

Responding to the Mental Health Needs of Pediatric Patients: Practical Roles, Workflows, and Skills for Every Member of the Care Team

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This training was made possible by Wyoming's

Pediatric Mental Health Care Access Program.

Enroll in the program for access to other resources and training opportunities for pediatric providers in Wyoming.

Enroll Here

Access other resources at the Children's Behavioral Health Alliance (CBHA) webpage.

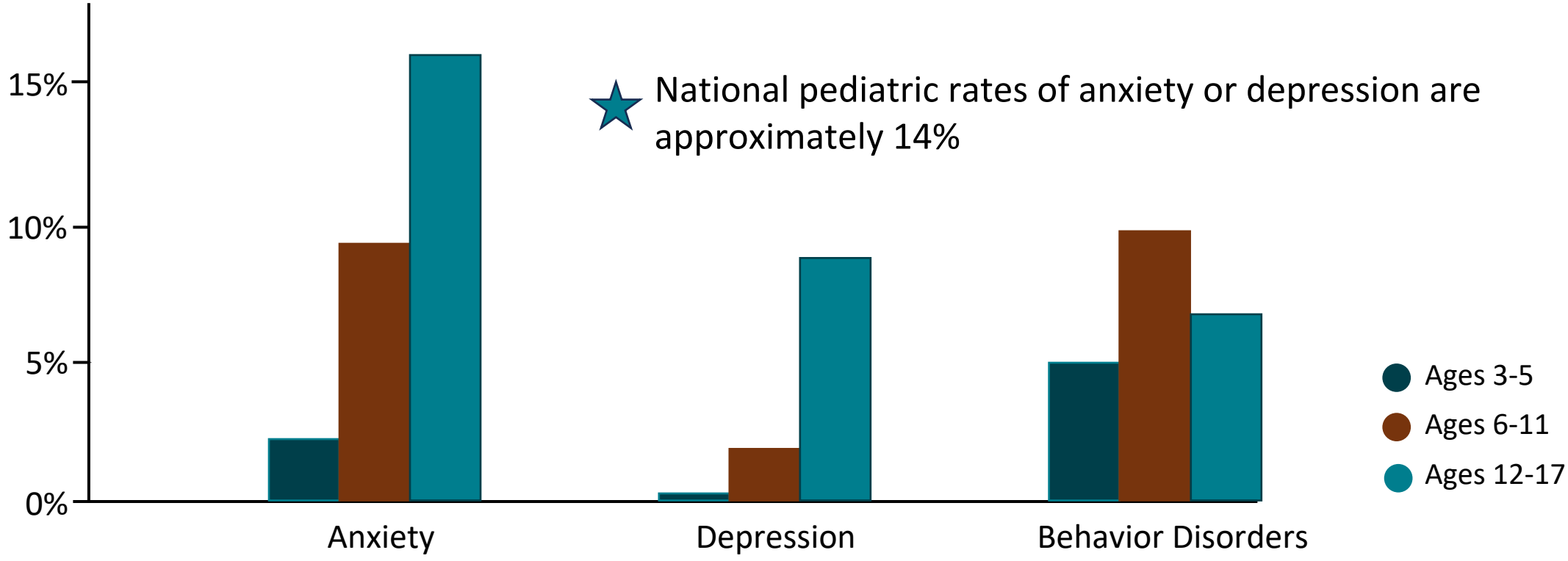
Access CBHA

John Karikas, Benjamin Miller, Emma Ansara, and all other in control of this CME activity, reported no relevant financial relationships that would create a conflict of interest for CME purposes.

Nursing Contact Hours will be awarded upon completion/submission of an evaluation.

This activity is approved for 1.0 Nursing Contact Hour. Cheyenne Regional Medical Center is an approved provider of nursing continuing professional development by Colorado Nurses Association, an accredited approver with by the American Nurses' Credentialing Center's Commission on Accreditation.

National Data on Common Pediatric Mental Health Concerns (2025)

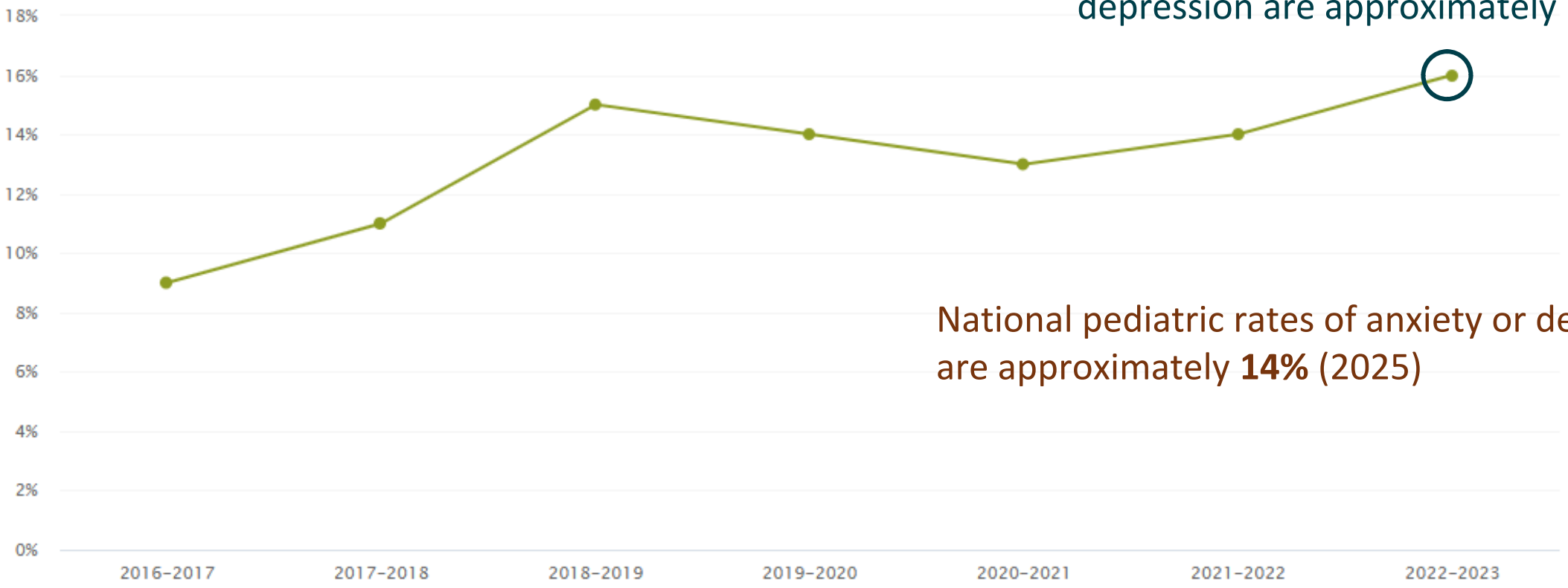


Source: https://www.cdc.gov/children-mental-health/data-research/index.html

What Are the Rates in Wyoming?

Children and teens with anxiety or depression in Wyoming

Wyoming pediatric rates of anxiety or depression are approximately **16%** (2023)

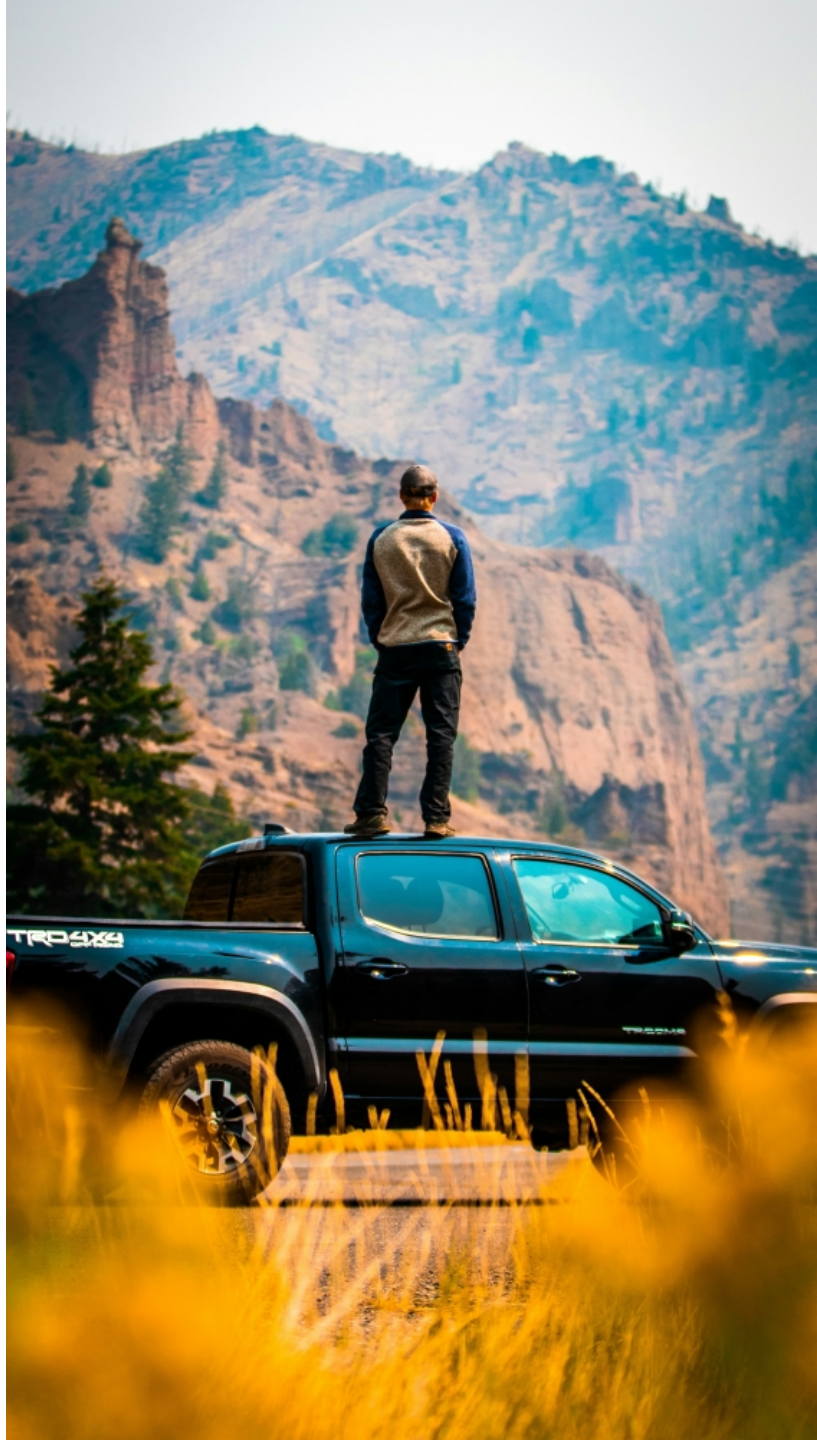


National pediatric rates of anxiety or depression are approximately **14%** (2025)

Source: https://mhanational.org/wp-content/uploads/2025/09/State-of-Mental-Health-2025.pdf

What Affects Rates?

1. Long distances and transportation barriers
2. Stigma
3. Workforce shortages
4. Limited funding and infrastructure for prevention
5. Isolation



Defining Integration

The care that results from a **practice team** of primary care **and** behavioral health clinicians, **working together with patients** and **families**, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), **life stressors and crises**, stress-related physical symptoms, ineffective patterns of health care utilization.

Peek, C. J., National Integration Academy Council. (2013). Lexicon for Behavioral Health and Primary Care Integration: Concepts and Definitions Developed by Expert Consensus. In Agency for Healthcare Research and Quality (Ed.), *AHRQ Publication No.13-IP001-EF*.

Three Levels of Response

Know which level you're operating in — the roles and tools change at each one

OFFICE / PRACTICE

The clinic, right now

- Front desk, MA, PCP, BHC, care coordinator
- Screening, warm handoff, huddles, documentation, follow-up

HEALTH SYSTEM

Across sites, over time

- Leadership, staffing/coverage, training, EHR standards
- Referral pathways to specialty and emergency behavioral health

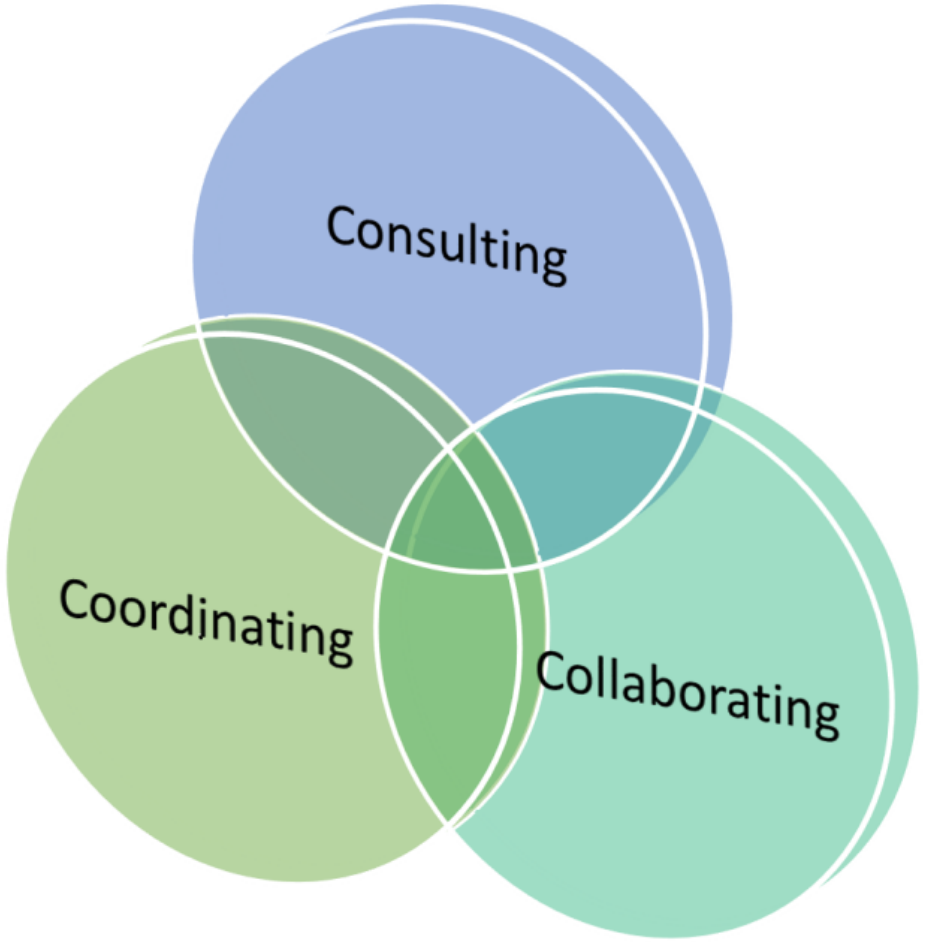
COMMUNITY

Beyond your walls

- Crisis lines, emergency departments, schools, social services, state policy
- Wyoming: designated shortage areas, zero pediatric BH hospitals



Primary care and behavioral health clinicians use three interpersonal strategies to work together in integrated settings.



Cohen, D. J., Davis, M., Balasubramanian, B. A., Gunn, R., Hall, J., deGruy, F. V., . . . Miller, B. F. (2015). Integrating Behavioral Health and Primary Care: Consulting, Coordinating and Collaborating Among Professionals. *The Journal of the American Board of Family Medicine, 28*(Supplement 1), S21-S31. doi:10.3122/jabfm.2015.S1.150042

The Three Cs

Consulting

Occurs when clinicians seek advice, validate care plans, or corroborate perceptions of a patient's needs with another professional

Coordinating

Involves two professionals working in a parallel or back-and-forth fashion to achieve a common patient care goal, while delivering care separately

Collaborating

Involves two or more professionals interacting in real time to discuss a patient's presenting symptoms, describe their views on treatment, and jointly develop a care plan

Reflect: Which techniques do you most commonly use? How could you collaborate more?

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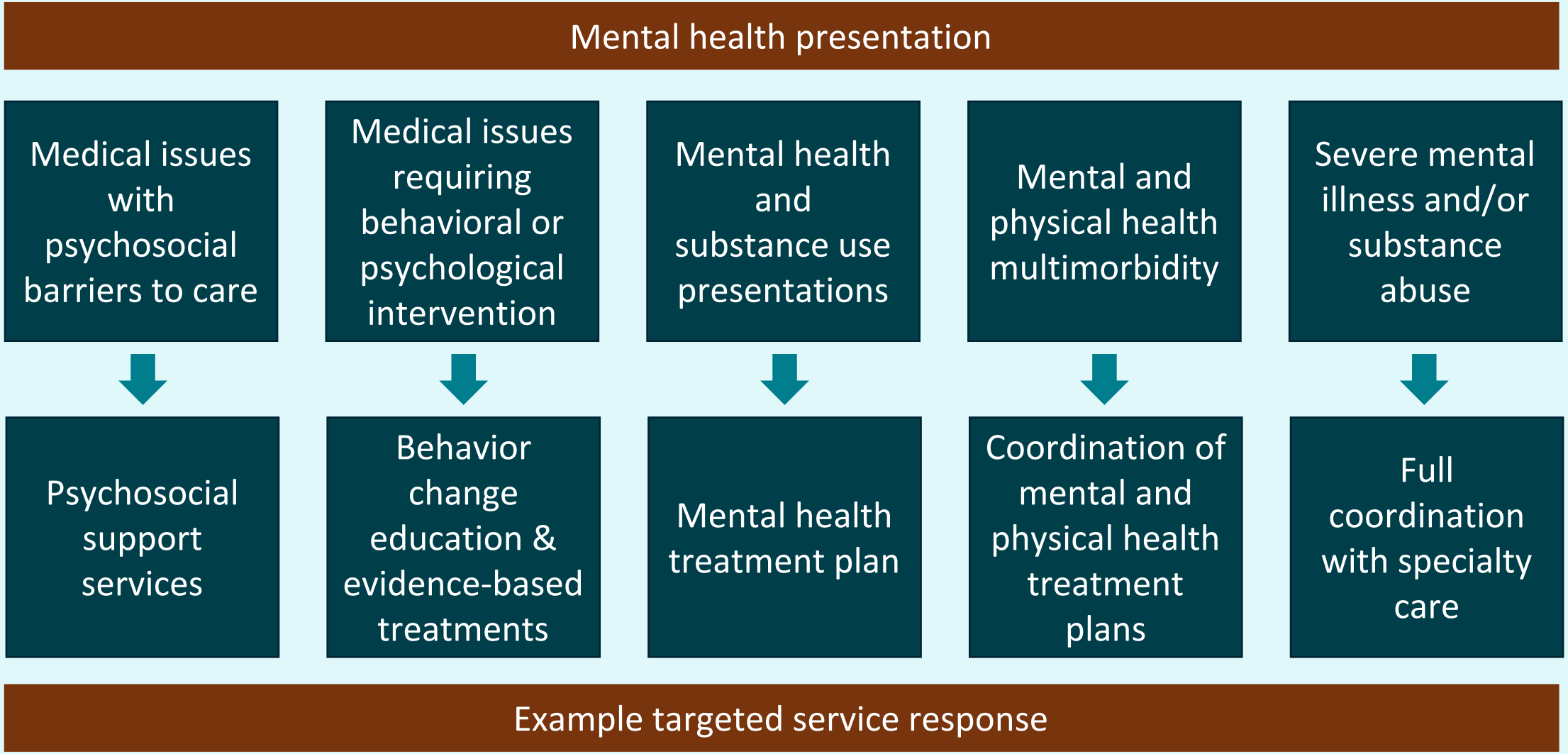
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What are the range of behavioral health services offered?



OFFICE / PRACTICE LEVEL

Crisis Response



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When a Crisis Happens, Everyone Has a Role

Not just the clinician in the room — the whole team moves

Front Desk

Notices distress at check-in; knows the signal to alert clinical staff without alarming the waiting room

Medical Assistant

Administers the screening, flags it in the chart, and stays with a patient who can't be left alone

Practice Manager / Scheduler

Makes the real-time coverage call — who's pulled, who covers, for how long

Care Coordinator

Owns what happens after the crisis moment ends — referral, follow-up, closing the loop

The PCP and BHC still lead clinical decision-making — but the moment usually starts and ends with someone else on this slide.

Case Study

- 12-year-old Jordan arrived for a same-day acute visit scheduled for a headache
- Staff noted behavioral changes, observing that Jordan was unusually withdrawn and avoiding eye contact
- The MA skillfully separated Jordan from their parent for private rooming
- Routine intake screening identified a positive response for self-harm

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Workflows & Skills for Non-Clinicians

Protocols • Scripts & Practicing • Drills • Debriefs

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Protocols: The Written Playbook

A protocol removes the guesswork in the first 60 seconds of a crisis.

A usable protocol answers four questions, on one page:

1

What triggers it?

What exactly do you see or hear that activates this protocol?

2

What is done immediately?

Who stays with the patient? Who leaves to get help?

3

Who do we call?

Named roles, in order — not "someone will know"

4

How is it documented?

What gets written down, where, and by whom

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Create protocols

Start with the two or three scenarios you're most likely to face: suicidal disclosure, an unsafe or agitated patient, disclosure of abuse.

On one page, cover:

1

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What exactly do you see or hear that activates this protocol?

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Scripts: Exact Words, Practiced Until Automatic

A protocol tells you what to do; a script gives you the words to do it with



Reading a script once is not the same skill as saying it out loud under pressure. Rehearse scripts in staff meetings, not just at onboarding.

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Example Script

A protocol tells you what to do; a script gives you the words to do it with

Front desk → clinical team

"Can you help me with Ms. [name] in room 2 — she seems like she needs a few extra minutes."

Signals urgency without naming the concern in front of others

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Example Script 2

A protocol tells you what to do; a script gives you the words to do it with

MA → BHC (warm handoff)

"I'd like to bring in [BHC name] — she's great with exactly what you're describing."

Names the BHC, frames the value, keeps the patient in control

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Drills

The protocol on paper and the protocol your team can execute are two different things.



A drill only works if leadership treats the outcome as information, not a performance review.

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Drills: Rehearse Before It's Real

The protocol on paper and the protocol your team can execute are two different things

Cadence

Quarterly is enough to keep it fresh without becoming routine

Format

Tabletop (talk through a scenario) or live (walk the actual physical steps)

Rotate roles

Everyone plays front desk, MA, and "patient" at some point

Keep it short

15 minutes is enough for one scenario, run at the end of a staff meeting

Site visit

Have a local crisis team/clinicians to your facility, discuss information sharing, what their scope/availability/hours are, and then come up with a one pager for the clinic team.

OFFICE + COMMUNITY

Community Drill: Bring Your Crisis Partner In

Same rehearsal logic — but this walkthrough happens with the partner you'd actually call

Host the visit

Invite your local crisis team or mobile crisis clinicians to the practice for a working session, not just a phone call

Map scope & hours

What they cover, their catchment area, and what hours they're actually reachable

Talk information sharing

What can be shared, under what consent, and how it moves between your systems

Build the one-pager

Contact info, hours, and what to say when you call — kept at the front desk and by the phone

Treat this like any other drill: the deliverable is a document your team can act on, not just a good conversation.

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Debriefs: Close the Loop for the Team

A real crisis and a drill both deserve the same four questions afterward

1

What happened?

A shared, factual timeline — no blame, no editorializing

2

What worked?

Name it specifically so it gets repeated

3

What didn't?

Gaps in the protocol, the script, or the handoff

4

One change?

Pick a single, assignable fix — not a wish list

Timing matters: debrief within 24-48 hours, while details are fresh, and hold it as a psychologically safe space — this is a process review, not a performance one.

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Practical Considerations

The details that make the protocol usable in your building

Physical space

Is there a private, safe room — and does everyone know where it is?

After-hours coverage

What happens at 4:45pm on a Friday, not just at 10am on a Tuesday?

Confidentiality & parental involvement

What can you share with a parent, and when does the minor's confidentiality apply?

Escalation

Who is authorized to call 911 or a mobile crisis team — and do they know it?

Community resource list

Is it current, printed, and within reach of the front desk — not just bookmarked somewhere?

Documentation

What lives in the EHR vs. an incident log, and who has access?

Key Takeaways

1. **Defined protocols protect patients and staff:** Without clear, established protocols, staff are forced to scramble during time-sensitive crises, creating potentially dangerous care scenarios.
2. **Scripts prevent high-pressure improvisation:** Utilizing consistent language and standardized keywords prevents care team members from relying on untrained instincts when under stress.
3. **Debriefing prevents repeated mistakes:** Omitting post-crisis reviews leaves critical care gaps unaddressed and leads to recurring errors, whereas debriefs build long-term operational learning.
4. **Crisis preparedness is a muscle:** Small, routine process investments—like spending 15 minutes at a staff meeting—directly build clinic-wide competency, capacity, and confidence through practice.

Next Steps: Go Deeper Where the Energy Is

Whichever topic you think is most important for your work site — start there this month

Writing scripts?

Draft one script this month for your highest-frequency scenario and rehearse it at your next staff meeting.

Running drills?

Schedule your first 15-minute tabletop drill in the next 30 days — put it on the calendar today.

Doing debriefs?

Build a one-page debrief template using the four questions, before you need it.

Considering practicalities?

Audit your safety protocols and community resource list this week.

Don’t forget! Wyoming providers can call the **Partnership Access Line** for teleconsultation support. Contact the PAL if you have any questions about:

- Mental health care
- Diagnostic clarification
- Medication adjustment
- Treatment planning
- Child psychiatry

More Info



You can reach the PAL at **(877) 501-7257** during normal business hours.

Thank you!

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