ECHO IDAHO

K12 School Nurses

Management of Mental and Behavioral Health Part 1

12/10/25

KC Knudson, DO, Child Psychiatrist
Noreen Womack, MD, Pediatrician
St. Luke's Children's Hospital

None of the planners or presenters for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

University of Idaho
School of Health and Medical Professions
College of Education, Health and Human Sciences

Project ECHO

Learning Objectives

- Review DSM V criteria for Depression Disorder, Anxiety Disorder, Attention Deficit and Hyperactivity Disorder, Oppositional Defiant Disorder and Disruptive Mood Dysregulation Disorder
- Review student cases that illustrate common presentations of the above disorders
- Discuss management strategies for school personnel

ADHD in Youth

- “ADHD” = Attention Deficit Hyperactivity Disorder
  - Poor focus/concentration, easily distracted, fidgety, restless, disruptive
- What constitutes a diagnosable disorder?
  - When child/adolescent is experiencing distress related to the disorder
    - Failing classes
    - Disruptive in the classroom/at home
    - Struggling with friendships
  - Impairment in functioning within everyday life
- Approximately 11.4% of U.S. children aged 3-17 years have been diagnosed with ADHD (data from 2022)
  - Boys (15%) more likely to be diagnosed with ADHD than girls (8%)

ADHD – Diagnostic Criteria

People with ADHD show a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development:

1. Inattention: Six or more symptoms of inattention for children up to age 16 years, or five or more for adolescents age 17 years and older and adults; symptoms of inattention have been present for at least 6 months, and they are inappropriate for developmental level:
    - Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities.
    - Often has trouble holding attention on tasks or play activities.
    - Often does not seem to listen when spoken to directly.
    - Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked).
    - Often has trouble organizing tasks and activities.
    - Often avoids, dislikes, or is reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework).
    - Often loses things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
    - Is often easily distracted
    - Is often forgetful in daily activities.

ADHD – Diagnostic Criteria

2. Hyperactivity and Impulsivity: Six or more symptoms of hyperactivity-impulsivity for children up to age 16 years, or five or more for adolescents age, 17 years and older and adults; symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for the person's developmental level:

- Often fidgets with or taps hands or feet, or squirms in seat.
- Often leaves seat in situations when remaining seated is expected.
- Often runs about or climbs in situations where it is not appropriate (adolescents or adults may be limited to feeling restless).
- Often unable to play or take part in leisure activities quietly.
- Is often "on the go" acting as if "driven by a motor".
- Often talks excessively.
- Often blurts out an answer before a question has been completed.
- Often has trouble waiting their turn.
- Often interrupts or intrudes on others (e.g., butts into conversations or games)

ADHD – Diagnostic Criteria

Based on the types of symptoms, 3 kinds (presentations) of ADHD can occur:

1. Combined Presentation: if enough symptoms of both criteria inattention and hyperactivity-impulsivity were present for the past 6 months
2. Predominantly Inattentive Presentation: if enough symptoms of inattention, but not hyperactivity-impulsivity, were present for the past six months
3. Predominantly Hyperactive-Impulsive Presentation: if enough symptoms of hyperactivity-impulsivity, but not inattention, were present for the past six months.

University of Idaho
School of Health and Medical Professions
College of Education, Health and Human Sciences
Project ECHO

6-year-old male

- First year of formal instruction – no preschool attendance
- “Bullying” other children. To get attention from classmates, would run and tackle them
- Always moving, short attention span despite sitting next to his teacher or in front of the classroom
- His behavior was distracting to those around them
- Other students exhibited similar behaviors at times, but teacher noticed this behavior all during the day, every day

6-year-old male, cont'd-Teacher Vanderbilt

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	(3)
2. Has difficulty sustaining attention to tasks or activities	0	1	2	(3)
3. Does not seem to listen when spoken to directly	0	1	(2)	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	(3)
5. Has difficulty organizing tasks and activities	0	1	2	(3)
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	(2)	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	(3)
8. Is easily distracted by extraneous stimuli	0	1	2	(3)
9. Is forgetful in daily activities	0	1	2	(3)
10. Fidgets with hands or feet or squirms in seat	0	1	2	(3)
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	(2)	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	(1)	2	3
13. Has difficulty playing or engaging in leisure activities quietly	(0)	(1)	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	(2)	3
15. Talks excessively	0	1	2	(3)
16. Blurts out answers before questions have been completed	0	1	2	(3)
17. Has difficulty waiting in line	0	1	(2)	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	(3)
19. Loses temper	(0)	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	(2)	3
21. Is angry or resentful	(0)	1	2	3
22. Is spiteful and vindictive	(0)	1	2	3
23. Bullies, threatens, or intimidates others	(0)	1	2	3
24. Initiates physical fights	(0)	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	(1)	2	3
26. Is physically cruel to people	(0)	1	2	3
27. Has stolen items of nontrivial value	0	(1)	2	3
28. Deliberately destroys others' property	0	(1)	2	3
29. Is fearful, anxious, or worried	(0)	1	2	3
30. Is self-conscious or easily embarrassed	(0)	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	(1)	2	3

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	(1)	2	3
33. Blames self for problems; feels guilty	0	1	(2)	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	(1)	2	3
35. Is sad, unhappy, or depressed	0	(1)	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	(5)
37. Mathematics	1	2	3	4	(5)
38. Written expression	1	2	3	4	(5)

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	(4)	5
40. Following directions	1	2	3	4	(5)
41. Disrupting class	1	2	3	4	(5)
42. Assignment completion	1	2	3	4	(5)
43. Organizational skills	1	2	3	(4)	5

University of Idaho
School of Health and Medical Professions
College of Education, Health and Human Sciences

Project ECHO

6-year-old male, continued

- Seen in clinic twice, second time teacher and family Vanderbilt questionnaires were reviewed, and diagnosed with ADHD
- Started seeing a behavioral consultant and started on long-acting methylphenidate (Concerta), and behaviors improved
- Note: young children have short attentions and are physically active, but the pervasiveness and impairment are what leads to diagnosis

Oppositional Defiant Disorder = “ODD”

- Symptoms for ODD are of three types: *angry/irritable mood, argumentative/defiant behavior,* and *vindictiveness.* (Vindictiveness is a strong desire to get back at someone. People who hold grudges and seek revenge are full of vindictiveness)
- For a child or adolescent to qualify for a diagnosis of ODD, behaviors must cause considerable distress for the family or interfere significantly with academic or social functioning.
- Interference might take the form of preventing the child or adolescent from learning at school or making friends, or placing him or her in harmful situations.

ODD in Youth

Note:

- The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic.
- For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8).
- For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8).
- While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

ODD Diagnostic Criteria

A. A pattern of angry/irritable mood, argumentative/defiant behavior, or vindictiveness lasting at least 6 months as evidenced by at least four symptoms from any of the following categories, and exhibited during interaction with at least one individual who is not a sibling.

Angry/Irritable Mood

- 1. Often loses temper.
- 2. Is often touchy or easily annoyed.
- 3. Is often angry and resentful.

ODD Diagnostic Criteria

Argumentative/Defiant Behavior

- 4. Often argues with authority figures or, for children and adolescents, with adults.
- 5. Often actively defies or refuses to comply with requests from authority figures or with rules.
- 6. Often deliberately annoys others.
- 7. Often blames others for his or her mistakes or misbehavior.

Vindictiveness

- 8. Has been spiteful or vindictive at least twice within the past 6 months.

ODD Diagnostic Criteria

Note:

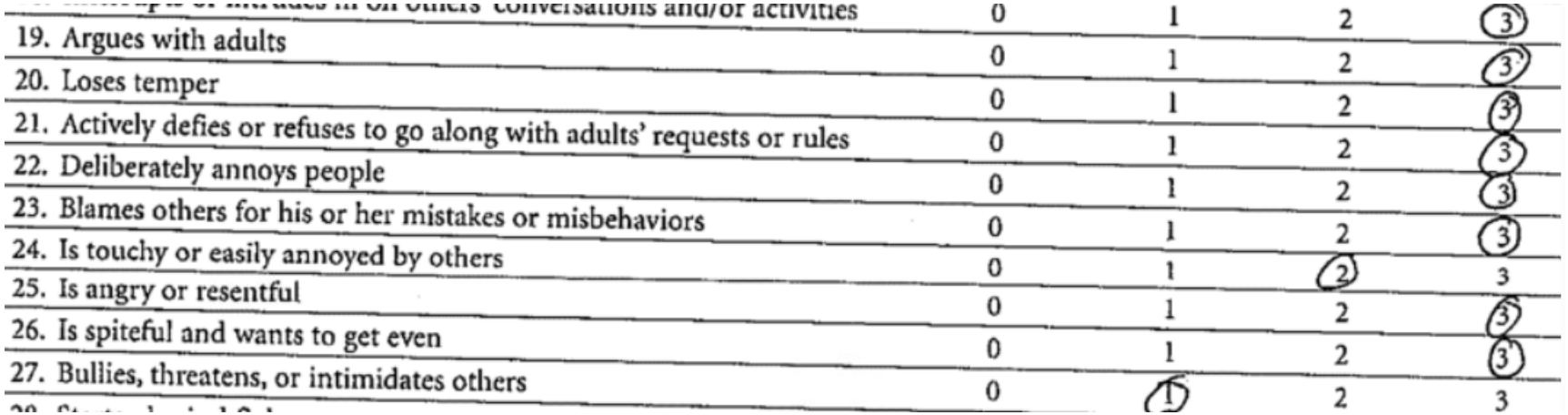
- The persistence and frequency of these behaviors should be used to distinguish a behavior that is within normal limits from a behavior that is symptomatic.
- For children younger than 5 years, the behavior should occur on most days for a period of at least 6 months unless otherwise noted (Criterion A8).
- For individuals 5 years or older, the behavior should occur at least once per week for at least 6 months, unless otherwise noted (Criterion A8).
- While these frequency criteria provide guidance on a minimal level of frequency to define symptoms, other factors should also be considered, such as whether the frequency and intensity of the behaviors are outside a range that is normative for the individual's developmental level, gender, and culture.

8 year old male

- Presented as a referral from the school for behavior issues and stitch removal (he was playing with a bow saw)
- “Big” behaviors since age 3 years, getting worse: emotional outbursts, meltdowns, hits his mother and grandmother when they take away screen time. Mom feels he is baseline irritable. Manipulative, blames things on others.
- Pertinent history: dad is in Alaska with the military, and has anger issues per mom. Mylo says dad yells and threatens to hit him but never has. They moved to Idaho when he was being bullied in school in Alaska: mom said he would come home with bruises. He is not reading yet
- Plays violent video games: Fortnite. He has been bullied and will physically retaliate

8-year-old male, continued

Vanderbilt questionnaire from parent is below:



[illegible] conversations and/or activities	0	1	2	(3)
19. Argues with adults	0	1	2	(3)
20. Loses temper	0	1	2	(3)
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	(3)
22. Deliberately annoys people	0	1	2	(3)
23. Blames others for his or her mistakes or misbehaviors	0	1	2	(3)
24. Is touchy or easily annoyed by others	0	1	(2)	3
25. Is angry or resentful	0	1	2	(3)
26. Is spiteful and wants to get even	0	1	2	(3)
27. Bullies, threatens, or intimidates others	0	(1)	2	3
[illegible]				

- Diagnosed with ODD
- Started counseling and guanfacine, with some improvement in emotional regulation
- Note: as with other mental health diagnoses, ODD is thought to be caused by genetic, environmental and neurobiological factors

Disruptive Mood Dysregulation Disorder = "DMDD"

- Disrupted family life and peer relationships
- Poor school performance
- Risk high for dangerous, violent, suicidal behaviors, and for psychiatric hospitalizations
- Predominantly male
- Differs from bipolar and IED – irritability in these is NOT episodic
- If PDD also present, DMDD takes precedence

DMDD Diagnostic Criteria

- Severe recurrent temper tantrums - verbal or behavioral – grossly out of proportion to provocation
  - Inconsistent with developmental level
  - Occur on average 3 or more times per week
- Mood between tantrums persistently irritable or angry
- Temper and mood symptoms
  - Present for at least 12 months
  - Present in at least two of three settings (home, school, with peers)
- Do not diagnose before age 6 or after age 18 years
- Age of onset is before age 10 years
- Cannot be comorbid with ODD, Bipolar or IED

DMDD Case Presentation

A 9-year-old boy is brought to you by his parents for concerns of volatile mood and aggressive behaviors. He feels irritable every day, most of the time. He got suspended from school for throwing a desk at a peer who was making faces at him. He broke his tablet at home last week when asked to turn the tv down.

University of Idaho
School of Health and Medical Professions
College of Education, Health and Human Sciences
Project ECHO

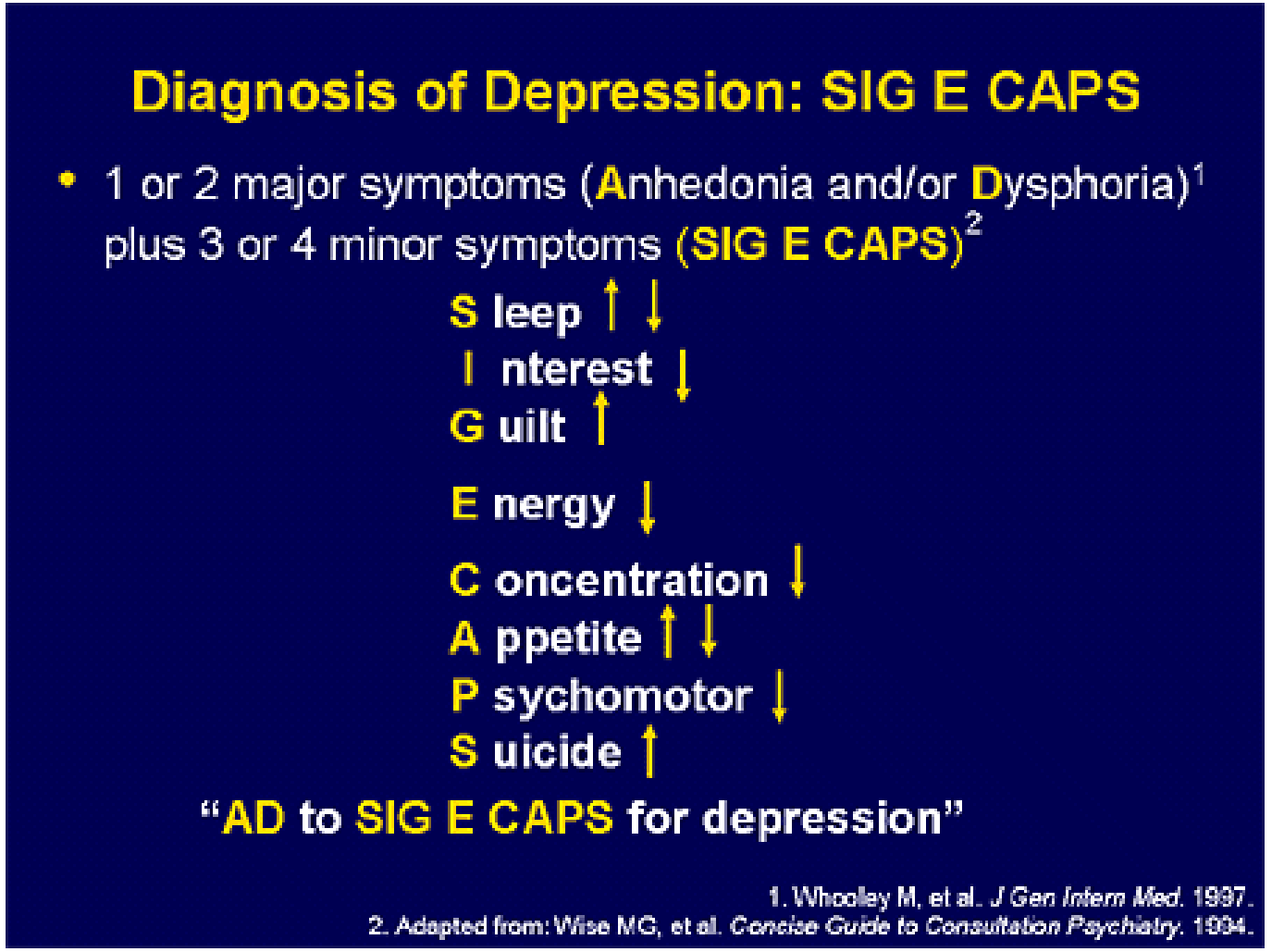
Depression in Youth

- Lifetime prevalence – Overall: 17%
  – F:M: 1.7:1
- 4% of children ages 3-17 had current, diagnosed depression (3% of males and 6% of females).
- Among children with depression, 79% received treatment or counseling, compared with 59% of children with anxiety and 52% of children with behavior disorders.
- Among US adolescents ages 12–17 in 2021-2022
  - 17% reported symptoms of depression in the past two weeks.

Depressive Disorders

- Major Depressive Disorder
- Persistent Depressive Disorder (dysthymia)
- Premenstrual Dysphoric Disorder
- Disruptive Mood Dysregulation Disorder (DMDD)
- Substance(or medication) induced Depressive Disorder
- Depressive Disorder due to another medical condition
- Other specified depressive disorder
- Unspecified depressive disorder

Major Depression Diagnostic Criteria



***Depressed children/adolescents may have an irritable mood rather than a sad mood.

University of Idaho
School of Health and Medical Professions
College of Education, Health and Human Sciences
Project ECHO

Persistent Depressive Disorder

*** Symptoms only have to persist for 1 year in children

Premenstrual Depressive Disorder

Substance Induced Depressive Disorder

Depression Due to Another Medical Condition

Test	Conditions to Rule Out
CBC, ferritin and TIBC	Anemias, infections
Electrolytes, calcium, magnesium	Hyponatremia, SIADH
Glucose	Diabetes, hypoglycemia
BUN/Creatinine	Renal disease
TSH	Hypo- and hyper-thyroidism
Liver enzymes	Hepatic disease
Vitamin B_{12}	B12 deficiency
Urine toxicology screen	Substance use disorders

15-year-old female

- 15-year-old female presented frequently to the school nurse for nausea, abdominal pain. “No absences” but multiple calls to home and leaving school early
- When speaking to mom, learned that she had been doing online school for the last 4 years, and just started attending school this fall. Mom mentioned worry about recent 10-pound weight loss
- PHQ-9: 22. on Columbia screening was low risk for suicidal ideation
- After workup: Abdominal pain due to constipation. Diagnosis: Depression DO, Eating DO.
- Started counseling recently, and ”really likes” her counselor, recent appropriate weight gain, being followed by the Adolescent clinic
- Note: many behavioral diagnoses present with physical complaints
- Note: Student mentioned that daily check-ins with her school counselor help

Anxiety Disorders

- Generalized Anxiety disorder, Social Anxiety disorder, Panic Disorder, Obsessive compulsive disorder
- Very common (5-10% in youth), including types we don't think as much about in adults!!
- Tend to travel in packs - I.E., the most common comorbidity of one anxiety disorder is another anxiety disorder
- Watch for the onset of OCD – It begins in childhood and is often missed (average time to diagnosis is 10 years), often travels with tic disorders and ADHD
- Consider – is this secondary to trauma or ADHD?

Generalized Anxiety Disorder Diagnostic Criteria

- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months (*Note: Only one item is required for children.)
  - Restlessness or feeling keyed up or on edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability.
  - Muscle tension.
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

Other Anxiety Disorder Diagnostic Considerations

- Social Anxiety Disorder
  - With social anxiety, some symptoms of GAD, such as fatigue, restlessness, and irritability, may occur along with difficulty making eye contact, rigid body posture, and feelings of self-consciousness or fear that people will judge them negatively.
- Panic Disorder
  - With panic disorder, some of the GAD symptoms may overlap as well, but additional symptoms can include physical signs, such as excessive sweating, racing heartbeat, chest pain, feeling of impending doom, and feeling of being out of control.
- Selective Mutism
  - In children, a related condition with anxiety is selective mutism, where they do not speak in social situations when they are asked or expected to talk in small or large groups, such as at school. They do tend to speak around immediate family members but often will not talk to other people. Selective mutism may not be identified until a child enters school, but usually begins before age 5. Many children outgrow this condition
- Separation Anxiety Disorder
  - This tends to be part of normal development for children from age eighteen months until three years when parent leaves (i.e., “stranger danger” phase), or perhaps when entering a new situation such as starting school. If persisting beyond that timeframe and/or taking longer to calm down than their peers

14-year-old male

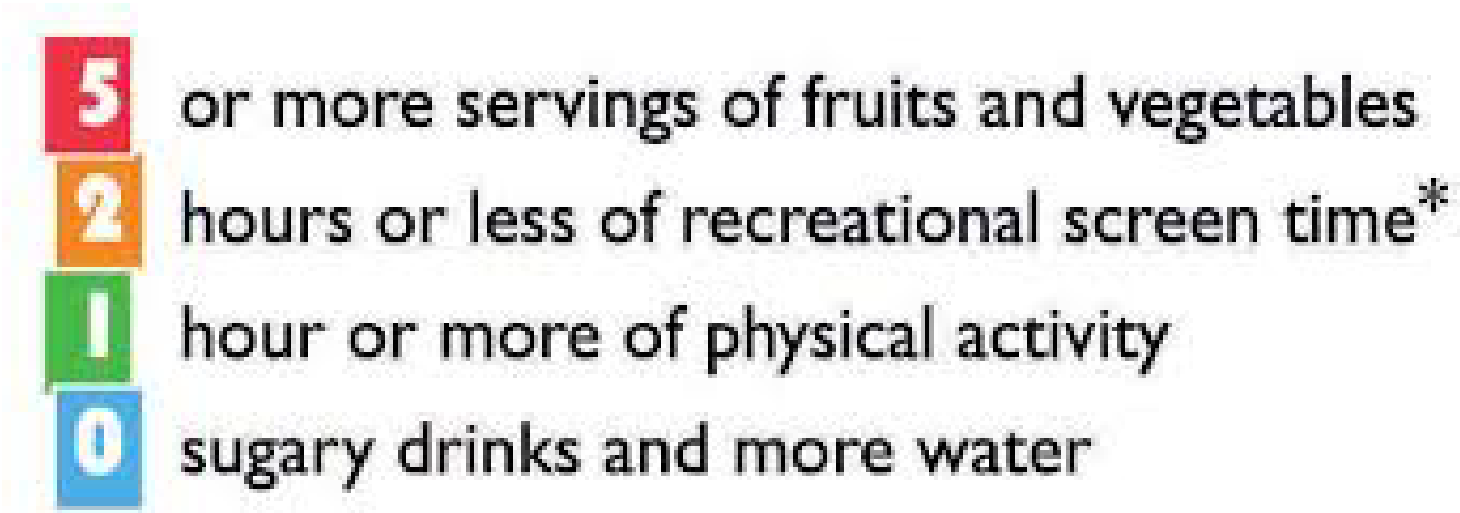
- Native Spanish-speaker who presented to the clinic for chest pain and difficulty breathing at rest. He has missed 19 days of school in the fall semester
- Workup in the ED 3 months prior to clinic visit showed negative CXR, EKG
- Other pertinent history
  - emigrated from Colombia 13 month prior with mom and stepdad. Mom admits Jose will cry with worry that he will lose her
  - Poor sleep
- High scoring on GAD7 and SCARED questionnaires – diagnosis: Generalized Anxiety Disorder and Separation Anxiety Disorder
- Discussion with mom regarding continuous/gradual exposure to school is the best way around school avoidance
- Note: School enrolled him in an ESL group of peers, which he has enjoyed

Recognizing comorbidities

- In 2018-2019: 1 in 7 children ages 3 to 17 (13%) had a current, diagnosed mental or behavioral health condition.
- Anxiety Disorder can occur alongside other mental health diagnoses: Substance use, Depression, ADHD, **Childhood Trauma**
- The core symptoms of Anxiety Disorder overlap with many other conditions. They can also be a normal, adaptive response to life circumstances and can even be helpful (e.g., studying for a test)
- Anxiety Disorder can be more prevalent in certain populations

Other ways to help students decrease anxiety

- Be a link between the school and the family
- Listening is a powerful tool. Practice “WAITing” Communication is key
- Trauma-informed care
- Enlist the help of your colleagues in administration, social work, and counseling
- Encourage healthy habits! Physical health and mental health are inextricably linked



Key Points

- School personnel are often the first to identify students that may need further evaluation. One of the major diagnostic criteria for all of these disorders is IMPAIRMENT. If a student's behavior has required the attention of more than their classroom teacher, and behaviors persist or worsen despite customary interventions, then please refer, starting with the primary physician
- It can be at times difficult to have open lines of communication and understanding with families.
- Listening skills and trauma-informed skills can be crucial. We must continue to reframe our question from what is
- WAIT ("Why Am I Talking?")

Key Points

- In 2018-2019: 1 in 7 children ages 3 to 17 (13%) had a current, diagnosed mental or behavioral health condition.
- Comorbitidities are common among mental health diagnoses: Substance use, Depression, ADHD, **Childhood Trauma**

References

- Health Resources and Services Administration. (October, 2020). *National Survey of Children's Health Mental and Behavioral Health, 2018-2019.* [Issue Brief]
- Aap.org – parents resources for mental health
- ADAA.org – clinician resources Anxiety & Depression Association of America
- Social Media and Youth Mental Health, US Surgeon General's Advisory, 2023

References

- Danielson ML, Claussen AH, Bitsko RH, et al. ADHD Prevalence Among U.S. Children and Adolescents in 2022: Diagnosis, Severity, Co-Occurring Disorders, and Treatment. J Clin Child Adolesc Psychol. Published online May 22, 2024.
- Bitsko RH, Claussen AH, Lichstein J, et al. Mental health surveillance among children—United States, 2013–2019. MMWR Suppl. 2022;71(2):1-48.
- The Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM–5; American Psychiatric Association, 2013).
- Child and Adolescent Health Measurement Initiative. (2021-2022). National Survey of Children's Health. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).
- National Center for Health Statistics. (2021-2022). National Health Interview Survey— Teen. Generated interactively: Aug 06 2024 from https://wwwn.cdc.gov/NHISDataQueryTool/NHIS_TEEN/index.html