are present before a child enters school and in some cases, can be recognized in infancy. In a classic case, the child is often irritable, a poor sleeper, and a particularly impatient toddler. Further, the cardinal symptoms of ADHD are commonly seen in normal healthy preschoolers. Usually, a severe case is spotted easily; the child is highly mobile, climbing up on the counter, standing on the chair, prying into drawers and cabinets. However, a mild case may not be as easily recognized in the office setting but only in an environment filled with stimulation. The physician must gather and consider information about the child's behavior in other settings. A phone conference or meeting with school personnel can provide you with valuable information.

## Diagnosis

Research shows us that one is less likely to over- or under-diagnose ADHD if the *DSM-IV* criteria are used as a guide. The core symptoms are listed below.

### Hyperactivity/Impulsivity

(Six of nine symptoms is positive.)

#### Hyperactivity

- Often fidgets with feet or hands or squirms in seat;
- Often leaves seat in classroom or other settings;
- Often runs about or climbs excessively in inappropriate situations (adolescents have feelings of restlessness);
- Often has difficulty playing or engaging in leisure activities quietly;
- Is often on the go or acts as if "driven by a motor"; and
- Often talks excessively.

#### Impulsivity

- Blurts out answers before questions are completed,
- Difficulty waiting for his or her turn, and
- Often interrupts or intrudes on others.

### Inattention

(Six of nine symptoms is positive.)

- Often fails to attend to details, makes careless mistakes;
- Often has difficulty sustaining attention in tasks or play activities;
- Often does not seem to listen when spoken to directly;
- Often does not follow through on instructions and fails to finish tasks;
- Often has difficulty organizing tasks and activities;
- Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental efforts;
- Often loses things necessary for tasks and activities;
- Often distracted by extraneous stimuli; and
- Often forgetful in daily activities.

In addition to the above symptoms, these criteria also **must** be present:

- The symptoms have to be present for at least six months;
- Symptoms need to be present in more than one setting (school, home, church, daycare);
- The symptoms occur in a greater degree than appropriate for age, gender, and cognitive ability of the child; and
- The symptoms affect the child's functioning at home, in school, or with peers.

If the above criteria are met and the child exhibits:

| Core ADHD Symptoms Present | Then | Diagnosis Is |
|---|---|---|
| 6 of 9 symptoms of hyperactivity/impulsivity | → | ADHD, hyperactive/impulsive type Subset only |
| 6 of 9 symptoms of inattentive subset only | → | ADHD, inattentive type |
| 6 of 9 symptoms of both H/I and I | → | ADHD, combined type |
| Less than 6 of 9 symptoms | → | ADHD NOS* |

**ADHD NOS is reserved for those children who do not meet full criteria for ADHD but are still impaired because of the present symptoms.*

## Tips

1. There is no definitive test for ADHD, but use of scales is very helpful.
2. A blinded placebo/medication trial using clinical scales can be revealing.
3. Symptoms may not be observable when patient is in highly structured or novel setting, engaged in interesting activity, receiving one-to-one attention, or overly anxious. (Patients learn to "hyper-focus" to control activity and concentration.)
4. Integration of the clinical presentation (*DSM-IV* criteria) with the functional status of the child leads to accurate diagnosis.
5. There are evidence-based guidelines and algorithms for the practitioner to refer to in the diagnosis and management of ADHD. (See table below for assessment of these guidelines.)
6. Most patients with ADHD have comorbidity (e.g., socio-emotional and learning problems) at some time in their childhood.

| Rating Scale and Internet Site | General Information |
|---|---|
| **ADHD Rating Scale**<br>http://elcaminopediatrics.com/forms_medrecords_adhdhome_pf.htm | An 18-item scale using *DSM-IV* criteria. Free access and download. |
| **Connors Rating Scale***<br>www.mhs.com | Parent, teacher, and self-report available. For pricing, visit www.mhs.com/conners/c3.aspx. |
| **SNAP-IV Rating Scale-revised**<br>www.adhd.net | *DSM-IV*-based scale contains criteria for ADHD and other *DSM-IV* diagnoses with free access and download with scoring instructions. |
| **Vanderbilt ADHD Diagnostic Scale***<br>www.psychiatrictimes.com/scales | Parent and teacher forms available for ADHD criteria and other diagnoses with free access and download. |

** Most commonly used in pediatrics.*

| Clinical Guideline | Information |
|---|---|
| ***Caring for Children with ADHD: A Resource Toolkit for Clinicians***<br>www.aap.org/pubserv/adhdtoolkit/ | Developed by AAP. Excellent tool kit with multiple forms and references for complete management of ADHD. Free for AAP members. |
| Pliszka S, et al. "The Texas Children's Medication Algorithm Project: Revision of the Algorithm for Pharmacotherapy of Attention-Deficit/Hyperactivity Disorder," *Journal of the American Academy of Child and Adolescent Psychiatry*, 45;6 (2006):642-657.<br>www.jaacap.com | Evidence-based consensus algorithm on pharmacological treatment of ADHD. Also access Web site: www.dshs.state.tx.us/mhprograms/adhdpage.shtm |

### Treatment/Management

The American Academy of Pediatrics has guidelines for treating ADHD:

1. Set specific, appropriate target goals to guide therapy.
2. Start medication and behavior therapy.
3. If treatment does not meet the target goals, evaluate the original diagnosis, the possible presence of other conditions, and how well the treatment plan has been implemented.
4. Systematic follow-up is important to regularly reassess target goals, results, and any side effects of medications. Gather information from parents, teachers, and the child.
5. All children and parents should receive education about the nature of the disorder and its natural history.
6. Appropriate school arrangements should be made; however, most children with ADHD don't receive educational placement unless their academics decline. In that event, ADHD should be addressed with special education counselors in the school. Other comorbid learning disabilities are common and should be addressed.

### Medication Treatment

- Stimulant treatment has been used for childhood behavioral disorders since the 1930s. Psycho-stimulants are highly effective for 85 to 90% of children with ADHD.
- As with any medication, the benefits of psycho-stimulants must be weighed against the risks of untreated ADHD and/or the side effects. **However, most of the side-effects (i.e., growth retardation, appetite suppression, cardiovascular symptoms, sleep issues) can be effectively managed without compromising effective dosing or having to change the medication. Effectiveness of second-line medications is not equivalent with stimulants**.
- While combined treatment consisting of medication management and behavioral therapy has best overall satisfaction with treatment, it does not yield statistically greater benefits than medication management alone.

### American Academy of Pediatrics ADHD Tool Kit

Attention-deficit/hyperactivity disorder is challenging for clinicians. AAP has developed a tool kit to help clinicians provide quality care for children with ADHD. Rooted in the AAP guidelines for the diagnosis and treatment of children with ADHD, this tool kit can provide the basis for a coordinated, integrated, and multidisciplinary system of care for ADHD patients. Purchase *Caring for Children with ADHD: A Resource Toolkit for Clinicians* at www.aap.org/pubserv/adhdtoolkit/; download additional forms at www.utmem.edu/pediatrics/general/clinical/behavior/index.php.

## C. Depressive Disorders in Children and Adolescents

**Typical case presentation:** *In hindsight, Melvin's behavior has changed drastically. Before he turned 12 years old, he played in the school band and looked forward to daily practice. Now, he is not practicing and doesn't seem interested in practice or events at all. He started missing class more and more, and became increasingly irritable and argumentative in the classroom on most days. His grades have gone down overall, and the teachers see that he is more distracted and has forgotten to turn in several homework projects. His social connectivity has changed, and he is more withdrawn. His classmates are wondering what is bugging him, and his parents are concerned about his erratic sleep and picky eating, which has resulted in a 10-pound weight loss.*

### Overview

Depression is a cause of significant morbidity in children and adolescents. Untreated depression can lead to suicide (12% mortality in adolescents), substance abuse, unplanned pregnancy, physical illness, exposure to more negative and dangerous life events, and poor social and academic functioning. It also is commonly associated with other comorbid psychiatric disorders like: anxiety disorders (55%), disruptive behavior disorders (45%), ADHD (40%), dysthymia (55%), and substance abuse (25%).

Current prevalence for major depression is 6% in adolescents and 2.5% in children. A larger number of adolescents, around 28.3% describe symptoms of depression that may lead to impairment in functioning. Children in foster care are up to 10 times more likely to suffer from depression or other mental illness.

The median duration of an episode is approximately seven to nine months. Although 90% of cases remit after one to two years, the relapse rate is high. Approximately 6 to 10% of cases become chronic. Risk factors for chronicity include greater severity, comorbid disease, parental psychopathology, negative life events, personality disorder, and poor psychosocial functioning.

### Diagnosis

The symptoms of depression must cause significant distress or impairment and represent a change from

previous functioning. The diagnosis is based on the following *DSM-IV-TR* criteria.

At least *two weeks* of depressed mood (irritable mood in children); and/or five or more of the following:

**S** **S**leep disturbance

**I** Anhedonia (or decreased **I**nterest)

**G** Inappropriate feelings of **G**uilt or worthlessness

**E** Loss of **E**nergy, or fatigue

**C** Decreased **C**oncentration

**A** **A**ppetite or weight disturbance

**P** **P**sychomotor agitation or retardation

**S** Hopelessness or **S**uicidal ideation

"**SIG: E CAPS**" is a mnemonic device to remember the actual DSM-IV-TR criteria for major depression.

Other factors include:

- Female gender,
- Negative view of self, and
- Chaotic families (current parental psychopathology causes slower recovery time, lower level of functioning, and slower response to treatment).

The U.S. Preventive Services Task Force does not recommend routine periodic screening. However, presence of any of the above risk factors warrants a higher level of clinical suspicion, and physicians should give screening tests to these high-risk patients. Such tests include Pediatric Symptom Checklist (PSC) (see Appendix A); Patient Health Questionnaire (PHQ-9M) (see Appendix A); and Moods and Feelings Questionnaire (MFQ) (see Depression section of Appendix G).

## Classification of Depressive Symptoms

| **Major Depressive Disorder** | **Dysthymia** | **Depression NOS** |
|---|---|---|
| 4 of 8 DSM-IV Criteria | or 3 DSM-IV criteria with depressed mood >1 year | 2 or 3 of DSM-IV Criteria |
| Mood must be depressed or irritable and/or anhedonia present for 2 weeks | | |
| Symptoms represent functional change from baseline | | |

## Clinical Presentation

| **Children usually present with:** | **Adolescents usually present with:** |
|---|---|
| Anxiety (phobia, separation anxiety) | Appetite and/or sleep changes |
| Somatic complaints (head/stomach aches) | Delusions |
| Auditory hallucinations | Depressed mood |
| Temper tantrums | Worthlessness/Hopelessness |
| Irritability | Guilt |
| Aggressive behaviors | Suicidal ideation/ intent |
| Declining grades at school | Declining academic and social functioning |

There are three major factors that help identify children and adolescents at risk for depressive disorders:

- Parental depression,
- Prior depressive symptoms, and
- Prior depressive disorder (45 to 70% recurrence in three to seven years).

## Treatment

Treatment works best if the physician uses a multimodal approach from those listed below. The emphasis the physician places on each treatment area will vary according to the severity of the depressive disorder, patient-parent preference, financial resources, and comfort level of the primary care doctor. Referrals to mental health providers are based on the primary care physician's comfort level.

### Somatic Treatment

Selective serotonin reuptake inhibitors (SSRIs) and newer antidepressant agents (e.g., Wellbutrin, Remeron, Effexor, Cymbalta) are the standard of treatment. More severe forms of depression require medication and psychotherapy. Antidepressants may be started alone until the child is amenable to psychotherapy, or they can be combined from the start of treatment. Data show that SSRIs as a group are the safest to use in children and adolescents. Fluoxetine (Prozac) and sertraline (Zoloft, Lustral) are FDA approved for treating anxiety and depression in the pediatric population.

Common side effects of SSRIs include headache, nausea, diarrhea, sleep changes, weight changes, sexual dysfunction, and vivid dreams and nightmares.

"Behavior activation" maybe observed when first starting an SSRI; it presents as an increase in impulsivity, irritability, mood lability, and vocalization of suicidal thoughts. Standard of care includes educating the child and family about potential side effects and keeping close watch and follow-up visits in the first few weeks of initiating the medication. Decreasing the dose may help with the activation seen with the SSRIs.

### Acute Treatment

Start with an SSRI (fluoxetine has the most evidence for success). If there is no change in two weeks, increase the dosage. If no change occurs in another two weeks, switch to another SSRI. After two SSRI failures, switch to a non SSRI bupropion) or a combined serotonin/norepinephrine reuptake blocker (venalfaxine or duloxetine). If monotherapy with these agents fails, consider an augmentation strategy. (See CMAP depression guidelines in Appendix A: Tools for Your Practice.) Refer to or consult a pediatric psychiatrist if you are uncomfortable with the child's response to treatment.

### Maintenance Treatment

To minimize chances of relapse, continue the same dose at which the patient achieved remission for nine to 12 months. Then slowly taper off medication. If symptoms return, titrate patient back to the previous efficacious dose.

### Psychotherapeutic Intervention

1. Relapse Prevention: Educate the patient and family about the impact of noncompliance with medications, factors that may precipitate relapse, and how to recognize relapse symptoms (such as sleep/appetite changes, pervasive low mood, decreasing grades).
2. Individual Psychotherapy: Cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) have the most evidence of efficacy. Three to six sessions of brief supportive therapy are immensely useful in uncomplicated depression with mild psychosocial impairment.
3. Social and Family Functioning: Mood disorders significantly impact social, family, and developmental functioning. Parents should consider themselves collaborators of care and help formulate an individualized plan that is directed at improved communication and problem-solving skills.
4. Academic and Occupational Functioning: These interventions help promote long-term academic growth. School consultation for children and early teenagers, and occupational support for older adolescents must be an integral part of a comprehensive treatment plan.
5. Community Consultation: Patients and families often benefit from participation in community support programs like the YMCA and Big Brothers Big Sisters.

## D. Bipolar Disorder

**Brief Case Presentation:** *Ruben is 14 years old. Last year, he became depressed for reasons that never were clear and talked of killing himself by walking into highway traffic. After a three-month wait, he was seen by a psychiatrist in a nearby urban community who believed Ruben was no longer suicidal, but wanted him to return for evaluation and therapy for a possible underlying depression. His parents could not afford the costs and the time off for travel and appointments. Until this spring, Ruben did well in school but had ongoing discipline problems. Last week, he suddenly had major arguments with authorities at school and his parents at home. He ran away from home, trying to get his girlfriend to go with him and get married. He showed up at an urban emergency room acutely disoriented and psychotic.*

### Overview

The number of children and adolescents receiving the diagnosis of bipolar disorder (BD) has increased remarkably over the past decade in the United States. Much controversy exists about what constitutes this diagnosis. Although data for prevalence studies are limited, the prevalence of BD in adolescents is less than 1%, the same as adults, and is rare in preadolescence.[61] The presentation of BD in youth, especially children, is often considered atypical (based on periods of elated, irritable, or expansive moods), compared with the classic adult disorder (characterized by distinct phases of mania and depression). Children receiving the diagnosis of bipolar

61 Geller B, Luby J. "Child and Adolescent Bipolar Disorder: A Review of the Past 10 Years," *Journal of American Academy of Child Psychiatry*, 36;9 (September 1997):1168-1176. www.jaacap.com

disorder in the community setting typically present with fluctuations in mood and behaviors, often associated with disruptive behavior disorders. Because this is a difficult disorder to diagnose and treat, if you suspect BD, you should refer the patient to a child psychiatrist for evaluation and initiation of treatment.

**The best method to diagnose bipolar disorder in preschool children and the boundaries of the diagnosis remain a source of debate even among experts in the childhood mood disorder scheme. Therefore , take particular caution before applying this diagnosis in preschool children.** Preschool children who present with mood and behavioral concerns need to be carefully assessed for other contributing factors, including developmental disorders, psychosocial stressors, parent-child relationship conflicts, and temperamental difficulties. It is particularly important with preschoolers that intervention strategies address environmental, developmental, temperamental, and social factors that may relate to symptom presentation.

## History/Behaviors to Look For

Classic mania in children presents as:

- Euphoria (e.g., dancing around the home after being expelled from school).
- Grandiosity (e.g., instructing the teacher about educational policy; going to the principal saying that the teacher should be fired for incompetence).
- Decreased need for sleep (e.g., 7-year-old girl arriving at a neighbor's house ready to play at 7 am).
- Racing thoughts and flight of ideas (e.g., girl pointing to her head saying "I need a spotlight up there.").
- Incessant talking and bizarre behavior.

**Younger children exhibit more agitation, mood lability, dysphoria, and hypomania.**

Adolescents may wear flamboyant clothing, drive recklessly, engage in buying sprees and sexual indiscretions. Behavior is often markedly labile and erratic, rather than persistent. Irritability, belligerence, and mixed manic-depressive features are more common than euphoria. School truancy and failure, antisocial behaviors, and illicit drug use/experimentation maybe present. Adolescents are more likely to have comorbid conduct, anxiety, and substance abuse problems than youth with unipolar depression.

As many as 20% of youth with depression may go on to develop mania and rapid cycling.

## Diagnosis

### Bipolar I Disorder

- The occurrence of a manic (or mixed) episode with duration of at least seven days (unless hospitalization is required).
- Episodes of depression are not required, but most patients experience major or minor episodes of depression over their life span.
- The episodes represent a significant departure from the individual's baseline function.
    - o **Manic Episode**
      Abnormally expansive and persistently elevated mood lasting seven days.
    - o **Mixed Episode**
      A period lasting seven days or more in which symptoms for both a manic and depressive episode are met.

### Bipolar II Disorder

The occurrence of periods of major depression and hypomania (episodes lasting at least four days) but no full manic or mixed manic episodes.

### Bipolar Disorder NOS

This term is used for cases that do not meet full criteria for other bipolar diagnoses.

### Rapid Cycling

The occurrence of at least four mood episodes in one year.

## Treatment/Management

Treatment for bipolar disorder is controversial, partly because the disease is difficult to diagnose and difficult to treat. Treatment should be provided to control and eliminate acute symptoms and to reduce the chance for relapse. The side effects of medications used to treat bipolar disorder are significant. Patients and families should be educated about what to expect. Getting patients and families to comply with treatment may be quite difficult because of the denial and paranoia associated with mania.

- Antipsychotic medication can cause major side effects, and patients on these drugs should be monitored closely. Not only can antidepressants cause manic switching, but there also is some concern that they cause rapid cycling and perhaps a more treatment-resistant course of disease.
- Patients should be educated about the disease and its natural history.
- Counseling should cover the impact of noncompliance, how to identify a relapse, and how to address a relapse.

Be sure to underline the need for family support with this particular disorder. Families should seek counseling and support, particularly for siblings or members who have been frightened or harmed by the patient's episodes. Having bipolar disorder is a terrifying experi-

ence, as is having a child with the disease; parents and caregivers may harbor guilt. Family members may need the services of a mental health professional.

### Somatic Treatment

1. For mania in well-defined *DSM-IV-TR* bipolar I disorder, pharmacotherapy is the primary treatment.
    - Lithium is approved down to age 12 years for acute mania and maintenance therapy.
    - Aripiprazole, valproate, olanzapine, risperidone, quetiapine, and ziprasidone are all approved for acute mania in adults. Aripiprazole and risperidone have been approved for children with bipolar disorder.
    - Both lamotrigine and olanzapine are approved for maintenance therapy in adults.
    - The combination of olanzapine-fluoxetine is approved for bipolar depression in adults.
    - Antidepressants (SSRIs or nontricyclics) may be useful adjuncts for depression as long as the patient is also taking at least one mood stabilizer. They may destabilize the mood, or incite a manic episode.
2. Most youth with bipolar I disorder will require ongoing medication therapy to prevent relapse; some individuals will need lifelong treatment. If, however, the initial diagnosis of bipolar was provisional or atypical, be prepared to revise or inactivate the diagnosis if the child's clinical course changes.
3. Psychopharmacological interventions require baseline and follow-up symptom, side effect (including the patient's weight), and laboratory monitoring as indicated.

### Psychotherapeutic Intervention

Psychotherapeutic interventions are an important component of a comprehensive treatment plan for early onset bipolar disorder.

1. Psychoeducational Therapy: School consultation is usually necessary, both to address the nature of the patient's unique manifestations of the disorder and the frequent comorbid conditions of ADHD, conduct problems, and learning disabilities. For late adolescents, the same issues need to be addressed for vocational and occupational development.
2. Individual Psychotherapy: These support psychological development, skill-building, and close monitoring of symptoms and progress.
3. Social and Family Functioning: Bipolar disorder significantly impacts social, family, academic, and developmental functioning. Psychosocial interventions are needed to enhance family and social relationships, and include therapies directed at communication and problem-solving skills.
4. Community Consultation: Consultation may be needed with other involved community resources, juvenile justice, and/or social welfare programs. Some patients may need foster care or residential services. Finally, patients and families often benefit from participating in community support groups and advocacy programs.

## E. Conduct Disorder

**Typical case presentation:** *Maybelle is a 13-year-old female. She recently was arrested at her school by the city police for selling prescription medications to her peers, and at this time is awaiting a juvenile court hearing. In fact, this was the second time she was caught. The first time was managed with the school principal, her parents, and juvenile probation six months earlier. An evaluation by a school counselor at that time revealed Maybelle was sexually active, used alcohol and drugs regularly, and for awhile was an active member of a local gang, THE SKUNKS. Even in her early elementary school years, Maybelle could not follow rules, frequently got into physical fights with her peers, and had great difficulty academically. Her father, who is alcoholic, is serving a prison term for repeated arrests for selling methamphetamines. Her mother is now in her local family physician's office in tears telling this story and asking for some kind of help for herself and her daughter. She doesn't know where else to turn.*

### Overview

The conduct-disordered adolescent acts without remorse, and does not care about rules, social norms, or the rights of others. This includes adolescents involved in gangs and drug dealing; they often are aggressive, violent, and unconcerned about punishment. If left untreated, the conduct-disordered adolescent will likely be headed for juvenile detention, then on to prison.

Early expressions of the disorder are seen in preschoolers. Recently, high expulsion rates (up to 20%) from child care and preschools have been attributed to early symptoms of oppositional defiant disorder and conduct disorder. Many teachers identify these children in kindergarten through third grade as doomed to school failure; however interventions for parents and in the schools are not available, and the children are "left behind" by repeating years without addressing needed socio-emotional skills.

- Prevalence ranges between 6 and 16% for boys depending on population and criteria used in studies.
- Prevalence ranges between 2 and 9% for girls, depending on population and criteria used in studies.
- Arrest rates may indicate higher prevalence.
- Comorbidities common: ADHD, mood disorders,

alcohol/drug abuse, thought and dissociative disorders, learning disabilities.

### History/Behaviors to Look For

Children with oppositional defiant disorder (ODD), especially when combined with ADHD, are at high risk for conduct disorder. Often the parents of these children have the same problems — substance abuse/addiction, violence, and poor education and employment history. This frequently results in failure to address the problems early when remediation is more likely to be successful.

Early onset usually results in violent physical and verbal outbursts that are inappropriate. Onset in adolescence may result in less aggressive behaviors characterized by repetitive dishonestly, cheating, theft, truancy, and destruction of property, behaviors that violate basic social norms and rules. There usually is an absence of remorse. The behaviors are repetitive despite admonishment and discipline.

### Diagnosis

Conduct disorder is diagnosed by using the same techniques used to identify other psychiatric disorders in children. Assessment should include talking with the child and the parents or caregivers, and reviewing the medical and social history.

- Onset may be as early as 5 or 6 years of age but is usually in late childhood or early adolescence.
- Consideration should be given to comorbidities.

1. Conduct disorder childhood onset, 312.81; conduct disorder adolescent onset, 312.82
    - Repetitive, persistent disrespect of the basic rights of others;
    - Violating social norms or rules;
    - Harming others;
    - Adolescents display delinquent, aggressive behavior, including deviant sexual behavior, use of illegal drugs, recklessness, and serious academic problems.
2. Adjustment disorder with disturbance of conduct, 309.3; disruptive behavior disorder, 312.9.

Screening scales for both parents and school personnel may help determine whether a full diagnostic evaluation is appropriate, particularly with doubting parents: (See Achenbach Child Behavioral Checklists and Conner's Rating Scales in Appendix A.)

### Treatment/Management

Multimodal psychosocial treatment is the mainstay of conduct disorder treatment, along with treating the comorbidities. Treatment of comorbidities is paramount. You must address ADHD, anxiety, depression, and substance abuse in patients with conduct disorder. Like ADHD and other conditions associated with children and adolescents, conduct disorder is a continuum, with cases appearing in a range from mild to moderate to severe.

- Treating comorbid ADHD is the most well-established psychopharmacological intervention, and improvement in conduct disorder symptoms usually accompanies resolution of the ADHD symptoms.
- Lithium, valproate, and second-generation antipsychotics have been shown to improve impulsive, explosive aggression even in the absence of bipolar disorder. Close monitoring of side effects, particularly weight gain and extrapyramdial symptoms, is important.
- Behavior modification plans should target unwanted behaviors with clear, consistent direction and rewards based on privileges. Parents and caregivers should be willing to focus on a couple of behaviors at first, and agree to ignore others until they succeed.
- There is some evidence of success with the following interventions:
    - Parent Management Training (PMT);
    - Cognitive Problem Solving Skills (PSST);
    - Multi-Systemic Therapy (MST); and
    - Community-based interventions: Mentoring, tutoring, Big Brothers Big Sisters, boys and girls clubs, YMCAs/YWCAs, asset acquisition-based programs.
- Success is *not* likely if comorbid conditions are not first addressed successfully.

## F. Substance Abuse

**Typical case presentation:** *Scott is a 14-year-old in the eighth grade. Since starting school three months ago, he has gotten more argumentative and reluctant to spend time with the family. His clothing has changed, his hygiene has changed, and he is now more openly defiant about vehicle or phone rules. He has developed a new set of friends this year, and they are sneaking out at night two to three times each week. His parent has found cigarettes and smelled smoke on Scott, and has noticed liquor disappearing from the cabinet in small but definite amounts. Although he has been honest and trustworthy up until this year, he has been caught twice "twisting the truth." The school called today wondering if Scott was sick and had an excused absence.*

## Overview

The U.S. Surgeon General's Report on Mental Health found that 2% of children between the ages of 9 and 17 experience major substance abuse problems. The AMA's Guidelines for Adolescent Preventive Services (GAPS: see Appendix A) recommends patient education, anticipatory guidance, and early preventive intervention strategies to reduce adolescent substance abuse. Recommendations include:

- Begin screenings during prenatal visits and continue with developmentally appropriate information as the child/family matures.
- Conduct screening inquiries for all schoolchildren and adolescents.
- Routinely ascertain risk factors, including a family history of alcoholism.

Eighty percent of teen deaths are due to accidents, homicide, and suicide. Fifty percent of those events involved alcohol and/or drugs. The prevalence of regular alcohol and drug use (at least once in the past month) for youth in America is 9% according to data from the Substance Abuse and Mental Health Services Administration (SAMHSA). Higher rates have been noted by the CDC's Youth Risk Behavior Survey.

Remember that possession and use of tobacco (before age 18), alcohol (before age 21), and illicit drugs are illegal and can be prosecuted.

## History/Behaviors to Look For

The cardinal sign of substance abuse in youth is a change in usual basic behaviors over a two- to four-month period. These symptoms can manifest as:

- Increased irritability, loss of patience, manners;
- Dishonesty;
- Unaccountable periods of time;
- Fall in performance (academics, sports, hobbies);
- Change in appetite or eating and sleeping; and
- New peers, new "looks."

### Risks/Assets

- Genetic, early age of onset, using peers/parental monitoring, abstinent peers.
- Family history may be useful. A history of substance abuse in parents and siblings — current or in recovery — substantially increases likelihood.
- Comorbid conditions very common (40 to 90% of youth populations studied):
    - o Disruptive disorders,
    - o Mood disorders, and
    - o Anxiety disorders.

## Screening and Diagnosis

**CRAFFT** cards are specifically intended as a substance abuse screening test for adolescents, and can be handed out with well-child and sports exams. Reliability is increased if you defuse the "charge" of the issue. For example, you might say, "Most of your peers are exposed or are already using alcohol. Here is a questionnaire card to help you determine if this is an issue for you." (See Appendix B: Screening Tools Available for Copying for a replicable copy.)

**C** Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

**R** Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

**A** Do you ever use alcohol or drugs while you are by yourself, ALONE?

**F** Do you ever FORGET things you did while using alcohol or drugs?

**F** Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

**T** Have you ever gotten into TROUBLE while you were using alcohol or drugs?

**Interpretation:** Two or more "yes" answers suggest a serious problem.

## A Note on Drug Testing

You may want to consider a policy for drug testing in your practice, in case the topic comes up or a parent requests it. While you want to be deliberate about deciding to use drug testing with a patient, there are several possible ways that you can discuss substance use or abuse with children and adolescents, in the context of drug testing.

For example, if a parent or teacher has expressed a substance use concern to you, tell the child or adolescent that there are people who are worried about him or her and things he or she might be doing. Ask what the child or adolescent thinks a drug test would show. It may turn out that the potential for drug testing by a physician becomes an excuse for a child or adolescent to resist peer pressure.

If parents come to you requesting drug testing for their child, talk to the parents about how they would use the information. Only in rare cases would you consider having a patient drug tested without the patient's knowledge.

### ICD-9 Codes for Diagnosis

- Non-dependent abuse of drugs, 305.xxx
- Drug dependence, 304.xxx
- Alcohol dependence syndrome, 303.xxx

The following are criteria to help determine dependence:

- Substance(s) taken often, in large quantities, and over a longer period of time than intended.
- Substance use takes up a significant portion of time and may interfere with other activities.
- Recurrent substance abuse results in failure to fulfill major obligations at home and school.
- Substance(s) is used in hazardous situations, resulting in legal problems.
- The pattern continues despite persistent social and interpersonal problems.

### Treatment

Treatment for substance abuse can occur in a variety of settings, in many different forms, and for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence. When chronic relapsing adolescents reach a point where they want to abstain, reaching a "bottom," 12-step programs (i.e., AA and NA) may be quite helpful in sustaining recovery.

For statewide treatment referral information, call toll free (877) 9-NO DRUG [(877) 966-3784].

It is important to distinguish developmental stages of substance use patterns for management.

| Developmental Stage | Management |
|---|---|
| 1. Experimental | Education |
| 2. Recreational | Education and counseling |
| 3. Misuse | Education, counseling, and family therapy (parent management training) |
| 4. Substance abuse disorder | 12-Step Approaches<br>Multi-System Therapy<br>Motivational Training |
| 5. Substance dependent disorder | Same as #4, but precede with detoxification |

There are school and community evidence-based prevention programs that have demonstrated the delay in onset of substance abuse and the severity of its consequences. These include:

- Project SMART[62]
- Life Skills Training[63]
- Project STAR[64]
- ATLAS (steroids)[65]

Physicians working with their community's schools can have a powerful impact on implementing evidenced-based programs and reducing the prevalence and consequences of these diseases.

## G. American Academy of Child and Adolescent Psychiatry (AACAP) Recommendations

AACAP has published more than 17 practice parameters for clinical practice, which appear in the *Journal of the American Academy of Child and Adolescent Psychiatry.* Summaries of many of these parameters are available for free at www.aacap.org/cs/root/publication_store/practice_parameters_and_guidelines. According to the AACAP, "the Practice Parameters are designed to assist clinicians in providing high quality assessment and treatment that is consistent with the best available scientific evidence and clinical consensus. The Practice Parameters describe generally accepted practices, but are not intended to define a standard of care, nor should they be deemed inclusive of all proper methods of care or exclusive of other legitimate methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a patient and family must be made by the clinician in light of all of the clinical evidence presented by the patient and family, the diagnostic and treatment options available, and available resources."

62 Hansen WB, Johnson CA, Flay BR, Graham JW, Sobel JL. "Affective and Social Influences Approaches to the Prevention of Multiple Substance Abuse Among Seventh Grade Students: Results From Project SMART," *Preventive Medicine*, Vol. 17 (1988):1-20.

63 Botvin GJ, Baker E, Dusenbury L, Botvin EM, Diaz T. "Long-term Follow-Up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-Class Population," *JAMA*, Vol. 273 (1995):1106-1112.

64 Pentz MA, MacKinnon DP, Dwyer JH, Wang EYI, Hansen WB, Flay BR, Johnson CA. "Longitudinal Effects of the Midwestern Prevention Project (MPP) on Regular and Experimental Smoking in Adolescents," *Preventive Medicine*, 18 (1989):304-321.

65 Goldberg L, Elliot D, Clarke GN, MacKinnon DP, Moe E, Zoref L, Green C, Wolf SL, Greffrath E, Miller DJ, Lapin A. "Effects of a Multi dimensional Anabolic Steroid Prevention Intervention: The Adolescents Training and Learning to Avoid Steroids (ATLAS) program," *JAMA*, 276;19 (1996):1555-1562.


# V. Barriers to Prevention and Treatment and Consequences of Untreated Mental Illness

No discussion of the prevalence of mental illness among youth would be complete without a review of the barriers to recognition, evaluation, and treatment of these illnesses. Many families face serious barriers to receiving mental health care, such as lack of appropriate mental health specialists in their area or inability to pay for psychiatric evaluation and care. Because of these barriers, many patients will rely on their primary care physician to recognize that a problem exists, evaluate it, and work with a team of mental health professionals and others to treat the problem as efficiently and effectively as possible.

## A. Barriers

### Decreased Access

As a practicing physician, you are no doubt aware of the challenges that exist in today's health care system that make it difficult for you to deliver optimal care to your patients. Managed health care has segregated and minimized access to mental health care, and quality mental health care services in Texas are less available and more difficult to access than ever before. Due to insurance trends toward outpatient care, Texas hospitals have cut 4,826 psychiatric beds since 1996, a 39% drop, according to a Texas Society of Psychiatric Physicians (TSPP) survey. [66]

The TSPP survey also revealed that access to specialist care in child psychiatry, inpatient and outpatient services, substance dependence treatment, and psychotropic medication has decreased over a five-year

66 Santos GD. "A Crisis of Capacity." *Texas Society of Psychiatric Physicians Newsletter*. February/March 2002.

period, especially in rural and inner-city communities. Ideally, child psychiatrists and appropriately trained child psychologists would serve as the primary care physician's referral resource for in-depth diagnosis and treatment of children with mental health problems. Even the availability of other competent mental health professionals is limited because of a lack of sufficient geographic distribution and inadequate numbers. In 2006, 184 counties (72%) were designated as mental health professional shortage areas.

## Lack of Insurance Parity

While federal law requires insurance parity for mental health care, most health plans do not comply. New legislation is before Congress to close loopholes and weaknesses. Specific systematic problems include:

- Limits on inpatient and outpatient visits,
- Restrictive pharmacy formularies,
- Inadequate drug and alcohol dependence/abuse programs, and
- Limited or nonexistent preventive services.

A recent report in 2008 detailed the problems of reimbursement in primary care settings and suggested a number of remedies at the state and federal level for public insurers (i.e., Medicaid and SCHIP). Advocacy is needed to ensure these recommendations are implemented at the state level.[67]

However, thanks in part to Texas Medical Association efforts, the Children's Health Insurance Program (CHIP) includes substantial mental health benefits. In addition, Medicaid and CHIP reimbursements were increased for psychiatrists in 1999 and for primary care physicians in 2001 after TMA worked to make the case that fee increases were critical to maintaining the provider base. Unfortunately, most of these gains were lost in the 2003 legislative session.

As a result of *Frew vs. Hawkins* and TMA advocacy, in 2007, the legislature increased funding for child-related services by 25% (total funding increased by 25% not 25% per CPT code). New payment rates for physicians began September 2007. For the complete Medicaid physician fee schedule, go to www.tmhp.com.

## Lack of Resources, Integrated Services, and Funding

While about half of mental and behavioral health problems can be managed successfully in primary care settings with mental health professional backup, treatment for some mental illness requires long-term commitment from the health care community, as well as support services for parents, guardians, and school personnel. Such treatment may work, but it often is limited to pilot projects, is poorly funded, and lacks statewide organization. Also lacking is a team approach to community-based service delivery programs using counselors and case management models. Such programs involve a "wrap-around" approach that provides patients with continuity of care across agencies and provider networks that are involved in their care.

> Of the 15 most populous states in the country, Texas spends the least amount on mental health treatment. Texas ranked 47th in per-capita spending by state mental health treatment.[68]
> ($39 v. $92)
> 2001-2004

Recently, the Hogg Foundation launched a $3 million project (seven sites) using a variety of integrated health models. One approach uses clinical managers in primary care practices monitoring the treatment of children with supervision provided by an off-site psychiatrist using electronic records. At this point in time, we just do not know which of these various delivery models provides "best practice" or the most cost-efficient approach.

The legislative funding cutbacks to Medicaid and the Children's Health Insurance Program in 2003 reduced preventive and mental health services to more than 150,000 children between 2004 and 2007. As a result of the *Frew vs. Hawkins* lawsuit settlement and new funding from the Texas Legislature in 2007, it is hoped that about 100,000 children will regain access to public medical insurance. The legislature has set aside $150 million to more effectively render the Texas Health Steps program. It is likely this will positively impact the manner and reimbursement levels for children's mental health services. Ten model practice sites using an integrated approach will be funded.

## Stigmatization and Stress on Families

The stigma surrounding mental disorders often is as damaging as the diseases themselves. Many parents will not accept a diagnosis of a mental or behavioral disorder. The National Alliance for the Mentally Ill (NAMI) specifically identified that almost 50% of families with mentally ill children were the object of discrimination from neighbors and the community. Further, out of fear

67 Kautz C, et al. Reimbursement of Mental Health Services in Primary Care Settings. (HHS Pub. No. SMA-08-4324). Rockville, MD: Center for Mental Health Services Administration, 2008.

68 Texans Care for Children. "Children's Mental Health." *Children's Campaign for the Decade: A Report on the Agenda for the Decade — 2007 Update.* www.texanscareforchildren.org

that the child will suffer from being "labeled" as mentally ill, parents frequently refuse or avoid getting services. They may be uncomfortable and in denial when their physicians discuss the possibility of a diagnosis of mental illness, and often parents resist sharing such information with schools or community programs.

At the same time, confidentiality concerns certainly are valid. Although the Health Insurance Portability and Accountability Act (HIPAA)[69] and Family Educational Rights and Privacy Act (FERPA)[70] provide some degree of protection, informal local "networks" and gossip all too often are the rule, not the exception. Parents do have a right not to pass on this information, and practitioners do need to be sensitive to these issues.

According to FERPA, the number of children eligible for public mental health services who actually received services:[71]

- 2001: 25% (37,404)
- 2004: 15% (22,499)

According to *Families on the Brink*, a 1999 study conducted by NAMI:

- Nearly half of respondents felt shunned by neighbors and friends because of their children's illnesses, and half said they were blamed for their children's conditions.
- In 55% of the families, one of the parents had to change jobs or quit to take care of the ailing offspring.
- 59% said they felt like they were pushed to the breaking point.
- 70% reported that their marriages had been severely stressed by caring for a sick child.

Physicians need to readily acknowledge the burdens on families and provide support to parents and siblings as needed.

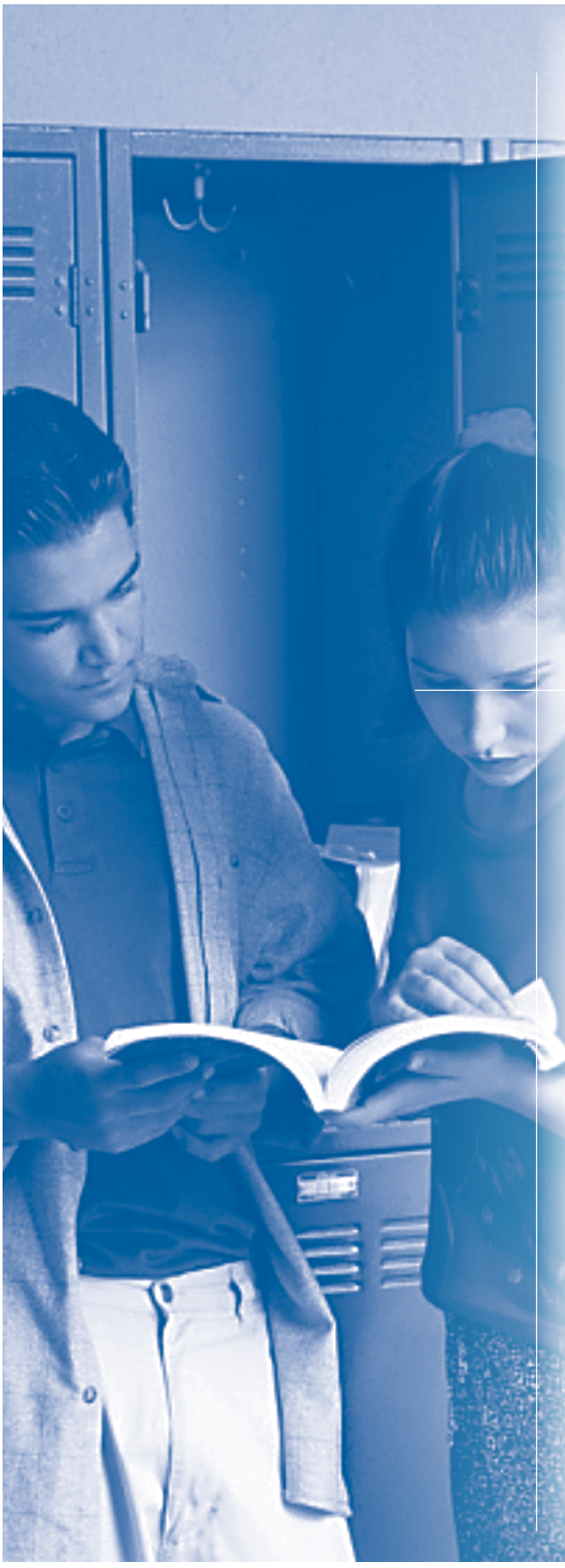
## B. Consequences of Untreated Mental Illness

Left untreated or uncontrolled, mental illness among children and adolescents can lead to hospitalizations, incapacitation, disability, incarceration, and even death through suicide and murder. If ignored, these disorders can lead to substance abuse, violence, and other antisocial behaviors currently left to the confines of the juvenile justice system, which is not equipped nor funded to address the issues.

Mental Health American of Texas (MHAT) estimated the total cost of mental illness in 2003 in Texas to be $16.6 billion.[72] Children whose mental illness goes untreated may become adults who are more seriously debilitated, have limited social and employment skills, and require more intense, prolonged, and costlier treatment. Undiagnosed and untreated mental illness in adults contributes to unemployment, then homelessness; burdens the justice system; and depletes the social and economic resources that contribute to the livelihood and well-being of the population at-large.

While work continues on addressing the barriers to prevention and treatment of mental illness, it is clear that primary care physicians can play a major role in reducing this burden. By developing relationships with mental health professionals, schools, and communities, primary care physicians can bolster the needed resources to avoid the unnecessary negative outcomes and costs of untreated mental illness in our society.

69 Health Insurance Portability and Accountability Act. www.hipaa.org
70 Family Educational Rights and Privacy Act. www.ed.gov/policy/gen/guid/fpco/ferpa
71 Ibid.
72 Mental Health America of Texas. *Turning the Corner: Toward Balance and Reform in Texas Mental Health Services.* 2005.



# VI. What You Can Do in Your Community

As a physician who has begun to integrate mental health into your primary care practice, you can now go beyond practice boundaries and develop your community team. This team will help you perform levels of diagnosis and management, find referrals to other physicians, and better manage and improve your patient's mental health. This chapter will discuss with whom and how you can build your community team of referral networks designed to meet the diverse needs of your patients with serious or complicated mental and behavioral health problems. By coordinating and uniting the multitude of resources within the community, primary care physicians become leaders in their communities and advocates for their patient's mental health.

## A. Physicians as Advocates

Physicians are usually considered role models and community leaders and can find valuable ways to improve the safety, well-being, and mental health of youth. As a physician, you have numerous opportunities to serve as a leader in your community.

Some advocacy roles may be more involved, such as serving on community boards, coalitions, and campaigns. For example, as a physician concerned about the impact of homelessness on children, you could seek out a shelter and work to identify and help meet the needs of the youth served there. If your interests lie in education or school health, you could attend the next school board meeting and discuss the issues of importance to you. Better yet, find out if your school district has a functioning local school health advisory council/wellness council. Make a point to attend the next meeting to find out who participates in the council and how the agenda might focus on improving coordination of care with primary care practices, especially around chronic care issues like mental/behavioral health, asthma, diabetes, epilepsy, and technologically dependent children. What efforts or curriculum are in place to address the positive aspects of child development and asset acquisition that your practice team is promoting in well care exams?

Other activities may be less demanding but just as important. For example, agree to be interviewed for the school newspaper, or talk to a class about the medical profession. As you develop connections, make yourself available to key school personnel by e-mail or Web page so they can contact you with questions. In this way, you can serve as a resource for sound medical advice in the community. Know that even by advocating for just one child, you could initiate a relationship with individuals who could become a partner with you on youth mental health or other issues you are working to address.

American Academy of Pediatrics'(AAP) Council on Community Pediatrics and Council on School Health have excellent resource manuals and information on how physicians can effectively engage with schools and community.[73,74] If you need help establishing community/school health coordination, you are eligible for a Mentorship and Technical Assistance Program (MTAP) grant by joining AAP's Council on Community Pediatrics ($35 per year). See www.aap.org/sections/socp/mtap.html for information on the grants.

## B. Building Your Community/External Team

As a physician, you can initiate cooperative efforts among community practitioners and programs to better serve your patients and their families. The team strives to meet the unique needs of each young person and his or her family in or near their home. These services should address and respect the culture and ethnicity of the people they serve. This multidisciplinary team will include a variety of resources, both formal and informal: physician services in government-funded clinics, respite care and social services for the family, counseling for the patient, and recreation/mentoring programs such as Big Brothers Big Sisters for role modeling and social skill acquisition. To achieve this approach requires time and effort. **The CEO of the practice will need to ensure this activity is supported and rewarded**.

### External Health Team Development

1. Establish a team leader or "champion" in the practice.
2. Establish clear goals and objectives, and timelines for achieving goals.
3. Identify community-based organizations that provide services to youth. (See list of potential team members below.)
4. Start with just one organization and establish a linkage.
5. Determine roles and responsibilities, and establish informal/formal agreements.
6. Establish referral protocols.
7. Monitor progress.
8. Continue to build a network of team members and referral entities.

### The Process: Health Team Development

The practice needs first to establish who in the practice will be on its "community team" and who will be the team leader and champion (e.g., a senior administrator or physician with authority and experience in working with outside partners or institutions). The team needs to establish clear goals, measurable objectives/timelines to achieving the goals, and role assignment/negotiation as to who is responsible for what. The initial effort should be focused and perhaps limited to one community-based institution. The first contact should be initiated by one of the practice physicians, who would spell out what kind of formal or informal relationship the practice would like to establish and what the goal for collaboration might be. The appropriate team member then will follow up. These voluntary teams require maintenance and support; that is, set aside time from regular duties (about one hour per week) for commitment to the effort. The team should be rewarded for accomplishments; there is a definite payoff for the practice and the patients.

Coordinated/collaborative approaches often result in more efficient use of limited resources, acquisition of new resources, a broader array of services, and improved quality of care and clinical outcomes. Most significant socio-emotional problems are complicated, with issues involving family and schools, and thus require services beyond the scope or resources of primary care practice. However, the medical home remains the best site for the coordinated care of children and adolescents with mental illness; only with help and collaboration from the community is it possible to do this well.

By working to develop a team of resources and providers you can trust, you can offer your patients optimal care both in your own office and in the community. As a result, you gain not only referral sources, but also a network of organizations and professionals who can support your efforts, improve compliance/adherence, and provide follow-up monitoring and care your office cannot. In the long run, you are likely to see greater improvement and sustained mental health in your patients when maximizing all the resources your community offers.

73 American Academy of Pediatrics. Council on Community Pediatrics. Contact: mjones@ajap.org.
74 American Academy of Pediatrics. Council on School Health. Contact: rschaefer@app.org.

## Potential Team Members

As a beginning, identify those agencies in your community that serve youth. Talk to leaders within school systems to learn what services are offered and who delivers them. Find out what substance abuse treatment programs are available, and talk with the local mental health agencies that provide services for children. Become involved where possible in working with these organizations to stay on top of community needs and resources, then use your standing as a physician to advocate those resources. Community partners highly value physician advocacy. The result is a higher quality working relationship *and* better services for your patients.[75]

Here are a handful of community resources you may want to recruit for your referral network and care team.

### Potential External Health Team Members

1. Local mental health providers.
2. Substance abuse program workers (e.g., AA, Al-Anon, Alateen).
3. Contacts in juvenile justice (judges, prosecutors) and juvenile probation.
4. Local school personnel (school nurse, counselor, teacher, administrator).
5. Regional school health specialists.
6. Local or regional health department director or contact.

## Systems of Care

This is a concept of the Substance Abuse and Mental Health Services Administration developed in the late 1990s to integrate all the different community sites that may contribute services that address children's mental health.[76] There are at least four state efforts attempting to address the concept: Mental Health Transformation in Texas;[77] Texas Integrated Funding Initiative (TIFI);[78] 10 model sites funded by HHSC through the *Frew vs. Hawkins* lawsuit; and a Hogg Foundation initiative with seven model sites.[79]

In some areas of the state, systems of care and referral networks already may be in place to support coordinated, community-based services. However, such infrastructure is lacking in most Texas communities. To create an effective system of care, local organizations need to work in teams — with families as critical partners — to provide a wide range of services to children and adolescents with mild to serious emotional disturbances.

**For more information on community-based interventions and systems of care, contact the National Mental Health Information Center at http://mentalhealth.samhsa.gov/ or (800) 789-2647.**

# C. Early Childhood Resources

## Early Childhood Intervention (ECI)

For children aged 0 to 3 years, concerns of delay in any area are evaluated through Early Childhood Intervention (ECI), a state-funded program. Physicians are required by law to refer for this program if they expect delays. The Texas Pediatric Society has developed a standardized referral form.[80] The ECI number in Texas (if you don't know your local ECI provider) is **(800) 628-5115**. (See Appendix D: Community Resources for additional information). When a child is 3 years old, the public school system becomes responsible for identifying and evaluating children with suspected disabilities.

## Early Education/Child Care Centers

More than 65% of families with children 0-5 years of age use child care. Over the past decade, a high prevalence (15+%) of mental and behavioral problems have been identified in this population.[81] Expulsion rates for behavior are as high as 20-30%. Just as schools can help enormously with chronic disease monitoring, child care staff can be similarly helpful. There have been efforts to develop pediatric consultants with Healthy Child Care Texas (HCCT).[82] Being a consultant would further the team relationship and encourage more appropriate developmental curriculum consistent with the practice efforts of well-child exams.

75 Epstein JN, Rabiner D, Johnson DE, FitzGerald D, Chrisman A, Erkanli A, Sullivan KK, March JS, Margolis P, Norton EC, Conners CK. "Improving Attention-Deficit/Hyperactivity Disorder Treatment Outcomes Through Use of a Collaborative Consultation Treatment Service by Community-Based Pediatricians." *Archives of Pediatrics and Adolescent Medicine*, 161;9 (2007):835-40.
76 United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. *Family Guide to System of Care for Children with Mental Health Needs*. http://mentalhealth.samhsa.gov/publications/allpubs/Ca-0029/default.asp
77 Texas Department of State Health Services. Mental Health Transformation Initiative. www.mhtransformation.org
78 Texas Health and Human Services Commission. Texas Integrated Funding Initiative. www.hhsc.state.tx.us/tifi/
79 Hogg Foundation for Mental Health. Integrated Health Care. www.hogg.utexas.edu/programs_ihc.html
80 Texas Pediatric Society. Statewide ECI Referral Form. http://txpeds.org/u/documents/eci_tps_statewide_referral_form4.pdf
81 Willis D. "The Emerging Role of Pediatricians in Children's Mental Health: Implications from the Epidemiology." Presentation at the Section on Community Pediatrics, American Academy of Pediatrics Conference. New Orleans (Nov. 3, 2003). dwwillis@nweci.org
82 Texas Health and Human Services Commission. Healthy Child Care Texas. www.healthychildcaretexas.org

### Early Childhood Prevention Programs

There are several preventive interventions that target infants and toddlers at high risk. Nurse-Family Partnership programs have been documented to reduce abuse and to enhance school readiness.[83] Parents As Teachers is another educational intervention supported by the Mental Health America of Texas.[84] Child Protective Services carries out home evaluations for children identified at risk, and local health departments often will conduct home assessments.

## D. Working With Schools

Because the education system is a major factor in the everyday lives of children and adolescents, it makes sense for physicians who care for youth to have ongoing working relationships with schools. However, few physicians are trained in this area. This section reviews the basics.

Each of the 20 Education Service Centers in Texas has a school health specialist (listed in Appendix D: Community Resources) who can provide information on how to interact with school nurses and explain the school district's testing procedures and staff organization. A senior clinician working with your practice team should make first contact with the district's superintendent or assistant superintendent for special services. The clinician should outline for the district what the practice's community goals and objectives are then try to develop a mutually rewarding understanding.

The direct observation of your patients by counseling and nursing staff can add greatly to the effectiveness of your clinical management. Some districts have adopted the Community in Schools model of early identification, referral, and management, which has reduced school dropout rates in high-risk districts. Others have implemented primary and secondary prevention curriculum to help students better develop socio-emotion assets and skills that reduce risk-taking behaviors.[85]

In addition, each school district is required by law to have a local school health advisory council. These councils comprise members of the community who serve the school board by helping to determine school health education and service needs. These councils need physician leadership, consultation, and encouragement. In Texas, less than 60% of school districts have active, effective school health advisory councils, despite the fact that state law mandates that such advisory councils exist.

### Children With Disabilities

All children have the right to a free and public education in the least restrictive environment. Because of specific disabilities, some children have even greater rights.

#### Section 504

"Section 504" stems from the Rehabilitation Act of 1973, a federal law which states that individuals cannot be discriminated against because of their disabilities. (ADHD is included in this.) Section 504 is not the same as special education, which refers to the 1997 Amendments to the Individuals with Disabilities Education Act (IDEA-97). Thus, utilizing Section 504 does not automatically place a child under the special education umbrella. It does allow modifications and a plan to deal with the disability, generally in the context of a regular classroom. School districts may have a Section 504 specialist to assist with this area, but districts may be reluctant to provide special education services because there are no federal funds available for this under Section 504.

#### Individuals With Disabilities Education Act (IDEA)

Under IDEA-97, special education brings with it many more legal rights for the child. A child can become eligible for special education services under many different categories. (See list below for categories and abbreviations.) As you can see, some of these categories require physician assessment while others rely on the school's evaluation.

A parent, teacher, or physician may request a comprehensive, multidisciplinary assessment for special education because of concerns that a child's disability may be interfering with education or social achievement. If a parent, teacher, or guardian submits this request in writing, a school must respond and complete the evaluation within a certain time period. If a child is comprehensively assessed and determined to qualify for services during a multidisciplinary qualification meeting, a formal meeting is held. This meeting also is multidisciplinary and even can occur at the same time as the qualification meeting. Parents and any advocates they deem appropriate attend this meeting, and an individualized education plan (IEP) is developed.

Parents must receive evaluations of the child's progress at least as often as parents of regular education children, i.e., six- or nine-week report cards. Yearly multidisciplinary team meetings review the child's IEP and monitor progress, with reevaluations required every three

83 Texas Health and Human Services Commission. Nurse-Family Partnership. www.hhsc.state.tx.us/NurseFamilyPartnership/index.html
84 Parents as Teachers Texas. www.txpat.org
85 Substance Abuse and Mental Health Services Administration. Evidence-Based Practices Web site: www.samhsa.gov/ebpWebguide/appendixB_Health_Treatment.asp#16.

years. Appeals processes are available if parents are not satisfied with the outcome or with recommendations that emerge from the multidisciplinary meetings. In certain situations, parents can request an independent education evaluation, or IEE, if they feel that the school's evaluation is not appropriate or adequate. The school is required to reimburse the provider of the IEE but may contest this through an appeals process.

As a physician, you may 1) recommend a comprehensive evaluation, 2) sign a form that verifies a medical disability which allows a student to be qualified as eligible for placement in special education, 3) attend the multidisciplinary qualification and IEP meetings, 4) request the results of the comprehensive education evaluation and IEP, 5) coach families as to their rights or refer them to an advocacy organization, or 6) serve as a mediator between school and family. While the rights of the child come first, we should remember that advocating for cordial relationships often produces the best results. School districts are always overwhelmed. As long as remediation is not delayed more than six months, patience is often rewarded.

### Special Education Eligibility Categories and Criteria

1. Mental retardation (MR): Below 70 IQ and comparable adaptive functioning despite adequate opportunity to progress.
2. Learning disability (LD): A >1 standard deviation discrepancy between IQ and achievement in specific subject such as math or reading in spite of adequate teaching and opportunity to learn.
3. Speech impaired (SI): Can be articulation or expressive-receptive speech delay.
4. Emotionally disturbed (ED): Five specific criteria that identify emotional or other conditions which interfere with educational or social achievement to the point of interfering with school function.
5. Visually impaired or hearing impaired (VI/HI): Visual or auditory impairment that interferes with achievement.
6. Orthopedic handicapped (OH): Such as spina bifida that interferes with educational achievement.
7. Traumatic brain injury (TBI): Central nervous system involvement that interferes with educational achievement.
8. Other health impairment (OHI): A physician documents a specific medical condition such as seizure disorder, ADHD, severe asthma, etc., that interferes with educational or social achievement.

## E. Working With the State Mental Health Systems

The Texas Department of State Health Services manages contracts for local community mental health organizations. (See www.dshs.state.tx.us/mentalhealth.shtm, and Appendix D: Community Resources in this guide for locations.) Some of its state mental health components provide short- and long-term residential inpatient services. The scope of mental health services provided at the county and regional levels of the MHMR system is highly variable and often limited to severe diagnoses. Medicaid/CHIP-eligible children must be enrolled prior to receiving services from the state. Exceptions may be made for severe cases.

## F. Working With the Juvenile Justice System

Physicians should be aware of the tremendous mental health needs of youth in the juvenile justice system. According to officials of the Texas Youth Commission, increasing numbers of young people with mental illness are sent to juvenile prisons, with evidence that the severity of illness is increasing. Judges can order that a youth receive mental health services, insisting, for example, that psychological evaluation, counseling, or medical examinations be a part of probation conditions. If a clear medical or mental health need is shown, treatment may be recommended, giving the youth the opportunity to get some help.

> The Coalition for Juvenile Justice estimates that 50 to 75% of teenagers in the juvenile justice system have a diagnosable mental disorder.[86]

A great deal of effort usually goes into trying to deal with the mental health needs of youths before they are sent to a juvenile prison. Still, there is a shortage of services. Families and youth are on waiting lists to meet with therapists, and emergency psychiatric care facilities are often full or only willing to keep a patient for a few days at the most.

Many probation officers today operate very much like social workers and can be partners in helping you obtain a better psychiatric evaluation or get a court order to get a youth's needs met. Depending on your practice, you may have a number of patients who are assigned to probation officers. Find out if your patient likes his or

86 Coalition for Juvenile Justice. *Handle With Care: Serving the Mental Health Needs of Young Offenders.* 2000.

her probation officer. If so, it might be worth getting the officer's name and number and contacting him or her.

If you find that the juvenile justice system is having an impact on patients you see in your office, find out about medical advisory positions at the nearest detention center. Or take a first step by calling the director and making an appointment to visit the facility to learn more about the environment presented to children and adolescents who are placed in the system. See Appendix D: Community Resources for information on contacting the juvenile justice system.

## G. Working With State Agencies

The primary provider for public mental health services in the state is the Texas Department of State Health Services. Other agencies that serve children and adolescents with mental illnesses are:

- **Governor's Office of Juvenile Justice Program:** www.governor.state.tx.us/divisions/cjd
- **Texas Education Agency (TEA):** www.tea.state.tx.us
- **Texas Department of Family and Protective Services:** www.dfps.state.tx.us
- **Texas Department of Aging and Disability Services:** www.dads.state.tx.us
- **Texas Department of Assistive and Rehabilitative Services:** www.dars.state.tx.us
- **Texas Juvenile Probation Commission:** www.tjpc.state.tx.us
- **Texas Youth Commission:** www.tyc.state.tx.us

### Texas Department of Family and Protective Services

TDFPS is the state agency charged with child safety and welfare activities including investigating reports of child abuse and neglect, placing children in foster care, placing children in permanent adoptive homes, and providing services to help stabilize at-risk youth.

#### TDFPS Abuse Hotline

(800) 252-5400 - Texas, Oklahoma, Louisiana, Arkansas, and New Mexico

(512) 834-3784 - Out of State (Reporting abuse/neglect occurring in Texas)

Report abuse, neglect, or exploitation of children 24 hours a day, 7 days a week.
www.dfps.state.tx.us or www.txabusehotline.org

#### Foster Care

(800) 233-3405 - Foster care hotline at TDFPS

With regard to foster care, TDFPS certifies and oversees foster care for Texas children. Training and support is given to private individuals who are certified to provide foster care, based on the foster family's strengths and needs. TDFPS also helps foster families obtain needed services.

A new managed care contract, STAR Health Program for Children in Foster Care, now covers all foster children with a mobile medical record.[87]

See Appendix D: Community Resources for general contact information for state agencies.

## H. Using Other Resources

In addition to building care teams and working with the school system, mental health, juvenile justice, and other state agencies, a number of resources may be available at the community level. If not, you might be able to advocate the development of resources such as local chapters of advocacy groups, prevention programs, and other community resources. The next few sections provide an overview of programs and information sources for individuals and communities.

### Advocacy Groups and Information Networks

One of the best resources for you and your patients is consumer advocacy groups. Well-organized, knowledgeable, and vocal, groups like Mental Health America of Texas, Texas Alliance for the Mentally Ill, and Texas Association for Infant Mental Health can be forces for change in bringing more attention to mental health and in helping to make resources available where they are needed.

Texans Care For Children, an umbrella organization representing child advocacy groups and associations, and Advocacy, Inc. carefully follow children's legislation and agency administrative action, to monitor and promote improved mental health. In addition, the Center for Mental Health Services offers information on mental health programs and services throughout the United States. This guide's Appendix D provides you with an overview of these and other entities, as well as contact information.

### Prevention Programs

In addition to advocacy groups and other networks of assistance, your community may be implementing population-based prevention programs for mental health. If not, you may be able to initiate such a pro-

87 Texas Health and Human Services Commission. STAR Health Program for Children in Foster Care. Health Passport. www.hhs.state.tx.us/medicaid/FosterCare_FAQ.shtml

gram. Communities in Schools and Parents As Teachers are two well-known examples of programs that focus on helping kids to achieve healthy relationships, succeed in learning, and lead productive lives. Appendix D provides more information, phone numbers, and Web sites for these and other sample prevention programs.

## Community Resources

Whether you practice in a major metropolitan area or a small-town rural setting, or something in between, you may be surprised at the range of community resources available to help you and your patients address their mental health needs. Many of the examples of community programs are city-specific but provide models for what works and what is feasible. Texas Community Solutions and Texas Council of Mental Health and Mental Retardation Centers have a broader focus. Appendix D in this guide provides a starting point with phone numbers, Web sites, and descriptions of programs and services that you might be able to tap or replicate in your community.

## Treatment Facilities

Psychiatric Solutions, Inc. (PSI) offers an extensive continuum of behavioral health programs to critically ill children, adolescents, and adults and is the largest operator of owned or leased freestanding psychiatric inpatient facilities, with approximately 10,000 beds in 31 states, Puerto Rico, and the U.S. Virgin Islands. In Texas, PSI has 14 facilities in Arlington, Austin, DeSoto, Fort Worth, Houston, Kingwood, Lewisville, San Antonio, and San Marcos. (See Appendix D: Community Resources for a list of these facilities.)

Access to private treatment facilities in Texas and other states continues to evolve rapidly due to instability in the health care system in general and particularly in psychiatric care. One example of available care is through facilities such as the Phoenix House, which offers outpatient and residential services as well as school-based programs. The Phoenix House system focuses on providing accelerated high school programs allowing youngsters to reclaim opportunities lost to drugs. For more information, see www.phoenixhouse.org/Texas.

# VII. Appendices

This appendix is designed to provide you with quick access to resources that are referenced throughout the guide, including tools for your practice, online resources, community resources, bibliography, and references.

**A.** Tools for Your Practice: Information on Use and Ordering Information

**B.** Screening Tools Available for Copying

**C.** Online Resources

**D.** Community Resources

**E.** Original Authors of *Integrating Child and Adolescent Mental Health Into Primary Care: A Resource Guide for Physicians*

**F.** American Academy of Pediatrics Coding Examples

**G.** Annotated Bibliography

**H.** References

# Appendix A: Tools for Your Practice

One key to dealing with youth mental health issues is knowing about tools and programs to help you in your practice. Lists of preventive guidelines, screening tools, and other resources follow.

## 1. *Ages & Stages Questionnaires®: Social-Emotional (ASQ:SE)*

*A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors*

*ASQ:SE* is a low-cost, culturally sensitive screening system for identifying young children (6 to 60 months) at risk for social or emotional difficulties. Areas covered include self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people.

The complete system, which includes eight color-coded questionnaires, scoring sheets, and user's guide, is available for purchase through Brooks Publishing at www.brookespublishing.com/tools/asqse/index.htm.

## 2. American Academy of Child and Adolescent Psychiatry (AACAP) Facts for Families

AACAP developed Facts for Families to provide concise, up-to-date information on issues that affect children, teenagers, and their families. AACAP provides this important information as a public service, and the Facts for Families may be duplicated and distributed free of charge as long as the American Academy of Child and Adolescent Psychiatry is properly credited and no profit is gained from their use.

To find out more, visit www.aacap.org/cs/root/facts_for_families/facts_for_families.

## 3. American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters

AACAP has published more than 17 practice parameters designed to help clinicians provide high-quality assessment and treatment that is consistent with the best available scientific evidence and clinical consensus.

Full text parameters are available at www.aacap.org/cs/root/publication_store/practice_parameters_and_guidelines.

## 4. Beaufort Pediatrics Modified PSEI Social Inventory Form

This is a screen for family stress and is thought to be less intrusive than other family screens.

See Stress Index: Beaufort Pediatrics Modified PSEI Social Inventory Form in Appendix B: Screening Tools Available for Copying of this manual.

## 5. *Bright Futures: Mental Health I and II*

*Bright Futures: Mental Health* presents information on early recognition and intervention for specific mental health problems and mental disorders, and provides a tool kit with hands-on tools for health professionals and families for use in screening, care management, and health education.

These tools are available in PDF at www.brightfutures.org/mentalhealth.

## 6. Behavioral and Emotional Rating Scale, 2nd Ed. (BERS-2)

The BERS-2 is a measure of personal strengths and competencies of children ages 5 to 19 years of age. The BERS-2 examines several aspects of a child's strengths, such as interpersonal strengths, functioning in and at school, affective strength, intrapersonal strength, family involvement, and career strength. The BERS-2 can be used to identify children with limited behavioral and emotional strengths, identify a child's strengths and weaknesses for intervention, target goals to be used for IEPs and/or treatment plans, and document progress.

These tools are available for purchase through Psychological Assessment Resources, Inc., at www3.parinc.com/products/product.aspx?Productid=BERS-2#.

## 7. **CAGE** Questionnaire: Alcohol Use (With Adults)

The CAGE questionnaire is a short screening instrument commonly used in the clinical setting that asks if an individual has thought about Cutting down on their drinking, become Annoyed by criticism of their drinking, felt Guilty about their drinking, or had a morning drink as an Eye opener.

**C** Have you ever thought you should **CUT DOWN** on your drinking?

**A** Have you ever felt **ANNOYED** by others' criticism of your drinking?

**G** Have you ever felt **GUILTY** about your drinking?

**E** Do you have a morning **EYE OPENER**?

## 8. *Caring for Children With ADHD: A Toolkit for Clinicians*

The American Academy of Pediatrics (AAP) offers a comprehensive tool kit developed from evidence-based guidelines for the diagnosis and treatment of children with attention-deficit/hyperactivity disorder (ADHD). This resource contains a wide array of screening, diagnosis, treatment, and support materials for clinicians and other health care professionals, as well as practical tools to help incorporate the new AAP guidelines into your practice, including:

- Symptom checklists for parents and teachers to use,
- Guidance on selecting appropriate therapy,
- Forms to acquire teacher reports,
- Examples of written management plans to help strengthen family skills, and
- Strategies to assist the clinician in monitoring the child.

Purchase the tool kit through the AAP Bookstore at www.aap.org/pubserv/adhdtoolkit.

## 9. Child Behavior Checklist for Ages 1½-5 (CBCL/1½-5/LDS)<br>Child Behavior Checklist for Ages 6-18 (CBCL/6-18)

These tests are designed to assess a child's behavior and social competency, as reported by their parents. The questionnaire includes questions on social issues, such as whether the child has friends, relationships with family members, extracurricular activities, and hobbies. In addition, the questionnaire asks the parents to rate their child, on a scale of not true, somewhat true, or true on many different issues including academics, inattention, relationships, and behaviors.

Purchase these tools from Achenbach System of Empirically Based Assessment at www.aseba.org/products.

## 10. Children's Medication Algorithm Project (CMAP)

CMAP is a collaborative venture involving Texas Department of State Health Services, The University of Texas at Austin College of Pharmacy, The University of Texas Southwestern Medical Center at Dallas, The University of Texas Health Science Center at San Antonio, parent and family representatives, and representatives from various mental health advocacy groups, i.e., NAMI-Texas, Texas Federation of Families for Children's Mental Health, Texas MH Consumers, and the Mental Health Association in Texas. The project involves developing and testing specific medication treatment guidelines, or "algorithms," for attention-deficit/hyperactivity disorder (ADHD) and major depressive disorder (MDD) in children and adolescents.

Information on this Web site has links to the algorithms, the specially developed patient and family education materials for ADHD and depression, and the relevant published literature on the program. Visit www.dshs.state.tx.us/mhprograms/CMAP.shtm.

## 11. Conner's Rating Scales: Parent, Teacher, and Self-Report

Various CRS-R (Conners' Rating Scales-Revised) versions offer flexible administration options while also providing the ability to collect varying perspectives on a child's behavior from parents, teachers, caregivers, and the child or adolescent. There are three versions — parent, teacher, and adolescent self-report — all of which have a short and long form available. In addition, there are three screening tools that offer the option of administering a 12-item ADHD Index or the 18-item DSM-IV Symptom Checklist, or both.

These instruments also offer versions for parents, teachers, and adolescents. See www.pearsonassessments.com/tests/crs-r.htm.

## 12. **CRAFFT**: Substance Abuse Screening Test for Adolescents

The brief alcohol- and drug-screening test is known by a mnemonic, CRAFFT, based on the first letter of key words in the six easy-to-remember questions. CRAFFT is intended specifically for adolescents. It draws upon adult screening instruments, covers alcohol and other drugs, and uses situations suited to adolescents. Of the six questions, two or more positive items indicate the need for further assessment.

**C** Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

**R** Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

**A** Do you ever use alcohol or drugs while you are by yourself, ALONE?

**F** Do you ever FORGET things you did while using alcohol or drugs?

**F** Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

**T** Have you ever gotten into TROUBLE while you were using alcohol or drugs?

Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. "Validity of the CRAFFT substance abuse screening test among adolescent clinic patients." *Archives of Pediatrics & Adolescent Medicine*, 156;6 (2002): 607-614. http://archpedi.ama-assn.org/cgi/reprint/156/6/607.pdf Request CRAFFT cards at www.ceasar-boston.org/clinicians/crafft.php.

## 13. Depression Management Algorithm

This algorithm was provided by Blue Cross of Northeastern Pennsylvania for its providers.

To access the algorithm, visit www.bcnepa.com/BCNEPAProviderCenter/QualityManagement/qm_flowcharts/Depression2007.pdf.

## 14. Depressive Symptom Inventory: Suicide Subscale (DSI-SS)

DSI-SS is a four-item self-report questionnaire designed to identify the frequency and intensity of suicidal ideation and impulses in the past two weeks. Scores on each item range from 0 to 3, and on the overall questionnaire from 0-12, with higher scores reflecting greater severity of suicidal ideation (Joiner, Pfaff, & Acres, 2002). The DSI-SS was developed by Metalsky and Joiner (1997) as part of a larger depressive symptom index called the Hopelessness Depression Symptom Questionnaire. Internal consistency and construct validity have been demonstrated.

## 15. Edinburgh Postnatal Depression Scale (EPDS)

The authors of this scale freely give permission to use it in patient care. Copies in both English and Spanish are available. The Edinburgh has been the subject of a number of psychometric studies that provide support for its accuracy, validity, and standardization in Britain, Canada, and the United States.

The Edinburgh consists of 10 multiple choice items that produce a "possible depression" score and a single question focusing on potential suicidal ideation. It is available at www.dbpeds.org/media/edinburghscale.pdf.

## 16. Family Building Blocks: Positive Parenting from A-Z, 2008 Calendar

This 2008 calendar from the Texas Department of Family and Protective Services provides tips for parents on positive parenting, effective consequences, giving praise, time out, and avoiding problems.

This calendar is available for download at www.dfps.state.tx.us/itsuptoyou/default.asp. If you have questions about ordering the 2009 calendar, e-mail preventioncalendar@dfps.state.tx.us.

## 17. Family Psychosocial Screen (FPS)

This screen, developed by Kathi J. Kemper, MD, MPH, and Kelly Kelleher, MD, MPH, includes a four-item screen for depression, substance use, domestic violence, and other risk factors (such as low socioeconomic status, absence of social support, and others).

The FPS is often used as a clinic intake form. It is available for free download at http://pedstest.com/content.php?content=download_resources.html.

## 18. Feelings Need Checkups Too

The American Academy of Pediatrics, in conjunction with the 9-11 Children's Fund at the National Philanthropic Trust, has developed a comprehensive CD-ROM and 30-page tool kit for physicians who are helping children experiencing emotional distress. This resource informs pediatricians about crisis-related mental health problems, demonstrates the use of various screening tools through a case study approach, and provides information on other needs such as parental reassurance and bereavement support. It also describes treatment options and provides information on accessing mental health resources that are available for treatment referrals.

You can find information on the tool kit at www.aap.org/profed/childrencheckup.htm. To order the tool kit, e-mail feelings@aap.org.

## 19. Guidelines for Adolescent Preventive Services (GAPS)

The AMA's Guidelines for Adolescent Preventive Services (GAPS) is a comprehensive set of recommendations that provides a framework for the organization and content of preventive health services. The GAPS recommendations were designed to be delivered ideally as a preventive services package during a series of annual health visits between the ages of 11 and 21. The GAPS Recommendations Monograph provides information on the 24 recommendations, which are organized into four types of services that address 14 separate health topics or conditions. GAPS implementation materials include downloadable PDF questionnaires that you may reproduce for use in clinical practice.

Download the monograph and the questionnaires at www.ama-assn.org/ama/pub/category/1980.html.

Younger Adolescent Questionnaire

Younger Adolescent Questionnaire (Spanish)

Middle/Older Adolescent Questionnaire

Middle/Older Adolescent Questionnaire (Spanish)

Parent/Guardian Questionnaire

Parent/Guardian Questionnaire (Spanish)

## 20. **HEADSSS** Adolescent Screening Interview

HEADSSS is an adolescent interview tool that screens for a number of mental health issues. Christopher Reif, MD, of Health Partners in St. Paul, Minn., developed the interviewing guide, based on the work of other specialists in adolescent health.

**H** **Home** How are things at home? Who lives at home? How do you get along with mom, dad, and siblings?

**E** **Education** How are things at school? What classes do you like the best, the least? How are your grades?

**A** **Activities** How many good friends do you have? What do you do together? What do your parents think of your friends?

**D** **Drugs** Do any of your friends smoke? Drink alcohol? Do you? Have you tried other drugs?

**S** **Sexual Activity/Identity** Are you attracted to boys? Girls? Do you have a boyfriend or girlfriend? For how long? Do you get along well? Do you have sex? Does it go OK? Do you know how to protect yourself from STDs and pregnancy?

**S** **Suicide/Depression** Do you ever feel really depressed? How long does it last? Have you ever thought of hurting yourself or suicide?

**S** **Safety** Do you wear your seat belt? Are you ever around guns? Do you ever feel unsafe? When? At school? At home? In your neighborhood? Have you seen other people get hurt? Have you ever been hurt by someone?

This screen, along with additional screens, is available in English and Spanish at www.health.state.mn.us/youth/providers/screening.html.

## 21. I Am Your Child Parenting Guides: A Parent's Guide to Raising Healthy, Happy Children

Texans Care For Children is excited to partner with the Raising Texas initiative to provide parents and other caregivers of young children with easy-to-use information and resources to help kids grow up healthy, safe, and ready to succeed. Raising Texas, a statewide initiative spearheaded by the Office of Early Childhood Coordination within the Texas Health and Human Services Commission, has recently coordinated and funded a recent effort to update and expand

the Texans Care I Am Your Child developmental calendar and parenting guide. Updates include:

- New information on the importance of a medical home and regular dental care;
- A place to record a child's immunizations;
- Updated information about where parents can go to learn more about their child's development; and
- Helpful resources in their community, including information on enrolling in Medicaid and CHIP, and private health care options.

The guides are available for only $1 each, with free shipping and handling, at www.texanscareforchildren.org/innerpage.php?pageid=149. All orders must be prepaid. Purchase orders will not be accepted. Download the order form directly at Order Form: I Am Your Child Parenting Guide.

Direct questions about the parenting guide purchasing process to Beth Coffey, Texans Care For Children, at (512) 473-2274 or bcoffey@texanscareforchildren.org.

## 22. Modified Checklist for Autism in Toddlers (M-CHAT)

The M-CHAT is designed to screen for autism spectrum disorders in toddlers (i.e., over the age of 12 months, and ideally over the age of 18 months). A parent can complete the items independently. The M-CHAT does not allow a clinician to make a diagnosis of an autism spectrum disorder, but is a very useful clinical tool that has excellent sensitivity and specificity. Positive results suggest a high risk for an autism spectrum disorder, and may necessitate referral.

The form and information on using the checklist are available at www.dbpeds.org/articles/detail.cfm?TextID=%20466.

## 23. Parents' Evaluation of Developmental Status — Developmental Milestones (PEDS:DM)©

The PEDS:DM is for children birth to 7-11 years of age. Items are completed by parent report (but also can be administered directly to children). Each item on the PEDS:DM taps a different developmental domain (fine motor, gross motor, expressive language, receptive language, self-help, social-emotional, and for older children, reading and math).

PEDS-DM is available at http://pedstest.com/dm/index.php.

## 24. Patient Health Questionnaire (PHQ-9M)

The Patient Health Questionnaire, derived from the clinician-administered Primary Care Evaluation of Mental Disorders, was developed to detect mental disorders in primary care patients. The long form of the questionnaire screens for eight mental disorders, including major depressive disorder, anxiety disorder, and depressive disorders not otherwise specified. A short form is included in the Depression Tool Kit available as part of the MacArthur Initiative on Depression & Primary Care (www.depression-primarycare.org). By asking yes-or-no questions, primary care physicians can elaborate on the results of the Patient Health Questionnaire, thereby providing a more thorough examination for the presence of depression.

The Depression Tool Kit is available at www.depression-primarycare.org/clinicians/toolkits.

## 25. Pediatric Symptom Checklist (PSC)

The PSC is a parent-completed screening questionnaire intended for use as part of routine primary care visits to facilitate recognition and referral of psychosocial problems. The one-page questionnaire, which lists a broad range of children's emotional and behavioral problems, reflects parents' impressions of their children's psychosocial functioning.

Find more information and technical assistance on the Pediatric Symptom Checklist Web site at http://psc.partners.org or www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf.

## 26. Pediatric Symptom Checklist: Youth Report (Y-PSC)

The Y-PSC is a youth self-report psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. This screen can be administered to adolescents aged 11 and up.

Download for free at http://psc.partners.org/psc_order.htm or www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf.

## 27. Psychotropic Medication Utilization Parameters for Foster Children

The Texas Department of State Health Services has coordinated the creation of the accompanying best practice guidelines, "Psychotropic Medication Utilization Parameters for Foster Children," developed by a panel of child and adolescent psychiatrists, psychologists, guideline development specialists, and other mental health experts.

The guidelines were developed for use in the treatment of foster children who receive services through Medicaid. There are particular clinical and social issues surrounding the care of these children. However, the guidelines may be a valuable resource in the treatment of any child diagnosed with a mental health disorder, regardless of the type of health insurance coverage the child may have.

Find links to the parameters at www.dshs.state.tx.us/mhprograms/psychotropicMedicationFosterChildren.shtm.

## 28. SIG: E CAPS: A Mnemonic for Symptoms of Major Depression and Dysthymia

The mnemonic "SIG: E CAPS," devised by Carey Gross, MD, and used by psychiatry residents at Massachusetts General Hospital, refers to a prescription one might write for a depressed patient: **SIG: E**nergy **CAPS**ules with each letter representing one of the major diagnostic criteria for major depressive disorder:

**S**leep Disorder (either increased or decreased sleep)*

**I**nterest deficit (anhedonia)*

**G**uilt (worthlessness,* hopelessness,* regret)

**E**nergy deficit*

**C**oncentration deficit*

**A**ppetite disorder (either decreased or increased)*

**P**sychomotor retardation or agitation

**S**uicidality

**Note:** *To meet the diagnosis of major depression, a patient must have four of the symptoms plus depressed mood or anhedonia, for at least two weeks. To meet the diagnosis of dysthymic disorder, a patient must have two of the six symptoms marked with an asterisk (*), plus depression, for at least two years.*

**Suggestion:** *Rather than asking about each of the symptoms, a more efficient approach is to ask, "How has your depression affected your life over the past couple of weeks? For example, how has it affected your sleep? Your appetite?" and so forth. For patients who seem reluctant to admit to a depressed mood, beginning with the question, "Do you have any problems sleeping?" provides a nonthreatening introduction to a discussion of depressive symptoms.*

## 29. SOS Signs of Suicide Program

This is an empirically supported suicide prevention program for students in secondary schools. Students are instructed through use of a video, real-life interviews, and a discussion guide about how to identify depression and suicidal signs, and how to seek help for themselves and others. Students also complete a brief depression screening measure. The program is completed in an average of two and one-half days and costs $200.

To obtain a program kit, contact

Sharon Pigeon, MSW, LICSW
Screening for Mental Health, Inc.
One Washington St., Suite 304
Wellesley Hills, MA 02481
Phone: (781) 239-0071
Fax: (781) 431-7447
E-mail: spigeon@mentalhealthscreening.org
Web site: www.mentalhealthscreening.org/highschool/index.aspx

## 30. TeenScreen Program

The goal of the TeenScreen Program, developed, researched, and validated by Columbia University, is to ensure that all youth are offered a voluntary mental health check-up before leaving high school. The program screens for risk factors associated with depression and other mental health illnesses, but does not make a formal diagnosis. Parents of youth found to be at possible risk are notified and helped with connecting to local mental health service.

For information, contact

TeenScreen Program
Columbia University
1775 Broadway, Suite 715
New York, NY 10019
Phone: (866) TEENSCREEN (866-833-6727)
E-mail: teenscreen@childpsych.columbia.edu
Web site: www.teenscreen.org

## 31. Texas Implementation of Medication Algorithms (TIMA)

TIMA is a collaborative venture involving Texas Department of State Health Services, The University of Texas at Austin College of Pharmacy, The University of Texas Southwestern Medical Center at Dallas, The University of Texas Health Science Center at San Antonio, parent and family representatives, and representatives from various mental health advocacy groups, i.e., NAMI-Texas, DMDA, Texas MH Consumers, and the Mental Health Association of Texas. The project involves developing and testing specific medication treatment guidelines, or "algorithms," for schizophrenia, major depressive disorder, and bipolar I disorder.

This Web site has links to the algorithms, manuals for use, patient and family education materials for all three disorders, and links to the relevant published literature on the program. See www.dshs.state.tx.us/mhprograms/TIMA.shtm.

## 32. Texas Pediatric Society — Statewide ECI Referral Form

Visit http://txpeds.org/u/documents/eci_tps_statewide_referral_form4.pdf.

## 33. Vanderbilt ADHD Diagnostic Parent Rating Scale

This initial assessment tool, for use with children ages 6 to 12, contains rating scales for symptoms and for impairment in academic and behavioral performance. Although this tool is not intended for diagnosis, it is widely used to provide information about symptom presence and severity, and performance in the classroom, home, and social settings.

The parent form has 55 items and is available online in PDF at www.vanderbiltchildrens.com/uploads/documents/ccdr_adhd_scale.pdf.

The teacher form is free and available online in PDF at www.brightfutures.org/mentalhealth/pdf/professionals/bridges/adhd.pdf.

# Appendix B: Screening Tools Available for Copying

The following screening tools are of public domain and are available for copying for use in your practice.

1. CAGE Questionnaire: Alcohol Use (With Adults)
2. CRAFFT Screening for Substance Use/Abuse
3. Family Stress Index: Beaufort Pediatrics Modified PSEI Social Inventory Form
4. HEADSSS Adolescent Screening Interview
5. Pediatric Symptom Checklist-17
6. SIG: E CAPS Screening for Depression

# **CAGE** Questionnaire – Alcohol Use (With Adults)

The CAGE questionnaire is a short screening instrument commonly used in the clinical setting that asks if an individual has thought about **C**utting down on their drinking, become **A**nnoyed by criticism of their drinking, felt **G**uilty about their drinking, or had a morning drink as an **E**ye opener.

**C** - Have you ever thought you should **CUT DOWN** on your drinking?

**A** - Have you ever felt **ANNOYED** by others' criticism of your drinking?

**G** - Have you ever felt **GUILTY** about your drinking?

**E** - Do you have a morning **EYE OPENER**?

## **CRAFFT** Screening for Substance Use/Abuse

**C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

**R** Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?

**A** Do you ever use alcohol or drugs while you are by yourself, **ALONE**?

**F** Do you ever **FORGET** things you did while using alcohol or drugs?

**F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

**T** Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?

**Interpretation:** Two or more "yes" answers suggest a serious problem.

PSC Checklist is available at http://psc.partners.org/

# Family Stress Index

## Beaufort Pediatrics Modified PSEI Social Inventory Form[88]

*(Refer is greater than 10 "yes" checks.)*

| Have any of these things happened in your life in the last year? | Yes | No |
|---|---|---|
| 1. A family member died. | ☐ | ☐ |
| 2. You worried about the safety of your children. | ☐ | ☐ |
| 3. Someone close to you was in an accident. | ☐ | ☐ |
| 4. You were hospitalized for something besides having a baby. | ☐ | ☐ |
| 5. You worried about a health problem (such as high blood pressure, diabetes, etc.). | ☐ | ☐ |
| 6. You worried about how your neighborhood affected your children. | ☐ | ☐ |
| 7. Your husband or boyfriend lost his job. | ☐ | ☐ |
| 8. One of your children was in an accident. | ☐ | ☐ |
| 9. You were ill for longer than a week. | ☐ | ☐ |
| 10. You worried about your children's emotions. | ☐ | ☐ |
| 11. You worried about the baby's health when you were pregnant. | ☐ | ☐ |
| 12. You had to put off starting prenatal care because of money. | ☐ | ☐ |
| 13. You lost your job. | ☐ | ☐ |
| 14. Your husband or boyfriend had a drinking problem. | ☐ | ☐ |
| 15. Someone close to you got in trouble with the law. | ☐ | ☐ |
| 16. You worried about being able to be a good parent. | ☐ | ☐ |
| 17. You worried about how breaking up with your husband or boyfriend would affect your children. | ☐ | ☐ |
| 18. One of your children had a chronic health problem. | ☐ | ☐ |
| 19. You worried about spotting, bleeding or pain when you were pregnant. | ☐ | ☐ |
| 20. Your home was too crowded or needed repair to be safe. | ☐ | ☐ |
| 21. One of your children had a serious illness. | ☐ | ☐ |
| 22. You worried that other children might be a bad influence on your own. | ☐ | ☐ |
| 23. You worried about having enough money to pay your bills. | ☐ | ☐ |
| 24. You and your husband or boyfriend broke up. | ☐ | ☐ |
| 25. You worried because you had problems with an earlier pregnancy. | ☐ | ☐ |
| 26. Someone in your family was sick for longer than a week. | ☐ | ☐ |
| 27. A family member had money problems. | ☐ | ☐ |
| 28. A family member was using drugs. | ☐ | ☐ |
| 29. Caring for the baby or your children all the time was a problem for you. | ☐ | ☐ |
| 30. You had problems with your mother or father. | ☐ | ☐ |
| 31. A family member had a drinking problem. | ☐ | ☐ |
| 32. You and another family member didn't get along. | ☐ | ☐ |
| 33. You worried when you were pregnant about how your drug use would affect the baby. | ☐ | ☐ |
| 34. You were sick to your stomach a lot with your pregnancy. | ☐ | ☐ |
| 35. You wanted to go back to school but you couldn't. | ☐ | ☐ |
| 36. You were unhappy in your job. | ☐ | ☐ |
| 37. You worried about labor and childbirth. | ☐ | ☐ |
| 38. Your husband or boyfriend was without a job for more than a month. | ☐ | ☐ |
| 39. You were without a job for more than a month. | ☐ | ☐ |

PSC Checklist is available at http://psc.partners.org/

88 Orr ST, James SA, Caspter R. "Psychosocial Stressor and Low Birth Weight: Development of a Questionnaire," *Journal of Developmental and Behavioral Pediatrics*, 13;5 (1992):343-347.

## **HEADSSS** Adolescent Screening Interview

**H** **Home** How are things at home? Who lives at home? How do you get along with mom, dad, and siblings?

**E** **Education** How are things at school? What classes do you like the best, the least? How are your grades?

**A** **Activities** How many good friends do you have? What do you do together? What do your parents think of your friends?

**D** **Drugs** Do any of your friends smoke? Drink alcohol? Do you? Have you tried other drugs?

**S** **Sexual Activity/Identity** Are you attracted to boys? Girls? Do you have a boyfriend or girlfriend? For how long? Do you get along well? Do you have sex? Does it go OK? Do you know how to protect yourself from STDs and pregnancy?

**S** **Suicide/Depression** Do you ever feel really depressed? How long does it last? Have you ever thought of hurting yourself or suicide?

**S** **Safety** Do you wear your seat belt? Are you ever around guns? Do you ever feel unsafe? When? At school? At home? In your neighborhood? Have you seen other people get hurt? Have you ever been hurt by someone?

Evaluation & Quality Improvement Laboratory

# PEDIATRIC SYMPTOM CHECKLIST - 17

COLUMBUS Children's RESEARCH INSTITUTE
Supporting The Mission Of Columbus Children's Hospital, Inc.

| | Please mark under the heading that best fits your child | | | For Office Use | | |
|---|---|---|---|---|---|---|
| | NEVER | SOMETIMES | OFTEN | *I* | *A* | *E* |
| 1. Fidgety, unable to sit still | | | | | | |
| 2. Feels sad, unhappy | | | | | | |
| 3. Daydreams too much | | | | | | |
| 4. Refuses to share | | | | | | |
| 5. Does not understand other people's feelings | | | | | | |
| 6. Feels hopeless | | | | | | |
| 7. Has trouble concentrating | | | | | | |
| 8. Fights with other children | | | | | | |
| 9. Is down on him or herself | | | | | | |
| 10. Blames others for his or her troubles | | | | | | |
| 11. Seems to behaving less fun | | | | | | |
| 12. Does not listen to rules | | | | | | |
| 13. Acts as if driven by a motor | | | | | | |
| 14. Teases others | | | | | | |
| 15. Worries a lot | | | | | | |
| 16. Takes things that do not belong to him or her | | | | | | |
| 17. Distracted easily | | | | | | |
| *TOTAL* | | | | | | |

**To Score**:
1. Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.
2. Sum the columns. **PSC17-Internalizing** score is the sum of column I.
**PSC17-Attention** is the sum of column A.
**PSC17-Externalizing** is the sum of column E.
3. **PSC-17 Total Score** is the sum of PSC17-I + PSC17-A + PSC17-E.

**Positive Scores**:

| | | |
|---|---|---|
| PSC17-I | ≥ | 5 |
| PSC17-A | ≥ | 7 |
| PSC17-E | ≥ | 7 |
| Total Score | ≥ | 15 |

 The PSC-17 was first described in Gardner, W., et al.. (1999). The PSC-17: A brief Pediatric Symptom Checklist including psychosocial problem subscales. *Amb Child Health, 5*, 223-236. The PSC-17 is based on the Pediatric Symptom Checklist (psc.partners.org): Jellinek, M., et al. (1988). Pediatric symptom checklist: Screening school-age children for psychosocial dysfunction. *J Peds, 112*, 201-209.

## **SIG: E CAPS** Screening for Depression

| | |
|---|---|
| **S**leep | Do you have trouble going to bed and going to sleep? Are you staying asleep or waking up too early and can't go back to sleep? |
| **I**nterest | What did you like to do for fun that just doesn't seem like fun now? Do you find pleasure in what you used to do? |
| **G**uilt | Do you feel like you caused the badness in your life? Are you the reason for the divorce or death or dad leaving without saying good-bye? Do you ever think that life is crummy? (A depressed child will say, "Yeah.") Do you ever feel like you will never feel better? |
| **E**nergy | Do you have more or less energy than you used to? Compared to your friends? Do you play as hard as the other kids do, or do you sit by yourself? |
| **C**oncentration | Do you daydream more? Have trouble making decisions? Find it hard to concentrate or stay focused? |
| **A**ppetite | Are you eating more or less than you used to? Have you gained or lost weight? Over what period of time has your weight changed? |
| **P**sychomotor | Do you ever feel you have to drag yourself from one side of the room to the other? Or do you feel yourself running around more and not getting anything done? |

### Suicidality/ Homicidality

(You always have to consider these for depression.)

Do you ever feel so bad that you wish you weren't here? (Children don't understand the finality of death until around age 9.) If they say, "Yeah," ask them, "Have you ever thought of how you would kill yourself?"

# Appendix C: Online Resources

Following is a list of state and national organizations helpful in providing information and connections for serving the mental health needs of young people.

- American Academy of Child and Adolescent Psychiatry: www.aacap.org
- American Academy of Pediatrics: www.aap.org
- Center for Effective Collaboration and Practice: http://cecp.air.org/
- Federation of Families for Children's Mental Health: www.ffcmh.org
- Georgetown University Child Development Center's Center for Child Health and Mental Health Policy: http://gucchd.georgetown.edu/projects_programs.html
- National Business Group on Health: www.wbgh.com/
- National Mental Health Services Knowledge Exchange Network: www.manitowocresources.com/view.php?cat=127&id=492&page=0
- National Resource Network on Child and Family Mental Health Services: http://cecp.air.org/teams/stratpart/nrn.asp
- National Technical Assistance Center for Children's Mental Health: http://gucchd.georgetown.edu/programs/ta_center/
- SAMHSA's National Mental Health Information Center, Child and Adolescent Mental Health: http://mentalhealth.samhsa.gov/child/childhealth.asp
- Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov/

# Appendix D: Community Resources

Mental health services in Texas are available through several mechanisms, such as area information centers, early childhood resources, the school system, the mental health and mental retardation system, the juvenile justice system, state agencies, advocacy groups and information networks, prevention programs, other community resources, and treatment facilities.

## 1. 2-1-1 and Area Information Centers

### A. Texas Health and Human Services Commission, Texas Information and Referral Network

www.211texas.org/211/index.jsp

Area Information Centers (AICs) are the first places to call to find local health and social services. They serve as links between people who need assistance and service providers. Selected by their communities and designated by the Texas Information and Referral Network, each AIC maintains a comprehensive database of area resources including federal, state, and local government agencies; community-based organizations; and private nonprofit agencies. These AICs are part of the 211 Texas system and may answer "2-1-1" when called. Calls to 2-1-1 are automatically routed to the AIC in your area.

For contact information for the Area Information Centers, visit www.211texas.org/211/AIClinks.jsp.

## 2. Early Childhood Resources

### A. Early Childhood Intervention Directory 2007

www.dars.state.tx.us/ecis/publications/Directory2007.pdf

This directory provides information about the Texas ECI system, including eligibility, a description of services, and how to find services. A list of state and national resources available for families with children with disabilities and for the professionals who work with them is included, along with an alphabetical list of counties that includes the ECI program serving it: the program name, its host agency, telephone number used for referring to ECI, mailing address, fax number, the program director's e-mail address, and, if available, Web site address.

### B. ECI Resources

DARS Inquiries Line: (800) 628-5115, (866) 581-9328 (ECI TDD/TTY)

The DARS Inquiries Line provides information about and referral to early childhood intervention services.

Callers also may order ECI literature through the line. The Inquiries Line operators can provide information about other early childhood resources for families of children with disabilities. English- and Spanish-speaking operators answer the Inquiries Line during regular business hours, 8 am to 5 pm, Monday through Friday. Interpretation for other languages through Language Line Services is available during all hours that the line is open.

### C. Healthy Child Care Texas

www.healthychildcaretexas.org

Initiated in 1995, Healthy Child Care America (HCCA) is a joint effort between the American Academy of Pediatrics and the U.S. Department of Health and Human Services' Child Care Bureau and Maternal and Child Health Bureau.

HCCA seeks to ensure that all children experience quality child care in a nurturing environment and have a medical home. Its principles are based on the fact that families, child care providers, and health professionals in partnership can promote the healthy development of young children in child care settings and increase access to preventive health services and safe physical environments.

Healthy Child Care Texas (HCCT) brings together health care professionals, early care and education professionals, child care providers, and families. The current HCCT initiative has a two-pronged approach to training consultants. It trains qualified individuals to be child care health consultants (i.e., registered nurses, child development specialists, early childhood education specialists) or medical consultants (i.e., physicians, residents, physician assistants, nurse practitioners).

### D. Nurse-Family Partnerships

www.nursefamilypartnership.org

The Nurse-Family Partnership program works to improve the health and self-sufficiency of low-income, first-time parents and their child. Through this program, registered nurses make home visits to the parents. The visits will start no later than the 28th week of pregnancy and continue until the child turns 2 years old. The visiting nurses focus on the mother's health, the parents' quality of care giving for the child, and the child's development. Participation in the program is voluntary, and visits usually take place in the family's home.

Implementing Agency: YWCA of Metropolitan Dallas
Service Areas: Dallas County
Contact: Susan Smithson
E-mail: ssmithson@ywcadallas.org

### E. Parents as Teachers

5952 Royal Ln., Suite 261
Dallas, Texas 75230
Phone: (214) 363-8661
Fax: (214) 363-8664

Parents as Teachers (PAT) is a parent education and family support program serving families throughout pregnancy until their child enters kindergarten, usually age 5. Parents are supported by PAT-certified parent educators trained to translate scientific information on early brain development into specific when, what, how, and why advice for families.

By understanding what to expect during each stage of development, parents can easily capture the teachable moments in everyday life to enhance their child's language development, intellectual growth, social development, and motor skills.

Texas Parents as Teachers local programs are working with parents to provide them parenting support and information on their developing child. PAT is designed to foster strong, loving relationships between parents and their children. To find a program in your area, visit: http://txpat.org/roster1_1.htm.

### F. Texas Department of Family and Protective Services, Child Care Information Hotline

(800) 862-5252
www.dfps.state.tx.us

Provides information about child care in Texas.

## 3. Working With Schools

### A. Texas Department of State Health Services, School Health Program

Information Line: (888) 963-7111
Phone: (512) 458-7279 in Austin
Fax: (512) 458-7350
www.dshs.state.tx.us/schoolhealth

The School Health Program provides leadership and support to communities in their efforts to meet the health services and health education needs of their children in a school setting. The School Health Program Web site provides a great deal of information on school health requirements and educational materials:

#### *School Health Specialists*

Each Education Service Center (ESC) of the Texas Education Agency is staffed with a regional school health specialist who provides and promotes wellness information, materials, and other resources to teachers, administrators, other school personnel, parents, and community members within the school community through in-service training, workshops, and other technical assistance. These regional school health specialists receive specialized training in behavioral health and suicide prevention programs.

To find contact information for the school health specialist for your area, visit www.dshs.state.tx.us/schoolhealth/netlist.shtm.

To find contact information for the regional ESC in your area, visit www.tea.state.tx.us/ESC.

### B. Texas Education Agency, Division of Special Education IDEA

Information Line: (800) 252-9668
(512) 463-9414 in Austin
www.tea.state.tx.us/special.ed

The Texas Education Agency (TEA) oversees the public school systems. The Division of Special Education within TEA provides information regarding services for children ages 3 to 21 who qualify for special education. The agency can answer questions regarding parents' and children's rights as well as special education services in the public school system.

## 4. Working With the Mental Health System

To learn more about DSHS community mental health services available in your area for adults or children, you can contact your local mental health authority. You also will be able to access the local information and referral line, which is answered 24/7.

To find the proper mental health authority and their telephone number, visit http://webds.dshs.state.tx.us/mhservices/.

**Community Mental Health Program Contacts**

- Community Mental Health Contracts: (512) 206-5828
- Community Mental Health Data and Reports: (512) 206-5968
- Community Mental Health News and Information: (512) 458-7400
- Community Mental Health Programs and Initiatives: (512) 206-5968
- Community Mental Health Rules and Statutes: (512) 206-4591
- Community Mental Health Services: (512) 206-5968
- Community Relations: (512) 458-7111 ext. 6605
- Consumer Rights for Mental Health Services:
  (800) 252-8154 - Texas Only, 8 am-5 pm, M-F
  (512) 206-5760 - Outside Texas, 8 am-5 pm, M-F
  (800) 735-2988 - Relay Texas, Voice
  (800) 735-2989 - Relay Texas, TTY
- Mental Health State Hospitals: (512) 206-4616
- Quality Management for Community Mental Health: (512) 206-5818

## 5. Working with Child Welfare and Juvenile Justice

### A. Key Contacts and Hotlines

| Hotline | Number/Use | Availability |
|---|---|---|
| **Abuse in MHMR Facilities** | **(800) 647-7418**<br>To report abuse, neglect, or exploitation in MHMR facilities | 24 hours a day, seven days a week |
| **Child Care Information** | **(800) 862-5252**<br>For information about child care in Texas | 8 am-5 pm (CT), M-F |
| **Foster Care and Adoption Inquiry Line** | **(800) 233-3405**<br>For information on becoming a foster or adoptive parent through DFPS | 8 am-5 pm (CT), M-F |
| **Office of Consumer 8 am-5 pm (CT), M-F** | **(800) 720-7777**<br>To make an inquiry or complaint about an existing DFPS case | 8 am-5 pm (CT), M-F |
| **Texas Abuse/Neglect Hotline** | **(800) 252-5400 or**<br>www.txabusehotline.org<br>For reporting abuse, neglect, or exploitation of children, the elderly, or people with disabilities | This number is available 24/7, across the United States. |
| **Texas Runaway Hotline** | **(888) 580-HELP [(888) 580-4357]**<br>To provide peer counseling to runaways and family members | 24/7 |
| **Texas Youth Hotline** | **(800) 210-2278**<br>To provide peer counseling to youth and family members for family conflicts, delinquency, truancy, abuse and neglect, and running away | 24/7 |

### B. Texas Juvenile Probation Commission

**Phone: (512) 424-6700 in Austin**
Fax: (512) 424-6717
info@tjpc.state.tx.us

The Texas Juvenile Probation Commission works in partnership with local juvenile boards and juvenile probation departments to support and enhance juvenile probation services throughout the state by providing funding, technical assistance, and training; establishing and enforcing standards; collecting, analyzing, and disseminating information; and facilitating communications between state and local entities.

This mission is accomplished through a continuum of services and programs that:

- Include prevention, early intervention, and rehabilitative programs;
- Maximize family participation and accountability;
- Are community based, family oriented and as least restrictive as possible;
- Include a mix of residential and nonresidential services, which reduces commitments to the Texas Youth Commission; and
- Are a balance of public and private services and resources.

To find the local juvenile probation department in your area, visit www.tjpc.state.tx.us/publications/other/all_juvenile_departments.asp.

## 6. State Agencies

| Agency | Division | Description | Phone | URL |
|---|---|---|---|---|
| **General** | | | | |
| **Texas Department of Aging and Disability Services** | Information and referral services | Provides customer service and assistance, and information on the Medically Dependent Children (MDCP) Program | **(512) 438-3011** | Customer service: www.dads.state.tx.us/<br><br>MDCP: www.dads.state.tx.us/providers/MDCP/index.cfm |
| **Insurance Benefits: Health/Disability** | | | | |
| **Children's Health Insurance Program** | Customer service | Offers insurance for children at extremely affordable rates; available to families who earn too much to qualify for Medicaid coverage | **(800) 647-6558** | www.chipmedicaid.com/english/index.htm |
| **Medicaid Hotline** | Customer service | Provides information on Medicaid and Healthy Steps (children's immunizations). Helps clients with doctor referrals, billing, paying problems, and other general information relating to Medicaid | **(800) 252-8263** | www.hhsc.state.tx.us/medicaid/index.html |
| **Social Security Administration** | General information on disability benefits | Information on social security programs, including financial assistance for the elderly and individuals who are blind or otherwise disabled | **(800) 772-1213** | www.ssa.gov/dallas<br><br>To find local offices, visit www.ssa.gov/dallas/state_tx.html |
| **Texas Department of Assistive and Rehabilitative Services** | General information | Main line for inquiries about Texas Rehabilitation Commission services | **(800) 628-5115** | www.dars.state.tx.us/ |
| **Texas Department of Insurance** | Insurance Information and assistance | Provides general information on companies and agencies, information regarding complaints, and aid in educating the general public on insurance issues | **(800) 578-4677** | www.tdi.state.tx.us |
| **Texas Department of State Health Services** | Children with special health care needs | Provides information on the Chronically Ill and Disabled Children (CIDC) Program | **(800) 252-8023** | www.dshs.state.tx.us/CSHCN/client.shtm |
| **Texas School for the Deaf** | Deaf services | Automated line that takes messages by answering machine and teletypewriter. Calls are returned at a later date. Callers may request general information on the school, or leave a message for a specific party. | **(512) 462-5353** | www.tsd.state.tx.us/ |
| **Substance Abuse** | | | | |
| **Texas Department of State Health Services** | Prevention Resource Centers: Maximizes efforts by acting as a point of coordination among agencies and public | | **(866) 378-8440** | www.dshs.state.tx.us/sa |

## 7. Advocacy Organizations and Information Networks

### A. Advocacy, Inc.
(800) 252-9108
(512) 454-4816 in Austin
(800) 252-9108 (Voice/TDD)
www.advocacyinc.org
Advocates for Texans of all ages with disabilities and mental illness. Provides information for parents about their children's rights in the school system and can help resolve disputes.

### B. ARC of Texas
(800) 252-9729
(512) 454-6694 in Austin
www.thearcoftexas.org
Promotes community inclusion for people with mental retardation and other developmental disabilities through advocacy, training and information, and referral services. The ARC also administers a low-cost supplemental needs trust for people with disabilities.

### C. Autism Society of America
(800) 328-8476
www.autism-society.org
Promotes access and opportunity for individuals with autism and their families, to be fully participating, included members of their community. Education, advocacy, public awareness, and the promotion of research.

### D. Council for Exceptional Children
(888) 232-7733
www.cec.sped.org
Nonprofit organization advocating for individuals who work with or on behalf of children with special needs, birth through age 8, and their families. Children with special needs include those who have disabilities, developmental delays, are gifted/talented, or are at risk of future developmental problems.

### E. Federation for Children With Special Needs
(800) 331-0688
www.fcsn.org
Center for parents and parent organizations to work together on behalf of children with special needs and their families.

### F. Mental Health America of Texas
(512) 454-3706
www.mhatexas.org
Formerly the Mental Health Association in Texas, this organization and eight local affiliates provide mental health information, education, and advocacy.

### G. National Alliance for the Mentally Ill
(800) 633-3760 in Texas
(512) 693-2000 in Austin
www.namitexas.org
NAMI Texas offers family education courses across Texas and support groups for family members and persons with mental illness.

### H. National Mental Health Information Center
(800) 789-2476
http://mentalhealth.samhsa.gov/
The center is a service of the Substance Abuse and Mental Health Services Administration (an agency of the U.S. Department of Health and Human Services) that offers a locator for mental health services.

You can find the locator at http://mentalhealth.samhsa.gov/databases/ and the Child and Adolescent Mental Health Program at http://mentalhealth.samhsa.gov/child/childhealth.asp.

### I. Texans Care for Children
(512) 473-2272
Fax: (512) 473-2173
www.texanscareforchildren.org
This is a statewide umbrella organization for all of the state's child advocacy groups. TCFC has a 10-year plan that focuses on each legislative session with a set of specific priorities designed to achieve their 10-year goals. Children's mental health is one of their principal goals.

### J. Texas Council for Developmental Disabilities
(800) 262-0334 in Texas
(512) 437-5432 in Austin
www.txddc.state.tx.us
Advocates for Texans with a disability that started before age 22, to help them obtain the services they need to be fully included in their community. The council administers a leadership program for individuals who have disabilities and parents who have young children with disabilities.

## K. Texas Federation for Families for Children's Mental Health

Federation of Families for Children's Mental Health (FFCMH) is an advocacy group for parents and caregivers. Texas Chapter contact information follows.

**Austin Travis County FFCMH**
6602 Lancret Hill Dr., Austin, TX 78745
(512) 804-3174
Cell Phone: (512) 663-8163
Fax: (512) 804-3169
Home: (512) 416-0840
Stephany.bryan@atcmhmr.com

**Bell County Chapter FFCMH**
10707 Pendleton Troy Rd., Troy, TX 76579
(254) 938-2307
Fax: (254) 938-2431
Gerskd@vvm.com

**Bexar County Federation of Families**
5901 Flynn Dr., Suite 921, San Antonio, TX 78228-2440
(210) 435-2874 (Call before faxing)
paula_foster07@hotmail.com

**Coming Together for Children**
**Texana MHMR Center**
711 S. 11th St., Richmond, TX 77469
(281) 342-0090
Fax: (281) 341-9388
calmeida@texanamhmr.com

**Dallas FFCMH**
2629 Sharpview Ln., Dallas, TX 75228
(214) 320-1825
Home: (214) 320-3516
Fax: (214) 320-3750
dallasffcmh@earthlink.net

**Deep East Texas FFCMH**
Rt. 3, Box 800-5, Jasper, TX 75951
(409) 384-7292
jdmc@jas.net

**Familias Preciosas**
3205 S. 1st St., Austin, TX 78704
(512) 407-8844
Fax: (512) 407-8266
Toll-free: (800) 860-6057
familiapreciosas@yahoo.com
www.txffcmh.org

**Families in Unity**
111 N. Wall, Floydada, TX 79235
(806) 983-4929
brother@texasonline.net

**Navarro County FOF**
416 SW CR 0020, Corsicana, TX 75110
(903) 874-1773
robinshaw75110@hotmail.com

**Newton County FFCMH**
Rt. 3, Box 800-5, Jasper, TX 75951
(409) 384-7292
jdmc@jas.net

**North Central Texas FFCMH**
809 Liberty Ln., Blue Mound, TX 76131
(817) 306-9825
Fax: (817) 847-1407
ld_still@msn.com

**North Texas FFCMH**
4820-C Highgrove, Sherman, TX 75090
(903) 893-3742 home
(903) 883-3742 fax (Call before faxing)
patoadv@msn.com

**South Plains FFCMH**
Rt. 7, Box 269, Lubbock, TX 79403
(806) 790-5323
Fax: (806) 740-1574
spffcmh@hotmail.com

**Southwest Houston FFCMH**
6515 Hillcroft St., Apt. 441, Houston, TX 77081
(713) 777-0195

**START for Families**
2020 Greg St., Azle, TX 76020
(817) 444-4067
Fax: (817) 444-5830
josephroxann@cs.com

**Texas FFCMH**
7701 N. Lamar Blvd., Suite 505, Austin, TX 78752
(512) 407-8844
Fax: (512) 407-8266
Toll-free: (866) 893-3264
dibbihyatt@txffcmh.org
www.txffcmh.org

## 8. Prevention Programs

### A. Communities in Schools

(800) CIS-4KIDS
www.cisnet.org
This initiative focuses on keeping kids in schools by bringing existing resources into the schools and providing children the supportive relationships they need to stay in school and lead productive lives. Each CIS operation surrounds young people with a community of tutors, mentors, health care professionals, and career counselors — caring adults who can help kids help themselves.

### B. Prevention and Early Intervention

(800) 210-2278 8
www.dfps.state.tx.us/Prevention_and_Early_Intervention/Programs_Available_In_Your_County/default.asp
Prevention and Early Intervention (PEI) manages community-based programs that prevent delinquency, abuse, neglect, and exploitation of Texas children; helps communities enhance services provided through the Texas Department of Family and Protective Services; assists communities in identifying prevention and early intervention needs; and supports the development of and modifications to new and existing programs designed to prevent or reduce poor outcomes for children, youth, and their families.

### C. Search Institute

(800) 888-7828
www.search-institute.org
This organization has developed a model for population-based mental health prevention and promotion services. The work of the Search Institute is based on assessing the strengths of an individual or community rather than the deficits. The Search Institute model identifies 40 critical factors for young people's growth and development. Together, the critical factors, or assets, offer a set of benchmarks for positive child and adolescent development.

## 9. Other Community Resources

Following are phone numbers, Web sites, and descriptions of programs and services that you might be able to tap or replicate in your community.

### A. Any Baby Can (ABC)

(800) 672-0238
(512) 454-3743 in Austin
(800) 373-3400 in Kerrville
(210) 227-0170 in San Antonio
Comprehensive support and crisis assistance for children, with special health care needs, ages 0 to 12.
www.ABCaus.org

### B. Child Guidance Centers in Texas

Child guidance centers work to provide and/or coordinate a range of mental health services including psychiatric or psychological assessments; individual, family, and group counseling; parent education; and other activities to promote mental health in youth and their communities. Child guidance centers in Texas are listed below.

**Austin Child Guidance Center**
810 W. 45th St.
Austin, TX 78751
(512) 451-2242
www.austinchildguidance.org

**Child Guidance Center of San Antonio**
2135 Babcock Rd.
San Antonio, TX 78229
(210) 614-7070
Fax: (210)615-0249
http://www.cgcsanantonio.org

**Child Guidance Clinic of Texoma**
707 S. Sam Rayburn Frwy.
Sherman, TX 75092
(903) 893-7768
www.childguidancetx.org/

**Child Study Center**
1300 W. Lancaster
Fort Worth, TX 76102
(817) 336-8611
Fax: (817) 390-2941
http://www.cscfw.org/

**Dallas Child and Family Guidance Center**
8915 Harry Hines Blvd.
Dallas, TX 75235
(214) 351-3490
Fax: (214) 352-0871
http://childrenandfamilies.info

### C. Children and Adults With Attention-Deficit/ Hyperactivity Disorder (CHADD)

(800) 233-4050
Information on ADHD in children, teens, and adults. Information for those who may qualify for special education and related services under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act solely on the basis of their ADHD when it impairs educational performance or learning.
www.chadd.org

### D. The Children's Partnership

(512) 854-4596
This organization coordinates local resources to maintain a system of care in Travis County, a system that works hand-in-hand with families and focuses on the unique strengths of each child. Local organizations work in teams — with families as critical partners — to provide a full range of services to children and adolescents with serious emotional disturbances. This team strives to meet the unique needs of each young person and his or her family in or near their home.
www.childrenspartnership.com.

### E. Community Resource Coordination Groups of Texas

(512) 424-6963
Composed of public and private providers who come together to develop individual service plans for children, youth, and adults whose needs can be met only through interagency coordination and cooperation.
www.hhsc.state.tx.us/crcg

### F. Family Service Centers

(409) 762-8636
(409) 762-4185
Family Service Centers are nonprofit organizations offering counseling to families and individuals on a sliding scale basis. One such center is Family Service Center of Galveston County, Texas, a private, nonprofit agency offering professional counseling by licensed mental health professionals to individuals and families experiencing emotional and/or relational problems. Offices are located in Galveston, Texas City, Dickinson, Liberty, Cleveland, and Mount Belvieu. Fees, ranging from $5 to $65 per hour, are based on family income and size.

For information or to schedule an appointment, call (409) 762-8636, or for the Services to At-Risk Youth [STAR] Program, call (800) 392-3352.
www.fsc-galveston.org/

### G. ParentingInformation.org

(512) 454-3706
This Web site contains parenting resources especially related to mental health issues. ParentingInformation.org is a program of the Children's Mental Health Public

Information and Community Outreach Project of the Mental Health Association in Texas.
www.parentinginformation.org

### H. Texas Council of Community MHMR Centers, Inc.

(512) 794-9268
The purpose of the council is to provide an organization through which community MHMR centers can work together as a public system serving Texans with mental illness, mental retardation, and chemical dependency, and improve services that communities and consumers need. The council is accountable to sponsoring governmental entities, other funding sources, and the state governance for its investments in services.
www.txcouncil.com

## 10. Treatment Facilities

### A. Psychiatric Solutions, Inc., facilities in Texas:

**Austin Lakes Hospital**
1025 East 32nd St.
Austin, TX 78705
(512) 544-5253
Fax: (512) 544-5831

**Compass Hospital**
14743 Jones Maltsberger
San Antonio, TX 78247
(210) 402-0029
Fax: (210) 490-8616

**Cypress Creek Hospital**
17750 Cali Drive
Houston, TX 77090
(281) 586-7600
Fax: (281) 586-5925

**The Excel Center**
1220 W. Presidio St.
Fort Worth, TX 76102
(817) 335-6429

**The Excel Center Lewisville**
190 Civic Cir.
Lewisville, TX 75067
(817) 335-6429

**Hickory Trail Hospital**
2000 N. Old Hickory Trail
DeSoto, TX 75115
(972) 298-7323
Fax: (972) 709-0581

**Kingwood Pines Hospital**
2001 Ladbrook Dr.
Kingwood, TX 77339
(281) 358-1495
Toll-free: (866) 347-7223
Fax: (281) 404-1015

**Laurel Ridge Treatment Center**
17720 Corporate Woods Dr.
San Antonio, TX 78259
(210) 491-9400
Fax: (210) 491-3550

**Millwood Hospital**
1011 North Cooper St.
Arlington, TX 76011
(817) 261-3121
Fax: (817) 261-7574

**Mission Vista Behavioral Health Center**
14747 Jones Maltsberger
San Antonio, TX 78247
(210) 497-0004
Fax: (210) 572-1447

**The Oaks Treatment Center**
1407 West Stassney Ln.
Austin, TX 78745
(512) 464-0200
Fax: (512) 464-0439

**San Marcos Treatment Center**
120 Bert Brown Road
San Marcos, TX 78666
(512) 396-8500
Fax: (512) 754-3883

**Texas NeuroRehab Center**
**and Texas Star Recovery Program**
1106 West Dittmar Rd.
Austin, TX 78745
(512) 444-4835
Fax: (512) 462-6749

**West Oaks Hospital**
6500 Hornwood
Houston, TX 77074
(713) 995-0909
Fax: (713) 778-5253

# Appendix E: Original Authors of *Integrating Child and Adolescent Mental Health Into Primary Care: A Resource Guide for Physicians*

A project of TMA's Committee on Child and Adolescent Health, 1999-2001: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# Appendix F: American Academy of Pediatrics Coding Examples

## Developmental Screening/Testing Coding Fact Sheet for Primary Care Pediatricians

### I. Coding

Developmental screening, surveillance, and assessment are often complemented by the use of special tests, which vary in length. This Coding Fact Sheet provides guidance on how pediatricians can appropriately report limited and extended developmental screening and testing services.

### A. How To Report Developmental Testing

**96110** *Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report*

The use of developmental screening instruments of a limited nature (e.g., Developmental Screening Test II, Early Language Milestone Screen, PEDS, Ages and Stages, and Vanderbilt ADHD rating scales) is reported using CPT code 96110 (*developmental testing; limited*). Code 96110 is often reported when performed in the context of preventive medicine services, but may also be reported when screening is performed with other evaluation and management (E/M) services such as acute illness or follow-up office visits. On the 2005 Medicare Fee Schedule (Resource-Based Relative Value Scale or RBRVS), the Centers for Medicare and Medicaid Services (CMS) published a total relative value unit (RVU) of 0.36 for 96110, which amounts to a Medicare payment of $13.64 (0.36 x $37.8975 {Medicare 2005 conversion factor} = $13.64). Because an office nurse or other trained non-physician personnel typically performs the service, this relative value reflects only the practice expense of the office staff and nurses, the cost of the materials, and professional liability — there is no physician work value published on the Medicare physician fee schedule for this code.

On the less common occasion where a physician performs this service, it may still be reported with code 96110 but the time and effort to perform the testing itself should not count toward the key components (history, physical exam, and medical decision making) or time when selecting an E/M code for a significant, separately identifiable service performed during the same patient encounter. When a limited screening test is performed along with any E/M service (e.g., preventive medicine or office outpatient), both services should be reported and modifier -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) should be appended to the E/M code to show the E/M service was distinct and necessary at the same visit.

**96111** *Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report*

Extended developmental testing using standardized instruments (e.g., Bayley Scales of Infant Development, Woodcock-Johnson Tests of Cognitive Abilities (Third Edition) and Clinical Evaluation of Language Fundamentals (Fourth Edition)) are reported using CPT code 96111. This service may be reported independently or in conjunction with another code describing a separate patient encounter provided on the same day as the testing (e.g., an evaluation and management code for outpatient consultation). A physician or other trained professional typically performs this testing service. Therefore, there are physician work RVUs published on the Medicare physician fee schedule (Resource-Based Relative Value Scale or RBRVS) for this code. In 2005, code 96111 has 3.83 total RVUs, which calculates to a Medicare payment of $145.15 (3.83 x $37.8975 {Medicare 2005 conversion factor} = $145.15).

When 96111 is reported in conjunction with an E/M service, the time and effort to perform the developmental testing itself should not count toward the key components (history, physical exam, and medical decision making) or time for selecting the accompanying E/M code. Just as discussed for 96110, if the E/M code is reported with 96111, modifier -25 (*significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) should be appended to the E/M code or modifier -59 (*distinct procedural service*) should be appended to the developmental testing code, showing that the services were separate and necessary at the same visit.

In 2005, the CPT code descriptor of 96111 was revised to reflect the deletion of the test examples as well as the "per hour" designation. Thus, starting January 1, 2005, physicians will report the service without regard to time. The typical testing session, including the time to perform the interpretation and report, was found in the American Academy of Pediatrics (AAP) survey used to value the service to be slightly over an hour.

## B. When To Report Developmental Testing

### 96110

The frequency of reporting 96110 is dependent on the clinical situation. The AAP "Recommendations for Preventive Pediatric Health Care" schedule recommends developmental/behavioral assessment at each preventive medicine visit, and the AAP "Developmental Surveillance and Screening of Infants and Young Children" policy statement recommends that physicians use validated developmental screening tools to improve detection of problems at the earliest possible age to allow further developmental assessment and appropriate early intervention services.

Thus, the use of screening tests of a limited nature seems to enhance the task of developmental assessment typically done in the preventive medicine setting. The exact frequency of testing therefore depends on the clinical setting and the provider's judgment as to when it is medically necessary. When physicians ask questions about development as part of the general informal developmental survey or history, this is not a "test" as such, **and is not separately reportable**. Examples of validated limited screening tests along with clinical vignettes are provided below.

### 96111

Longer, more comprehensive developmental assessments of patients suspected of having problems are typically reported using CPT code 96111 (*developmental testing; extended*). These tests are typically performed by physicians or psychologists and require upwards of an hour of time. They also are accompanied by an interpretation and formal report, which may be completed at a time other than when the patient is present.

Like code 96110, the frequency of reporting code 96111 is dependent on the needs of the patient and the judgment of the physician. When developmental surveillance or screening suggests an abnormality in a particular area of development, more extensive formal objective testing is needed to evaluate the concern. In contrast to adults, the limited ability of children to maintain focused selective attention and testing speed may mean that several sessions are needed to properly evaluate the problem. Code 96111 is reported only once the testing and its accompanying report are completed.

Additionally, subsequent periodic formal testing may be needed to monitor the progress of a child whose skills initially may have not been "significantly low," but who was clearly at risk for maintaining appropriate acquisition of new skills.

## II. Clinical Vignettes

### 96110 Vignette #1

At a 24-month well child check, the mother describes her toddler as "wild," completes the PEDS (Parent Evaluation of Developmental Status), and responds positively to the question "Do you have concerns about your child's language skills?" The nurse scores the PEDS and places the answer sheet on the front of the chart with a red arrow sticker next to it. When the pediatrician examines the child, he is alerted to ask the mother about her observations of the child's language ability. He then confirms the delay in language, and makes a referral to a local speech pathologist.

| CPT | ICD-9-CM |
|---|---|
| **99392-25** Preventive medicine service; established patient, age 1-4 (appended with modifier -25) | V20.2 Routine infant or child health check |
| **96110** Developmental testing; limited | V20.2 Routine infant or child health check<br>315.31 Expressive language disorder |

If the pediatrician spent significant extra time evaluating the language problem, then an E/M service office/outpatient code from the 99201-99215 series may be reported using a modifier -25, linked to the appropriate ICD-9-CM code(s) as appropriate (e.g., 315.31, *Expressive language disorder;* 315.32, *Mixed receptive-expressive language disorder;* 315.39, *Other developmental speech or language disorder).*

### 96110 Vignette #2

At a five-year health maintenance visit, a father discusses his daughter's difficulty "getting along with other little girls." "Doctor, she wants friends, but she doesn't know how to make — much less keep — a friend." Further questioning indicates the little girl is already reading and writing postcards to relatives, but has not learned how to ride her small bicycle, is awkward when she runs and she avoids the climbing apparatus at the playground. Her father wondered if

her weaker gross motor skills affected her ability to play successfully with other children. She seems very happy to sit and look at books about butterflies — her all consuming interest! The child's physical exam consistently fell in the range of 'normal for age' in previously health maintenance visits. The pediatrician asks her nurse to administer the Australian Scale for Asperger's Syndrome and the father's responses yield 16/24 items with an abnormal score being >3. The pediatrician reviews the form, writes a brief summary, and discusses her observations with the father. A referral is made to a local physical therapist who has a playground activities group and to a local psychologist who has expertise in diagnosing autism spectrum disorders.

| CPT | ICD-9-CM |
|---|---|
| **99393-25** Preventive medicine service; established patient, age 5-11 (appended with modifier –25) | V20.2 Routine infant or child health check |
| **96110** Developmental testing; limited | V20.2 Routine infant or child health check<br>315.4 Developmental coordination disorder<br>313.9 Unspecified emotional disturbance of childhood |

### 96111 Vignette #1

An 8-year-old boy with impulsive, overly active behavior and previously assessed "average" intelligence is referred for evaluation of attention deficit disorder. He has by prior history reading and written expression skills at first grade level, and received speech and language therapy during his attendance at Head Start when he was 4 years old.

Behavior and emotional regulation rating scales completed by the parent and teacher were reviewed at an earlier evaluation and management service appointment. History, physical and neurological examination were also completed at that visit.

On this visit, standardized testing was administered to confirm auditory and visual attention, short term and working memory as well as verbal and visual organization. Testing was administered for standard scores as well as structured observations of behavior. These scores and observations were integrated into a formal report to be used to individualize his education and treatment plan. Testing and the report took approximately 75 minutes. The family schedules a follow up visit to discuss this report and the final diagnosis and treatment plan with the physician.

| CPT | ICD-9-CM |
|---|---|
| **96111** Developmental testing; extended | 314.0x Attention deficit disorder<br>x = 0 for no hyperactivity<br>x = 1 for hyperactivity |

### 96111 Vignette #2

A 5 4/12 year old boy just beginning kindergarten whose mother's responses on the Pediatric Evaluation of Developmental Status (PEDS) suggested expressive language delays was seen for developmental testing. After greeting the parent and child and explaining to the child that he and the doctor would do some 'non-school' activities to see how he 'used words to tell others about (his) good ideas', the child and the examiner spent fifty minutes together completing the tasks on the Peabody Picture Vocabulary Test-Third Edition, and the Clinical Evaluation of Language Fundamentals-Fourth Edition. The examiner scored the two tests in five minutes and there was a significant discrepancy detected between the Receptive Language Composite and the Expressive Composite on the CELF-4. Both test scores were abnormal, indicating a mixed receptive-expressive disorder.

| CPT | ICD-9-CM |
|---|---|
| **96111** Developmental testing; extended | 315.32 Mixed receptive expressive language disorder |

## III. Documentation Guidelines

Each administered developmental screening and testing instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). This is often included in the test itself, but these elements may alternatively be documented in the progress report of the visit itself. Physicians are encouraged to document any interventions based on abnormal findings generated by the tests.

Following are examples of appropriate documentation for some testing tools:

### 96110

**PEDS (Parents' Evaluation of Developmental Status)**

This questionnaire is designed to identify any parent/primary caretaker's concerns about a birth through 8-year child's developmental attainment and behavioral/mental health concerns. There are eight specific domain queries and one asking, "please list any concerns about your child's learning, development and behavior" and a final "please list any other concerns." The parent answers are scored into the risk categories of high, moderate, or low. The report form is included with the test.

***ASQ* (*Ages and Stages Questionnaire*)**

This parent report instrument, covering ages 1 month through 60 months, includes objective information as the adult notes whether the child performs the skill identified. There are six questions in each of five domains: Communication, Gross Motor, Fine Motor, Problem Solving and Personal-Social. All questions are scored on a point system, with summary scores indicating the need for further evaluation. The *ASQ* also has a non-specific comprehensive section where general concerns are addressed. No score is provided for these answers, but the instrument developers note any "Yes" responses should also be referred.

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In general, the documentation of developmental testing includes the scoring, interpretation, and the development of the report. This typically includes all or some of the following: identifying data, time and location of testing, the reason for the type of testing being done, and the titles of all instruments offered to/completed by the child; presence (if any) of additional persons during testing, child's level of cooperation and observations of child's behavior during the testing session. Any assistive technology, prosthetics or modifications made to accommodate the child's particular developmental or physical needs should be described, and specific notations should be made if any items offered resulted in a change in the child's level of attention, willingness to participate, apparent ease of task accomplishment. The item results should be scored and the test protocol and any/all scoring sheets should be included in the medical chart (computer scanning may be needed for electronic medical records). A brief interpretation should be recorded and notation should be made for further evaluation or treatment of the patient or family. A legible signature should also appear.

## IV. Sample Testing Tools

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*Ages and Stages Questionnaire-Second Edition (ASQ)* and *Ages and States Questionnaire: Social-Emotional (ASQ:SE)* (Brookes Publishing: Jane Squires, PhD and Diane Bricker, PhD, et al.)

*Australian Scale for Asperger's Syndrome (ASAS)* (Michelle Garnett, Master's Clinical Psychology and Anthony Attwood, PhD)

*Behavior Assessment Scale for Children-Second Edition (BASC-II)* (American Guidance Service: Cecil Reynolds and Randy Kanphaus)

*Behavioral Rating Inventory of Executive Functioning (BRIEF)* (Psychological Assessment Resources, Inc.: Gerald Gioia, PhD, Kimberly Espy, PhD, and Peter Isquith, PhD)

*Child Development Review* (Behavior Science Systems, Inc.: Harold Ireton, PhD, et al.)

*Communication and Symbolic Scales Developmental Profile (CSBS DP)* (Brookes Publishing: Amy Wetherby, PhD, CCC-SLP, Barry M. Prizant, PhD, CCC-SLP)

*Kaufman Brief Intelligence Test* (American Guidance Service: Alan Kaufman and Nadeen Kaufman)

*Parents' Evaluation of Developmental Status (PEDS)* (Ellsworth and Vandermeer Press, LLC: Frances Page Glascoe, PhD)

*Pediatric Symptom Checklist: A Primary Care Screening Tool to Identify Psychosocial Problems (PSC)* (http:psc.partners.org: Michael Jellinek, MD, and J. Michael Murphy, PhD)

*Vanderbilt Rating Scales* (Mark L. Wolraich, MD)

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*Beery-Buktenica Developmental Test of Visual-Motor Integration-Fourth Edition, Revised (VMI)* (Modern Curriculum Press: Keith E. Beery, PhD)

*Clinical Evaluation of Language Fundamentals-Fourth Edition* (The Psychological Corporation: Eleanor Semel, PhD, CCC-SLP, Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP)

*Clinical Evaluation of Language Fundamentals-Preschool Version-Second Edition* (Psychological Corporation: Elisabeth Wiig, PhD, CCC/SLP, Wayne A. Secord, PhD, CCC-SLP, and Eleanor Semel, PhD, CCC-SLP)

*Comprehensive Test of Nonverbal Intelligence* (Pro-Ed: Donald Hammill, Nils Pearson, and J. Lee Wiederholt)

*Developmental Test of Visual Perception-Second Edition* (Pro-Ed: Donald Hammill, Nils Pearson, Judith Voress)

*Peabody Picture Vocabulary Test-Third Edition* (American Guidance Service: Lloyd M. Dunn and Leola M. Dunn)

*Test of Auditory-Perceptual Skills-Revised* (Psychological and Educational Publications: Morrison Gardner)

*Test of Language Competence-Expanded Edition* (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

*Test of Nonverbal Intelligence-Third Edition* (Pro-Ed Publishing: Linda Brown, Rita Sherbenou, Susan Johmsen)

*Test of Problem Solving-Revised* (LinguiSystems, Inc: Linda Zachman, Rosemary Huisingh, Mark Barrett, Jane Orman, Carolyn LoGiudice)

*Test of Word Knowledge* (The Psychological Corporation: Elisabeth Wiig and Wayne Secord)

*Woodcock-Johnson Test of Cognitive Abilities-Third Edition* (Riverside Publishing: Richard W. Woodcock, PhD, Kevin S. McGrew, PhD, and Nancy Mather, PhD)

# Appendix G: Annotated Bibliography

## Adolescents

The Parent Package. www.ama-assn.org/ama/upload/mm/39/parentinfo.pdf

The Parent Package is an American Medical Association program that includes 15 reproducible tip sheets on different topics (e.g., teens and alcohol) and offers useful facts, parenting tips, and other resources. (312) 464-5315

## Advocacy

American Academy of Pediatrics (AAP) Task Force on Mental Health (TFOMH). *Strategies for System Change in Children's Mental Health: A Chapter Action Kit.* 2007. www.aap.org/mentalhealth/mh2ch.html

The purpose of this kit is to assist AAP chapters in addressing and improving children's mental health in primary care in their state. The Chapter Action Kit focuses on the following six core action areas that provide strategies for improving children's mental health programs and services: 1) partnering with families; 2) assessing the service environment; 3) collaborating with mental health professionals; 4) educating chapter members; 5) partnering with child-serving agencies; and 6) improving children's mental health financing. Within each core action area, information is included on the overall issue, implications for AAP chapter work, suggested chapter strategies, resources for further information, and selected tools related to the topic.

Center for Public Policy Priorities. *The State of Texas Children 2007: Texas KIDS COUNT Annual Data Book.* www.cppp.org/category.php

This report provides data on Texas children's population, economic insecurity, economic support, maternal and infant health, nutrition, health care, child abuse and neglect, death and violence, early care and education, education, and selected county data.

Children's Hospital Association of Texas. "Children's Mental Health in Texas: A State of the State Report". May 2006. www.childhealthtx.org

This report provides an overview of the state's system of mental health service delivery for children and makes recommendations on steps to take to correct our dilemma.

Docs For Tots. http://docsfortots.org

Docs For Tots is a nonpartisan, advocacy organization formed to encourage more doctors to fulfill their important role as active advocates for infants, toddlers, and preschoolers on the national, state, and local levels. We are committed to making it as simple as possible for doctors to become involved in advocacy or to increase their advocacy activity. The Web site provides documents, tools, and other resources to assist physicians in advocacy.

Mental Health Association in Texas. *Turning the Corner: Toward Balance and Reform in Texas Mental Health Services.* 2005. www.mhatexas.org/mhatexasMAIN/TurningtheCorner.pdf

This report provides information on the high cost of not addressing mental health in Texas as well as recommendations.

Texans Care for Children. "Children's Mental Health," *Children's Campaign for the Decade: A Report on the Agenda for the Decade — 2007 Update.* www.texanscareforchildren.org

This report provides updated statistics in an effort to measure the well-being of Texas children and to track progress in children's mental health. It also provides long-term as well as first steps for addressing the lack of availability of children's mental health services in Texas.

Zero to Three. www.zerotothree.org

Zero to Three's mission is to support the healthy development and well-being of infants, toddlers, and their families. It is a national nonprofit multidisciplinary organization that advances its mission by informing, educating, and supporting adults who influence the lives of infants and toddlers. This Web site provides scientifically documented information about how a baby's brain develops during the first three years of life.

## Child Care

American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education (2002). *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd edition.* Elk Grove Village, IL: American Academy of Pediatrics and Washington, DC: American Public Health Association. http://nrc.uchsc.edu

This compendium is the "Bible" for health and safety standards for child care.

National Resource Center for Health and Safety in Child Care and Early Education. *Healthy Kids, Healthy Care: Parents as Partners in Promoting Healthy and Safe Child Care.* Aurora CO: 2006. www.healthykids.us

This publication and Web site answer questions regarding health and safety issues for parents of children who attend child care programs.

National Resource Center for Health and Safety in Child Care and Early Education. *Stepping Stones to Using Caring for Our Children, 2nd Edition.* 2003. http://nrc.uchsc.edu/STEPPING/index.htm

*Stepping Stones* contains 233 standards selected as a subset of the 659 national health and safety performance standards in *Caring For Our Children: National Health and Safety Performance Standard: Guidelines for Out-of-Home Child Care Programs, 2nd Edition* (CFOC). This subset includes the standards that have the greatest impact on disease, disability, and death (morbidity and mortality) in out-of-home child care. To keep the document size manageable, *Stepping Stones, 2nd Edition* contains only the unaltered text of the selected standards without the rationale, comments, or references. Please consult the hard copy or the Internet version of *Caring for Our Children, 2nd Edition* (CFOC) for the rationale, comments, references, cross-referenced standards, and full set of appendices.

## Child Development

Center for Promotion of Child Development through Primary Care. www.childhealthcare.org/

The center seeks to improve the lives of children and families through research, training, and support for parents and health care professionals in the primary care application of child development knowledge. It also is the home of CHADIS, an interactive computer system for parents, primary care clinicians, and mental health professionals.

Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* JP Shonkoff and DA Phillips, eds., National Academy of Sciences. 2000. www.nap.edu

This authoritative yet accessible compendium presents the evidence about "brain wiring" and how children learn to speak, think, and regulate their behavior. It examines the effect of the climate — family, child care, community — within which the child grows.

Commonwealth Fund. *A Practical Guide for Healthy Development.* April 1, 2006. www.commonwealthfund.org/General/General_show.htm?doc_id=335599

*A Practical Guide for Healthy Development* is a set of materials and tools designed and tested in the Healthy Development Learning Collaborative, a 12-month quality improvement initiative. The initiative was designed to help primary care practices in Vermont and North Carolina engage families in a partnership to promote positive developmental outcomes for the families' children through the development of improved office systems.

Commonwealth Fund. *A Practical Guide for Improving Child Development.* 2006. www.commonwealthfund.org/innovations/innovations_show.htm?doc_id=372065

This manual was created to help pediatric practices redesign their office systems to improve the quality of preventive and developmental services they provide to young children. The resources — which include checklists, surveys, bibliographies, and more — in this guide were developed and tested in the Healthy Development Learning Collaborative, a year-long quality improvement initiative in which primary care practices in Vermont and North Carolina used improved office systems to engage families in efforts to promote positive developmental outcomes.

Dreikurs, R. Children: *The Challenge*. New York: Hawthorn/Dutton. 1964.

Dreikurs was a student and colleague of social psychologist Alfred Adler. This is a classic work on improving child and parent relationships.

Drotar D, Stancin T, Dworkin P. *Pediatric Developmental Screening: Understanding and Selecting Screening Instruments*. February 2008. www.commonwealthfund.org/publications/publications_show.htm?doc_id=614864

This manual provides a detailed review of the scientific research on available developmental screening instruments and information on practitioners' selection and application of screening instruments in a range of practice settings.

Hagan JF, Shaw JS, Duncan PM, eds. (2008). *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics. www.brightfutures.aap.org

These guidelines describe a system of care that is unique in its attention to health promotion activities and psychosocial factors of health and its focus on youth and family strengths. The guidelines address the care needs of all children and adolescents, including children and youth with special health care needs and children from families from diverse cultural and ethnic backgrounds.

Schmitt BD. *Your Child's Health*. New York: Bantam Books. 2005.

Barton D. Schmitt, MD, FAAP, is professor of pediatrics at the University of Colorado School of Medicine. This book is a classic medical reference for parents regarding symptoms, emergencies, common illnesses, behavior problems, and healthy development. Dr. Schmitt uses the same protocols for management he used in his pediatric telephone protocol manuals.

Tellett-Royce N. "Ensuring the Healthy Development of Children and Youth." Search Institute. Aug. 31, 2001. www.search-institute.org

This PowerPoint presentation examines developmental assets and provides an example of using community assets to promote medical homes (CATCH).

## Counseling

Schmitt BD. "Pediatric Counseling" in *Developmental-Behavioral Pediatrics*, Third Edition. Levine MD, Carey WB, Crocker AC, eds. (1999). Philadelphia: W.B. Saunders Company.

Classic reference for pediatricians.

## Depression

Dubowitz H, et al. "Screening for Depression in an Urban Pediatric Primary Care Clinic," *Pediatrics*, 119;3 (March 2007):435-443. http://pediatrics.aappublications.org/cgi/content/abstract/119/3/435?rss=1

The authors, from the Department of Pediatrics, Epidemiology and Preventive Medicine, University of Maryland School of Medicine, Baltimore, examined parental depressive symptoms among 216 mothers at a pediatric primary care clinic to evaluate predictive values of a very brief screen for parental depression. Maternal depressive symptoms are prevalent. A very brief screen can identify reasonably those who could benefit from additional evaluation and possible treatment. This should benefit mothers, families, and children.

Goodyer I, et al. "Selective Serotonin Reuptake Inhibitors (SSRIs) and Routine Specialist Care with and without Cognitive Behaviour Therapy in Adolescents with Major Depression: Randomised Controlled Trial," *British Medical Journal*, 2007;335(7611):142. http://bmj.bmjjournals.com/cgi/content/abstract/335/7611/142

The authors, from the Developmental Psychiatry Section, Department of Psychiatry, University of Cambridge, sought to determine whether a combination of a selective serotonin reuptake inhibitor (SSRI) and cognitive behavior therapy (CBT) together with clinical care is more effective in the short term than an SSRI and clinical care alone in adolescents with moderate to severe major depression.

Conclusions: For adolescents with moderate to severe major depression, there is no evidence that the combination of CBT plus an SSRI in the presence of routine clinical care contributes to an improved outcome by 28 weeks compared with the provision of routine clinical care plus an SSRI alone.

Heneghan AM, et al. "Factors Associated With Identification and Management of Maternal Depression by Pediatricians," *Pediatrics*, 119;3 (March 2007):444-454. http://pediatrics.aappublications.org/cgi/content/abstract/119/3/444?rss=1

The authors sought to identify characteristics of pediatricians that were associated with identification or management (referral and/or treatment) of mothers with depression. Positive correlates of identification and management of maternal depression included practicing in the Midwest, using ≥1 method to address maternal depression, working in a practice that provides child mental health services, thinking that care-giving problems attributable to maternal health have an extreme *effect* on children's physical health, having attitudes that are more inclined to identify and to manage maternal depression, and usually inquiring about symptoms routinely to identify maternal depression.

Messer SC, Angold A, Costello EJ, Loeber R, Van Kammen W, Stouthamer-Loeber M. "Development of a Short Questionnaire for use in Epidemiological Studies of Depression in Children and Adolescents: Factor Composition and Structure Across Development," *International Journal of Methods in Psychiatric Research*, 5;4 (1995):251-262. http://devepi.mc.duke.edu/MFQ.html

The MFQ consists of a series of descriptive phrases regarding how the subject has been feeling or acting recently. Codings reflect whether the phrase was descriptive of the subject most of the time, sometimes, or not at all in the past two weeks. The MFQ package includes:

- One child self report MFQ - long version
- One child self report MFQ - short version
- One parent MFQ reporting about the child - long version
- One parent MFQ reporting about the child - short version
- One parent self report MFQ

The MFQ is free to download at the Web site address above. Direct questions about the MFQ to Anita Chalmers, (919) 687-4686, ext. 230, or achalmers@psych.duhs.duke.edu.

Copyright Permission: Should you wish to administer the MFQ to your clients or for your research study, please describe your proposed use and write to the above address to receive a letter of copyright approval from the first author, Adrian Angold, MRCPsych, at no charge. Citation in published work would be appreciated.

Olson AL, et al. "Brief Maternal Depression Screening at Well-Child Visits," *Pediatrics*, 118;1 (July 2006):207-216. http://pediatrics.aappublications.org/cgi/content/abstract/118/1/207

The authors, with Community and Family Medicine, Dartmouth Medical School, Lebanon, N.H., sought (1) to determine the feasibility and yield of maternal depression screening during all well-child visits, (2) to understand how pediatricians and mothers respond to depression screening information, and (3) to assess the time required for discussion of screening results. Practices were able to screen in the majority of well-child visits. Pediatrician actions included discussion of the impact on the child, a follow-up visit or call, and referral to an adult primary care provider, a mental health clinician, or community supports. Routine, brief, maternal depression screening conducted during well-child visits was feasible and detected mothers who were willing to discuss depression and stress issues with their pediatrician. Discussion after screening revealed additional mothers who felt depressed among those with lesser symptoms. The additional discussion time was usually brief (< 5 minutes).

Stein EK, Zitner LE, Jensen PS. "Interventions for Adolescent Depression in Primary Care," *Pediatrics*, 118;2 (August 2006):669-681. http://pediatrics.aappublications.org/cgi/content/abstract/118/2/669

The authors sought to examine the evidence for the treatment of depression in primary care settings, focusing on evidence concerning psychosocial, educational, and/or supportive intervention strategies. A review of literature identified 37 studies relevant to treating adolescent depression in primary care settings. Only four studies directly examined the impact of primary care-delivered psychosocial interventions for adolescent depression, but they suggest that such interventions can be effective. Indirect evidence from other psychosocial/behavioral interventions, including anticipatory guidance and efforts to enhance treatment adherence, and adult depression studies also show benefits of primary care-delivered interventions as well as the impact of provider training to enhance psychosocial skills.

## Developmental Screening

American Academy of Pediatrics, Committee on Children With Disabilities. "Developmental Surveillance and Screening of Infants and Young Children," *Pediatrics*, 108;1 (July 2001):192-196. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/1/192

This policy statement from the AAP recommends that all infants and young children should be screened for developmental delays. Screening procedures should be incorporated into the ongoing health care of the child as part of the provision of a medical home. Pediatricians should consider using standardized developmental screening tools that are practical and easy to use in the office setting. Successful early identification of developmental disabilities requires the pediatrician to be skilled in the use of screening techniques, actively seek parental concerns about development, and create links with available resources in the community.

American Academy of Pediatrics, Council on Children With Disabilities, Section on Developmental Behavioral Pediatrics, Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening," *Pediatrics*, 118;1 (July 2006):405-420. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;118/1/405

This AAP clinical report provides an algorithm, or a decision tree, as a strategy to support health care professionals in developing a pattern and practice for addressing developmental concerns in children from birth through 3 years of age. The statement recommends that developmental surveillance be performed at every preventive visit and that a screening tool should be administered at 9-, 18-, and 24- or 30-month visits and for those whose surveillance yields concerns about delayed or disordered development.

American Academy of Pediatrics, Illinois Chapter. Screening Tools & Education for Pediatric Providers (STEPPS): Developmental Screening and Referral Program. Resource & Referral Kit. Contact: Kathryn Hawley, Project Manager, Illinois Chapter, American Academy of Pediatrics. Phone: (312) 733-6207, khawley@illinoisaap.net

Developed by advisory teams of experts in the fields, including developmental pediatricians as well as pediatricians and family physicians currently in practice, this resource and referral kit provides information on instructions on the use of screening tools, including the *Ages & Stages Questionnaires*® (*ASQ*) system and the Edinburgh Postnatal Depression Scale. The kit also covers recordkeeping and billing issues as well as referral procedures.

Dunkle M. "High Quality Developmental Screening." May 31, 2005. www.dbpeds.org

Margaret Dunkle is a senior fellow with the Center for Health Research Services and Policy, Department of Health Policy at George Washington University. She is the winner of the American Academy of Pediatrics' Section on Developmental and Behavioral Pediatrics' Dale Richmond Award for contributions to the field by a nonphysician. This document provides very practical guidance on changing screening practices in physician offices.

Earls MF, Shackelford Hay S. "Setting the Stage for Success: Implementation of Developmental and Behavioral Screening and Surveillance in Primary Care Practice — The North Carolina Assuring Better Child Health and Development (ABCD) Project," *Pediatrics*, 118;1 (July 2006):e183-e188. http://pediatrics.aappublications.org/cgi/content/abstract/118/1/e183

This article provides a description of the North Carolina Assuring Better Child Health and Development Project, where careful attention to and training for office process has resulted in a significant increase in screening rates to >70% of the designated well-child visits. Although there are features of the project that are unique to North Carolina, there also are elements that are transferable to any practice or state interested in integrating child development services into the medical home. Included here are lessons learned and a list of practical tools for implementation.

Glascoe FP, Robertshaw NS. Parents' Evaluation of Developmental Status: Developmental Milestones (PEDS:DM)©. Nashville, Tennessee: Ellsworth & Vandermeer Press, LLC 1013 Austin Court, Nolensville, Tenn. 37134 (October, 2006). Phone: (615) 776-4121, fax: (615) 776-4119. www.pedstest.com

The PEDS:DM is for children birth to 7-11 years of age. Items are completed by parent report (but also can be administered directly to children). Each item on the PEDS:DM taps a different developmental domain (fine motor, gross motor, expressive language, receptive language, self-help, social-emotional, and for older children, reading and math). PEDS-DM is available at http://pedstest.com/dm/index.php.

Glascoe FP, Shapiro HL. "Introduction to Developmental and Behavioral Screening." May 27, 2004. www.dbpeds.org/articles

This document provides an introduction to screening young children for development and behavior problems in primary care, emphasizing standardized tools.

Nelson HD, et al. "Screening for Speech and Language Delay in Preschool Children: Systematic Evidence Review for the US Preventive Services Task Force," *Pediatrics*, 117;2 (February 2006):2005-1462. http://pediatrics.aappublications.org/cgi/content/full/117/2/e298

The authors, from the Oregon Evidence-based Practice Center, Oregon Health and Science University, Portland, Ore., sought to evaluate the strengths and limits of evidence about the effectiveness of screening and interventions for speech and language delay in preschool-age children to determine the balance of benefits and adverse effects of routine screening in primary care for the development of guidelines by the U.S. Preventive Services Task Force.

Conclusions: Studies do not support the use of risk factors to guide selective screening. Several aspects of screening have been inadequately studied to determine optimal methods, including which instrument to use, the age at which to screen, and which interval is most useful. Trials of interventions demonstrate improvement in some outcome measures, but conclusions and generalizability are limited. Data are not available addressing other key issues including the effectiveness of screening in primary care settings, role of enhanced surveillance by primary care physicians before referral for diagnostic evaluation, non–speech and language and long-term benefits of interventions, and adverse effects of screening and interventions.

Ploof D, Hamel S. "Developmental Screening Is an Important Part of Well Care: How Can We Really Make It Happen? Basic Principles for Practice Change in The Real World," *American Academy of Pediatrics' Section on Developmental and Behavioral Pediatrics' Newsletter*. June 2002. www.medicalhomeinfo.org/screening/Screen%20Materials/dbpeds%20newsletter%20article.pdf

This article provides specific change principles when initiating quality screening in primary care including 1) committed leadership, 2) shared definition of need/problems, and a 3) process planning approach.

Squires J, Bricker D, Twombly E. *Ages & Stages Questionnaires®*: *Social-Emotional* (*ASQ:SE*): *A Parent-Completed, Child-Monitoring System for Social Emotional Behaviors*. Brooks Publishing. 2002. www.brookespublishing.com

*ASQ:SE* is a low-cost, culturally sensitive screening system for identifying young children (6 to 60 months) at risk for social or emotional difficulties. The areas covered include self-regulation, compliance, communication, adaptive functioning, autonomy, affect, and interaction with people. The complete system, which includes eight color-coded questionnaires, scoring sheets, and user's guide, is available for purchase through Brooks Publishing at www.brookespublishing.com/tools/asqse/index.htm

Wegner L. "Screening for Speech and Language Delay in Preschool Children: More Answers Are Needed," *Pediatrics*, 117;2 (February 2006):2005-2734. http://pediatrics.aappublications.org/cgi/content/full/117/2/533

This commentary by Lynn Wegner, MD, FAAP, Learning and Development Associates, Morrisville, N.C., is in response to the article by Nelson, et al., regarding screening for speech and language delay in preschool children. The author indicates that it is apparent that screening can identify children with delays. The next step is to ensure that there are resources in every community for accurate identification and interventions for those young children with disordered speech and/or language. Without a seamless system that links screening with evaluation and treatment, the question about the positive or negative effects of screening and intervention for children with speech and language delays cannot be studied or answered.

## Early Childhood Mental Health

Early Childhood Mental Health Consultation: An Evaluation Toolkit. www.rtc.pdx.edu/pgECMHCToolKit.shtml

This Web-based resource combines a brief review of the literature and current research addressing the effectiveness of early childhood mental health consultation with guidance for designing and implementing program evaluation. It will help states, communities, and programs increase their capacity for high-quality evaluation of early

childhood mental health consultation in community-based settings. Researchers, policy makers, and program evaluation teams will find:

- A brief review of the evidence base, current issues, and questions;
- Defining characteristics of early childhood mental health consultation;
- Components of high-quality evaluation and sample logic models;
- Evaluation tools to measure both process and outcome, including outcomes for children, families, staff, and programs; and
- Guidance for using evaluation data for improving programs and communicating outcomes.

Developed collaboratively by and available for download online from:

- Georgetown University, National TA Center for Children's Mental Health
- Johns Hopkins University, Women's and Children's Health Policy Center
- Portland State University, RTC on Family Support and Children's Mental Health

Georgetown University Center for Child and Human Development. Early Childhood Mental Health in a System of Care. http://gucchd.georgetown.edu/programs/ta_center/topics/early_childhood.html

This online resource describes the early childhood mental health system of care.

Texas Department of Assistive and Rehabilitative Services. *Early Childhood Intervention Directory 2007.* www.dars.state.tx.us/ecis/publications/Directory2007.pdf

This directory provides information about the Texas ECI system, including eligibility, a description of services, and how to find services. A list of state and national resources available for families with children with disabilities and for the professionals who work with them is included, along with an alphabetical list of counties that includes the ECI program serving it: the program name, its host agency, telephone number used for referring to ECI, mailing address, fax number, the program directors' e-mail address and, if available, Web site address.

Zero to Three. *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (*DC:0-3R*). 2005. www.zerotothree.org

This document is a useful tool for every practicing mental health clinician who works with the early years of life. It provides the only existing criteria for psychological evaluation of the very young. *DC:0-3R* is designed to help mental health and other professionals:

- Recognize mental health and developmental challenges in young children,
- Understand how relationships and environmental factors contribute to mental health and developmental disorders,
- Use diagnostic criteria effectively for classification and intervention, and
- Work more effectively with parents and other professionals to develop effective treatment plans.

Zero to Three's *DC:0-3R* is available for $32.95 at www.zerotothree.org.

## Impact of Mental Illness

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, et al. "The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction," *American Journal of Preventive Medicine*, 14;4 (1998):245-258. www.ncbi.nlm.nih.gov/pubmed/9635069

The Adverse Childhood Experiences (ACE) study is a major research study that compares current adult health status with childhood experiences decades earlier. With the cooperation of 17,421 adult health plan members and with the ongoing collaboration of Robert F. Anda, MD, MS, at the Centers for Disease Control and Prevention (CDC), the study is being carried out in the Department of Preventive Medicine at Kaiser Permanente (KP) San Diego. The ACE study reveals a powerful relation between our emotional experiences as children and our adult emotional health, physical health, and major causes of mortality in the United States. Moreover, the time factors in the study make it clear that time does not heal some of the adverse experiences we found so common in the childhoods of a large population of middle-age, middle-class Americans. One doesn't "just get over" some things. This has substantial implications for prevention and early detection of these events in early years.

National Alliance for the Mentally Ill. *Families on the Brink: The Impact of Ignoring Children with Serious Mental Illness: Results of a National Survey of Parents and Other Caregivers*. July 1999. www.nami.org

The nation's largest organization for families facing serious mental illness, NAMI commissioned and helped conduct a national survey of families with children who have such a brain disorder. Developed using focus groups with such family members, the survey asked about the health status of the child or adolescent, treatment experience, and issues of treatment and service access, stigma, and family pressures. Families in all 50 states provided 903 responses. The results paint a dire picture of what families with a child or adolescent with a serious mental illness contend with today. The report indicates that we must, as a nation, work to alleviate the gaps in illness recognition and treatment, remove unethical barriers to needed care and services, and end unthinkable requirements to relinquish custody to gain access to treatment. We must stop the stigma and inhumane conditions that too often surround serious mental illness in children and adolescents.

## Insurance

Azrin ST, et al. "Impact of Full Mental Health and Substance Abuse Parity for Children in the Federal Employees Health Benefits Program," *Pediatrics*, 119;2 (February 2007):e452-e459. http://pediatrics.aappublications.org/cgi/content/abstract/119/2/e452

This study examined the effects of full mental health and substance abuse parity for children.

Conclusions: Within the context of managed care, full mental health and substance abuse parity for children can achieve equivalence of benefits in health insurance coverage and improve financial protection without adversely affecting health care costs, but may not expand access for children who need these services.

Glied S, Cuellar A. "Better Behavioral Health Care Coverage for Everyone," *New England Journal of Medicine*, 354;13 (March 30, 2006):1415-1417. http://content.nejm.org/cgi/content/short/354/13/1415

This commentary from the Department of Health Policy and Management, Columbia University, is in response to the study by Goldman, et al., regarding behavioral health parity for federal employees. The authors indicate that while the results of this study ought to pave the way for broader acceptance of parity on the part of employers, insurers, and legislators, parity does not guarantee that insurance will cover the unique forms and settings of care that have been shown to benefit persons with mental illness (i.e., assertive community-treatment teams, supportive employers).

Goldman HH, et al. "Behavioral Health Insurance Parity for Federal Employees," *New England Journal of Medicine*, 354;13 (March 30, 2006):1378-1386. http://content.nejm.org/cgi/content/abstract/354/13/1378

The authors compared seven Federal Employees Health Benefits (FEHB) programs from 1999 through 2002 with a matched set of health plans that did not have benefits on a par with mental health and substance-abuse benefits (parity of mental health and substance-abuse benefits).

Results: The implementation of parity was associated with significant reductions in out-of-pocket spending in five of seven plans.

Conclusions: When coupled with management of care, implementation of parity in insurance benefits for behavioral health care can improve insurance protection without increasing total costs.

## Integrated Primary Care

American Academy of Pediatrics (AAP) Children's Mental Health in Primary Care, E-Newsletter. www.aap.org/mentalhealth/

This is a quarterly e-newsletter regarding children's mental health in primary care.

Blount, A (ed.). *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*. New York: W.W. Norton & Company. 1998.

This book presents models for integrating medical and mental health services to best address patients' needs. Integrated primary care, now instituted in many areas of the country, is both the service that integrates medical and mental health primary care and the practice of defining the problem brought by a patient without using "medical" or "mental" as inevitable distinctions. This volume makes the case for this approach, shows how to implement it, and describes some successful programs. It will be attractive to medical managers, plan administrators, physicians, and mental health providers.

Coleman WL. *Family-focused Behavioral Pediatrics*. Philadelphia: Lippincott, Williams, & Wilkins. 2001.

Part of the Core Handbooks in Pediatrics, a series designed to explore common problems of infants, children, and adolescents, this book was written by a pediatrician at the Center for Development and Learning in Chapel Hill, N.C. This is a comprehensive manual to help clinicians transition from a child-focused to a family-focused model of intervention for pediatric behavioral and interactional problems. It is relevant for family physicians as well as all providers who work with children and adolescents. The author describes the text as a beginner's step-by-step guide for providers who are just learning to use a family systems approach to behavioral pediatrics. The techniques and interventions taught are illustrated with case examples, which are helpful and "real-life." In addition to theory, the author addresses the practicalities of incorporating the above-mentioned skills into one's own practice, including the details of coding and billing.

Robinson PJ, and Reiter JT. *Behavioral Consultation and Primary Care: A Guide to Integrating Services*. New York: Springer. 2007.

Written by two veteran behavioral health consultants (BHCs), the guide offers a wealth of practical advice for all levels of therapists entering primary care. Every detail of BHC work is discussed, ranging from key job competencies to proven strategies for navigating challenging new terrain. Detailed case examples also bring theory to life for a wide variety of common clinical problems.

### Co-location Model

Campo J. "Addressing the Interface Between Pediatrics and Psychiatry," *Psychiatric Times*, 21;10 (September 2004). www.psychiatrictimes.com/display/article/10168/48161?pageNumber=1

In "Addressing the Interface Between Pediatrics and Psychiatry," John Campo, MD, FAAP, addresses efforts at collaboration between the two disciplines.

Williams J, et al. "Co-location of Mental Health Professionals in Primary Care Settings: Three North Carolina Models," *Clinical Pediatrics*, 45;6 (July 2006):537-543. http://cpj.sagepub.com/cgi/content/abstract/45/6/537

This article describes three North Carolina practice models in which mental health professionals are co-located with pediatric primary care providers. Each of the models was sustainable, partly due to systemic changes brought about by advocacy efforts. In addition to providing practical guidance for possible replication in primary care, this article reflects on how advocacy efforts can impact the success of co-location models.

## Juvenile Justice

Lieberman A, Simkins S. "Your Patients in the Juvenile Justice System, and Your Role in Their Care and Well-being," *Contemporary Pediatrics* (July 1, 2008). http://contemporarypediatrics.modernmedicine.com/

Are any of your patients headed for legal trouble? Can you do anything to alter their risk? The authors provide navigation through the juvenile justice system so that you can accomplish the most good.

## National Initiatives

American Academy of Pediatrics. *Improving Mental Health in Primary Care Through Access, Collaboration, and Training (IMPACT) E-News*. Electronic newsletter. www.aap.org/mentalhealth

Each monthly e-news issue contains the latest news, research, and resources in children's mental health; upcoming conferences and Web casts; funding opportunities; as well as current articles of interest in *Pediatrics*.

American Academy of Pediatrics, Task Force on Mental Health. Update from Task Force on Mental Health to Chapter, Committee and Section Leaders. February 2006. www.aap.org/mentalhealth/

According to the U.S. Surgeon General's 1999 report on mental health, more than 14 million children and adolescents in the United States, or 1 in 5, have a diagnosable mental health disorder that requires intervention or monitoring and interferes with daily functioning. While many children with mental health disorders are not being diagnosed, primary care clinicians have been identifying children with emotional and behavioral disorders at an increasing rate. The need for primary care clinicians to manage children with mental health concerns only will continue to increase in the future. Primary care clinicians are, and will continue to be, an important first resource for parents.

## Practice Management

American Academy of Child and Adolescent Psychiatry. When to Seek Referral or Consultation with a Child and Adolescent Psychiatrist. www.aacap.org/cs/root/physicians_and_allied_professionals/when_to_seek_referral_or_consultation_with_a_child_and_adolescent_psychiatrist

The information on this Web page provides specific referral criteria for pediatricians, family practitioners, psychiatrists, and nonphysician mental health practitioners.

American Academy of Pediatrics. *The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version*. Elk Grove, IL. 1996. www.aap.org/bst/showdetl.cfm?&Product_ID=756&DID=15

This step-by-step guide helps assess, diagnose, and refer mental health conditions. The manual includes symptom listings for simple, comprehensive diagnoses; mental/physical disorder differential diagnosis for psychosocial problems; enhanced communication between colleagues by *DSM-IV* compatibility; and easy-to-use charts, tables, and text.

Commonwealth Fund. ABCD Project. "Screening Implementation Worksheet." Dec. 28, 2004. www.dbpeds.org

This worksheet developed by the Commonwealth Fund generates questions about staff responsibilities for developmental screening.

Glascoe FP. "Organizing Offices for Detecting and Addressing Developmental Behavioral Problems," in *Collaborating with Parents*. Nashville, TN: Ellsworth & Vandermeer Press, Ltd. Nov. 3, 2004. www.dbpeds.org

This article provides practical recommendations on how to incorporate high-quality developmental and behavioral screening in a primary care practice. The key to success: training staff, having materials available, and knowing about community resources.

Goulden KJ." Teaching Developmental-Behavioral Screening/Surveillance to Healthcare Professionals," Feb. 15, 2005. www.dbpeds.org

Keith Goulden, MD, FRCPC, is a developmental-behavioral pediatrician working in Edmonton, Alberta, Canada, where he is an associate professor of pediatrics at the University of Alberta and director of the Sub-specialty Residency (Fellowship) in developmental pediatrics. He trained in pediatrics at Dalhousie University (Halifax, Nova Scotia, Canada) and in developmental pediatrics at the Albert Einstein College of Medicine Rose F. Kennedy Center (Bronx, N.Y.). This article provides practical recommendations on how to educate primary care professionals on screening.

North Carolina ABCD Project. "Getting Started with Developmental Screening and Surveillance." www.dbpeds.org/articles/detail.cfm?TextID=98

This worksheet is intended to guide an office through the planning process of developing their procedures for developmental screening. Help is available through the Pediatric Development and Behavior Clinical Care forum.

Rosman EA, et al. *The Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Families*. Georgetown University National Technical Assistance Center for Children's Mental Health. August 2005. http://gucchd.georgetown.edu/files/products_publications/TACenter/bestbeginfinal.pdf

This SAMHSA-funded, Web-based resource features eight innovative medical home practices that integrate behavioral health screening for the whole family, facilitate referrals to community services, and offer follow-up care. This resource describes how the practices use very different approaches to do it and fund it, and the lessons they learned. A must-read for practitioners who want to replicate an integrated primary care and behavioral health model.

Rubin IM, Plovnick MS, Fry RE. *Improving the Coordination of Care: A Program for Health Team Development*. Cambridge MA: Ballinger Publishing Company. 1975.

This workbook of task-oriented activities is aimed at helping any group of health workers and/or administrators responsible for the delivery of health care do its job in the most effective way possible. Developed at the Sloan School of Management at MIT, the program focuses on specifically defining tasks and procedures for doing them. It requires seven sessions to complete and requires no outside consultants, facilitators, or specially trained helpers. This book contains an introduction, guidelines for administrators regarding its use, guidelines for users, and seven recommended task-oriented modules. Topics include defining and clarifying goals; setting measurable performance objectives; defining and allocating responsibilities; negotiating day-to-day conflicts; making more

efficient and effective decisions and referral procedures; and increasing results for time spent in meetings and case conferences. Each module is designed around a common format that specifies desired outcomes expected from a session and the pre-meeting preparation required. Each gives an overview of major activities, and provides an introduction to the module, an outline of the team meeting, and a series of summary comments. Six optional modules cover specific work issues: 1) bringing a new member into the team; 2) running a better meeting; 3) improving leadership and team interaction; 4) identifying and eliminating behavioral habits that hinder the team's work; 5) improving interaction with the rest of the organization; and 6) obtaining feedback from patients.

Zero to Three, The DC:0-3R Revision Task Force. *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood, Revised* (*DC:0-3R*). Washington, D.C.: Zero to Three Press. 2005. www.zerotothree.org

This document was designed to address the need for a systematic, developmentally based approach to the classification of mental health and developmental difficulties in the first four years of life.

## Psychotropic Medications

Bridge JA, et al. "Clinical Response and Risk for Reported Suicidal Ideation and Suicide Attempts in Pediatric Antidepressant Treatment: A Meta-analysis of Randomized Controlled Trials," *JAMA*, 297;15 (April 18, 2007):1683-1696. http://jama.ama-assn.org/cgi/content/abstract/297/15/1683

The authors sought to assess the efficacy and risk of reported suicidal ideation/suicide attempt of antidepressants for treatment of pediatric major depressive disorder (MDD), obsessive-compulsive disorder (OCD), and non-OCD anxiety disorders, in response to FDA warnings that use of antidepressant medications poses a small but significantly increased risk of suicidal ideation/suicide attempt for children and adolescents.

Conclusions: Relative to placebo, antidepressants are efficacious for pediatric MDD, OCD, and non-OCD anxiety disorders, although the effects are strongest in non-OCD anxiety disorders, intermediate in OCD, and more modest in MDD. Benefits of antidepressants appear to be much greater than risks from suicidal ideation/suicide attempt across indications, although benefit-to-risk comparison varies as a function of indication, age, chronicity, and study conditions.

Coyle JT. "Drug Treatment of Anxiety Disorders in Children," *New England Journal of Medicine*, 344;17 (April 26, 2001):1326-1327. http://content.nejm.org/

This commentary by Joseph T. Coyle, MD, Harvard Medical School, indicates that the findings of the report by the Research Unit on Pediatric Psychopharmacology Anxiety Study Group make clear the benefits of therapy with a selective serotonin reuptake inhibitor (SSRI) in children. However, many issues remain unresolved, such as when should medication alone be prescribed as opposed to or in combination with cognitive behavioral therapy; how long should an SSRI be administered to a child with a serious anxiety disorder, given the chronic nature of these disorders; and most important, will pharmacologic treatment alter the course of the disorder and reduce the emergence of comorbid conditions such as depression and substance abuse?

National Institute of Mental Health, National Institute of Health. "Benefits of Antidepressants May Outweigh Risks for Kids." April 17, 2007. www.nimh.nih.gov/press/ssri-risksbenefits.cfm

Jeffrey Bridge, PhD, of the Columbus Children's Research Institute and The Ohio State University in Columbus, Ohio; corresponding author David Brent, MD, of the Western Psychiatric Institute and Clinic in Pittsburgh, Pa.; and colleagues examined data from 27 clinical trials involving antidepressant use among participants younger than 19 years of age who were being treated for major depression, obsessive-compulsive disorder (OCD), or non-OCD anxiety disorders such as generalized anxiety disorder or social phobia. Their analysis included data from more recent trials that were not included in the FDA analysis. By pooling the data, the researchers found that antidepressants were significantly more effective than placebo in treating these disorders. Antidepressants were especially effective in treating non-OCD anxiety disorders, in which the overall pooled response rate was 69% for those taking antidepressants compared with 39% taking placebo. Among those with OCD, the pooled response rate of the young people taking antidepressants was 52%, compared with 32% of those taking placebo. Among those with depression, the pooled response rate of the young people taking antidepressants was 61%, compared with 50% of those taking placebo. Overall, there was a slight but statistically significant increase in the risk of suicidal thoughts and actions, but no suicides occurred. "The evidence suggests that treating young people with antidepressants is worth the small risk associated with them," said Dr. Brent. "New research should focus on developing the most efficient and effective methods for monitoring these young patients, to put both doctors and parents at ease, and to match patients with the best treatments."

Texas Department of State Health Services. Criteria Indicating Need for Further Review of a Child's Clinical Status in "Psychotropic Medication Utilization Parameters for Foster Children." Nov. 11, 2006; updated Jan. 10, 2007. www.dshs.state.tx.us/mhprograms/pdf/PsychotropicMedicationUtilizationParametersFosterChildren.pdf

These guidelines provide suggestions for when a child being prescribed a psychotropic medication requires additional review of clinical status.

Texas Department of State Health Services. "Psychotropic Medication Utilization Parameters for Foster Children." Jan. 10, 2007. www.dshs.state.tx.us/mhprograms/psychotropicMedicationFosterChildren.shtm

These guidelines provide general principals regarding the use of psychoactive medications in foster children.

## Role of Primary Care Physicians

American Academy of Family Physicians. "The Provision of Mental Health Care Services by Family Physicians." Position Paper. Fall 2001. www.aafp.org/online/en/home/policy/policies/m/mentalhealthcareservices.html

This American Academy of Family Physicians (AAFP) position paper indicates that while psychiatric professionals are an essential element of the total health care continuum, the majority of patients with mental health issues will continue to access the health care system through primary care physician. The desire of patients to receive treatment from their primary care physician, or at least to have their primary care physician more involved in their care, has been repeatedly documented. Improving mental health treatment requires enhancing the ability of the primary care physician to treat and be appropriately reimbursed for that care. Reimbursement mechanisms should recognize the importance of the primary care physician in the treatment of mental illness as well as the significant issues of comorbidity that require nonpsychiatric care.

Rosman EA, et al. *The Best Beginning: Partnerships Between Primary Health Care and Mental Health and Substance Abuse Services for Young Children and Families*. Georgetown University National Technical Assistance Center for Children's Mental Health. August 2005. http://gucchd.georgetown.edu/files/products_publications/TACenter/bestbeginfinal.pdf

See entry under Practice Management in this appendix.

Willis D. "The Emerging Role of Pediatricians in Children's Mental Health: Implications from the Epidemiology." Presentation at the Section on Community Pediatrics, American Academy of Pediatrics Conference. New Orleans (Nov. 3, 2003). dwwillis@nweci.org

## Screening for Mental Illness

American Academy of Pediatrics. Screening. www.dbpeds.org/screening

These articles provide materials to support improvement in developmental and behavioral screening, surveillance, and identification of disabilities.

Carlat DJ. "The Psychiatric Review of Symptoms: A Screening Tool for Family Physicians," *American Family Physician*, 58;7 (Nov. 1, 1998). www.aafp.org/afp/981101ap/carlat.html

Daniel J. Carlat, MD, is a psychiatrist in practice in Newburyport, Mass., and has taught courses on psychiatric interviewing for primary care medicine residents. This article provides specific information on using the psychiatric review of symptoms for the major psychiatric disorders: depression, personality disorders, substance abuse disorders, anxiety disorders, somatization disorder, eating disorders, cognitive disorders, and psychotic disorders. For each category, an initial screening question is used, with a positive response leading to more detailed diagnostic questions. The psychiatric review of symptoms is both rapid and thorough, and can be readily incorporated into the standard history and physical examination.

Friedman RA. "Uncovering an Epidemic — Screening for Mental Health in Teens," *New England Journal of Medicine*, 355;26 (Dec. 28, 2006):2717-2723. http://content.nejm.org/cgi/content/full/355/26/2717

This commentary by Dr. Friedman, a professor of clinical psychiatry and the director of the Psychopharmacology Clinic at Weill Cornell Medical College, New York, indicates his belief that voluntary mental health screening of teens should be universal; however, he goes on to say that physicians must go beyond school-based screening if they optimally are to reach young people who are at risk for psychiatric illness and suicide. Pediatric clinicians are in an ideal position to detect mental illness in young people, and they should be better trained to probe for and recognize the signs and symptoms of major psychiatric disorders.

Jellinek M, Patel BP, Froehle MC, eds. (2002). *Bright Futures in Practice: Mental Health — Volume I. Practice Guide* and *Volume II. Tool Kit*. Arlington VA: National Center for Education in Maternal and Child Health. www.brightfutures.org

This comprehensive guide provides health and development information, detailed discussion of specific concerns, and a variety of resources and tools to help primary care health professionals meet the mental health needs of today's children, adolescents, and their families. These tools are available in PDF at www.brightfutures.org/mentalhealth/.

Weist MD, et al. "Mental Health Screening in Schools," *Journal of School Health*, 77;2 (February 2007):53-58. www.nami.org/Template.cfm?Section=schools_and_education&template=/ContentManagement/ContentDisplay.cfm&ContentID=43074

This article discusses the importance of screening students in schools for emotional/behavioral problems.

Conclusions: When implemented with appropriate family and community involvement, mental health screening in schools has the potential to be a cornerstone of a transformed mental health system. As a part of a coordinated and comprehensive school mental health program, screening complements the mission of schools, identifies youth in need and links them to effective services, and contributes to positive educational outcomes valued by families, schools, and communities.

## State Initiatives

Children's Hospital of Illinois. Resource Link: A Resource Center for Child and Adolescent Behavioral Health. Phone: (309) 671-7520, Fax (309) 671-7521, shaune.l.kemper@osfhealthcare.org.

Resource Link is a resource center for child and adolescent behavioral health. This service offers support to primary care physicians who are treating a child or adolescent diagnosed with a mental illness. By contacting Resource Link, a physician can receive on-site trainings regarding the diagnosis and treatment of child and adolescent depression and other mental illnesses, consultation from a child psychiatrist, service coordination from a case coordinator, and general information about child and adolescent mental illness. Service coordination includes screening the pediatric patient for depression and other mental illness, making appropriate referrals to mental health providers in the community, and helping facilitate effective communication among all providers serving the patient and family.

Massachusetts Child Psychiatry Access Project. www.mcpap.org

The Massachusetts Child Psychiatry Access Project (MCPAP) provides primary care clinicians with timely access to child psychiatry consultation, including legislative-funded regional coordinators who identify appointment availability to psychiatrists and mental health practitioners.

Texas Legislative Budget Board. "Create a Coordinated State Infrastructure to Support Children's Behavioral Health Services," *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*. January 2007. www.lbb.state.tx.us/Performance%20Reporting/TX_Govt_Effective_Efficiency_Report_80th_0107.pdf#Page1

## Substance Abuse

U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. *Quick Guide for Clinicians*. http://kap.samhsa.gov/products/tools/index.htm

Each *Quick Guide* clearly and concisely presents the information from a TIP or other document in a pocket-size booklet. Each guide is divided into sections to help clinicians quickly locate relevant material. Of particular interest are the following:

- *Quick Guide for Clinicians Based on TIP 34: Brief Interventions and Brief Therapies for Substance Abuse*
- *Quick Guide for Clinicians Based on TIP 35: Enhancing Motivation for Change in Substance Abuse Treatment*
- *Quick Guide for Clinicians Based on TIP 39: Substance Abuse Treatment and Family Therapy*

## Suicide

Bridge JA, et al. "Clinical Response and Risk for Reported Suicidal Ideation and Suicide Attempts in Pediatric Antidepressant Treatment: A Meta-analysis of Randomized Controlled Trials," *JAMA*, 297;15 (April 18, 2007):1683-1696. http://jama.ama-assn.org/cgi/content/abstract/297/15/1683

See entry under Psychotropic Medications in this appendix.

Friedman RA. "Uncovering an Epidemic — Screening for Mental Health in Teens," *New England Journal of Medicine*, 355;26 (Dec. 28, 2006):2717-2723. http://content.nejm.org/cgi/content/full/355/26/2717

See entry under Screening for Mental Illness in this appendix.

Gibbons RD, et al. "Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions and Suicide in Children and Adolescents," *The American Journal of Psychiatry*, 164 (September 2007):1356-1363. http://ajp.psychiatryonline.org/cgi/content/abstract/164/9/1356

The authors examined U.S. and Dutch data on prescription rates for selective serotonin reuptake inhibitors (SSRIs) from 2003 to 2005 in children and adolescents (patients up to age 19), as well as suicide rates for children and adolescents, using available data (through 2004 in the United States and through 2005 in the Netherlands).

Results: SSRI prescriptions for youths decreased by approximately 22% in both the United States and the Netherlands after the warnings were issued. In the Netherlands, the youth suicide rate increased by 49% between 2003 and 2005 and shows a significant inverse association with SSRI prescriptions. In the United States, youth suicide rates increased by 14% between 2003 and 2004, which is the largest year-to-year change in suicide rates in this population since the Centers for Disease Control and Prevention systematically began collecting suicide data in 1979.

Conclusions: In both the United States and the Netherlands, SSRI prescriptions for children and adolescents decreased after U.S. and European regulatory agencies issued warnings about a possible suicide risk with antidepressant use in pediatric patients, and these decreases were associated with increases in suicide rates in children and adolescents.

National Institute of Mental Health, National Institute of Health. "Benefits of Antidepressants May Outweigh Risks for Kids." April 17, 2007. www.nimh.nih.gov/press/ssri-risksbenefits.cfm

See entry under Psychotropic Medications in this appendix.

Simon GE. "The Antidepressant Quandary — Considering Suicide Risk When Treating Adolescent Depression," *New England Journal of Medicine*, 366;26 (Dec. 28, 2006):2722-2723. http://content.nejm.org/cgi/content/full/355/26/2722

Gregory E. Simon, MD, MPH, is an investigator at the Center for Health Studies at Group Health Cooperative in Seattle, Wash., and is the chair of the Scientific Advisory Board of the Depression and Bipolar Support Alliance. This article provides specific recommendations to physicians who are considering the treatment of depression in a child or adolescent.

## Workforce

Berndt D, Hogg Foundation for Mental Health. *The Mental Health Workforce in Texas: A Snapshot of the Issues.* May 2007. www.hogg.utexas.edu/PDF/MH%20Workforce%20in%20Texas_%20A%20Snapshot.pdf

This snapshot of the current state of the Texas mental health workforce provides preliminary information to highlight issues that key stakeholders — professionals, employers, higher education, consumers of services, and licensing boards, among others — must address to assure the availability of a qualified mental health workforce.

Texas Department of State Health Services, Health Professions Resource Center. *Highlights: The Supply of Mental Health Professionals in Texas — 2005.* February 2006. Publication No. 25-12347; E-Publication No. E25-12347. www.dshs.state.tx.us/chs/hprc/MHhigh05.pdf

According to a recent analysis of health provider supply data conducted by the Health Professions Resource Center, Texas is experiencing a shortage of mental health professionals. Mental health providers include but are not limited to psychiatrists, psychologists, psychoanalysts, social workers, licensed professional counselors, licensed chemical dependency counselors, marriage and family therapists, and psychiatric nurses. Also, primary care physicians provide a growing percentage of mental health services, particularly with increased availability of psychotropic drugs. All of these professions play an important role in improving the mental health of Texans, yet to some degree there is evidence to suggest that there is a shortage of all of these professional types who serve the 23 million people in the state.

# Appendix H: References


American Academy of Child and Adolescent Psychiatry. When to Seek Referral or Consultation with a Child and Adolescent Psychiatrist. www.aacap.org/cs/root/physicians_and_allied_professionals/when_to_seek_referral_or_consultation_with_a_child_and_adolescent_psychiatrist

American Academy of Family Physicians. "The Provision of Mental Health Care Services by Family Physicians." Position Paper. Fall 2001. www.aafp.org/online/en/home/policy/policies/m/mentalhealthcareservices.html

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American Academy of Pediatrics. *Improving Mental Health in Primary Care Through Access, Collaboration, and Training* (*IMPACT*) *E-News*. Electronic newsletter. www.aap.org/mentalhealth

American Academy of Pediatrics. Screening. www.dbpeds.org/screening

American Academy of Pediatrics. Strategies for System Change in Children's Mental Health: A Chapter Action Kit. 2007. www.aap.org/mentalhealth/mh2ch.html

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