Maternal Depression

Screening For Postpartum Depression at Infant Well-Visits:

Screening, Follow-up and Referral

Community Care of North Carolina

February, 2017

Contents

Background

ASSUMPTIONS: (links to resources provided)
PCC's (Primary Care Clinicians) are conversant with:

- The AAP Statement on perinatal and postpartum depression:

  Earls MF, Committee on Psychosocial Aspects of Child and Family Health American Academy of Pediatrics. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics.* 2010;126(5):1032–1039. http://pediatrics.aappublications.org/content/pediatrics/early/2010/10/25/peds.2010-2348.full.pdf
- CCNC Pediatrics "one pager" on maternal depression screening https://www.communitycarenc.org/media/files/maternal-depression-screening-2016.pdf
- CCNC Pediatrics Coding Guidance on developmental/behavioral/social-emotional screening https://www.communitycarenc.org/media/files/coding-developmental-behavioral-screening.pdf

USPSTF

- Recommends perinatal depression screening using either the Edinburgh or PHQ-9
- Grade B recommendation
- January 2016
- Therefore mandates payment by all commercial payers, without cost-sharing, under the Affordable Care Act (ACA)

Source:
http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1

NQF

- NQF 1401: Maternal Depression Screening
- Endorsed by CMS for EHR Incentive Program 2013
- % of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and child during the child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life

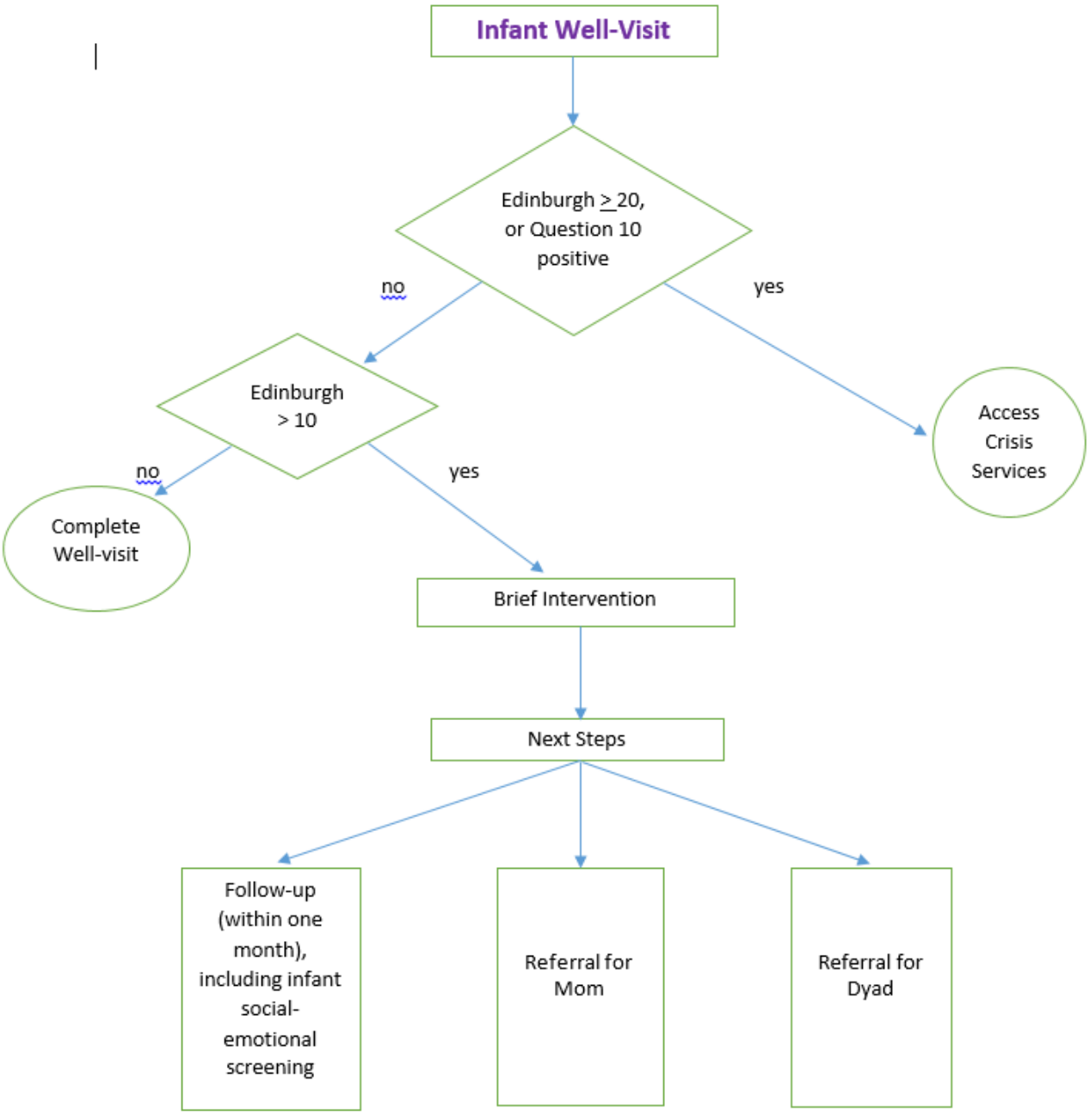
CMS Guidance May 11, 2016

- Based on AAP 2010 Clinical Report
- On May 11, 2016, the Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin on maternal depression screening and treatment, emphasizing the importance of early screening for maternal depression and clarifying the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences, and connecting mothers and children to the help they need.
- State Medicaid agencies may cover maternal depression screening as part of a well-child visit.
- In addition to screenings, states must also cover any medically necessary treatment for the child as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additionally, treatment for maternal depression that includes both the child and the parent, such as family counseling, may also be paid for under EPSDT.
- While Medicaid programs are permitted to pay for these services, states must affirmatively act to implement coverage. States also have discretion regarding the procedures used to pay pediatricians for providing maternal depression screening services.

Evidence-based Interventions for the Dyad.

- Circle of Security (www.circleofsecurity.org)
- Child-Parent Psychotherapy (Child First)
- ABC (Attachment & Biobehavioral Catch up)

Algorithm


Infant Well-Visit
Edinburgh ≥ 20, or Question 10 positive
no
yes
Edinburgh > 10
Access Crisis Services
no
yes
Complete Well-visit
Brief Intervention
Next Steps
Follow-up (within one month), including infant social-emotional screening
Referral for Mom
Referral for Dyad

Screening Guidance

- Edinburgh Postpartum Depression Scale; PHQ-2 followed by the Edinburgh or PHQ-9
    - Massachusetts version of SWYC (Survey of Well-Being of Young Children) contains the Edinburgh
- Screen at the 1, 2, 4, and 6 month well visits
- *When positive, follow-up screen to assess attachment between the mother and infant within the next month.*
- ASQ SE-2 (Ages and Stages Questionnaire- Social-Emotional 2), BPSC (Baby Pediatric Symptom Checklist)

Edinburgh Postpartum Depression Scale

- Completed by the mother
- At 1 month, 2 month, 4 month, 6 month visits
- Simple 10 multiple choice questions
- Score of 10 or greater indicates possible depression
- English and Spanish
- Sensitivity – 86%; Specificity – 78%
- Available on line

Coding for Screening

- AAP recognizes the screening as a measure of risk in the infant's environment.
- CMS endorsed coverage under EPSDT at infant visits (May 2016)
- Billing is appropriate at the infant's visit.
- CPT code 96161 for the Edinburgh (for *caregiver-focused health risk assessment for the benefit of the patient, new in January 2017)*
- CPT code for ASQ-SE or BPSC is 96127
- If there are concerns about the dyad relationship, the code Z62.898, Parent-infant Bonding Problem, or Z62.820, Relationship Specific Disorder or Infancy/Early Childhood, (published in the DC: 0-5 - Diagnostic Classification for 0-5 year olds, 2016) can be used as secondary to the well-visit code.

Brief Intervention

- Strengthen the mother-child relationship.
- Understand and respond to baby's cues.
- Encourage routines for predictability and security.
- Focus on wellness: sleep, diet, exercise, stress relief.
- Acknowledge, accept and heal personal experiences.
- Encourage realistic expectations; prioritize important things.
- Encourage social connections.

Referral and Follow-up

Immediate Action

If the Edinburgh Score is 20 or greater or the answer to question 10 is yes, or
If the mother expresses concern about her or her baby's safety, or

If the PCC suspects the mother is suicidal, homicidal, severely depressed/manic or psychotic…

- ✓ Refer for emergency mental health services
- ✓ Be sure she leaves with a support person (not alone) and has a safety plan

If Screening shows a concern

- Communication
- Demystification
- Support Resources – family, community
- Referrals:
    - Integrated/Co-located Mental Health Provider
    - For mom
    - For dyad (*note: refer all to CC4C*)
    - For child for targeted prevention and early intervention

Intervention

- For Mom – Ranges from:

    support, to
    therapy, to
    therapy plus medication, to
    emergency mental health services/hospitalization.

- For Dyad Relationship – Includes:

  therapy with child mental health professional re: attachment and bonding;
  follow-up social-emotional screen, and
  if Attachment Disorder of Infancy, referral to Part C.

For Mom

- Who?
  - Mother's PCC
  - Mental health provider
  - Mother's obstetrician
- For
  - Individual and/or couple's therapy
  - Medication management

For Dyad

- Referral to CC4C
- The mother and child need to be referred to a professional with expertise in infant and early childhood mental health.
- Evidenced based treatments
  - Circle of Security (www.circleofsecurity.org)
  - Child-Parent Psychotherapy (Child First)
  - ABC (Attachment & Biobehavioral Catch up)
- Part C services can provide modeling for interaction and play with the infant to promote healthy development

Follow-up Plan

Follow-up at more frequent intervals for support and monitoring. Social-emotional screening for the infant.

Co-management with the Mental Health Professional serving the dyad

- Established referral relationship
- Warm hand off to the MHP
- Standardized exchange of information (see AAP-AACAP joint statement on HIPAA and communication between PCC and MHP: www.aap.org/mentalhealth click on Key Resources, then HIPAA Privacy Rule and Provider to Provider Communication)
- Shared record if integrated or co-located

Resources

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Patient Health Questionnaire-2

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Feeling down, depressed, or hopeless.

0 = Not at all

1 = Several days

2 = More than half the days

3 = Nearly every day

Total point score: _____

Information from Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

Source:
Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110

Patient Health Questionnaire-2
Instructions for Use

The PHQ-2 includes the first 2 items of the PHQ-9. The stem question is, "Over the past 2 weeks, how often have you been bothered by any of the following problems?" The 2 items are "Little interest or pleasure in doing things" and "Feeling down, depressed, or hopeless." For each item, the response options are "Not at all," "Several days," "More than half the days," and "Nearly every day," scored as 0, 1, 2, and 3, respectively. Thus, the PHQ-2 score can range from 0 to 6.[2] A score of 3 points or more on this version of the PHQ-2 has a sensitivity of 83 percent and a specificity of 92 percent for major depressive episode.[1]

Screening with the PHQ-2 is only a first step. Patients who screen positive should be further evaluated with the PHQ-9, other diagnostic instruments, or direct interview to determine whether they meet criteria for a depressive disorder.[2]

Score interpretation:

PHQ-2 score	*Probability of major depressive disorder (%)*	*Probability of any depressive disorder (%)*
1	15.4	36.9
2	21.1	48.3
3	38.4	75.0
4	45.5	81.2
5	56.4	84.6
6	78.6	92.9

Sources:
1. Thibault JM, Steiner RW. Efficient identification of adults with depression and dementia. *Am Fam Physician.* 2004;70:1101–1110
2. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care.* 2003;41:1284–1292

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite —being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
		add columns	+	+
		TOTAL:		

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

A2662B 10-04-2005

CCNC Pediatrics: Maternal Depression Screening

Psycho-social screening and surveillance for risk is an integral part of routine care and the relationship with the child and family. Medical Homes can be timely and proactive by implementing the screening, supporting the mother-child relationship and using community resources for referral and treatment.

40% - 60% of parenting teens and mothers who have low income report depressive symptoms

Spectrum of Maternal Depression	Prevalence	Time Frame	Characteristics	Recommended Treatment *Mom*	Recommended Treatment *Dyad*
Maternity (Baby) Blue	50%-80% of all mothers experience "baby blues" after birth	Begins a few days after birth. May last up to 2 weeks	Transient depressed mood, irritability, crying, anxious, afraid, confused	Family support	Family Support groups
Postpartum Depression	13%-20% of mothers experience PD after birth	Occurs during postpartum or within the 1st year	Meets DSM V criteria as a minor/major depressive disorder. *depressed mood, reduced interest in activities, loss of energy, difficulty concentrating*	Family Support Mental Health provider Psychiatry	Early Childhood Mental Health provider CC4C CDSA
Postpartum Psychosis (PPP)	1-3 of 1,000 mothers experience PPP after birth	Occurs in the first 4 weeks after birth	Paranoia, mood shift, hallucinations, delusions, suicidal/homicidal thoughts	Emergency mental health services Mobile Crisis Inpatient setting	Early Childhood Mental Health provider CC4C CDSA

Evidence-Based Intervention:

- Edinburgh Postpartum Depression Scale – available in English and Spanish
  - Mother completes a 10 multiple choice questionnaire at 1, 2, 4, and 6 month visits. (Note peak occurrence at 2-3 months for minor depression; 6 weeks for major depression)
  - Billed at the infant visit with CPT code 99420. *As of January 2017 this code will change to 96161* (health risk screen of the caregiver for the benefit of the patient).
    If the mother is the patient, (i.e. Family Medicine or OB practice), Bill CPT Code 96127
    Per NC DMA, OB providers can bill CPT code 96127 in addition to OB package codes

For Positive Screens:

- If the Edinburgh score is *20 or greater*, or the mother answers yes on question 10, or if the mother expresses concern about her or her baby's safety or the PCP suspects the mother is suicidal, homicidal, severely depressed/manic/psychotic
  - Contact your Mobile Crisis provider: service available through your MCO
  - Refer to emergency mental health services and be sure she leaves with a support person
- Communication, Support, Demystification and focus on wellness
- Referral Resources: see above

Follow-up of the infant includes social-emotional screening.

HIPAA Privacy Rule and Provider to Provider Communication

American Academy of Child and Adolescent Psychiatry (AACAP) and the American Academy of Pediatrics (AAP)

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides an important privacy rights and protections standard for patients with respect to their health information. HIPAA provides a uniform minimum standard, which individual state laws may supersede by mandating additional restrictions. AAP and AACAP both support the importance of this HIPAA rule in helping to protect against the inappropriate release of private health information, as well as to optimize safe care by allowing important clinical information to be shared among the clinicians of the patient's care team. It is considered a best practice to inform patients and parents about the critical need for care providers to communicate with each other in providing high quality care.

Unfortunately there are misperceptions about the HIPAA Privacy Rule which have developed and persisted over the past decade, which can interfere with appropriate patient care. Collaborative and integrated care systems rely on the appropriate and timely sharing of clinical information among a patient's treatment providers. If professionals do not appropriately communicate about their shared patients under the belief that HIPAA requires a signed consent for each communication, then patient care may suffer. Therefore AAP and AACAP have created this issue brief to clarify what the HIPAA rule does and does not limit regarding clinical care information exchange among pediatricians, child psychiatrists and other physicians and mental health providers.

The following are answers to commonly asked questions:

1. **What information can be disclosed between treatment providers without a patient/legal guardian's written authorization under HIPAA?**

   Any pertinent clinical care information, including mental health treatment information, can be disclosed and discussed between a patient's current treatment providers without written disclosure authorization except for the following two types of information: A) the content of written psychotherapy notes (see below), and B) substance abuse treatment records that are maintained by a licensed substance abuse program (42 USC § 290dd–2; 42 CFR 2.11). Substance abuse information obtained in other treatment settings may be communicated among a patient's treating providers without written consent.

2. **What constitutes psychotherapy note information that cannot be disclosed under HIPAA without a patient's explicit consent?**

   The HIPAA definition of a "psychotherapy note" is quite restrictive. A psychotherapy note per HIPAA can only consist of a mental health professional's written analysis of a conversation that occurred during a private counseling session that is maintained separately from the medical

record. These written analyses serve as working process notes about sessions to assist the therapist, and are not put into the medical record billing document. Anything which appears in the patient's medical record cannot be categorized as a psychotherapy note under the HIPAA rule. Specific content that has been listed as not falling under the "psychotherapy note" protections include medication management information, counseling session start and stop times, the type and frequency of treatment delivered, the results of clinical tests, diagnosis summaries, functional status, treatment plan, symptoms, prognosis, and progress to date. 45 CFR 164.501

3. **Can treatment providers who work in separate care systems communicate with each other about a shared patient?**

   Yes. Treatment providers do not have to share the same employer or share the same electronic health record in order to disclose pertinent protected health information about a mutual patient without consent from the patient or parent. The key component for this HIPAA allowance is that both providers have a treatment or consultative role with that patient. (See also http://www.hhs.gov/ocr/hipaa). Whenever PHI is transmitted electronically (eg, telephone voice response, text messaging, faxback, or email, etc) it is covered by the Security Rule and must be made secure by measures such as encryption, secure platforms, or closed systems. Voice mail messages, telephone conversations, and paper-to-paper faxes are not subject to the Security Rule. All PHI (eg, in oral, electronic and written forms) fall under the Privacy Rule.

4. **Does HIPAA allow for sharing treatment information via an electronic health record without written consent?**

   Yes, but there are additional regulations around the security standards needed for protecting electronic health records. Essentially, rules and procedures are required in the maintenance of an electronic health record to prevent their unauthorized access, alteration, deletion, and transmission. These security regulations for electronic records are outlined in the HIPAA security rule of 2005, and the HITECH act of 2009.

5. **Are there any other regulations that conflict with HIPAA communication allowances?**

   Yes. Providers need to be aware that any state regulations that are more restrictive than the HIPAA rules will take precedence in those states, and so providers need to be aware of their own state's information regulations. If you are unfamiliar with your state's regulations, it will be important to specifically seek out your state department of health's privacy rules. To obtain information on current state laws, you may also contact the AAP Division of State Government Affairs at stgov@aap.org

   Also, clinical information obtained at a certified substance abuse treatment center is subject to additional federal privacy rules, which at this time do not allow provider to provider communication without formal consent.

Case examples where HIPAA allows for provider to provider communication without a signed release:

1. At his 13 yr old well-visit, an adolescent (and his parent) tells his pediatrician that he is seeing a psychiatrist because of depression and he is doing better. The pediatrician contacts the psychiatrist to discuss medication and the pediatrician's role in supporting the young man and his family.
2. A 13 year old boy is receiving depression treatment from a child psychiatrist, including both a fluoxetine prescription and counseling. The same boy is also having problems with recurrent pain for which he regularly sees his pediatrician, who has been prescribing a low dose of amitriptyline for that problem. Because of treatment plan overlaps, both treatment providers discuss and coordinate their care.

3. A 15 year old girl has just completed a well child check at her pediatrician's office. It was noted that she had a blood pressure of 145/95 and pulse of 130. The pediatrician learns that she has recently started taking methylphenidate as prescribed by a child psychiatrist. Because high blood pressure may be a side effect of methylphenidate, the pediatrician contacts the child psychiatrist to discuss and coordinate care.
4. A 5 year old boy with significant behavior problems is being seen by a child psychiatrist. In the course of treatment, it becomes apparent that poorly skilled parenting practices at home are the main reason for his symptoms. The psychiatrist reaches out to the child's pediatrician to share this assessment and the behavior management advice that is being offered to the family.

View other case examples and the rest of the FAQs at www.aap.org/mentalhealth.