



Fierce Hope: *Helping Youth Thrive in rural & frontier Eastern Oregon*

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October 16, 2026



Youth Mental Health: Why Primary Care Matters

- **Nearly 40%** of U.S. high school students report persistent sadness or hopelessness
- **18%** experience major depression; **10%** report a suicide attempt
- **Rural youth face greater risk** alongside significant barriers to behavioral health care.
- In rural/frontier Oregon: **provider shortages, distance, stigma, and limited broadband** compound access challenges
- **Highest-risk populations** include LGBTQ+ youth, American Indian/Alaska Native youth, and youth involved in foster care or juvenile justice

We are the safety net. Primary care may be the only point of contact for these kids.

Learning Objectives

1. **Recognize** the most common mental health conditions affecting youth encountered in primary care, including anxiety, depression, ADHD, and substance use disorders
2. **Initiate** evidence-based first-line interventions, including screening, brief counseling, and appropriate pharmacologic treatment when indicated
3. **Identify** when referral to psychiatry, behavioral health, or higher levels of care is appropriate, and describe community resources that support youth and families (e.g., IIBHT, wraparound services, and virtual DBT)
4. **Assess** suicide risk using a structured, compassionate approach and determine appropriate next steps based on the level of risk
5. **Discuss** practical strategies that promote youth resilience and wellbeing, including sleep, physical activity, family engagement, and other holistic interventions

“Learn to read symptoms not only as problems to be overcome but as messages to be heeded.”

– Dr. Gabor Mate





Common Youth Mental Health Conditions

1. ANXIETY — Most common pediatric psychiatric disorder

GAD, social anxiety, separation anxiety

Look for **somatic symptoms**: headaches, stomachaches with school refusal

2. DEPRESSION — It may not look like sadness

Adolescents often present with **irritability**

Ask about **anhedonia** and co-occurring anxiety

3. ADHD — Function matters

Symptoms + impairment must occur across settings

Get teacher/school input whenever possible

4. SUBSTANCE USE — Screen early, treat together

Alcohol, nicotine, cannabis, stimulants & opioids/fentanyl

Mental health + SUD frequently **co-occur**

→ Integrated treatment improves care

Clinical pearl: Ask what has changed—in school, at home, with friends, sleep, behavior, and functioning.



Don't Miss: Youth Eating Disorders

Third most common chronic illness in adolescents

- **Most are NOT underweight** — atypical anorexia, bulimia, binge-eating disorder, avoidant/restrictive food intake disorder
- Screen when concerned: SCOFF (≥ 2) or ESP — case-finding, not universal (USPSTF "I")
- **Medical instability:** HR < 50 , significant orthostasis, or electrolyte/ECG abnormalities → urgent evaluation
- **Treatment:** early multidisciplinary referral; family based therapy is first-line for adolescent anorexia (Telehealth for eating disorders when appropriate)
- **Medication is an adjunctive:** fluoxetine may help bulimia
- **Suicide risk is independently elevated:** ask directly
- **Rural teens present later and sicker** — think of it early



ANXIETY



DEPRESSION





ADHD





ADHD in girls



Screening: Our 2-Minute Superpower

Screen Early → Start the Conversation

Routine screening

Anxiety: ages 8–18

Depression: ages 12–18

Behavioral/emotional screening
throughout well-child-care

Quick Tools for Primary Care

Broad: PSC-17 | SDQ

Anxiety: SCARED

Depression: PHQ-A

ADHD: Vanderbilt (parent and teacher)

Substance use: CRAFFT 2.1

Suicide: ASQ → C-SSRS for further assessment

Make It Routine

Incorporate screening into the **rooming workflow**

Complete + score **before the provider enters**



ADHD Screening Forms

Vanderbilt (teacher/parent)

Conners (teacher/parent/self)

NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____
Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Profile for Males: Conners' Teacher Rating

Name: _____ Gender: M F
Birthdate: _____ Age: _____ School Grade: _____
Teacher's Name: _____ Today's Date: _____

Legend:
A. Oppositional: Are likely to break rules, have problems with authority, are easily annoyed
B. Cognitive Problems/Inattention: Are likely to be inattentive, have organizational problems
C. Hyperactivity: Have difficulty sitting still for very long, feel restless and impulsive
D. Anxious-Shy: Have atypical amount of worries and fears, prone to be emotional and sensitive to criticism, anxious in unfamiliar situations, are shy and withdrawn
E. Perfectionism: Set high goals for themselves, are very fastidious about the way they do things, are obsessive about their work
F. Social Problems: Are likely to perceive that they have few friends, have low self-esteem and self-confidence, feel socially detached from their peers
G. Conners' ADHD Index: Identifies children/adolescents "at risk" for ADHD
H. CGI Restless-Impulsive: This subscale indicates restlessness, impulsivity, and inattention/verve

Note:
For age-groups:
Column 1: ages 3 to 5
Column 2: ages 6 to 8
Column 3: ages 9 to 11
Column 4: ages 12 to 14
Column 5: ages 15 to 17

	A. Oppositional	B. Cognitive Problems/Inattention	C. Hyperactivity	D. Anxious-Shy	E. Perfectionism	F. Social Problems	
	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
80	16+ 15+ 14+ 13+ 12+	16+	16+	16+	16+	16+	80
81	15+ 14+ 13+ 12+ 11+	15+	15+	15+	15+	15+	81
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92	4+ 3+ 2+ 1+ 0+	4+	4+	4+	4+	4+	92
93	3+ 2+ 1+ 0+ 0+	3+	3+	3+	3+	3+	93
94	2+ 1+ 0+ 0+ 0+	2+	2+	2+	2+	2+	94
95	1+ 0+ 0+ 0+ 0+	1+	1+	1+	1+	1+	95
96	0+ 0+ 0+ 0+ 0+	0+	0+	0+	0+	0+	96
97	0+ 0+ 0+ 0+ 0+	0+	0+	0+	0+	0+	97
98	0+ 0+ 0+ 0+ 0+	0+	0+	0+	0+	0+	98
99	0+ 0+ 0+ 0+ 0+	0+	0+	0+	0+	0+	99
100	0+ 0+ 0+ 0+ 0+	0+	0+	0+	0+	0+	100



First-Line Interventions

PSYCHOTHERAPY

- **Anxiety:** CBT first-line
- **Depression:** CBT or interpersonal therapy
- **Substance use:** SBIRT → Screen • Brief Intervention • Refer
- PCPs can use **motivational interviewing, behavioral activation, psychoeducation & problem-solving**

First-Line Interventions

MEDICATION

- **Anxiety:** SSRI ± CBT → combination often most effective
- **Depression:** Fluoxetine first-line (age 8+)| Escitalopram also FDA-approved ≥12
- **ADHD:** Stimulants first-line → consider non-stimulants when appropriate
- **Start low → titrate thoughtfully → monitor**

⚠ Antidepressant Safety

FDA boxed warning for increased suicidal thoughts/behaviors in youth and young adults → **counsel families + monitor closely**, particularly early in treatment and after dose changes



Clinical Pearl: Medication works best as part of a treatment plan—not as the entire treatment plan.

Depression/Anxiety Medications

Comparing SSRIs to SNRIs for Depression and Anxiety Treatment in Children and Teens

	SSRIs	SNRIs
Efficacy for depression	Fair (fluoxetine and escitalopram)	Not shown (duloxetine possible exception)
Efficacy for anxiety	Good	Fair (duloxetine)
Common side effects	Behavioral activation, withdrawal symptoms	Gastrointestinal upset, sedation
Shared risks	Suicidal ideation (1%)	Suicidal ideation (1%)
FDA approvals	Fluoxetine (MDD 8+, OCD 7+), escitalopram (MDD 12+, GAD 7+), sertraline (OCD 6+), fluvoxamine (OCD 8+)	Duloxetine (GAD 7+, fibromyalgia 13+)

GAD = generalized anxiety disorder; MDD = major depressive disorder; OCD = obsessive-compulsive disorder

From the Clinical Update:

“SNRIs in Kids: When to Use Them for Depression and Anxiety”

By Kristen Kim, MD and Charmi Patel Rao, MD, DFAACAP

The Carlat Child Psychiatry Report

Volume 16, Issue 6&7, October/November/December 2025

www.thecarlatreport.com

Table 2.

Medications that may be used to treat anxiety disorders in children and adolescents.						
Class	Medication (Brand name)	Common dose range (mg/day)	Tablet size (mg)	Common side effects	Serious side effects	Uncommon, serious side effects
SSRI	Citalopram/escitalopram (Celexa/Lexapro TM)	10/5–40/20	10/5, 20/10, 40	• Headache • Insomnia • Diarrhea	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults	• Serotonin syndrome • Bleeding problems
	Fluvoxamine (Luvox TM , Luvox CR TM)	100–300	25, 50, 100, 150	• Decreased appetite • Hyperactivity/restlessness • Vomiting	• Potential for abnormal heart rhythm	
	Sertraline (Zoloft TM)	25–200	25, 50, 100	• Increased anger/irritability • Sexual dysfunction	• Mania	
	Fluoxetine (Prozac TM , Sarafem TM)	10–60	10, 20, 40, 60	• Muscle pain • Weight loss/gain		
	Paroxetine (Paxil TM , Pezeva TM)	10–50	10, 20, 40			
SNRI	Venlafaxine ER (Effexor TM)	37.5–225	37.5, 75, 150, 225	• Sleepiness • Insomnia	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults	• Serotonin syndrome • Bleeding problems
	Duloxetine (Cymbalta TM)	30–120	20, 30, 40, 60	• Restlessness • Sexual dysfunction		
	Atomoxetine (Strattera TM)	10–100	10, 18, 25, 40, 60, 80, 100	• Headache • Dry mouth • Increased anger/irritability • Increased blood pressure • Increased heart rate • Muscle pain • Weight loss/gain	• Mania	
Tricyclic antidepressant	Clomipramine (Anafranil TM)	75–250	25, 50, 75	• Sleepiness • Dry mouth • Weight gain	• Boxed warning—suicidal thinking and behavior in children, adolescents, and young adults	Serotonin syndrome
	Imipramine (Tofranil TM , Trofranil-PM TM)		10, 25, 50		• Heart rhythm problems; electrocardiogram and blood levels • Mania	
Benzodiazepine	Alprazolam (Xanax TM , Alprazolam Intensol TM)	0.5–1.5	0.25, 0.5, 1, 2	• Drowsiness • Clumsiness • Dry mouth • Dizziness • Abdominal pain	• Possible dependence • Withdrawal symptoms when used at high doses, especially when administered over long periods. Decreasing the dose gradually is a common strategy to decrease the risk of withdrawal symptoms.	Respiratory depression (possible at high doses and when combined with other central nervous system depressants)
	Clonazepam (Klonopin TM)	0.5–3	0.5, 1, 2			
	Lorazepam (Ativan TM , Lorazepam Intensol TM)	1–2	1, 2		• Disinhibition • Memory impairment • Worsening depression	
Atypical anxiolytic	Buspirone (Buspar TM)	15–60	5, 10, 15, 30	• Dizziness • Lightheadedness • Tiredness		
Antihistamine	Diphenhydramine (Benadryl TM , Banophen TM , Diphenhist TM)	12.5–50	25, 50	• Sleepiness • Dry mouth • Decreased sweating	• Abnormal heart rhythms • Agitation	
	Doxylamine (Unisom TM , WalSom TM)	12.5–50	25, 50		• Difficulty completely emptying the bladder • Harm to certain types of blood cells	
	Hydroxyzine (Atarax TM)	25–50	10, 25, 50		• Seizures	

Adapted from Wilens, Hamner. *Straight Talk about Psychiatric Medications in Kids* (Guilford Press, 2016).

From AACAP “Anxiety Disorders Parents Medication Guide”

Table 1. Stimulant Medications

Methylphenidate (MPH) for ADHD					
Medication	Starting Dose	How Supplied	Dosage Form	Duration of Medication Effects	Given how many times a day?
Adhansia XR	25 mg	25, 35, 45, 55, 70, 85 mg	capsules	Up to 16 hours	Once
Aptensio XR	10 mg	10, 15, 20, 30, 40, 50, 60 mg	capsules	12 hours	Once
Azstarys XR	26.1/5.2 mg	26.1/5.2, 39.2/7.8, 52.3/10.4 mg	capsules	12 hours	Once
Concerta	18 mg	18, 27, 36, 54 mg	capsules	12 hours	Once
Contempla XR	8.6 mg	8.6, 17.3, 25.9 mg	disintegrating tablets	12 hours	Once
Daytrana	10 mg	10, 15, 20, 30 mg	patch	6–16 hours	Once
Focalin	2.5 mg	2.5, 5, 10 mg	tablets	4–5 hours	Two to three times
Focalin XR	5 mg	5, 10, 15, 20 mg	capsules	10–12 hours	Once
Jornay PM	20 mg	20, 40, 60, 80, 100 mg	delayed-release capsules	12 hours	Once
Metadate CD	20 mg	10, 20, 30, 40, 50, 60 mg	capsules	8 hours	Once
Quillivant	<10 mg	25 mg	suspension	12 hours	Once
Quillichew	<10 mg	20, 30, 40 mg	chewable tablets	8 hours	Once
Ritalin IR	5 mg	5, 10, 20 mg	tablets	3–4 hours	Two to four times
Ritalin LA	20 mg	10, 20, 30, 40 mg	capsules	8 hours	Once
Amphetamine (AMPH) for ADHD					
Medication	Starting Dose	How Supplied	Dosage Form	Duration of Medication Effects	Given how many times a day?
Adderall	2.5–5 mg	5–30 mg	tablets	6 hours	Once to twice
Adderall XR	2.5–5 mg	5, 10, 15, 20, 25, 30 mg	capsules	12 hours	Once
Adzenys XR	6.3–12.5 mg	3.1, 6.3, 9.4, 12.5, 15.7, 18.8 mg	disintegrating tablets	12 hours	Once
Dexedrine Spansule	5 mg	5, 10, 15 mg	spansules	6 hours	Once to twice
Dexedrine Tablets	2.5–5 mg	5, 10, 15, 20 mg	capsules	3–5 hours	Two to three
Dyanavel XR	2.5–5 mg	2.5 mg	suspension	13 hours	Once
Evekeo	2.5–5 mg	5, 10 mg	tablets	3–5 hours	Two to three
Mydayis	12.5 mg	25, 50 mg	capsules	Up to 16 hours	Once
Vyvanse	30 mg	20, 30, 40, 50, 60, 70 mg	capsules	12–14 hours	Once

ADHD Medications

Nonstimulants:

Intuniv (guanfacine) 1-4mg/d- age 6-17

clonidine ER 0.1-0.4mg/24 hours (given BID) 6-17, or clonidine patch (7 days)

atomoxetine (old Strattera): dose based on weight 1.2-1.4mg/kg-age 6+

New since 2020:

Xelstrym (Adderall transdermal patch)

Onyda XR (clonidine suspension)- YAYY!

Qelbree (viloxazine)- like Strattera. Works faster(2 vs 4-6w), can be put on food.

Simtriyo (centanafadine)- triple reuptake inhibitor NDSRI “stimulant” though many consider nonstimulant (no A/R)

Antipsychotics FDA approval

Abilify/aripiprazole: Autism irritability(6+), Bipolar manic/mixed (10+), Schizophrenia (13+), Tourette's (6+)

Risperdal/risperidone: Autism (5+), Bipolar mania (10+), Schizophrenia (13+)

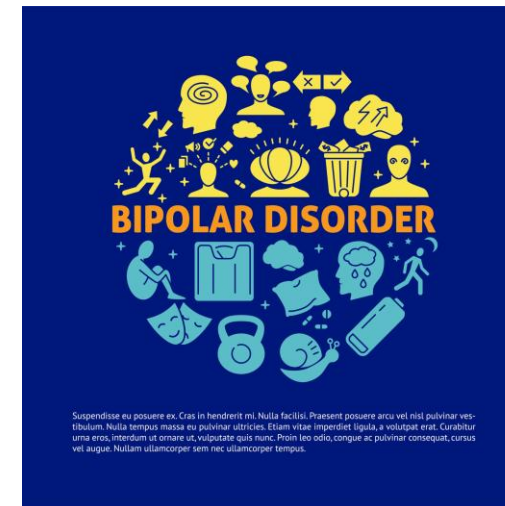
Zyprexa/olanzapine: SZP/BP (13+)

Seroquel/quetiapine: BP mania (10+), SZP (13+)

Saphris/asenapine: BP manic/mixed (10+)

Invega/paliperidone: SZP (10+)

Latuda/Lurasidone: BP depression (10+), SZP (13+)



Suicide Prevention: Ask Every Time

SCREEN

- **≥12:** Universal suicide risk screening
- **Ages 8–11:** Screen when clinically indicated
- **ASQ:** 4 questions • <2 minutes • excellent for initial screening
- **C-SSRS:** Assesses severity of suicidal ideation & behavior

ASSESS → ACT

- **Low risk:** No current intent/plan → safety plan + close follow-up
- **Moderate risk:** Suicidal thoughts/behavior requiring further assessment → safety plan + lethal means counseling + urgent behavioral health evaluation
- **High risk:** Current intent/plan or inability to maintain safety → **do not leave alone** → **emergency evaluation**

Clinical Pearl: A positive screen requires further assessment—not automatically hospitalization.



Safety Planning Saves Lives

Stanley-Brown Safety Plan

1. Recognize **warning signs**
2. Use **internal coping strategies**
3. Identify **people & places for distraction**
4. Identify **people who can help**
5. Contact **professionals/crisis resources**
6. **Make the environment safer**



Lethal Means Counseling



An Essential, Do-Not-Miss Component of Safety Planning

- Ask directly about **firearms, medications & other accessible means**
- Partner with families on **temporary secure storage/reduced access**
- Especially important where firearm access is common
- **Safety plan ≠ “no-harm contract”**
- Safety planning is **collaborative, specific & actionable**



Case Study

Maddie: age 15 (Risk Assessment)

- 15 y/o, lives on a cattle ranch outside Pendleton; presents for a **sports physical**

Mom: "hasn't been herself" — poor sleep, quit volleyball, isolating

- Routine tablet screening in waiting room:

PHQ-A = 18 (moderately severe); item 9 endorsed

ASQ = positive

C-SSRS interview (seen privately):

Active ideation, several times/week

Method considered (home medications); **no plan or intent**

No prior attempts; recent superficial self-scratching

Lethal means accessible — firearms, medications in home

- **Risk formulation: MODERATE** → same-day intervention, not emergency transfer



Maddie: Intervention & Referral

- **Safety plan (Stanley-Brown)** completed together, copy to her phone
Warning signs → coping → contacts → crisis lines (988, Lines for Life)
- **Lethal means counseling** with mom:
Firearms locked/off-site with a neighbor
Medications locked or removed
- **Stepped, rural-adapted referral:**
OPAL-K — same-day psychiatric phone consult
IOP with warm handoff (or **telepsychiatry + virtual DBT** if distance)
IIBHT + wraparound to bring services to the family
- **Bridging care:** start **fluoxetine** (boxed-warning counseling), **48–72 hr safety check**, follow-up ≤ 1 week
- **Escalation plan given:** plan/intent or means not secured → ED / 988, do not leave alone



When to Refer & Finding Help

Refer to psychiatry when there is:

- **Diagnostic complexity** → bipolar disorder, psychosis, complex comorbidity
- **Treatment resistance** → inadequate response to ~2 appropriate treatment trials
- **High-risk presentation** → significant suicidality, serious self-harm, escalating safety concerns
- **Complex co-occurring SUD**
- **Complex pharmacotherapy** → polypharmacy, off-label treatment, significant adverse effects

Refer urgently / escalate level of care when:

- **Safety cannot be maintained outpatient**
- **Acute psychosis, mania, severe agitation, or inability to function safely**
- **Medical instability or intoxication/withdrawal** requires acute care

Match the Youth to the Right Level of Care

Increasing intensity

Outpatient → Therapy + medication management

IOP → More support than weekly outpatient care

IIBHT → Intensive treatment **in the home/community**

Wraparound → Family-driven, cross-system care coordination

Residential / Inpatient → Highest-acuity treatment

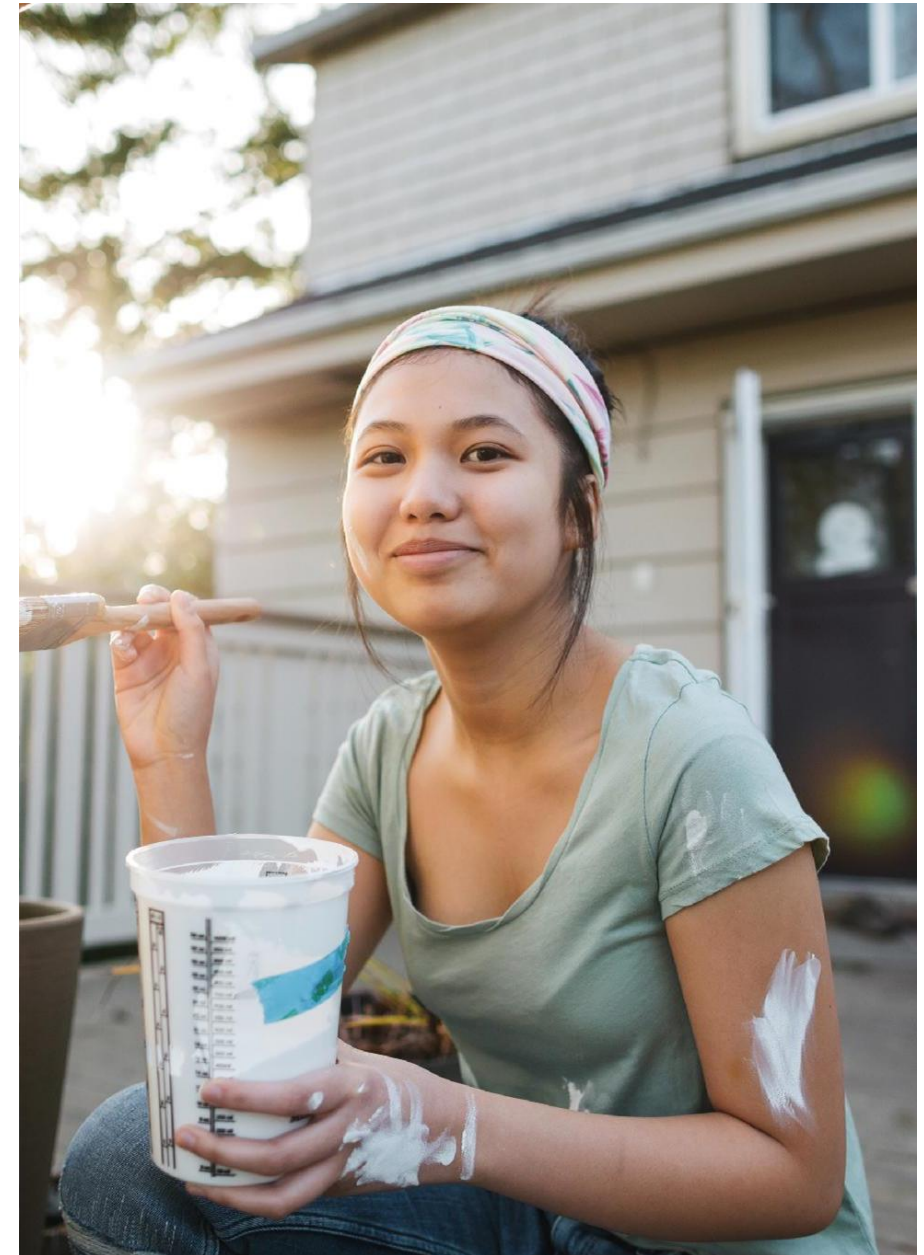
Oregon Resources

OPAL-K → Pediatric psychiatric consultation for PCPs

Virtual DBT → Expands access, especially in rural/frontier communities

988 / Lines for Life → Crisis support

Oregon Family Support Network → Family/peer support





Telepsychiatry: Bridging the Gap in Frontier Oregon

- **Rapid expansion:** Transformed access to behavioral health care for Medicaid-enrolled youth
- **Benefits:** ↓ travel barriers • ↓ stigma • ↓ no-shows • ↑ family involvement
- **Best uses:** Therapy • medication management • follow-up • specialty consultation
- **Challenges:** Broadband gaps • smartphone-only access • not appropriate for every youth or clinical situation
- **Think hybrid:** Match **virtual vs. in-person care** to the youth, family, acuity, and clinical need

Building Resilience: The Basics Matter

Resilience isn't simply a trait → it can be strengthened.

- **SLEEP**

School-age: **9–12 hrs** | Teens: **8–10 hrs**

Consistent routine • screens out of the bedroom

Poor sleep ↔ depression, anxiety & suicide risk

- **MOVEMENT**

Aim for **≥60 min/day** for ages 6–17

Make it accessible: sports • walking • hiking • outdoor play

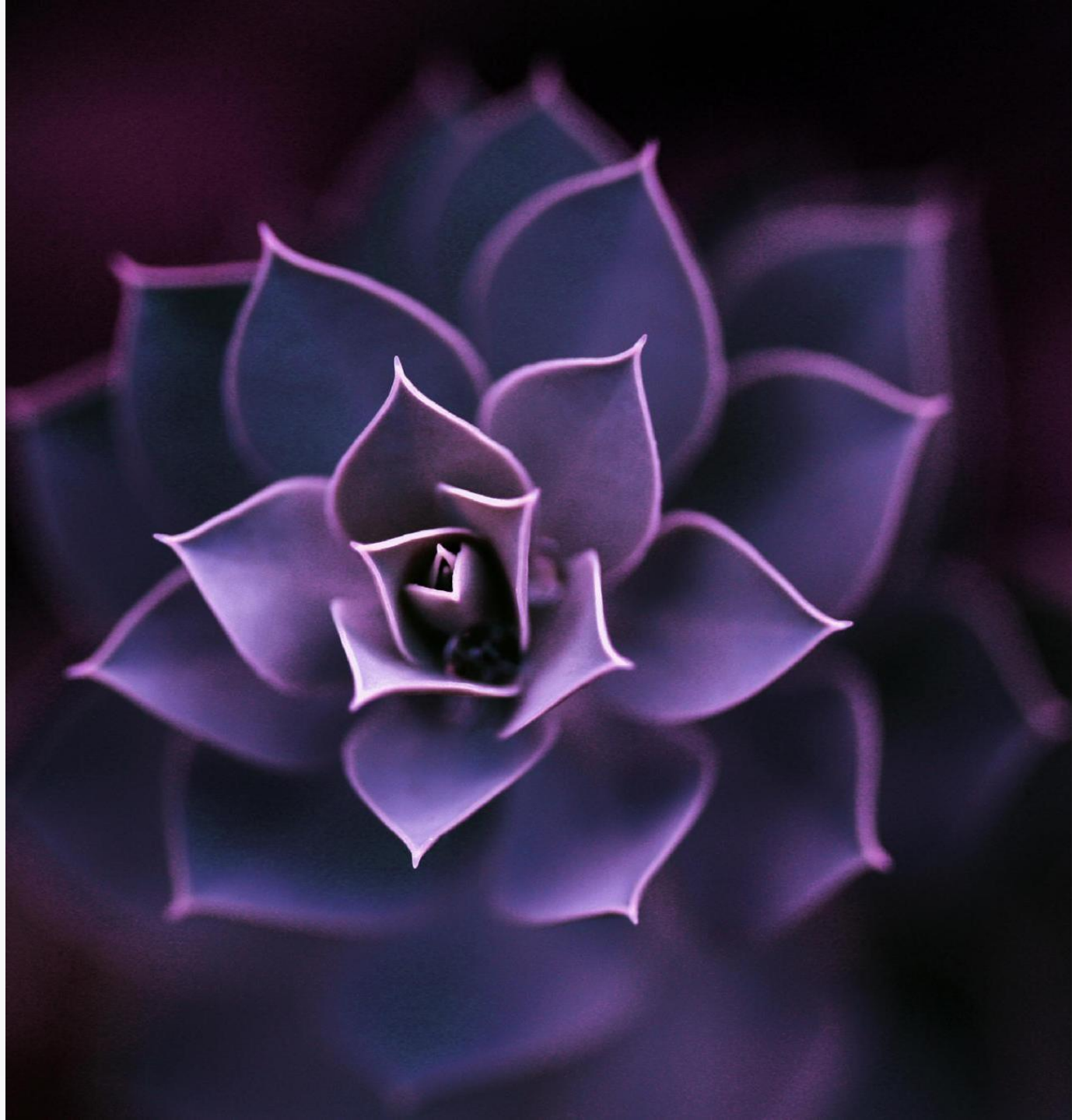
Movement + sleep + less sedentary screen time support wellbeing

- **FAMILY**

Shared meals • open communication • consistent support

Include families in **treatment + safety planning**

Strengthen connection—not perfection



Cultivating Resilience: Connection Matters



- SOCIAL CONNECTION**

- Belonging is protective → actively address isolation
- School • sports • 4-H/FFA • faith/cultural communities • peer support
- Help each youth identify **where they belong**

- DIGITAL WELLBEING**

- Create an individualized **Family Media Plan**
- Encourage realistic, collaborative limits
- Protect sleep and prioritize **real-world connection**
- “Prescribe” Protective Factors**

Make them **specific, achievable, measurable, follow up**



Natural Remedies

Melatonin for insomnia

- Article BMC Pediatrics 2026.
- Another study: Autism
- My experience practicing



Omega-3 Fatty Acids (O3FA): for ADHD.

- Article Neuropsychopharmacology 2018.
- Helps mildly sometimes in my experience.



NAC (N-acetylcysteine): for OCD.

- Case study 2014, 2015.

Key Takeaways

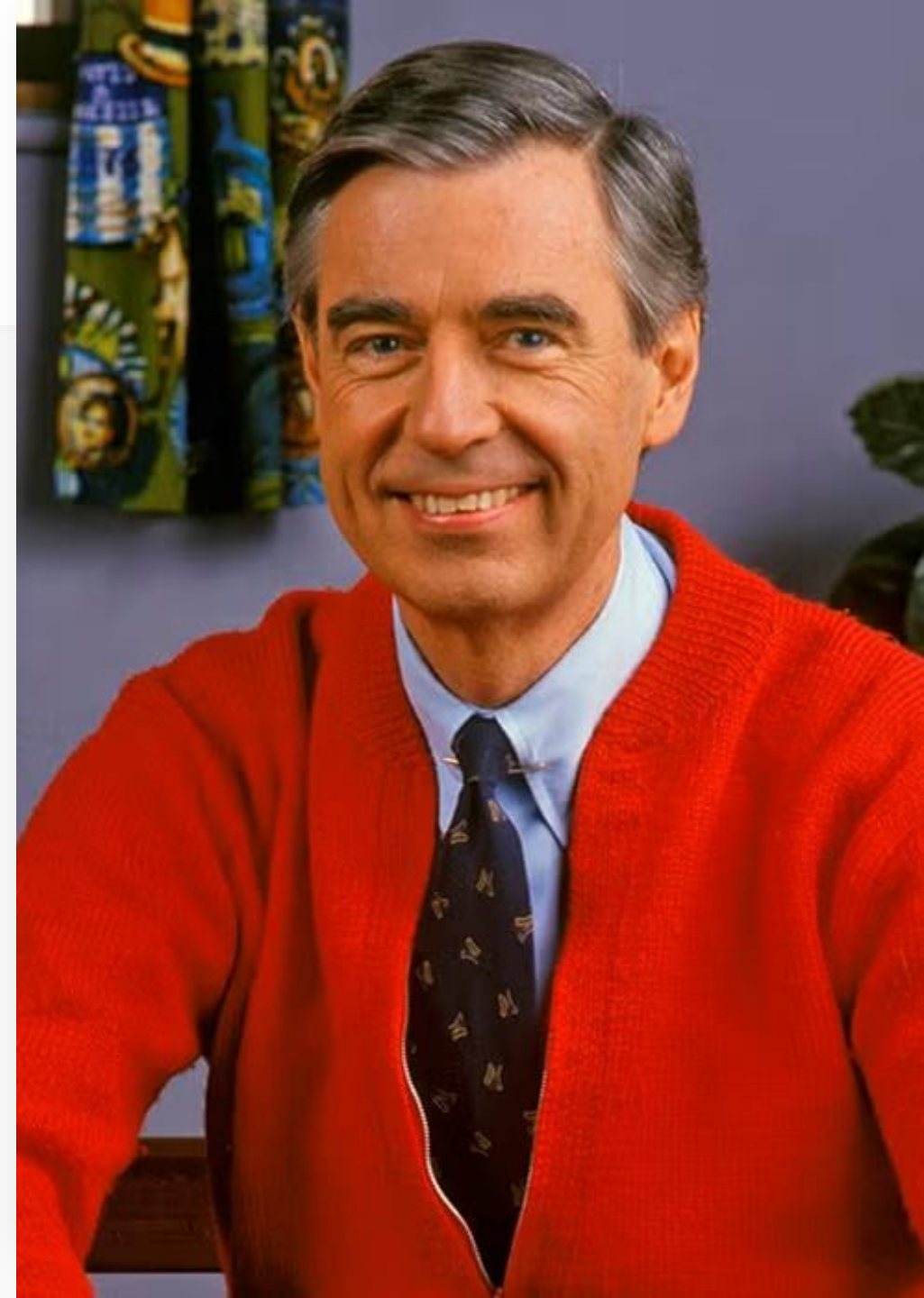


1. **Screen early.** Primary care may be the first—or only—place youth receive mental health support
2. **Treat what you can.** Evidence-based interventions work, and many can begin in primary care
3. **Know when to partner.** Psychiatry, OPAL-K, telehealth, IIBHT, wraparound, DBT & peer support extend your reach
4. **Prioritize safety.** Ask about suicide, safety plan, reduce access to lethal means & follow up
5. **Build resilience.** Relationships, routines, movement, sleep & belonging matter

We believe every young person can thrive—fierce hope is acting on that belief.

*“Anything that's
human is
mentionable, and
anything that is
mentionable can be
more manageable .”*

— Fred “Mister” Rogers



Resources

- OPAL-K: 503-346-1000 (free PCP psychiatric consultation)
- 988 Suicide & Crisis Lifeline (call or text 988)
- Lines for Life: 1-800-273-8255
- Crisis Text Line: Text HOME to 741741
- Stanley-Brown Safety Plan Template: available at suicidesafetyplan.com
- CRAFFT 2.1: crafft.org
- AAP Blueprint for Youth Suicide Prevention
- Oregon Health Authority behavioral health resources

*Please reach out to our team at **GOBHI Care Management** **401-406-8612** if you need assistance navigating a complex case or have questions about available resources.*



Q & A

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*Rooted in community,
dedicated to care.*





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