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:

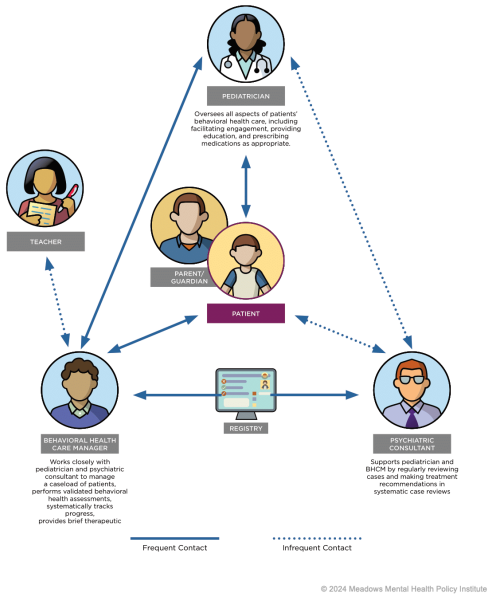
- Virna Little, PsyD, LCSW-r, MBA, CCM, SAP, Co-Founder and Special Advisor, Research and Advocacy, Concert Health
- Clare McNutt, Vice President of Primary Care Innovation, Meadows Mental Health Policy Institute
- Roshni Koli, MD, Chief Medical Officer, Meadows Mental Health Policy Institute
- Cody Hostutler, PhD, Pediatric Psychology & Primary Care Downtown, Nationwide Children's Hospital
- Jenny Ryan, LCSW-C, Chief Clinical Officer, Backpack Healthcare
- Jill Donelan, PsyD, VP of Clinical Operations, Mirah
- Rachel Tenenbaum, PhD, Clinical Supervisor, Collaborative Care Lead, Fort Health
- Sara Barker, MPH, Associate Director for Implementation, University of Washington AIMS Center
- Jian Joyner, LSW, Research Assistant, Concert Health

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.

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/fpsyt.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/fpsyt.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.

Notes about Development of the Pediatric CoCM Pathway

Role of Social Factors

The developers of the Pediatric CoCM Pathway acknowledge that social factors play a critical role in child and adolescent development and behavioral health. These care pathways do not explicitly address social needs, as they are not the primary focus of CoCM care. However, careful assessment of the youth's social environment and needs remains essential to holistic pediatric care. Some children with behavioral health concerns will require social support in addition to services provided through CoCM.

Selection of Assessment Tools

Assessment tools were selected to optimize for multiple factors, including:

- Adequate reliability and validity
- Free to use/inexpensive
- Accessibility within EHR platforms
- Availability of validated translations in multiple languages
- Brevity and appropriateness for use in primary care
- Ease of scoring and interpretation

Symptom Monitoring and Reliable Change:

Wherever possible/available, published Reliable Change Indices (RCIs) for each scale are included in the care pathways. RCIs provide evidence of clinically significant improvement, although they do not always align with full remission.

For measures without published RCIs, alternative indicators of meaningful improvement may include:

- A 50% reduction from baseline scores
- Crossing a clinical severity threshold (e.g., moving from severe to moderate range)

- Achieving remission (e.g., moving from the clinical to subclinical range)

This framework provides flexible but consistent standards for evaluating progress within CoCM.

Pediatric Symptom Checklist (PSC)

Both the PSC-17 and PSC-35 are widely used in pediatric practice:
- **PSC-17** is most commonly used in primary care and is practical for routine screening.
- **PSC-35** has more published data on reliable change indices and subscale scoring.

Practices may choose either version. The care pathway acknowledges both, and scoring guidance should be drawn from the original measure documentation.

Evidence-Based Treatments and Interventions

The intervention models listed are representative of best practices for the pediatric primary care setting, though not all-inclusive. The following priorities guided selection:
- Brief interventions suitable for the time-limited CoCM model
- Strong evidence base for efficacy in pediatric populations
- Feasibility for implementation in primary care
- Exclusion of models requiring extensive training/certification

Interventions appropriate for paraprofessional-level care managers are included alongside those requiring a licensed behavioral health provider.

It is important to note that many interventions cited in the literature are **manualized, longer-term treatments**. In practice, however, CoCM, often relies on **modular** or **skills-based adaptations** of these approaches. To reflect this, the pathways acknowledge three broad categories of evidence-based interventions:

1. **Manual-based treatments** – structured, protocol-driven approaches (e.g., FAST protocols)
2. **Modular-based treatments** – flexible combinations of treatment modules (e.g., MATCH-ADTC)
3. **Process-based treatments** – approaches that emphasize core processes and skills rather than manuals

Where specific interventions (e.g., CBT, DBT) are referenced, it should be noted that evidence may derive from full manualized protocols, but skills and components can often be adapted effectively for CoCM.

Use and Scope of the Pathway

The Pediatric CoCM Pathway is designed to inform individual patient care decision-making within the Collaborative Care Model. While it may also inform program-level quality improvement, it is not intended to define inclusion criteria, program quality metrics, or serve as comprehensive clinical guidelines. Instead, it provides examples, tools, and practical direction for implementation in primary care.

For differential diagnostic tools not fully detailed in this document, practices are encouraged to reference scoring and interpretation guidance provided by the measure developers.

	Attention	Anxiety/Depression (Internalizing)	Conduct (Externalizing)	Trauma	Suicide
Initial Screening: PSC (Pediatric Symptom Checklist) Subscales **Either the PSC-17 or PSC-35 may be used.*	• Fidgety, unable to sit still • Daydreams too much • Easily distracted • Trouble concentrating • Acts as if driven by a motor	• Feels sad or unhappy • Feels hopeless • Has low self-esteem • Worries a lot • Less enjoyment in activities	• Fights with others • Does not follow rules • Does not understand others' feelings • Teases others • Blames others for their troubles • Takes things that do not belong to them • Refuses to share		
PSC Scoring and Considerations	PSC-17 Total Score: Normal < 15 PSC-17 Attention Subscale: Normal < 7 PSC-35 Total Score: Normal < 27 PSC-35 Attention Subscale: Normal < 7	PSC-17 Total Score: Normal < 15 PSC-17 Attention Subscale: Normal < 5 PSC-35 Total Score: Normal < 27 PSC-35 Attention Subscale: Normal < 7	PSC-17 Total Score: Normal < 15 PSC-17 Attention Subscale: Normal < 7 PSC-35 Total Score: Normal < 27 PSC-35 Attention Subscale: Normal < 7		
Tools for Differential Diagnosis (indicates that the tool is available in multiple languages) **Please refer to the attached spreadsheet for a comprehensive list of behavioral health tools for pediatric primary care.* **Only freely available resources are included due to the restricted availability of other tools.* **See included references for specific*	Attention-deficit/hyperactivity disorder (ADHD): • NICHQ Vanderbilt Assessment Scale (Q1-18) and Follow-up (Q1-26)	Anxiety disorders: • SCARED (Screen for Child Anxiety Related Emotional Disorders) • SCAS (Spence Children's Anxiety Scale) Depressive disorders: • SMFQ (Short Mood and Feelings	Conduct disorder: • NICHQ Vanderbilt Assessment Subscales for Oppositional-Defiant Disorder (Q19-26 AND Q48-54) and Conduct Disorder (Q27-40 AND Q48-54)[1]	Post-traumatic stress disorder: • CTS (Child Trauma Screen) • CATS (Child and Adolescent Trauma Screen)	Suicide risk: • ASQ (Ask Suicide-Screening Questions) • C-SSRS (Columbia-Suicide Severity Rating Scale) Screener - Recent - Child

**See included references for specific scoring and interpretation of tools for differential diagnosis.*		Questionnaire)			
Symptom Monitoring (Indicators of Reliable Change)	PSC-35 Total Score: Change score of ≥ 6 PSC-35 Subscales: Change score of ≥ 2 PSC-17: 50% reduction from baseline[2]	PSC-35 Total Score: Change score of ≥ 6 PSC-35 Subscales: Change score of ≥ 2 PSC-17: 50% reduction from baseline[2]	PSC-35 Total Score: Change score of ≥ 6 PSC-35 Subscales: Change score of ≥ 2 PSC-17: 50% reduction from baseline[2]	CTS: Youth report: Cut-off ≥ 6; Caregiver report: Cut-off ≥ 8; Young child version: Cut-off ≥ 6 (threshold change)[2]	ASQ: Reduction in suicidal ideation, behaviors, or risk categorization (threshold change)[2]
	NICHQ Vanderbilt 1.1: 50% reduction from baseline on total score (sum total of Q1-18)[1]	SCARED: 50% reduction from baseline on caregiver and/or youth self report SCAS: 50% reduction from baseline or threshold change[2] SMFQ: Caregiver report: Change score of ≥ 8; Self-report: Change score of ≥ 6	[redacted]	CATS: Ages 3–6: Cut-off ≥ 16; Ages 7–17: Cut-off ≥ 21 (threshold change)[2]	C-SSRS: Reduction in suicidal ideation, behaviors, or risk categorization (
Care Manager Prep for Psychiatric Consultation (Questions to Consider)	Have you/ the patient, or has there been a formal evaluation for ADHD? Is there an educational plan that has been established with the school?	Have you/ the patient ever been to the hospital or emergency room for feeling down, depressed or hopeless? Do you/ does the patient have trouble falling asleep or staying asleep? Do you/ does the patient have any physical health conditions? Do you have concerns that a physical health condition may be affecting sleep or appetite? Have you noticed any changes in your appetite – eating more or less than usual? Have you (has the	Legal problems, on probation or legal/criminal concerns? Is there an educational plan that has been established with the school?	[redacted]	

		patient) noticed any changes in their weight? If not aware, another question may be: Do clothes fit differently? Have there been any changes in your physical health or medications that could be affecting your appetite or weight gain/loss? 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? 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) Never__ Rarely__ Sometimes__ Often__ Very__ (Scoring & Interpretation: https://novopsych.com.au/assessments/diagnosis/adult-adhd-self-report-scale-asrs/)		[redacted]	
Evidence-Based Practices and Treatments **Brief skills-based interventions were selected for their proven effectiveness and fit with primary care settings.* **Add note from recording here*	Programs and Therapies: • FAST (First Approach Skills Training) programs • PSST (Problem-Solving Skills Training) • 4 Rs and 2 Ss • Motivational interviewing	Programs and Therapies: • FAST (First Approach Skills Training) programs • Behavioral activation • BBT (Brief Behavioral Therapy) • CBT (Cognitive Behavioral Therapy) • DBT skills	Programs and Therapies: • FAST (First Approach Skills Training) programs	Programs and Therapies: • PFA (Psychological First Aid) • SPR (Skills for Psychological Recovery)	Programs and Therapies: • Stanley-Brown Safety Planning Intervention • CALM (Counseling on Access to Lethal Means)
				[redacted]	

	Parent Management: • Skills training • Classroom behavior management	Parent Management: • SPACE (Supportive Parenting for Anxious Childhood Emotions)	Parent Management: • Classroom behavior management	[redacted]	
Additional Resources	• For Professionals | CHADD • For Parents | CHADD • ADHD Resource Center | AACAP • ADHD & Attention Resources | Child Mind Institute • Free Materials on ADHD | CDC • How To ADHD	• Anxiety Disorders Resource Center | AACAP • Depression Resource Center | AACAP • Anxiety in Children and Teenagers | Child Mind Institute • Depression & Mood Disorders | Child Mind Institute	• Conduct Disorder Resource Center | AACAP • Behavior Problems | Child Mind Institute	• Trauma and Child Abuse Resource Center | AACAP • Disaster and Trauma Resource Center | AACAP • Trauma and Grief in Children | Child Mind Institute	• Suicide Resource Center | AACAP • Suicide & Self-Harm Warning Signs | Child Mind Institute

[1] There are multiple methods for scoring the NIQHC Vanderbilt.

[2] For scales without a published RCI value, the authors suggest substituting a 50% reduction from baseline or a threshold change as a reasonable way to measure treatment improvement, as this standard is frequently used in the field.

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
- 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

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
- 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

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
- Liu, F. F., & Adrian, M. C. (2019). Is treatment working? Detecting real change in the treatment of child and adolescent depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 58*(12), 1157-1164. https://doi.org/10.1016/j.jaac.2019.02.011

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/fpsyt.2023.1252037

PSST (Problem-Solving Skills Training)

- 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

BBT (Brief Behavioral Therapy)

- 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

CBT (Cognitive Behavioral Therapy)

- 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

- Groves, S., Backer, H. S., van den Bosch, W., & Miller, A. (2011). Dialectical behaviour therapy with adolescents. *Child and Adolescent Mental Health, 17*(2), 65-75. https://doi.org/10.1111/j.1475-3588.2011.00611.x
- McCredie, M. N., Quinn, C. A., & Covington, M. (2017). Dialectical behavior therapy in adolescent residential treatment: Outcomes and effectiveness. *Residential Treatment for Children & Youth, 34*(2), 84-106. https://doi.org/10.1080/0886571X.2016.1271291
- 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. https://doi.org/10.1016/j.cbpra.2023.12.014

PFA (Psychological First Aid)

- 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

SPR (Skills for Psychological Recovery)

- 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
- Stanley, B., & Brown, G. K. (2012). Safety Planning Intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256-264. https://doi.org/10.1016/j.cbpra.2011.01.001

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)	**PROMIS® (Patient Reported Outcomes Measurement Information System)**	**NICHQ Vanderbilt Assessment Scale (Q1-18) and Follow-up (Q1-26)**	**GIPD (Global Impression of Perceived Difficulties) Scale**	**SNAP-IV 26-item scale**	**SWAN (Strengths and Weaknesses of Attention-Deficit/Hyperactivity Disorder Symptoms and Normal Behavior Scale)**	**SCARED (Screen for Child Anxiety Related Emotional Disorders)**	**SCAS (Spence Children's Anxiety Scale)**	**CAIS (Children's Anxiety Impact Scale)**	**OASIS (Overall Anxiety Severity and Impairment Scale)**	**SMFQ (Short Mood and Feelings Questionnaire)**	**CES-DC (Center for Epidemiological Studies Depression Scale for Children)**	**CTS (Child Trauma Screen)**	**CATS (Child and Adolescent Trauma Screen)**	**CPSS (Child PTSD Symptom Scale)**	**CAPS-CA-5 (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 behavior	Evaluates the severity and risk of suicide
Age Range	4-17 years	8-17 years	6-12 years	5-17 years	6-18 years	18 years and younger	8-18 years	8-15 years	7-17 years	8 years and older	6 years and older	6-17 years	7-17 years	7-17 years	8-18 years	7 years and older	8-24 years	6-12 years
Number of Items	35 (PSC-35), 17 (PSC-17)	Variable	55 (Parent Initial), 43 (Teacher Initial), 26 (Follow-up)	5	26	18	41	44	27	5	13	20	10	40	27	30	4	5-15
Measure Type																		
Screening	☑	☑	☑	☐	☐	☐	☑	☑	☐	☐	☑	☐	☑	☑	☑	☐	☑	☑
Diagnostic	☐	☐	☑	☐	☑	☑	☑	☑	☐	☐	☐	☑	☐	☑	☑	☑	☐	☐
Symptom Monitoring	☑	☑	☑	☑	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☐	☐
Reporter Type																		
Provider	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐	☐
Patient	☑	☑	☐	☐	☐	☐	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☑	☑
Parent/Caregiver	☑	☑	☑	☑	☑	☑	☑	☑	☑	☐	☑	☐	☑	☑	☑	☐	☐	☐
Teacher	☐	☐	☑	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Integration with EHR	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑
Multi-Language Availability	☑	☑	☐	☐	☑	☑	☑	☑	☐	☑	☑	☐	☑	☑	☑	☐	☑	☑
Outcome Measures	Total Score: A change score of 6 or greater indicates reliable change Subscales: Changes of 2 or more points indicate reliable change	Group Comparisons: A change score of 3 T-score points or more generally indicates a meaningful difference Individual Assessments: 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 13 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 less than 85%) is within the "normal" range A T-score of 60 or more (top 15% or more) suggests "elevated" 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 cut-off score of 8 correctly classifies 87% of a clinical population sample as having an anxiety diagnosis or not	Caregiver Report: A change score of 6 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 6 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 clinical cutoff score of 11 indicates significant trauma symptoms	A symptom is considered present only if the corresponding item severity score is rated 2 ("moderate/threshold") 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, behaviors, or risk categorization is considered indicative of an improvement in the patient's condition; can be assessed by a decrease in the frequency, intensity, or severity of suicidal thoughts, a reduction in suicidal behaviors, or a shift from a higher to a lower risk category
Authors	Jellinek, Murphy, & Burns, 1986	National Institutes of Health (NIH)	National Institute for Children's Health Quality (NICHQ)	Wehmeier 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, Orvaschel, & Padian, 1980	Lang & Connell, 2017	Sachser et al., 2017	Foa et al., 2001	National Center for PTSD	Horowitz et al., 2012	Posner et al., 2008
Citations	Jellinek et al., 1988; Jellinek et al., 1999; Murphy & Jellinek, 1988; Murphy et al., 1992; Murphy et al., 1995	Irwin et al., 2010; Irwin et al., 2012	Becker et al., 2012; Wolraich et al., 2003; Wolraich et al., 2004	Wehmeier et al., 2008	Busking et al., 2006; Stevens, Quittner, & Abikoff, 1998	Brites et al., 2015; Lakes, Swanson, & Riggs, 2012	Birmaher et al., 1997; Birmaher et al., 1999	Ramme, 2018; Spence, 1998; Spence, Barrett, & Turner, 2003	Langley et al., 2014	Campbell-Sills et al., 2009; Norman et al., 2006	Angold et al., 1995; Messer et al., 1995; Liu & Adrian, 2019	Faulstich et al., 1986; Fendrich, Weissman, Warner, 1990; Weissman, Orvaschel, & Padian, 1980	Lang, Connell, Macary, 2021; Lang & Connell, 2018; Lang & Connell, 2017	Sachser et al., 2017	Foa et al., 2018; Foa et al., 2001	Kouki et al., 2023	Horowitz et al., 2012	The Columbia Lighthouse Project, n.d.; Posner et al., 2011
Additional Links	https://novopsych.com.au/assessments/child-pediatric-symptom-checklist-17-psc-17/	https://www.healthmeasures.net/explore-measurement-systems/promis	https://nichq.org/resource/nichq-vanderbilt-assessment-scales		https://greenspacehealth.com/wp-ua/child-adhd-snap-iv-26/	https://www.phenotips.org/protocols/view/121502	https://www.aacp.org/patient-care/evidence-based-practice-resources/test-measures/screen-child-anxiety-related-disorders-scared	https://www.scasewebsite.com/		https://greenspacehealth.com/en-us/anxiety-oasis/	https://psychiatry.duke.edu/research/research-programs-areas/assessment-intervention/developmental-epidemiology-instruments-2	https://greenspacehealth.com/en-us/child-depression-ces-dc/	https://www.chs9.org/our-work/trauma-informed-initiatives/ct-trauma-screen-cts/	https://istss.org/clinical-resources/child-adolescent-trauma-assessments/child-and-adolescent-trauma-screen/	https://istss.org/clinical-resources/child-adolescent-trauma-assessments/child-and-adolescent-trauma-screen/child-and-symptom-scale-for-dsm-5/	https://www.ptsd.va.gov/professional/assessment/child/ptsd-cas.asp	https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials	https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/
Notes/Comments		Although the PROMIS assessment system is not included in the pathway due to its multiple variations, we recognize it as a valuable tool supported by robust research and an effective alternative to the validated tools we have listed.																