Evidence-Based Screening, Assessment, and Brief Intervention for Common Mental Health Disorders

Pamela Lusk, DNP, RN, PMHNP-BC, FAANP
Jessica Kozlowski, DNP, RN, CPNP-PC

3/17/17 Session 217

Disclosures

- Jessica has no disclosures to report
- Pam has no disclosures to report

Learning Objectives

- Discuss the need to integrate Mental Health screening, assessment, and early intervention into primary care, so that children/adolescents receive the timely evidence-based treatment they need.
- Identify evidence-based mental health screening tools, assessments, and brief interventions for children/adolescents seen in primary care.
- Develop a clinical toolkit, and plan for business aspects of integrating mental health into pediatric practice (coding, billing, scheduling, and office management).

“Take chances, make mistakes, get messy”
~Miss. Frizzle

FACT:
4 out of 5 children ages 6 to 17 did not get any help for their mental health problem (Institute of Medicine, 2009; Kolko & Perrin, 2014).
“Let's get the Facts!”
Keesha, student Magic School Bus

- It is estimated that 75 percent of children with mental health problems are seen in the primary care setting (Williams et al., 2004; Melnyk & Jensen, 2013).
- Only approximately 63 percent of U.S. counties have at least 1 mental health provider for children (Cummings, Wen, & Druss, 2013.)
- This value is much less when we look at the rural communities around our country.

*“The National Association of Pediatric Nurse Practitioners (NAPNAP) acknowledges the importance of providing children and adolescents with comprehensive mental health services including anticipatory guidance, prevention strategies, standardized screening, early and evidence-based intervention, and timely follow-up. One out of every four to five children has a mental/behavioral health disorder that constitutes a major public health concern (Merikangas et al., 2010). The incidence of mental/behavioral health disorders is thought to be grossly underestimated because of a lack of appropriate screening, identification, and referral by primary care providers (PCPs). 2013”*

**Common externalizing disorders seen in Primary Care**
Disruptive Behavior Disorders
- DSM 5 criteria
  - ADHD inattentive, hyperactive, or combined subtype
  - Adjustment disorders with disturbance of conduct and emotions
  - Oppositional defiant disorder
  - Disruptive behavior disorder
  - Conduct disorder
  - Intermittent explosive disorder

**Common Internalizing disorders of childhood seen in Primary Care**
- Anxiety disorders
  - DSM 5 criteria
  - Separation Anxiety Disorder
  - Selective Mutism
  - Social Anxiety Disorder
  - Panic Disorder
  - Specific Phobia
  - Agoraphobia
  - Generalized Anxiety Disorder
  - Substance/Medication Induced Anxiety

- Depressive disorders
  - DSM 5 criteria
  - Depressive Mood Disorder
  - Major Depressive Disorder
  - Persistent Depressive Disorder (Dysthymia)
  - Premenstrual Dysphoric Disorder
  - Substance/Medication Induced Depressive Disorder due to another Medical Condition

- Trauma & Stress related disorders & OCD
  - DSM 5 criteria
  - Obsessive-Compulsive Disorder
  - Body Dysmorphic Disorder
  - Hoarding disorder
  - Trichotillomania
  - Excoriation disorder
  - Reactive attachment disorder
  - Disinhibited social engagement
  - PTSD
  - acute stress disorder
  - adjustment disorder

**Model of care for the integration of behavioral health into primary care**
- Screen for a mental health disorder by a Pediatric Nurse Practitioner
- Brief intervention that can be provided in the primary care location
- Referral to a mental health provider or utilize a consultation service
- Treatment by a mental health provider or a PNP with mental health certification
Disruptive Behaviors in Children and Adolescents

Disruptive Behaviors (Externalizing Behaviors)

- Openly uncooperative and angry/hostile behavior becomes a concern when it is so frequent and consistent that it stands out when compared to other children of the same age and developmental level and when it affects the child's home, school, and social life (AACAP – 2011 Facts for Families).

All children behave badly at times

When does the behavior occur

- All children are oppositional from time to time, particularly when tired, hungry, stressed or upset. They may argue, talk back, disobey, and defy parents, teachers and other adults in authority.

The first rule/out

- Symptoms of ADHD that present as disruptive behaviors include impulsivity, not following directions, intruding in others activities, & not listening.
- These behaviors cause difficulties at home, school and social situations.
- If there is a possibility that the child’s behaviors may meet criteria for ADHD, that will be the first rule/out.
- Screen with the Vanderbilt Parent Assessment Scale or Conners’
The first rule/out

- Parent Rating Scale can be started in the office. These ADHD scales also have Oppositional Defiant subscales.
- In addition to the significant overlap between ADHD and ODD, the two conditions are often co-morbid. Current evidence-based Guidelines for treating ODD – recommend treating the ADHD symptoms first as the best initial approach.

DSM 5

- In DSM 5, Adjustment Disorders with disturbance of conduct and emotions are found in the section on Trauma and Stressor Related Disorders.
- In DSM 5 – Oppositional Defiant Disorder and Disruptive Disorder NOS are found in the section on Disruptive, Impulse Control and Conduct Disorders.
- Specific diagnostic criteria for each disorder will be presented as each is discussed.

DSM criteria for Adjustment Disorder: (category in DSM 5 – Trauma and Stressor Related Disorders)

- The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviors are clinically significant as evidenced by either of the following:
  - Marked distress that is in excess of what would be expected from exposure to the stressor
  - Significant impairment in social or academic (occupational) functioning.

Engage the parents: teach discipline
Prevalence

- Oppositional Defiant Disorder is found in 3% - 4% of children whose disruptive behaviors persist over months or years, occur across many situations, and result in pronounced impairment in their functioning in home, school, and peer settings.
- These children’s anger is usually directed at authority figures.
- These children show extreme levels of argumentativeness, disobedience, stubbornness, negativity, and provocation of others.

DSM 5 Oppositional Defiant Disorder

A persistent pattern of angry/ irritable mood, argumentative/ defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, observed during interaction with at least one individual that is not a sibling.

Angry/Irritable Mood "these emotional symptoms have been found to be uniquely predictive of mood and anxiety disorders"
1. Often loses temper
2. is often touchy or easily annoyed
3. is often angry and resentful

Oppositional Defiant Disorder DSM 5 criteria (cont.)

- Argumentative/Defiant Behavior
  4. Often argues with authority figures or adults (for children and adolescents)
  5. Often actively defies or refuses to comply with requests from authority figures or rules
  6. Often deliberately annoys others
  7. Often blames others for his or her mistakes or misbehavior

- Vindictiveness
  8. Has been spiteful or vindictive at least twice within the past six months

Note: For children under 5 years of age, the behavior should occur on most days for a period of at least six months unless otherwise noted. For individuals 5 years or older, the behavior should occur at least once per week for at least six months, unless otherwise noted.

Risk Factors

- Biological factors may include— family clustering of similar disorders, genetic predisposition, and co-morbid conditions, such as ADHD. Disruptive or oppositional behaviors are common in children with language disorders (receptive disorders in particular), cognitive deficits, delays in development with limited problem solving skills, and other neuropsychological deficits.

“Don’t give in, Don’t give up”

It is helpful to consider this particular child’s Risk/ Protective factor ratio.
**Make a Family Crisis Plan**

- **RISK ASSESSMENT:** Whenever we see a young person who has extreme, impulsive anger a risk assessment needs to be conducted. Often we ask, “Do you feel safe with this young person?” and we ask the youth, if they feel safe, and if they feel they can keep themselves safe from hurting someone or hurting themselves.
- A psychiatry consult, or evaluation in the Emergency Department by a mental health crisis team can always be arranged if the primary care provider assesses the situation to be acute, and requiring immediate psychiatric evaluation and treatment.

**Evidence-Based Management**

- **PRESTO plan:**
  
  - **P** – Partner with the family
  - **R** – assess risk, identify professional reinforcements and Refer if need be
  - **E** – Educate the family on evidence based practices and expectations of treatment
  - **S** – Ascertain Support in the community
  - **T** – Track signs and symptoms with tools
  - **O** – Objectives and Action Plans are established with the family.

**Practice Parameters**

- According to the American Academy of Child and Adolescent Psychiatry, in the Practice Parameter for the assessment and treatment of Children and Adolescents with Oppositional Defiant Disorder, the “treatment of ODD may be particularly problematic and often requires multimodal treatment, including *psychosocial interventions* and *occasionally medication therapy* (2007).

**Co-ordinator of the team**

Sometimes it takes finesse for the PCP to be the leader/coordinator of the parent/ child/ teacher / health care provider/ and specialty psychiatry (if involved) team – and keep everyone reminded that the “battle” is against the “problem behaviors” (not blame for each other) and all are on the same team – moving forward, fighting that battle together.

**Therapeutic Approach**

- Dr. Greene writes in the “Explosive Child” - “children do well if they can”. Your child longs for your approval.
- Because your child has some very real challenges with their “wiring” and temperament possibly genetics and early developmental stress, it is very likely that your child has trouble with
  1. Flexibility,
  2. Frustration tolerance, and
  3. Problem Solving.

  *(From "The Explosive Child" by Ross W. Greene (2010).*

**Ending the visit**

- Instill Hope
- Establish a working relationship as coordinator of the team
- Make referrals as indicated:
  - The intensity of the services should match the intensity of the child's needs.
  - Provide information for the parents and child (crisis plan, contact numbers)
Conduct Disorder
(DSM 5 criteria contd.)

Aggression to people and animals
1. often bullies, threatens, or intimidates others
2. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
3. has been physically cruel to people
4. has been physically cruel to animals
5. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
6. has forced someone into sexual activity

Conduct Disorder
(DSM 5 criteria contd.)

Destruction of property
7. has deliberately engaged in fire setting with the intention of causing serious damage
8. has deliberately destroyed others’ property (other than by fire setting)

Deceitfulness or theft
9. has broken into someone else’s house, building, or car
10. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
11. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Conduct Disorder
(DSM 5 criteria contd.)

Serious violations of rules
12. often stays out at night despite parental prohibitions, beginning before age 13 years
13. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
14. is often truant from school, beginning before age 13 years

Reminder

Attention deficit/Hyperactivity disorders

- Most common behavioral disorder in children
- Occurs in up to 12% of school age children
- More common in males 3:1 in females
- New change for DSM 5 criteria is acknowledging it may not present in certain populations until 10-12 years of age
- Also, new literature supports diagnosis in certain situations down to 3 years of age.
- Very commonly have co-morbid diagnosis (ODD, anxiety, learning disorder) (Melniky & Jensen, 2013)
Screening for ADHD

- Typical presentation:
  - Normally, problems at school and/or daycare brings the parent to their primary care provider
- Screening tools
  - NICHQ Vanderbilt Assessment Scale
  - Connor’s Forms
  - Clinical Attention Profile
  - SNAP IV

DSM 5 criteria for ADHD

- Symptoms have to persist for 6 months and have a negative impact academically or socially
- 6 or more out of 9 = inattentive subtype
- 6 or more out of 9 = hyperactive subtype
- 6 or more in both sections = combined subtype

Brief intervention/Treatment of ADHD

- Pharmacologic management
  - Stimulant medications
    - Methylphenidate (Ritalin, Metadate, Concerta, Focalin, Daytrana, Quillivant)
    - Dextroamphetamine (Adderall, Vyvanse, Dexadrine)
  - Non stimulant medications
    - Strattera
    - Alpha 2 agonists (Tenex, Intuniv, Clonidine, Kapvay)
  - Medical Food
  - Vayarin

Treatment of ADHD

- Truth: Evidence based treatment for ADHD level 1 is pharmacologic treatment specifically a stimulant medication in ages 6-12 (AAP, 2011)
- Behavioral support at school and home
  - 504 Plan (accommodations)
  - Routines at home
  - Behavioral therapy (ages 4-5)

Anxiety Disorders: Screening

- Typical presentation:
  - 2:1 ratio between girls and boys
  - Parents and child voice difficulty in school and home with a variety of symptoms especially school avoidance, excessive worry, irritability; severe shyness, or panic attacks.
  - Somatic complaints: headache, abdominal pain, nausea/vomiting, and chest pain

Screening tools for Anxiety Disorders

- The State-trait Anxiety Inventory of Children and Adults-ages 9 to college age
- KySS Worries Questionnaire-ages 10-21 years
- Generalized Anxiety Disorder (GAD) 7-most studied with adults however good support with adolescent use
- Screen for Child Anxiety Related Disorders (SCARED) Child and parent version-ages 8 to 17 years
Screening tools for Anxiety Disorders

Assessment of anxiety disorders

Generalized anxiety disorder
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
B. The individual finds it difficult to control the worry.
C. The anxiety and worry are associated with one (or more) of the following six symptoms (with at least one having been present for more days than not in the past 6 months).
D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013).

Specific phobia
- significant fear about certain things or situations

Selective mutism
- fear to speak in social situations

Social anxiety disorder
- significant fear about social situations

Panic disorder
- recurring unexpected panic attacks in which at least 4 criteria are met (palpitations/fast heart beat, SOB, sweating, trembling, feelings of choking, dizziness, abdominal discomfort, nausea, depersonalization, derealization, or fear of losing control)

Agoraphobia
- fear of being outside the home alone

Separation anxiety
- fear of being left away from loved one (usually parent or grandparent)

History of Present Illness
- Is this a normal level of anxiety for this child?
- The anxiety has to be affecting the child’s quality of life for it to be significant.
  - Missing school
  - Avoiding social situations
- Rule out diagnoses such as lead intoxication, PANDAS, hypoglycemia, hyperthyroidism, seizure disorders, brain tumor, asthma, hypoxia, and migraines (Melnyk & Jensen, 2013)

Trauma Related Disorders

Obsessive - Compulsive Disorders

Why does this happen?
- Overwhelming or chronic traumatic experiences during childhood can disrupt the normal progression of the child's physical, emotional, and cognitive development.

Traumatic-Related Disorders
**Traumatic events**

- **Violence:** (community, school, family/domestic, war, rape)
- **Natural/Manmade Disasters:** (earthquakes, floods, hurricanes, fires)
- **Death of a Loved One:** (murder, suicide, illness)
- **Child Maltreatment:** (neglect, sexual, physical or emotional abuse)
- **Accidents:** (motor Vehicle, plane crashes)
- **Medical Trauma:** (Illness/medical procedures)

**Traumatic-Related Disorders: Step 1 Identify**

- **DSM-5 criteria characteristics**
  - Diagnosis based on time from the trauma
  - Characterized by reliving the trauma which causes significant disruption in the child's life.
  - Presentation includes:
    - **A Change from Usual Behavior**
      - (behavior at home or school, school performance) withdrawal, aggressive or angry behavior, fearful behavior, regressive behavior, such as bedwetting or thumb sucking

**Screening for Trauma-related disorders**

- **Self reported scale:**
  - **When Bad Things Happen Scale** UCLA PTSD Reaction Index: ages 7 to 12 years of age to assess stress reactions
  - **Standardized Assessments for stress/trauma:**
  - **Parenting Stress Index (PSI)** for ages 0 to 12 or the Stress Index for Parents of Adolescents (SIPA) for ages 11 to 19.
  - **Trauma Symptom Checklist for Children (TSCC)** for ages 8 to 16 or the **Trauma Symptom Checklist for Young Children (TSCYC)** for ages 3 to 12.
  - **The Achenbach System of Empirically Based Assessment Child Behavior Checklist (ASEBA CBCL)** for ages 1½ to 5 or 6 to 18.

**Brief Intervention: COPE program**

- The COPE program is an evidence-based Cognitive skills building program that can be utilized in the primary care setting as a brief intervention (Kozlowski, Lusk & Melynky, 2015).
- Cognitive Behavioral Skills Building (CBSB) interventions have a Cognitive Therapy component which builds on each step.

**COPE 7 Session Manual**

- **Session 1:** Thinking, Feeling, and Behaving: What is the Connection?
- **Session 2:** Self-esteem and Positive Thinking/Self Talk
- **Session 3:** Stress and Coping
- **Session 4:** Problem Solving & Setting Goals
- **Session 5:** Dealing with your Feelings in Healthy Ways
- **Session 6:** Coping and Stressful Situations
- **Session 7:** Pulling it All Together for a Healthy YOU!

- The child with anxiety has deficits in coping skills as evidenced by: avoidance, distraction, self-blame, and dooms day mentality (Simpson et al., 2012).
- Children with anxious thoughts, such as “What if I fail? What if I look stupid and the class laughs? What if I throw up and am embarrassed?” (Knapp & Beck, 2008).
- COPE program focuses on skills such as positive self-talk, self-control strategies, and finally ‘Staying in the Moment’ exercises to combat these negative automatic thoughts/worries.
The Epidemiology of Child and Adolescent Depression

- 5% Children; 9%-20% Adolescents (2016 11%)
- Risk increased in children of depressed parents
- Higher incidence in minority populations
- M:F ratio: Children 1:1 Young adult 1:2
- Mean age of onset of Major Mood Disorder (MMD) = 14 yrs; Mean age of DD = 8 years
- Detection LOW, < 20% of cases
- Average length of untreated episode of MDD 7-9 months

Risk increased in children of depressed parents

Higher incidence in minority populations

M:F ratio: Children 1:1 Young adult 1:2

Mean age of onset of Major Mood Disorder (MMD) = 14 yrs; Mean age of DD = 8 years

Detection LOW, < 20% of cases

Average length of untreated episode of MDD 7-9 months

ComPresentation in Toddlers/Preschool Children

- Behavior problems
- Excessive tantrums
- Aggression
- Irritability
- Regression

Common Modes of Presentation in School-Age Children**

- Sadness
- Irritability
- Impulsive
- Crying spells
- Loss of pleasure or interest in activities
- Frequent complaints that no one likes me
- Somatic complaints
- Externalizing (i.e., acting out) behaviors

**Often misdiagnosed as AD/HD

Common Modes of Presentation in Adolescents

- Sadness
- Hopelessness
- Self-hatred
- Anger
- Withdrawn
- Loss of pleasure/interest in activities
- Neurovegetative symptoms (e.g., decrease in sleep, appetite and concentration)
- Drug and alcohol use common
- Comorbidity with anxiety common

Screening for Depression

- The Center for Epidemiological Studies Depression Scale (CES-DC) for Children; valid & reliable instrument for depression screening in older school-age children & teens; 20 items on a 4 point Likert scale from 0 Not at All to 3 A Lot (During the past week, I felt down and unhappy); scores over 15 indicate significant levels of depression.

- This scale is free and in the public domain; it can be downloaded at http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

- The older teen/young adult version of the CES-D can be downloaded for free at http://cooccurring.org/public/document/ces-d.pdf
Screening for Depression

- The Patient Health Questionnaire-9 (PHQ-9), 9 item depression scale for screening and monitoring depression (free). Valid and reliable down to age 13.
- There also is a PHQ-9 Modified for Teens. The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the DSM-IV.
  Download at: http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
- The Patient Health Questionnaire-2 (PHQ-2) (free)
  Uses the first 2 questions from the PHQ-9:
  Over the past 2 weeks, how often have you been bothered by any of the following:
  (1) little interest or pleasure doing things
  (2) feeling down, depressed or hopeless

Model of care for the integration of behavioral health into primary care

USPSTF Recommendation

Routine screening of all adolescents 12-18 yrs. for MAJOR DEPRESSION in primary care

WHEN

Systems are in place to ensure:

- Accurate diagnosis
- Cognitive – Behavioral or Interpersonal Psychotherapy
- Follow-up

Brief Intervention: COPE program

- The COPE program is an evidence-based Cognitive skills building program that can be utilized in the primary care setting as a brief intervention (Kozlowski, Lusk & Melnyk, 2015).
- Cognitive Behavioral Skills Building (CBSB) interventions have a Cognitive Therapy component which builds on each step.

COPE 7 Session Manual

- Session 1: Thinking, Feeling, and Behaving: What is the Connection?
- Session 2: Self-esteem and Positive Thinking/Self Talk
- Session 3: Stress and Coping
- Session 4: Problem Solving & Setting Goals
- Session 5: Dealing with your Feelings in Healthy Ways
- Session 6: Coping and Stressful Situations
- Session 7: Pulling it all Together for a Healthy YOU!
How can I bring this to my practice?

- **Scheduling**
  - Most brief intervention or treatment appointments can be done in 20-30 minutes.
  - Utilize front desk in scheduling to give appropriate screening tools for the parent/child to complete before the appointment.

- **Billing**
  - insurance with a diagnostic code of 99214 based on “more than 50% of the visit spent in – counseling” rule (Foy, Lusk & Melnyk, 2013; Meadows et al. 2010) for a 30 minute appointment.

---

**References**

- T-May (Treatment of Maladaptive Aggression in Youth) Rutgers CERTs Pocket Reference Guide for Primary Care Clinicians and Mental Health Specialists. (2020) Center for Education and Research on Mental Health Therapeutics (CERTs) Rutgers University, The REACH Institute, University Texas at Austin College of Pharmacy, New York State Office of Mental Health, California Department of Mental Health.