MindPeace School Summit

Mental Health Challenges for Children and the System of Care
How Do We Get the Intensity of Care the Children Need
An Example of Medication Management

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What is this talk about?

This is not a talk about how therapists should use medicine

It is not at presentation to suggest all children in treatment need medication

Rather the talk is to encourage development of care pathways that optimize treatment by providing the intensity of care a child and family needs

In this case we are going to use referral to medication therapy as an example

Before the Pandemic

- 10-12% of nation's youth suffer from serious mental illness that causes significant impairment. One in five have a mental health condition.
  - » Surgeon General, 1999
- Half of all mental health disorders start by age 14.
  - » SAMSHA, 2008
- 8% of adolescents are estimated to experience a major depressive episode each year (age 12-17).
  - » Kessler, 2005
- Only one-third receive treatment. Many less get evidence-based care.
- Suicide is the 2nd leading cause of death in ages 10-24.
- In previous year, 17% of U.S. high school students seriously thought about killing themselves; 13% made a suicide plan; 8% report a prior suicide attempt.
  - » CDC, 2009.
- Untreated mental illness associated with drug and alcohol abuse, violence, school failure, involvement in legal system, potential suicide.

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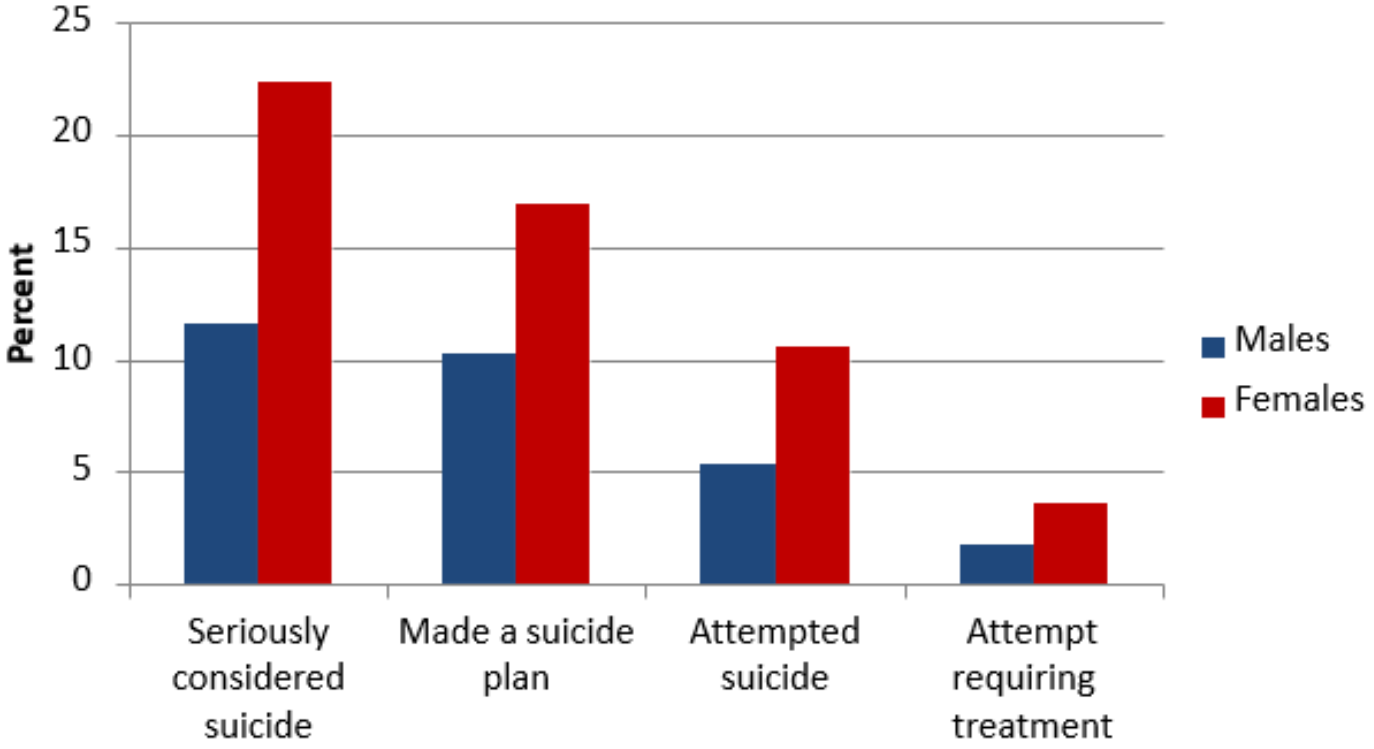
Percentage of U.S. High School Students Reporting Suicidal Thoughts and Behavior in the Past 12 Months, by Sex, 2013



Source: Youth Risk Behavior Surveillance-US, 2013; USDHHS, CDC.

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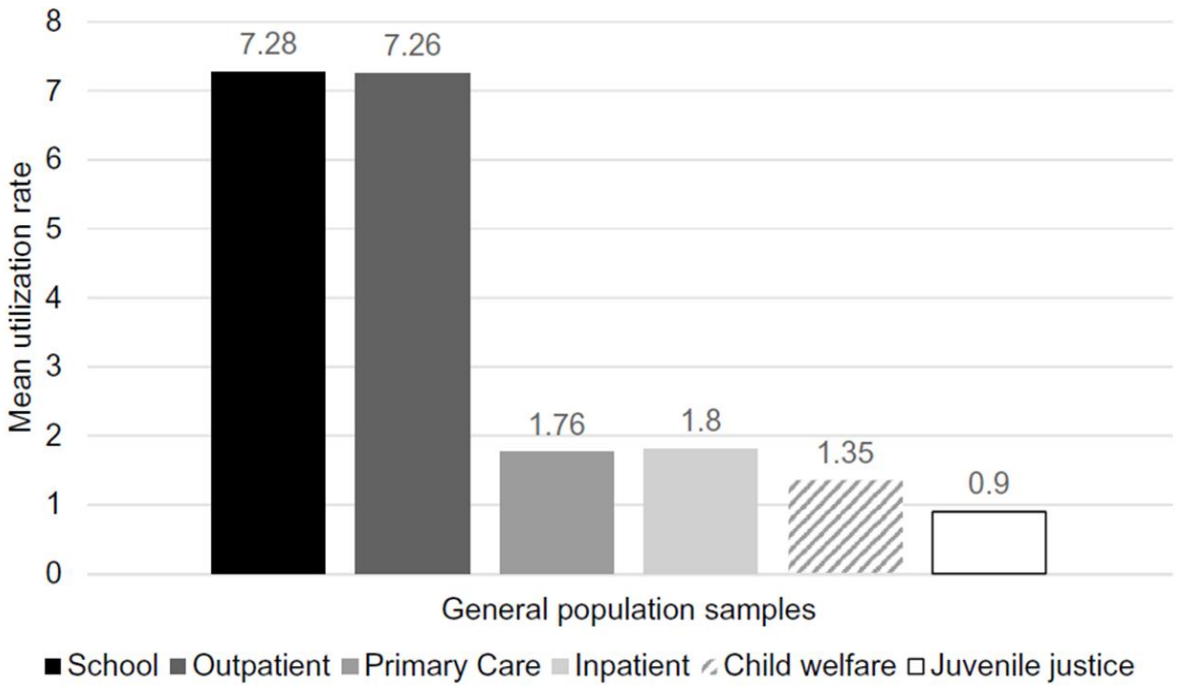
Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis

Administration and Policy in Mental Health and Mental Health Services Research

Fig. 1 Rates of service utilization across settings for studies sampling from general populations of youth



https://www.researchgate.net/publication/344305016_ May 2021

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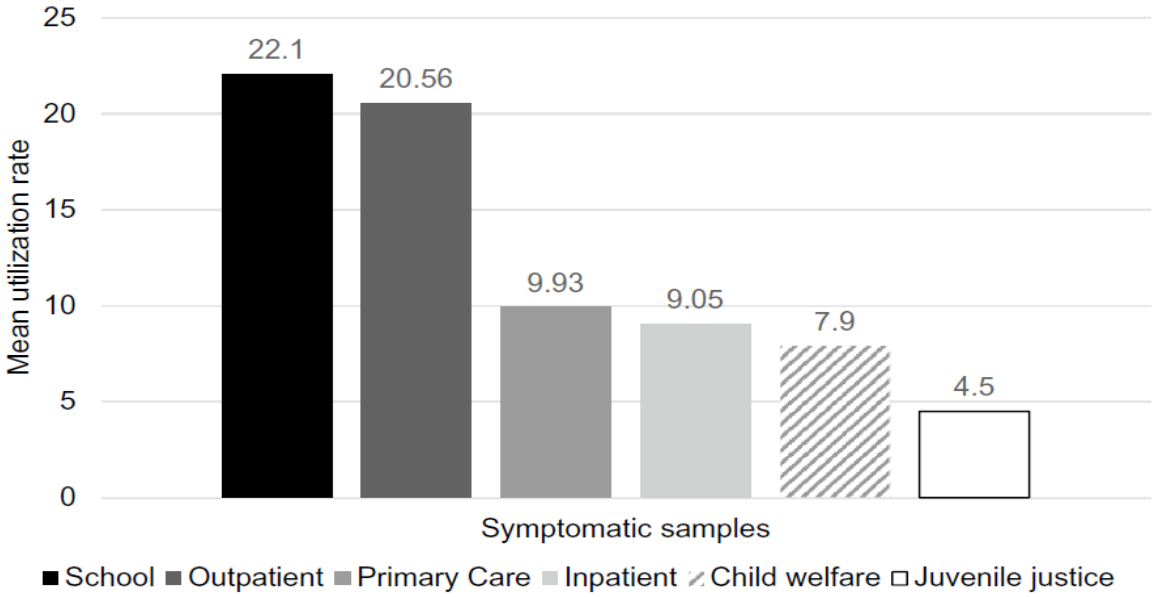
Rates of Mental Health Service Utilization by Children and Adolescents in Schools and Other Common Service Settings: A Systematic Review and Meta-Analysis

Administration and Policy in Mental Health and Mental Health Services Research

Fig. 4 Rates of service utilization across settings for studies sampling from youth with elevated mental health symptoms and/or clinical diagnoses



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Mental Health Care

Regional System of Care

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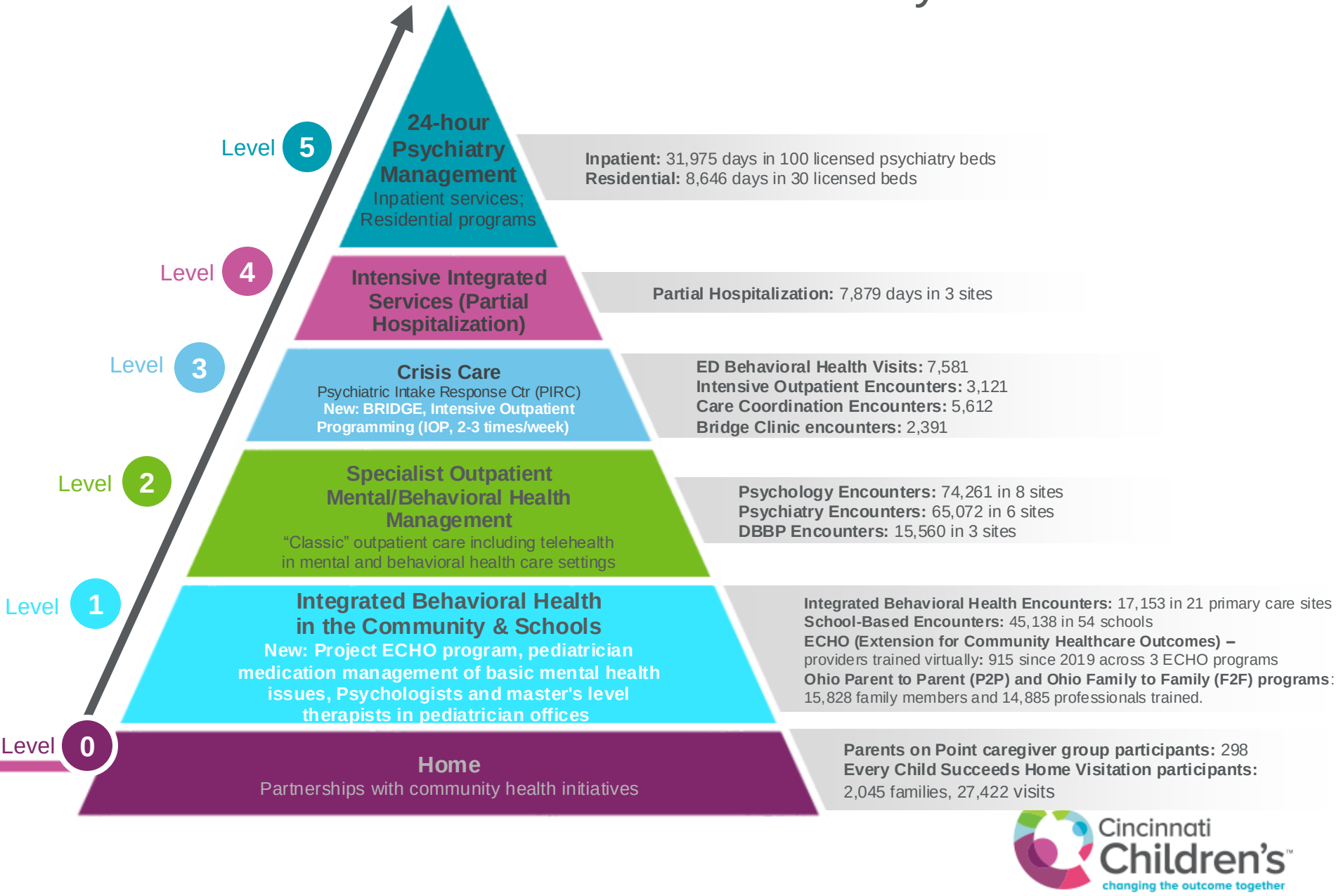
CCHMC Framework for Mental Health System of Care



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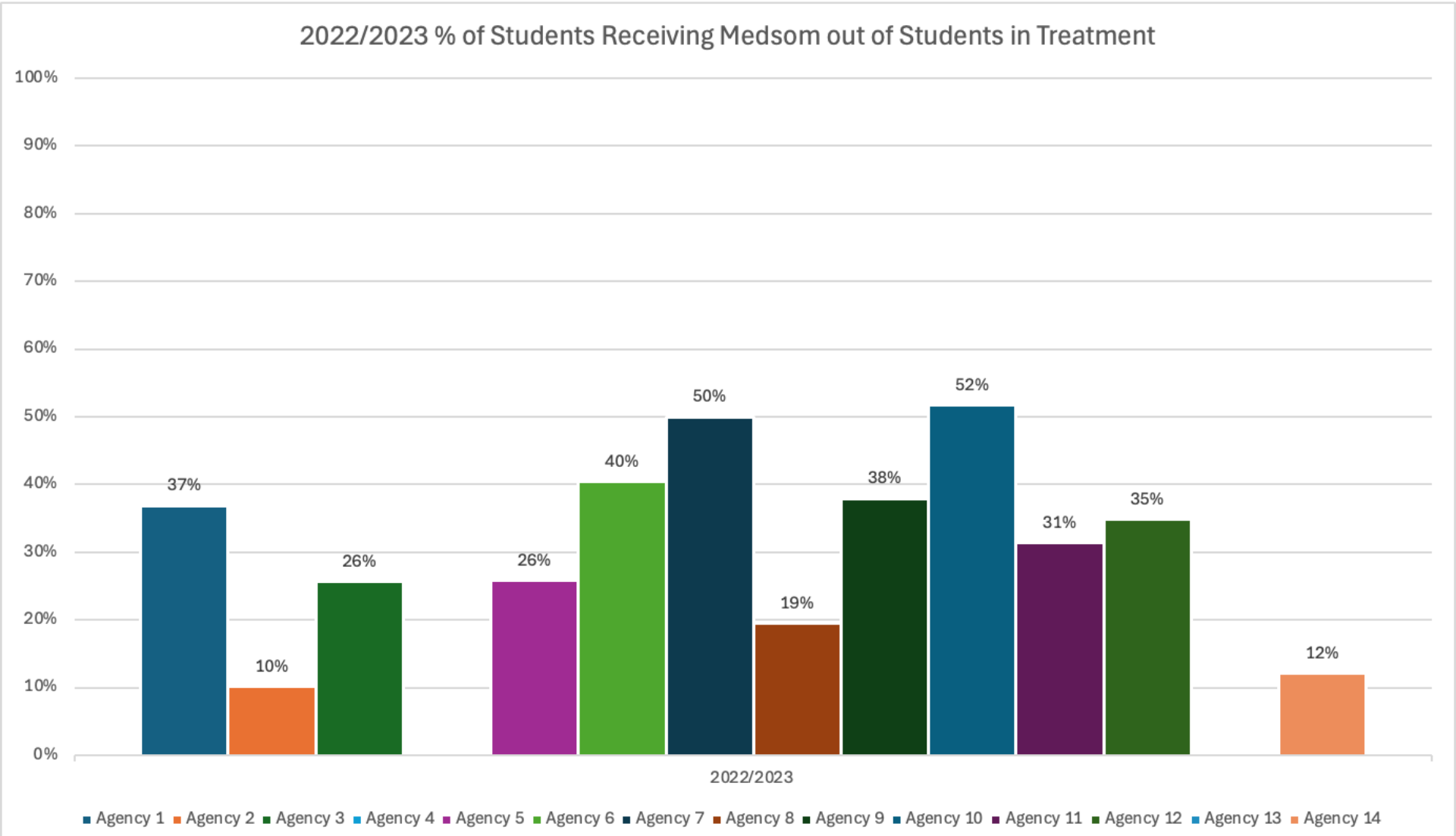

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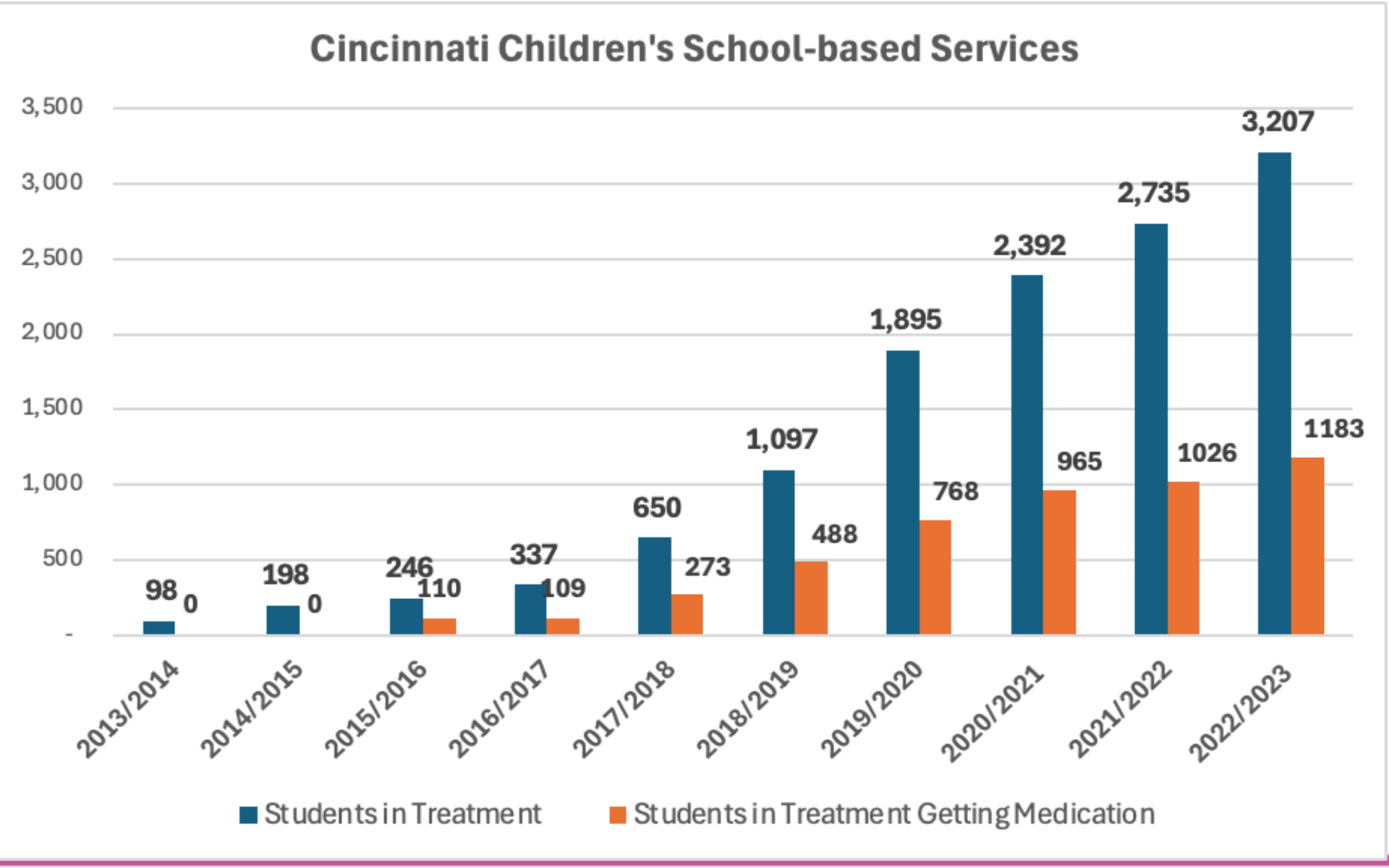

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Barriers to receiving evidence-based therapies

- Service level factors including limited availability of effective clinicians with shortages in many child mental health providers
- Societal influences that include bias, discrimination, state and local policies
- Economic factors that include insurance status and a whole array of social determinants of health
- Individual challenges from transportation, parental work leave, medical illness
- Cultural beliefs that may limit interventions
- Ongoing role of stigma
- Belief of the primary therapist

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Social Workers' Attitudes about Psychotropic Drug Treatment with Youths

Tally Moses and Stuart A. Kirk July 2006

Medication's Harms (M= 2.2, SD = .60, Cronbach's a = .84)

Psychotropic medication is often used as a substitute for other treatments.	67.2%
Psychotropic medication is often given to youths because of their parent' poor parenting skills	40.6%
Relying on psychotropic medication for treatment takes professionals' attention away from broader problems in our society	51.3%
Psychotropic medication sends youths the wrong message about dealing with problems	22.9%
In the end, psychotropic medication can make youths even more disturbed.	15.5%
The primary function of psychotropic medication is to control youths.	11.8%

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Social Workers' Attitudes about Psychotropic Drug Treatment with Youths

Tally Moses and Stuart A. Kirk July 2006

Medication's Benefits (M = 2.5, SD = .44, Cronbach's a = .64)	
Psychotropic medication is a necessary part of treatment for many emotional disorders.	81.1%
The benefits of psychotropic medication far outweigh any risks associated with it.	59.5%
Psychotropic medication is the treatment most likely to bring about rapid improvement.	54.6%
Taking psychotropic medication results in higher self-esteem among youths.	28.1%
Psychotropic medication is the most effective way of getting adolescents' behaviors under control.	8.9%

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Social Workers' Attitudes about Psychotropic Drug Treatment with Youths

Tally Moses and Stuart A. Kirk July 2006

Medication and Other Treatments* (M = 3.2, SD =.54, Cronbach's a = .47 *Scale dropped from bivariate/regression analysis due to low Cronbach's alpha.	
Psychotropic medication should always be accompanied by other forms of therapy.	88.8%
Taking psychotropic medication without therapy leaves the basic problems unchanged.	80.6%
Before recommending psychotropic medication, all other treatment options should be explored.	67.9%

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Treatment of Adolescent Depression the TADS Study

Landmark study evaluating the role of psychotherapy and medication

Background: Major depression is one of the most common disorders of adolescents
5% have moderate to severe major depression in the United States
With depression adolescents suffer greatly with poor peer relationships, school difficulties, disrupted function in family life and without effective treatment some may die by suicide.

This study: 439 patients with major depression received 1 of 4 treatments
Fluoxetine (Prozac) alone
Placebo
Cognitive behavioral therapy (CBT)
Combination of fluoxetine and CBT

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The TADS Study

AT 12 Weeks

71% receiving the combination treatment were much improved or very much improved
61% receiving fluoxetine alone improved
44% of those receiving CBT improved
35% of those receiving placebo improved

AT 18 Weeks

Results remain consistent
85% response rate of combination treatment
69% response rate for fluoxetine alone
65% for CBT alone

At 36 weeks

combination treatment response still remains high, however response rates to fluoxetine and CBT nearly caught up

Patients receiving fluoxetine alone had a higher rates of some suicidal thinking (15%) while those in combination treatment (8%) and CBT (6%) had lower rates of suicidal thoughts. These events were particularly in the early stages of treatment. There were no suicides in the study

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The TADS Study

What do the results mean:

Suggest the combination treatment is the safest and most effective treatment overall for adolescents with moderate to severe depression.

Fluoxetine alone or in combination with CBT accelerates recovery

Response rate of CBT alone gradually catches up however exposes patient to depression for a long period of time and potential complications

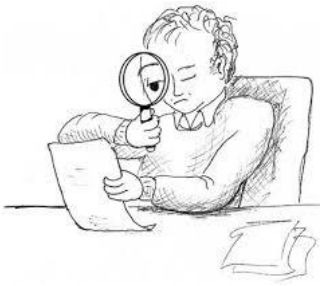
It appears adding CBT lessens the risk of suicidal thinking and behavior in patients given fluoxetine.

CBT assist patient's and developing new skills to contend with difficult and negative emotions

Child and Adolescent Anxiety Multimodal Study (CAMS)

488 children and adolescents were assigned to one of four groups:

- Placebo
- Sertraline (Zoloft)
- Cognitive Behavior Therapy (CBT)
- A combination of CBT and Sertraline



Evaluated at 12, 24, and 36 weeks plus follow-up

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CAMS

Results of Study

At 12 weeks

Patients rated as much or very much improved
23% for placebo
55% for sertraline
59% for CBT
80% for combination therapy

At 24 and 36 weeks

The bottom line is that combination therapy remained the best however CBT and sertraline groups closed the gap

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Medication and Evidence Based Care in Youth

ADHD

The most common chronic neurodevelopmental disorder among children and adolescents,
one in 10 youth between the ages of three and 17

Potential severe impairment due to symptoms of inattention, disorganization, hyperactivity, impulsivity

Associated with poor health outcomes, twofold risk for premature death by the age of 46

Range of negative outcomes that include accidental injuries, risky behaviors, aggression, peer rejection, school failure

Multimodal Treatment of ADHD the MTA study

The bottom line is that groups treated with medication, or a combination of medication and behavioral therapy did markedly better than behavioral therapy or routine community care

75% of children with ADHD experience significant reductions in the primary symptoms of ADHD with stimulants.

Some may have normalization of behavior

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New Opportunities for Better Access to Evidence-Based Therapies.

Connection to a System of Care.

Improved Access to training for therapists.

Commitment of Pediatrics to improve training for treatment of ADHD, Depression, and Anxiety.

Evidence-Based educational programs REACH, ECHO,

The rise of APRNs

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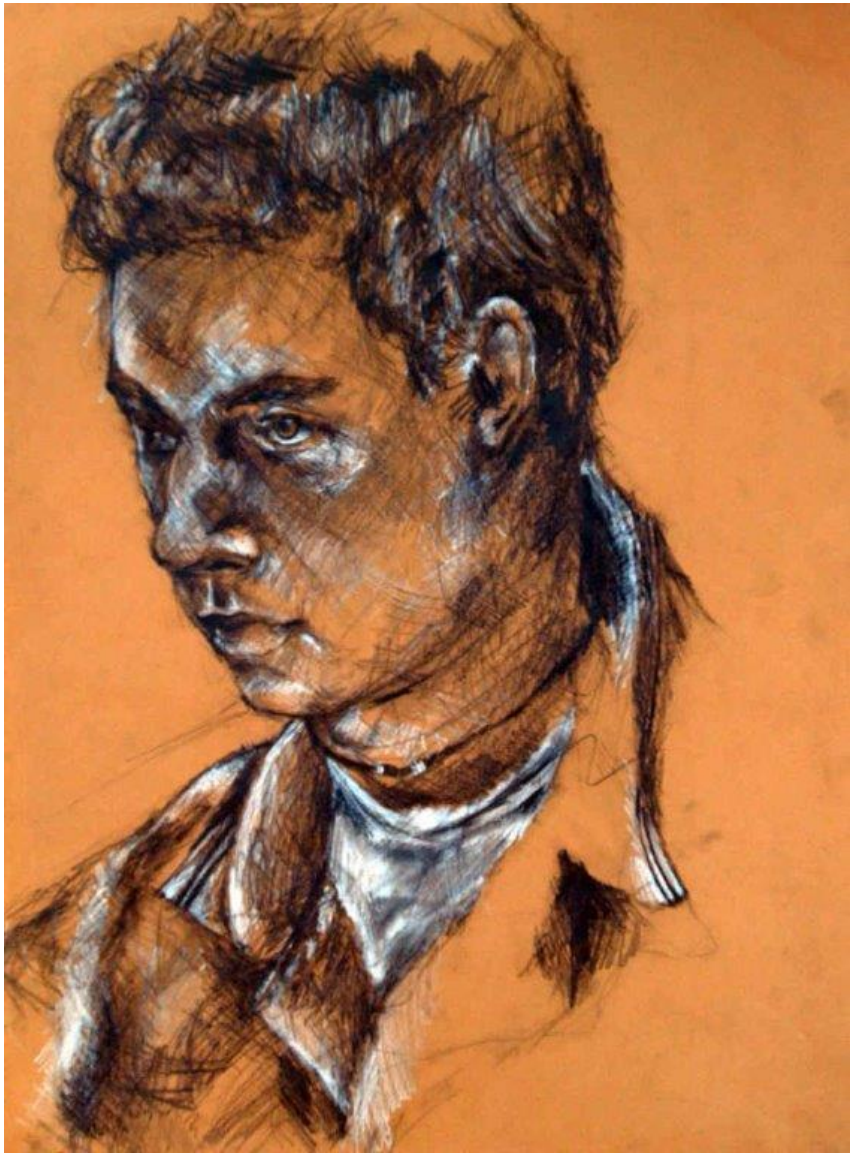

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Case Example of Moderate to Severe Depression

Question, how do we improve outcomes of adolescents with moderate to severe depression in our outpatient clinic

Challenges to address: Do we diagnose depression in a consistent way? Do we treat depression in a reliable evidence based way?

How do we know when treatment is not going the way it should and what do we do?

What we did:

1 Train people on reliable way to diagnose depression using DSM

2 Use the Global Assessment of Functioning (GAF) to assess severity

3 Train providers in evidence based therapy and set expectation to use that training.

4 Discuss with caregiver referral to prescriber MD or APRN if severity mod to severe after 4 sessions, repeat at 8 if needed

5 Prescribers to review with family evidence based medication and use these as first line. Prozac and Lexapro.

6 If caregivers agree medication treatment is added to psychotherapy.

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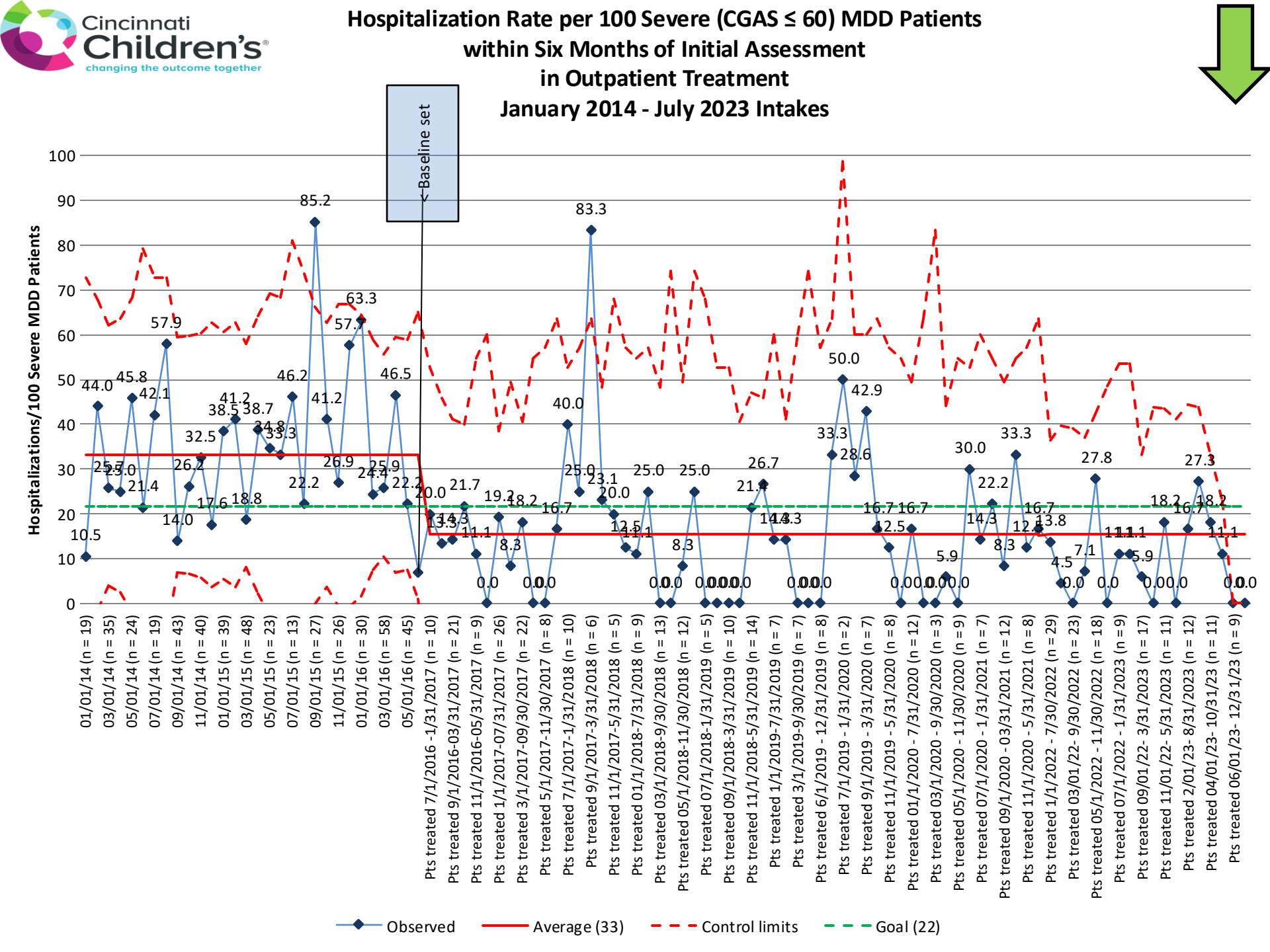
Hospitalization Rate per 100 Severe (CGAS ≤ 60) MDD Patients within Six Months of Initial Assessment in Outpatient Treatment
January 2014 - July 2023 Intakes



The Global Assessment of Functioning (GAF)

Source: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition

- **100-91:** Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
- **90-81:** Absent minimal symptoms (e.g. mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
- **80-71:** If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
- **70-61:** Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
- **60-51:** Moderate symptoms (e.g., flat and circumstantial speech, occasional panic attacks) OR moderate difficulty in social occupational, or social functioning (e.g., few friends, conflicts with co-workers).

The Global Assessment of Functioning (GAF)

Source: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition

• **50-41:**	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
• **40-31:**	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work, child frequently beats up younger children, is defiant at home, and is failing at school).
• **30-21**	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
• **20-11**	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
• **10-1**	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
• **0**	Inadequate Information.

Clinical Global Impression- Severity Scale

CGI-S guidelines

1 = Normal—not at all ill, symptoms of disorder not present past seven days
2 = Borderline mentally ill—subtle or suspected pathology
3 = Mildly ill—clearly established symptoms with minimal, if any, distress or difficulty in social and occupational function
4 = Moderately ill—overt symptoms causing noticeable, but modest, functional impairment or distress; symptom level may warrant medication
5 = Markedly ill—intrusive symptoms that distinctly impair social/occupational function or cause intrusive levels of distress
6 = Severely ill—disruptive pathology, behavior and function are frequently influenced by symptoms, may require assistance from others
7 = Among the most extremely ill patients—pathology drastically interferes in many life functions; may be hospitalized
Adapted from Kay SR. Positive and negative symptoms in schizophrenia: Assessment and research. Clin Exp Psychiatry Monograph No 5. Brunner/Mazel, 1991.

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Clinical Global Impression- Improvement scale

CGI-I guidelines

1 = Very much improved—nearly all better; good level of functioning; minimal symptoms; represents a very substantial change
2 = Much improved—notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain
3 = Minimally improved—slightly better with little or no clinically meaningful reduction of symptoms. Represents very little change in basic clinical status, level of care, or functional capacity
4 = No change—symptoms remain essentially unchanged
5 = Minimally worse—slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity
6 = Much worse—clinically significant increase in symptoms and diminished functioning
7 = Very much worse—severe exacerbation of symptoms and loss of functioning
Adapted from Spearing MK, Post RM, Leverich GS, et al. Modification of the Clinical Global Impressions (CGI) Scale for use in bipolar illness (BP): the CGI-BP.Psychiatry Res 1997;73(3):159–71.

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How do we get to the right care path
some questions and challenges

1 Do we have the workforce equipped, trained, and supported to implement the best therapies for patients? (Does not mean CBT for all) (A systems issue)

2 Do we have methods and measures in place to tell us when a patient is not making the progress needed and as a result a change is needed in therapy? (A systems issue)

3 Do we communicate in a consistent way with patients and families that we support escalating care if progress is not as expected ? (a systems issue)

4 How do we convey that message ?
("That's all I can do" versus "let's work together to find the extra care you need") (a systems issue)

5 Do you have well established connections to a system of care to escalate care concerns and provide more intensive care when it needs to happen ?

6 We all are part of the system and can help shape its function.

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Suggestions moving forward.

1 We have strong mental health programs in our area and a skilled group of providers lets take advantage of that.

2 We should use our system of care to train and assist the frontline provider so that they are able to provide the most helpful care to that individual patient and family. This includes the best therapies but also the best measures to help us understand how patients are responding.

3 The system of care needs to support and help patients, families and caregivers find the care needed when more help is required

4 We must focus on coordinating our efforts to make access to the right level of care easy

5 We have the capability to do these things now with collaboration of our efforts.

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

WWW.AACAP.ORG

FAMILIES/YOUTH

- Facts for Families
- Resource Centers
- Resource Libraries
- Parents' Medication Guide
- CAP Finder
- Getting Help

QUICK LINKS

- Parents' Medication Guides
- Facts For

Parents' Medication Guides

The American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA) have developed Parents' Medication Guides to help individuals make informed decisions about treating mental disorders in children and adolescents.

ADHD: Parents' Medication Guide

ADHD: Parents' Medication Guide (Spanish)

ADHD in Youth with ASD: Parents' Medication Guide

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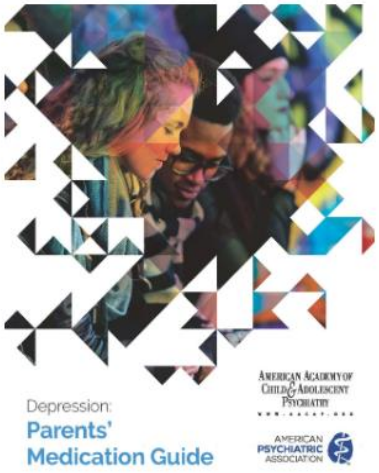
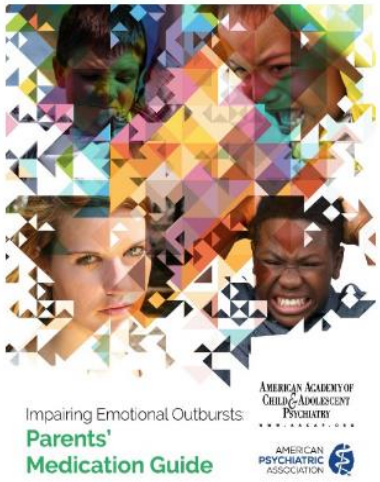
American Academy of Child & Adolescent Psychiatry

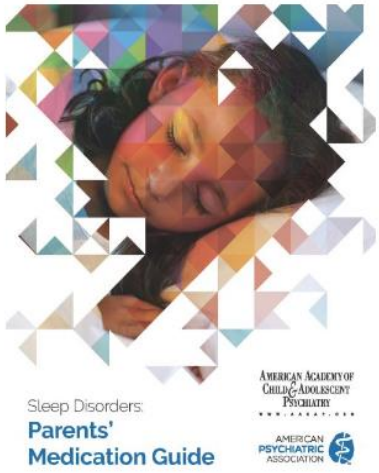
WWW.AACAP.ORG



Depression: Parents' Medication Guide



Impairing Emotional Outbursts: Parents' Medication Guide



Sleep Disorders: Parents' Medication Guide

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Ohio Minds Matter
Ohio Youth Behavioral Health Resource

Medication Guides

Prescribing Principles of Psychotropic Medication

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Treatment Guide for Families

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ADHD Nonstimulant Medication Aid

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ADHD Stimulant Medication Aid

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Antidepressant Medication Aid

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Antipsychotic Medication Aid

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Thank you

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