Child Psychiatric Issues in Urgent Care and Ambulatory Settings

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Objectives

- Psychiatric Assessment Of Children
- Psychiatry Essentials For PCP First Responders
  - Psychotherapy (Referrals)
  - Medication
  - Restraints
- Resources and Systems Issues
Hungry

Prenatally drug exposed

He's just like his dad

Overwhelmed, sensory motor integration difficulties.

Tired

3 years old

Saw parents fight

Parenting problems

Language difficulties, can't express what he wants

Parent is depressed

Parent is depressed
Domains Of Assessment

- Child Behaviors and Symptoms
- Dyadic and Caregiver Functioning
- Safety Issues
- Trauma In Children
  - Poverty, Incarceration, Separation, Foster
- Case Illustrations
Do Children Have Psychiatric Disorders?

- Up to 20% of children have a mental health disorder—the vast majority are undiagnosed.
- Up to 50% of impoverished children have psychiatric/behavioral disorders.
- Young children who have parents with mental illness, substance abuse, or are victims of violence and poverty are at particularly high risk.
Practicing Child & Adolescent Psychiatrists in Michigan

Michigan: Practicing Child and Adolescent Psychiatrists
Number per county

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Preschool Child Differential Diagnosis

- Childhood Psychiatric Disorders
  - Anxiety Disorders – Often look disruptive
  - Trauma often underlies aggressive behavior
  - Autism – May go unrecognized
  - Emerging ADHD
  - Cognitive/Language
  - Neurodevelopmental Disorder Associated with Prenatal Alcohol exposure
Older Youth Differential Diagnosis

- Depressive Disorders/Bipolar Affective Disorder
- Substance Use Disorders
- ADHD/Oppositional Defiant Disorders
- Undiagnosed Autism Spectrum Disorders
- Trauma/PTSD
- Psychotic Disorders (Emerging)
- Catatonia or adverse medication reactions
- Safety Issues – Assessing Self Harm is Key
14 month old

- Sleeps poorly
- Impossible to soothe
- Dysregulated
- Headbanging
A.M. Referred for hyperactivity and for diagnostic clarification

- Very active, impulsive and difficult to settle from birth
- Frequent emotional meltdowns
- Few friends
- Often lines up toys and has an interest in pirates
- Dx: ADHD in pediatric setting.
N Michigan Consultation
Assessment Of Caregiving System

- Intergenerational Risk Factors
- Family and Psychosocial Domains
  - Poverty, Incarceration, Trauma, Homelessness, Separation, Foster Care
- Parental Mental Illness
  - Mood Disorders/Bipolar Illness
  - Substance Abuse
  - PTSD
Why Assess Dyad

- Development of young children “nested” in relationship with parents
- Relationships influence regulatory capacity, cognitive/social development and intimacy
- Parents are primary attachment figures for children
Ghosts In The Nursery

- May follow parents history of neglect/abuse or trauma
- Negative parental attributions “you are bad”
- Traumatic expectations “you will hurt me”
- Child internalizes and conforms to parental expectations.
Clinical Vignette

- Mother describes a childhood in which she witnessed domestic violence at the hands of her father, directed toward her mother. On one occasion seeing her mother battered to unconsciousness. Parents divorced when she was 5yo. Her mother was verbally abused and she left home at age 16 years, and became involved with a man several years older who was HIV + and conceived her child now age 4. He was also assaultive to mother.
Clinical Vignette

- This 4 y/o child is presented by his mother, for “impossible behavior”. He is bossy to her and intermittently aggressive. He won’t mind her, and she describes him as frequently oppositional. Mother wonders whether her own illness (HIV) may play a role. She recognizes that he was left to his own resources early in his toddler years. Father is incarcerated, and has history of substance abuse. Violence was witnessed by child, as was his mother’s arrest.
In This Child

- Intergenerational Transmission of Risk
- Parental Depression and PTSD
- Child PTSD
- Aggressive, Role Reversed and Punitive Behavior: A Function of Trauma and Neglect
Treatment Strategies: First Do No Harm

- Treatment of Preschool Children Involves The Parents
- Engaging Parents Means Welcoming Them, Supporting Them and Acknowledging Struggle
- Behavioral Treatments And Dyadic Treatments: Treatment Of Choice
- Often referrals to Early On (4 and older) and Infant Mental Health Programs (3 and under) are most efficient venues for treatment
Use of restraints

- The first person whose affect you need to regulate is your own
- Mental Health Code: Use Least Restrictive Means Of Controlling Behavior
- Young children
  - Soothe by play, distraction, holding
  - Facilities and Quiet Room
  - Hospital environment/white coats may trigger
- Older youth – reserve restraint for acute injury to self-others (explanation of restraints)
Pharmacotherapy for Disruptive Behavior

- Medications for aggression are overused and coming under intense scrutiny at national levels
- For young children attempt use of behavioral, parenting and trauma treatments first
- Refer to medication cards
  - Guanfacine or Clonidine (Impulsivity)
  - Stimulants
  - Neuroleptics for intractable aggression
Common Indications For Neuroleptics in Emergency Settings

- New Onset Psychosis
- Acute Manic Agitation
- Substance Induced Agitation/Mania
- Aggression and SIB or Acute Disruptive Behavior
Pharmacotherapy For Behavioral Disruption in Emergency Settings

- Lorazepam 0.5-2 mg IV/IM/PO
- Risperidone 1-2 mg PO/IM
- Olanzapine 5-10 mg PO/IM

(Warning: Use of neuroleptics in children with catatonia, neuroleptic sensitivity, DD)
Neuroleptic Sensitivity

- History of “stilling” or frozen posture (catatonia)
- Paradoxically may also be intermittent frenetic activity
- Elevation in CPK
- Vasomotor Instability (elevation in BP/Pulse)
- Increase in Temperature
- Muscular Stiffness, Rigidity and EPS Sx.
- Psychiatric Emergency – Withdraw Neuroleptics
Safety Essentials

- In children of all ages review self-injurious behavior (impulsivity, head-banging)
- Suicide assessment in youth age 7 and above
- Trauma - domestic violence, abuse, neglect, other trauma (MVA, drug exposure, medical trauma, prolonged separation/foster, incarceration of parents) in children
The Michigan Child Collaborative Care Program (MC3)

- **Aims**
  - Improve access to child psychiatrists/
    psychologists/social workers/nurses
  - Improve access to evidence-based therapies
  - Improve competence and confidence of PCP’s treating children
  - Similar models throughout the country.
What Children and Families Can We Serve?

- Infants and children ages infancy through 26
- High risk women during pregnancy and postpartum

• Common problems: ADHD, mood disorders and r/o bipolar illness, autism, anxiety/OCD/trauma, substance disorders, high risk young children (premature, foster care, fetal alcohol)
Components of MC3

- Telephone Access: “Answers in real time” for PCPs in 31 counties in state of MI (northern 21)
- Consults: Telepsychiatry for rural areas of state
- Care Coordination: Help with disposition and triage between PCPs and mental health
- Education - Webinars, ongoing case consultations.
- Relationships with PCPs/CAPs/CMH providers
Progress To Date

- 178 PCP’s in 18 counties enrolled
- 710 Consultations To Date (Child and Perinatal)
- Telepsychiatric Consultations Initiated April 2013
Planned Expansion 2015

- 21 counties in northern LP all will be included in MC3
- Communication with regional CMHs occurring now
- Hiring of BHC (behavioral healthcare specialist for each region) between November 1 and February 1 2015
  - Willing to enroll to use phone, telepsychiatry consultations
  - Willing to participate in developmental screening and receive longitudinal metrics on patients
  - Willing to work with local behavioral specialist to assist with referrals
- Interested PCP practices should contact Anne Kramer (ack@umich.edu) for more information or sign list after this talk
Pharmacotherapy

- Additional Information:
  www.depressioncenter/mc3
  - Depressive Disorders, Disruptive Disorders, Aggression, Perinatal Psychiatry

- Laminated Medication Cards Available To All Participants
  - Review Essentials of Pharmacotherapy for Common Psychiatric Conditions
Referrals

**Referral Options for Preschoolers**
- Infant Mental Health Services (birth-3 years)
- Behavioral Treatments/Dyadic Treatments
  - Contact local CMH
  - Contact behavioral healthcare specialist through MC3 for other referrals

**Referral Options for Older Youth**
- Private psychiatrists in Traverse City
- CMH for those meeting severity
- Behavioral healthcare specialist can assist with referrals
Systems Issues

- Inadequate Providers
- Patchwork System for Crises
- Silos Between Primary Care/Mental Health Providers
- Interest in Task Force?