MCPAP
Massachusetts Child Psychiatry Access Program

NEWS

October 2022

Addressing School Refusal

Clinical Conversation: April 2022
Presented by R. Meredith Elkins, MD

Most children will have days when they just want to stay in bed and not go to school. But when school refusal is an ongoing problem, it may indicate an underlying issue, such as a behavioral health condition or family problem. At the April Clinical Conversation, Dr. R. Meredith Elkins, a clinical psychologist and co-program director of the McLean Anxiety Mastery Program (MAMP), provided a comprehensive overview of school refusal, including causes and treatment options.

School refusal can range in severity from difficulty attending school to complete absence from school for an extended period of time. It can be due to legitimate reasons, such as true medical illnesses, hazardous weather, or an unsafe school environment (bullying or verbal or physical assaults). "School refusal isn't associated with a single diagnosis or family situation. You can help the family determine if there is a legitimate reason for the child's difficulty attending school," says Dr. Elkins.

Family circumstances can make it difficult to attend school: An adolescent may need to work to help support the family; parents may have trouble separating from the child; and since the COVID-19 pandemic, parents may fear the child contracting the disease.

Reasons for school refusal and the functions they serve

School refusal has four major causes, which serve two different functions. "It's critical to consider the function that school refusal serves for the child and the context. Perhaps the school is located in an unsafe area or the child is struggling with schoolwork," says Dr. Elkins.

Refusal due to negative reinforcement:

- To **AVOID** general school-based situations or stimuli that evoke negative affect
- To **ESCAPE** aversive school-based or social activities or evaluative situations

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Leadership:

MCPAP
Massachusetts Child Psychiatry Access Program

1000 Washington St., Suite 310
Boston, MA 02118
Email: mcpap@beaconhealthoptions.com

www.mcpap.org

MCPAP is funded by the Massachusetts Department of Mental Health.

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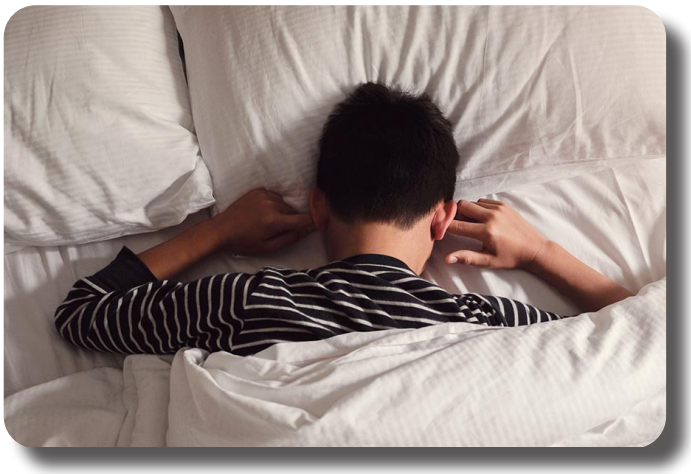
Refusal due to positive reinforcement:

- To **ACCESS** attention from significant others/ caregivers
- To **ACCESS** tangible reinforcers outside of school/ to do fun activities outside of school

Youths who avoid school will often have somatic complaints, such as stomachaches, headaches or sleep problems and should have a thorough physical examination prior to addressing the behavior and choosing the appropriate therapy.



Assessment tools

Assessment tools can help evaluate the reasons for school refusal and the scope of the problem. The *School Assessment Scale-Revised C* is a questionnaire that can be used with children ages 6-17.

School behavior can also be monitored with a form that tracks how long the child spent at school each day and the level of distress experienced.

Anxiety and school refusal

Anxiety isn't always the cause of school refusal but it is often a key contributor. Anxiety can lead to avoidance, which creates a vicious cycle: "When you avoid a situation, anxiety lessens so the child learns that the only way to deal with anxiety is to avoid it. It sets the child up for repetition; the next time the situation comes up, they avoid it again which makes it more likely that the anxiety will increase. The cycle becomes more entrenched and may lead to the development of an anxiety problem or disorder," says Dr. Elkins.

When a child avoids school, it reinforces the belief that they cannot tolerate school. "The worst thing you can do is encourage avoidance," says Dr. Elkins.

COVID-19 and school avoidance

Remote learning due to the COVID-19 pandemic increased school anxiety and made students who were vulnerable to anxiety more prone to developing a disorder. "A break from the stressors of school led directly to a lack of opportunity to develop coping skills. We've seen a major increase in the number of referrals for school refusal. It's the number one issue that schools are requesting help with," says Dr. Elkins.

Addressing anxiety with exposure therapy

Exposure therapy is a technique for addressing anxiety that identifies the areas of greatest anxiety and slowly exposes the child to anxiety-provoking situations to build mastery and become fully engaged in school. "It's important to set expectations for coping skills; they don't relieve anxiety completely but lessen it so the child can stay in school. Kids need to understand the relationship between avoidance and anxiety, that over time it will make things worse and make it harder for them to achieve their future goals and desires," says Dr. Elkins.

For example, one of Dr. Elkins' patients, 15-year-old Seneca, was anxious and nauseous most weekday mornings and often went to see the school nurse when she attended school. With exposure therapy, she started by eating a small breakfast, gradually progressing to more challenging tasks to the most difficult, not going to the nurse's office.

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How pediatricians can address school refusal

The following guidance can be offered during a primary care appointment:

- Discuss the importance of monitoring and functional assessment:
  - Provide psychoeducation about the association between anxiety and avoidance
  - Suggest that days at home from school be similar to school days – get up at the same time and do homework
- Recommend ways to cope with stress:
  - Diaphragmatic breathing
  - Progressive muscle relaxation (PMR)
  - Mindfulness practices
- Brainstorm rewards/consequences for school attendance
- Recommend a sleep hygiene/behavioral sleep plan
  - Suggest ways to address the "Sunday scaries" – plan a fun activity on Sunday and keep the evening quiet and relaxing; encourage kids to focus only on Monday; plan a small reward after school on Monday.
  - Refer, if needed, to a behavioral health specialist

Behavioral Health Resources

Outpatient Psychotherapy

- Center for Effective Child Therapy (CECT) at Judge Baker Children's Center
- Massachusetts General Hospital Child CBT Program
- CBTeam
- The Concord Center
- New England Center for OCD and Anxiety
- Boston Child Study Center
- McLean Anxiety Mastery Program (MAMP; IOP) Outpatient Parent Coaching/Guidance
- The Be Center—Daniel Crump, LISCW and Dr. Luciana Payne, PhD
- The Concord Center

Residential Treatment and Partial Hospitalization Programs

- McLean Acute Residential Treatment Program (ART, Belmont)
- McLean 3East PHP (DBT)
- Salem Hospital Adolescent Partial Hospital Residential Treatment Programs
- McLean Acute Residential Treatment Program (ART, Middleboro)
- McLean 3East Residential (DBT)
- McLean OCDI-Jr
- Franciscan Hospital CBAT

To maximize the chances of getting a therapy appointment, Dr. Elkins recommends getting on as many waiting lists as possible.

Dads Get Depressed Too: Addressing Paternal Postpartum Depression

Clinical Conversation: June 2022
Presented by: therapist Charles C. Daniels, Jr., PhD, MDiv, LICSW; pediatrician Mark R. Friedman, MD; clinical social worker Daniel Rodrigues, LICSW, PMH-C; and pediatrician Michael Yogman, MD

In recent years, maternal postpartum depression has been widely recognized and researched. But depression in fathers often goes undiagnosed and untreated. When parental depression isn't addressed, it negatively impacts children. At the June Clinical Conversation, four experienced providers discussed all aspects of paternal PPD. They included: therapist Charles C. Daniels, Jr., PhD, MDiv, LICSW; pediatrician Mark R. Friedman, MD; clinical social worker Daniel Rodrigues, LICSW, PMH-C; and pediatrician Michael Yogman, MD.

Over the past 50 years, the role of fathers has undergone a major evolution, from breadwinner to actively engaged parent; fathers spend three times more time with their children than they did in 1965. Today, there are approximately two million stay-at-home dads, and that number is likely to increase as a greater number of women pursue higher education and careers. Currently 60 percent of college students are women and 40 percent are men.

More attention is being paid to issues fathers face, including paternal postpartum depression (PPD), but evidence is limited. Across studies, PPD prevalence in men ranges from 6 to 25 percent; when the mother is depressed, the incidence increases to 50 percent. Fathers undergo hormonal changes during the postpartum period, most significantly a decrease in testosterone, which can be associated with an increase in depression.

Paternal presentation

While fathers with PPD may have similar symptoms as mothers, such as depressed mood and lack of interest in activities, they can also exhibit symptoms such as irritability, substance abuse, anger and aggressiveness, and avoidance and denial, which can lead to domestic violence. "Depressed dads often work longer hours, have less support, and turn to alcohol or drugs. They can become violent and are less likely to be involved with their child and more likely to leave, which increases the risk of financial insecurity," says Dr. Friedman, a retired pediatrician who practiced in Norwood.

Paternal PPD tends to manifest later with the highest number of cases beginning between three and six months after birth and continuing through the first five years of age.

PPD risk factors

The following are risk factors for PPD:

- Controlling relationship by the mother or father
- History of anxiety or depression
- Lower socioeconomic status
- Smoking
- Parental relationship for two years or less
- Partner depression
- Poor mother/father relationship
- Poor sleep quality for mother and/or father
- Poor social support after birth

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- Preterm infant/infant in neonatal intensive care unit
- Unintended pregnancy

Impact on children

Depression in fathers affects the child as adversely as depression in mothers. The child is more likely to have:

- Sleep disturbances
- Poor language skills
- Behavior problems at age two
- Antisocial behavior
- Oppositional defiance
- Peer problems
- Adverse childhood experiences (ACES)

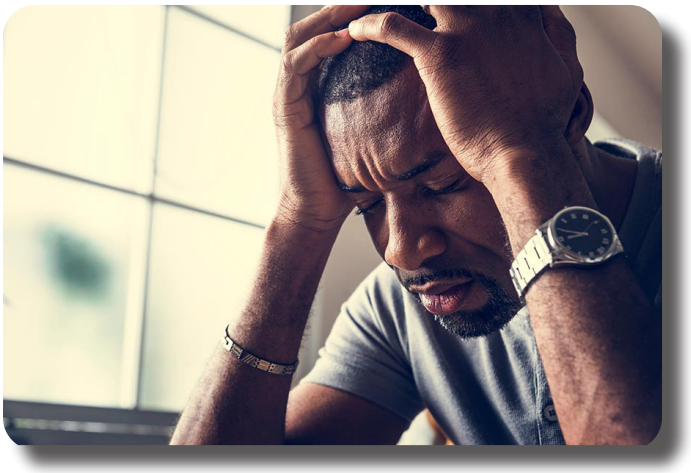
"Depressed fathers are less involved with their child, more likely to spank the child, and less likely to read to them," says Dr. Yogman, CEO of Yogman Pediatrics and an Assistant Clinical Professor of Pediatrics at Harvard Medical School.

Engaging with fathers

Most men under 40 don't see a primary care physician; often the only physician they have contact with is their child's pediatrician. While this is changing, it is usually the mother who accompanies the child to pediatrician visits.

Due to their work schedule among other reasons, fathers may find it difficult to go to a well-child visit, so it is important to reach out to them. "Keep engaging with fathers," says Dr. Charles Daniels, a therapist and Chief Executive Officer of *Fathers' Uplift*, which offers individual and group therapy, coaching, and youth enrichment programs for African American men. "Send letters, leave messages; it helps fathers to feel appreciated."

It may take more effort to engage African American men who, based on historical injustice, distrust institutions. "There are high rates of anxiety, depression, and undiagnosed prediabetes among African American men. They need medical attention," says Dr. Daniels. Be aware of racial stereotypes: "Providers often assume that minority mothers are single mothers and don't ask about fathers."



When fathers do come to an appointment, "Providers need to create a warm environment and make dads feel included and that they are important," says Daniel Rodrigues, Director of Substance Use Disorder Services at *Duffy Health Center*, Mashpee. "I felt like an outsider at pediatric visits; all the questions were directed at my wife." Front-office staff also need training in interacting with fathers.

After the birth of his second child, he developed PPD. "I was depressed and anxious and felt disconnected from my son. I had to give myself permission to recognize that I had PPD." After two years, he recovered.

Prevention and education

Preventing PPD can begin during prenatal care. Obtain a health history of both parents, including mental health. Provide education about the physical and emotional effects of parenting, including parental postpartum depression, and lifestyle education such as nutrition, sleep health, and postpartum sexual activity. Fathers can benefit from father-centered education groups.

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Dad's Get Depressed Too *Continued from page 5*

Screening fathers at pediatric visits

The American Academy of Pediatrics (AAP) currently recommends screening mothers for postpartum depression at the 1-, 2-, 4-, and 6-week well-child visit. Medicaid has a billing code for screening. While no recommendations exist for fathers, organizations and providers are increasingly advocating for screening both parents at pediatric visits.

For many pediatricians, screening fathers for depression is a new practice; the reasons given by pediatricians for not doing screening include lack of time, training, and reimbursement. Screening can be done quickly: studies show it only adds a few minutes to an office visit. When beginning parent screening, it is helpful to designate a physician or nurse who strongly supports screening as the "screening champion."

Drs. Friedman and Yogman support having a Family Four-Month Visit, an idea proposed by Community Catalyst, a family advocacy organization. Four months is a pivotal time in the baby's development and for mothers who may be returning to work. It offers an opportunity to discuss the family's health, including how the parents are coping with their new responsibilities and any mental and behavioral health challenges, and to conduct screening.

The *Edinburgh Postnatal Depression Scale (EPDS)*, a well-validated screening tool for mothers, has been validated for fathers with minor adjustments; the two-item Patient Health Questionnaire, used to screen all adults at primary care visits, can also be used.

Treating PPD

If the screening suggests that the father is depressed, "it is better to say that the dad needs help dealing with his stress rather than to say he needs counseling," suggests Dr. Friedman. Fathers can be referred for individual or group therapy or a support group. "It is helpful for someone from the provider's office to follow up with the father a few weeks after the office visit."

The Fathers' Uplift program stresses self-parenting, teaching fathers how to care for themselves, manage emotions, be a parent, and support their partner. At Duffy Health Center, Daniel Rodrigues created a dads in recovery support group. "It's a safe space for fathers to share and cut through socially constructed frameworks that make it hard for men to express emotions," says Rodrigues.

To fully address PPD in pediatric primary care, "providers need more support, resources and reimbursement for working with fathers," says Dr. Daniels.

Resources

View this document for resources related to Paternal Post-Partum Depression.

Boston Children's Hospital | Adolescent Substance Use and Addiction Program
Until every child is well

MCPAP
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Supporting Adolescents Using Substances

ASAP-MCPAP Virtual Care Program

Since 2020, Boston Children's Hospital's Adolescent Substance Use and Addiction Program (ASAP) and the Massachusetts Child Psychiatry Access Project (MCPAP) have been partnering with one another to offer virtual substance use screening, evaluation and treatment to adolescents and young adults.

Who qualifies for this service?

Any adolescent or young adult with a history of substance use followed by a pediatric practice part of MCPAP. Patients do not need to identify their substance use as a primary concern; counseling can be focused on addressing stress, anxiety, mood or other mental health problems. The virtual care model is appropriate for any individual who would be appropriate for routine outpatient counseling. We do not provide crisis evaluations; and anyone in need of an urgent evaluation should be directed to their local mobile crisis unit or the nearest emergency room to receive a psychiatric evaluation.

What type of services do you offer?

The ASAP-MCPAP social workers provide comprehensive substance use evaluations of patients to determine the best treatment plan. In addition to individual counseling, caregiver guidance and group therapy are other services that may be recommended depending on individuals' clinical needs.

How do I refer to ASAP-MCPAP Virtual Care Program?

Call your regional MCPAP line and ask to connect with the ASAP team. The ASAP consultant will help determine if virtual substance use counseling would be appropriate. The ASAP-MCPAP staff will complete intake information and reach out to your patient to schedule the first appointment.

If you have any general questions about this service, you can contact Maria Alden, LICSW at *maria.alden@childrens.harvard.edu*.

What's Happening for you at MCPAP

Clinical Conversations

We invite you to log in on the fourth Tuesday of each month from 12:15-1:15 p.m. to learn more about managing pediatric behavioral health issues in your practice.

Upcoming Clinical Conversations:

October 25, 2022:
Role of Assessment in Psychiatric Treatment: When, Where, Why, and How to Use Referrals for Neuropsychological, Psychoeducational, and related Evaluations
Tessa Hamilton, PhD, NCSP

November 29, 2022:
DMH and MassHealth Behavioral Health Service Changes for 2023
Katherine Ginnis, MSW, MPH and Emily Bailey, LICSW

January 24, 2023:
ECHO Focus on Early Childhood Mental Health Concerns for Pediatric Primary Care Clinicians
Yael Dvir, MD, Kara Lindquist, MD, Carolina Clark, LICSW, and Roxanne Hoke-Chandler, MS

Click *here* to register for any of these upcoming webinars. Please visit our *website* to view previously offered Clinical Conversations.

To receive monthly Clinical Conversation invitations, updates, and newsletters please email us at *MCPAP@beaconhealthoptions.com*.

For questions regarding Clinical Conversations, please contact Johnna at *johnna.gracik@beaconhealthoptions.com*.