It Takes A Village:
Collaborating With Schools to Provide Psychiatry to Treat Depression, Anxiety, and ADHD

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The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

"No relationships to disclose"

Workshop Agenda

* Background
* Mental health referral process
* Role of Psychiatrists in Schools
* Depression in the Classroom
* Self-injurious behaviors vs. suicidal ideation
* Anxiety in the Classroom
* ADHD in the classroom
* Small group activity
* Questions

Video

https://www.youtube.com/watch?v=UucoD_OkBcA&feature=youtu.be

Denver Health School Based Centers Denver, CO

* After receiving a grant in 1987, Denver Health opened their first school based health center in the Denver Public School District (DPS) at Abraham Lincoln High School in 1988.
* In 1993, Denver Health partnered with the Mental Health Corporation of Denver (MHCD) to provide comprehensive mental health services to DPS.
* Currently, there are 17 health centers located in Denver Public Schools across Denver and we continue to grow.
* Our centers provide primary care, mental health, reproductive health education and insurance enrollment assistance services to DPS students
* Each center is staffed by medical and mental health professionals that specialize in pediatrics and adolescent medicine

Denver Health SBHC Mental Health Model

* Three Regional Health Centers open to all DPS students and their siblings.
* Community partnerships to provide MH services with Mental Health Center of Denver, Jewish Family Services, Project PAVE, and Maria Droste Counseling
* All DH sites have one of two psychiatrists who roll out to each clinic to provide medication evaluation and support to patients in order to minimize barriers to effective treatment.

How Referrals Are Made

* We have a mandate to see the most severe children who would not generally have access to mental health services in their communities.

* Referrals come from a variety of sources including the PCP in the clinic, the School social worker (SW), School Psychologist, School Counselors. We also receive referrals from the court system or law enforcement agencies as well as limited self-referrals.

* We work closely with the people referring to ensure cases are triaged correctly and services are truly necessary.

Indicators for Mental Health Evaluation

* Change in function
* Grades slip
* Truancy
* Self harm/ ideation
* Anger/ aggression
* Acting out
* Drug/ alcohol use
* Suicidal ideation/ homicidal ideation
* Self report of physical or emotional abuse
* Limited support system
* Withdraw socially/ activities

Role of Psychiatrists in Schools

* Psychiatrist at a school based health center
* Case consultation in student's school
* Provide training and education for teachers and parents- i.e. Mental Health First Aid for Teachers, CBITS (Cognitive Behavioral Intervention for Trauma n Schools).
* Advise schools about general mental health issues- i.e. developing and implementing prevention programs such as bullying, substance use, suicide attempts, etc.
* Schools can employ psychiatrists to assess students with problems and make recommendations

Signs of Depression Frequently Seen in Youth[5]

Symptoms of Depression	Signs of Depression in Youth
Depressed Mood	Irritable or cranky mood
Sleep problems	Delays in falling asleep, refusal to wake for school
Interest loss	Boredom, loss of interest in sports, video games, giving up favorite activities
Guilt, worthlessness, hopelessness	Self-critical "no one likes me, everyone hates me," feels stupid
Energy loss	Persistently tired, feels lazy
Concentration Difficulties	Decline in performance in school due to decreased motivation and ability to concentrate, frequent absences
Appetite change	Failure to gain weight, or overeating and weight gain especially in teens
Psychomotor	Difficulty sitting still, pacing, or very slowed down
Suicidality	Frequent thinking & talking about death; writing about death, giving away favorite toys or belongings.

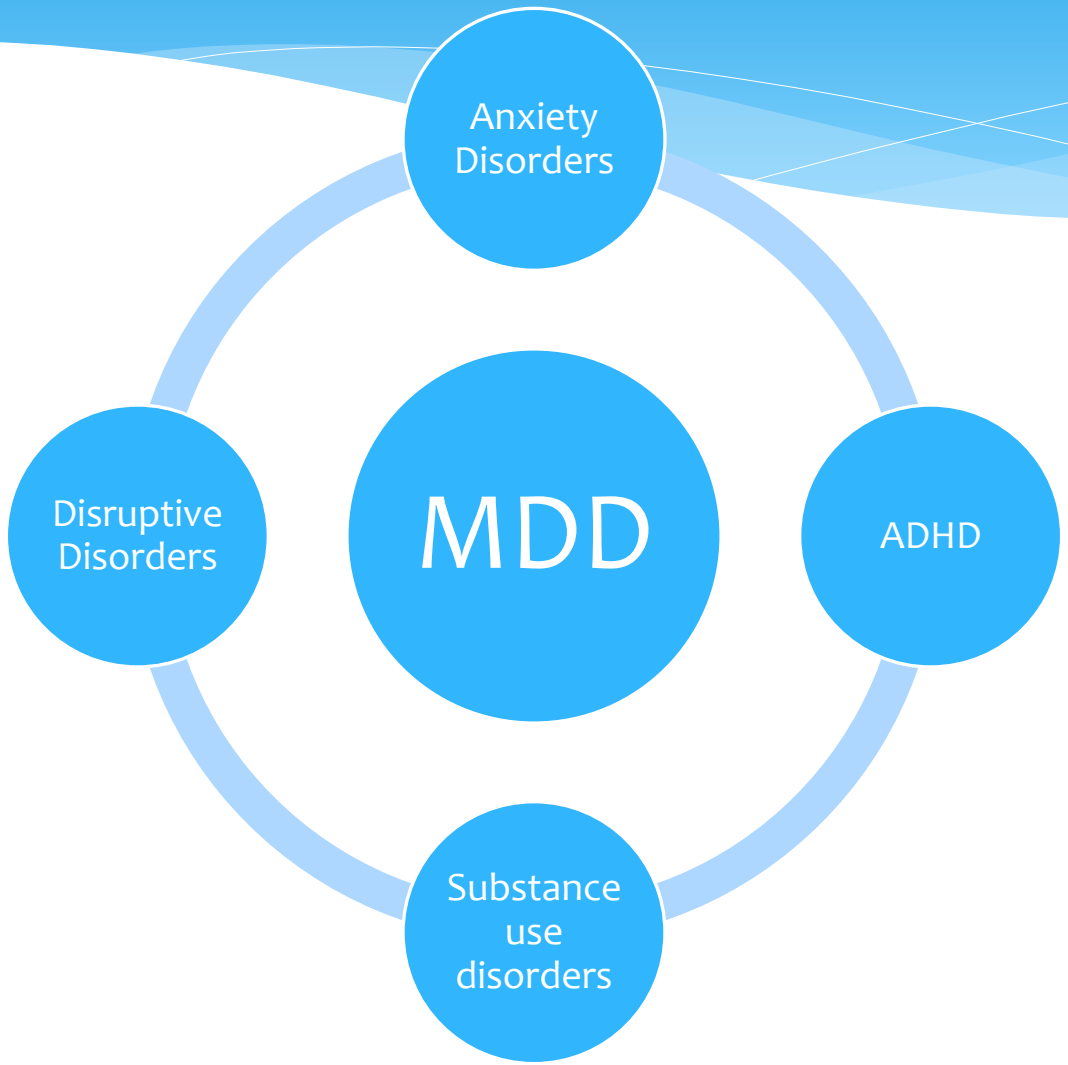
Major Depressive Disorder Epidemiology[5]

* Approximately 4% to 8% in adolescents with male to female ratio of 1:2
* Approximately 2% in children with male to female ratio of 1:1
* Risk of depression increases by a factor of 2 to 4 after puberty especially in females
* Cumulative incidence by age 18 is approximately 20% in community samples
* Approximately 5% to 10% children and adolescents have subsyndromal symptoms of MDD

Epidemiology Continued

* MDD is the leading cause of disability among young people aged 10–24.[2]
* < 50% of youth with MDD seek treatment[3]
* 48.3% of adolescents with MDD report that it severely impaired their ability to function in at least 1of 4 areas of their lives (home, school/work, family relationships, and social life). [4]
* Adolescents reporting the most severe impairment were unable to carry out normal activities on an average of 58.4 days in the past year.[4]

MDD Comorbidity[5]



Establishing Relationships with School Staff

* Work closely with school SW, school nurse, school psychologist, and school counselors
* Mental health meetings with school staff
* Collaborate closely with Affective Needs classroom teachers and Special Education Staff
* Ensure we meet with entire school staff at the beginning of the year to discuss various clinic roles and how to utilize services

How We Collaborate

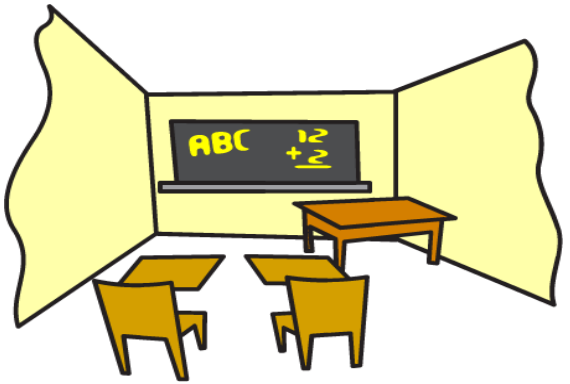
* SW/Psych/Counselors will often send fact sheet on depression to client's teacher with permission of the student.
* Therapist will work with student on developing healthy communication skills with teachers and other school staff.
* Therapists will often work with teachers and staff to provide classroom support, elicit feedback, and monitor progress.
* Teacher are often more receptive to our suggested interventions which leads them to be more open and empathetic to their student rather than seeing them as oppositional.

Collaboration continued

* Therapists will work with SW/Psych/Counselors on appropriate classroom interventions such as scheduling changes, “Brain Breaks,” and time outs.
* Therapists will initiate mental health holds on their students and acts as a liaison between the hospital and the school.
* Therapist and psychiatrists will attend IEP (Individual Education Plans) and 504 meetings, to help ensure client’s mental health needs are being addressed and to understand what’s in place to help assure consistent enforcement.

Classroom Intervention Strategies

* Seating modification
* Schedule modification, i.e. changing start/end times, scheduling harder classes when student is more alert
* Testing modifications- changing testing format, allowing more time to complete assignments, alternate scheduling



Instructional Techniques for Students With Depression [1]

Develop clear expectations and guidelines	Teach problem solving skills
Provide frequent feedback on progress	Strategically increase opportunities for positive social interaction with peers
Teach goal setting and monitoring	Modify assignments to accommodate mood and energy
Break large projects into manageable tasks	Assign tasks one at a time

Depression medication considerations

* Share decision making with client and family
* Review side effects: Most common with SSRI's include gastrointestinal symptoms, sleep changes, restlessness, headaches, diaphoresis, changes in appetite, and sexual dysfunction [5]
* Medication commitment
* Continue for at least 4-8 weeks
* See client after 2 weeks with therapist visiting in between medication follow up appointments

Why treat Depression with Medication?

* The consequences of childhood and adolescent depression are serious
* Patients may have ongoing problems in school, at home, and with their friends
* 40% will go on to have a 2nd episode of depression in 2 years[6]
* Increased risk for substance abuse, eating disorders, and teen pregnancy [5]
* It is estimated that depression increases the risk of a first suicide attempt by at least 14 fold [5]
* With careful monitoring, the development of a safety plan, and the combination of medication with psychotherapy, the risk of suicide can be managed

Talking to Teachers About Medications

* Gather information
* Clarify expectations regarding medication
* Educate teachers and staff as to timeframe for medication effectiveness
* Assisting teachers in being sensitive to possible stigma around medication and client's feelings
* Enlist teacher support around medication interventions

Mental Health Screenings

* In 2009 the U.S Preventative Services Task Force published a paper calling for an annual depression screening for all teen ages 12-18 [7]
* The Institute of Medicine and National Research Council also issued a paper calling for evidenced-based screening of adolescents and highlights primary care settings as a key location for screening
* PHQ-9 was developed by researchers at Columbia University and is an easy and effective screening tool

Self-Injurious Behavior (SIB) [8]

Non-suicidal self-injury (NSSI)

* 13%-23% lifetime prevalence
* often begin age 13-15
* cutting and hitting most common
* high risk for suicide and suicide attempts 70 % of adolescents who engaged in NSSI had made at least 1 suicide attempt
* risk factors include: depression, substance use, anxiety, impulsive aggression, and history of trauma
* 1:6 teenagers have tried self-harm at least once

Self-Injurious Behaviors vs. Suicidal Ideation

Self-Injurious Behaviors

* "Self Injury is intentional, non-life threatening, self effected bodily harm or disfigurement of a socially unacceptable nature, performed to reduce psychological distress."[12]
* Self Injury is a coping mechanism; it is an attempt to survive and manage the affect of an overwhelming experience or emotion.
* Injuries are generally non-life threatening, repeated pattern of self-injury.

Suicidal Ideation

* Must assess plan, means, and intent
* Intent is to escape pain or terminate consciousness
* There is rarely chronic repetition; some repeatedly overdose
* Persistent feelings of helplessness and hopelessness, little or no future casting, all or nothing thinking [13]
* Other lethal means

TABLE 1 ASSESSING SELF-INJURY

WHAT TO ASSESS	SAMPLE QUESTIONS
The function of self-injury	○ What does your self-injury help you with? ○ Do you remember how you were feeling before you injured yourself? How did that change afterward?
The method of self-injury	○ How do you do it? ○ What instrument do you use? ○ How often do you do it? ○ What part of your body is involved?
The potential for medical complications	○ Have you required medical attention (eg, stitches)? ○ Do you use a clean blade or have you shared a blade with anyone? ○ When was your last tetanus shot?
Other dangerous behaviors	○ Do you do anything else to make yourself feel better that might be risky in the long run? ○ Have you used drugs or alcohol to make yourself feel better? ○ Do you find yourself restricting your food or purging after meals? ○ Are you sexually active? Do you feel comfortable with your level of sexual activity?
Abuse or bullying	○ Has anyone hurt you—physically or mentally—in a way that is still affecting you? ○ Do you feel safe at home? ○ Do you feel safe at school?
The risk of suicide	○ Have things ever gotten so bad that you thought you might be better off dead? Have you thought about killing yourself? ○ Are you thinking of killing yourself now? ○ Do you have a plan for how you might do it? What is the relationship between your self-injury and thoughts of suicide?
Areas of strength	○ What is going well in your life? ○ Who are the people you can count on? ○ Who or what do you turn to for comfort?


KEEP
CALM
AND
DON'T
SELF HARM!

Anxiety Epidemiology

* Prevalence rates for having at least one childhood anxiety disorder vary from 6% to 20% over several large epidemiological studies [15]
* One sample of adolescents and young adults indicated that the overall lifetime prevalence of Post Traumatic Stress Disorder (PTSD) in the general youth population was 9.2%. [14]
* A recent national sample of adolescents (12–17 years old) indicated that 3.7% of male and 6.3% of female adolescents met full diagnostic criteria for PTSD.[14]
* Children with PTSD often have comorbid psychiatric conditions. PTSD commonly occurs in the presence of depressive disorders, ADHD, substance abuse, and other anxiety disorders [14]

Comorbidity of Anxiety Disorders[15]

A Few Words on PTSD

Another important clinical aspect about the youth we work with is the topic of trauma. Anxiety in general is very distressing for children and adolescents and can cause severe impairment.

Examples of traumatic events:

* Community violence (school violence, neighborhood shootings)
* Interpersonal violence (i.e. sexual or physical abuse, domestic violence)
* Hurricanes and tornados

The overall lifetime prevalence of PTSD in the general population is 9.2%. [14]

Just because our patients have been exposed to trauma does not mean they will develop PTSD.

Collaboration Specific to Anxiety

* Work collaboratively with the school nurse to help clients who frequently exhibit somatization symptoms.
* Clients will often present to the clinic with headaches and stomachaches.
* We work closely with the school nurse, teachers, and clinic providers on positive communication and classroom management strategies:
  * Quiet time
  * Pressure pass
  * Calm tone of voice

Anxiety in the Classroom

Instructional Techniques for Students with Anxiety [17]	
Encourage slow, deep breaths before tests/quizzes	Develop a coping plan for unscheduled events
Allow extra time	Do relaxation exercises with entire class
Provide clear schedules and deadlines	Have a quiet place where student can go when feeling overwhelmed
Inform student ahead of time of schedule changes	Maintain calm tone of voice
Use checklists and visual reminders	Address bullying in class
Provide calm, but firm limits	Avoid penalizing entire class


AD/HD
HIGHWAY TO HEY LOOK A SQUIRREL!

Attention-Deficit/Hyperactive Disorder [16]

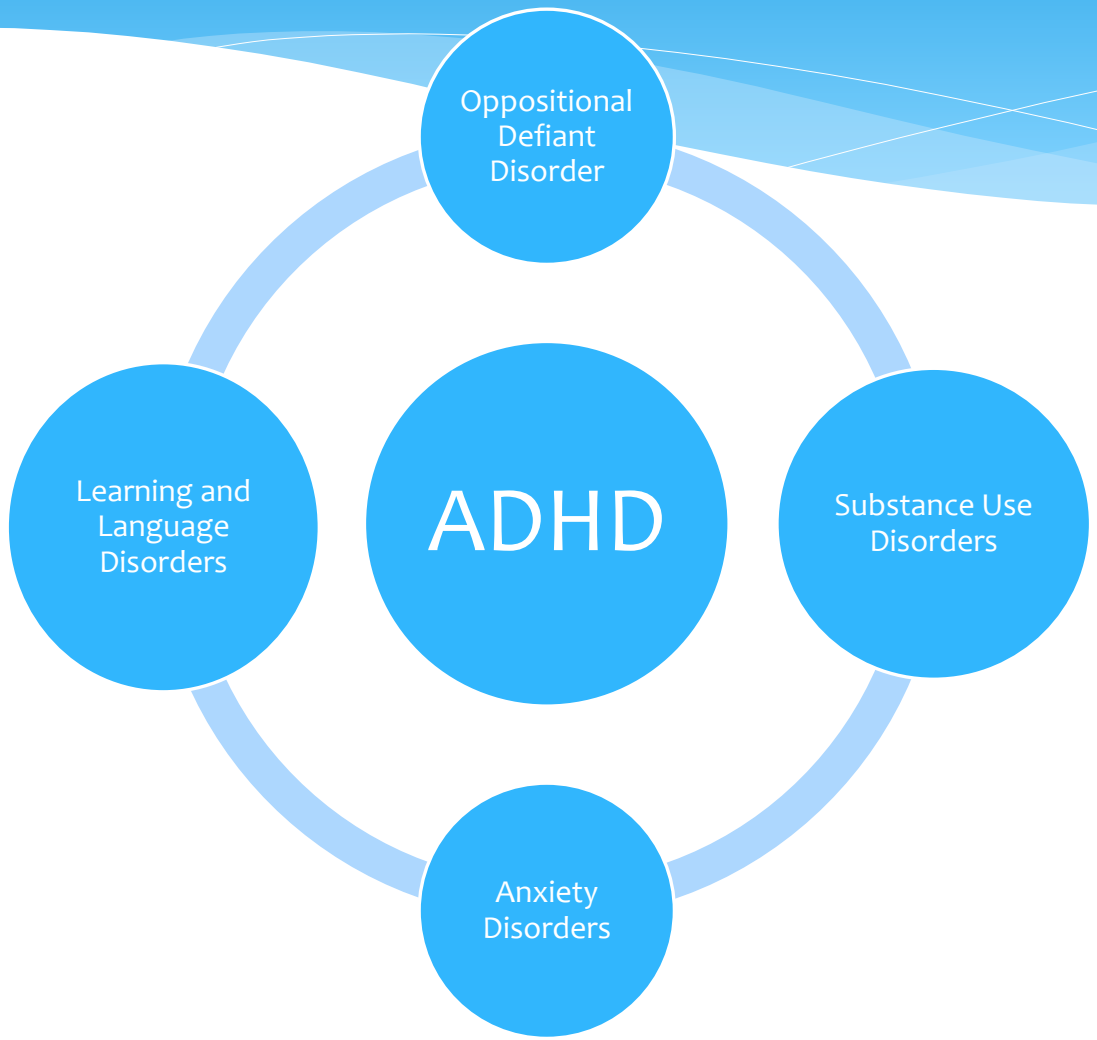
Combined Type	Predominantly Inattentive Type	Predominantly Hyperactive Type
6 or more symptoms of hyperactivity-impulsivity that have persisted for at least 6 months. Most children and adolescents with the disorder have this type.	6 or more symptoms of inattention (fewer than six symptoms of hyperactivity-impulsivity)	6 or more symptoms of hyperactivity-impulsivity (fewer than 6 symptoms of inattention)

ADHD Epidemiology

* The prevalence of ADHD was found to be 6.7% by the U.S. National Health Interview Survey. The Centers for Disease Control and Prevention found the lifetime childhood diagnosis of ADHD to be 7.8% [16]

* It is frequently accepted that ADHD is more common in boys than in girls, at a ratio ranging from 2.5: 1 to 5.6:1 [10]

ADHD Comorbidity [16]



Considerations for ADHD Students

* In children with ADHD it is important to ensure student has an IEP or 504 plan in place to ensure academic success. [11]
* Therapist can help design classroom management strategies and modifications.
* Collect Vanderbilts or similar assessments (i.e. Connors)

ADHD in the Classroom

Classroom Intervention Strategies [18]	
Seating modifications	Testing modifications
Fidgets	Positive Behavior Supports (PBS)
Pressure passes	Activity breaks
Attention cues	Consistent rules and expectations
Positive reinforcement for appropriate behavior	Token economy
Check-ins with trusted adult	Organizational skills training
Social skills training	Assign tasks one at a time

Group Activity

Vignette

Patient is a 15 y/o male who was recently discharged from a residential facility, and presents to the school social worker asking for his schedule. He has severe PTSD symptoms due to witnessing his maternal aunt being shot at age 8 y/o. He has also been diagnosed with Major Depressive Disorder Recurrent Severe with Psychotic Features, has a history of gang involvement, substance use, and hasn't been in school for the past year, due to being on the run and being in placement. The patient's probation officer calls the school social worker begging her to see the patient. He informs the social worker that this is the patient's last chance, and if the patient messes up in any way he will be committed to the Division of Youth Corrections. Two weeks later the school social worker checks in with the student, and with his teachers. After checking in, she finds out that he is skipping some classes, walks out of class, and is sometimes found roaming the hallways. The school social worker refers the patient to the school based clinic for further evaluation and treatment.

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 probation?
* Would you consider medications as part of the treatment plan for this case?

Questions?

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* Email: monica.morris2@dhha.org

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[4] http://oas.samhsa.gov/2k8/youthdepress/youthdepress.cfm.

[5] American Academy of Child and Adolescent Psychiatry, (2007) Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders. *Journal of the American Academy of Child and Adolescent Psychiatry* (46)11 (1503-1526)

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[7]http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening

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[18] Eiraldi, R.B., Mautone, J.A., Power T.J., (2012) *Strategies for Implementing Evidence-Based Psychosocial Interventions for Children with Attention-Deficit/Hyperactivity Disorder.* Child and Adolescent Clinic of North America (21): 145-159.

Internet Links

DSM-IV TR and V:

* New information added to PTSD diagnosis in the DSM-V: http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf
* Depressive Disorders DSM-IV diagnoses: http://www.psyweb.com/mdisord/jsp/gendepress.jsp
* Anxiety Disorders DSM-IV diagnoses: http://www.psyweb.com/mdisord/jsp/anxd.jsp
* New info added to the ADHD diagnosis in the DSM-V: http://www.dsm5.org/Documents/ADHD%20Fact%20Sheet.pdf
* ADHD DSM-IV diagnosis: http://www.ldawe.ca/DSM_IV.html
* Other changes from DSM-IV TR to DSM-V: http://www.dsm5.org/Pages/RecentUpdates.aspx

Vanderbilt Assessment Scales (VAS): VAS assessment and follow up forms for Parent and Teacher in English and Spanish: http://www.mahec.net/ic/forms.aspx

Patient Health Questionnaire (PHQ-9): http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf