



CAPPCC

CHILD AND ADOLESCENT PSYCHIATRY FOR PRIMARY CARE

CAPPCC is a program of the New York State Office of Mental Health



QUARTERLY NEWSLETTER

SUMMER 2017



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in this issue



An Update from the Boss

David Kaye MD

PLUS

-Childhood Delirium

-Hallucinations

-A Message from Jim Wallace

-Book Review

-and more!



David Kaye MD
CAP University at Buffalo

Greetings CAP PC/Project TEACH PCPs,

A very disturbing, and thankfully uncommon, occurrence is when an adolescent becomes psychotic. This condition represents a sharp change in functioning for an adolescent and may present with hallucinations, delusions, paranoia, sleep disturbances, and disorganized or erratic behavior. Sometimes this occurs in the context of medical illness or post-operatively and is usually referred to as delirium, and not psychosis. Psychosis per se can be caused or associated with many etiologies. This is truly a medical emergency and patients, families, and doctors often feel overwhelmed and don't know where to turn. As you know, you can always call CAP PC when these issues arise. In the past few years, in several parts of the country programs have been developed to specifically help patients and families facing this situation for the first time. In New York, OnTrackNY was started in 2013 and is now available in 19 sites across the state to assist patients ages 16-30 who are having a first episode of psychosis that is not due to medications, substance misuse/abuse, medical conditions, mania, or psychotic depression. The program provides a "one stop shop" for patients and families and can remain involved for up to 2 years. We are detailing more about the program in this issue of the newsletter, as well as articles from our Rochester and Buffalo teams on delirium and hallucinations in pediatric populations. Shout out to Jim Wallace and Amy Lyons, our fearless Editors, and Vijeta Kushwaha, Josh Russell, and Sourav Sengupta for their contributions to this edition.

If your practice is interested in hosting a "core training" let us know. All our sites are actively scheduling these 5 hour CME programs that cover ADHD, anxiety, depression and aggression at no cost to you or your practice. If we can't schedule for this year we can make plans for 2018. As always keep your calls coming! Together we are making a huge difference for kids and families across New York.

Best,

David



Jim Wallace MD
CAP University of Rochester

Okay, so there are some scary things that happen to the mental health of children and teens and we decided to address them. We start with a nice overview of hallucinations and help you decide if what is being described is pathological or not and, if so, whether it is likely from a psychotic illness or from another source like PTSD or anxiety. If you follow the article closely and learn the algorithm it will serve you for years in those later afternoon moments when a family brings in a child reporting that he/she is hearing “voices”. If you keep in mind that schizophrenia affects about 1% of adults and ½% of 12-17 year olds and very few preteens, it will help you keep these moments in perspective.

Delirium is another scary change in mental status that is concerning. It is not common in an outpatient setting but is possible with acute situations like a toxic ingestion or high fever. It is more common and concerning in the setting of acute medical treatment like in a pediatric intensive care unit or burn unit where it can be a sign of destabilization that needs to be addressed immediately. You may get frightened calls from the families who trust you to help them understanding signs of delirium that may be happening to their child in a hospital setting.

Both of these articles remind me that we should talk more about the Mental Status Exam, (MSE) of children and teenagers in a future newsletter. We will review the parameters we consider and how we go about assessing those parameters in the clinical setting. More to come so stay tuned...

A handwritten signature in black ink that reads "Jim Wallace MD". The signature is written in a cursive, flowing style.

Jim





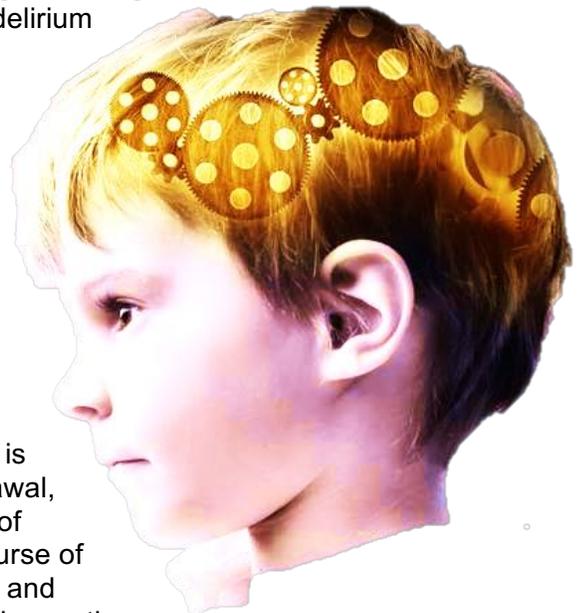
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Vijeta Kushwaha MD
CAP University of Rochester

An Introduction to Childhood Delirium

Delirium comes from the Latin word *de-lira*- which means out of the track. Even though delirium has been described in medical literature using various terminologies, dating back to the Middle Ages, it was Engel and Romano who in 1959 described delirium as a disturbance in the level of consciousness manifesting as cognitive and attentional disturbances which was due to disruption of brain metabolism ⁽¹⁾. In pediatric population, delirium is an important but neglected disorder with significant morbidity and high mortality ⁽²⁾.

In the current DSM-V literature, delirium is defined as an acute confused state characterized by an alteration of consciousness with reduced ability to focus, sustain, or shift attention. It can be associated with disturbance in cognition (memory, orientation, language, visuospatial ability) or perception that are not better explained by another preexisting, evolving or established neurocognitive disorder. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by a medical condition, substance intoxication or withdrawal, or medication side effect. Delirium develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. Psychomotor behavioral disturbances agitation, tremor, and hallucinations can be additionally present but are not essential diagnostic features of delirium in the DSM-V.



Epidemiology: The data regarding the prevalence in pediatric population is limited. The prevalence rate is variable depending upon the age, study setting (general inpatient vs. ICU), illness severity and assessment tools. It is more likely to be encountered in acute care setting than in community sample. Delirium constitute almost 10% of all inpatient referrals to child and adolescent consultation–liaison psychiatry services and between 17% and 66% of psychiatry referrals from pediatric intensive care ⁽²⁾. Incidence of delirium in critically ill children ranges from 5% to 44% and rates over 50% have been reported in children less than 2 years old. In PICU the prevalence is estimated to range from 20% to 30% ⁽³⁾. Pediatric delirium has been associated with high mortality ranging from 12.5% to 29% ^(2, 4). Observational studies revealed that pediatric delirium (PD) is associated with an increased PICU length of stay, a higher chance of neurocognitive dysfunctions, perceptual motor abnormalities, and posttraumatic stress symptoms after discharge ⁽⁵⁾. In another study, about 33% of the PICU patients reported memories of psychotic features, including delusions and disturbing hallucinations, 3 months after discharge ⁽⁶⁾.

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Etiopathogenesis/pathophysiology: Delirium is the culmination of insult to the brain which can involve a variety of pathways and neurotransmitter systems. Dysregulation in acetylcholine and dopamine play an important role but changes have been noted in levels of other neurotransmitter including gamma amino-butyric acid (GABA), glutamine, serotonin, and histamine ⁽⁴⁾.

Risk Factors: Critical illness is the most common cause leading to delirium. The severity of the underlying illness is a major risk factor for pediatric delirium. Other factors can predispose the kids to develop delirium. Some of them are- young age, male gender, preexisting progressive cognitive impairment, mental retardation, preexisting emotional and behavioral problems, physical ill health, and caregiver factors such as care giver anxiety or absence ^(2, 7). Below (Figure 1) is a table with mnemonic "I WATCH DEATH" modified for risk factors pertinent to pediatric population ⁽⁸⁾.

I- infections (leading cause of delirium in children), Intellectual disability
W- withdrawal from drugs
A-age (very young age), acute metabolic conditions
T- trauma- closed head injury, extensive burns
C- CNS tumors, Encephalitis, meningitis,
H- Hypoxia, carbon monoxide poisoning
D- Distress (pain), Developmental delay, Drugs (benzodiazepines, opioids, steroids, and sedatives like propofol and ketamine), deficiency (vitamin deficiency)
E- Emotional and behavioral problems
A-anesthetic agents, absence of caregiver
T- Tumors, Toxins (poisoning)
H – heavy metals, hospital stay (prolonged)

Figure 1

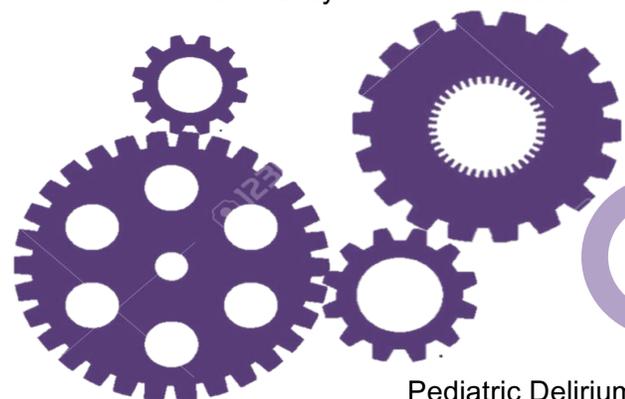
Clinical presentation: Similar to adult and geriatric population, Delirium in children has been subtyped as hyperactive, hypoactive, and mixed type based on motor activity. As opposed to adults, delirium in children may have a distinct course with a more acute onset, less diurnal variability of symptoms, less severe cognitive deficits, more severe perceptual disturbances including more intense hallucinations, more severe delusions, more agitation, and more severe lability of mood. Some unique features of delirium in children and adolescent include developmental regression with transient loss of previously acquired skills, inability of care giver to console the child, reduced eye contact with the usual care giver/parent, and other subtle changes in the quality of the parent–child interaction ^(4, 9). Even though they are not part of diagnostic criteria, they can be very helpful in evaluation of a child. Thus, getting a parent's perspective of their child's baseline level of activity and ability to communicate can be of tremendous significance.

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Diagnosis: The diagnosis of delirium in children older than 5 years (verbal) with normal development is based on DSM-5 or ICD-10 or in children with developmental issues, formal assessment can be challenging. In addition to clinical interview, standardized assessment scales can be handy tools. There are a few validated rating scales available for use in pediatric

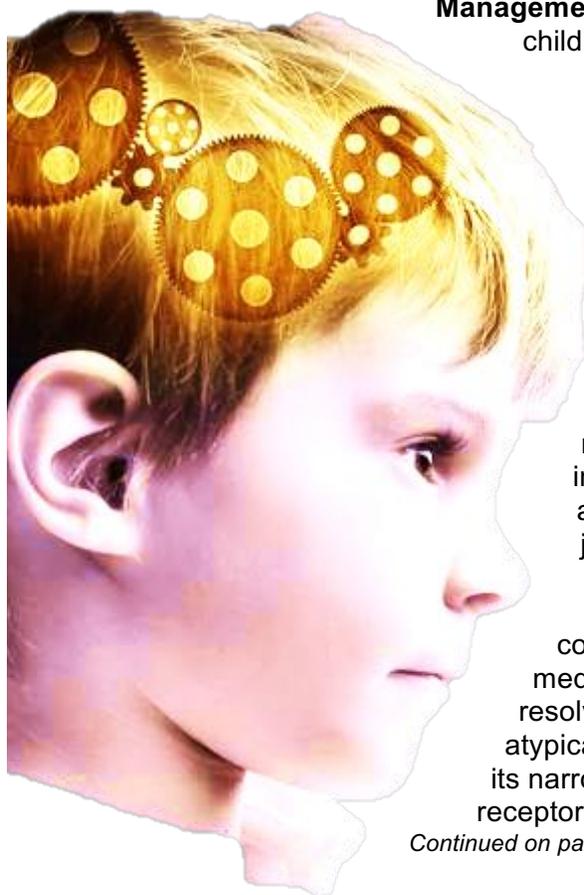
population. Two derivatives from Confusion Assessment Method for the ICU (CAM-ICU) have been developed and validated for use in children- Pediatric CAM-ICU (pCAM-ICU) can be used in children 5 years and older, and Preschool CAM-ICU (psCAM-ICU) can be used for kids between 6 months to 5 years. Paediatric Anaesthesia Emergence Delirium (PAED) scale has been validated in children 19 months to 6 years of age for delirium that occurs following anesthesia. Cornell Assessment of



Pediatric Delirium (CAP-D) is a modified from PAED scale to use in PICU setting and can help in differentiating subtypes of delirium in children^(2, 3, 7).

EEG can be sometimes helpful in assessment of delirium in children. The findings are similar to those in adults with generalized background slowing. The frequency of EEG abnormalities among children and adolescents with delirium ranges from 65% to 86% and the EEG findings fluctuate based on the clinical waxing and waning of symptoms which can limit its utility⁽²⁾.

Management: The basic principles that guide management of delirium in children are same as that in adults, including, management of underlying illness and electrolyte abnormalities, removing any offending agents if present, modifying environment, and using antipsychotics if needed. Environmental modifications can be helpful in providing orientation and calming anxiety of young kids. Some of these could be- presence and active involvement of family member, having familiar objects (like favorite toys, blankets, pictures of home, pets) in the room, familiar music and sounds, limiting noxious noise and light, limiting room and staff changes, maintaining approximately normal diurnal schedules, early mobilization, and using one-on-one nursing observation as necessary. In a child experiencing delirium, pharmacological means should be resorted to only when the non-pharmacological interventions have not been effective and the symptoms of severe anxiety, agitation, hallucinations and delusions can potentially jeopardize child's safety and/or interfere with their treatment. The literature on pharmacological management of Delirium in children is limited and the use of medications is primarily based on consensus. Antipsychotics are the most commonly used medications for delirium in pediatric subgroup and may be helpful in resolving delirium and in reducing agitation. In hyperactive delirium, atypical antipsychotic like haloperidol may be more effective because of its narrower receptor targeting and strong affinity for the dopamine D2 receptor. Atypical antipsychotics may be more useful in mixed or



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hypoactive delirium because of their wider receptor effects, and may have lesser cognitive side effects compared with typical antipsychotics. Risperidone is the most commonly used atypical antipsychotic. All antipsychotics carry the risk of QT prolongation, which can lead to torsade de pointes. The risk is increased if there are underlying electrolyte abnormalities, infection, hypoxia, or with use of certain medications that change cardiac electrophysiology and thus these factors should be considered when using antipsychotics and cardiac status should be monitored. It is prudent to stop antipsychotic treatment if there is significant QTc prolongation, a QTc >500 msec, new T wave abnormalities, and marked bradycardia^(2, 4, 6, 7).

Discussion: Delirium can be a disturbing and stressful experience for children and their families. It is thus important to recognize the risk factors, presentation and management and the risk that Delirium poses. While it is not uncommon to encounter delirium in critically ill pediatric population in hospital setting, it can also be seen in community setting and can camouflage with varied presentations. Primary care physicians may find themselves in role of psycho-educators for families and may need to help family navigate through this phase.

Teaching points:

- Delirium in pediatric population is common in critical care setting.
- It is not only associated with high mortality, increased length of hospital stay, but can lead to PTSD related to the experience of Delirium.
- Diagnosis is clinical based on DSM V or ICD 10 criteria
- Pharmacological management using antipsychotics is usually the last resort when non-pharmacological interventions have not helped.

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What is OnTrackNY?

OnTrackNY is an innovative treatment program for adolescents and young adults who recently have had unusual thoughts and behaviors or who have started hearing or seeing things that others don't. OnTrackNY helps people achieve their goals for school, work, and relationships. Programs are located throughout New York State.

OnTrackNY provides consultation and training, as well as manuals and web-based resources, to programs and State agencies that would like to implement Coordinated Specialty Care teams for people with early psychosis.

The program is for adolescents and young adults between the ages of 16 and 30 who have recently begun experiencing psychotic symptoms, such as hallucinations, unusual thoughts or beliefs, or disorganized thinking, for more than a week but less than 2 years.

OnTrackNY teams provide services to all referred individuals meeting clinical admission criteria, without wait lists and regardless of their insurance status or ability to pay.

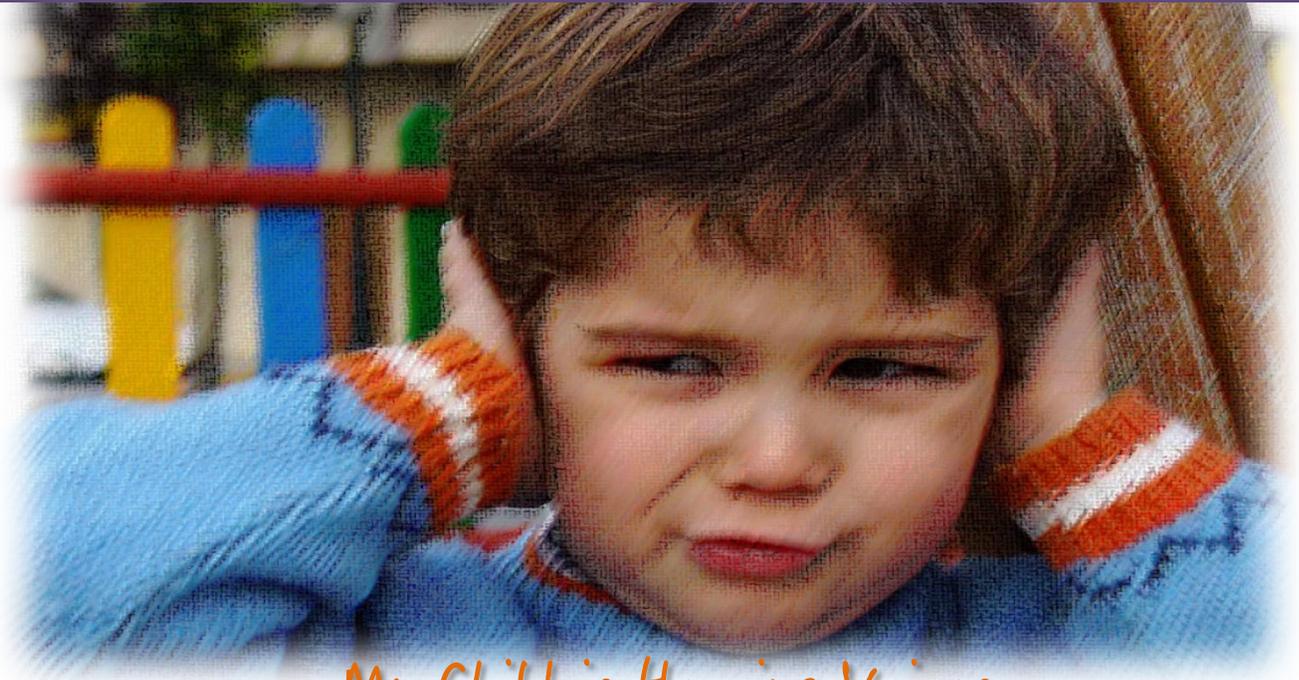
What services does OnTrackNY offer?

OnTrackNY utilizes a "shared decision making" model and involves:

- Comprehensive treatment using evidence-based practices delivered by an integrated clinical team specializing in early psychosis
- Psychiatric treatment, employment and educational support, substance abuse treatment, family education and support, and other services as needed.

How can I make a referral to OnTrackNY?

Contact your nearest OnTrackNY program at www.ontrackny.org



My Child is Hearing Voices: Understanding Hallucinations in Children and Adolescents

By Joshua Russell MD and Sourav Sengupta MD

Most Mental Health and Primary Care providers, schools, and the general public would agree that hallucinations in childhood are extremely rare events. However, surprise, we are all wrong! The prevalence rate of having experienced any kind of hallucination, according to a 2012 meta-analysis by Kelleher et al, is 17% (1/6) for 9-12 year olds, and 7.5% (1/13) for adolescents¹. As gatekeepers to children's health, Pediatric Primary Care providers are often the first to encounter a distraught child and family presenting with hallucinations, usually on a busy Friday afternoon. These kids and their families are often terrified and beg their providers to figure out what is happening, fearing that the hallucinations signal the onset of a chronic psychotic illness² as it often does with adults.

Fortunately, the good news for children is that experiencing hallucinations is not usually a precursor to a lifelong serious mental illness. In one study, 2 out of 3 of children who endorsed hallucinations were determined to have "non-psychotic" or even "non-pathological" hallucinations³. The majority of families of children experiencing these scary symptoms can be reassured that their child is NOT developing something like schizophrenia or schizoaffective disorder.

That said, why do children experience hallucinations if not from a "psychotic process"? The answer is that there are many reasons and to uncover the underlying cause often takes some detective work. Hallucinations, like fevers, are symptoms and NOT disorders. They indicate an underlying problem that needs to be addressed to resolve the symptom and prevent recurrence.

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It is useful to categorize the problems that lead to pediatric hallucinations into two broad categories, benign and pathological. The benign category contains hallucinations related to phobias, other anxiety in young or delayed children, brief hallucinations related to grief or a child misinterpreting their environment.

These cases can be met with reassurance, education, and additional monitoring from the family and PCP. Consider the case below:

Her worried parents brought their 6-year-old daughter, Amanda, to the Pediatrician's office because an hour ago she reported seeing and feeling "bugs crawling on her." She has no past psychiatric history except for being a little shy and slow to warm up to new people and experiences. The parents also report that she has always been deathly afraid of insects, particularly spiders, but has never experienced anything like this before. During the episode, which lasted for about 30 minutes when she came home on the school bus, she cried inconsolably and hyperventilated. The parents were unaware of any particular trigger. However, during the careful history gathering, she revealed that her class had a Halloween party today and they ate cookies that looked like spiders. She was too scared and embarrassed to discuss the cookies with her parents earlier.

When a child experiences a short, self-resolving episode, there is no history of hallucinations, and her level of functioning (outside of the 30 minutes) has not been impacted, she and her parents can be reassured that their child's experience is not a sign that she is developing a chronic psychotic illness.

When trying to determine if a hallucinatory experience is benign or pathological, it is important to consider context, such as the presence of an identifiable trigger and impact on functioning like with Amanda. Another consideration is the actual phenomenology of the hallucination such as how long it lasts, the child's ability to control the hallucination and how the hallucination affects the child. Benign hallucinations typically do not have a major impact on a child's day-to-day functioning, are infrequent, and the content of the hallucinations are not overly concerning in nature.

Pathological hallucinations, in contrast, impact a child's thoughts and behaviors in a way that leads to a sustained change in functioning. The content is often very upsetting and the child feels a loss of control during the experience.

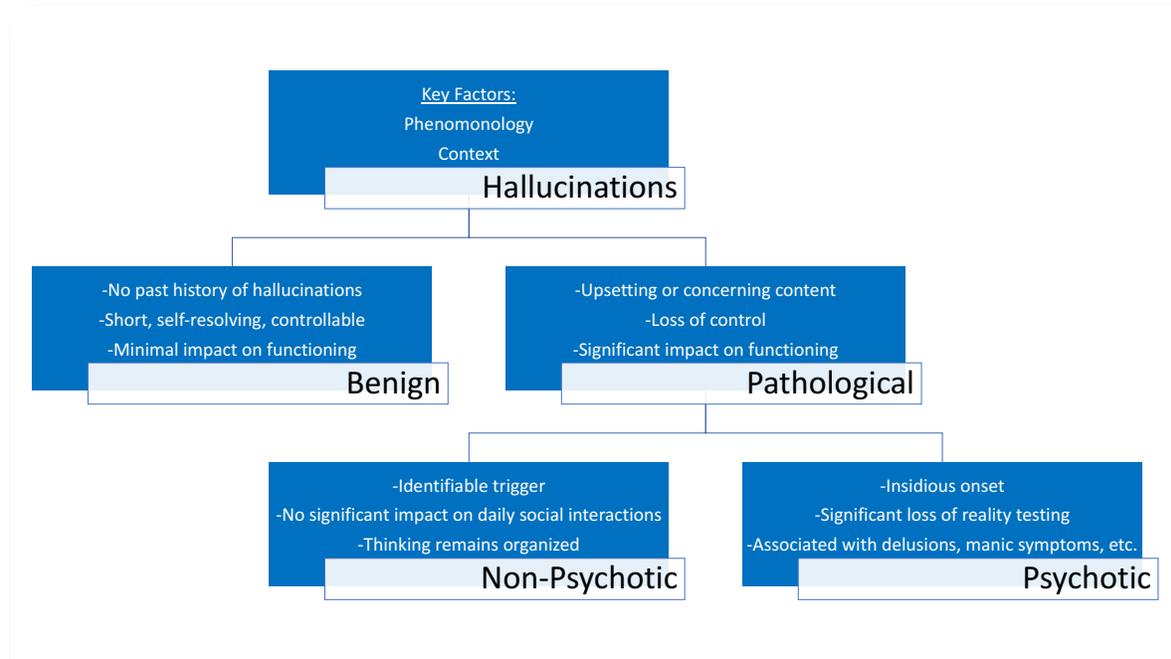
Six-year-old Emily presents with her foster mother to the outpatient clinic for an initial appointment. Her foster mother is concerned because, ever since she arrived in her home eight weeks ago, Emily has been "talking to people that aren't there." She has a history of significant acute and chronic trauma and neglect and foster mom reports that the child constantly worries that something will happen to her, experiences frequent mood swings, and frequently becomes aggressive. At times, Emily plays well with peers at school but is explosive whenever she becomes upset. During the clinical interview, she says that she talks to one of the people that used to live with her when she lived with her biological mother and they say things that are not nice.

Once a hallucination is determined to be "pathological", it is important to distinguish whether it is related to a psychotic or non-psychotic process because the treatment can differ. Frequently, non-psychotic pathological hallucinations can be traced back to a trigger, which causes a stress or anxiety response in the child.

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In Emily's case, she has experienced significant trauma, which has left her body and mind in a constant state of high alert, which is likely what led to her hallucinatory experience. Emily's thoughts are not disorganized and she is able to interact with other people and think about everyday situations in a rational way.



This child will likely need trauma-related therapy to build coping skills and eventually process her traumatic experiences. If she is already connected to mental health treatment, the Primary Care Provider should coordinate care with them so they are aware of what her foster mother is reporting. If she is not in any treatment, the Primary Care Provider should refer them to an appropriate treatment provider or utilize the CAP-PC Liaison Coordinator to help in this process. An antipsychotic medication might alleviate some of her symptoms but would put her at risk for significant adverse side effects and would not address the underlying trauma-based process, which will continue to impact this child's functioning.

Pathological hallucinations resulting from a psychotic process have a more gradual, insidious onset called the "prodrome" with deterioration in functioning including personal hygiene, social engagement and school performance. Psychotic hallucinations are often longer in duration with primitive and frightening content. Another distinguishing aspect of psychotic hallucinations is their association with delusions, grandiosity, disorganized thinking and broad changes in language and motor behavior⁴⁻⁵:

Jameer is a 12-year-old boy who presents to the emergency department from his middle school after an unprovoked physical assault of a younger peer. He reports that he hit this peer because "a death angel told me I needed to destroy him to save the world." A month ago, he came to his parents with concerns that his teachers were plotting to prevent him from "fulfilling his mission". His parents report that he has been sleeping less than two hours a night for the past week but doesn't appear tired. He has been talking faster than usual and continuously changes topics in the middle of a conversation. When interviewed, the child is agitated, has great difficulty staying on task and speaks very rapidly.

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In this case, the hallucinations have been present for a week and are associated with multiple concerning symptoms that point towards a psychotic process. In most children, including Jameer, this is more often a bipolar spectrum illness than schizophrenia. This child has lost his sense of reality and is unable to interact with the world in a rational way. This child will require an intense level of treatment, which may include hospitalization and/or an antipsychotic medication as a central part of his treatment regimen.

To conclude, encountering a family whose child has experienced a hallucination can often be an emotionally taxing process. The child and family will likely be experiencing significant distress and may expect you to “save” their child from a chronic, psychotic illness. It is important to be able to categorize and triage the child’s symptoms because the child usually has a better prognosis than either the child or family think. These families can be reassured and educated about non-pathologic and non-psychotic hallucinations and how they might best be managed. In addition, identifying hallucinations that are pathological and/or psychotic will lead to efficient referrals to the appropriate treatment.

As always, the CAP-PC phone line (1-855-227-7272) is available to help you sort through these more challenging cases!

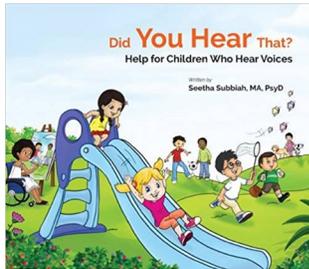
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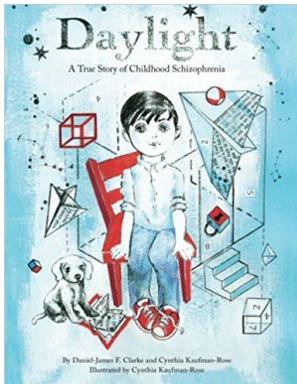
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book review



DID YOU HEAR THAT? HELP FOR CHILDREN WHO HEAR VOICES
 By Seethalakshmi Subbiah PsyD
 ISBN-13:9789813144149
 Publisher: WS Education 2016

Susie is a 9-year-old who keeps her challenges with auditory and visual hallucinations a secret until a teacher alerts her parents of her difficulties at school. With compassion, empathy, love and understanding, Susie's parents encourage her to see a counselor. Susie builds trust and rapport with her counselor, which finally allows her to share her well-guarded secret.



DAYLIGHT: A TRUE STORY OF CHILDHOOD SCHIZOPHRENIA
 By Daniel-James F. Clarke, Cynthia Kaufman-Rose
 ISBN-13: 9780982548097
 Publisher: Sunny Day Publishing LLC 2013

Gentle prose and thought-provoking illustrations take young and old on an extraordinary journey into the mind of Daniel, a young boy with schizophrenia.

you have questions...

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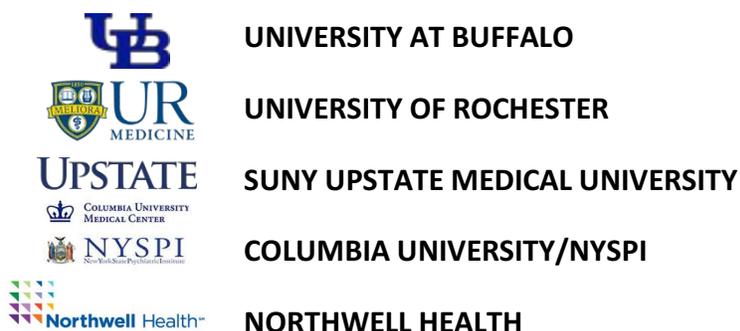
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