UVM Project ECHO
School Nurses: Mental Health in the School Setting

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                    Cynthia LaRiviere, PhD
                    Liz Manz, RN
                    Kaitlyn Kodzis, MSN, BSN, RN
                    Allison Conyers, MSN, RN, NCSN
• RECORDING OF SESSION TO BEGIN
Agenda

• Introductions
• Objectives
• Didactic Presentation (~20-30 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
Series Objectives

Learning objectives for this ECHO series include the ability to:

• Apply wellness and self-care techniques to personal and professional life.

• Describe best practices in managing anxiety, psychiatric emergencies, oppositionality and disruptive behaviors, and eating disorders.

• Identify ways to apply strategies learned about caring for mental health in the school setting to school nursing practice.

• Use the resources available in your community in school nursing practice.
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 1.5 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1.5 Nursing Contact Hours.

Participants should claim only the credit commensurate with the extent of their participation in the activity.
CME Disclosures

**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.

**Meeting Disclaimer:** Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.
Addressing the non-compliant child: oppositionality and disruptive behavior for school nurses

Presenters

Rebecca Ruid, PhD
Psychologist
University of Vermont Medical Center

Greta Spottswood, MD, MPH
Child Psychiatrist
Community Health Centers of Burlington

We have no conflicts to disclose.
Learning Objectives: non-compliance

1) Behavior type and epidemiology
2) Approach
3) Evidence based treatments
   - Therapeutic
   - Medical
4) Medical care referral sources
Learning Objectives: non-compliance

1) Behavior type and epidemiology
2) Approach
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   - Therapeutic
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School nurse alerted by...

1. **School staff:** direct/indirect

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

3. **IEP/504 meetings:** dependent on school
Urgent Intervention Needed...

Conduct Problems Diagnosis Across the Lifespan

Tempermental Toddler: 20-30%

ODD: 5-11%

Conduct Disorder: 4-10%

ASPD: .2-.3%
Epidemiology

★ 17% age 2-5y present with externalizing behavior

★ <8y primary MH presentation to PCP is disruptive/aggressive/defiant

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

★ Subclinical disruptive behaviors

→ Overlap
→ Increased risk of later dx

Epidemiology: Etiology

Birth complications

Low IQ/Learning differences

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

Trauma

Lack of parental warmth

Parental maltreatment

Violent video games*

Hilt 2019
Epidemiology: Etiology

Self Care

• Sleep hygiene
• Eating a healthful diet
• Exercise
• Screen limits and monitoring

Health class topics

Education insufficient ➔ Change the environment!
✓ Move it, Move it
# Epidemiology: Etiology

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODD (5-11%)</td>
<td>Noncompliance</td>
</tr>
<tr>
<td></td>
<td>Frequent tantrums/anger</td>
</tr>
<tr>
<td></td>
<td>Mean when upset</td>
</tr>
<tr>
<td></td>
<td>Arguing with adults</td>
</tr>
<tr>
<td></td>
<td>Blame others/question rules rules</td>
</tr>
<tr>
<td>Conduct disorder (4-10%)</td>
<td>Repetitive persistent violation of others</td>
</tr>
<tr>
<td></td>
<td>Aggressive to people/animals</td>
</tr>
<tr>
<td></td>
<td>Destruction of property</td>
</tr>
<tr>
<td></td>
<td>Deceitful</td>
</tr>
<tr>
<td></td>
<td>Fires/thealing/lying/truant</td>
</tr>
<tr>
<td>ADHD (9-12%)</td>
<td>Impulsive prior to age 12</td>
</tr>
<tr>
<td></td>
<td>2+ settings</td>
</tr>
<tr>
<td></td>
<td>Family correlation</td>
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</tbody>
</table>
Epidemiology: Etiology

FURTHER DIFFERENTIAL

**Depression/anxiety**—PHQ-9, GAD-7

**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, consult if concern or fam hx
Learning Objectives: non-compliance

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   ■ Therapeutic
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(adult attends to negative behavior, applies discipline)

(child reacts negatively, has outburst)

School Interventions
Approach

**FAIR Plan**

*Functional Hypothesis of behavior*

*Accommodations*

*Interaction strategies*

*Response strategies*
Approach: ABC Functional Hypothesis

1. Assess across locations, times, staff
2. Assess teacher expectations/skills

ANTECEDENT
- What occurred just prior?

BEHAVIOR
- Intensity
- Duration
- Frequency

CONSEQUENCE
- How did it end?
- What did staff do?
- What did child do?
# Antecedents – Behaviours – Consequences (ABC) Chart

<table>
<thead>
<tr>
<th>Date:</th>
<th>Data collected by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student:</td>
<td>Grade: Age: Teacher: School:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>A</strong></th>
<th><strong>B</strong></th>
<th><strong>C</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Antecedents</td>
<td>Behaviour</td>
<td>Consequences</td>
</tr>
<tr>
<td>(Describe what happens before the behaviour)</td>
<td>(Describe what the student does)</td>
<td>(Describe what happens after the behaviour)</td>
</tr>
</tbody>
</table>

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Section 4 - Appendix
Functional Behavioural Assessment with Planning Process
Approach: Accommodations

- Environmental
- Curriculum
- Teach underdeveloped skills explicitly
- Replacement behaviors
- Regulation of self and self-monitoring

Accommodations:
Spelled out in IEP/504 material, should be constantly adjusted as warranted – these are “living” documents
Approach: Interaction Strategies

Accept the feelings driving the behaviors first...

then set limits around behaviors
Approach: Interaction Strategies

- Strength-based terminology
- Explicit relationship building
- Transition warnings/strategies
- Positive reinforcement
- Noncontingent reinforcement
- Leadership-building, self-esteem-building activities

Strategies for giving instruction:

- Avoid asking, saying “ok?”
- Embed choice
- Give demand, move away
- Extended time for compliance
- Use humor when appropriate
- Make it a game

Minahan and Rappaport 2012
Approach: Response Strategies

Determine response based on function:

*Escape*
No time-out/removal/avoidance

*Attention*
No verbal/visual response

*Tangible*
No giving an object/allowing to do something

*Sensory*
Provide an acceptable form of stimulation
Approach: Response Strategies

- Rewards/points for self-regulation/pro-social
- Answer simple questions
- Redirect challenging questions/provide a limit
- Enforceable/reasonable/simple limits
- Incremental rewards/consequences
- Address frustration tolerance
Learning Objectives: non-compliance

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Evidence Based Treatments: Therapeutic

<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>
Evidence Based Treatments: Therapeutic

“Special time” as a given
- Praise good behaviors, instead of 1:1 when dysregulated only

Encourage parent management training
- Engage caregivers/parents for success
- Offer parent programming

Use self-regulation curriculum
- Zones of regulation
- Superflex curriculum
- School/home notes CAT Track

Hilt 2019
Evidence Based Treatments: Medical Care
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*
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, externalizing comes from something

“It might be helpful to talk to your PCP about this”
Medical Care

Medications supplementary

*No FDA approval for aggression*

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indications</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risperidone</strong></td>
<td>Dev Dis, Conduct Dis, ADHD</td>
<td>Large effect size (0.9)</td>
</tr>
<tr>
<td>Alpha-2 agonist</td>
<td>Autism, ADHD</td>
<td>Medium effect size (0.5)</td>
</tr>
<tr>
<td><strong>Methylphenidate</strong></td>
<td>ADHD</td>
<td>Large effect size (0.9)</td>
</tr>
<tr>
<td><strong>Atomoxetine</strong></td>
<td>ADHD</td>
<td>Low-med effect size (0.2)</td>
</tr>
</tbody>
</table>

Hilt 2019, Pappadopulos et al 2006
Learning Objectives: non-compliance

1) Behavior type and epidemiology
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4) Medical care referral sources
Referral Sources

Start with PCP
Referral Sources

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/

PCP consult until connected:
Vermont Child Psychiatry Access Program
References


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


References


References


Discussion and Q & A
The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
Case Presentation Format

Case presentation from a participant (a real-world case, from the field)
Then
Clarifying questions about the case from group to case presenter
Then
Ideas, suggestions, recommendations from participants
Then
Ideas, suggestions, recommendations from ECHO faculty team
Then
Additional discussion, if any (All)
Then
Summary of case discussion
(course co-directors: Michael Hoffnung, DO and Katherine Mariani, MD, MPH)
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

<table>
<thead>
<tr>
<th>DATES</th>
<th>SESSION</th>
<th>DIDACTIC TOPICS (in addition to case review)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 13</td>
<td>TeleECHO Session 1</td>
<td>Wellness and Self Care for Ourselves and Our Students (Michael Hoffnung, DO)</td>
</tr>
<tr>
<td>Feb 10</td>
<td>TeleECHO Session 2</td>
<td>Eating Disorders (Katherine Mariani, MD)</td>
</tr>
<tr>
<td>Mar 10</td>
<td>TeleECHO Session 3</td>
<td>Addressing the Non-compliant Child: Oppositionality and Disruptive Behaviors (Margaret Spottswood, MD and Rebecca Ruid, PhD)</td>
</tr>
<tr>
<td>Apr 14</td>
<td>TeleECHO Session 4</td>
<td>Managing Psychiatric Emergencies (Haley McGowan, DO and Yasmeen Abdul-Karim, MD)</td>
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<tr>
<td>May 12</td>
<td>TeleECHO Session 5</td>
<td>Managing Anxiety: What School Nurses Need to Know (Stephanie Fosbenner, MD and Cynthia LaRiviere, PhD)</td>
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Conclusion

• Slides are posted at www.vtahec.org

• Volunteers to present cases (this is key to the Project ECHO model)
  • Please submit cases to lizmanzvt@gmail.com

• Please complete evaluation survey after each session

• Once your completed evaluation is submitted, CE information will be emailed to you.

• Please contact us with any questions, concerns, or suggestions
  • Michael. Hoffnung@uvmhealth.org
  • Elizabeth.Cote@uvm.edu