Mental Disorders in Children: Primary Care and Child Behavior Disorders

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Director of Integrated Health Care, American Psychological Association (APA) Center for Psychology and Health, Washington, DC.

Tynan is a leader in the development of multidisciplinary teams and strategies to meet mental health needs effectively within primary care. His current area of focus involves training mental health professionals to work on integrated health teams in primary care settings in order to support health behavior change. Particular interests include working with health coaches and community health workers that serve all age groups, particularly among populations that have high mental health needs (e.g., those in the Veterans Health Administration, geriatric settings, or rural areas). Tynan's past work includes development and implementation of culturally sensitive, evidence-based mental health programs (including evaluation and satisfaction components) in pediatric settings in high-need urban and rural locales. At Nemours, he directed a statewide program on child obesity prevention that focused on breastfeeding and weaning to solid foods, and involved work in medical settings, child care settings, and schools. In addition, he has been involved in several clinical initiatives focused on treatment of attention deficit-hyperactivity disorder (ADHD), child overweight, and developmental screening. He is one of the authors of a chapter in the recently published American Academy of Pediatrics handbook on psychosocial treatments for behavior disorders.

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Learning Objectives

1. Identify symptoms of common emotional and behavioral disorders that frequently affect children, particularly attention deficit hyperactivity disorder, depression and generalized anxiety.
2. Determine when a child with depression or anxiety might be affected by a more serious underlying condition and recommend additional testing as needed.
3. Utilize screening tools and checklists during routine pediatric office visits to help determine whether a child is affected by an emotional or behavioral disorder before he or she enters school.
4. Help parents develop discipline and behavioral modification plans to ensure children with emotional and behavioral disorders will thrive.

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Audience Engagement System

Step 1 Step 2 Step 3

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Goals of this Presentation

- By the end of this presentation, we will…
- Consider the needs in child mental health
- Review the interaction of genetic, environmental, social and developmental risk factors on health and mental health in children
- Review screening instruments for general child & adolescent behavior screening.
- Discuss how to counsel families and refer for evidence based treatment.

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Child Mental Health Needs

- The 20/20 problem
- 20% of children with diagnosable conditions
- Of them only 20-30% receive treatment
- Treatment systems are scattered
  - Mental Health Services
  - Primary Care – 90% of Rx
  - School services
  - Counseling services in other organizations

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Child Mental Health: We Need to Use What We Know: Evidence Based Treatments.

- Progress has been made in research and treatment.
  - Progress in both pharmacological & psychotherapy
- We do not always use the latest knowledge.

- *All child mental health problems are multi-factorial!*
- *All child mental health problems play out over time and development.*
  - *Knowledge of etiology and progression of disorders necessary for effective comprehensive treatment.*

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AES Question: Causes of Behavior Problems

Most of the common child behavior problems are caused by:

A. Ineffective and Inconsistent parenting practices.
B. Genetic factors contributing to difficult temperament starting in infancy.
C. Vaccinations
D. Challenging social environments in neighborhoods and schools.
E. Answers A, B, & D but not C.

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Risks to Emotional and Behavioral Health: Factors of Disruptive Behavior

- Temperament
  - Genetics & other factors
    - Behavioral style that is not learned.
- Environment
  - Physical environment
  - Social & Emotional environment
- Parenting
  - Skills
  - Availability
  - Stress

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Temperament

- Temperament is behavioral individuality in infants, children and adults

- In the same way that babies are born with their own combination of physical characteristics such as hair and eye color, skin tone, and physique, each one has patterns of behavior, or temperament, that are also part of their uniqueness
- Temperament characteristics have a genetic component but are shaped by experience

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Temperament: Short Form

- Researchers indicate 9 areas of temperament, but for practical purposes consider the child's behavior in these major areas:
  - Activity & Attention Span
  - Sociability
  - Emotionality

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Risk Factors: Temperament

- Defined as traits, that are constitutional and not learned. A familial (genetic?) basis.
- Talked about in many ways:
  - "He's just like his daddy" – a simple genetic view – JLD syndrome
  - "Everyone in the family is like that" – a group genetic view
  - "Its a chemical imbalance" – the pharmacological explanation
  - "Temperament is an expression of genetic potential expressed or not expressed due to environmental events".- the advanced genetic-environment interaction explanation
    - Temperament is what we have to work with in the child.

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Risk Factors: Environment

- Physical Environment: Housing, neighborhoods.
- Community: School, organizations.
- Family & Parenting: Interpersonal

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Risk Factors: Physical and Community Environment

- Environment interacts with temperament and skills.
  - "There's gangs in that school" – simple environmental view
  - "No one in that family gets along in school"- the interactive view, family and environment
  - "If we only had better housing, food, social support, we could alleviate all of these problems" –simple unidirectional environmental solution.
  - "There are no bad kids, just bad environments". – environment as destiny, another one factor solution

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Risk Factors: Parenting

- There are no bad kids, just bad homes – a simple blaming view.
  - They should have a license to have kids – a view of parents needing a minimal skill level
  - Its impossible to raise a child with this neurologically based disorder – a medicalized view
  - Many parents need help and education– a parent deficiency view
  - All parents need support – recognizing parenting is difficult, a support view
  - All families are equal – the egalitarian, liberal view
  - Two parent families work best – a conservative view.

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Simple Solutions

- All of the above, temperament, environment and parenting, are correct to some degree, but none of the putative causes account for all of the problem.
- It is extremely rare to have a single cause for problems.
- "All complex problems have simple solutions. Inevitably, those solutions are wrong." H.L. Mencken
- *All behavior problems are multi-factorial!*
- *All behavior difficulties also play out over time and development.*

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AES Question: Child Mental Health Services

In most states child mental health services are easily accessible and coordinated between health care, mental health providers and school services.

A. True

B. False

Child Mental Health Needs

- In most states, system is patched together from a number of well intended providers representing many systems.
  - Health
  - Mental Health
  - Public Schools
- Services are focused on the top of the pyramid, wrap around, individual therapy and are rarely coordinated
- Few services offered that are cost effective: group, psycho-educational prevention/promotion

Childhood Emotional and Behavioral Health

Health and Mental Health and Education care responses are changing

- More…
  - Demand on all providers in health, education, child care, mental health to address developmental, emotional and behavioral problems
- Less…
  - Access to effective effective help for parents and families

Also, There is a Need to Understand Changing Risk Factors: Demand Is Increasing.

Families are changing

- More…
  - Single parent births > 45%
  - Parents are working
  - Women in workforce> 65% mothers
    - Back to work 6 weeks
    - Lack of good childcare
  - Medicaid-eligible children>24%
- Fewer…
  - Engaged fathers
  - Community connections

Childhood Emotional and Behavioral Health

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  - Demand on all providers in health, education, child care, mental health to address developmental, emotional and behavioral problems
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  - Access to effective help for parents and families

Problems more profound for children with special needs

Emotional and Behavioral Health: Changing Risk Factors

Out-of-home care is changing

- More…
  - Children in non-parental childcare
  - Time spent daily in out-of-home care
  - Much day care is poor quality
- And in care, teachers have less…
  - Opportunities for professional development or for working full time
  - Adequate compensation and benefits

Emotional and Behavioral Health

To summarize risks…
The world of children has changed.

- Children are exposed to many types of risk: Within child, within family, within child care, within community
- Many adults and systems have a hand in raising young children
- Nearly all young children birth to five share exposure to risk
- Working with agencies we can improve access to treatment
- Emphasis from funding agencies on evidence based treatment
- Working with child care, primary care, community organizations and with parents can reduce risk
- Need to examine how risks play out over time.
- RISK & PROTECTIVE FACTORS AFFECT BOTH PHYSICAL AND MENTAL HEALTH

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AES Question

Early Stressful experiences in the first six months of life:

A. Have little or no impact on child development.
B. Can affect later self control of behavior and mood.
C. Can have an impact on physiology
D. Can be ameliorated with appropriate interventions: Effective Parenting program
E. B, C, & D but not A.

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Lets look at one set of disorders: The path to disruption and dysfunction

How do we get from that cute adorable 7-lb newborn to:

- The 18 month old who screams and bites
- The 2 year old kicked out of child care
- The 3 year old that Child Find cannot help.
- The 4 year old kicked out of Preschool
- The 5 year old referred for both special education and then started on stimulants.
- The 8 year old prescribed atypical antipsychotics.
- The obese angry 10 year old repeated a grade.
- At 12 years, involved with juvenile justice system

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The Path: Prenatal to Six Months

- Prenatal risk factors
  - Alcohol, substance abuse, stress
- Many mothers have to return to work by 6 to 8 weeks of age of child.
- Lack of quality infant care.
- Common belief that early experiences not that important. *But if can profoundly affect health and behavioral function*
- Protective factor: Need for responsive care giving: Consistent presence of a person who can read the baby's cues and adjust the environment.
  - Responsiveness, nurturance, intrusiveness, inconsistency and harshness.

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The Path: Prenatal to Six Months

- Responsive caregiving: lays a foundation of learning that influences basic biological functioning of
  - Emotion regulation
  - Sleep and wake patterns
  - Attentional processes
- Responsive caregiving predictive of asthma outcome, overweight status, cardiovascular functioning and behavioral functioning (ACE study – Kaiser)

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The Path: Prenatal to Six Months

- Responsive care giving is the buffer for all of the other risk factors.
- Highly valuable for outcome in all ways.
- Not highly valued by society.
  - TANF mothers must return to work
  - Low quality child care
  - Poor social support for family care.
  - Responsive caregiving while valuable is not supported in the US as in other countries.

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The Path: Prenatal to Six Months

- Care giving & Comforting affects physiological response systems
- Infants who are responded to quickly and comforted:
  - Likely to have better neural foundation for self sooth and return to a non distressed state.
  - "Triggers" that promote calming or distress are learned.
  - Secure attachment in early infancy a protective factor.
  - Inconsistent care a risk factor
  - No overt symptoms at this age, usually, but foundation is laid down.

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Six Months to 18 Months

- Family adaptation to this age transition forms the basis of subsequent developmental transition.
- Critical ages at first transition when child begins to walk and becomes physically autonomous.
  - Onset of walking, mobility
  - Stranger anxiety – protective function
  - Language
  - Beginnings of autonomy "NO"

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Six Months to 18 Months

- Parenting practice are involved in the early onset disruptive behavior problems, and parenting interventions are integral to the solution.
- Negative parenting practices, which are sometimes triggered by difficult temperament, at age 2 are prognostic of later problem behavior.
- Child behavior alone at this age IS NOT predictive, but parenting practices are.

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Six Months to 18 Months

- For 'difficult' children at age two, early screening and parenting intervention is critical.
- For the most part, children do not fully "grow out of it"
- Without treatment, half or more of toddlers with difficult behavior, still have them at age six.
- To deal with this problem effectively, screening and intervention should occur in the second year of life (12-24 months)

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18 – 36 Months

- For example, increased parent and child social and play behavior by age 2, greatly decreases problems by age 4.
- Poor temperament coupled with harsh, ineffective parenting = coercive patterns and disruptive behavior.
- But few parents can be reached by group programs.
- To be successful parenting needs to be universal, socially desirable and effective.

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36 months to school age

- If disruptive or mood regulation problems continue
  - A clear coercive cycle, parent and child control each other by avoidance & threats, aversive control.
  - Behavior problems at school
  - Peer rejection
  - Parent discouragement, isolation from school
  - Ineffective teaching approaches
  - Parental depression
  - Worsening of child behavior
  - Academic failure

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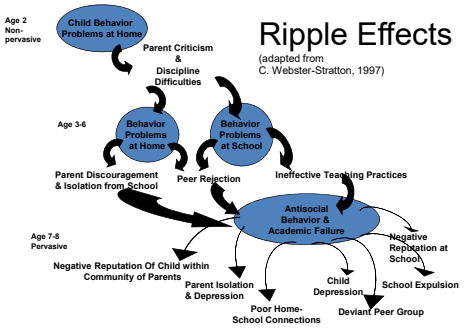
Ripple Effects

(adapted from C. Webster-Stratton, 1997)



We have science that explains etiology, and can predict outcomes over time

In addition, there are evidence based practices that are effective in changing this developmental trajectory…the problem is not what to do, but rests in where and how we can support children and help families access services

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Common Behavior Disorders of Childhood DSM V (2013 – APA)

- Adjustment Disorders
- Attention Deficit Hyperactivity Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Disruptive Mood Dysregulation Disorder
- (essentially replaces bipolar disorder in children)
- ALL of these diagnoses respond to parent & teacher management training

Common Behavior Disorders of Childhood DSM V (2013-APA)

- Changes in DSM V
- Autism & Asperger: All diagnosed now as Autism spectrum, patients formerly diagnosed Asperger, now mild Autism. Key symptoms are social impairment and preoccupation & repetitive behavior.
- ADHD: Diagnose for preschool age, but first line treatment is parenting intervention.
- OCD now in a group with Body dysmorphic, hoarding & trichotillomania

Parenting Treatment

- Parenting & family therapy:
  - Incredible Years groups
  - Chicago Parenting Program groups
  - Parent Child Interaction Therapy
  - Triple P Parenting
  - Kazdin Parenting Program
- School - Positive Behavior Support
- Pharmacology – Best when used in conjunction with therapy and school programming

Primary Care & Mental Health

- Use of brief evidence based treatments.
- Model for transforming primary care
- Goals for:
  - Anticipatory guidance (brief counseling)
  - Screening
  - Integrated care

Effective Parenting Programs: Common Elements

- Increasing Positive Interactions
- The most important variable!!
- Use of Time Out/other consistent discipline
- Effective Commands
- Use of rewards
- Meta Analysis – Kaminski 2008 shows
  - Positive Interaction, active teaching and use of time out all critical
  - Effective commands and use of rewards deemed necessary but not sufficient

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Practice Recommendation: 10 Minute Parenting Intervention

- Define the specific behavior problem.
- Suggest to the parent that you have some possible ideas to help, ask if they want to discuss.
- Review tip sheet on that topic
- http://www.nemours.org/service/health/parenting/tips.html
- Summarize, tell parent to get back in touch if it does not improve.

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Practice Recommendation: 10 Minute Parenting Tipsheets

- Fighting & Aggression
- Tantrums
- Bedtime Problems
- Eating Mealtime Problems
- Not Listening
- Reading to a Child*
- Special Playtime*
- Also available: CDC videos http://www.cdc.gov/parents/essentials/videos/index.html

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AES Question

Screening for Behavior is mandated in the ACA as a prevention service. The best way to do screening:

A. Wait for the parent to bring up a problem.

B. Use clinical judgment

C. Routinely use a valid & reliable screening questionnaire designed for primary care.

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Screening Basics: Tools

- What Questionnaire to use
- Sensitivity – does it pick up all of the cases?
- Specificity- does it only pick up the positives. Many false positives overwhelm the referral system.
- Cultural Sensitive
- Is clinical judgment just as effective?
  - NO

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Pediatric Symptom Checklist

- More than 35 year history.
- Long 35 and Short 17 item Parent forms.
- Youth Self Report for Adolescents
- Sensitivity 88-95%
- Specificity 68-100%
- Agreement between parents 79-92%
- In the public domain
- http://www.massgeneral.org/psychiatry/services/psc_research.aspx

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Add to Work Flow

- Can be adapted to an EMR
- Can be administered at check in, scored by front desk staff or MA.
- Results summarized for chart.
- Billing: CPT 99420 Administration and Interpretation of Health Risk Assessment.

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Alternative Questionnaires

- Strengths and Difficulties Questionnaire.
- http://www.sdqinfo.org - free with online scoring.

- Ages & Stages Social Emotional Scale
- Parenting Stress Index
- ASEBA – Child Behavior Checklist
  - Diagnostic, not a screener

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AES Question: Case Vignette

- Four year old child, in foster care for 8 months, referred to family services for 'neglect'. Biological parent single young mother with substance abuse problem. Foster parent experienced but frustrated.
- Child has language delay, attending Head Start, receiving speech & language services.
- Intermittent tantrums, with clingy and anxious behavior, difficulty separating at Head Start, voracious appetite and food hoarding, poor sleep & night terrors, some aggression

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AES Question

What possible diagnoses?

A. Post traumatic Stress Disorder.
B. Disruptive Mood Dysregulation
C. Eating Disorder
D. Sleep Disorder
E. Developmental Delay Speech & Language
F. Autism

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Diagnostic Considerations

- Once a child screens positive on the PSC or Strengths and Difficulties, next step. To refer or to further evaluate.
- From the screener, is it internalizing (Anxiety/Depression) or externalizing (ADHD/Conduct/Oppositional)
- Vanderbilt Questionnaire – focused on ADHD, anxiety, conduct, depression
- www.nichq.org
- For severe mood problems:
- Achenbach Child Behavior Checklist (www.ASEBA.com)

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Diagnostic Consideration

- Along with screener
- History since birth of family disruption, moves, any possible trauma, family services involvement
- Serious illness.
- ER visits
- School information
- This is where a co-located mental health provider can be of great help, they can review your chart for information they need.

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Diagnostic Consideration

- From AAP & AAFP guidelines on the diagnosis of ADHD, good template for all disorders.
- A history, including developmental history of any behavior difficulties.
- History of illness or injury.
- Checklist data or interview data from home and school (day care).
- Review of environmental stressors
- Template in EMR to summarize these, even as bullet points or check sheets.

Integrated Care: Health & Mental Health

- *Coordinated Care: Close collaboration with co-management agreement*
- *Co-located Care: Coordinated but Mental Health Professional is on site.*
- *Integrated: Same employer, shared chart, shared recommendations.*

Integrated Care: Health & Mental Health

- Integrated provider can assist with:
  - Universal screening system.
  - Immediate initial triage visit for brief therapy or referral to specialty care.
  - Coordinate with school services, contact Child Find services in the state.
  - Provide preventative services.
  - Consultation on cases seen by the primary care physician.

Integrated Care: Health & Mental Health

- How to get started?
  - Contact State Psychological Association
  - Ask if providers interested?
  - Start with a specific patient population that a psychologist could help. (e.g. ADHD population)
  - Determine business relationship, value of their consultation vs value of your space.
  - Determine who should do the mental health billing.
  - Start small & grow.

Questions?

Contact Information

- dtynan@apa.org
- @dougtynan on twitter.
- Web site: http://www.apa.org/health/about/index.aspx

Additional Information

- CDC:

http://www.cdc.gov/parents/essentials/videos/index.html
http://www.cdc.gov/features/adhd-awareness/

- American Psychological Association: Center for Psychology & Health

www.apa.org/health

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Billing & Coding

When services performed in conjunction with:

Office Visit 992xx *

*Time-based selection documentation criteria:

- Face-to-face time
- greater than 50% spent counseling/coordinating care

Additional tests to confirm or monitor:

99490	**Chronic Care Management-20 minutes monthly**
99420	Administration and interpretation of health risk assessment instrument (PHQ-9)

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Associated Session

- Mental Disorders in Children: Ask the Expert

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Interested in More CME on this topic?

aafp.org/fmx-kids

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