Body System: Psychogenic

Session Topic: Mental Disorders in Children

Educational Format		Faculty Expertise Required
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	Learning Objective(s) that will close the gap and meet the need	Outcome Being Measured
• Mental disorders in children are underdiagnosed. • Mental disorders in children are often undertreated, or were receiving inadequate treatment. • Physicians have knowledge gaps in the medical skill necessary to provide optimal care and management of children with mental disorders, including psychotropic medication management, depression and mood disorders, bipolar disorder, and attention deficit hyperactivity disorder. • Physicians are often challenged to provide appropriate transitional care into adulthood as children outgrow their diagnosis. • There have been significant changes from	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.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

the DSM-IV to the DSM-V.		

ACGME Core Competencies Addressed (select all that apply)

	Medical Knowledge		Patient Care
	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
  - Visit http://www.aafp.org/journals for additional resources
  - Visit http://familydoctor.org for patient education and resources
- Provide recommendation for identifying symptoms of common emotional and behavioral disorders that frequently affect children, particularly attention deficit hyperactivity disorder, depression and generalized anxiety.
- Provide recommendations for determining when a child with depression or anxiety might be affected by a more serious underlying condition and recommend additional testing as needed.
- Provide recommendations for 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.
- Provide strategies and resources to help parents develop discipline and behavioral modification plans to ensure children with emotional and behavioral disorders will thrive.

Needs Assessment

*Note: In terms of scope, ADHD, abuse/addiction, depression and mood disorders are specifically covered in other CME sessions. This topic is intended to provide a broader overview, including changes from DSM-IV to DSM-V *Diagnoses for Children*.[1]

Mental disorders are common among children in the United States, and can be particularly difficult for the children themselves and their caregivers. While mental disorders are widespread, the main burden of illness is concentrated among those suffering from a seriously debilitating mental illness. Just over 20 percent (or 1 in 5) children, either currently or at some point during their life, have had a seriously debilitating mental disorder.[2] Childhood and adolescent mental

disorders can lead to more severe, more difficult to treat illness and develop into co-occurring mental illnesses; however, in any given year, only 20% of children with mental disorders are identified and receive mental health services.[3,4]

Attention-deficit/hyperactivity disorder (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum disorders (1.1%), and Tourette syndrome (0.2% among children aged 6–17 years). An estimated 4.7% of adolescents aged 12–17 years reported an illicit drug use disorder in the past year, 4.2% had an alcohol abuse disorder in the past year, and 2.8% had cigarette dependence in the past month. The overall suicide rate for persons aged 10–19 years was 4.5 suicides per 100,000 persons in 2010. Approximately 8% of adolescents aged 12–17 years reported ≥14 mentally unhealthy days in the past month.[5]

Over 8.9% of persons 12 years of age and over report to have used an illicit drug in a thirty day period, with 6.9% reporting to have used marijuana, and 2.7% having used a psychotherapeutic drug for nonmedical use.[6] Young adults (age 18 to 25) are the biggest abusers of prescription opioid pain relievers, ADHD stimulants, and anti-anxiety drugs, with more than 8 persons per day dieing from prescription-drug related overdose.[7,8] In 2011 there were more than 2.4 million ER visits for drug misuse/abuse.[9] Synthetic legal intoxicating drugs have risen dramatically in recent years and have powerful adverse effects, including acute psychosis with delusions, hallucinations, and potentially dangerous abnormal behavior.[10] In 2012 President Obama signed the Food & Drug Administration Safety & Innovation Act that illegalizes all synthetic marijuana compounds along with two stimulants sold as bath salts and nine hallucinogens called 2C substances by adding them to the list of controlled Schedule I substances.[11]

A review of the literature identifies the following practice gaps: [1,12-34]

- Adolescents are underdiagnosed and undertreated for depression
- There is a shortage of providers dedicated to child and adolescent mental health, and limited coverage for mental health services
- Most adolescents do not report depressive symptoms and do not seek treatment
- Bipolar disorders are often misdiagnosed, particularly among those patients with depression; resulting in delayed treatment
- Physicians often exhibit poor adherence to bipolar management guidelines
- Physicians are often unfamiliar with evidence-based treatment recommendations
- There is often a lack of coordination of care between primary care and psychiatrists
- Long-term depression is adolescence is a predictor of continued mental health problems in adulthood; therefore, it is imperative that depression is recognized and treated early
- There have been significant changes between the DSM-IV and the DSM-V with regard to the diagnosis of depressive, mood, bipolar, and behavior disorders
- Less than 1 in 3 children with ADHD received both medication treatment and behavioral therapy, which is now the preferred treatment approach for children ages 6 and older.
- Only half of preschoolers (4-5 years of age) with ADHD received behavioral therapy, which is now the recommended first-line treatment for this group.
- About half of preschoolers with ADHD were taking medication for ADHD, and about 1 in 4 were treated only with medication.

- Repeat visits to the emergency department among transition age youths with psychiatric diagnoses suggest inadequate or complete lack of access to appropriate care.
- ADHD treatment rates decline sharply from childhood through adulthood, as adolescents with ADHD face specific burdens associated with transitioning into adulthood that can impede the achievement of academic and occupational goals

Data from a recent American Academy of Family Physicians (AAFP) CME Needs Assessment survey indicate that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal care and management of children with mental disorders, including psychotropic medication management, depression and mood disorders, bipolar disorder, and attention deficit hyperactivity disorder.[35] More specifically, CME outcomes data from 2012 AAFP Assembly: *Adult and Child Attention Deficit Hyperactivity Disorder,* and *Pediatric Behavior and Emotional Development* sessions; 2013 AAFP Assembly: *Pediatric Attention Deficit Hyperactivity Disorder (ADHD)*sessions; and 2014 AAFP Assembly: *ADHD and Comorbid Disruptive, Impulse-Control, and Conduct Disorders (Child)* sessions suggest that physicians require additional continuing medical education with regard to prevention/management of co-morbid substance abuse and anxiety; making individual clinical decisions that are derivations of evidence-based guideline recommendations; knowledge of how to integrate a behavioral health specialist into practice; providing parents with behavioral medication tools and resources; efficacy of new medications; an awareness of new DSM-V criteria; and how to effectively adjust medications.[36-38] Additionally, CME outcomes data from 2012 and 2013 AAFP Assembly: *Mood Disorders, Depression, and Bipolar Disorders* sessions suggest that physicians need continuing medical education with regard to standardized clinical monitoring and follow-up; consistent use of patient health questionnaire (PHQ) and other screening tools; screening for comorbid conditions; appropriate use of pharmacologic treatments; being aware that bipolar disorder is underdiagnosed; and efficiently managing bipolar disorder within the time frame of a typical office visit.[36,37]

Although patients may present to a family physician's office with symptoms of persistent sadness, anxiety or feelings of pessimism and overall hopelessness, it is important for physicians to know that mood disorders are highly individualized; the severity, frequency and duration of symptoms depend on the individual and his/her illness. Many patients experience physical manifestations of depression, including fatigue, decreased energy, insomnia, overeating or appetite loss and persistent pain (including headaches, cramps or gastrointestinal problems).[39] Because such physical symptoms may exist in the absence of other causative factors, family physicians should have a heightened index of suspicion for depression and thus may want to screen patients specifically for a mood disorder.

The U.S. Preventive Services Task Force (USPSTF) recently revised their recommendations for screening for depression in both children/adolescents and adults. The current statement for adults recommends screening for depression when staff-assisted depression care supports [defined as "clinical staff that assist the primary care clinician by providing some direct depression care, such as care support or coordination, case management or mental health treatment"] are in place to ensure accurate diagnosis, effective treatment and follow-up. When such support mechanisms are not in place, routine screening is not recommended.[40]

For children and adolescents, the current recommendation is to screen "adolescents 12-18 years of age for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal) and follow-up." Evidence was determined to be insufficient to recommend screening children 7-11 years old.[41]

There are many significant updates to disorder criteria in the DSM-V. One of the most significant changes is a new lifespan approach to mental health, which is particularly important as physicians are often challenged to provide transitional care for children with diagnosed mental disorders as they age into adulthood.[1,42,43]

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Adolescent health screening and counseling[29]
- Adolescent Substance Use and Abuse: Recognition and Management[44]
- AAP ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents[45]
- Diagnosis and management of ADHD in children[46]
- ADHD interventions in children younger than six years[47]
- Current strategies in the diagnosis and treatment of childhood attention-deficit/hyperactivity disorder[48]
- Childhood and adolescent depression[49]
- Screening for depression[50]
- Bipolar disorders: a review[51]
- AAFP Mood Disorder Questionnaire[52]
- Treatment of childhood and adolescent depression[53]
- Evaluation and treatment of the suicidal patient[54]
- Adding health education specialists to your practice[55]
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes[56]
- The benefits of using care coordinators in primary care: a case study[57]
- Engaging Patients in Collaborative Care Plans[58]
- The Use of Symptom Diaries in Outpatient Care[59]
- Health Coaching: Teaching Patients to Fish[60]
- Medication adherence: we didn't ask and they didn't tell[61]
- Encouraging patients to change unhealthy behaviors with motivational interviewing[62]
- Integrating a behavioral health specialist into your practice[63]
- Simple tools to increase patient satisfaction with the referral process[64]

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