The 2019 Annual Conference on Advancing School Mental Health

Where Education and Medicine Meet: A Collaborative Approach to Mental Health in Schools
Kristie Ladegard, M.D.

- Dr. Kristie Ladegard, a child and adolescent psychiatrist who works in the school-based clinics.
- At eight School Based Health Centers (SBHC) in Denver, CO
- Substance Abuse Treatment Education & Prevention program (STEP)

- Worked with Denver Health since completing child and adolescent fellowship.
- Works with fellows from the University of Colorado Residency Training Program
Kristie Ladegard
Disclosures:
I HAVE NO CONFLICTS OF INTEREST
Vicky Virnich, an Assistant Principal at South High School and a DPS staff member will discuss her experience working with the Denver Health team to better serve students.

With regard to utilization of public school services, School Based Health Clinic (SBHC) and Denver Public School (DPS) staff work collaboratively to identify students at risk and provide appropriate care. She will discuss how the school functions with a clinic on site, how educators make referrals and work on treatment planning with the medical team.

The goal for DPS and SBHC staff is to minimize overlapping of services, foster unity in a team approach, and support academic and health care professionals who provide services to mutual students. To help bridge the gap and overlap of care, the development of a social and emotional meeting between school staff and medical staff was formed. This program enables all professionals to come together to address issues in a case format.
Vicky Virnich
Disclosures:
I HAVE NO CONFLICTS OF INTEREST
Outline

1. Illustrate the need for mental health services in youth
2. Identify how mental health conditions in youth may impact academic outcomes and school functioning.
3. Describe the program at Denver Health School Based Clinics and how our team collaborates with the school. Discuss successes and barriers of our program.
4. Review mental health and educational outcomes in Denver urban school based clinics and discuss case examples.
Mental Health Diagnosis: One in Five\textsuperscript{1}
Most children – nearly 80% who need mental health services won’t receive them.\textsuperscript{3}

Minority and uninsured children even less likely to receive services.\textsuperscript{3}

Of those who receive services over 75% received services in school.\textsuperscript{4}
What are the Consequences?

50 percent dropout rate in kids 14 years old and older with mental health disorders. \(^2\)

Untreated mental illness in children and adolescents are associated with:

- School failure
- Teenage pregnancy
- Unstable employment
- Substance use
- Violence including suicide and homicide
- Development of co-occurring mental disorders
- Poor medical outcomes

- Youth with emotional and behavioral disorders have a lower graduation than all other students with disabilities.\(^2\)
- Children with mental health conditions face more challenges that may interfere with their ability to learn and succeed in school.
Better Together?

Delays in treatment due to limited access to trained pediatric mental health professionals.

Have 8300 practicing CAP’s (Child and Adolescent Psychiatrists) however, the need is projected for 30,000.

Shortage places burden on Pediatricians and Family Practitioners, other clinicians to identify and treat children with mental health issues.
Why Schools?

Schools are the most universal natural setting for delivering services to children.

When groups are held in schools compared to community mental health clinics, there is more attendance to the groups in schools.\(^\text{12}\)

Schools with social emotional learning programs had an average increase of 11–17 percentile points on standardized tests compared with scores from non-intervention schools.\(^\text{11}\)
Who We Serve
Denver Health received a grant to open the first School Based Health Center at Abraham Lincoln.

As of 2019 we have 18 SBHCs in the City and County of Denver, CO.

Every student enrolled in the Denver Public Schools (DPS) has access to their community school clinic.

Every SBHC has mental health services and 7 clinics have substance use treatment available directly on site.

Collaborative effort with the community including Denver Health, DPS, Mental Health Center of Denver, and Jewish Family Services.
Who We Serve

- 54% Hispanic
- 24% White
- 13% African American
- 4% Two or more races
- 3% Asian
- 10% Nat. Hawaii or Pac. Island
- 3% Am Indian - Alaskan Native
- 2% Two or More Races

Who We Serve
Total Student Enrollment: 93,356 (October 2018)

Free/Reduced-Price Lunch Eligible Students: 68.51%

37% are Spanish speaking students
Not a traditional medical hierarchy model

School Staff

- Psychiatrists
- Health Educators
- Therapists
- Clerks/Medical Assistants
- Pediatricians/ Nurse Practitioners
- Physician Assistants
Improved mental health and academic outcomes from this model of care.

Coordinated approach to help improve both mental health and academic outcomes.
School Support Versus SBHC Support

South SE Team

2 School Psychologists
1 Health Educator
1 Social Worker
6 School Counselors
Principal; Assistant Principal; 5 Interns; Counseling Support Secretary
School Based Health Centers Denver
Fill Mental Health Gap
Compared to community mental health centers SBHC’s are 10 times more likely to evaluate and follow up with youth for treatment of mental health or substance use disorders.  

How to Assess Efficacy

SBHC’s have so many advantages to increasing access to care we wanted to try and assess the efficacy of the mental health care that we provide.

Recent findings from Oregon: mental health services in SBHC’s may reduce suicide risk and substance use among at-risk adolescents.
Ohio Youth Problems, Functioning and Satisfaction Scales (OYPFS)

Developed by Benjamin M. Ogles a professor of Psychology and Dean of the College of Family, Home and Social Sciences at Brigham Young University.

Inexpensive, practical measures with demonstrated validity and reliability in order to accurately monitor change as a result of treatment.  

Valuable tool in measuring mental health services at several school-based health centers in Denver.

Available in seven languages.
### Instructions:
Please rate the degree to which you have experienced the following problems in the past 30 days.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at All</th>
<th>Once or Twice</th>
<th>Several Times</th>
<th>Often</th>
<th>Most of the Time</th>
<th>All of the Time</th>
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<tbody>
<tr>
<td>1. Arguing with others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>2. Getting into fights</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>3. Yelling, swearing, or screaming at others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>4. Fits of anger</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>5. Refusing to do things teachers or parents ask</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>6. Causing trouble for no reason</td>
<td>0</td>
<td>1</td>
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<td>7. Using drugs or alcohol</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>8. Breaking rules or breaking the law (cut out curfew, stealing)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>9. Skipping school or classes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>10. Lying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>11. Can’t seem to sit still, having too much energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>12. Hurting self (cutting or scratching self, taking pills)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>13. Talking or thinking about death</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>14. Feeling worthless or useless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<tr>
<td>15. Feeling lonely and having no friends</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>16. Feeling anxious or fearful</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>17. Worrying that something bad is going to happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
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<td>18. Feeling sad or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>19. Nightmares</td>
<td>0</td>
<td>1</td>
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<td>4</td>
<td>5</td>
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<tr>
<td>20. Eating problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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(Add ratings together) Total _______
Mental Health Outcomes Illustrating the Effectiveness of our Program

- Self-harm
  - Baseline proportion: 0%
  - 3 month proportion: 16%
  - 6 month proportion: 12%
  - Absolute Reduction: 0%
  - Relative Reduction: 0%

- Talking/Thinking about Death
  - Baseline proportion: 32%
  - 3 month proportion: 27%
  - 6 month proportion: 24%
  - Absolute Reduction: 5%
  - Relative Reduction: 16%

- Feeling sad or depressed
  - Baseline proportion: 52%
  - 3 month proportion: 20%
  - 6 month proportion: 28%
  - Absolute Reduction: 34%
  - Relative Reduction: 65%
Potential Impact of our Program
Educational Outcomes: Attendance and Behavior

<table>
<thead>
<tr>
<th>Attendance and Behavior</th>
<th>N</th>
<th>Mean ± SD</th>
<th>P-Value</th>
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<td>Attendance Per Year Prior to Treatment</td>
<td>475</td>
<td>67 ± 44</td>
<td>0.0192</td>
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<tr>
<td>Attendance Per Year During Treatment</td>
<td></td>
<td>64 ± 34</td>
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<tr>
<td>Behavioral Incidents Per Year Prior to Treatment</td>
<td>490</td>
<td>1.2 ± 1.8</td>
<td>&lt;.0001</td>
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<tr>
<td>Behavioral Incidents Per Year During Treatment</td>
<td></td>
<td>0.6 ± 0.7</td>
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This integrated model in DSBHC has continually shown improved mental health and educational outcomes.
Overall four year graduation rate for the district: 70.2%

<table>
<thead>
<tr>
<th>High Schools with a SBHC</th>
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<tbody>
<tr>
<td>Abraham Lincoln</td>
<td>73.0%</td>
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<tr>
<td>Bruce Randolph</td>
<td>89.0%</td>
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<tr>
<td>Montbello</td>
<td>82.7%</td>
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<tr>
<td>(East)*</td>
<td>93.2%</td>
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<tr>
<td>JFK</td>
<td>86.8%</td>
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<tr>
<td>Kunsmiller</td>
<td>95.8%</td>
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<tr>
<td>Manual</td>
<td>71.9%</td>
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<tr>
<td>MLK</td>
<td>57.9%</td>
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<tr>
<td>North</td>
<td>85.1%</td>
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<tr>
<td>South</td>
<td>89.4%</td>
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<tr>
<td>Thomas Jefferson</td>
<td>83.0%</td>
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<tr>
<td>West</td>
<td>69.8%</td>
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</table>

*They have a SBHC now, but did not at the time of this data

Average of 81.4% if we include East and 74.08% if we do not.

Florence Crittendon has a clinic and a 14% grad rate. This school is for pregnant teens and their children.
• 16 y/o Arabic female who presented with illogical, disorganized speech reporting elevated mood in the setting of not sleeping for three days without fatigue.

• FOC noticed when he took her to school she was convinced people were following her and trying to hurt her. And she was often speaking to people that weren’t there.

• Patient was hospitalized for severe psychotic and elevated mood symptoms. During hospitalization patient was stabilized and placed on medications. Psychological testing completed while hospitalized and patient found to have IQ of 52.

• There was concern about her abilities given she had not had any schooling prior to immigrating from Iran in 2013 and was working at a first grade level.

• Patient did have to repeat the 8th grade because she didn’t understand reading or writing.

• Patient returned to school after hospitalization.
Case Collaboration (continued)

• School had a re-entry meeting after her discharge from the hospital. Family and her therapist were present at the meeting. Due to the psychological testing a plan to start an individual education plan was discussed.

• Licensed Clinical Social Workers- Therapist saw her the week after discharge at South High School based clinic.

• Medical Provider: Met with patient the week after discharge to make sure patient wasn’t having side effects from her medications and to follow up for mental health symptoms until patient could be seen by the psychiatrist. Also patient complains of several somatic symptoms.

• Psychiatrist- met with patient and family two weeks after patient was discharged from the hospital. Educated about diagnosis and medications. Met with school staff to discuss Individual Education Plan and to update this to meet the patient’s educational needs since IQ was found to be 52.
Small Group Discussion

- What are the next steps that you would take?
- How would you collaborate with the school and teachers?
- What classroom interventions would you suggest?
- How would you coordinate with the school and family?
- How do you envision the primary care provider and the psychiatrist working together in this case?
After two years of collaboration between SBHC and school:

Amber completed an internship working on the school garden learning basic job skills.

- Coffee Cart
- McDonald’s
- Criminal Justice
- Internship
- 18 – 21
- Mental health symptoms are stable
Barriers and Successes
Barriers

• Confidentiality
  • Not always guaranteed in a school setting
  • Have to follow health privacy laws
• Truancy
  • Limited resources in schools
  • Lack of mental health training among educational staff
Schools are Reaching out for Support

Increased suicide rate in teens $^5$

School violence

Substance use as many states legalize marijuana $^8$
Team Strategies

- Team approach mental health issues
- Difficult outcomes occur in youth

Primary Care Providers
Psychiatrists
School Officials
Educators
Successes

• Students have access to several services including psychiatric care in a familiar environment
• Able to serve students who would never make it to a community mental health clinic.
• Access to school administration and staff with potential to educate, advocate and positively influence the school environment
• Able to positively impact youth with severe mental health conditions that interfere with school functioning
• Access to a team of professionals at every visit
<table>
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<tr>
<th>A</th>
<th>Student Last Name</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
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<td>Jane</td>
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<tr>
<td>Margaret</td>
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**Student Last Name:** Jane

**Student First Name:**

**Student ID:**

**Referring Person:** ABCS Team

**Referral Made To:** Scott/Lindsey

**Date Referred:** 9/19/2019

**Referral Concern:**

- Decision making (behavior incidents in IC), failing grade, possible substance use

**Date of Check In & Notes:**

- 10/15: attempted SE check in. Student was absent.

**Treatment Plan:**

- Scott will check in with student and determine need for ongoing support. Jacie will follow up with Scott re: support.

**Action Items:**

**Documented in IC?**

**Student Last Name:** Margaret

**Student First Name:**

**Student ID:**

**Referring Person:** ABCS Team

**Referral Made To:** Botnick

**Date Referred:** 9/19/2019

**Referral Concern:**

- Family stress & conflict, family responsibilities

**Date of Check In & Notes:**

- Larry will check in & offer support. 9/30/19- Hattie referring to Denver Health. Kelly met with her last year.
School Based Team Approach

- School based team approach to mental health issues
- Role of medical providers
- Both psychiatrists and primary care providers
- Educators and School administrators
- How to interface to provide the most helpful team approach to addressing mental health issues in their schools.
Barriers to Partnering with MH Providers in the Community:

- **Access to care**
  - Kaiser locations in relation to South
  - Long waiting lists for private providers
  - High cost for middle income families

- **Absenteeism for students**
  - Leads to additional stress and anxiety
  - Working parents need to leave work
Barriers to working with Medical Staff in School Based Clinics

Fewer Barriers for working with the School Clinic Staff......but barriers still exist:

• Teachers are sometimes reluctant to honor passes sent by the School Based Clinic Staff

• Some students who become “over-served”

See counselor, nurse, School SW, SBHC staff
Mental health conditions among children are of the utmost concern and often negatively impact academic functioning.

School Based Clinics are an important growing model of care

Not only does this profoundly impact long-term outcomes, but also academic performance, school safety and generational outcomes.
Collaborate with school staff to coordinate care for students effectively.

Build on social and emotional learning (SEL)

With this creative team approach, leveraging various areas of talent through a coordinated fashion Denver Health SBHC and DPS are heading in the right direction to meet the growing needs of the community.
Case Collaboration

• 14 y/o female who presents to a primary care appointment in a school based clinic complaining of stomach pain. Her physical exam was noted to be unremarkable. In the room she presents as hyperactive with a possible developmental delay.

• Patient referred to mental health therapist and psychiatrist for an evaluation.

• Patient presented to the therapist and psychiatrist with symptoms of hyperactivity, inattention, irritability, argues with authority figures (teachers and parents), actively defies rules, and struggling with school for the past 3 years.

• Patient recently moved from Liberia Africa to the United States in July 2018. She does have a history of exposure to violence since she was raised in a war torn country but she is unwilling to describe details about this.
Case Collaboration (continued)

• Patient starts individual therapy and medication (Prozac and Tenex) to help target mood and ADHD symptoms.
• Tried to communicate and collaborate with the school, however medical staff were unable contact them.
• Patient referred for psychological testing
• Tried to educate parents on obtaining a 504 or Individual Education Plan
• A month after the intake patient is handcuffed by the resource officer at school after she physically hit a teacher.
Small Group Discussion

• What are the next steps that you would take?
• Are there steps that could have been taken to prevent patient being handcuffed at school?
• What classroom interventions or educational supports would you suggest?
• How would you coordinate with the school and family?
• How do you envision the primary care provider and the psychiatrist working together in this case?
Outcome

• Patient transferred schools to an educational setting that provided an affective needs classroom where she could receive more educational support.
Lisa Kelly Physician Assistant who provides medical care in DSBC will discuss how the incidence of mental illness and demand for mental health services in our communities and country has increased in recent years. While the demand for medical care has remained stable at DSBCs the demand for mental health services has increased significantly. Between 2017 and 2018 medical care visits actually decreased just under 3% to 27,693, while mental health visits increased almost 10% to 18,857.

The challenges of meeting the increasing mental health needs of the pediatric and adolescent population in the school setting are numerous. Pediatric and adolescent clinicians are now, more than ever, called upon to learn how to become more comfortable with recognizing and treating mental health conditions in their practice, as well as learn how to collaborate with school staff, mental health therapists and child and adolescent psychiatrists (CAPS).
Lisa Kelly, PA

Disclosures:

I HAVE NO CONFLICTS OF INTEREST
Objectives

- Demonstrate how to identify at risk students by providing both universal and as indicated screening tools to diagnose common mental health disorders
- Decide how to differentiate which patients should be referred to a behavioral health professional (therapist and/or child and adolescent psychologist)
- Compare and contrast Family Educational Rights and Privacy Act (FERPA) with Health Insurance Portability and Accountability Act (HIPAA) confidentiality and how to communicate with school staff to ensure coordinated care for students
Dramatic Rise in Mental Health Needs vs. Medical Needs

Percent Growth in Visits from 2013

- Identify

Medical Visits
Mental Health Visits
The Primary Care Approach

How do I get started on this case?

What needs to be done outside of this visit for the ongoing care plan?

What can I do for this patient today in my office?

What exactly is going on here?

- Approach
- Diagnosis
- Management
- Treatment
PHQ 9*

- Nine questions in a simple format
- Covers depression criteria
- Last question identifies suicidal ideation
- Scoring is simple but interpretation can be tricky:
  - 0-4: Normal
  - 5-9: Mild
  - 10-14: Mild-Moderate
  - 15-19: Moderate
  - 20+: Severe

* Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Identification At Risk Students

Collaborate with school staff to coordinate care for students effectively

Triaging patients to school mental health support staff versus behavioral health professionals

Licensed Clinical Social Worker and/or a Child and Adolescent Psychiatrist
Diagnosing Depression

Two main areas

Two aspects of the emotional brain (limbic system)

- Dysfunction of the pleasure/reward system
- Sleep/wake disturbance
Depression Symptoms

Systems Likely to Report:

• Don’t Care, No Motivation for School
• Less Interest in Music/Recreational Activities
• Less Interest in Friends – Social Withdrawal
• Irritable/ Argumentative

Classic Symptom:

• Waking in Middle of Night for 20+ Minutes
• Waking in Morning Before Alarm and Not Returning to Sleep
• Staying Up Late – “Not Tired” – Wanting to Sleep In
• Wanting to Sleep All the Time
Emma, a 16-Year-Old Junior at South High School

Chief Complaint/Presenting Problems

- Sad
- Unmotivated
- Decreased energy
- Sleep disturbance
- Guilty
- Hopeless
- Worthless
- Isolating
- Worrying
- Anxious
- Palpitations
- Decreased concentration
Diagnostic Process

• Screening Tools: PHQ-9 / Risk Assessment
• History of Present Illness – PHQ9
• Family Dynamics
• Psychiatric Treatment History
• Family Psychiatric History

• Abuse History
• Social Functioning
• Family Psychosocial and Cultural Assessment
• Substance Use History
• Review of Symptoms: Risk Assessment
• Assessment/Goals/Plan

Treat/Refer
Tools to Assist with Diagnosis

SIGECAPS
• Diagnostic Criteria for MDD
• At least five of the following must be present for at least two weeks:
  • Sleep – increased or decreased (if decreased, often early morning awakening)
  • Interest – decreased
  • Guilt/worthlessness
  • Energy – decreased or fatigued
  • Concentration/difficulty making decisions
  • Appetite and/or weight increase or decrease
  • Psychomotor activity – increased or decreased
  • Suicidal ideation

MFCRIS
• Diagnostic Criteria for GAD
• At least three of the following must be present for at least six months
  • Muscle tension
  • Fatigue
  • Concentration problems
  • Restlessness, feeling on edge
  • Irritability
  • Sleep problems

Treat/Refer
Assessment/Goals/Plan Details

Initial Goals for Treatment: Improve mood and anxiety levels, improve energy level

• Emma is a 16yo young woman who currently meets criteria for MDD and GAD.
• Biologically predisposed to mood/anxiety issues given both of her parents have struggled with this in the past.
• Parents are adopted: unclear how strongly she is biologically disposed to mental health issues.
• Stress in her home environment
• It is likely her anxieties about her future also play into her mood
• Stress on herself to excel in multiple areas of life.
• Promising that she is hopeful to the idea of combination treatment with medications and therapy, as this is likely to benefit her most going forward.

Plan:
• Discussed common side effects of SSRI's with both MOC and PT who agree to a trial of Prozac
• Start Prozac 10mg PO daily
• Start individual therapy
• Will call FOC to also discuss medications
It Takes a Village

Clinician

- Child and Adolescent Psychiatrist
- Parent
- DH Therapist
- DH STEP Therapist
- DPS Psychologist
- DPS Counselor
- DPS Social Worker

Treat/Refer
Indications for direct referral to CAPS: bipolar, psychosis, etc....

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<th>DIGFAST Mnemonic</th>
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First, Do No Harm


Mood Disorder Questionnaire

Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...

   - Yes
   - No

   - ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?
   - ...you were so irritable that you shouted at people or started fights or arguments?
   - ...you felt much more self-confident than usual?
   - ...you got much less sleep than usual and found that you didn’t really miss it?
   - ...you were more talkative or spoke much faster than usual?
   - ...thoughts raced through your head or you couldn’t slow your mind down?
   - ...you were so easily distracted by things around you that you had trouble concentrating or staying on track?
   - ...you had more energy than usual?
   - ...you were much more active or did many more things than usual?
   - ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?
   - ...you were more interested in sex than usual?
   - ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
   - ...spending money got you or your family in trouble?

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

   - No problems
   - Minor problem
   - Moderate problem
   - Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMS Hornefeld, MD.
Consultation with Child and Adolescent Psychiatrists (CAPS)

Consultation with Child and Adolescent Psychiatrists (CAPS) can support Pediatric Providers and schools in implementation of practices that promote resilience and enhance mental health, reducing the burden on the nation’s mental health system and promoting youth mental wellness.

CAPS partner with Pediatric Providers in Denver School-Based Clinics (DSBC) to provide comprehensive mental health treatment to inner city youth while collaborating with school systems to improve academic functioning for all students.
Quiz: Patient Health Rights and Responsibilities

True or False?

• Teens can see a doctor about mental health issues, drug and alcohol use, or sexually transmitted infections without their parent’s consent.

• Colorado laws allow persons 15 or older to obtain care for mental health issues without parental consent. Teens of any age can consent to care for sexually transmitted infections or drug and alcohol issues without parental consent.

Click for “True”  
Second paragraph will automatically follow with a delay.
Quiz: Patient Health Rights and Responsibilities

True or False?

• A teen can always see a doctor without a parent’s permission.

• Teens cannot see a doctor without their parents’ permission for health services like treatment of injuries, colds, flu and physicals. The doctor will need a parent/guardian’s consent for these services. (i.e. DH SBHC parental written consent)

FALSE
True or False?

• A teen can ask a doctor about what will stay private in a visit, and what information will be shared with parents/guardians.

• There are many laws about what information your parent/guardian will be given. It is important to talk to your doctor about what will stay private. In some situations, you get to decide what is shared.

TRUE
True or False?

- Under FERPA school employees are not allowed to disclose records to teachers and other “school officials” without a release.

- School employees can disclose records as long as that school official has a “legitimate educational interest” in the information.

FALSE
Quiz: Patient Health Rights and Responsibilities

True or False?

• Under HIPAA health providers can disclose a patient’s health information to another provider.

• HIPAA allows health providers to disclose individual health information for treatment purposes to a provider working with the same client in another agency or clinic.

TRUE
Quiz: Patient Health Rights and Responsibilities

**True or False?**

- Under both FERPA and HIPAA, providers may disclose protected information when a youth is in danger.

- How the danger is defined under each law and to whom the provider may disclose differs between HIPAA and FERPA.

TRUE
Confidentiality Issues

Family Educational Rights and Privacy Act (FERPA)

These acts can slow and even prevent the provision of needed services.

Health Insurance Portability and Accountability Act (HIPAA)

Accessing written parental and student/patient consent.
Similarities Between HIPAA and FERPA

• Both contain exceptions that allow sharing information without a written release in some cases.

• A few of these exceptions are similar – for example, both HIPAA and FERPA contain exceptions that allow sharing protected information for:
  
  • Research purposes
  • Emergencies
  • Child abuse reporting without need of a release
## Comparison of Regulatory Rules

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<th>Family Educational Rights and Privacy Act (FERPA)</th>
<th>Health Insurance Portability and Accountability Act (HIPAA)</th>
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### Differences Between HIPAA and FERPA

- There are exceptions under each law that do not exist under the other. For example:
  - FERPA allows school employees to disclose records subject to FERPA to teachers and other “school officials” without need of a release, as long as that school official has a “legitimate educational interest” in the information. No similar exception exists in HIPAA.
  - By contrast, HIPAA allows health providers to disclose individual health information for treatment purposes to a provider working with the same client in another agency or clinic. FERPA does not contain a similar exception.

- Even where similar exceptions exist, they can apply in different ways. For example, under both FERPA and HIPAA, providers may disclose protected information when a youth is in danger, but how danger is defined under each law and to whom the provider may disclose that information is different under HIPAA and FERPA.
Questions?

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References:


5. Child and Adolescent Psychiatry Workforce Crisis: Solutions to Improve Early Intervention and Access to Care American Academy of Child and Adolescent Psychiatry May 2013


Helpful Links:

Minor consent and confidentiality-related resources available online / FERPA / HIPAA:

1. National Center for Youth Law: http://www.youthlaw.org
2. Center for Adolescent Health & the Law: http://www.cahl.org
3. Society for Adolescent Health and Medicine:
   http://www.adolescenthealth.org

Pediatric Psychiatry ECHO series

1. https://echo.unm.edu/locations/global
2. https://echo.unm.edu/locations/us