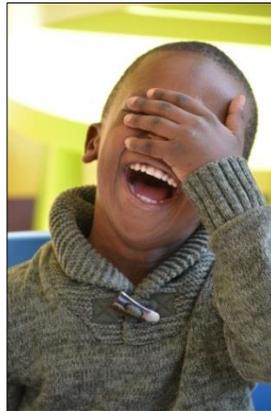


Spring 2018

The DC Collaborative for Mental Health in Pediatric Primary Care's Child & Adolescent Mental Health Resource Guide

The DC Collaborative for Mental Health in Pediatric Primary Care aims to improve the integration of mental health in pediatric primary care for children in the District of Columbia. We have a strong commitment to addressing the mental health needs of diverse children, from birth through 20, and their families, through culturally competent, family-focused initiatives. The Collaborative is a multidisciplinary group, comprised of the following lead organizations, and guided by a Community Advisory Board: Children's Law Center, Children's National Health System, DC Chapter of the American Academy of Pediatrics, DC Department of Behavioral Health, DC Department of Health, DC Department of Health Care Finance, and Georgetown University.

As part of our work, we have compiled the following **mental health resource guide for use by pediatric primary care providers in the Washington, DC area**. If you have updates, questions or comments, please contact Penelope Theodorou at pthodoro2@childrensnational.org or Erica Smith-Grasse at esmithgras@childrensnational.org.



COMMON DISORDERS & TREATMENT MODALITIES

- 1) **ADHD** symptoms benefit most from psychopharmacological intervention (particularly **stimulant medication**) with or without behavior therapy (the latter especially beneficial in the context of comorbid psychiatric disorders, family stress or suboptimal response to medication). **Behavioral parent training** may include guidance on home token economy and enhanced school-home communication (classroom accommodations including use of daily classroom behavioral report card).
- 2) **Disruptive Behavior Disorder (including Oppositional Defiant Disorder, Conduct Disorder, and anger management problems)** include symptoms of oppositionality, angry or vindictive behavior, problems with temper control or aggression (verbal and / or physical).
 - a. **Parent Management Training**, including Parent-Child Interaction Therapy, aims to support the caregiver in reducing positive reinforcement for negative behavior, increasing positive reinforcement for prosocial and compliant behavior and providing consistent limits.
 - b. **Problem-Solving Skills Training** introduces children to five steps to handle hypothetical and real-life problematic situations.
 - c. **Multi-Systemic Therapy** provides extensive and intensive treatment (case management, family interventions, prosocial activity) in the child's own psychosocial environment.
 - d. **Functional Family Therapy** is an intervention for the treatment of violent, criminal, behavioral, school, and conduct problems with youth and their families.
 - e. Medication is ineffective as monotherapy but may be considered as an adjunctive treatment when therapies are insufficient.
- 3) **Anxiety Disorders** involve excessive fears that may be generalized or that may be focused on varying themes including separation from caregivers or social situations.
 - a. Exposure-based **Cognitive Behavioral Therapy** (CBT) equips children with coping skills and provides practice in developing a sense of mastery over anxiety triggers and symptoms.
 - b. With moderate or severe anxiety or symptoms persistent despite regular psychotherapy, **SSRIs** are considered first-line psychopharmacologic intervention.
- 4) **Depression** may manifest as depressed or irritable mood in the context of loss of interest in previously enjoyed activities or changes in sleep, appetite, energy and concentration; also of concern are suicidal ideation or attempt.
 - a. **Psychoeducation, supportive management and simple case management** (relating to family or school stress) are reasonable initial interventions for mild depression.

- b. **Cognitive Behavioral Therapy (CBT)** involves cognitive restructuring (changing negative thinking patterns) and behavioral activation (engaging in positive activities).
- c. **Interpersonal Therapy (IPT)** directly addresses interpersonal conflicts or deficits, role transitions, or grief.
- d. **SSRIs** are considered first-line psychopharmacologic intervention.

5) Trauma Disorder symptom clusters include re-experiencing of the trauma, persistent avoidance of trauma reminders or negative alterations in cognitions and mood, and persistent symptoms of hyperarousal.

- a. **Trauma Focused- Cognitive Behavioral Therapy (TF-CBT)** introduces stress-management skills with exposure-based interventions with the objective of providing a sense of mastery over trauma reminders.
- b. **Child-Parent Psychotherapy** targets younger children (younger than age 7 years) and their parent with focuses on the attachment relationship, processing traumatic grief, and emotional and technical support to the dyad.

6) Autistic Spectrum Disorder symptoms include social communication deficits and restricted, repetitive behaviors in the early developmental period.

- a. **Applied Behavioral Analysis (ABA)** involves functional analysis of maladaptive behaviors and utilization of targeted behavioral techniques to provide desired behavioral alternatives generalizable to other areas of life.
- b. **Pivotal Response Treatment (PRT)** focuses upon target behaviors with a more child-driven approach (child's own interests and situation determining behavioral activities and rewards).
- c. Communication skills are enhanced and optimized in **Speech and Language Therapy**- while this intervention is widely accepted as beneficial, diversity of models lends to smaller mass of research studies and therefore weaker evidence base.
- d. Contingent upon the child's level of function, **Social Skills Groups** may provide education and practice on social reciprocity- while this intervention is widely accepted as beneficial, diversity of models lends to smaller mass of research studies and therefore weaker evidence base.