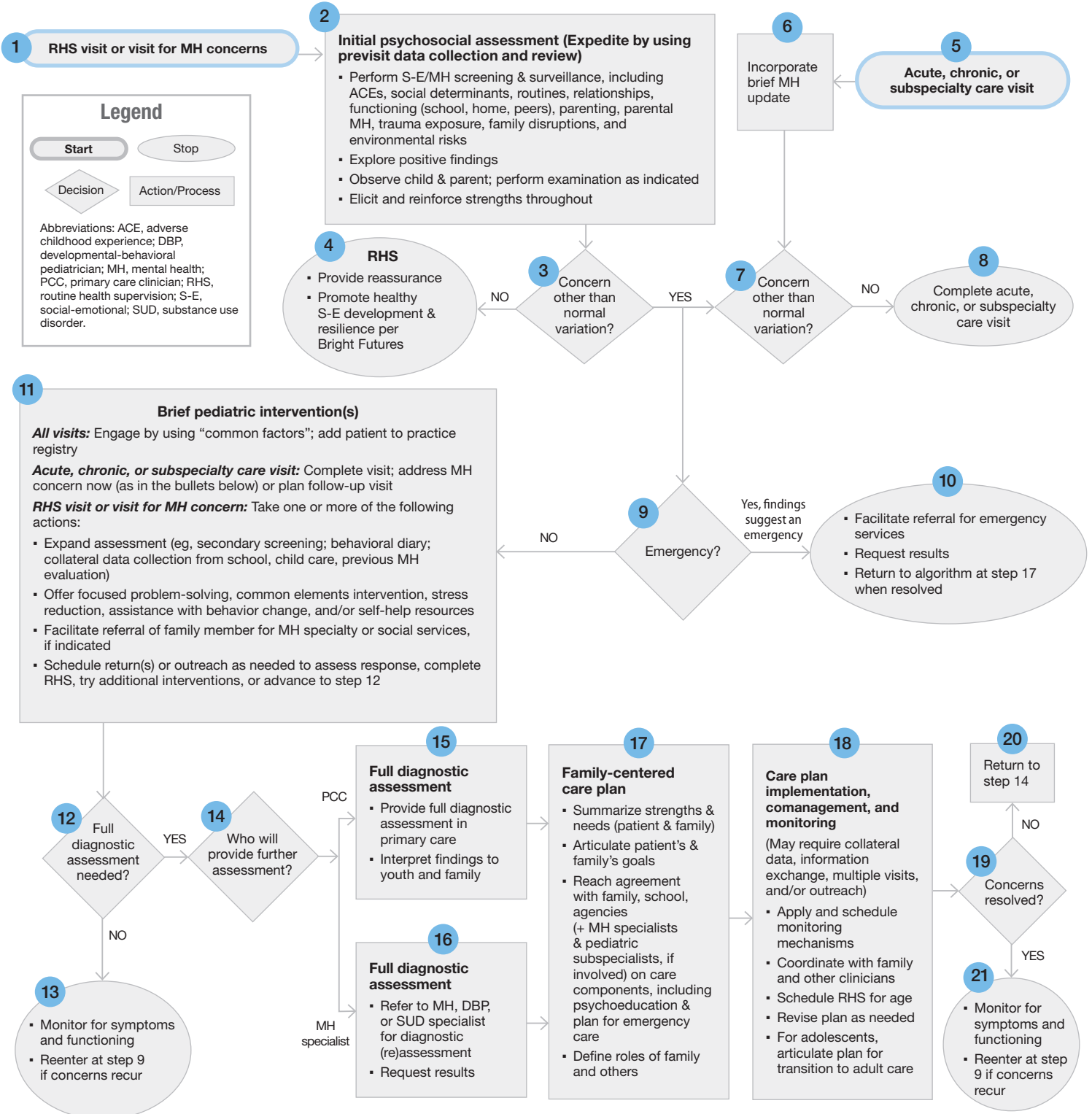




Mental Health Care in Pediatric Practice

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Algorithm Step	Description of Step
<p>1 RHS visit or visit for MH concerns</p>	<p>Mental health (MH) concerns can be raised by the patient, family, child care providers, and/or school personnel. The patient and family may not recognize an MH problem, may perceive it as un concerning, or may not reveal it because of stigma, family conflict, or denial. Routine health supervision (RHS) visits are an opportunity to assist youth and families in raising and addressing their MH concerns.</p>
<p>2</p> <p>Initial psychosocial assessment (Expedite by using previsit data collection and review)</p> <ul style="list-style-type: none"> Perform S-E/MH screening & surveillance, including ACEs, social determinants, routines, relationships, functioning (school, home, peers), parenting, parental MH, trauma exposure, family disruptions, and environmental risks Explore positive findings Observe child & parent; perform examination as indicated Elicit and reinforce strengths throughout 	<p>Psychosocial assessment in pediatrics is iterative. It can begin prior to the RHS visit, using surveillance forms and validated screening tools (electronic or paper and pencil) to assess, systematically, the functioning of the patient and family and to identify both their strengths and concerns. The clinician can then explore findings, both positive and negative, by interviewing the patient and family member (separately if the patient is an adolescent) as part of the clinic visit; observe the child, the parent, and their interactions; examine the child (eg, growth parameters, affect, signs of trauma, physical findings related to somatic concerns); and plan for collection of additional information as needed. Consider screening for suicide risk. By noting and reinforcing strengths throughout each interaction, the clinician can build rapport with the family and enhance their confidence in revealing sensitive information and help seeking.</p>
<p>3</p> <p>Concern other than normal variation?</p>	<p>Finding a problem that is not simply a normal behavioral variation necessitates further assessment. Data gathering can continue over multiple visits and include information from collateral sources between visits (eg, noncustodial parent, teacher, coach, other health care professionals) as well as the youth and family (eg, diary of problem behaviors with antecedents and consequences, response to interventions, periodic repeated screening and functional assessment). If any concern is raised, the process moves on to triage for emergencies (step 9).</p>
<p>4</p> <p>RHS</p> <ul style="list-style-type: none"> Provide reassurance Promote healthy S-E development & resilience per Bright Futures 	<p>If the family is concerned about normal variation, reassure the family and return to RHS visit. Use Bright Futures guidelines to promote healthy social-emotional development and resilience.</p>



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Algorithm Step	Description of Step
<p style="text-align: center;">5 Acute, chronic, or subspecialty care visit</p>	<p>MH concerns can be raised by the family or identified by the clinician during acute, chronic, or subspecialty visits.</p>
<p style="text-align: center;">6 Incorporate brief MH update</p>	<p>The clinician can incorporate questions into the visit (eg, How have things been going since your last visit? How did this injury happen? Do you have any worries about your child's emotions or behavior?) Consider screening for suicide.</p>
<p style="text-align: center;">7 Concern other than normal variation?</p>	<p>Finding a problem that is not simply a normal behavioral variation necessitates further assessment. Data gathering can continue over multiple visits and include information from collateral sources between visits (eg, noncustodial parent, teacher, coach, other health care professionals) as well as the youth and family (eg, diary of problem behaviors with antecedents and consequences, response to interventions, periodic repeated screening and functional assessment). If any concern is raised, the process moves on to triage for emergencies (step 9).</p>
<p style="text-align: center;">8 Complete acute, chronic, or subspecialty care visit</p>	<p>If no concerns are raised, the clinician can highlight the child's and family's strengths and return to the acute, chronic, or subspecialty care visit.</p>
<p style="text-align: center;">9 Emergency?</p> <p style="text-align: center;">Yes, findings suggest an emergency →</p> <p style="text-align: center;">10</p> <ul style="list-style-type: none"> ▪ Facilitate referral for emergency services ▪ Request results ▪ Return to algorithm at step 17 when resolved 	<p>Triage to determine if there is imminent risk of harm to the patient or others and/or if immediate care in the MH/substance use disorder (SUD) specialty or social service system is needed. Identify patients at risk for suicide (validated screening tools are available, such as the Ask Suicide-Screening Questions and the Columbia-Suicide Severity Rating Scale), other urgent MH or social problems, and/or other acute safety concerns (eg, risk of harm to others). In making determinations of risk, it is important to understand the family context, namely, the added risks conferred by adverse social determinants of health, which may exacerbate the problem and precipitate an emergency. Intervention will need to include supports to address unmet basic needs (eg, food insecurity, unsafe living conditions, homelessness).</p>



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Algorithm Step	Description of Step
<p>11</p> <p>Brief pediatric intervention(s)</p> <p>All visits: Engage by using “common factors”; add patient to practice registry</p> <p>Acute, chronic, or subspecialty care visit: Complete visit; address MH concern now (as in the bullets below) or plan follow-up visit</p> <p>RHS visit or visit for MH concern: Take one or more of the following actions:</p> <ul style="list-style-type: none"> ▪ Expand assessment (eg, secondary screening; behavioral diary; collateral data collection from school, child care, previous MH evaluation) ▪ Offer focused problem-solving, common elements intervention, stress reduction, assistance with behavior change, and/or self-help resources ▪ Facilitate referral of family member for MH specialty or social services, if indicated ▪ Schedule return(s) or outreach as needed to assess response, complete RHS, try additional interventions, or advance to step 12 	<p>Add patients with positive findings on screening and other concerns to practice registry. If an identified problem is not an emergency, undertake one or more brief interventions, as time allows, during the current visit or at follow-up visit(s). Begin by using “common factors” communication techniques (the HEL²P³ mnemonic^a) to build a therapeutic alliance—a bond of trust—with the child and family and address any barriers to their accepting help. With permission, offer one or more of the following additional brief interventions:</p> <ol style="list-style-type: none"> 1. Iteratively expanding the assessment (eg, through use of secondary screening tools^b) and/or gathering more information from others) 2. General measures to enhance MH (eg, physical activity, sleep, outdoor time, reduced media exposure, stress reduction, 1:1 time with parent^c) 3. Advice to parents about managing/solving identified problems^d 4. Common elements of evidence-based techniques to address the child’s symptoms and manage stress^e 5. Self-help resources^f 6. Referral of family member(s) for assistance in addressing their social or MH problems that may be contributing to the child’s^g
<p>12 Full diagnostic assessment needed?</p>	<p>When indicated by severity of symptoms or high level of impairment and/or by persistence or worsening of problems despite brief interventions, consider the need for a full diagnostic assessment. Regardless of other factors, diagnostic assessment is necessary if the clinician is considering medicating the patient.</p>

^a HEL²P³ mnemonic annotated.

^b For a listing of secondary screening tools, see “Mental Health Tools for Pediatrics.”

^c See “Ideas for Enhancing a Family’s Mental Health.”

^d See “Advice for Parents Regarding Common Mental Health Concerns.”

^e See “Common-Elements Approaches: Brief Interventions for Common Pediatric Primary Care Problems.”

^f See “Sites for Families of Children With Behavioral Problems.”

^g See “Sources of Key Mental Health Services.”



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Algorithm Step	Description of Step
<p>13</p> <ul style="list-style-type: none"> Monitor for symptoms and functioning Reenter at step 9 if concerns recur 	<p>If full diagnostic assessment is not needed, monitor for symptoms and functioning, as for other patients with special health care needs. If problems recur, return to step 9.</p>
<pre> graph TD 14{14 Who will provide further assessment?} -- PCC --> 15[15 Full diagnostic assessment] 14 -- MH specialist --> 16[16 Full diagnostic assessment] </pre> <p>14 Who will provide further assessment?</p> <p>15 Full diagnostic assessment</p> <ul style="list-style-type: none"> Provide full diagnostic assessment in primary care Interpret findings to youth and family <p>16 Full diagnostic assessment</p> <ul style="list-style-type: none"> Refer to MH, DBP, or SUD specialist for diagnostic (re)assessment Request results 	<p>A full diagnostic assessment can be performed, either by the pediatric clinician (typically at a follow-up visit) or through referral to an MH, developmental-behavioral pediatrician (DBP), or SUD specialist. Considerations in making this decision include the clinician's training and comfort, family's preferences and resources, and availability/accessibility of referral sources.</p>
<p>17</p> <p>Family-centered care plan</p> <ul style="list-style-type: none"> Summarize strengths & needs (patient & family) Articulate patient's & family's goals Reach agreement with family, school, agencies (+ MH specialists & pediatric subspecialists, if involved) on care components, including psychoeducation & plan for emergency care Define roles of family and others 	<p>The plan of care centers on the patient's and family's strengths, goals, and priorities. It identifies modalities of treatment and person(s) responsible for each (ie, family; MH, DBP, SUD, or early intervention specialist; school personnel; primary care clinician; pediatric subspecialist) and ideally includes all of them in planning and coordination. In particular, the plan should clarify responsibility for psychoeducation of the patient and family and emergency care, if and when needed.</p>



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Algorithm Step	Description of Step
<p style="text-align: center;">18</p> <p>Care plan implementation, comanagement, and monitoring (May require collateral data, information exchange, multiple visits, and/or outreach)</p> <ul style="list-style-type: none"> ▪ Apply and schedule monitoring mechanisms ▪ Coordinate with family and other clinicians ▪ Schedule RHS for age ▪ Revise plan as needed ▪ For adolescents, articulate plan for transition to adult care 	<p>To implement the care plan, involved partners need to establish mechanisms for monitoring progress (person responsible, measurement tools, laboratory testing if indicated), information exchange, schedule of RHS visits, periodic reassessment, and revision of the plan as needed. By mid-adolescence, planning should begin for eventual transition to independent living, job training, or further education (as appropriate to the circumstances) and adult medical and MH care.</p>
<pre> graph TD 19{19 Concerns resolved?} -- NO --> 20[20 Return to step 14] 19 -- YES --> 21((21 Monitor for symptoms and functioning Reenter at step 9 if concerns recur)) </pre>	<p>If problems persist or worsen, reassessment will be needed: return to step 14. Otherwise, continue to monitor for symptoms and functioning, as for other children and youth with special health care needs.</p>

