Welcome to UVM/AHEC ECHO: Children’s Mental Health

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Presenters:
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• RECORDING OF SESSION TO BEGIN
Addressing the Non-Compliant Child: Oppositionality and Disruptive Behavior for Primary Care

Presenters
Rebecca Ruid, PhD
Greta Spottswood, MD, MPH
Agenda

• Introductions
• Objectives
• Didactic Presentation (30 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.0 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

• As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.
Series Objectives

• By the end of this series, the learners should be able to:

  • Feel more comfort and confidence in identifying, treating, and referring a variety of complex children's mental health presentations.
Presenter Disclosures

Rebecca Ruid, PhD—no disclosures

Greta Spottswood, MD, MPH—no disclosures, specifying non-FDA approved uses of medications
Learning Objectives: non-compliance

Behavior type

Epidemiology

Evidence based treatment

Access to level of care

0) PCP
1) PCP/consult help
2) Shared care
3) Mental health team
Sample Case

“Molly”

• 5 year old female
• Parents, twin 4 yo brothers
• “Wild” at school and home
• Hyper, melt downs
• Lives in rural VT
• Presents for well child visit
Urgent intervention needed

Conduct Problems Diagnosis Across the Lifespan

Tempermental Toddler: 20-30%
ODD: 5-11%
Conduct Disorder: 4-10%
ASPD: .2-3%

Craig 2020
PCP alerted by...

1. Clinical discovery: direct/indirect

2. Parent report: if <60% child compliance, parent avoids, expresses fear/contempt, doesn’t like friends, child lacks responsibility for actions


Risk Factors for aggression/non-compliance

Birth complications

Low IQ

Mental health disorders: ADHD, PTSD, ODD

Temperament

Poor communication skills

Male gender (if > preschool)

Disadvantaged neighborhood

Nonresponsive parenting 0-2y

Coercive discipline as toddler

Parent modeled aggression

Lack of supervision as adolescent

Lack of parental warmth

Parental maltreatment

Violent video games*
Addressing caregiver resistance

1. Parent feels blamed/criticized
   - Normalize, empathize, their childhood
   - Innate parent-child fit--->“Some kids are harder than others”

2. Responsibility on child to change
   - Parent-level interventions more effective
   - Parents as change-agent

3. Not worth effort
   - Status quo effort
   - Effort up front will pay off

4. Stigma re: MH treatment
   - Normalize/psychoeducation

Camenisch 2020
Levels of care
Levels of care: 0
Level 0: PCP

➔ Sleeping/eating
➔ Tantrums
➔ Medical non-compliance
➔ Straightforward ADHD/depression/anxiety
➔ Subclinical symptoms
Level 0: PCP

★ 20-30% toddler parents present with behavior concerns
★ 17% age 2-5y present with externalizing behavior
★ <8y primary MH presentation to PCP is disruptive/aggressive/defiant

Level 0: PCP

★ 80% who bring up MH concern in primary care → no treatment

#1 help caregiver regulate
- take space/breath, then help child regulate
- STOPS pattern of coercion

Craig 2020, Horwitz 2007, Cuellar 2015
Level 0: PCP

POSITIVE SKILLS

- Praise specific behaviors
- Simple words to reflect child’s communication
- Imitate and play
- Describe behavior
- Enthusiasm

LIMIT SETTING

- Few questions
- Limit direct instructions
- One instruction: wait 5 sec
- Ignore annoying behaviors
  "I'm going to ignore it so I don't reinforce it"

Listen/validate feelings

Decrease visit goals if kid is aggressive in office

Craig 2020
**Level 0: PCP--SLEEP**

**Recommended Amount of Sleep for Pediatric Populations***

<table>
<thead>
<tr>
<th>Age</th>
<th>Recommended Sleep Hours per 24 Hour Period</th>
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<tbody>
<tr>
<td><strong>Infants:</strong> 4 to 12 months</td>
<td>12 to 16 hours (including naps)</td>
</tr>
<tr>
<td><strong>Toddlers:</strong> 1 to 2 years</td>
<td>11 to 14 hours (including naps)</td>
</tr>
<tr>
<td><strong>Preschoolers:</strong> 3 to 5 years</td>
<td>10 to 13 hours (including naps)</td>
</tr>
<tr>
<td><strong>Gradeschoolers:</strong> 6 to 12 years</td>
<td>9 to 12 hours</td>
</tr>
<tr>
<td><strong>Teens:</strong> 13 to 18 years</td>
<td>8 to 10 hours</td>
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*The American Academy of Pediatrics (AAP) has issued a Statement of Endorsement supporting these guidelines from the American Academy of Sleep Medicine (AASM).*

Division of Responsibility in Feeding

Parents are responsible for:
What, When and Where

Parents’ Feeding Jobs:
• Choose and prepare the food.
• Provide regular meals and snacks.
• Make eating times pleasant.
• Show children by example how to behave at family mealtime.
• Be considerate of children’s lack of food experience without catering to likes and dislikes.
• Not let children have food or beverages (except for water) between meal and snack times.
• Let children grow up to get bodies that are right for them.

Children are responsible for:
How Much and Whether

Children’s Eating Jobs:
• Children will eat.
• They will eat the amount they need.
• They will learn to eat the food their parents eat.
• They will grow predictably.
• They will learn to behave well at mealtime.
Level 0: PCP--FUNCTION OF BEHAVIOR
(e.g. tantrums)

1. Assess across locations, times, caregivers
2. Rating scales--identify symptoms and rule-out other
3. Assess parent expectations/skills

ANTECEDENT
- What occurred just prior?

BEHAVIOR
- Intensity
- Duration
- Frequency

CONSEQUENCE
- How did it end?
- What did caregivers do?
- What did child do?

Camenisch 2020
Level 0: PCP--MEDICAL NON-COMPLIANCE

1. Clear expectations/in-office protocols for procedures
2. Provide expectations prior to visit
3. Model healthy responses for caregivers
Levels of care: 1
Level 1: PCP/MH consultation

➔ Diagnostic clarification
➔ Mild-moderate ADHD/depression/anxiety
➔ Mild ODD
➔ Subclinical symptoms
Level 1: PCP/MH consultation

★ 12% (4-16 year olds)--psychosocial dysfunction +/- ADHD, ODD/CD, ASD

★ Subclinical disruptive behaviors
  ➔ Overlap
  ➔ Increased risk of later dx

Kuhlthau 2011, DSM 5
Level 1: PCP--ADHD

a. Treat to target symptoms

   Serial Vanderbilt/Conners rating scales

a. Organizational Skills Training (parent, child, school)

b. Methylphenidate as first line, other stimulants, guanfacine, atomoxetine

c. Reassess the efficacy of treatment/medication

d. Majority in community care not benefitting from medication after >2 years

Cortese 2018, Molina 2009
Level 1: PCP--DEPRESSION/ANXIETY

a. Treat to target symptoms

   PHQ-9 for teens, or GAD-7, Vanderbilt to screen

a. Fluoxetine (most activating), sertraline, escitalopram

b. In younger kids--choose target symptoms

c. Therapy/parent support

d. Underlying cause

More to come from Dr. Pawlowski in April!!
Level 1: PCP/MH consultation

➔ Parents unable/unwilling to engage in MH services

➔ Refer for brief behavioral intervention

➔ Resource recommendations
  ◆ Seattle Children’s PAL Family Handouts
  ◆ Parenting The Strong-Willed Child
  ◆ 1-2-3 Magic
  ◆ Lives in the Balance
Level 1: PCP/MH consultation

→ Educational programing (e.g. ECHO, psych talk at your practice)

→ 1x consultative visit with community provider (psychologist or social worker)

→ Collaborative Care (new reimbursement! COCM codes)

→ Brief psychiatric questions
  ◆ UVMMC email/telephone consultation
  ◆ CHCB Child Psychiatry Consultation Clinic 2x visit

30 states with real-time telephone consultation
 +/- in person consult
Level 1: PCP/MH consultation

Child Psychiatry Consultation Clinic @ CHCB
◆ 2-6 week wait
◆ Two 1h visits
◆ Bio/psycho/social and dx clarity
◆ Community resources

◆ Reinforce recommendations for families re: environmental changes, level of care, medications

◆ Support PCP decision making
Levels of care: 2
Level 2: PCP/MH shared care

➔ Diagnostic uncertainty
➔ Moderate-severe ADHD/depression/anxiety
➔ Moderate-severe ODD/CD
Level 2: PCP/MH--SHARED CARE

Therapy care

➔ Parent consultation clinic
➔ Medical phobia clinic
➔ Community therapy--mainly to work with parents

Medication care

➔ Adjunct treatment
➔ In PCP office, consider consultative help (CPCC, UVM MC)
Level 2: PCP/MH--SHARED CARE

★ ADHD recommendations
  ○ <6y behavioral parent trainings
  ○ 6-11y meds and BPT/school intervention/educational support
  ○ 12-17y medications, BPT, educational support

★ ODD
  ○ BPT first line

★ Conduct Disorder
  ○ BPT
  ○ Family therapy

Craig 2020, Cortese 2020, AACAP 2020, Ollendick 2006
Level 2: PCP/MH--SHARED CARE

ODD definition*, often...

1. Loses temper
2. Argues with adults
3. Defies/refuses to comply
4. Deliberately annoys ppl
5. Blames others
6. Touchy/annoyed by others
7. Angry or resentful
8. Spiteful or vindictive

*n/a if sibling interaction
Level 2: PCP/MH--SHARED CARE

Conduct Disorder

1. Aggression to people/animals
2. Destruction of property
3. Deceitfulness or theft
4. Serious violations of rules

DSM 2013
Level 2: PCP/MH--SHARED CARE

ODD/CD treatment

Behavior parent/management training
  • Engage parents for success

Offer parent support, nurtured parent helps their child
  • Parenting groups/classes
  • Individual counseling

“Special” time for parent and child
  • Praise good behaviors
Level 2: PCP/MH--SHARED CARE

Behavioral Parent Training ("BPT", "BMT", "PMT")

8 types--similar elements
- 1) education re: changing behaviors (e.g. good consequence)
- 2) child directed interactions (special time)
- 3) attend differently to good/bad behaviors
- 4) giving instructions in helpful ways

Tools for immediate issues--timeout/points/groundings
- Keep timeouts short
- Reinforce good behaviors

Craig 2020
Negative Attention

(Parent yells at child, loses control)

Negative Behavior

(child reacts negatively, has outburst)

Parent Interventions

Child Interventions
Level 2: PCP/MH--SHARED CARE

Behavioral Parent Training

*Young Children*

Helping the Noncompliant Child (HNC)

Parent Management Training (PMT)

Kazdin 2005)

Parent Management Training Oregon

Model (PMTO)

Parent Child Interaction Therapy (PCIT)

The Incredible Years

*Older Youth (9+)*

Multisystemic Therapy (MT)--effective/costly

Functional Family Therapy (FFT)--includes teenager; becoming parent of cooperative/warm/connected family
Level 2: PCP/MH--SHARED CARE

Medications supplementary

*No FDA approval for aggression*

**Risperidone**
Dev Dis, Conduct Dis, ADHD

*Large effect size (0.9)*

**Alpha-2 agonist**

Autism, ADHD

*Medium effect size (0.5)*

**Methylphenidate**

ADHD

*Large effect size (0.9)*

**Atomoxetine**

ADHD

*Low-med effect size (0.2)*

Hilt 2019, Pappadopulos et al 2006
Level 2: PCP/MH--SHARED CARE

FURTHER DIFFERENTIAL

**ASD**--CAST and AQ screeners, AACAP guide, kids rehab gym, consult for formal dx

**Reactive attachment issues** (e.g. adopted)--parent therapist for better attachment

**Fetal Alcohol Spectrum Disorders**--3-10% of children, adjust expectations

**Bipolar spectrum**--clear long episodes, often conflated with ADHD (stimulants work), consult if concern or fam hx
Levels of care: 3
Level 3: Mental Health Management

➔ Diagnostic high complexity
➔ Severe ADHD/depression/anxiety
➔ Severe ODD/CD
➔ Prodromal concern (e.g. bipolar, psychotic)
## Level 3: Mental Health Management

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Description</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT</td>
<td>correct cognitive errors in thinking, encourages different behaviors</td>
<td>ODD, depressive, anxiety, PTSD, SUD</td>
</tr>
<tr>
<td>Family therapy</td>
<td>Change family interaction patterns that cause dysfunction</td>
<td>Conduct depressive, substance, eating</td>
</tr>
<tr>
<td>Behavior parent (management) training</td>
<td>caregiver responses, positive interaction, changing caregiver behavior</td>
<td>ODD, CD</td>
</tr>
<tr>
<td>Applied behavioral analysis</td>
<td>1:1 intensive to gradually teach socially normative behaviors, resource intensive</td>
<td>ASD</td>
</tr>
<tr>
<td>Social skills training</td>
<td>class/group/1:1, basic behavioral/cognitive skills, social problem solving</td>
<td>ODD, ADHD, ASD</td>
</tr>
<tr>
<td>Motivational interviewing</td>
<td>nonconfrontational/nonjudgmentally helping pts state own reasons for change</td>
<td>SUD</td>
</tr>
</tbody>
</table>
Level 3: Mental Health Management

Designated Agencies

Howard Center
Counseling Service of Addison County
United Counseling Service
Northwestern Counseling and Support Services
Lamoille County Mental Health Clara Martin Center
Northeast Kingdom Human Services
Rutland Mental Health Services
Washington County Mental Health Healthcare and rehabilitation services
Pathways Vermont
Northeastern Family Institute

UVM MC Child Psychiatry
DHMC Child Psychiatry
Psychologytoday.com
211
https://www.vermont211.org/
Partners for Access (HC)
https://howardcenter.org/pfa/

Consult until connected with ongoing treatment
UVM eliza.pillard@uvmhealth.org
CPCC www.chcb.org/cpcc
Key points...

Aggression

- Environmental trigger
- Disorder
- Biology
- Obtain a goal

Intervention

- Help subclinical kids
- Help parents
- Environment not child
- Treat comorbidities
- Resolve recurring conflicts
- Medications not the answer for ODD/CD
Resources: VT Child Psychiatry Consult Clinic

PCP Mental Heath Care Guide Algorithms:

- Developmental, ADHD, ASD, bipolar, depression, disruptive behavior and aggression, eating disorder, substance abuse
- Psychosis
- Prodromal Family and Provider Resource
- Fetal Alcohol Spectrum Disorders (FASD)

Screening Tools and Other Diagnostic Resources:

- University of Washington Screening Tools
- Project TEACH NY
- Massachusetts Child Psychiatry Access Program

Vermont Resources:

- CPCC Vermont Resource Guide

Family Handouts:

- Needle Phobia
- Feeding handout
- Sleep Handout
Resources: U of Wash Partnership Access Line

Care Guides and Resources

Care Guides

+ Alaska

+ Washington
References


Best Principles for Integration of Child Psychiatry into the Pediatric Health Home: AACAP; June 2012.


References


Conclusion

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to Michael.Hoffnung@uvmhealth.org

• Please complete evaluation survey after each session

• Claim your CME at www.highmarksce.com/uvmmmed

• Please contact us with any questions, concerns, or suggestions
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