

Accreditation & Credit Designation Statements

Joint Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Colorado and the American Society of Addiction Medicine. The American Society of Addiction Medicine is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.



Physicians

The American Society of Addiction Medicine designates this live activity for a maximum of 5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses

This activity awards 5 Nursing contact hours.

Social Workers

As a Jointly Accredited Organization, ASAM is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit. Social workers completing this course receive 5 general continuing education credits.

Disclosure Information

In accordance with disclosure policies of ASAM and Joint Accreditation, the effort is made to ensure balance, independence, objectivity, and scientific rigor in all CME/CE activities. These policies include mitigating all relevant financial relationships with ineligible companies for the Planning Committees and Presenters. All activity Planning Committee members and Presenters have disclosed all financial relationship information. The ASAM CE Committee has reviewed these disclosures and determined that the relationships are not inappropriate in the context of their respective presentations and are not inconsistent with the educational goals and integrity of the activity.

The planners, faculty and have no relevant financial relationships.

Please note I will also discuss some off label uses of medications

Learning Objectives

- Audience will understand the value of integrated care approaches to treatment of children and adolescent mental health, including pitfalls and supports
- Audience will be able to apply key principles of developmental expectations to their treatment of children and adolescents, including impacts on medication approaches
- 3. Audience will be able to apply key principles of trauma informed care and consideration of context in their treatment of children and adolescents, including impacts on medication approaches

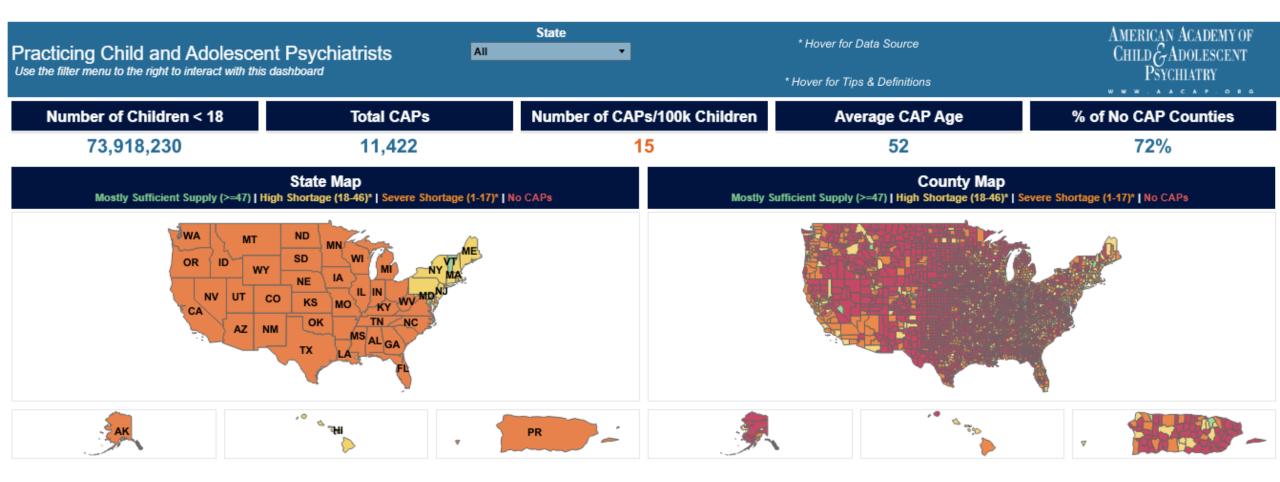


Mental Health in Children/Adolescents

- One in 5 US children have a mental, emotional, or behavioral disorder in a given year.
- Half of all mental health disorders show first signs before a person turns 14 years old, and 75% of mental health disorders begin before age 24.
- In 2020, 1 in 6 young people experienced a major depressive episode and suicide was the 2nd leading cause of death for people ages 10-24.
- Only half of children and adolescents with diagnosable mental health problems receive the treatment they need.



Child and Adolescent Psychiatry Shortages



- Ratios of child and adolescent psychiatrists per 100,000 children range by state from 4 to 65, with a national average of 14 child and adolescent psychiatrists per 100,000 children.*
- *Includes Puerto Rico and District of Columbia

Child and Adolescent Psychiatry Shortages



CAP in Integrated Care

- Allows for broader reach and reduces 'falling through the cracks'
- Collaborative care as opposed to 'colocated' care
- Patient-centered and evidence-based
- Compared to usual care, strong evidence for improved outcomes, greater patient satisfaction, greater provider satisfaction, and more cost effective



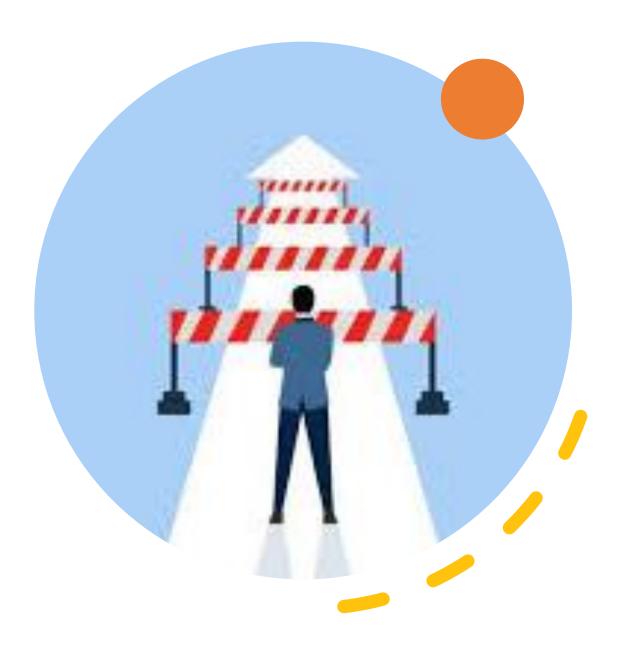
What does it mean to be integrated consultation vs treatment service?

- Recommendations vs active treatment
 - Medications recommended not ordered
 - Supports long term treatment relationship with PCP and reduces EMR 'misses'
- Limited session numbers
 - Typically 5-6 (fixed flexible conversation)
 - This means increased availability!
- Available for discussion/consultation outside of specific treatment time



Barriers

- Habits of siloed nature of care
 - Value of prescreening
- Time for communication
 - Value of scheduled collaboration time
- Recognizing severity appropriate for consultation vs referral
 - Recognizing limits of what can be offered in bridge care and ensure appropriate boundaries/expectations



What does a good consult look like?

- Good initial screening (recognizing time limits)
- Clear question
 - Who is the patient
 - What is their presenting concern
 - What are their other diagnoses
 - What have you done
 - What are you looking for help with
- Directly state whether there are safety evaluation concerns or not
 - If active/imminent, send them to emergency care and don't wait for consultation!
- Active discussion when possible

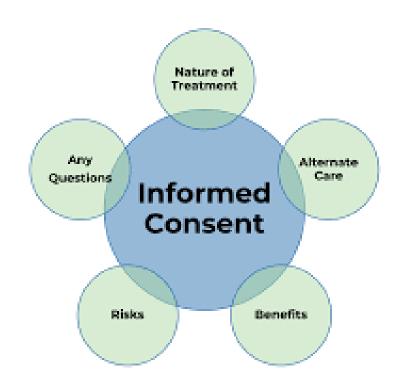


What does a good consult look like?

- ➡ Please see this child. They are struggling and I need support
- **▼** 3 year old child; mother is worried they are too oppositional.
- ✓ 14 year old male with history of depression previously well treated with Prozac who is
 describing worsening symptomatology (worsened sleep and decreased appetite) despite
 no clear changes in life/environment. No active safety concerns. Medication next
 steps/recommendations would be helpful
- ✓ 6 year old female without formal past history presenting with concerns for ADHD; showing decreased ability to attend to things at home and at school. Vanderbilts sent to parent and teachers. Diagnostic evaluation and treatment recommendations appreciated.

What does a good consult look like?

 Remember to let the patient know what the service is and what to expect!



CASE 1

16 yr old male with history of depression and anxiety. He was put on Prozac titrated to 30 mg daily which initially seemed to help but seems to have 'stopped working' a few months ago per patient. Not sleeping well and reports feeling 'unreal' at times. There is a history of bipolar in the family. Struggling with attention in school as of late as well which seems to be new. Support with diagnostic and treatment guidance would be helpful.



Pause



What are you worried about?



What are initial low time burden steps that can be taken to support team work?

Discussion in huddle

Send out screenings

 Can consider baseline battery such as depression screening, anxiety screening, and trauma screening for all patients. For this patient, may consider adding on bipolar screening if there is a concern. For others maybe an ADHD screening, etc.

Ask about context/stressors

Ask about **sleep details**

Screenings to Consider

All free, quick, and easy!

Initial battery of screenings Depression

- Short Mood and Feelings Questionnaire (SMFQ; 6-18; caregiver and self report versions)
- Patient Health Questionnaire-9 or PHQ-9 A which has wording for adolescents (12+/13-18; self report)

Anxiety

- Screening for Child and Anxiety Related Disorders (SCARED; 8-18; caregiver and self report versions)
- Generalized Anxiety Disorder Assessment (GAD-7; 13+; self report)

• Trauma

- Child PTSD Symptom Scale (CPSS; 8-18; parent and caregiver report versions)
- Primary care PTSD Screen (13+; self report)
- Child and Adolescent Trauma Screen (CATS; 3-17; caregiver and self report versions)

Add ons when there is concern

- Bipolar
 - Mood Disorder Questionnaire (MDQ; 11+; caregiver and self report versions).
- ADHD
 - Vanderbilt (6-12; caregiver and teacher reports; requires both!)
 - SNAP-IV (6-18; caregiver and teacher reports; requires both!)
- Development
 - Ages and Stages questionnaire (ASQ-3; 1m-5 ½ y; parent report)
 - Parents Evaluation of Developmental Status (PEDS:DM; 0-8 y; parent report)
- Eating Disorder
 - Eating Attitudes Test (EAT-26; 12-18+; self report)
- Substance use
 - CRAFFT (14-21; self report)



Power of some informal screening as well

- "Have you experienced anything in your life that you would consider traumatic or extremely stressful?"
- Sleep: onset, maintenance, energy during the day
- What does this look like: at home, at school, with friends?







Context

Don't forget to ask about social history! **Fear can be functional.**

- Who lives with the child?
- Any recent changes?
- What is social connectivity like?
- Recent losses or traumatic events?
- Timeline relations to any of these pieces
 - Remember to always spend some time interviewing kiddo without parents present for most kids over the age of 10

Consultation

- Met with patient with mother, alone, and then together again
- Notable details:
 - Grandmother moved in 3 months ago after father died unexpectedly
 - Introvert but has good friendship circle and is still social
 - Decline in school functioning from straight As to difficulty passing within last 3 months
 - Now with pan positive symptoms of PTSD
 - Sleep- 'all over the place'; difficulty falling asleep, going to bed very late, nightmares that awaken him, difficulty falling back asleep (activation)
 - Good appetite; eating well
 - Engaged in therapy; reports some difficulty opening up but overall helpful for grief processing
 - Denies substance use



Key Points

Developmental Expectations

- It is imperative to interview teens both alone and with parents
- Appropriate sleep delay; inappropriate nightmares and perseveration at night
- Friendship groups and identity formation

Context

- Spending time on social history; who's around, who's supportive/conflictual, recent deaths
- Ask about trauma
- Without too much invasive detail, can get a sense of severity of trauma

Key Points

Medications

- What to do next
 - Only at 30 mg Prozac; can increase!
 - If not good fit can consider:
 - Other SSRIs (Prozac can be activating)
 - SNRIs
 - Mirtazapine
 - Wellbutrin
- Adjuncts:
 - Prazosin, clonidine
 - Guanfacine XR
 - Antipsychotics*

How common is trauma?

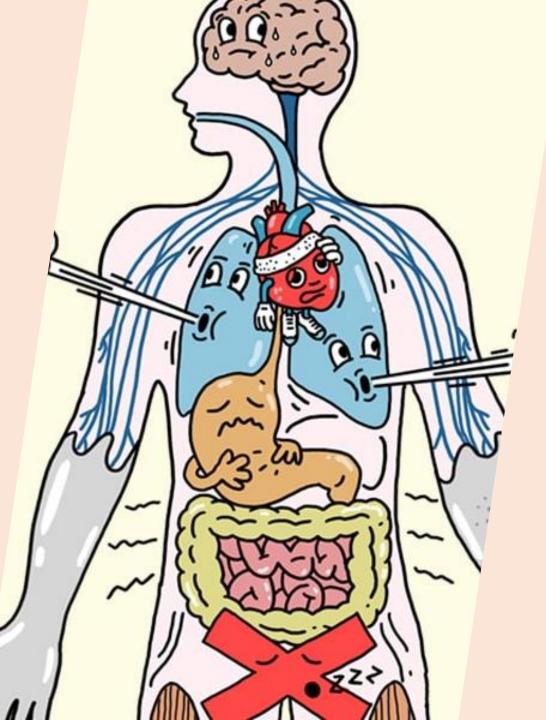
Over 60% of children report at least 1 traumatic event by age 16

97% incarcerated adults have experienced Adverse Childhood Experiences (ACEs).

90% of health care consumers report exposure to at least 1 traumatic event

How to think about impact of trauma; the Stress Injury Model

Injury Type: SINGLE	Intervention/Treatment	Time Period to Recovery
Abrasion	Natural recovery	days
Knee Sprain	Ice, brace, analgesia	Several weeks
Simple fracture	Casting, analgesia	Many weeks/months
Organ laceration/internal bleeding	Surgery, rehabilitation, analgesia	Months or longer
Psychological Injury	Intervention/Treatment	Time Period to Recovery
Irritability, anxiety,	None	days
Above and hypervigilance, intrusive thoughts	Support from family/friends	Several weeks
Partial PTSD	Brief Counseling	Many weeks/months
DSM 5 PTSD	Psychotherapy, medications, possible inpatient hospitalization	Months or longer



Effects of stress; Why is this important?

- Unaddressed stress reactions can influence health and the healthcare system
- Stress has direct biological effects (alterations in heart rate, cortisol levels, etc.) as well as indirect effects via behavioral dysregulation (ex: avoidance)
- Research has demonstrated associations with:
 - Adverse health outcomes including higher rates of ischemic heart disease, adolescent pregnancy, COPD, and liver disease
 - Worse functional outcomes with the same diagnoses
 - Poorer adherence with needed treatment and medication

Trauma Informed Care

- Integration of the understanding of trauma into policies, procedures, and practices in order to minimize traumatization and re-traumatization
- NOT a treatment for symptoms or syndromes related to trauma, but a recognition of trauma to provide care in effective and caring ways
- Think Universal precautions: Don gloves with the presumption of blood borne disease, presume trauma history and reaction when working with patients.



Younger Kid Tips and Tricks

- For younger kids, it is even more important to ask about developmental milestones/screening (most basic: walking, talking, fine motor, toileting, peer interactions)
- Look for symptoms that do or don't cross realms (home, school, peer)
- Careful of misunderstandings of development!
 - 'He's evil; he lies all the time' 4 year old when in trouble.
 - 'She doesn't pay attention and can't do what's asked of her at home. I give her three chores and when I check in she's only done 1' 7 year old asked to do several time intensive chores without visual or reminders
- Attention Guideline: Adult focused attention is about 20 min. Child focused attention is ~
 age +3-5 min



Questions?

