Bridging Systems: Supporting Mental Health in Military Children Across School and Healthcare Settings

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Ruth holds a Master of Social Work from New York University and a Master's in Child Development from Sarah Lawrence College. She has extensive experience supporting children and families across hospitals, Head Start programs, milieu therapy, and school-based settings. Specializing in behavioral interventions, parenting coaching, classroom management, and trauma-informed care, Ruth brings a collaborative, evidence-based approach to promoting the mental health and well-being of military children and their families.

Disclosures

- Ruth Djarbeng Boadi has no relevant financial or non-financial relationships to disclose relating to the content of this activity
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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. **Recognize** how mental health concerns present in military-connected children, particularly internalizing symptoms and layered stress response.
2. **Differentiate** between diagnostic codes and how they help shape treatment of mental health disorders.
3. **Apply** a context-first approach to assessment and collaboration using psychosocial history and cross system coordination to guide care.

Outline

- Background/laying the foundation
- Assessment philosophy
- Screening and standardized measures
- Mental Health Presentation Patterns in Military Children
- Diagnoses of Mental Health conditions
- Where and how does treatment happen?
- What Next? Military Child Context and System Navigation

Background

Introduction: who is Ruth and how do I fit in?

- As a school-based clinician, how do I go about my day supporting dependents of active-duty members?
- This is a glimpse into the world of a school-based clinician working with military children
- A quote often stated in the Army which deeply resonates with CAFBHS Model.

"The strength of our Nation is our Army.
The strength of our Army is our Soldiers.
The strength of our Soldiers is our Families.
This is what makes us Total Army Strong."

Children are also serving, not just their parents or guardians

Assessment Philosophy

Why psychosocial history as the foundation of assessment?

- Parable of the blind men and elephant: in assessment it relates to not seeing only a part but being able to see the whole picture.
- Military children face added stresses on 3 levels: pre-deployment, deployment, post deployment. This affects their schools, peer relationships, health and mental health services, and local support systems (APA, 2021;Leskin, 2025)
- Military children move 6-9 times between kindergarten and high school (APA, 2021).

Assessment Philosophy

What do we know over the years about the impact of military service on children?

Gorman et al.,2010	Cunitz et al.,2019	Opie et al.,2024
• During a parent's deployment, pediatric mental health visits increased by 11% overall, with behavioral disorders increasing by 19% and stress disorders by 18%.	• Children with military parents showed higher rates of mental health problems compared to their civilian counterparts. • Within military families, children of deployed parents showed more problem behavior than children of non-deployed parents. • Children of deployed children having higher rates of internalizing and externalizing symptoms.	• Across all developmental stages, military children experience a considerably higher risk for negative psychological, social, and behavioral health outcomes. • Identified adolescents as the highest-risk group, with military youth being twice as likely to attempt suicide. • There are worse outcomes for miliary children associated with frequency and duration of a deployed parent.

Polling Question

What are some ways that military connected children are impacted from your experience?

Assessment Philosophy

“Build the child’s world”

- Gather collateral information from parents, teachers, child, doctor, and other environments that the child routinely interacts with
- Screening tools global vs domain specific

Screening and Standardized Measures

- Bright Futures Periodicity Schedule recommends developmental screening from newborn to 21 years.
- Standardized screenings reduce reliance of clinical judgment alone.
- The good news is that over the years developmental screening by pediatric primary care clinicians have increased even though only 59% report using standardized tools in 2019. (Weitzman et al., 2025).

Screening and Standardized Measures

Importance Of Screenings (Weitzman et al., 2025):

- Some problems are not readily apparent
- Identify family strengths
- Enhance relationships
- Reduces biases
- Allow for mental health concerns to be identified early

Screening and Standardized Measures

- Bright future recommends Mental Health screenings at:
  - 6months
  - 12months
  - 24months
  - 36months
  - yearly until 21 years (AAP, 2026; Weitzman et al., 2025)

Screening and Standardized Measures

Global vs Domain Specific

- Global: screens for general , broad and quick.
- Examples are
  - Pediatric Symptom Checklist
  - Strengths vs. Difficulties questionnaires
  - Child Behavior Checklist
  - PROMIS Pediatric Global Health

Polling Question

What are some global and domain specific screeners that you use?

Screening and Standardized Measures

- Domain specific: Targeted for specific problems (depression, suicide screenings, anxiety, Attention Deficit Hyperactivity Disorder (ADHD).
- Examples are:
  - Depression: Patient Health Questionnaire-9 (PHQ-9) Modified for Adolescents: Evaluates depressive symptoms. recommended age for screening is 12 years
  - Anxiety: Screen for Child Anxiety Related Emotional Disorders (SCARED): Screens for different types of anxiety. Recommended age is 8.
  - ADHD: Vanderbilt Assessment Scales: Evaluates symptoms of inattention and hyperactivity
  - Autism: Modified Checklist for Autism in Toddlers, Revised (M-CHAT-R/F): Screens for autism in toddlers.
  - Trauma: UCLA PTSD Reaction Index: Assesses trauma-related symptoms.
  - Substance Use: National Institute on Drug Abuse (NIDA)-Modified ASSIST: Screens for adolescent substance use.
  - Suicide: Use the Ask Suicide Screening Questionnaire (ASQ) suicide screening questionnaire entails 4 questions and can be used quicky. Recommended age is 12 unless clinically indicated for younger children.

Mental Health Presentation Patterns in Military Children

- Military connected children face increased risks of depression, anxiety, behavioral challenges- ADHD, Conduct Disorders (Leskin et al., 2025).
- Resilience and protective factors- Kids wanting to grow up and be in the military, peer support, supportive resources. The studies also show that these children are more resilient than their civilian counterparts (Leskin et al, 2025).
- Internalizing vs. externalizing trends (Opie et al., 2024). The kids we service have more internalizing problems like anxiety and depression compared to their civilian peers (Cunitz et al., 2019).

Mental Health Presentation Patterns in Military Children

- Suicidality risk patterns “adolescents of currently serving members showed highest risk, particularly concerning suicidal ideation and suicidal behaviors” (Opie et al., 2024).
- A study conducted in Canada showed that the greatest difference in mental health needs between civilian and military connected youth is among younger adolescents aged 11-13. With high-risk behaviors including substance use and tobacco consumption (Leskin et al., 2025).

Diagnoses of Mental Health Conditions

- ICD codes can be used to comprehensively document both psychosocial and clinical presentation.
- The 3 codes that can be used are Z, R and F codes
  - Z codes capture social determinants of health, social risk factors like conditions that shape people's daily lives and psychosocial circumstances. Z codes are presently underutilized with usage rate ranging from 0.4% to 17.6% in studies prior to 2024 (Baker et al., 2025)
  - R codes capture symptoms and observable clinical concerns
  - F codes capture formal mental and behavioral health diagnoses

Diagnoses of Mental Health Conditions

Examples of Z codes:

- **Z63.31** - Absence of family member due to military deployment
- **Z63.71** - Stress on family due to return of family member from military
- **Z63.7** - Other stressful life events affecting family and household
- **Z65.5** - Exposure to disaster, war and other hostilities
- **Z63.0** - Problems in relationship with spouse or partner (maybe relevant for family dynamics)
- **Z63.5** - Disruption of family by separation and divorce
- **Z62.82x** - Parent-child conflict
- **Z62.0** - Inadequate parental supervision and control
- **Z55.3** - Underachievement in school

Diagnoses of Mental Health Conditions

Examples of R codes that relate to military children:

- **R45.0:** Nervousness
- **R45.4:** Irritability and anger
- **R45.81:** Low self-esteem
- **R45.82:** Worries
- **R45.850:** Homicidal ideations
- **R45.851:** Suicidal ideations
- **R45.86:** Emotional lability
- **R45.87:** Impulsiveness
- **R45.88:** Non-Suicidal Self Injury

Diagnoses of Mental Health Conditions

- Examples of F codes:
- **F43.20 - F43.25:** Adjustment disorders (reaction to stress)
- **F32.A:** Depression
- **F41.1:** Generalized anxiety disorder
- **F90:**Attention-Deficit Hyperactivity Disorders
- **F91.3:** Oppositional defiant disorder

Polling Question

What other R, Z, or F codes do you see/use in your practice with this population?

Diagnoses of Mental Health Conditions

Provisional vs. Rule out diagnosis

- A provisional diagnosis is a temporary, "best guess" diagnosis based on current evidence, used to start treatment while waiting for more information.
- A rule-out diagnosis indicates a condition is suspected but needs further testing to confirm or eliminate it.

Where And How Does Treatment Happen?

Three- tiered framework

- A three-tiered framework is commonly used to support military-connected children in school settings(Frederick & Siebler, 2022)
- Tier 1: Universal supports for all students
- Tier 2: Targeted supports for at risk-students
- Tier 3: Intensive, individualized interventions

Where And How Does Treatment Happen?

Day-to-day In A School

- Consultation with teachers
- Classroom observations
- Individual psychotherapy
- Parent sessions
- Group interventions
- School-wide interventions
- Participation in meetings(Individualized Education Plan [IEP], Support Staff meetings)
- Communication with primary care manager (PCM) and psychiatry
- Referrals and coordination of care

What Next? Military Child Context and System Navigation

- Military children's resilience is often supported by systems available to them such as:
  - Purple Star Schools
  - EFMP (Exceptional Family Member Program)
  - DoDEA (Department of Defense Education Activity)
  - MFLC (Military and Family Life Counseling Program)
  - FAP (Family Advocacy Program)
  - Army Family and Morale
  - Welfare and Recreational Programs
  - Military One Source

Key Takeaways

- **Context matters before diagnosis.** Military children's behaviors are often rooted in life experiences such as deployment, transitions, and family stressors.
- **Symptoms may be internal, not visible.** Many military-connected children present with anxiety, depression, and distress that can be easily overlooked.
- **Taking Time for assessment.** Trauma, stress, and environmental disruption can mimic clinical disorders and require careful assessment.
- **Build the child's world first.** A thorough psychosocial history is essential to understanding the full picture and guiding appropriate care.
- **Collaboration is critical.** Effective support requires coordination across school, healthcare, and family systems.

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