

October 4, 2024

We are pleased to introduce a new resource designed to support the adoption of Collaborative Care for pediatric patients. While there is substantial evidence supporting Collaborative Care for adolescents, resources specifically tailored for younger children have been notably lacking.

Enclosed, you will find a comprehensive packet detailing the Pediatric Collaborative Care Pathway, specifically designed for patients aged 6 to 11. This includes essential behavioral health tools for primary care settings, as well as a structured approach to effective screening, differential diagnosis, and symptom monitoring within a primary care environment. Our goal is to equip pediatricians with the necessary tools to enhance Collaborative Care for this younger demographic, based on evidence-based practices and without financial or organizational incentives.

The packet includes:

- An introduction to the Collaborative Care Model (CoCM)
- A detailed workflow from initial screening to evidence-based treatment
- An overview of select behavioral health tools for pediatric primary care

We hope these resources will assist in improving Collaborative Care practices and contribute to advancements in pediatric healthcare. We anticipate ongoing updates and refinements as the field evolves.

For any questions or suggestions, please contact Dr. Virna Little at virna@concerthealth.io.

We extend our sincere gratitude to the dedicated collaborators who contributed to the development of these materials:

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Introduction to the Collaborative Care Model (CoCM)

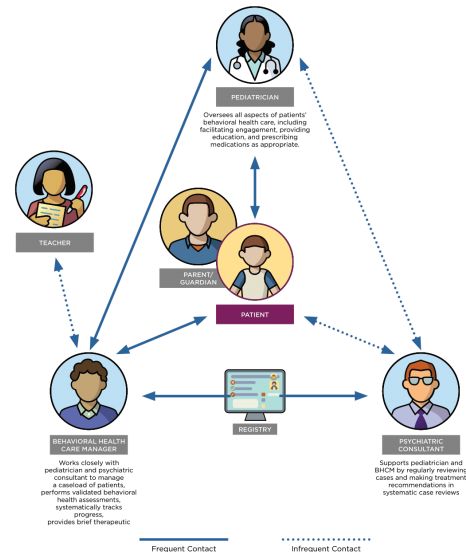
Integrating behavioral health with general medical services has been shown to improve patient outcomes, reduce costs, and lessen the stigma associated with mental health issues. For over 30 years, research has consistently demonstrated that the Collaborative Care Model (CoCM) is an effective, evidence-based approach.

How It Works

The Collaborative Care team is led by a primary care provider (PCP) and includes behavioral health care managers, psychiatrists, and other mental health professionals, all working to their full capacity. This team implements a measurement-guided care plan based on evidence-based practice guidelines, specifically targeting patients who are not meeting their clinical goals.

CoCM adheres to chronic care principles, and emphasizes accountability and quality improvement (QI). Expert consensus has identified five essential elements of the CoCM:

- 1. Patient-Centered Team Care:** The care team, comprising primary care and behavioral health providers, collaborates using shared care plans. This integration enhances patient comfort and reduces the need for duplicate assessments, leading to a better healthcare experience and improved outcomes.
- 2. Population-Based Care:** The team manages a defined patient population through a registry to ensure comprehensive care. This approach prevents patients from falling through the cracks by enabling proactive outreach and targeted interventions, with mental health specialists providing focused consultation rather than just ad-hoc advice.
- 3. Measurement-Based Treatment to Target:** Each patient's treatment plan includes clear personal goals and clinical outcomes, which are regularly measured using evidence-based tools. If patients are not meeting their goals, treatment plans are adjusted until the desired clinical outcomes are achieved.
- 4. Evidence-Based Care:** CoCM is grounded in treatments supported by strong research evidence for their efficacy. It stands out for its substantial evidence base, making it one of the few integrated care models with proven effectiveness.
- 5. Accountable Care:** Providers are held accountable for the quality of care and clinical outcomes, rather than just the volume of services provided. This accountability ensures a focus on achieving positive patient outcomes and delivering high-quality care.



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Key Findings

The Collaborative Care Model has proven effective in controlling costs, improving access to care, enhancing clinical outcomes, and increasing patient satisfaction across diverse primary care settings. While most research focuses on adult populations, emerging evidence indicates that CoCM is also beneficial for pediatric populations (see articles below).

For additional information, visit:

<https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn>

Articles on Pediatric Applications of Collaborative Care:

- American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Collaborative and Integrated Care & AACAP Committee on Quality Issues. (2023). Clinical update: Collaborative mental health care for children and adolescents in pediatric primary care. *Journal of the American Academy of Child and Adolescent Psychiatry*, 62(2), 91-119. <https://doi.org/10.1016/j.jaac.2022.06.007>
- Asarnow, J. R., Jaycox, L. H., Duan, N., LaBorde, A. P., Rea, M. M., Murray, P., ... Wells, K. B. (2005). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *JAMA*, 293(3), 311-319. <https://doi.org/10.1001/jama.293.3.311>
- Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics*, 133(4), e981-e992. <https://doi.org/10.1542/peds.2013-2516>
- Parkhurst, J. T., Ballard, R. R., Lavigne, J. V., Von Mach, T., Romba, C., Perez-Reisler, M., & Walkup, J. T. (2022). Extending collaborative care to independent primary care practices: A chronic care model. *Clinical Practice in Pediatric Psychology*, 10(1), 32-43. <https://doi.org/10.1037/cpp0000383>
- Parkhurst, J. T., Garcia-Goetting, C., Peist, E., Ballard, R., Romba, C., & Lavigne, J. V. (2023). Pediatric collaborative care outcomes in a regional model. *Frontiers in Psychiatry*, 14, 1252505. <https://doi.org/10.3389/fpsy.2023.1252505>
- Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., ... Katon, W. (2014). Collaborative care for adolescents with depression in primary care: A randomized clinical trial. *JAMA*, 312(8), 809-816. <https://doi.org/10.1001/jama.2014.9259>
- Silverstein, M., Hironaka, L. K., Walter, H. J., Feinberg, E., Sandler, J., Pellicer, M., ... Cabral, H. (2015). Collaborative care for children with ADHD symptoms: A randomized comparative effectiveness trial. *Pediatrics*, 135(4), e858-e867. <https://doi.org/10.1542/peds.2014-3221>
- Shippee, N. D., Mattson, A., Brennan, R., Huxsahl, J., Billings, M. L., & Williams, M. D. (2018). Effectiveness in regular practice of collaborative care for depression among adolescents: A retrospective cohort study. *Psychiatric Services*, 69(5), 536-541. <https://doi.org/10.1176/appi.ps.201700298>

- Vanderwood, K., Joyner, J., & Little, V. (2023). The effectiveness of collaborative care delivered via telehealth in a pediatric primary care population. *Frontiers in Psychiatry, 14*, 1240902. <https://doi.org/10.3389/fpsy.2023.1240902>
- Yonek, J., Lee, C. M., Harrison, A., Mangurian, C., & Tolou-Shams, M. (2020). Key components of effective pediatric integrated mental health care models: A systematic review. *JAMA Pediatrics, 174*(5), 487-498. <https://doi.org/10.1001/jamapediatrics.2020.0023>

Pediatric CoCM Pathway (Ages 6 to 11)

Pathway Structure and Flow

1. **Screening:** Conducted during the primary care provider (PCP) appointment using the Pediatric Symptom Checklist (PSC). Variations in PSC usage among practices are acknowledged.
2. **Referral and Differential Diagnosis:** Guidelines for referral and differential diagnosis, addressing symptom overlap in pediatric populations.
3. **Ongoing Evaluation:** Ongoing monitoring and assessment of symptoms.
4. **Evidence-Based Treatment:** Application of tailored treatments based on individual needs.

Pediatric CoCM Pathway (Ages 6 to 11)

<p>Initial Screening: PSC (Pediatric Symptom Checklist) Subscales</p>	<p style="text-align: center;">Attention</p> <p><input type="checkbox"/> Fidgety, unable to sit still</p> <p><input type="checkbox"/> Daydreams too much</p> <p><input type="checkbox"/> Easily distracted</p> <p><input type="checkbox"/> Trouble concentrating</p> <p><input type="checkbox"/> Acts as if driven by a motor</p>	<p style="text-align: center;">Anxiety/Depression (Internalizing)</p> <p><input type="checkbox"/> Feels sad or unhappy</p> <p><input type="checkbox"/> Feels hopeless</p> <p><input type="checkbox"/> Has low self-esteem</p> <p><input type="checkbox"/> Worries a lot</p> <p><input type="checkbox"/> Less enjoyment in activities</p>	<p style="text-align: center;">Conduct (Externalizing)</p> <p><input type="checkbox"/> Fights with others</p> <p><input type="checkbox"/> Does not follow rules</p> <p><input type="checkbox"/> Does not understand others' feelings</p> <p><input type="checkbox"/> Teases others</p> <p><input type="checkbox"/> Blames others for their troubles</p> <p><input type="checkbox"/> Takes things that do not belong to them</p> <p><input type="checkbox"/> Refuses to share</p>
<p>PSC Scoring and Considerations</p>	<p>PSC-17 Total Score: Normal < 15</p> <p>Attention Subscale: Normal < 7</p>	<p>PSC-17 Total Score: Normal < 15</p> <p>Internalizing Subscale: Normal < 5</p>	<p>PSC-17 Total Score: Normal < 15</p> <p>Externalizing Subscale: Normal < 7</p>

<p>Tools for Differential Diagnosis</p> <p>(indicates that the tool is available in multiple languages)</p> <p><i>*Please refer to the attached spreadsheet for a comprehensive list of behavioral health tools for pediatric primary care.</i></p>	<p style="text-align: center;">Attention</p> <p>Attention-deficit/hyperactivity disorder (ADHD):</p> <ul style="list-style-type: none"> • NICHQ Vanderbilt Assessment Scale (Q1-18) • NICHQ Vanderbilt Assessment Follow-up (Q1-26) 	<p style="text-align: center;">Anxiety/Depression (Internalizing)</p> <p>Anxiety disorders:</p> <ul style="list-style-type: none"> • SCARED (Screen for Child Anxiety Related Emotional Disorders) • SCAS (Spence Children's Anxiety Scale) <p>Depressive disorders:</p> <ul style="list-style-type: none"> • SMFQ (Short Mood and 	<p style="text-align: center;">Conduct (Externalizing)</p> <p>Conduct disorder:</p> <ul style="list-style-type: none"> • NICHQ Vanderbilt Assessment Scale (Q1-18) 	<p style="text-align: center;">Trauma</p> <p>Post-traumatic stress disorder (PTSD):</p> <ul style="list-style-type: none"> • CTS (Child Trauma Screen) • CATS (Child and Adolescent Trauma Screen) 	<p style="text-align: center;">Suicide</p> <p>Suicide risk:</p> <ul style="list-style-type: none"> • ASQ (Ask Suicide-Screening Questions) • C-SSRS (Columbia-Suicide Severity Rating Scale)
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<p><i>*Only freely available resources are included due to the restricted availability of other tools.</i></p>		<p>Feelings Questionnaire</p>		<p>CTS: Youth report: Cut-off ≥ 6; Caregiver report: Cut-off ≥ 8; Young child version: Cut-off ≥ 6</p>	<p>ASQ: "Yes" to any screening question indicates a positive screen for suicidal ideation/behavior</p>
<p>Symptom Monitoring (Indicators of Reliable Change)</p>	<p>PSC: Total Score: Change score of ≥ 6; Subscales: Change score of ≥ 2</p>	<p>PSC: Total Score: Change score of ≥ 6; Subscales: Change score of ≥ 2</p>	<p>PSC: Total Score: Change score of ≥ 6; Subscales: Change score of ≥ 2</p>	<p>CATS: Ages 3–6: Cut-off ≥ 16; Ages 7–17: Cut-off ≥ 21</p>	<p>C-SSRS: Reduction in suicidal ideation, behaviors, or risk categorization</p>
<p>Care Manager Prep for Psychiatric Consultation (Questions to Consider)</p>	<p>Have you/ the patient, or has there been a formal evaluation for ADHD?</p>	<p>Have you/ the patient ever been to the hospital or emergency room for feeling down,</p>	<p>Legal problems, on probation or legal/criminal concerns?</p>		

	<p>Is there an educational plan that has been established with the school?</p>	<p>depressed or hopeless?</p> <p>Do you/ does the patient have trouble falling asleep or staying asleep?</p> <p>Do you/ does the patient have any physical health conditions?</p> <p>Do you have concerns that a physical health condition may be affecting sleep or appetite?</p> <p>Have you noticed any changes in your appetite – eating more or less than usual?</p> <p>Have you (has the patient) noticed any changes in their weight? If not aware, another question may be: Do clothes fit differently?</p> <p>Have there been any changes in your physical health or medications that could be affecting your appetite or weight gain/loss?</p>	<p>Is there an educational plan that has been established with the school?</p>	
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		<p>Have you/ has the patient gone for long periods of time (8 waking hours or more) without eating anything at all in order to influence your/ their shape or weight?</p> <p>How often do you/ does the patient feel overly active and compelled to do things, like you/ they were driven by a motor? (ASRS Q6)</p> <p>Never__ Rarely__ Sometimes__ Often__ Very__</p> <p>(Scoring & Interpretation: https://novopsych.com.au/assessments/diagnosis/adult-adhd-self-report-scale-asrs/)</p>			
<p>Evidence-Based Practices and Treatments</p> <p><i>*Brief skills-based interventions were selected for their proven effectiveness and fit with primary care settings.</i></p>	<p>Programs and Therapies:</p> <ul style="list-style-type: none"> • FAST (First Approach Skills Training) Programs • Problem-Solving Skills Training (PSST) • 4 Rs and 2 Ss • Motivational Interviewing 	<p>Programs and Therapies:</p> <ul style="list-style-type: none"> • FAST (First Approach Skills Training) Programs • Behavioral Activation • Brief Behavioral Therapy (BBT) (Weersing et al., 2017) 	<p>Programs and Therapies:</p> <ul style="list-style-type: none"> • FAST (First Approach Skills Training) Programs 	<p>Programs and Therapies:</p> <ul style="list-style-type: none"> • Psychological First Aid (PFA) • Skills for Psychological Recovery (SPR) 	<p>Programs and Therapies:</p> <ul style="list-style-type: none"> • Stanley-Brown Safety Planning Intervention • CALM (Counseling on Access to Lethal Means)

		<ul style="list-style-type: none"> • Cognitive Behavioral Therapy (CBT) • DBT Skills 			
	Parent Management: <ul style="list-style-type: none"> • Skills training • Classroom behavior management 	Parent Management: <ul style="list-style-type: none"> • SPACE (Supportive Parenting for Anxious Childhood Emotions) 	Parent Management: <ul style="list-style-type: none"> • Classroom behavior management 	Parent Management: <ul style="list-style-type: none"> • 	Parent Management: <ul style="list-style-type: none"> •
Additional Resources	<ul style="list-style-type: none"> • For Professionals CHADD • For Parents CHADD • ADHD Resource Center AACAP • ADHD & Attention Resources Child Mind Institute • Free Materials on ADHD CDC • How To ADHD 	<ul style="list-style-type: none"> • Anxiety Disorders Resource Center AACAP • Depression Resource Center AACAP • Depression & Mood Disorders Child Mind Institute • Anxiety in Children and Teenagers Child Mind Institute 	<ul style="list-style-type: none"> • Conduct Disorder Resource Center AACAP • Behavior Problems Child Mind Institute 	<ul style="list-style-type: none"> • Trauma and Child Abuse Resource Center AACAP • Disaster and Trauma Resource Center AACAP • Trauma and Grief in Children Child Mind Institute 	<ul style="list-style-type: none"> • Suicide Resource Center AACAP • Suicide & Self-Harm Warning Signs Child Mind Institute

Tools for Differential Diagnosis: Psychometric Validation

PSC (Pediatric Symptom Checklist)

- Jellinek, M. S., Murphy, J. M., Robinson, J., Feins, A., Lamb, S., & Fenton, T. (1988). Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics*, 112(2), 201-209. [https://doi.org/10.1016/s0022-3476\(88\)80056-8](https://doi.org/10.1016/s0022-3476(88)80056-8)
- Jellinek, M. S., Murphy, J. M., Little, M., Pagano, M. E., Comer, D. M., & Kelleher, K. J. (1999). Use of the Pediatric Symptom Checklist to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatrics & Adolescent Medicine*, 153(3), 254-260. <https://doi.org/10.1001/archpedi.153.3.254>
- Murphy, J. M., & Jellinek, M. (1988). Screening for psychosocial dysfunction in economically disadvantaged and minority group children: Further validation of the Pediatric Symptom Checklist. *American Journal of Orthopsychiatry*, 58(3), 450-456. <https://doi.org/10.1111/j.1939-0025.1988.tb01605.x>
- Murphy, J. M., Arnett, H. L., Bishop, S. J., Jellinek, M. S., & Reede, J. Y. (1992). Screening for psychosocial dysfunction in pediatric practice. A naturalistic study of the Pediatric Symptom Checklist. *Clinical Pediatrics*, 31(11), 660-667. <https://doi.org/10.1177/000992289203101104>
- Murphy, J. M., Ichinose, C., Hicks, R. C., Kingdon, D., Crist-Whitzel, J., Jordan, P., ... Jellinek, M. S. (1996). Utility of the Pediatric Symptom Checklist as a psychosocial screen to meet the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) standards: A pilot study. *Journal of Pediatrics*, 129(6), 864-869. [https://doi.org/10.1016/s0022-3476\(96\)70030-6](https://doi.org/10.1016/s0022-3476(96)70030-6)

NICHQ Vanderbilt Assessment Scale

- Becker, S. P., Langberg, J. M., Vaughn, A. J., & Epstein, J. N. (2012). Clinical utility of the Vanderbilt ADHD diagnostic parent rating scale comorbidity screening scales. *Journal of Developmental and Behavioral Pediatrics*, 33(3), 221-228. <https://doi.org/10.1097/DBP.0b013e318245615b>
- Wolraich, M. L., Lambert, W., Doffing, M. A., Bickman, L., Simmons, T., & Worley, K. (2003). Psychometric properties of the Vanderbilt ADHD diagnostic parent rating scale in a referred population. *Journal of Pediatric Psychology*, 28(8), 559-567. <https://doi.org/10.1093/jpepsy/jsg046>
- Wolraich, M. L., Lambert, E. W., Bickman, L., Simmons, T., Doffing, M. A., & Worley, K. A. (2004). Assessing the impact of parent and teacher agreement on diagnosing attention-deficit hyperactivity disorder. *Journal of Developmental and Behavioral Pediatrics*, 25(1), 41-47. <https://doi.org/10.1097/00004703-200402000-00007>

SCARED (Scale Child Assessment of Anxiety and Related Emotional Disorders)

- Birmaher, B., Khetarpal, S., Brent, D., Cully, M., Balach, L., Kaufman, J., & Neer, S. M. (1997). The Screen for Child Anxiety Related Emotional Disorders (SCARED): Scale construction and psychometric characteristics. *Journal of the American Academy of Child & Adolescent Psychiatry*, 36(4), 545-553. <https://doi.org/10.1097/00004583-199704000-00018>
- Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): A replication study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(10), 1230-1236. <https://doi.org/10.1097/00004583-199910000-00011>

SCAS (Spence Children's Anxiety Scale)

- Ramme, R. (2018, April). *Spence Children's Anxiety Scale: An overview of psychometric findings*. School of Applied Psychology, Griffith University. <https://www.scaswebsite.com/portfolio/scas-child-psychometric-properties/>
- Spence, S. H. (1998). A measure of anxiety symptoms among children. *Behaviour Research and Therapy*, 36(5), 545-566. [https://doi.org/10.1016/s0005-7967\(98\)00034-5](https://doi.org/10.1016/s0005-7967(98)00034-5)
- Spence, S. H., Barrett, P. M., & Turner, C. M. (2003). Psychometric properties of the Spence Children's Anxiety Scale with young adolescents. *Journal of Anxiety Disorders*, 17(6), 605-625. [https://doi.org/10.1016/s0887-6185\(02\)00236-0](https://doi.org/10.1016/s0887-6185(02)00236-0)

SMFQ (Short Mood and Feelings Questionnaire)

- Angold, A., Costello, E. J., Messer, S. C., Pickles, A., Winder, F., & Silver, D. (1995). The development of a short questionnaire for use in epidemiological studies of depression in children and adolescents. *International Journal of Methods in Psychiatric Research*, 5, 237-249.
- Messer, S. C., Angold, A., Costello, E.J., Loeber, R., Van Kammen, W., & Stouthamer-Loeber, M. (1995). Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents: Factor composition and structure across development. *International Journal of Methods in Psychiatric Research*, 5, 251-262

CTS (Child Trauma Screen)

- Lang, J. M., Connell, C. M., & Macary, S. (2021). Validating the Child Trauma Screen among a cross-sectional sample of youth and caregivers in pediatric primary care. *Clinical Pediatrics*, 60(4-5), 252-258. <https://doi.org/10.1177/00099228211005302>
- Lang, J. M., & Connell, C. M. (2018). The Child Trauma Screen: A follow-up validation. *Journal of Traumatic Stress*, 31(4), 540-548. <https://doi.org/10.1002/jts.22310>
- Lang, J. M., & Connell, C. M. (2017). Development and validation of a brief trauma screening measure for children: The Child Trauma Screen. *Psychological Trauma: Theory, Research, Practice and Policy*, 9(3), 390-398. <https://doi.org/10.1037/tra0000235>

CATS (Child and Adolescent Trauma Screen)

- Sachser, C., Berliner, L., Holt, T., Jensen, T. K., Jungbluth, N., Risch, E., ... Goldbeck, L. (2017). International development and psychometric properties of the Child and Adolescent Trauma Screen (CATS). *Journal of Affective Disorders*, 210, 189-195. <https://doi.org/10.1016/j.jad.2016.12.040>

ASQ (Ask Suicide-Screening Questions)

- Horowitz, L. M., Bridge, J. A., Teach, S. J., Ballard, E., Klima, J., Rosenstein, D. L., ... Pao, M. (2012). Ask Suicide-Screening Questions (ASQ): A brief instrument for the pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine*, 166(12), 1170-1176. <https://doi.org/10.1001/archpediatrics.2012.1276>

C-SSRS (Columbia-Suicide Severity Rating Scale)

- The Columbia Lighthouse Project. (n.d.). *The Columbia Suicide Severity Rating Scale (C-SSRS): Psychometric evidence*. <https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/evidence/>
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., ... Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults.

American Journal of Psychiatry, 168(12), 1266-1277.
<https://doi.org/10.1176/appi.ajp.2011.10111704>

Evidence-Based Practices and Treatments: Evaluation Research

FAST (First Approach Skills Training) Programs

- Blossom, J. B., Jungbluth, N., Bolden, C., Woodruff, M. A., Pringle, W., Read, K. L., ... Schoenfelder Gonzalez, E. (2024). Evaluation of the First Approach Skills Training (FAST) Integrated Pediatric Primary Care Program: Implementation and clinical effectiveness. *Evidence-Based Practice in Child and Adolescent Mental Health*, 1-10. <https://doi.org/10.1080/23794925.2024.2330397>
- Schweitzer, J., Bird, A., Bowers, H., Carr-Lee, N., Gibney, J., Schellinger, K., ... Hollenbach, K. (2023). Developing an innovative pediatric integrated mental health care program: Interdisciplinary team successes and challenges. *Frontiers in Psychiatry*, 14. <https://doi.org/10.3389/fpsy.2023.1252037>

Problem-Solving Skills Training (PSST)

- Zhou, T., Luo, Y., Xiong, W., Meng, Z., Zhang, H., & Zhang, J. (2024). Problem-Solving Skills Training for parents of children with chronic health conditions: A systematic review and meta-analysis. *JAMA Pediatrics*, 178(3), 226-236. <https://doi.org/10.1001/jamapediatrics.2023.5753>

4 Rs and 2 Ss

- Acri, M., Hamovitch, E., Mini, M., Garay, E., Connolly, C., & McKay, M. (2017). Testing the 4Rs and 2Ss Multiple Family Group intervention: Study protocol for a randomized controlled trial. *Trials*, 18(1), 588. <https://doi.org/10.1186/s13063-017-2331-7>
- Acri, M., Falek, I., Hamovitch, E., Gopalan, G., Bornheimer, L., & McKay, M. (2023). An examination of the 4 Rs 2 Ss for problem behaviors: A preventive approach. *Families in Society*, 104(2), 154-166. <https://doi.org/10.1177/10443894221133419>
- Chacko, A., Gopalan, G., Franco, L., Dean-Assael, K., Jackson, J., Marcus, S., Hoagwood, K., & McKay, M. (2015). Multiple family group service model for children with disruptive behavior disorders: Child outcomes at post-treatment. *Journal of Emotional and Behavioral Disorders*, 23(2), 67-77. <https://doi.org/10.1177/1063426614532690>
- Gopalan, G., Chacko, A., Franco, L., Dean-Assael, K. M., Rotko, L. E., Marcus, S. M., Hoagwood, K. E., & McKay, M. M. (2015). Multiple Family Groups for children with disruptive behavior disorders: Child outcomes at 6-month follow-up. *Journal of Child and Family Studies*, 24(9), 2721-2733. <https://doi.org/10.1007/s10826-014-0074-6>

Motivational Interviewing

- Desai N. (2019). The role of motivational interviewing in children and adolescents in pediatric care. *Pediatric Annals*, 48(9), e376-e379. <https://doi.org/10.3928/19382359-20190816-01>
- Erickson, S. J., Gerstle, M., & Feldstein, S. W. (2005). Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health care settings: A review. *Archives of Pediatrics & Adolescent Medicine*, 159(12), 1173-1180. <https://doi.org/10.1001/archpedi.159.12.1173>

Behavioral Activation

- Martin, F., & Oliver, T. (2019). Behavioral activation for children and adolescents: A systematic review of progress and promise. *European Child & Adolescent Psychiatry*, 28(4), 427-441. <https://doi.org/10.1007/s00787-018-1126-z>
- Tindall, L., Kerrigan, P., Li, J., Hayward, E., & Gega, L. (2024). Is behavioural activation an effective treatment for depression in children and adolescents? An updated

systematic review and meta-analysis. *European Child & Adolescent Psychiatry*.
<https://doi.org/10.1007/s00787-024-02429-3>

Brief Behavioral Therapy (BBT)

- Weersing, V. R., Brent, D. A., Rozenman, M. S., Gonzalez, A., Jeffreys, M., Dickerson, J. F., ... Iyengar, S. (2017). Brief Behavioral Therapy for pediatric anxiety and depression in primary care: A randomized clinical trial. *JAMA Psychiatry*, 74(6), 571-578.
<https://doi.org/10.1001/jamapsychiatry.2017.0429>

Cognitive Behavioral Therapy (CBT)

- Krause, K., Zhang, X. C., & Schneider, S. (2024). Long-term effectiveness of cognitive behavioral therapy in routine outpatient care for youth with anxiety disorders. *Psychotherapy and Psychosomatics*, 93(3), 181-190. <https://doi.org/10.1159/000537932>
- Spirito, A., Esposito-Smythers, C., Wolff, J., & Uhl, K. (2011). Cognitive-behavioral therapy for adolescent depression and suicidality. *Child and Adolescent Psychiatric Clinics of North America*, 20(2), 191-204. <https://doi.org/10.1016/j.chc.2011.01.012>

SPACE (Supportive Parenting for Anxious Childhood Emotions)

- Lebowitz, E. R., Marin, C., Martino, A., Shimshoni, Y., & Silverman, W. K. (2020). Parent-based treatment as efficacious as cognitive-behavioral therapy for childhood anxiety: A randomized noninferiority study of supportive parenting for anxious childhood emotions. *Journal of the American Academy of Child and Adolescent Psychiatry*, 59(3), 362-372. <https://doi.org/10.1016/j.jaac.2019.02.014>

DBT (Dialectical Behavior Therapy) Skills

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<https://doi.org/10.1111/j.1475-3588.2011.00611.x>
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- Petsagourakis, D., Driscoll, C., Viswanadhan, K., & Lois, B. H. (2024). Promoting validation and acceptance: Clinical applications of dialectical behavior therapy with pediatric populations and systems. *Cognitive and Behavioral Practice*, 31(3), 299-312.
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Psychological First Aid (PFA)

- L, G., K, M., J, N., A, T. L., E, T., M, U., ... E, C. V. (2021). Child and adolescent psychosocial support programs following natural disasters: A scoping review of emerging evidence. *Current Psychiatry Reports*, 23(12), 82.
<https://doi.org/10.1007/s11920-021-01293-1>

Skills for Psychological Recovery (SPR)

- L, G., K, M., J, N., A, T. L., E, T., M, U., ... E, C. V. (2021). Child and adolescent psychosocial support programs following natural disasters: A scoping review of emerging evidence. *Current Psychiatry Reports*, 23(12), 82.
<https://doi.org/10.1007/s11920-021-01293-1>

Stanley-Brown Safety Planning Intervention

- Stanley, B., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G. W., Knox, K. L., ... Green, K. L. (2018). Comparison of the Safety Planning Intervention with follow-up vs

usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*, 75(9), 894-900. <https://doi.org/10.1001/jamapsychiatry.2018.1776>

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CALM (Counseling on Access to Lethal Means)

- Barber, C. W., & Miller, M. J. (2014). Reducing a suicidal person's access to lethal means of suicide: A research agenda. *American Journal of Preventive Medicine*, 47(3 Suppl 2), S264-S272. <https://doi.org/10.1016/j.amepre.2014.05.028>

	Comprehensive Assessment Tools		Attention Assessment Tools				Anxiety Assessment Tools				Depression Assessment Tools			Trauma Assessment Tools			Suicide Risk Assessment Tools																																																																																																																																																																																																									
	PSC (Pediatric Symptom Checklist)	PROMS (Parent Reported Outcomes Measurement Information System)	NICHQ Vanderbilt Assessment Scale (21-18) and Follow-up (20-26)	GDQ (Global Impairment of Perceived Difficulties) Scale	SNAP-IV 26-item scale	SWAN (Strengths and Weaknesses of Attention-Difficulties/Impulsivity Disorder Symptoms and Normal Behavior Scales)	SCARED (Screen for Child Anxiety Related Emotional Disorders)	SCAS (Spence Children's Anxiety Scale)	CAHQ (Children's Anxiety Impact Scale)	QASIS (Child Anxiety Severity and Impairment Scale)	SMFQ (Short Mood and Feelings Questionnaire)	CEDAC (Center for Epidemiological Studies Depression Scale for Children)	CTS (Child Trauma Screen)	CAT5 (Child and Adolescent Trauma Screen)	CPSS (Child PTSD Symptom Scale)	CAPE-CA-4 (Clinician Administered PTSD Scale for DSM-5 - Child and Adolescent Version)	ASQ (Ask Suicide-Screening Questions)	C-SSRS (Columbia-Suicide Severity Rating Scale)																																																																																																																																																																																																								
Description	Screens for emotional, behavioral, and cognitive symptoms	Assesses physical, mental, and social health across various domains	Evaluates symptoms of ADHD and related disorders	Assesses perceived difficulties in various domains related to ADHD	Evaluates symptoms of ADHD and oppositional defiant disorder	Measures ADHD symptoms and normal behavior	Screens for anxiety disorders	Assesses anxiety severity	Measures the impact of anxiety on daily functioning	Assesses severity and impact of anxiety	Screens for depressive symptoms	Evaluates depressive symptoms	Assesses exposure to traumatic events and associated symptoms	Evaluates trauma symptoms and functional impairment	Measures PTSD symptoms and severity	Assesses PTSD symptoms based on DSM-5 criteria	Screens for suicidal ideation and intent	Evaluates the severity and risk of suicide																																																																																																																																																																																																								
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Outcome Measures	Total Score: A change score of 4 or greater indicates reliable change. Subscale: Changes of 2 or more points indicate reliable change.	Group Composite: A change score of 3 T-score points or more generally indicates a meaningful difference. Individual Assessment: A change score of 10 points or more is considered indicative of reliable improvement or deterioration.	A 50% reduction in total score from baseline is considered indicative of meaningful improvement.	A 50% reduction in perceived difficulties at 70 days compared to baseline is considered significant.	Suggested Targets: Inattention: A score of less than 13 out of 26 indicates improvement. Hyperactivity/Impulsivity: A score of less than 23 out of 26 indicates improvement. Oppositional Defiant Disorder: A score of less than 8 out of 24 indicates improvement.	A total score of 25 or higher may indicate the presence of an anxiety disorder; scores higher than 30 are more specific. A T-score less than 60 (percentile score was less than 85%) is within the "normal" range. A T-score of 60 or more (top 15% or more) suggests "borderline" anxiety, though not necessarily clinical. A T-score of 65 indicates the child is in the top 6% of children. A T-score of 70 indicates the child is in the top 2% of children.	A cutoff score of 8 correctly classifies 87% of a clinical population sample as having an anxiety diagnosis or not. Self-report: A change score of 6 is considered significant.	Caregiver Report: A change score of 8 is considered significant. Self-report: A change score of 6 is considered significant.	A score of 15 or higher indicates a risk for depression in children and adolescents. A cutoff score of 8 or greater indicates a high likelihood of PTSD diagnosis and is recommended for referrals for trauma-focused assessment/treatment. Ages 3-6: A cutoff score of 16 or higher indicates clinically relevant symptoms in preschool children. Ages 7-17: A cutoff score of 21 or higher indicates clinically relevant symptoms.	A symptom is considered present if the corresponding item severity score is rated 2 ("moderate/severe") or higher. A "Yes" response to any one of the four screening questions indicates a positive screen for suicidal ideation or behavior. A reduction in suicidal ideation, behavior, or risk categorization is considered indicative of an improvement in the patient's condition, and is assessed by a clinician in the Researcher's interview, a reduction in suicidal thoughts, or a shift from a higher to a lower risk category.																																																																																																																																																																																																																
Authors	Jellinek, Murphy, & Burns, 1996	National Institutes of Health (NIH)	National Institute for Children's Health Quality (NICHQ)	Wehmer et al., 2008	Swanson et al., 1983; Swanson, 1992	Swanson et al., 2004	Birmaher et al., 1997	Spence, 1998	Norman et al., 2006	Angold & Costello, 1987	Weissman, Oroschick, & Pallas, 1989	Lang & Cornell, 2017	Sachser et al., 2017	Fox et al., 2001	National Center for PTSD	Horowitz et al., 2012	Pomer et al., 2008																																																																																																																																																																																																									
Citations	Jellinek et al., 1996; Jellinek et al., 2009; Murphy & Jellinek, 1996; Murphy et al., 1996	Wahl et al., 2010; Wahl et al., 2012	Bauer et al., 2012; Wahl et al., 2009; Wahl et al., 2008	Wehmer et al., 2008	Swanson et al., 2006; Swanson, Oroschick, & Pallas, 1989	Wahl et al., 2015; Wahl, Swanson, & Pomer, 2012	Birmaher et al., 1997; Birmaher et al., 1994	Spence, 1998; Swanson, Birmaher, & Turner, 2003	Langley et al., 2014	Canino et al., 2009; Norman et al., 2006	Angold et al., 1995; Meuser et al., 1995	Faulstich et al., 1989; Langley, Swanson, Birmaher, 1992; Wehmer, Oroschick, & Pallas, 1989	Lang & Cornell, 2017	Sachser et al., 2017	Fox et al., 2001; Gidycz et al., 2001	Koussis et al., 2003	Horowitz et al., 2012	The Columbia-Liberty, France, and Center et al., 2011																																																																																																																																																																																																								
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Notes/Comments	Although the PROMS assessment system is not included in the pathway due to its unique structure, we recognize it as a valuable tool supported by robust research and an effective alternative to the validated tools we have listed.																																																																																																																																																																																																																									