Pediatric Behavioral Health Integration Transcript

August 25, 2025

Bailey Stanley: Welcome to the Behavioral Health/Substance Use Disorder Integration Technical Assistance webinar, Pediatric Behavioral Health Integration. This webinar is supported by the Bureau of Primary Health Care of the Health Resources and Services Administration. Participants have entered in a listen-only mode. Submit questions by using the questions and answer feature. To open the Q&A, click the Q&A icon at the bottom of your Zoom window. If you experience any technical issues during the event, please message us through the Q&A feature or email bphc-ta@bizzellus.com. This event is being recorded, and the slides will be available on the TA portal following this event.

We offer behavioral health continuing education units for participation in BH/SUD integration technical assistance events. You must attend the event and complete the online Health Center TA Satisfaction Assessment Form after the event. A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BH/SUD TA Team via Smartsheet.

We're excited to share that we have more continuing education opportunities coming up for you. Please register now for fall webinars beginning on September 3rd. There is also space available to join the current communities of practice. We'll add the links to these events in the chat so you can take a closer look. I am pleased to introduce you to today's presenters. Jennie Cole-Mossman, JBS International, is a licensed mental health specialist and infant mental health clinical mentor with extensive expertise in child-parent relationships and early childhood mental health and primary care.

She serves as a Technical Expert Lead III for projects with the JBS Office of Victims of Crime and the Health Resources and Services Administration Rural Communities Opioid Response Program. Her work emphasizes behavioral health screening and treatment for young children, addressing the impact of opioid use disorders, and strengthening family-centered care in primary care and child welfare systems.

Jenna Quigley, JBS International, is a Deputy Project Director leading the Child and Adolescent Behavioral Health Program under the Health Resources and Services Administration Rural Communities Opioid Response Program. As a licensed marriage and family therapist, she specializes in the integration of mental health services for children and families in community settings. It is now my pleasure to turn the webinar over to Jennie and Jenna. Jennie, Jenna, please go ahead.

Jenna Quigley: Thank you, Bailey. Welcome, everyone. These are our objectives for today. We are going to be focusing on pediatric behavioral health and early intervention, as well as integration of pediatric mental health into primary care settings. Next slide, please. We have a few polling questions. Our first polling question is: Which of the

following options best characterizes the status of your health center's integrated services for pediatric patients with behavioral health needs? I'll give everyone a moment to fill that out.

[pause 00:03:32]

Okay. Bailey, can we show the results? Thank you. It looks like most folks in the room have made progress, but still have some room for improvement. We have some folks who are in the early planning stages or haven't started yet, and we have a few folks who have fully integrated care and comprehensive services. Thank you. Next slide, please. What is pediatric behavioral health? This slide shows different aspects of pediatric behavioral health. It starts prenatally, is complex and multifaceted. It includes both mental health and substance use. This presentation discusses ages birth through 19.

Well-being in general is the overall quality of life and satisfaction. It's multidimensional, including physical, mental, emotional health, social health, society. Children with good well-being and mental health tend to have positive quality of life, can function across settings, and can have positive relationships. Next slide, please.

Jennie Cole-Mossman: Hello. I'm going to talk to you today a little bit more about the early childhood and infant behavioral health. Many of you might be familiar with pediatric behavioral health, but when we talk about early childhood and infant, we're talking about that set of children who are five and younger. This is a period of development where secure relationships are really important. Everything we're doing is going to be supporting the continued cognitive and physical development of these children and their emotional regulation. We're really laying the groundwork.

In pediatrics, we're often talking about a parent-child dyad or a caregiver-child dyad, but especially when we're talking about infants and early childhood, we'll be talking about the caregivers, the quality, and consistency of those relationships. It's important for us to note that even infants and very young children can have behavioral health conditions. That may be new to some of you. It may be newer to some of you, but for a long time, we did not think that was the case. Now we know differently. We also know that with support, we can help set children on a path to secure relationships, healthy development, and resilience. Next slide.

These are some examples of what you may hear or see when people talk about examples of childhood disorders. There are whole sets of diagnostic codes, some separate for very young children. There are also these-- They're a label. We try not to use labels as person-first, but thinking about stress-related disorders might be something for younger children. Depression, anxiety, autism, attention deficit hyperactivity disorders, probably one you've heard about, and some more general childhood disorders like behavior disorders or eating disorders, learning disorders. We

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also include in this intellectual disabilities. These are some of the broader qualities or things that you might see a diagnostic code for.

I think we have another poll for you that Jenna's going to walk us through.

Jenna Quigley: Yes. Here is the next poll. What age group does your work primarily serve? Just trying to get an idea of what ages you work with. Give you a moment to complete that.

[pause 00:08:08]

Okay. Bailey, can we show the results? Great. Thank you. It looks like most folks serve about 5 to 18 age range, some young adults as well. We do have some folks who work with infants, toddlers, and preschool age. Great. We've got folks all across the board. Wonderful. Next slide, please. Why do we talk about pediatric behavioral health? We are talking about it because it's important to understand in order to prevent it, to identify it, and to intervene early. Childhood is a critical stage in life for mental health and overall well-being. It's a time of growth and brain development.

As you can see from the information on the slide, symptoms can begin in early childhood for some disorders. For others, they don't develop until later childhood or teen years, but we see signs for about half of the most common disorders before age 14. The CDC estimates that 13% of children ages 3 to 17 do have a diagnosable condition, but that 13% does not represent everyone. Some children experience symptoms but do not meet criteria for a diagnosis, but they may still benefit from support. Some may meet criteria but remain undiagnosed.

You can see on the right-hand part of the slide that those are the most prevalent behavioral health disorders that we see in these age ranges. ADHD, anxiety, depression, and behavioral problems. It's really important to think about, as we're going to talk about throughout, early identification and intervention, because suicide is the second leading cause of death, only second to accidents, in ages 10 to 14. It's the third leading cause of death among those ages 15 to 19.

Mental health and behavioral health can interfere with development, leading to concerns that last throughout adulthood, and many mental health conditions are chronic and last throughout the lifespan. Without prevention, early diagnosis, and treatment, people can have problems across multiple settings throughout their lives. Next slide, please.

This slide is adapted from Urie Bronfenbrenner's ecological systems theory, which was from 1979. As you can see, there are multiple complex influences on behavioral health and well-being across the lifespan. You may hear some of these influences that are listed as risk and protective factors. We can look at the different influences from the individual and relational levels, all the way through community and society. Your

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biology, genetics, your temperament and personality, experiences as a child and throughout your life, your stress response and coping, connections, relationships, and attachment all play a significant role. So do the community and societal factors that are listed.

When thinking about prevention and intervention for pediatric populations and their families, we need to be thinking across all of these different levels of influence. Jennie is going to start to share more information with us about attachment and its significance. Next slide, please.

Jennie Cole-Mossman: I could probably normally talk about this for about three days. I'm going to try to put it together for you in three slides. Long before young children can talk, long before kids get to a stage where they can express themselves verbally or even pretty significantly with behaviors, attachment is going on. Jenna mentioned that as one of those foundations. What is it? It's something that aids survival, as infants and young children they can't provide for most of their needs or their safety. They can't feed themselves. They often can't move without a parent. They need their diapers changed. They need their sleep regulated. All of these things.

It's also this long-lasting emotional bond that connects one person to another, or this psychological connectedness that we have. These are our very first experiences with other people, as they set the foundation for our later relationships. Next slide. Why we care about it is it does provide this framework for future relationships. You saw in the ecological model, and most of you probably know from your own childhood or the kids that you serve or in your family, that healthy attachments with a primary caregiver often lead to and promote healthy attachments with others.

What we get as very young children in terms of how folks respond to us and how they make us feel about other people carries throughout our lives. Unhealthy attachments with a primary caregiver lead to often emotional or behavioral problems and problems in relationships. Sometimes these don't show up until much later. Other times, we see them as problems in infancy that we didn't use to treat and think about, but now we know. We have interventions for that. Next slide.

This is the quick and dirty of how this happens. You're all wired to attach. Your brain circuitry ensures that you'll attach to assist you with survival. It's why most of us think that babies are cute. We respond to their cries and any behavior signals that they give us. We seem to feel like we just know some of the things that we need to do for them. Around the time of six to nine months, an attachment becomes focused, so they know that there is a person there that they want to engage with. Not just any old person, but a specific person or a couple people.

It happens during this sensitive period. Between six to nine months, all the way up to five years of age, we're forming an attachment. It doesn't mean that you can't form an

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attachment or that those attachments can't get healthier after that time. It just means that this is a sensitive period where our brain is ready to take in this information and set us forward in that development.

Nurturing sensitive and predictable caregiving is what wires the brain for secure attachment. It helps the child think the world is a safe and comfortable place, I can depend upon adults to take care of me when I need it. Neglectful or abusive caregiving still produces some kind of attachment. That's a little bit where we get stuck. Sometimes people think that attachment isn't happening, but it is actually happening, but it's not necessarily secure. The child isn't necessarily comforted by the presence of an adult or a caregiver. They don't necessarily form this opinion that the world is a safe place where you can get your needs met. Next slide.

The brain really dedicates itself to learning ways to stay connected to attachment figures and determine if they're consistent and safe or not. You may see, I always use the example when you're with an infant or a toddler and they knock things off of their tray, you pick it up, you give it to them, and you make eye contact. These are all behaviors that we're doing to stay connected to those attachment figures, or when you're feeding a baby and the baby is making eye contact with you. All those things, all those behaviors lead us to develop an attachment style.

That attachment style typically is an interplay between genes and environment. Back to that slide that Jenna showed you. Sometimes we don't always have goodness of fit between our personality and how we attached and the baby that we're taking care of. That may be an intervention point for an infant mental health therapist. Adults have this specific signature in their brain that's associated with their attachment style.

If you take nothing else from this today, what I try, folks, to help them understand is that you cannot give away what you didn't get without intervention. If you didn't get safe, nurturing, stable parenting and relationships at some point in your life, it's almost impossible without intervention for you to give that to the next generation that you're caregiving for. Next slide.

This is what folks typically think of this and the typologies of attachment, which we're not going to go through. You'll see that even at six weeks, babies are having a social stage of attachment. Different kinds of stimuli, both social and non-social, produce a favorable reaction. Babies smile at you. They coo at you. You often make that sound back to them. You may be talking to them quite a little bit, even though they don't understand your language, but they hear that sound of your voice, and it's soothing. You might be singing and rocking them. You're also, when they're hungry, you feed them.

About six weeks to seven months, babies enjoy human company. They will pretty much respond equally to any caregiver and get upset when there isn't a response to their discomfort. At about three months, we do see them start to smile at familiar faces a little

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bit more. We're going from this blob that takes care of me is okay. This blob that I can recognize a little bit more, I might smell or feel, and get to know them a little bit more, maybe I enjoy that. Then, at seven to nine months, or six to nine months, is really when a baby looks to a specific caregiver for comfort and protection.

This is where we start to see fear of strangers or unhappiness when babies are separated from the caregiver. That's really young. If we're thinking about those of you working with kids that are in grade school, this has been set up and is happening a long time ago, even at seven to nine months, that these babies are learning the world is a safe place where I can interact and develop, or people will meet my needs. By 10 months, what we see is that babies can have and are dependent on several attachments.

Usually, those are formed by those who can read their cues best. Again, what you can give away and what babies receive is building that attachment. As that happens over time, we see even at 10 months, that might be by a primary caregiver and another caregiver, or even babies that go to childcare are getting these same behaviors when they're being fed, read to, rocked, talked to, and played with. Next slide. All of this is going to impact development. Next slide.

When we are little bitty babies and young children, and we have secure attachment, it allows us to do some things that we can't when we aren't sure about whether or not the world's safe, and we don't have adults that are providing that kind of stimulation for us. Secure attachment or relatively secure attachment provides the brain with sensory stimulation to help it grow. You're talking to babies, you're responding when they cry, you're also responding to other noises they might be making, which encourages them to make those noises more, and you respond more. Babies are learning certain stimulation cause other things to happen.

They also learn that they can be soothed when they're in distress. Babies have very little ability to regulate themselves temperature-wise, even more so emotionally. A caregiver is able to rock them, sing to them, hold them tight, and provide them with some physical comfort, which also ends up being an emotional comfort. It gives the baby a sense of belonging. You saw on that slide before, even at nine months, they're starting to pick out who are my people. By 10 months, they're picking out who are the number of people in here.

These things reduce the stress hormones. They teach the baby that the world is a safe place that they can explore, and help the baby grow up to have secure relationships. If you have these good foundational relationships, then the baby has a better set of skills to have additional secure relationships, both in friendships and romantic relationships, relationships with teachers, and other people that they might interact with. Next slide.

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Unpredictable or frightening caregiving, for whatever reason that may be, often what we see in babies are regulatory or arousal issues. The baby has a really difficult time sleeping, eating on a schedule, or taking in food without really upset tummies. Arousal issues, so the baby is really upset, and we can't stop them from crying. Sometimes those are caused by medical issues, and folks are trying really hard. Sometimes they're caused by a combination of issues.

When we're unable to meet those needs for the baby, they're also learning that pattern of interaction. They're learning; this person doesn't really know how to stop this. Nobody can stop this, whatever upset I have. This leads to a reduced capacity to explore the environment and do those age-appropriate developmental tasks. If you feel like the world's predictable and you know that if you get into some trouble, there's going to be a person that can watch your cues and help you feel better, you're more likely to go out and explore.

We actually see this in kids. You will see toddlers physically go out from a parent, turn around, and look at them when they have a secure attachment, explore the world a little bit, and then they might come back. We see that happening. The more they stray away from those developmental trajectories, the more we see regressive behavior. They're not on track; they're falling behind their peer groups. Then, particularly when things are very unpredictable or frightening, one of the wonderful things about childhood is the imagination that kids have.

In this case, young children tend to blame themselves for frightening events because up until this point, they're learning, if I cry, someone comes and feeds me with a bottle. If I'm wet and I cry differently or I act uncomfortable, someone changes my diaper. They're learning this very, I make people respond. It also makes them think that they cause these frightening and scary things to happen because they don't understand cause and effect yet. Next slide.

Everybody has, some of us more than others, some unpredictable and some scary things happen when they're young children. When we have a secure attachment, that acts as a regulator. It helps the child when negative events occur, the caregiver is able to soothe that distress. Nobody loves to get shots with their baby, but if your caregiver's there and they're holding some pressure on that area and they're [shushing], and they're holding you and talking to you, they're soothing that distress.

The caregiver's response to these scary or unpredictable events, whether they be minor stressors like receiving a shot or neglect and abuse, influences how the child perceives events. Again, is adding to this, is the world a scary place? Can people keep me safe, or do I have to change to the things that I'm doing to get attention or to stay safe? Really, we see that when we have a secure attachment provider, they're that regulator. Their emotions are regulated, they're calm, they can handle situations, and they know

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what to do to help the baby feel better and feel safe. That is helping them learn to do that for themselves later on. Next slide.

Someone put in the chat, what are your top three do-these-now recommendations that will have the biggest impact for medical primary care providers in identifying behavioral issues in children 5 to 12 upon gaps that you personally have identified? I would say my top three do-these-now would be back up to children under 5 and think about that development. As we go through, we're moving into older children. Jenna, if you want to pop on, just let me know.

Jenna Quigley: For a medical primary care provider, we're going to talk about this later, but we really want to identify when you see concerns. If you're serving ages 5 to 12, you want to be screening, you want to be making sure people are connected to get a full assessment. If you're identifying concerns, you want to be supporting the family. We're going to go through what that looks like in a little bit more detail towards the end.

Jennie Cole-Mossman: I think, Michael, a lot of times, I'm hoping that you're also going to see them before five, but folks are coming in, and we just assume they know what to do with babies. We assume that someone has told them what to do or showed them what to do. There was this thinking that kids under five were like this black box, that it didn't matter so much, and we would figure it out later on. Not to add to all of the anxiety of having a baby anyway, but really, there are a lot of things we can do in early childhood that are going to set kids up for 5 to 12 to have better emotional regulation.

One of those is helping a parent provide secure attachment. Whatever's getting in the way of the parent being able to do that and/or the baby. I mentioned earlier that example of making sure there's no medical cause for gastrointestinal issues or things like that with the baby's feeding might be one thing that you could do that then the baby's more comfortable, the parent's more confident because they're able to help the baby be soothed and have feeding be a good experience. That's going to lead to great behavior in 5 to 12-year-olds.

I'm going to go through a little bit-- These are the domains of symptomology in pediatric behavioral health. Where does it show up, and what does it look like? These are the places that we typically see it showing up: emotional, behavioral, and cognitive symptoms. We do also see, I'm sure, those of you working in primary care; we see physical symptoms. We might be screening for development or receiving developmental screenings, and we see it there. We also see it in those relationships that are in front of us, whether that's in our office, in our waiting room, or wherever we're seeing those interactions. Next slide.

With school-age children, 5 to 12 or 6 to 12, what we're seeing typically is this increasing pressure that they're under. They are now going to be going to childcare, or they're going to school, and they're going to be separated from that primary caregiver.

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We have a little bit less supervision and a little bit of a decrease in the direct assistance. Kids are starting to be able to do some things on their own and experience frustration and emotions that they may not have had so much of, away from that primary caregiver, once they're headed to school. Next slide.

I'm going to show you these symptoms, and I'm going to give you the caveat that, like most mental health conditions, the things we are talking about are above and beyond what would be typical of normal development. That is another thing that I can't stress enough. Developmental guidance and helping parents understand this is what babies at two do, this is what they look like, this is what they're learning about, is really important. Same goes for older children.

We see in kids 5 to 12 emotional symptoms. Low mood, sadness, that might manifest itself as crying. Worry. Those things, folks tend to be a little bit more empathetic to those, but oftentimes what we see in kids is irritability and anger. Those tend to get you in trouble in school. They tend to be involving another relationship. You got to worry about both parties in that relationship. We also see this withdrawal from social situations. That age of 5 to 12 is all about getting school friends. You have recess still, who you sit by, you're having group activities, you're having these first experiences. In those places, we may start to see symptoms that are out of that normal range of normal development. Next slide.

Behavioral symptoms, and these are ones that'll catch your attention if you're working in school, and catch a parent's attention because they're getting phone calls, but difficulty with focus. This, again, outside of what would be normal for development. Three-year-olds, four-year-olds don't sit well. Even five, six, seven-year-olds need breaks. How far outside of their peer group is this difficulty with focus? We start to see some aggressive behavior and risky behavior, which oftentimes manifests as school problems. Intentionally or unintentionally breaking the norms and the rules of school.

At home, we might see sleep issues and eating issues as behavioral indicators. That maybe this child's needing some additional support. Next slide. Then cognitive symptoms. Even very young children have sometimes thoughts of self-harm and suicide. I can't stress that enough. I used to be in private practice, and I had 8 and 10-year-olds that had thoughts of harming themselves. They may not have been as well-organized as older kids, but they definitely had those thoughts.

We start to see some learning issues. Maybe they're unable to keep up with their work, or they're showing some frustration with their work. This might also be from problems of concentration. Problems of concentration can happen for a number of reasons. Kids can be easily distracted and have some of those symptoms of attention deficit, or they may have concentration problems because they're so worried, sad, and upset about something that happened before they came, or are they going to get picked up today? Because they have some anxiety.

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Sometimes that's hard to ferret out when you're thinking about what is driving that concentration issue. Same with headaches and stomach aches. Really young kids aren't real great at locating pain and upsets, so they're going to come in with the same thing over and over again. You also might see headaches and stomach aches in kids because anxiety tends to manifest itself even in us as adults as headaches and stomach aches, if you think about the times that you've been stressed the most.

Changes in weight. Before those behavioral symptoms where you're having issues with sleep or eating, might cause a decrease in weight outside of their peer group or an increase. You would probably have that information about how quickly that is happening outside that developmental trajectory. Then, excessive or difficulty, or disruptive sleep. These are times when we'll start to see kids who refuse to go to bed. They might be having tantrums at night, or they want to sleep all the time, or they're waking in the middle of the night. Nightmares, night terrors, those kinds of things. Next slide.

Adolescents. Ages about 12 to 19. Being developmentally aware again. There's two things I want you to take away. If you didn't get it, you can't give it away without some intervention. Two, adolescents are not just younger adults. They start to look like it. They start to act like it. While they're moving towards this independence, and that's normal for their development, they have a lot more tolerance of risk than we do. Their brain isn't fully ready to take on some of the social skills and emotional tasks that they're seeing. We're going to see them needing support in some of these areas. Next slide.

What that tends to look like are some of these specific behaviors that, if they're interfering with that child's ability to be in home or be at the school, we're going to be looking at offering some support. Substance use. This can have a broad range from using alcohol, prescriptions, and what have you. To maybe misusing their own prescriptions, even sometimes for later adolescents. Risky sexual behavior. Excessive rule or law breaking, both inside of school and outside of school. This could also be within the home rules.

We start to see some self-harm behavior sometimes. Sometimes that's very evident. I used to see a lot of teenage girls in my practice. I had a lot that were cutting and burning themselves. I also had some other kids where the self-harm behavior was putting themselves in very, very risky situations, intentionally thinking that they were going to cause harm to themselves.

Unhealthy relationships. Those aggressive or dramatic childhood fights that were happening get a little bit more serious when we're in adolescence. We start to see hygiene issues. Around this time, again, that's one of the tasks that they're taking on, and their body's starting to change and smell differently and need different hygiene. We've asked them to take on a task, and they may not be able to do that. Next slide.

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Jenna Quigley: Before we jump into the poll, I just want to piggyback on a few things that Jennie mentioned. One of the other things to pay attention to, in addition to is this behavior developmentally appropriate or outside of the norm for other children their age, is to also reflect on is this behavior typical for this child. Is this child having any regressive behaviors? In a primary care setting, if you're looking at milestones and you notice that at one visit they are on track for milestones, and then at the next visit you're seeing some differences or they're maybe not on track, or they've had some regression.

An example we see that with younger children might be with potty training. Maybe a child was fully independent, and now they're six and they're having accidents or things are happening. You're seeing some regression, regressive behavior. Again, ruling out medical concerns or reasons for it that might be an indication that something's going on or that might be a sign for you to take a look at. Just wanted to add that.

We are going to quickly do this poll, which is: What practices is your health center currently integrating to address pediatric behavioral health? I'm going to leave it up for just a few seconds this time.

[pause 00:39:16]

Okay. Answers are still rolling in. Let's show the results what we have so far. It looks like most folks that participated are doing screening and referral, and then some care coordination, collaboration, and patient-centered care. That's great. That's wonderful. Let's go to the next slide. Next slide, please. Thank you. Children with behavioral health conditions tend to have low treatment rates. Identifying and supporting them early are, again, opportunities to prevent long-term chronic concerns.

Integrated programs improve child and family well-being, reduce parental stress, and enhance treatment outcomes. These are four key components of integrated care across models, across the board. All of these domains should be child and family-centered and developmentally appropriate because we know that when services are integrated, we see greater follow-through with treatment and greater success. Next slide, please.

For folks that are already doing patient and family-centered practices or for those who aren't, a big difference between working with just the adult population and working with a pediatric population is the focus on the family. Services, really, we should be looking at both children and adults. We need to be forming partnerships with families. We can't serve a child independently and expect a whole lot of change. We need to pay attention and build relationships that value family voice. They are the experts on their own lives and should be viewed as decision-making partners.

Some quick tips on how to build relationships include active listening, being very clear, transparent, direct, predictable with our communication, following through on any commitments that we make to a family to support their child in a timely way, getting

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curious and asking questions, figuring out what their needs are and trying to meet them, and really being strengths-based.

Earlier, there was a question about what are the top three things, I can't emphasize listening enough. When you are working with a child and family, listening to them, really taking the time for them to feel heard and recognize that their concerns are important to you, that really does go a long way. Sometimes, that listening is enough. It's also important to match needs to services and engage in cross-system care coordination to meet some of those unmet needs.

A way of doing that is to coordinate across child services and the child-serving system of care. A system of care is a coordinated network of community-based services and supports for children with or at risk for mental health or other challenges. It's family-driven and child-guided, designed to promote evidence-informed, integrated care that promotes functioning at home, school, and in the community. We need to be looking across systems, healthcare, schools, community providers, et cetera, to really meet the needs of families. Next slide, please.

Screening and assessment. Early identification and support is key, as we've talked about before, so that things do not worsen or long-term consequences don't develop. Screening can take place in a variety of settings, including primary care and other healthcare settings, schools, childcare facilities, et cetera. Screenings are available for general mental health and substance use if you're working with adolescents. Any age for general mental health and for a variety of specific concerns, there's screening tools for ADHD, anxiety, depression, suicide, autism, and health-related needs, et cetera.

One of the things that you could look at or understand is the Americans with Disability Act and other federal and state policies that support integrating screening into your practice. I see that we have a couple questions. One is, when assessing, there's a comparison to child over time. However, there is a **[unintelligible 00:44:22]** Some assessments are not going to measure mood the same.

Part of what's important when you're talking with families is understanding their family, understanding what their needs are, how things look in their family, how things show up. The screening tools they have different ones that are validated across different populations. It's important to go even beyond just a screening tool and have conversations with family as a part of that screening process to determine what things really look like for them, what their concerns might be, because everyone is different.

Are there other assessments for emotional distress that you can recommend in those cases? Nothing's coming to the top of my head. I would have to do some digging to look at that for other assessments specifically. Jennie, I saw you come off mute.

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Jennie Cole-Mossman: I was just going to say, we've run into this with very young children because there are a lot of parenting practices that are specific to different cultures, too. I think when you said, Jenna, talking to folks, a screening tool is great, filling out, and sometimes those are reliable. Even when you're doing a screening tool like that, you might run into a family who, let's say, expressing anger is not something that anyone in the family is allowed to do. It won't show up on the screening tool, or it'll show up in excess on a screening tool because a kid has never learned how to express that emotion appropriately.

Having that conversation about is it okay to be upset in your family? What does that look like? What are the parameters around that? I think is most helpful for me in terms of the context, because not only do we have some cultural differences, we might have some family differences, whether or not that's okay. Then you have some kids that are in multiple caregiving situations. They might go back and forth between parents, or they might be going into some other parenting situation. Maybe they're in out-of-home placement for some reason, just to know what are the rules and the norms in the family that they're situated in and in that family of origin.

Jenna Quigley: Thank you. Next slide. I want to highlight the differences between screening and assessment. Screening, there's standardized, valid tools for different concerns and across ages. A general universal screening tool is the Pediatric Symptom Checklist. You can look at adolescent ESPER if you're serving older children for one model of screening. It can be done universally, meaning everyone receives the same set of screens, or as indicated for specific needs or concerns.

Universal screening is not indicated for all different types of concerns. An example is that it's not recommended to universally screen for suicidal ideation in children under age 12. It's only as indicated. If there's concerns for children ages 8 to 11, and it's not recommended to screen at all for children under age 8. Screens can often be administered by anyone on the care team.

Say someone's positive on a screen, you have further concerns, you can talk with them, you can ask questions, that's when you would refer for an assessment. For the folks that really have a fully integrated practice, you might be having them meet someone down the hall to do a further assessment, get more information, or you might be doing a warm handoff, which we'll talk about in a little bit.

The assessment really needs to be done by someone who has the credentials to do an assessment. It should be longer, comprehensive. It looks across various different psychosocial settings. You should be gathering information from multiple sources as you're doing assessment for a child. That would be parents, caregivers. You might need to talk with schools. You might need to look at them across all of the different settings in their life to get an idea of whether something is of concern or not. Next slide, please.

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One of the other things, sorry, I want to back up just for a second about screening and referral, is if you know that they just saw another provider and they completed a screen, that's where information sharing is really important. We don't want to have kids and families keep answering the same questions over and over and over again because that can be challenging for families. If they've worked with someone else, you want to get that information and share information as much as appropriate and allowable to help support care coordination.

We want to take time to provide feedback on screens, why we're doing them, what the results of those are, and provide information about available options for resources and services. Again, we want to gather input from the child and family. We want to highlight strengths and be clear. We want to have collaborative conversations, provide options, and be very clear about what next steps are. We could share that we're concerned about something based on a screen. We're going to refer them for an assessment and talk with them about what that looks like and what the next steps would be.

It's also important to prioritize needs. I'm sure most folks are familiar with Maslow's hierarchy of needs, but those bottom two tiers really focus on basic needs, so food, water, sleep, somewhere safe to live, et cetera. We need to focus on meeting some of the health-related needs before moving on to addressing other concerns that we might see need some support. Next slide, please.

Jennie Cole-Mossman: There's a couple of questions in there-

Jenna Quigley: Oh, go ahead.

Jennie Cole-Mossman: -too. I was just going to answer the one about diagnostic and billing codes for kids under four. There is a whole DC 0 to 5. It has a crosswalk with it. It's a whole separate diagnostic manual that you can find on places. You can use the Google or whatever AI you're using now, but there's a whole separate. It has separate training that goes along with it. I would say that's important because it's a different way of using those diagnostic codes, but there's a crosswalk that goes with it.

Jenna Quigley: The question about staffing to offer patient-centered approach because PCPs might not have time to be able to offer that type of care. Yes, you can use all different types of staff. Sometimes people have people in specific care coordination roles where their job is to help support the family and to make sure that they are connected to who they need to be connected to, that they're receiving the services, resources, and supports. Sometimes it might be a healthcare navigator. It could be called different things, but you can have other non-physician staff members that are there to support that child and the family in moving through the system and getting connected where they need to be connected.

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One of the things, as we're on this slide, is talking about warm handoff or connection. One of the things we don't want to do, we know is not usually successful, is handing someone a piece of paper with a phone number and saying, "Call this person to be able to get support." We often find that people aren't able to do that, or they don't follow through, or life gets busy, and they're struggling.

Being able to have a care coordinator or someone else in a similar role sit down with them, make a phone call together, or, if you have a fully integrated practice and you have someone in the office that they can meet at that time to help support, that would be ideal. Just note that wraparound is often a common approach. There's high-fidelity wraparound, and then there's other intensive care coordination models where there are different staff members on the team that can really help provide support. Next slide, please.

These are just a few, I'm going to go through these slides quickly so we have a little bit more time, evidence-based programs across the different lifespan. For early childhood, HRSA has home visiting programs that really support through the prenatal period through age five. There are a list of different home visiting programs. These are models that can help support for those younger ages. Next slide, please.

Same with HRSA's Healthy Start programs, just a different age range, the prenatal period through age 18 months. There's a care coordinator and really focused on meeting family-specific needs. Next slide, please. Then, these are a few integrated care models. Primary care behavioral health model, where there are behavioral health services directly in the primary care setting, which I imagine some of you that indicated that you were doing that are getting started. There are other consultation programs where you might use telehealth to call in a child psychiatrist or other team members to help provide support. Next slide. Other questions that we didn't get a chance to answer so far?

[pause 00:54:44]

Jennie Cole-Mossman: I think, Lisa, you had found a specific CDC resource on immigrant and refugee health, if you want to [crosstalk]--

Lisa Jacobs: I'll go ahead and put that in the chat for everybody. There is a link that the CDC put out, specific to refugees and behavioral health, that you might find helpful. I'll add that to the chat.

Jenna Quigley: There's a question about zero to five info and billing codes, Jennie.

Jennie Cole-Mossman: Oh, yes. It probably depends on your state, what you're billing it under. That was my whole job, whoever asked that, before I came. I'm from Nebraska, so working with our Medicaid, when I started doing infant mental health services, our

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case plan and court reports for kids under five in child welfare said the child is under five and therefore not in need of any mental health services.

When I finished, we had billing codes with our Medicaid and our other managed care. They were different. They did not fall under family therapy codes. They were specific to oftentimes the intervention. It would be a code for child-parent psychotherapy or a code for parent-child interaction therapy. You would have to check on the state you're in and their Medicaid plan, or who your insurance provider is, as to specifically what those codes are.

I have not been in private practice for a long time. I know they are even changing now I'm here, but they were different codes than just family therapy or individual therapy. I know in our state in Nebraska, there are different codes for play therapy also. That would sometimes be under the five and under. There is that crosswalk of diagnostic codes. If you start looking under that, you might start finding some billing guidance, too.

[pause 00:57:12]

Jenna Quigley: Thank you, Megan. I saw that Megan put in the chat that Maslow borrowed the hierarchy of needs from the theories and ideas originating in the Blackfoot Nation Tribe.

Jennie Cole-Mossman: Thanks to everybody. I know this was fast and furious. We hope we gave you enough snippets that you can take with you and put into practice, or go find out a little bit more information about some of those things.

Bailey Stanley: Thank you. Access more behavioral health substance use disorder integration technical assistance opportunities by emailing the team, visiting the TA portal, and scanning the QR code to subscribe to the Hub in Focus. Please consider joining us for the upcoming fall webinars. There is also space available in the current community of practice. We're adding the topics and registration links to the chat again for your convenience.

This presentation will be posted to the TA portal. References are included so you can delve more deeply into this topic. Don't forget, we offer behavioral health continuing education units for participation. You must complete the online health center TA Satisfaction Assessment to receive credit. We've added the link to the chat for your reference. CE certificates will be sent within five weeks of the event from the health center BH/SUD TA Team via Smartsheet. Thank you for your attendance. This concludes today's webinar. You may now disconnect.

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