Seattle Children's

Primary Care Principles for Child Mental Health

By **Robert Hilt, MD,** program director, Partnership Access Line and **Rebecca Barclay, MD,** associate clinical program director, Partnership Access Line Seattle Children's Hospital

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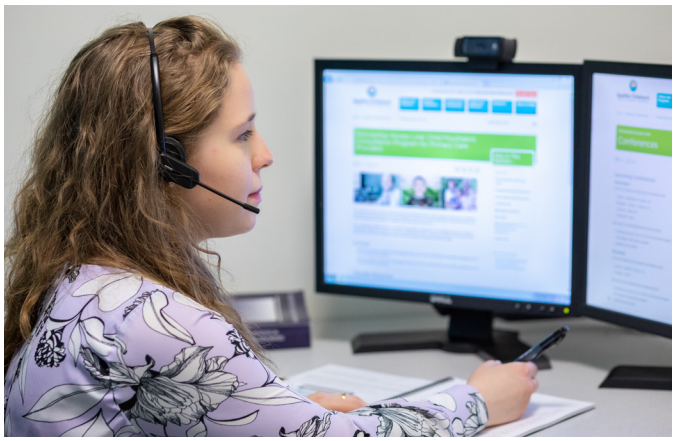

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PARTNERSHIP ACCESS LINE
Child Psychiatric Consultation for Primary Care Providers

Partnership Access Line:

Child Psychiatric Consultation Program for Primary Care Providers

The Partnership Access Line (PAL) supports primary care providers with questions about mental health care such as diagnostic clarification, medication adjustment or treatment planning. The PAL team is staffed with child and adolescent psychiatrists affiliated with the University of Washington School of Medicine and Seattle Children's Hospital.

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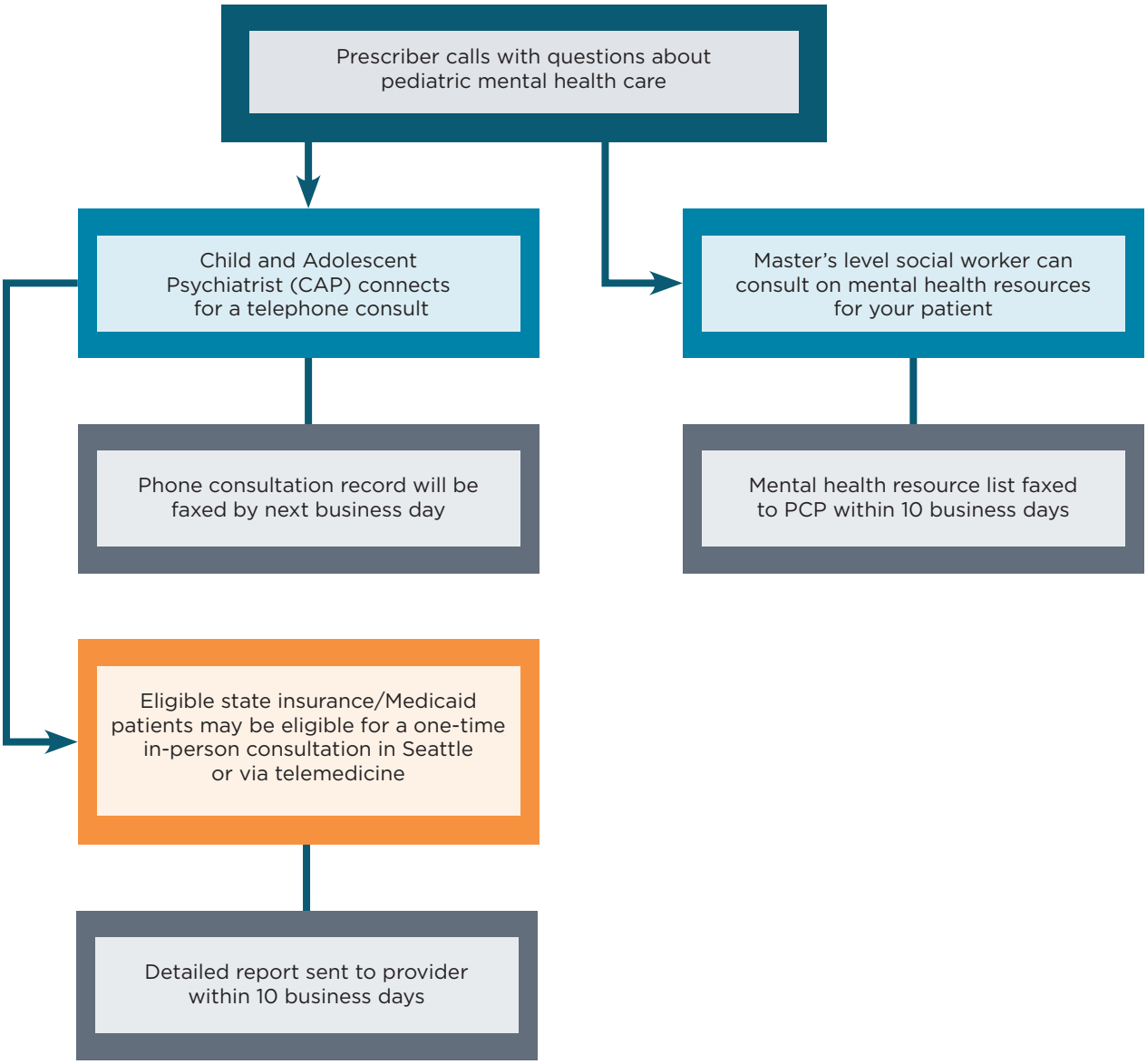
Consultations can be patient-specific or can be general questions related to child psychiatry.

The phone consultation is covered by HIPAA, section 45 CFR 164.506; no additional release of patient information is required to consult by phone.



The information in this book is intended to offer helpful guidance on the diagnostic and treatment process conducted by a primary care provider, and is not a substitute for specific professional medical advice. Providers are encouraged to reproduce pages as desired from this booklet for use in their own clinical practice.

There was no pharmaceutical industry or commercial funding for preparing this booklet.

Table of Contents

Peer Review

This guide is based on current evidence in the literature about mental health treatments in children. It is a digestion of current knowledge into focused points practical for the primary care physician. Future editions may cover additional topics in child health.

Although Professor Dr. Robert Hilt is the primary author, this guide has utilized peer review from a variety of mental health experts and the helpful input and guidance from state agencies.

During development, general and section specific peer review has included:

John Dunne, MD, Child and Adolescent Psychiatrist, Seattle Children's Hospital

Bryan King, MD, Professor of Psychiatry & Behavioral Sciences, U. of Washington

Matt Speltz, PhD, Professor of Psychiatry & Behavioral Sciences, U. of Washington

Eric Trupin, PhD, Professor of Psychiatry & Behavioral Sciences, U. of Washington

Child and Adolescent Outpatient Psychiatry Clinic, Seattle Children's Hospital

U. of Washington Division of Public Health and Justice Policy

Section specific peer review has included:

ADHD:
Chris Varley, MD, Professor of Psychiatry & Behavioral Sciences, U. of Washington
Nicole Nguyen, PharmD, DSHS
Siri Childs, PharmD, Pharmacy Administrator, DSHS

Anxiety:
Teresa Piacentini, PhD, Clinical Psychologist, Seattle Children's Hospital
Nicole Nguyen, PharmD, DSHS
Soraya Kanakis, PharmD, DSHS

Autism:
Bryan King, MD, Professor of Psych. & Beh. Sciences, U. of Washington

Bipolar:
Jack McClellan, MD, Associate Professor of Psych. & Beh. Sciences, U. of Washington
Kathleen Myers, MD, Associate Professor of Psych. & Beh. Sciences, U. of Washington
Nicole Nguyen, PharmD, DSHS
Soraya Kanakis, PharmD, DSHS

Depression:
Elizabeth McCauley, PhD, Professor of Psych. & Beh. Sciences, U. of Washington
Soraya Kanakis, PharmD, DSHS

Disruptive Behavior and Aggression:
Terry Lee, MD, Acting Assistant Professor, U. of Washington

Eating Disorder:
Rose Calderon, PhD, Associate Professor of Psych. & Beh. Sciences, U. of Washington
Cora Breuner, MD, Associate Professor of Pediatrics, U. of Washington

Substance Use Disorder:
Laura Richardson, MD, MPH, Professor of Pediatrics; Adolescent Medicine

Care Guide Methods

Dr. Hilt is the primary author of this guide, and peer reviewers have been utilized to verify the validity of the information and help guide the content of the final product. Patient handout information chosen for inclusion in the guide was selected based on the clinical experiences of Dr. Hilt, the PAL Consultant team, and the section reviewers.

The process of formulating the care recommendations in the original Care Guide document started with a review of the most recent applicable practice guidelines from the American Academy of Child and Adolescent Psychiatry, and reviewing the applicable sections of *Bright Futures in Practice: Mental Health* practice guide from HRSA (which has received widespread endorsements including from the American Academy of Pediatrics). Regarding medications, Ovid Medline searches were performed looking back at least 10 years with limits set to include only child studies. These Medline searches were supplemented by reviewing recent conference presentations of drug treatment studies, and reviewing bibliographies of the published studies that were found. Bibliographies of review textbooks were also searched, including the bibliography of a textbook, *Pediatric Psychopharmacology Fast Facts* by DF Connor and BM Meltzer (2006).

For Care Principles Guide version 2.0 and newer, additional Medline topic searches for papers published over the previous year were performed to be certain the medication advice remained up to date. An additional section on Autism care was added, for which Dr. Alison Golombek was a co-author. An additional section on Substance Use Disorders care was added, for which Dr. Rebecca Barclay was a co-author. Additional editing has been provided by Dr. Rebecca Barclay.

Psychosocial treatment guidance was formulated in consultation with the named section reviewers, the PAL Consultant team, and with members of the steering committee.

All recommendations in this guide were reviewed and modified by a panel of state experts in each of the applicable fields to reflect current and regionally endorsed care.

How This Care Guide Can Help You

As with all diagnostic processes, one has to think of the possibility of a mental health disorder before it is possible to diagnose it.

- Ask for the history of the child's problem
- Ask about acute and chronic stressors relating to their problem
- Then ask yourself if there is a mental health diagnosis to consider
- Ask whether appropriate social, behavioral and family support is present

Certain clusters of symptoms bring up the possibility of particular diagnoses. For instance consider:

- *ADHD if:* inattentive or hyperactive with school difficulty
- *Anxiety disorder if:* unexplained somatic complaints, general or specific worries
- *Autism if:* developmental concern with the most severe impairment in social functioning
- *Bipolar disorder if:* episodic mood changes with manic features
- *Depression if:* withdrawn, irritable, unexplained somatic complaints
- *Eating disorder if:* losing weight or odd eating habits
- *Conduct or Oppositional Defiant Disorder (ODD) if:* oppositional or aggressive behavior
- *Substance use disorder if:* change in functioning and suspected substance abuse

A primary care provider considering a particular mental health diagnosis can consult the corresponding section of this guide easily to find information and tools that they may need.

Contained inside:

- Tips on the general approach to mental health issues in primary care practices
- Recommended thought process for the evaluation and treatment of the above 8 common childhood disorders
- Free-to-reproduce rating scales for assistance with diagnosis and follow up
- Organized, current evidence based medication information
- Free-to-reproduce patient handouts (Spanish language versions available on the PAL website)
- Reference information that will be consistent with advice given out by PAL program psychiatrists

Washington Quick Provider Resources

General Information

- Washington Recovery Help Line – 24 hour help for substance abuse, problem gambling, and mental health
  1-866-789-1511
  www.warecoveryhelpline.org
- Washington Information Network
  2-1-1
  http://win211.org
- Washington State Department of Social and Health Services
  www.dshs.wa.gov
- Apply for Health Insurance
  www.wahealthplanfinder.org

Accessing a Mental/Behavioral Health Therapist

Find a therapist

- Contact Washington's Mental Health Referral Service for Children and Teens
  833-303-5437
  www.seattlechildrens.org/wa-mental-health
- http://therapists.psychologytoday.com
  www.helppro.com
- For those with Medicaid, contact your managed care plan:
  https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-managed-care

If you have private insurance you may also contact your insurance company for a list of providers.

Family Support Organizations

- DSHS Resources for Parents
  https://www.dcyf.wa.gov/services/getting-help
- Department of Children, Youth, and Families
  www.dcyf.wa.gov
- Parent Trust
  www.parenttrust.org
- Parent to Parent
  www.p2pusa.org

Developmental Disabilities Resources

- Developmental Disabilities Administration
  www.dshs.wa.gov/dda
- To apply for DD Services please request an application from your local office. Office locater:
  www.dshs.wa.gov/dda/find-dda-office

Juvenile Justice Services

- Juvenile Rehabilitation
  www.dcyf.wa.gov/services/juvenile-rehabilitation
- Office of Juvenile Justice and Delinquency Prevention
  www.ojjdp.gov

Military Family Resources

- Home Base Program
  http://homebase.org
- Resources for Military and Veteran Families
  www.mghpact.org/for-parents/other-resources/for-military-and-veteran-families
- National Resource Directory
  www.nrd.gov

Crisis Services

- HOME text – 741741
  www.crisistextline.org
- Crisis/Acute Mental Health Care
  https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/acute-mental-health-care-inpatient
- County Crisis Lines
  https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/mental-health-crisis-lines

  *Please note — anyone can call their local county crisis line regardless of their insurance coverage.
- National Suicide Prevention Lifeline
  1-800-273-8255
  www.suicidepreventionlifeline.org
- Teenlink — A confidential teen-answered help line and computer chat service
  1-866-833-6546
  https://www.teenlink.org/

Substance Abuse Services

- Substance Abuse Information for Washington State
  www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/substance-use-treatment
- Washington Recovery Help line
  1-866-789-1511
  www.warecoveryhelpline.org
- Alcoholics Anonymous
  https://aa.org
- Narcotics Anonymous
  http://na.org
- Treatment Locator
  http://findtreatment.samhsa.gov

Medicaid Guide to Services

Washington State Health Care Authority

Public Mental Health Overview

HCA/Washington Medicaid contracts for mental health services via two avenues:

- Contracts with Managed Care Organizations (MCO)
- Individual Care Provider Agreements with professionals who will accept payment on a fee-for-service basis for people who are eligible for Medicaid, but who are not enrolled with a MCO.

For more information, please visit https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/apple-health-managed-care

Behavioral Health – Administrative Services Organization (BH-ASO)

In addition to integrated managed care plans, clients in integrated regions have access to a regional Behavioral Health – Administrative Services Organization (BH-ASO). These organizations administer services such as:

- 24/7 regional crisis hotline for mental health and substance use disorder crises
- Mobile crisis outreach teams
- Short-term substance use disorder services for individuals who are intoxicated or incapacitated in public
- Application of behavioral health involuntary commitment statuses, available 24/7 to conduct Involuntary Treatment Act (ITA) assessments and file detention petitions.
- Regional Ombuds

Within available funding, a BH-ASO also has the discretion to provide outpatient behavioral health services or voluntary psychiatric inpatient hospitalizations for individuals who are not eligible for or enrolled in Apple Health. For more information on the BH-ASO, please visit: https://www.hca.wa.gov/assets/program/bhaso-fact-sheet.pdf

Apple Health Managed Care Organizations (MCO)

Washington State Health Care Authority

As of the date of this publication, the following Managed Care Organizations contract with HCA under the Apple Health MCO Program. If your patient is enrolled with a Apple Health MCO plan, you may call that health plan for assistance in coordination of benefits.

Plan	Phone Number
Amerigroup Washington Inc. www.myamerigroup.com/wa	800-600-4441
Community Health Plan of Washington www.chpw.org	800-440-1561
Coordinated Care Corporation www.coordinatedcarehealth.com	877-644-4613
Molina Healthcare of Washington, Inc. http://www.molinahealthcare.com/members/wa	800-869-7165
UnitedHealthcare Community Plan www.uhccommunityplan.com	877-542-8997

For an updated list of currently contracted Apple Health MCO providers visit HCA online at: https://www.hca.wa.gov/assets/free-or-low-cost/service_area_matrix.pdf

Not all MCO plans serve all counties.
To obtain more information managed care programs, visit HCA online at: www.hca.wa.gov/assets/free-or-low-cost/19-0025.pdf

Fee-For-Service

If your patient is not enrolled with a Apple Health MCO plan, you may contact Washington Medicaid by calling **800-562-3022 (TTY: 800-848-5429)** to find a mental health provider who will accept payment from Washington Medicaid to provide mental health services to your patient on a "fee-for-service" basis

Foster Care

All children in foster care will be served through Apple Health foster care program from Coordinated Care. More information can be found at: https://www.coordinatedcarehealth.com/members/foster-care.html

Additional Tools from HCA

Washington State Health Care Authority

Patient Review and Coordination (PRC) Program
PRC (formerly PRR) helps to prevent patients from inappropriate use of services by limiting patients to the following for a period of at least 24 months:

- One primary care provider
- One narcotic prescriber
- One pharmacy
- One hospital for non-emergent services

To refer your patient for enrollment in the Patient Review and Coordination (PRC) program, call HCA at: (800)562-3022 x15606 (Calls are returned within 24 hours) or visit HCA online at: www.hca.wa.gov/billers-providers/programs-and-services/patient-review-and-coordination-prc

CHET (Child Health & Education Tracking) screening tools for foster care
The purpose of Child Health & Education Tracking is to identify the well-being, needs and strengths of children in out-of-home care and to review and monitor the outcomes of the services provided to meet the needs or to support the strengths of the child.

What this means practically is that for children placed in foster care (for whom a greater than 30 day out of home placement is anticipated), a series of health screening questionnaires are administered by Children's Administration within that child's first 30 days of placement. The actual instruments in the CHET include the CBCL and ASQ-SE would have been the two items of particular interest to someone looking into a child's mental health needs.

The CHET rating scales are collected and maintained by Children's Administration, and *can be accessed by asking for any CHET results for the child from the child's foster care case worker.*

Adolescent Substance Abuse Treatment and Prevention

Washington State Health Care Authority

Behavioral Health Organizations (BHO and the MCO plans) oversee the provision of substance abuse treatment for adolescents in Washington state.

To learn more about substance abuse services, visit:
www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/substance-use-treatment

Adolescents who need alcohol/drug treatment should be referred to their MCO plan to arrange for an assessment, to locate a treatment agency, and to verify that they are eligible for state-funded services.

Washington Recovery Help Line – 24 Hour Help for Substance Abuse: 1-866-789-1511
www.warecoveryhelpline.org

Directory of Certified Behavioral Health Services in Washington State
www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf

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Reduce Under Age Drinking
Find resources parents can use to prevent underage drinking and marijuana use at Start Talking Now, the Washington Healthy Youth (WHY) website: www.starttalkingnow.org

Washington State Health Care Authority

Washington Second Opinion Review

Fact Sheet: Alpha Agonists Reviews

The following dosing guidelines regarding alpha-2 agonist medications were established by the Washington State Health Care Authority (HCA) Pediatric Advisory Group and Drug Utilization Review Board. Prescriptions outside of these dosing limits will require a safety/appropriate use review with a member of HCA's second opinion network.

Drug	Dosing Limits			
	0-3 years of age	4-5 years of age	6-8 years of age	9-17 years of age
Catapres (clonidine)	Review required	0.2 mg	0.3 mg	0.4 mg
Kapvay (clonidine SR)	Review required	0.2 mg	0.3 mg	0.4 mg
Tenex (guanfacine)	Review required	2 mg	3 mg	4 mg
Intuniv (guanfacine SR)	Review required	2 mg	3 mg	4 mg

If clonidine and guanfacine are prescribed together for the same patient, a cumulative alpha agonist dose will be calculated and a review will be required if that cumulative dose exceeds the individual class threshold. For this calculation, guanfacine 1mg is considered pharmacologically equivalent to clonidine 0.1mg.

Washington State Health Care Authority

Washington Second Opinion Review

Fact Sheet: ADHD Medications

The Washington State Health Care Authority (HCA) is interested in the safe and effective use of medications in all children up to age 18. This program is overall meant to assure prescriptions covered by HCA are within the safety review guidelines established by the HCA Pediatric Advisory Group and the Drug Utilization Review Board. The PAL child psychiatrist consultants are one step in the state-mandated medication review process. We do not set State guidelines or flag specific medications, but we do believe in the value of peer review and provider-to-provider collaboration.

ADHD Medication Review Guidelines

Drug	Dosing Limits			
	Age 0-4 years	**Age 5-8 years**	**Age 9-11 years**	**Age 12-18 years**
Methylphenidate (i.e. Ritalin, Concerta, Methylin)	Review required	70 mg per day	90 mg per day	120 mg per day
Methylphenidate transdermal (i.e. Daytrana)	Review required	35 mg per day	45 mg per day	60 mg per day
Dexmethylphenidate (i.e. Focalin)	Review required	35 mg per day	45 mg per day	60 mg per day
Amphetamines (i.e. Adderall, Dexedrine)	Review required	35 mg per day	45 mg per day	60 mg per day
Lisdexamfetamine (i.e. Vyvanse)	Review required	60 mg per day	75 mg per day	100 mg per day
Atomoxetine (i.e. Strattera)	Review required	120 mg per day	120 mg per day	120 mg per day

Prescriptions exceeding the Age and Dose Limitations will only be authorized for continuation of therapy (same medication/same dose) until a final decision can be made by HCA.

	Methylphenidate	**Dexmethylphenidate**	**Amphetamines**	**Atomoxetine**	**Clonidine XR or Guanfacine XR**
Methylphenidate		Review required	Review required	Review required	
Dexmethylphenidate	Review required		Review required	Review required	
Amphetamines	Review required	Review required		Review required	
Atomoxetine	Review required	Review required	Review required		Review required

Duplicate or combination ADHD medication prescriptions per the categories above will only be authorized for a period of up to 2 months without a review.

Washington State Health Care Authority

Washington Second Opinion Review

Fact Sheet: Antipsychotics

The following dosing guidelines regarding child antipsychotic medications were established by the Washington State Health Care Authority (HCA) Pediatric Advisory Group and Drug Utilization Review Board.

Child in crisis: Families can receive an urgent medication fill of an antipsychotic prescription that will trigger a review per the below guidelines if they indicate at the pharmacy that their child is in crisis, or if the provider writes "child in crisis" on the prescription.

Drug	Antipsychotic Dosing Limits*			
	Age under 3	**Age 3-5 years**	**Age 6-12 years**	**Age 13-17 years**
Abilify® (aripiprazole)	Review required	5 mg per day	20 mg per day	30 mg per day
Clozaril®/Fazaclo® (clozapine)	Review required	Review required	Review required	700 mg per day
Geodon® (ziprasidone)	Review required	Review required	80 mg per day	160 mg per day
Haldol® (haloperidol)	Review required	Review required	10 mg per day	15 mg per day
Latuda® (lurasidone)	Review required	Review required	40 mg per day	80 mg per day
Risperdal®/M-Tab® (risperidone)	Review required	2 mg per day	4 mg per day	6 mg per day
Seroquel®/XR (quetiapine)	Review required	Review required	400 mg per day	800 mg per day
Trilafon® (perphenazine)	Review required	Review required	12 mg per day	24 mg per day
Zyprexa®/Zydis® (olanzapine)	Review required	Review required	10 mg per day	20 mg per day

*Prescriptions exceeding dosing limitations for age require a HCA-approved second opinion

Antipsychotics for which reviews are always required before age 18 include: Invega® (paliperidone), Saphris® (asenapine), Fanapt® (iloperidone), and all long-acting (ex. monthly) injectible agents.

Antipsychotic Medications for Foster Care and Adoption Support Clients
Due to a State law (SHB 1879) all prescriptions for antipsychotic medications prescribed to clients age 17 and younger in the Foster Care and Adoption Support programs will require authorization and review regardless of the child's age or dose utilized.

Fact Sheet: Psychiatric Polypharmacy

Other criteria under which HCA will initiate a required second opinion review of child psychiatric medications (as advised by the HCA Pediatric Advisory Group and Drug Utilization Review Board) include:

- Two (2) or more antipsychotic medications prescribed concomitantly after 60 days
- Five (5) or more different psychotropic medications prescribed concomitantly after 60 days

Washington Second Opinion Review

Fact Sheet: Antidepressants

Class	SSRI	TeCA	NDRI	SNRI	SMO
SSRI (Selective Serotonin Reuptake Inhibitor)	PA			PA	PA
TeCA (Alpha-2 Receptor Antagonists — Tetracyclics)		PA	PA	PA	PA
NDRI (Norepinephrine — Dopamine Reuptake Inhibitor)		PA	PA		
SNRI (Serotonin Norepinephrine Reuptake Inhibitor)	PA	PA		PA	PA
SMM (Serotonin Modulator — Miscellaneous)	PA	PA		PA	PA

Products by Class				
SSRI	**TeCA**	**NDRI**	**SNRI**	**SMM**
Brisdelle (paroxetine)	Ludiomil (maprotiline)	Aplenzin (bupropion)	Cymbalta (duloxetine)	Serzone (nefazodone)
Celexa (citalopram)	Remeron (mirtazapine)	Forfivo (buproprion)	Desvenlafaxine ER	Trintellix (vortioxetine)
Lexapro (escitalopram)		Wellbutrin (bupropion)	Effexor (venlafaxine)	Viibryd (vilazodone)
Luvox (fluvoxamine)			Fetzima (levomilnacipran)	
Paxil (paroxetine)			Pristiq (desvenlafaxine)	
Pexeva (paroxetine mesylate)				
Prozac (fluoxetine)				
Sarafem (fluoxetine)				
Zoloft (sertraline)				

Generics First for New Starts of Psychiatric Medications

HCA will cover only preferred generic drugs as a client's first course of therapy within the following drug classes:

- Atypical Antipsychotics (for ages 17 and younger only)
- Attention Deficit Hyperactivity Disorder (ADHD) Drugs

Only clients who are new to the above drug classes will be required to start on a preferred generic product over a brand name product. Prescriptions filled for any one of the above drug classes within the preceding 180 days establishes that the patient is not new to the drug class. HCA is not requiring clients who are established and doing well on a drug to be changed to a generic product. See HCA Memo 09-61 found at https://www.hca.wa.gov/assets/billers-and-providers/Prescription-Drug-Program-20160701.pdf

To receive regular updates on the Washington HCA Medication review program, prescribers may sign up for the State information list serve at: https://public.govdelivery.com/accounts/WAHCA/subscriber/new

Who: Seattle Children's Medication Review Program, PO Box 5371, M/S S-232C, Seattle, WA 98145
Phone: 206-987-2702, Fax: 206-985-3109

Mental Health Assessment Principles

- ***You do not have to complete an assessment in one visit.*** Listen to the general problem, establish that the situation is safe to wait another week or so, and then schedule a second visit to finish your assessment. Mental health specialists often take more than one visit to decide on diagnoses.
- ***Establish what pushed the situation into your office, "Why are you here today?"*** A chronic stressor (like sadness about parents separating) does not usually trigger an office visit: acute stressors do (like a major child outburst after one parent cancels their upcoming weekend plans with the child).
- ***Strongly consider use of a general screening instrument*** during health maintenance visits, like the PSC-17, to see if mental health problems are worth investigating further.
- ***Seek to interview the child alone,*** especially if an internalizing problem like depression or anxiety is suspected, to obtain a more thorough history.
- ***Empathic engagement with the child is worth the effort.*** Young children open up better after inquiring about low risk topics like their name, birthday, or school. Adolescents open up better after showing genuine interest in them, such as asking about their interests, hobbies. If a patient looks like they don't want to be there, comment on this and show them you are able to connect with how they feel.
- ***Collateral information is invaluable.*** Parents often differ from each other in their view of their child, and schools often have other information vital to your assessment. Ensure that past medication history and treatments are available to you.
- ***If suspecting a particular disorder, give that specific rating scale to parent/child.*** You could leave the room to see another patient, then return and review rating scale results. Rating scales can help confirm diagnoses, and they provide an objective measure for following treatment responses.
- ***Recognize that child disorders have a developmental trajectory.*** For instance early oppositionality may evolve into depression or anxiety, and early depression may evolve into bipolar disorder.
- Pay close attention to what you see. The mental status exam of a child involves watching how they position themselves, process information and interact. For instance a child complaining of body aches who appears withdrawn, speaks softly, and will not look you in the eye should be screened for depression.
- ***Put it all together into your best clinical judgment, and then revise your diagnosis over time.*** It is very difficult to get it exactly right on the first visit. Mental health specialists often revise their diagnoses over time as more information becomes available. Also with children the process of development can make it hard to be definite about a diagnosis. You are ahead of the game if you can recognize with certainty the general category of problem, such as some type of learning disability or some type of anxiety disorder. Remember Occam's Razor; a single diagnosis plus a full social/family picture may explain things better than multiple mental health diagnoses.
- ***Remember you can ask for help.*** Contained in this care guide are numerous state and county programs, like the Partnership Access Line, that are designed to assist you and your patient. For severe behavioral problems always consider referral to a mental health provider to obtain a care assessment.

Robert Hilt, MD

What Can You Do For Multiple Problems?

- ***Establish what seems to be the leading problem and focus your attention on that.*** For instance if a child is having screaming tantrums, hitting other children, is sleeping poorly and sometimes appears anxious, one may decide the leading problem is unsafe externalizing behavior. In that case, review the steps of our disruptive behavior and aggression decision tree. The child's sleep problems and intermittent anxiety can be explored further at a future appointment.
- ***Get collateral information.*** Particularly if the caregiver does not know the child's full history, other information sources including school, former physicians or therapists, other relatives, and foster care case managers will likely be able to give you information that clarifies what should be done. Respect the fact that it takes time to gather this additional information, which can be done by phone calls, record requests, or by sending out questionnaires or rating scales. Remember our first assessment principle; you don't have to figure this all out in one visit.
- ***Use checklists for preliminary behavior/mental health screening.*** These will help you narrow down what area to investigate and can quantify the likelihood of finding different types of diagnoses.

  Options include:

  - PSC-17 (free, included in this guide)
  - SDQ (Strength and Difficulties Questionnaire, 25 questions, 5 subscales, good psychometrics, multiple languages available, free for individual providers to download and use, free online scoring.) You must go to the developer's website to obtain: www.sdqinfo.org
  - CBCL (Child Behavior Checklist, school age version has 113 core questions plus 2 other pages to describe child functioning, widely used, very good psychometrics, translated versions available.) Requires scoring software and requires purchase from the developer: https://aseba.org/
  - BASC-3 (Behavior Assessment Scale for Children, second edition, all multiple choice, 134-160 items for parent report on school age child, commonly used, very good psychometrics, scoring software recommended). Requires purchase from the developer: https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Behavior/Comprehensive/Behavior-Assessment-System-for-Children-%7C-Third-Edition-/p/100001402.html
- ***Discuss the scenario with a specialist.*** PAL psychiatrists would like to talk about any tricky situations with you, and are available Monday through Friday, 8am to 5pm.
- ***If you suspect a specific problem, a disorder specific rating scale can help you learn how likely or severe that diagnosis might be.*** Disorder specific scales like the Vanderbilt scale for ADHD will not make the diagnosis for you — a diagnosis must be based on your overall clinical impression. When children have severe mental health symptoms, referral to a mental health clinic is appropriate. Very high rating scale scores might similarly indicate that referral to specialty care is appropriate.
- ***A good therapist can help you refine your diagnosis over time.*** If you identify the child has a general problem for which a therapist referral is appropriate (such as having some sort of mood disorder), then the therapist can provide further specialized assessment (such as diagnosing Major Depression).
- ***If you choose to prescribe a medication when the diagnosis is still uncertain, be very clear what the target symptom is you are treating, and monitor that symptom closely.*** If that target symptom does not improve, then that medicine needs to be stopped. It is **very** important to not simply stack medicines one upon another without demonstrating a clear benefit to the child.

Robert Hilt, MD

Evidence Based Mental Health Care

Throughout this guide, the treatment options listed are based on both the best available research evidence, and expert opinions from Seattle Children's Hospital Department of Psychiatry and the UW Division of Public Behavioral Health and Justice Policy.

Evidence based care is a relative concept, not an absolute one. Evidence for treatment varies in its reliability: randomized controlled trials carry a different evidence weighting than individual provider experiences. As more information emerges, what is considered the most evidence based treatment is expected to evolve. Evidence based medication treatment advice is spread throughout this guide, in tables and care flow diagrams for each included disorder. Psychosocial treatment guidance is also listed briefly within each care flow diagram.

A common theme typically emerges in both clinical experience and in the results of formal research trials: that a combination of medical treatment and social/ behavioral care often ensures the best of outcomes.

The importance of engaging both a child and family in treatment can not be underestimated. An "evidence based treatment" will not work if families cannot make it to appointments, or if the treatment does not meet the child's or family's own goals. Engagement can be enhanced through educating your families about what to expect. "Wraparound" programs, where available, have a philosophy emphasizing engagement and shared setting of treatment goals, and can be a further asset in this regard.

Families can find additional support from organizations like NAMI, the National Alliance on Mental Illness (www.nami.org)., SAMHSA the Substance Abuse and Mental Health Service Administration (www.samhsa.gov), and the National Institute of Mental Health (www.nimh.nih.gov).

Where can I go to get unbiased information about child mental health treatment and medications?

Peer reviewed care guidelines from a professional association

American Academy of Pediatrics, Clinical Practice Guidelines
http://pediatrics.aappublications.org

American Academy of Child and Adolescent Psychiatry, Practice Parameters
www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Home.aspx

Peer reviewed care guidelines from a state sponsored workgroup

Partnership Access Line (PAL) in Washington
www.seattlechildrens.org/pal

Medication Project from Texas
www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf

Federal agency publications

National Institute of Mental Health
www.nimh.nih.gov

Substance Abuse & Mental Health Service Administration
www.samhsa.gov

Collaborative guidance from respected organizations

American Academy of Adolescent and Child Psychiatry (AACAP) and American Psychological Association (APA)
www.parentsmedguide.org

National Alliance for the Mentally Ill
www.nami.org

PracticeWise from the AAP
www.aap.org/en-us/Documents/CRPsychosocialInterventions.pdf

New original research, particularly if a randomized controlled trial design is used

Pub Med provides free Medline searches
https://pubmed.ncbi.nlm.nih.gov/

Washington state providers electronic library
http://heal-wa.org

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Developmental Screenings

Developmental Screening Tools and Rating Scales

The following is just a small number of the validated developmental screening tools available. They may be accessed at the website links provided. The ECSA is included in its entirety on the next page, which is free to reproduce for clinical care.

Validated scales with a per-use fee:

1. ***Ages and Stages Questionnaire (ASQ-3)*** — It takes 1-15 minutes for caregivers to complete; scoring takes 2-3 minutes. Child age range: 1 month to 5.5 years of age. Sensitivity 86%; specificity 85%. The ASQ addresses five developmental areas (communication, gross motor, fine motor, problem solving, and personal-social). https://agesandstages.com/products-pricing/asq3/
2. ***ASQ:SE-2*** — It takes 10-15 minutes for parents or caregivers to complete; scoring takes 2-3 minutes. Age range is 1 month through 6 years old. The Questionnaire asses seven social-emotional areas (self-regulation, compliance, communication, adaptive behaviors, autonomy, affect, and interaction with people). https://agesandstages.com/products-pricing/asqse-2/
3. ***Parents' Evaluation of Developmental Status (PEDS)*** — Time to administer and score is about two minutes. Child age range: birth to 8 years. Sensitivity 74-80%; specificity 70-80%. The tool elicits parents concerns about children's language, motor, self-help, early academic skills, behavior and social-emotional/mental health. www.pedstest.com

Validated scales that are free to use:

1. ***Modified Checklist for Autism in Toddlers*** — Revised (MCHAT-R) — The MCHAT takes parents 5 minutes to complete. The MCHAT is valid for children ages 16-30 months old. Sensitivity 91%; Specificity 95%. www.mchatscreen.com
2. ***Childhood Autism Spectrum Test (CAST)*** — This parental questionnaire is available through the ARC for use in research to screen for autism spectrum conditions. The target age range is 4-11 years old. Sensitivity 100%; specificity 97%. www.autismresearchcentre.com/arc_tests
3. ***Early Childhood Screening Assessment (ECSA)*** — The ECSA is a screening assessment for emotional and behavioral development as well as caregiver distress. The age range it covers is 1.5 to 5 years old. ECSA scores are associated to scores on longer, established measures including the Child Behavior Checklist. The sensitivity is 85% and the specificity is 83%.

   Scoring the ECSA: The child score is the sum of all circled numbers of items 1-36, with a maximum score of 72. A score of greater than or equal to 18 means the child needs further socioemotional assessment. Slightly more than 3/4 of children with this score will meet criteria for an impairing mental health problem. The ECSA is not valid if more than two child items are skipped.

   A parent depression score greater or equal to three suggests a higher rate of depression and should be followed up clinically. Items 38, 39, and 40 reflect caregiver distress.

   Thanks to Mary Margaret Gleason, MD for offering permission to incorporate the ECSA in the PAL Care Guide.

Early Childhood Screening Assessment (ECSA)

Child name:.....Date.....

- Please circle the number that best describes your child compared to other children the same age.
- For each item, please circle the + if you are concerned and would like help with the item.

0=Rarely/Not True 1=Sometimes/Sort of 2= Almost always/Very true *Completed by*.....

1.	Seems sad, cries a lot	0	1	2	+
2.	Is difficult to comfort when hurt or distressed	0	1	2	+
3.	Loses temper too much	0	1	2	+
4.	Avoids situations that remind of scary events	0	1	2	+
5.	Is easily distracted	0	1	2	+
6.	Hurts others on purpose (biting, hitting, kicking)	0	1	2	+
7.	Doesn't seem to listen to adults talking to him/her	0	1	2	+
8.	Battles over food and eating	0	1	2	+
9.	Is irritable, easily annoyed	0	1	2	+
10.	Argues with adults	0	1	2	+
11.	Breaks things during tantrums	0	1	2	+
12.	Is easily startled or scared	0	1	2	+
13.	Cries to annoy people	0	1	2	+
14.	Has trouble interacting with other children	0	1	2	+
15.	Fidgets, can't sit quietly	0	1	2	+
16.	Is clingy, doesn't want to separate from parent	0	1	2	+
17.	Is very scared of certain things (needles, insects)	0	1	2	+
18.	Seems nervous or worries a lot	0	1	2	+
19.	Blames other people for mistakes	0	1	2	+
20.	Sometimes freezes or looks very still when scared	0	1	2	+
21.	Avoids foods that have specific feelings or tastes	0	1	2	+
22.	Is too interested in sexual play or body parts	0	1	2	+
23.	Runs around in settings when should sit still (school, worship)	0	1	2	+
24.	Has a hard time paying attention to tasks or activities	0	1	2	+
25.	Interrupts frequently	0	1	2	+
26.	Is always "on the go"	0	1	2	+
27.	Reacts too emotionally to small things	0	1	2	+
28.	Is very disobedient	0	1	2	+
29.	Has more picky eating than usual	0	1	2	+
30.	Has unusual repetitive behaviors (rocking, flapping)	0	1	2	+
31.	Might wander off if not supervised	0	1	2	+
32.	Has a hard time falling asleep or staying asleep	0	1	2	+
33.	Doesn't seem to have much fun	0	1	2	+
34.	Is too friendly with strangers	0	1	2	+
35.	Has more trouble talking or learning to talk than other children	0	1	2	+
36.	Is learning or developing more slowly than other children	0	1	2	+
37.	I feel down, depressed, or hopeless	0	1	2	+
38.	I feel little interest or pleasure in doing things	0	1	2	+
39.	I feel too stressed to enjoy my child	0	1	2	+
40.	I get more frustrated than I want to with my child's behavior	0	1	2	+

Are you concerned about your child's emotional or behavioral development? Yes Somewhat No

Pediatric Symptom Checklist PSC-17 Description

The PSC-17 is a general mental health screening tool designed to be simple to use in primary care practices, based a longer form instrument known as the PSC-35. It can help primary care providers assess the likelihood of finding any mental health disorder in their patient. The brief and easy to score PSC-17 has fairly good mental health screening characteristics, even when compared with much longer instruments like the CBCL (Child Behavior Checklist by T. Achenbach).

A 2007 study in primary care offices compared use of the PSC-17 to simultaneous use of the CBCL in 269 children aged 8-15, showing reasonably good performance of its three subscales compared to similar subscales on the CBCL. The gold standard here was a K-SADS diagnosis, which is a standardized psychiatric interview diagnosis. These comparison statistics are summarized below, with positive and negative predictive values shown based on different presumed prevalence (5 or 15%) of the disorders. Providers should notice that despite its good performance relative to longer such measures, it is not a foolproof diagnostic aid. For instance the sensitivity for this scale only ranges from 31% to 73% depending on the disorder in this study:

K-SADS Diagnosis	Screen	Sensitivity	Specificity	PPV 5%	PPV 15%	NPV 5%	NPV 15%
ADHD	PSC-17 Attention	0.58	0.91	0.25	0.53	0.98	0.92
	CBCL Attention	0.68	0.90	0.26	0.55	0.98	0.94
Anxiety	PSC-17 Internalizing	0.52	0.74	0.10	0.26	0.97	0.90
	CBCL Internalizing	0.42	0.88	0.13	0.38	0.97	0.90
Depression	PSC-17 Internalizing	0.73	0.74	0.13	0.33	0.98	0.94
	CBCL Internalizing	0.58	0.87	0.19	0.44	0.98	0.92
Externalizing	PSC-17 Externalizing	0.62	0.89	0.23	0.50	0.98	0.93
	CBCL Externalizing	0.46	0.95	0.33	0.62	0.97	0.91
Any Diagnosis	PSC-17 Total	0.42	0.86	0.14	0.35	0.97	0.89
	CBCL Total	0.31	0.96	0.29	0.58	0.96	0.89

W Gardner, A Lucas, DJ Kolko, JV Campo "Comparison of the PSC-17 and Alternative Mental Health Screens in an At-Risk Primary Care Sample" JAACAP 46:5, May 2007, 611-618

PSC-17 Scoring:

PSC-17 Internalizing score positive if ≥ 5

PSC-17 Externalizing score positive if ≥ 7

PSC-17 Attention score positive if ≥7

PSC-17 Total score positive if ≥15

"Attention" diagnoses can include: ADHD, ADD

"Internalizing" diagnoses can include: Any anxiety or mood disorder

"Externalizing" diagnoses can include: Conduct disorder, Oppositional Defiant Disorder, adjustment disorder with disturbed conduct or mixed disturbed mood and conduct

Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: ..... Date:.....

Name of Child:.....

	Please mark under the heading that best fits your child			For Office Use		
	NEVER	SOMETIMES	OFTEN	I	A	E
1. Fidgety, unable to sit still						
2. Feels sad, unhappy						
3. Daydreams too much						
4. Refuses to share						
5. Does not understand other people's feelings						
6. Feels hopeless						
7. Has trouble concentrating						
8. Fights with other children						
9. Is down on him or herself						
10. Blames others for his or her troubles						
11. Seems to be having less fun						
12. Does not listen to rules						
13. Acts as if driven by a motor						
14. Teases others						
15. Worries a lot						
16. Takes things that do not belong to him or her						
17. Distracted easily						
(scoring totals)						

Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.
  PSC17 Internalizing score is sum of column I
  PSC17 Attention score is sum of column A
  PSC17 Externalizing score is sum of column E
  PSC-17 Total Score is sum of I, A, and E columns

Suggested Screen Cutoff:

PSC-17 - I ≥ 5

PSC-17 - A ≥ 7

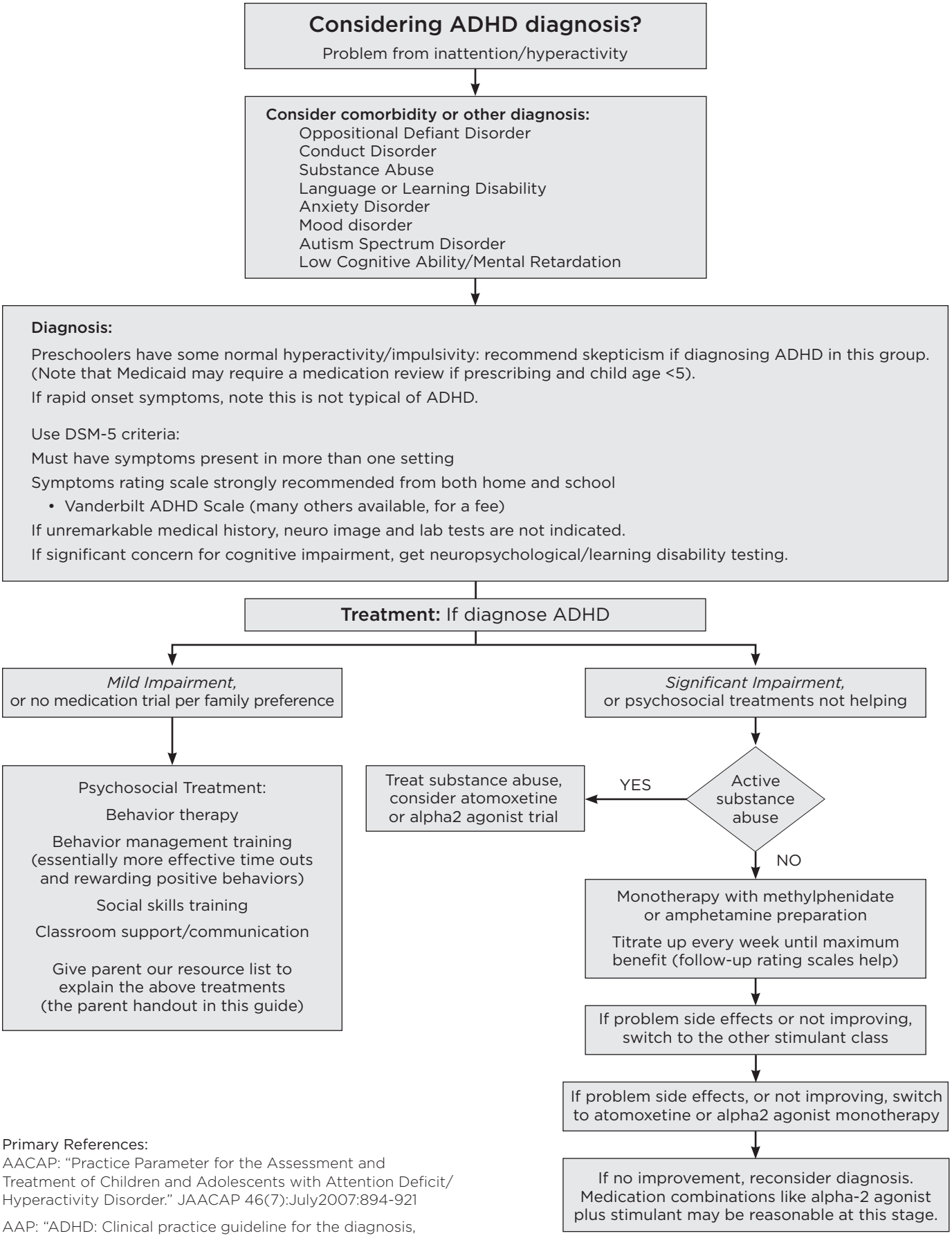
PSC-17 - E ≥7

Total Score ≥ 15

Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)
Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17

ADHD



Primary References:
AACAP: "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit/ Hyperactivity Disorder." JAACAP 46(7):July2007:894-921

AAP: "ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of ADHD in children and adolescents." Prediatrics 128(5), November, 2011:1007-1022

Vanderbilt ADHD Teacher Rating Scale

Child's Name .....

Date of Birth ..... Grade ..... Today's Date .....

Completed by ..... Subject Taught (if applicable) .....

Each rating should be considered in the context of what is appropriate for the age of the child. If you have completed a previous assessment, your rating should reflect the child's behavior since you last completed a form.

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes, such as in homework	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 instruction 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 when remaining in seated is expected	0	1	2	3
12.	Runs about or climbs excessively when 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 too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others (butts into conversations or games)	0	1	2	3
19.	Loses temper	0	1	2	3
20.	Actively defies or refuses to comply with adults' 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 ("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

Vanderbilt ADHD Teacher Rating Scale

Child's Name .....

Today's Date.....

	Symptoms	Never	Occasionally	Often	Very Often
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
32.	Feels worthless or inferior	0	1	2	3
33.	Blames self for problems, feels guilty	0	1	2	3
34.	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
35.	Is sad, unhappy, or depressed	0	1	2	3

Performance	Above Average		Average		Problematic
Academic Performance					
Reading	1	2	3	4	5
Mathematics	1	2	3	4	5
Written Expression	1	2	3	4	5
Classroom Behavior					
Relationship with Peers	1	2	3	4	5
Following Directions/Rules	1	2	3	4	5
Disrupting Class	1	2	3	4	5
Assignment Completion	1	2	3	4	5
Organizational Skills	1	2	3	4	5

Comments:

For Office Use Only

SYMPTOMS:

Number of questions scored as 2 or 3 in questions 1-9: .....

Number of questions scored as 2 or 3 in questions 10-18: .....

Total symptom score for questions 1-18: .....

Number of questions scored as 2 or 3 in questions 19-28: .....

Number of questions scored as 2 or 3 in questions 29-35: .....

Vanderbilt ADHD Diagnostic Teacher Rating Scale was developed by Mark L. Wolraich, MD.
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Vanderbilt ADHD Parent Rating Scale

Child's Name .....

Date of Birth .....Grade .....Today's Date .....

Completed by .....Relationship to child: ❑ Mom ❑ Dad ❑ Other.....

Each rating should be considered in the context of what is appropriate for the age of your child.
When completing this form, please think about your child's behaviors in the past 6 months.

	Symptoms	Never	Occasionally	Often	Very Often
1.	Does not pay attention to details or makes careless mistakes, such as in homework	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 instruction 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 when remaining in seated is expected	0	1	2	3
12.	Runs about or climbs excessively when 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 too much	0	1	2	3
16.	Blurts out answers before questions have been completed	0	1	2	3
17.	Has difficulty waiting his or her turn	0	1	2	3
18.	Interrupts or intrudes in on others (butts into conversations or games)	0	1	2	3
19.	Argues with adults	0	1	2	3
20.	Loses temper	0	1	2	3
21.	Actively defies or refuses to comply with adults' requests or rules	0	1	2	3
22.	Deliberately annoys people	0	1	2	3
23.	Blames others for his or her mistakes or misbehavior	0	1	2	3
24.	Is touchy or easily annoyed by others	0	1	2	3
25.	Is angry or resentful	0	1	2	3
26.	Is spiteful and vindictive	0	1	2	3
27.	Bullies, threatens, or intimidates others	0	1	2	3
28.	Initiates physical fights	0	1	2	3
29.	Lies to obtain goods for favors or to avoid obligations ("cons" others)	0	1	2	3
30.	Is truant from school (skips school) without permission	0	1	2	3
31.	Is physically cruel to people	0	1	2	3

Vanderbilt ADHD Parent Rating Scale

Child's Name .....

Today's Date.....

Symptoms		Never	Occasionally	Often	Very Often
32.	Has stolen things of nontrivial value	0	1	2	3
33.	Deliberately destroys others' property	0	1	2	3
34.	Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35.	Is physically cruel to animals	0	1	2	3
36.	Has deliberately set fires to cause damage	0	1	2	3
37.	Has broken into someone else's home, business, or car	0	1	2	3
38.	Has stayed out at night without permission	0	1	2	3
39.	Has run away from home overnight	0	1	2	3
40.	Has forced someone into sexual activity	0	1	2	3
41.	Is fearful, anxious, or worried	0	1	2	3
42.	Is afraid to try new things for fear of making mistakes	0	1	2	3
43.	Feels worthless or inferior	0	1	2	3
44.	Blames self for problems, feels guilty	0	1	2	3
45.	Feels lonely, unwanted, or unloved; complains that "no one loves him/her"	0	1	2	3
46.	Is sad, unhappy, or depressed	0	1	2	3
47.	Is self-conscious or easily embarrassed	0	1	2	3

Performance	Above Average		Average		Problematic
Academic Performance					
Reading	1	2	3	4	5
Mathematics	1	2	3	4	5
Written Expression	1	2	3	4	5
Classroom Behavior					
Relationship with Peers	1	2	3	4	5
Following Directions/Rules	1	2	3	4	5
Disrupting Class	1	2	3	4	5
Assignment Completion	1	2	3	4	5
Organizational Skills	1	2	3	4	5

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SYMPTOMS:

Number of questions scored as 2 or 3 in questions 1-9: .....

Number of questions scored as 2 or 3 in questions 10-18: .....

Total symptom score for questions 1-18: .....

Number of questions scored as 2 or 3 in questions 19-26: .....

Number of questions scored as 2 or 3 in questions 27-40: .....

Number of questions scored as 2 or 3 in questions 41-47: .....

Comments:

Vanderbilt ADHD Diagnostic Parent Rating Scale was developed by Mark L. Wolraich, MD. Reproduced and format adapted by R. Hilt, MD and PAL with permission.

Scoring the Vanderbilt ADHD Scales

The Vanderbilt rating scale is a screening and information gathering tool which can assist with making an ADHD diagnosis and with monitoring treatment effects over time. The Vanderbilt rating scale results alone do not make a diagnosis of ADHD or diagnose any other disorder — one must consider information from multiple sources to make a clinical diagnosis. Symptom items 1-47 are noted to be significantly present if the parent or teacher records the symptom as "often or very often" present (a 2 or 3 on the scale). The "performance" items at the end are felt to be significant if the parent or teacher records either a 1 or 2 on each item.

The validation studies for the Vanderbilt Assessment Scales were for the 6-12 year old age group. To the extent that they collect information to establish DSM-5 criteria, they are applicable to other groups where the DSM-5 criteria are appropriate.

Parent Version

Predominantly Inattentive Subtype
Requires 6 or more counted behaviors on items 1 through 9 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

Predominantly Hyperactive/Impulsive Subtype
Requires 6 or more counted behaviors on items 10 through 18 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

Combined Subtype
Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.

Oppositional-defiant disorder
Requires 4 or more counted behaviors on items 19 through 26.

Conduct disorder
Requires 3 or more counted behaviors on items 27 through 40.

Anxiety or depression
Requires 3 or more counted behaviors on items 41 through 47.

Teacher Version

Predominantly Inattentive Subtype
Requires 6 or more counted behaviors on items 1 through 9 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

Predominantly Hyperactive/Impulsive Subtype
Requires 6 or more counted behaviors on items 10 through 18 and a performance problem (score of 1 or 2) in any of the items on the *performance* section.

Combined subtype
Requires 6 or more counted behaviors each on both the inattention and hyperactivity/impulsivity dimensions.

Oppositional defiant and conduct disorders
Requires 3 or more counted behaviors from questions 19 through 28.

Anxiety or depression
Requires 3 or more counted behaviors from questions 29 through 35.

The **performance section** is scored as indicating some impairment if a child scores 1 or 2 on at least 1 item.

ADHD Stimulant Medications

Short Acting Stimulants

Drug Name	Duration	Dosages	Stimulant Class	Usual Starting Dose	FDA Max Daily Dose
Methylphenidate (Ritalin, Methylin)	4-6 hours	2.5, 5, 10, 20 mg	Methyl.	5mg BID 1/2 dose if 3-5yr	60mg
Dexmethylphenidate (Focalin)	4-6 hours	2.5, 5, 10 mg	Methyl.	2.5mg BID	20mg
Dextroamphetamine (Dexedrine, Dextro Stat, Pro Centra, Zenzedi)	4-6 hours	2.5, 5, 10 mg tabs	Dextro.	5mg QD-BID 1/2 dose if 3-5yr	40mg
Amphetamine Salt Combo (Adderall)	4-6 hours	5, 7.5, 10, 12.5, 15, 20, 30 mg	Dextro.	5mg QD-BID 1/2 dose if 3-5yr	40mg

Extended Release Stimulants

Drug Name	Duration	Dosages	Stimulant Class	Usual Starting Dose	FDA Max Daily Dose	Editorial Comments
Metadate ER	4-8 hours	10, 20mg tab	Methyl.	10mg QAM	60mg	Generic available. Uses wax matrix. Variable duration of action
Concerta	10-12 hours	18, 27, 36, 54 mg	Methyl.	18mg QAM	72mg	Generic available. Osmotic pump capsule
Adderall XR	8-12 hours	5, 10, 15, 20, 25, 30 mg	Dextro.	5mg QD	30mg	Generic available. Beads in capsule can be sprinkled
Metadate CD (30% IR) ~8 hours	~8 hours	10, 20, 30, 40, 50, 60 mg capsules	Methyl.	10mg QAM	60mg	Generic available. Beads in capsule can be sprinkled
Ritalin LA (50% IR) ~8 hours	~8 hours	10, 20, 30, 40 mg capsules	Methyl.	10mg QAM	60mg	Generic available. Beads in capsule can be sprinkled
Focalin XR	10-12 hours	5 to 40mg in 5 mg steps	Methyl.	5mg QAM	30mg	Beads in capsule can be sprinkled
Daytrana patch	Until 3-5 hours after patch removal	10, 15, 20, 30 mg Max 30mg/9hr	Methyl.	10mg QAM	30mg	Rash can be a problem, slow AM startup, has an allergy risk, peeling off patch a problem with young kids
Lisdexamfetamine (Vyvanse)	~10 hours	10, 20, 30, 40 50, 60, 70mg	Dextro.	30mg QD	70mg	Conversion ratio from dextroamphetamine is not established. Chewable available
Dexedrine Spansule	8-10 hours	5, 10, 15 mg	Dextro.	5mg QAM	40mg	Beads in capsule can be sprinkled
Quillivant XR	10-12 hours	25mg/5ml 1 bottle = 300mg or 60ml	Methyl.	10mg QAM	60mg	Liquid banana flavor
Quillichew ER	6-8 hours	20, 30, 40 mg	Methyl.	20mg QAM	60mg	Chewable cherry-flavored tablets

ADHD Non-Stimulant Medications

Drug Name	Dosages	Usual Starting Dose	FDA Max Daily Dose	Editorial Comments
Atomoxetine (Strattera)	10, 18, 25, 40 60, 80, 100mg	0.5mg/kg/day (1 to 1.2 mg/kg/d usual full dosage)	Lesser of 1.4mg/ kg/day or 100mg	Has GI side effects, takes weeks to see full benefit, do not open capsule — eye irritant
Clonidine (Catapres)	0.1, 0.2, 0.3mg	0.05mg QHS if <45kg, otherwise 0.1mg QHS Caution if <5 yr.	(Not per FDA) 27-40kg 0.2mg 40-45kg 0.3mg >45kg 0.4mg	Often given to help sleep, also treats tics, can have rebound BP effects
Clonidine XR (Kapvay)	0.1, 0.2 mg	0.1mg QHS	0.4mg daily	Lower peak blood level, then acts like regular clonidine (similar 1/2 life). Still is sedating. Approved for combo with stimulants
Guanfacine (Tenex)	1, 2 mg	0.5mg QHS if <45kg, otherwise 1mg QHS Caution if <5 yr.	(Not per FDA) 27-40kg 2mg 40-45kg 3mg >45kg 4mg	Often given to help sleep, also treats tics, can have rebound BP effects
Guanfacine XR (Intuniv)	1, 2, 3, 4 mg	1mg QD if over 6 years old (full dosage 0.05 to 0.12mg/kg)	Whichever is lower: a) 4mg/day 6-12 years old, 7mg/day 13-17 years old Or, b) 0.05-0.12 mg/kg/day	Lower peak blood level, then acts like regular Tenex (similar 1/2 life) Still is sedating. Approved for combo with stimulants

Reference: AACAP ADHD Practice Parameter (2007), Micromedex 2013

Relative Effect Size of ADHD Medication Choices

Effect size of all stimulants ~1.0

Effect size of atomoxetine ~0.7

Effect size of guanfacine ~0.65 (using Cohen's d-statistic)

Stimulant Relative Potencies:

Methylphenidate 10mg ≈ dexmethylphenidate 5mg

Methylphenidate 10mg ≈ dextroamphetamine 5mg

*ADHD Medication Monitoring:

With stimulant or atomoxetine treatment, follow vital signs, sleep, mood lability, appetite, growth, and cardiac symptoms with treatment.

With alpha agonist treatment, follow vital signs, symptoms of orthostasis, sedation, agitation, and for depressed mood.

ADHD Resources

Information for Families

Books families may find helpful:

Taking Charge of ADHD: The Complete Authoritative Guide for Parents (Revised Edition, 2000), by Russell A. Barkley, PhD

Raising Resilient Children: Fostering Strength, Hope and Optimism in Your Child (2002), by Robert Brooks, PhD and Sam Goldstein, PhD

Attention Deficit Disorder: The Unfocused Mind in Children and Adults (2006), by Tom Brown, PhD

Teenagers with ADD and ADHD: A Guide for Parents and Professionals (2006), by Chris Dendy

Books children may find helpful:

Learning to Slow Down & Pay Attention: A Book for Kids about ADHD (2004), by Kathleen Nadeau, PhD, Ellen Dixon, PhD, and Charles Beyl

Jumpin' Johnny Get Back to Work! A Child's Guide to ADHD/Hyperactivity (1981), by Michael Gordon, PhD

Websites families may find helpful:

Parents Med Guide
www.parentsmedguide.org (quality information about medications for ADHD)

Children and Adults with ADHD
www.chadd.org (support groups, information resource)

Teach ADHD
http://teachadhd.sharpschool.com/ (teaching advice for ADHD kids)

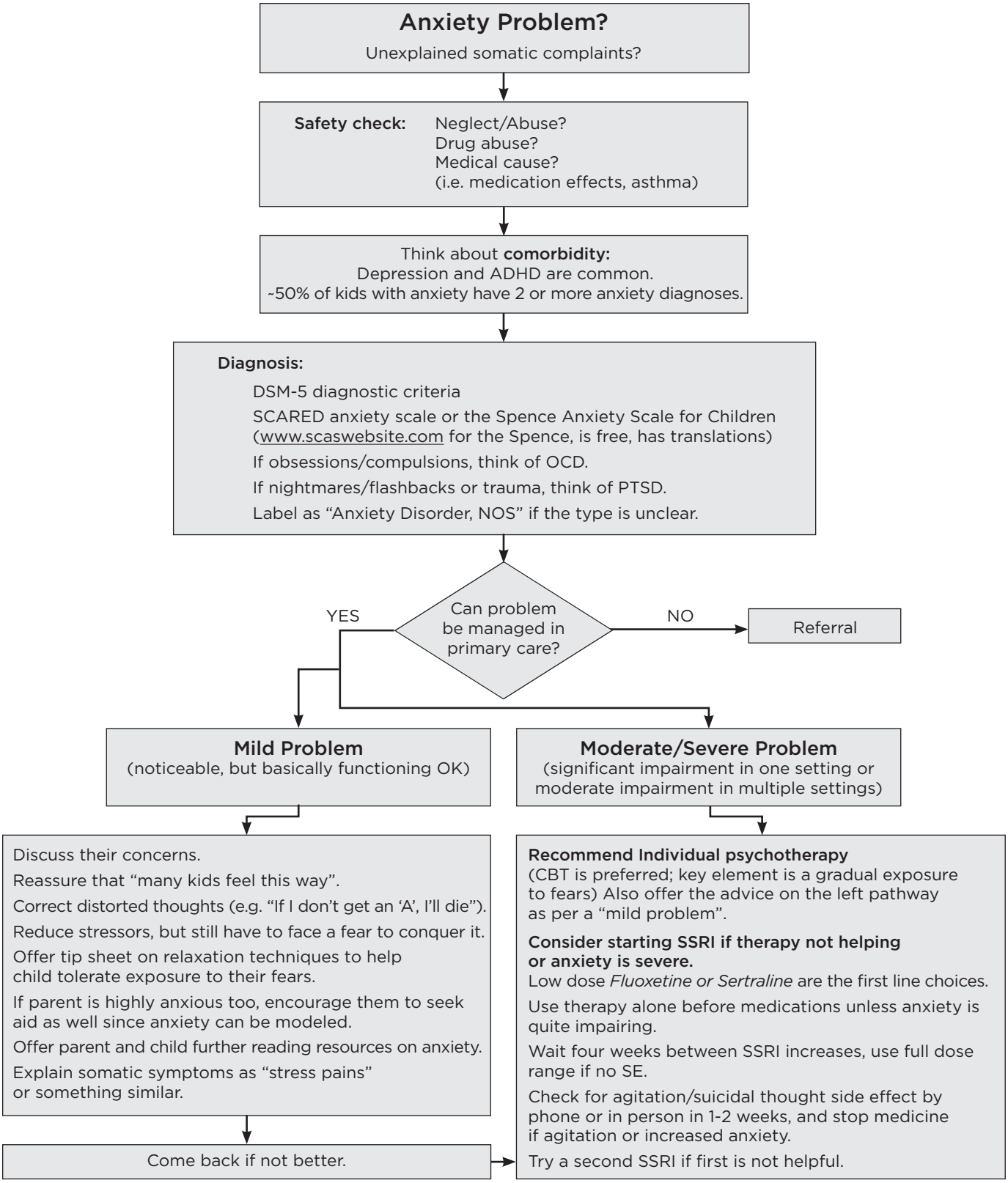
"Behavior Management Training" and "Behavior Therapy":

Manual and research based therapies for ADHD related problems lasting 10-20 sessions that can be performed by a qualified therapist. These treatments, though helpful with ADHD, are usually less effective than medications. But when combined with medications, these therapies may improve some difficulties (such as oppositional or aggressive behavior in ADHD) more than treating with medications alone.

The principle elements of these treatments are:

- reviewing information about the nature of ADHD
- learning to attend carefully to both misbehavior and when child complies
- establishing a "token economy," like sticker chart rewards
- using time out effectively
- managing non-compliant behavior in public settings
- using a daily school report card
- anticipating future misconduct

Anxiety



Primary References:
Jellinek M, Patel BP, Froehle MC eds. (2002): Bright Futures in Practice: Mental Health-Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health: 203-211

AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, JAACAP; 46(2): 267-283

Relaxation Therapy Tip Sheet

The following two techniques when practiced regularly can become useful skills that help a child face a plan of gradually increasing exposure to their fears. Gradual, tolerated exposures are a core element of "unlearning" a fear. It is suggested to do either or both of these once a day for a while until the calm state produced can be easily achieved. Using one of these behaviors will decrease physiological arousal if the body feels anxious, stressed or in pain. It is best to practice these skills at times when not feeling anxious so that it will be less intimidating to try at a time of high anxiety.

Breathing Control

- Imagine that you have a tube that connects the back of your mouth to your stomach. A big balloon is connected to the tube down in your stomach. When you breathe in the balloon blows up and when you breathe out the balloon deflates. Put your hand on your stomach and practice taking breaths that push your hand out as that balloon inflates. When learning this trick, it might be easier to lie down on your back while you observe what is happening.
- Now focus on doing these stomach balloon breaths as slowly and as comfortably possible. Inhale slowly, pause briefly, and then gently exhale. When you allow that balloon to deflate, notice the calm feeling that comes over you. Counting the length of each phase may help you find that sense of calm, such as counting slowly to 3 during inhalation, to 2 while pausing, then to 6 while exhaling.
- Now practice making your breath smooth, like a wave that inflates and deflates.
- If you experience brief dizziness or tingling in fingers, this just means you are breathing too quickly (hyperventilating), so slow your breathing further to stop that sensation. Once skilled at this, just a few controlled breaths at a time of stress will produce noticeable relief, and can be done anywhere.

Progressive Muscle Relaxation

This is particularly helpful for kids who experience body aches along with stress/anxiety. It is easier to have someone guide a child through this the first few times until the technique is learned. Tell kids this is like learning to turn their muscles from uncooked spaghetti into cooked spaghetti.

- Lie down in a quiet room and take slow breaths, try Breathing Control as above.
- Think about the muscles of your head and face, now scrunch them up tightly and clench your teeth, hold that as you count to 10, then allow all of those muscles to relax. Notice that feeling of relaxation in your face, and your jaw loosening.
- Now concentrate on muscles of your shoulders and neck, tighten up your neck muscles pulling your head down, shrug your shoulders up, hold that uncomfortable tightness, for a count of 10, then let all those muscles relax and notice the feeling.
- While continuing your slow breathing, move your attention to your arms and hands, tightening those muscles further and further, hold it as you count to 10. Then allow those muscles to relax.
- Now think about the muscles in your legs, your bottom and your feet, tighten all these muscles up, feel the hard tension throughout your legs, hold it as you count to 10, then allow your legs and feet to relax as you continue your slow breathing.
- Now that all of your muscles have relaxed, continue your slow breathing and take some time to enjoy the sense of relaxation. Focus on how the most relaxed areas of your body feel now.

Robert Hilt, MD

This resource page is now available in Spanish at www.seattlechildrens.org/pal

PTSD: Treating A Unique Anxiety Disorder

Identifying Post-Traumatic Stress Disorder (PTSD)

- Inquire directly about trauma, which could include child abuse, domestic violence, community violence, or serious accidents. Avoid asking the child for specific details of trauma during a brief office visit as this can be very distressing for the child, unless this is necessary to ensure their current safety.
  - Consider asking for trauma details from the caregiver instead.
  - Or ask the child a general question like, "What's the worst thing that ever happened to you?" so that the child can be in control of their response.
  - Or ask the child about current symptoms of PTSD (outlined below) rather than asking for trauma details.
- If a traumatic experience has occurred, screen for PTSD symptoms: "Sometimes when a child (or even an adult) experiences a frightening event, they can continue to be bothered by it and it can affect them in different ways..."
  - Look for symptoms such as: (1) intrusion (dreams/ nightmares, flashbacks or psychological/ physiological distress at trauma cues), (2) avoidance (of trauma reminders such as people/places or of distressing memories, thoughts, or feelings), (3) changes to cognition or mood (affecting beliefs about oneself or the world, willingness to engage in activities, or resulting in a negative emotional state), or (4) alterations in arousal (irritable outbursts, reckless behavior, hypervigilance, exaggerated startle, poor sleep, or concentration problems).
  - In children 6 years and younger, symptoms may emerge through play and the DSM-5 lists separate PTSD diagnostic criteria.
  - Symptoms causing distress or impairment for a period of more than 1 month suggest PTSD (versus an acute trauma reaction).
- When addressing trauma reactivity, the number one treatment tenet is: **ensure the child is safe.** Children cannot recover from a trauma if the trauma is on-going or at risk of occurring again.
- When parents are also affected by a trauma, their child's recovery can be delayed. Parents need to have their own mental health needs addressed as well to become an effective support for their child.

Treatment

Psychotherapy or counseling is the first-line treatment

- Refer to a licensed mental health professional.
- Trauma-focused therapy is preferred over non-specific therapy.
- Refer for Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) when possible for ages 3-17 years old.
- Younger children may benefit from joint child-parent therapy.

Medications

- There is no "PTSD medication" with compelling evidence for use in children.
- In some cases, medication can be considered for acute symptom reduction, treatment of a comorbid disorder, or if therapy response has been unsatisfactory.
- If other diagnoses are present, such as depression or anxiety, consider medications for those diagnoses. Sertraline is approved for adult PTSD. If ADHD is comorbid, guanfacine could be considered for hyper-reactivity.
- Sometimes medications such as Clonidine or Prazosin can be considered at bedtime if nightmares have not improved with other treatments.

Rebecca Barclay, MD and Robert Hilt, MD

Reference:
AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder, JAACAP; 49(4): 267-283.

Rating Scale:

The Screen for Child Anxiety Related Disorders (SCARED) Traumatic Stress Disorder Scale (Muris, Merckelbach, Korver, and Meesters, 2000) on the following page is a brief initial screen for the presence of PTSD symptoms. It is validated in youth age 7 to 19 years old with sensitivity of 100% and specificity of 52% for answers of "very true or often true" to all four questions. For children reporting a score ≥ 6, consider a referral for therapy.

Screen for Child Anxiety Related Disorders (SCARED) Traumatic Stress Disorder Scale

Name ..... Today's Date .....

Directions:
Below is a list of sentences that describe how people feel. Read each and decide if it is "Not True or Hardly Ever True," "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, choose the answer that seems to describe you **for the last 3 months.**

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
I have scary dreams about a very bad thing that once happened to me.	❍	❍	❍
I try not to think about a very bad thing that once happened to me.	❍	❍	❍
I get scared when I think back on a very bad thing that once happened to me.	❍	❍	❍
I keep thinking about a very bad thing that once happened to me, even when I don't want to think about it.	❍	❍	❍

Score .....

Screen for Child Anxiety Related Disorders (SCARED)

Name ..... Today's Date .....

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you **for the last 3 months.**

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When I feel frightened, it is hard for me to breathe	❍	❍	❍
2. I get headaches when I am at school	❍	❍	❍
3. I don't like to be with people I don't know well	❍	❍	❍
4. I get scared if I sleep away from home	❍	❍	❍
5. I worry about other people liking me	❍	❍	❍
6. When I get frightened, I feel like passing out	❍	❍	❍
7. I am nervous	❍	❍	❍
8. I follow my mother or father wherever they go	❍	❍	❍
9. People tell me that I look nervous	❍	❍	❍
10. I feel nervous with people I don't know well	❍	❍	❍
11. I get stomachaches at school	❍	❍	❍
12. When I get frightened, I feel like I am going crazy	❍	❍	❍
13. I worry about sleeping alone	❍	❍	❍
14. I worry about being as good as other kids	❍	❍	❍
15. When I get frightened, I feel like things are not real	❍	❍	❍
16. I have nightmares about something bad happening to my parents	❍	❍	❍
17. I worry about going to school	❍	❍	❍
18. When I get frightened, my heart beats fast	❍	❍	❍
19. I get shaky	❍	❍	❍
20. I have nightmares about something bad happening to me	❍	❍	❍
21. I worry about things working out for me	❍	❍	❍
22. When I get frightened, I sweat a lot	❍	❍	❍

Screen for Child Anxiety Related Disorders (SCARED)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
23. I am a worrier	❍	❍	❍
24. I get really frightened for no reason at all	❍	❍	❍
25. I am afraid to be alone in the house	❍	❍	❍
26. It is hard for me to talk with people I don't know well	❍	❍	❍
27. When I get frightened, I feel like I am choking	❍	❍	❍
28. People tell me that I worry too much	❍	❍	❍
29. I don't like to be away from my family	❍	❍	❍
30. I am afraid of having anxiety (or panic) attacks	❍	❍	❍
31. I worry that something bad might happen to my parents	❍	❍	❍
32. I feel shy with people I don't know well	❍	❍	❍
33. I worry about what is going to happen in the future	❍	❍	❍
34. When I get frightened, I feel like throwing up	❍	❍	❍
35. I worry about how well I do things	❍	❍	❍
36. I am scared to go to school	❍	❍	❍
37. I worry about things that have already happened	❍	❍	❍
38. When I get frightened, I feel dizzy	❍	❍	❍
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	❍	❍	❍
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	❍	❍	❍
41. I am shy	❍	❍	❍

** For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Name ..... Today's Date .....

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child **for the last 3 months.** Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe	❍	❍	❍
2. My child gets headaches when he/she is at school	❍	❍	❍
3. My child doesn't like to be with people he/she doesn't know well	❍	❍	❍
4. My child gets scared if he/she sleeps away from home	❍	❍	❍
5. My child worries about other people liking him/her	❍	❍	❍
6. When my child gets frightened, he/she feels like passing out	❍	❍	❍
7. My child is nervous	❍	❍	❍
8. My child follows me wherever I go	❍	❍	❍
9. People tell me that my child looks nervous	❍	❍	❍
10. My child feels nervous with people he/she doesn't know well	❍	❍	❍
11. My child gets stomachaches at school	❍	❍	❍
12. When my child gets frightened, he/she feels like he/she is going crazy	❍	❍	❍
13. My child worries about sleeping alone	❍	❍	❍
14. My child worries about being as good as other kids	❍	❍	❍
15. When he/she gets frightened, he/she feels like things are not real	❍	❍	❍
16. My child has nightmares about something bad happening to his/her parents	❍	❍	❍
17. My child worries about going to school	❍	❍	❍
18. When my child gets frightened, his/her heart beats fast	❍	❍	❍
19. He/she gets shaky	❍	❍	❍
20. My child has nightmares about something bad happening to him/her	❍	❍	❍

Screen for Child Anxiety Related Disorders (SCARED)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her	❍	❍	❍
22. When my child gets frightened, he/she sweats a lot	❍	❍	❍
23. My child is a worrier	❍	❍	❍
24. My child gets really frightened for no reason at all	❍	❍	❍
25. My child is afraid to be alone in the house	❍	❍	❍
26. It is hard for my child to talk with people he/she doesn't know well	❍	❍	❍
27. When my child gets frightened, he/she feels like he/she is choking	❍	❍	❍
28. People tell me that my child worries too much	❍	❍	❍
29. My child doesn't like to be away from his/her family	❍	❍	❍
30. My child is afraid of having anxiety (or panic) attacks	❍	❍	❍
31. My child worries that something bad might happen to his/her parents	❍	❍	❍
32. My child feels shy with people he/she doesn't know well	❍	❍	❍
33. My child worries about what is going to happen in the future	❍	❍	❍
34. When my child gets frightened, he/she feels like throwing up	❍	❍	❍
35. My child worries about how well he/she does things	❍	❍	❍
36. My child is scared to go to school	❍	❍	❍
37. My child worries about things that have already happened	❍	❍	❍
38. When my child gets frightened, he/she feels dizzy	❍	❍	❍
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport)	❍	❍	❍
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well	❍	❍	❍
41. My child is shy	❍	❍	❍

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). **Email:** birmaherb@msx.upmc.edu

SCARED Rating Scale Scoring Aid

Question	Panic Somatic	Generalized Anxiety	Separation	Social	School Attendance
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
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22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
Total					
	Cutoff = 7	Cutoff = 9	Cutoff = 5	Cutoff = 8	Cutoff = 3

0 = not true or hardly true
1 = somewhat true or sometimes true
2 = very true or often true

SCORING

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder.** Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms.**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder.**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder.**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder.**

A score of **3** for items 2, 11, 17, 36 may indicate Significant **School Avoidance.**

The SCARED target population is 9-18 years old.

Total anxiety ≥ 25

Anxiety Medications

Starting at a very low dose of SSRI for the first week or two with anxiety disorders is especially essential to reduce the child's experience of side effects (augmented by associated somatic anxieties).

Name	Dosage Form	Usual starting dose for adolescents	Increase increment (after ~4 weeks)	RCT anxiety treatment benefit in kids	FDA anxiety approved for children?	Editorial Comments
Fluoxetine (Prozac)	10, 20, 40mg 20mg/5ml	5-10 mg/day (60mg max)*	10-20mg**	Yes	Yes (For OCD ≥7yr) (For MDD ≥8yr)	Long 1/2 life, no SE from a missed dose, drug interactions may raise levels of concurrently administered medications.
Sertraline (Zoloft)	25, 50, 100mg 20mg/ml	25 mg/day (200mg max)*	25-50mg**	Yes	Yes (For OCD ≥6yr)	May be prone to SE from weaning off
Sertraline and Fluoxetine are both first line medications for child anxiety disorders, per the evidence base						
Fluvoxamine (Luvox)	25, 50, 100mg	25 mg/day (300mg max)*	50 mg**	Yes	Yes (For OCD ≥8yr)	Often more side effect than other SSRI's, has many drug interactions
Paroxetine (Paxil)	10, 20, 30, and 40 mg 10mg/5ml 12.5, 25, 37.5mg CR forms	5-10 mg/day (60mg max)*	10-20mg**	Yes	No	Not preferred if child also has depression. Can have short 1/2 life, and thus increased discontinuation symptoms
Citalopram (Celexa)	10, 20, 40 mg 10mg/5ml	5-10 mg/day (40mg max)*	10-20mg**	Yes	No	Very few drug interactions, dose maximum 40mg/day due to risk of QT prolongation
Escitalopram (Lexapro)	5, 10, 20mg 5mg/5ml	2.5 to 5 mg/day (20mg max)*	5-10mg**	No	No	Active isomer of citalopram
Duloxetine (Cymbalta)	20, 30, 40, 60mg	30 mg/day (120mg max)	30mg	Yes	Yes (For generalized anxiety ≥7yr)	May cause nausea. May help with somatic symptoms.

* Recommend decrease maximum dosage by at least 1/3 for pre-pubertal children

** Recommend using the lower dose increase increments for younger children.

Successful medication trials should continue for 6-12 months.

Anxiety Resources

Information for Families

Books parents may find helpful:

Freeing your Child from Anxiety (2004), by Tamar Chansky, PhD

Helping Your Anxious Child (2008), by Rapee, PhD, Wignall, DPsych, Spence, PhD, Cobham, PhD, and Lyneham, PhD

Worried No More: Help and Hope for Anxious Children (2005), by Aureen Pinto Wagner, PhD

Talking Back to OCD (2006), by John March, MD

Freeing Your Child from Obsessive-Compulsive Disorder (2001), by Tamar Chansky, PhD

Books children may find helpful:

What to Do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD (2007), by Dawn Huebner, PhD

What to Do When You Worry Too Much (2005), by Dawn Huebner, PhD

What to Do When You Are Scared and Worried (2004), by James Crist, PhD

Recording children may find helpful:

I Can Relax (2012), by Donna Pincus

Websites parents may find helpful:

Anxiety Disorders Association of America
www.adaa.org

Children's Center for OCD and Anxiety
www.worrywisekids.org

Child Anxiety Network
www.childanxiety.net/Anxiety_Disorders.htm

American Academy of Child and Adolescent Psychiatry
www.aacap.org/aacap/families_and_youth/resource_centers/Anxiety_Disorder_Resource_Center/Home.aspx

National Institute of Mental Health
www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

Anxiety Canada Youth (an online CBT tools website for teens)
https://youth.anxietycanada.com

After the Injury (from Children's Hospital of Philadelphia)
www.aftertheinjury.org

Autism Spectrum Disorders

This section was co-authored by Robert Hilt, MD and A.A. Golombek, MD

Considering an Autism Spectrum Disorder?

Any Early Red Flags?

Not smiling in response to being smiled at, or making eye contact
Does not develop shared attention with others
Does not respond to own name by 1 year of age
Poor social communication or lack of interest in other children

Consider a comorbidity or other diagnoses:

Intellectual Disability (ID), Global Developmental Delay (GDD), Learning Disorders
Speech and Language Disorders
Hearing or Vision Impairment
Neglect or Abuse
Other Neurologic Disorders (epileptic, infectious, auto-immune, neoplastic, metabolic)
Other Psychiatric Disorders (Anxiety, Depression, ADHD)

Diagnosis: Use DSM-5 diagnostic criteria which include presence or early developmental history of:

1. **Impairments in Social Communication and Social Interaction** — three domains of impairment in this area should include A) deficits in social-emotional reciprocity, B) deficits in nonverbal communication for social interaction, and C) deficits in developing, maintaining, and understanding relationships.
2. **Restrictive, repetitive, patterns of behavior, interests or activities** — including at least two of the following domains of A) stereotyped/repetitive movements, use of objects or speech, B) insistence on sameness, inflexible routines, ritualized patterns of behavior, C) highly restricted, fixated interests of abnormal intensity or focus, D) hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment

May augment one's assessment with an age-appropriate screening tool:

M-CHAT (Modified Checklist of Autism in Toddlers) for age 16-30 months.
Found at http://mchatscreen.com

CAST (Childhood Autism Spectrum Test) for age 4-11 years, and AQ (Autism Quotient) for age 12-15 years.
Found at www.autismresearchcentre.com/arc_tests

Treatment:

Refer to further evaluation, Early Intervention and education:
If birth to 3 years old, contact the Family Health Hotline (800-322-2588) or the Washington State Early Learning Program at (https://www.dcyf.wa.gov/services/early-learning-providers/eceap). They assist with evaluation and treatment of any developmental concerns.

If 3 years or older, contact the special education department in the local school system, and request an evaluation for an IEP. May ask for evaluation of intellect, academic progress, social and communication skills including pragmatic or social language, and occupational and adaptive function as all are relevant to the school setting.

Individually evaluate/address any deficits in the following areas (might consider a formal autism evaluation):
Speech and language deficits: consider referral to speech/language therapist
Social skills deficits: consider social skills groups or a speech/language therapist
Sensory sensitivities/motor abnormalities that impact function: consider referral to occupational or physical therapy
Maladaptive behavior that affects function: consider referral to a behavioral therapist, psychologist, or psychiatrist

Medical Evaluation:
1. Check hearing and vision. Check on dental status. Assure getting routine medical care.
2. Consider epilepsy if comorbid intellectual or global developmental delay, or decline in functioning.
3. Do genetic, metabolic, or other studies as indicated by presentation. Consider Fragile X testing.
4. Monitor closely for treatable medical problems like ear infections and constipation which can worsen symptoms.
5. Consider co-morbid psychiatric conditions (like ADHD, anxiety or depression) which can worsen functioning.

Primary References:
Johnson C, Myers S, Council on Children with Disabilities, "Identification and Evaluation of Children with Autism Spectrum Disorders," Pediatrics 120(5): November 2007: 1183-1215.

Myers S, Johnson C, Council on Children with Disabilities, "Management of Children with Autism Spectrum Disorders," Pediatrics 120 (5), November 2007: 1162-1182.

Treatments for Autism and Difficulties Associated with Autism

Treatment for Autism:
- Currently, there is no single treatment for autism, but a variety of approaches may fit the child's unique circumstances.

Speech and Language Therapy:
- Consider when communication is a key concern. Goal is to teach pragmatic or social language skills, rewarding any steps child makes in this direction. Alternative communication systems like Picture Exchange Communication System (PECS) may be needed if child remains non-verbal. The picture exchange system lets the child and others point to pictures representing things (like food) or activities (like using the bathroom) to communicate. Achieving a means of basic communication is often essential in improving function and reducing maladaptive behaviors.
- Speech/Language therapists are commonly available in most communities and/or schools.

Social Skills Training:
- Consider when this is appropriate to the child's developmental level. Social skills training often uses social stories, role-playing, and peer skills groups. Social stories are cartoon-like illustrations depicting social events (e.g., greeting new people, going to the store) or skills (e.g., asking for help when teased or distressed) to help children anticipate new events or practice skills. Social skills training may become a primary focus of the school environment to teach steps of how to interact with others, especially after basic communication skills are learned.
- May be available in communities and schools through the work of Speech and Language or other therapists.

Occupational and Physical Therapy:
- Consider when there are functional problems with adaptive skills or with muscle control. Occupational therapists (OTs) are often effective in improving function impaired by sensory sensitivities by modifying the environment. OTs may also assess and work on improving adaptive skills or skills of daily living. Physical therapists (PTs) can be helpful if the child has muscle control abnormalities which impair function.
- OT and PT providers are commonly available in communities

Medical Assessment:
- Consider medical, neurological, psychiatric, medication-induced, and trauma-related causes of maladaptive behaviors, especially if there are sudden changes in function. Rule out pain (head or ear aches, constipation) as a trigger for any new behaviors, particularly since children with autism are not typically very good at communicating distress and may exhibit maladaptive behavior when medically distressed.

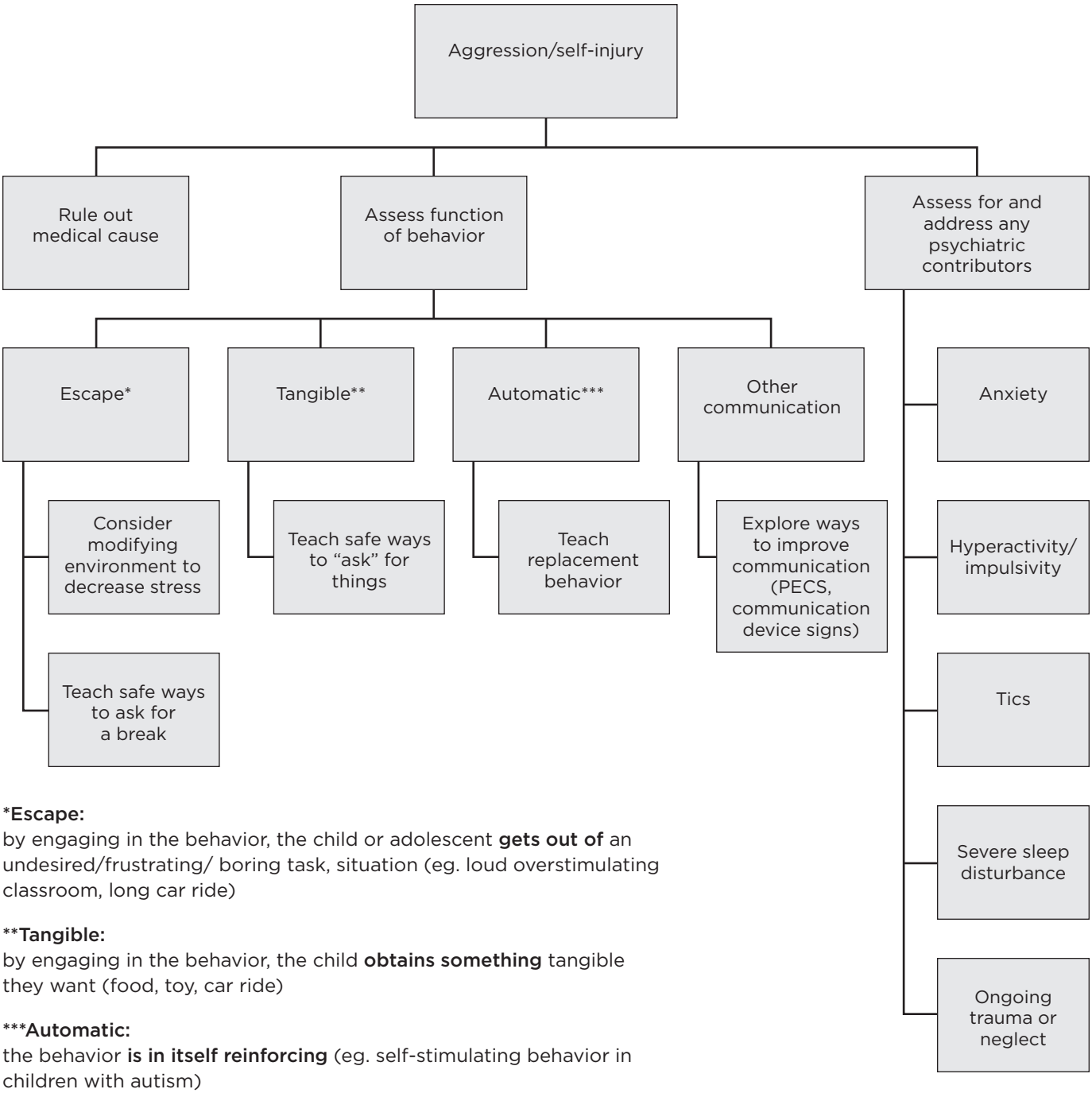
Behavior Therapy:
- Consider addressing core deficits associated with autism and to reduce maladaptive behaviors. Intensive behavioral therapy and related training methods (which are the components of Applied Behavior Analysis or "ABA") have been shown to improve many autism symptoms by teaching and reinforcing social and communication skills and by reducing maladaptive behaviors. Any behavioral program should be tailored to a child's needs, build on the child's interests, offer a predictable schedule, teach tasks as a series of simple steps, actively engage the child's attention in structured activities, and provide regular reinforcement of behavior. Efficacy of interventions should be tracked by establishing a baseline and monitoring progress, with interventions adjusted accordingly. Parental involvement is a major factor in treatment success — parents help identify target skills and behaviors, and are often trained to continue the therapy at home.
- Maladaptive behaviors can be reduced via a functional analysis of behavior, which includes characterizing the behavior, the setting, provoking, and reinforcing factors. The behavior is then modified by changing these factors. See also "Treating Maladaptive Behavior Using Functional Analysis," and "Autism Resources: Information for Families."
- Behavior therapists may be available in either a school or in the community.

Psychotropic Medications:
- If aggression, self-injury, irritability, or mood swings are severe, consider Risperidone or secondarily Abilify after reviewing "Psychotropic Medication Considerations for Children with Autism."

Co-morbid Psychiatric Disorders:
- Conditions such as ADHD, anxiety or depression do occur in children with autism, but avoid attributing core autism spectrum symptoms (e.g., poor eye-contact, flat affect, social withdrawal, repetitive behavior, rigidity, or concrete thought process) to a psychiatric diagnosis without noting if there had been a change from baseline. Use evidenced-based therapies for psychiatric disorders to the extent they are developmentally appropriate. Consider psychotropic medications when appropriate for a condition, but first review "Psychotropic Medication Considerations for Children with Autism."

A. A. Golombek, MD and Robert Hilt, MD

Evaluation and Management of Aggression or Self-Injurious Behavior in a Child or Adolescent with Communication Challenges



*__Escape:__
by engaging in the behavior, the child or adolescent **gets out of** an undesired/frustrating/ boring task, situation (eg. loud overstimulating classroom, long car ride)

**__Tangible:__
by engaging in the behavior, the child **obtains something** tangible they want (food, toy, car ride)

***__Automatic:__
the behavior **is in itself reinforcing** (eg. self-stimulating behavior in children with autism)

Aditi Sharma, MD

Treating Maladaptive Behavior for the Developmentally Disabled Using Functional Analysis

Identify the behavior

Character	*(what they do)*
Timing	*(especially noting provoking and reinforcing factors)*
Frequency	*(times per day or per week)*
Duration	*(i.e. 30 minute behaviors are different than 30 second behaviors)*

Analyze and make hypotheses about the function of the behavior

- *Communication.* This is the primary etiology to investigate if a child lacks communication skills. Maladaptive behavior may communicate physical discomfort like pain, constipation, reflux or a new illness. It may also communicate an emotional discomfort like boredom, anxiety, anger, frustration, sadness, or over-excitement.
- *Achieving a goal.* How does performing the behavior benefit the child, what does he/she gain? This might include escaping an undesired situation, avoiding a transition, acquiring attention, or getting access to desired things like toys or food.
- *No function.* If there is no function identifiable for the behavior, this suggests causes like seizures, medication side effects, sleep deprivation, and other medical or psychiatric disorders.

Modify the environment by changing provoking and reinforcing factors

- Enhance communication—consider using an alternative communication system, such as a picture-exchange communication system (PECS) for non-verbal children.
- Use simple, concrete sentences and questions with child. Remain calm.
- Increase structure — provide schedule of day's events, use routines, anticipate transitions. Consider social stories to practice routines, especially to prepare for new situations. Teach the child how to ask for help and how to tell adults when they need a break.
- Modify demands — match the task to their IQ, developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

Consult with a behavioral specialist to facilitate process and support family

- Behavior modification specialists can make tailored suggestions for the family's situation.
- If behavior is at school, consult with the school psychologist for a behavioral intervention.

If strategies are insufficient or behavior is severe, or places child or others at risk of harm, consider augmentation with medications

- See Care Guide sections, "Psychotropic Medication Considerations in Children with Autism" and "Non-Specific Medications for Disruptive Behavior and Aggression."

A. A. Golombek, MD and Robert Hilt, MD

Applied Behavioral Analysis (ABA) Tip Sheet

What is ABA?

ABA is a type of therapy that helps children improve communication and social skills as well as decrease or eliminate a range of problematic behaviors. Applied Behavior Analysis focuses on understanding behavior as a function of an individual's environment and then modifying behavior to achieve a range of goals. ABA uses the principles of learning to teach skills that improve behavior and communication related to core impairments associated with autism. ABA has the most empirical support of any treatment for autism spectrum disorder (ASD). It is also very time and labor intensive and very expensive.

What behaviors or skill deficits can be addressed with ABA?

ABA techniques have been shown to have efficacy for specific problem behaviors as well as academic tasks, adaptive living skills, communication, social skills, and vocational skills. In framing the need to parents, schools or an insurance company, consider both the need for *skill acquisition* and/or *reducing problem behaviors as goals.* Skills that can be improved include functional communication, social interaction, flexibility in play, frustration tolerance, self-care, affect regulation and relaxation strategies. Common behavioral targets include tantrums, physical aggression, property destruction, self-stimulation, pica, elopement/escape behaviors, and inappropriate social interactions/ boundaries. Because most children with ASD tend to learn tasks in isolation, generalization beyond an ABA setting is an important goal.

How do I help my patient and families access ABA?

The route to receiving ABA therapy varies depending on the type of insurance coverage, but it generally begins with a referral to, and evaluation by, an approved provider. Which individual or disciplines have been "approved" for determining the appropriateness of ABA varies by insurance carrier. It can be a challenging process to get a prescription for ABA and locate a provider who does this work, however, coverage is beginning to improve.

What if my patient is covered by a Medicaid managed care plan (eg. Apple Health)?

Because of federal mandates, children with public insurance often have an easier time accessing ABA compared to children with private insurance. For children under age 20 diagnosed with ASD who are covered by Medicaid or one of the associated managed care plans, the Washington State Developmental Disability Council (DDC) (www.ddc.wa.gov) recommends that parents or caregivers contact the Health Care Authority (aba@hca.wa.gov OR 800-562-3022) for assistance accessing ABA. The general process as outlined by the DDC involves.

a) a referral from a health care professional or caregiver for testing and comprehensive evaluation at a Center of Excellence (www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/autism-and-applied-behavioral-analysis)

b) the writing of an order for ABA services (usually in the form of a letter or embedded in encounter documentation)

c) assessment by a qualified board certified behavior analyst (BCBA) and development of a treatment plan

d) and then submission of plan for authorization by HCA. Re-authorization is typically required by BCBA at a 3-6 month interval.

What if my patient is covered by private insurance?

Washington Autism Alliance and Advocacy (www.washingtonautismadvocacy.org/updates) has Resource Coordinators to assist families in accessing private health insurance benefits for their children. Public employees and military personnel (Tricare) should contact their plan or benefits manager for guidance on how to apply for ABA.

David Camenisch, MD MPH

Psychiatric Medication Considerations for Children with Autism

- Medications do not improve core autism features; *i.e. there is currently no "autism medication."*
- Consider augmenting behavioral or counseling treatments with medications if there is moderate to severe distress and dysfunction in an area noted to be medication responsive.
- Use a single medication appropriate to a diagnosis or target symptom. Start low and increase slowly.
- Track the target symptom's response to interventions.
- Be skeptical about the utility of medicines that "work" for only a couple of weeks before a dose increase seems to be required — it is not safe to increase medicine doses indefinitely beyond the normal dosage range.
- If an intervention isn't reducing symptoms, taper and remove the medication, then reevaluate. Be vigilant about stopping any medication that is not clearly helpful.
- A history of past benefit from a medication does not necessarily mean there is continued benefit from ongoing use. Periodic attempts to wean off a previously helpful medication (such as annually) will reveal if ongoing use of that medicine is desirable.
- Do not exceed maximum dose recommendations for typically developing children. Note children with autism typically experience more adverse effects than others do from psychotropic medications.

Some medications to consider include:

Risperidone: FDA approved for children 5-16 years of age with irritability, aggression, self-injury, and quick mood swings associated with autism. Use if behavioral therapy is yielding inadequate results on severe symptoms. Can have many adverse effects including weight gain, dystonia, sedation, neuroleptic malignant syndrome, tardive dyskinesia and both cholesterol and glucose elevations. Suggest start at 0.25-0.5mg/day, usual effective dosage is less than 2mg/day. Requires glucose, lipid panel, and AIMS monitoring.

Aripiprazole: FDA approved for children aged 6 to 17 years for symptoms of aggression toward others, deliberate self injury, temper tantrums and quick mood swings associated with autism. Has same adverse effects and monitoring needs as risperidone, including probability of weight gain. As a newer agent, less autism research and clinical experience exists relative to risperidone. Effective in 2-15mg/day range of dosing. No generic formulation.

Stimulants: Consider if an ADHD comorbidity, though they may have less benefit on ADHD symptoms than children without autism. They have more adverse effects than children without autism, including more irritability, insomnia, and social withdrawal. Best studied of this group is methylphenidate. If used, start with 2.5mg/dose or 0.125mg/kg bid to tid.

SSRI's: Consider if an anxiety or depression comorbidity. Are shown to not improve any of the core autism features. SSRI's have increased rates of adverse effects including agitation, irritability, elation, and insomnia than for children without autism.

A. A. Golombek, MD and Robert Hilt, MD

Autism Resources

Information for Families

Books families may find helpful:

- Children with Autism: A Parent's Guide (2000), by Michael D. Powers
- A Parent's Guide to Asperger Syndrome and High-functioning Autism: How to Meet the Challenges and Help Your Child Thrive (2002), by Sally Ozonoff, Geraldine Dawson, and James McPartland

Websites families may find helpful:

- Autism Speaks
  www.autismspeaks.org
  (advocacy, diagnostic, treatment and support resources)
- Autism Center — University of Washington
  http://depts.washington.edu/uwautism
  (advocacy, diagnostic, treatment and support resources)
- ARC Washington State — Parent to Parent (peer mentorship program)
  http://arcwa.org/getsupport/parent_to_parent_p2p_programs

Resources for Teaching Social Skills

All Ages:

- The Social Skills Picture Book: Teaching Play, Emotion, and Communication to Children with Autism (2003), by Jed Baker (Future Horizons)
- The New Social Story Book, Illustrated Edition (2000), by Carol Gray (Linguisystems)

Preschool-Kindergarten:

- Skillstreaming in Early Childhood: Teaching Prosocial Skills to the Preschool and Kindergarten Child (1990), book and program forms booklet, by Ellen McGinnis and Arnold Goldstein (Research Press)
- Do, Watch, Listen, Say (2000), by Kathleen Ann Quill (Thinking Publications)

Elementary Grades (1st through 4th):

- Social Star: General Interaction Skills (Book 1), Social Star: Peer Interaction Skills (Book 2), and
- Social Star: Conflict Resolution and Community Interaction Skills (Book 3), by Nancy Gajewski, Patty Hirn, and Patty Mayo (Thinking Publications)
- Skillstreaming the Elementary School Child: New Strategies and Perspectives for Teaching Prosocial Skills (1997), by Ellen McGuinnis and Arnold Goldstein (Research Press)
- Comic Strip Conversations (1994), by Carol Gray (Thinking Publications)

Secondary Grades and Adolescents:

- SSS: Social Skills Strategies Book A and SSS: Social Skills Strategies Book B (1989), by Nancy Gajewski and Patty Mayo (Thinking Publications)
- Navigating the Social World: A Curriculum for Individuals with Asperger's Syndrome, High Functioning Autism and Related Disorders (2001), by Jeanette McAfee, MD (Future Horizon)
- Inside Out: What Makes the Individual with Social-Cognitive Issues Tick? (2000), by Michelle Garcia Winners (Thinking Publications)

Board Games and Online Games:

- 10 Say and Do Positive Pragmatic Game Boards (Super Duper Publications)
- The Non-Verbal Language Kit (ages 7-16, Linguisystems)
- http://do2learn.com (free games that teach about feelings and facial expressions)

Picture Exchange Communication System (PECS) resource:

- http://do2learn.com (has pictures that can be printed out for arranging a visual daily schedule)

This resource page is now available in Spanish at www.seattlechildrens.org/pal

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PARTNERSHIP ACCESS LINE
Child Psychiatric Consultation for Primary Care Providers

Bipolar Disorder

The diagnosis of bipolar disorder in children is a controversial topic even amongst child psychiatric specialists. This controversy makes it difficult for primary care providers to know what to do when they are wondering about bipolar disorder in their patient.

We would prefer that primary care providers would not have to struggle with this, and could refer all such patients to skilled mental health specialists to assist with diagnosis and treatment. The reality is that many primary care providers feel they do not have that option.

This guide on bipolar diagnosis and treatment aims to provide guidance to the primary care provider struggling on their own to sort out a diagnosis, or otherwise manage a bipolar disordered child in their practice.

Considering Bipolar Disorder?

Strongly consider other reasons for the symptoms such as:

- ADHD
- Conduct Disorder
- Oppositional Defiant Disorder
- Major Depression
- Early abuse or neglect in dysregulation syndromes
- "Difficult" temperament of child plus interpersonal conflicts
- Autism Spectrum Disorder, especially with oppositionality
- OCD, separation anxiety or other anxiety disorder
- Medical causes of mania (including fetal alcohol syndrome)

↔ Treat other causes of symptoms, especially if unsure of bipolar diagnosis

Safety check:

- Suicidality?
- Drug abuse?
- Current neglect/abuse?

Diagnosis:

- Does child have history of clear manic episode for >4 days?
- History of hospitalization for mania?
- History of psychosis or severe suicidality?
- Symptom of inappropriate euphoria/grandiosity?

YES → If yes to any, child should see a mental health specialist to evaluate/treat **Bipolar I or Bipolar II** (also called "narrow phenotype" bipolar)

MAYBE

Is this an "Unspecified," or "Other Specified" Bipolar disorder?
These are the DSM5 labels for bipolar symptoms that cause impairment, but the duration or other criteria for Bipolar I or II are not met.
This "soft" criteria bipolar diagnosis in children is controversial.
Most irritable, moody, irrational, hyperactive kids when evaluated more fully are found NOT to have a bipolar disorder.

More likely Bipolar spectrum if:

- *Episodic patterns* of changes in mood, activity and energy including elation, hyperactivity, grandiosity, hypersexuality, decreased sleep that are a departure from baseline function (and not fully explained by child's response to stressors)
- Have 1st degree relative with bipolar

Less likely Bipolar spectrum if:

- Younger age (such as <10)
- Rages only after frustrations
- Symptoms only in 1 setting (i.e. home)
- High expressed emotion in household (think of ODD)

→ Reconsider other etiologies like ADHD, PTSD, ODD, or Disruptive Mood Dysregulation Disorder: please see Disruptive Behavior section of this guide for behavior management guidance.

Treatment:

1. Consider consultation with a mental health specialist, especially if safety concerns.
2. Consider medical causes of manic symptoms like hyperthyroidism, neurological dysfunction.
3. Psychosocial/behavioral intervention tailored to family, including:
   a. family psychoeducation
   b. child/family focused CBT
   c. enhancing school and community supports
   d. individual or family psychotherapy
   e. behavior management training
4. Medication trial, single agent preferred, choose among:
   a. atypical antipsychotic
   b. lithium
   c. lamotrigine (especially if bipolar depression)
   d. divalproex, carbamazepine also options, though have less evidence basis
5. Be cautious of prescribing antidepressants (manic switching risk).
6. Follow up frequently, perhaps weekly until stabilizing.
7. Ensure adequate sleep hygeine — consider sleep medications if necessary.

Primary References:
AACAP "Practice Parameter for the Assessment and Treatment of Adolescents and Children with Bipolar Disorder" JAACAP 2007, 46(1), 107-125

DSM-5 May 2013, American Psychiatric Publishing, Inc.

Bipolar Disorder Medications

Evidence base on bipolar medications is for narrow phenotype, or classic Bipolar I or II. Broad phenotype, or Bipolar Not Elsewhere Classified has not been well researched in children.

Atypical Antipsychotics

Drug Name	Dosage Form	Usual Starting Dose	Sedation	Weight Gain	EPS (stiff muscles)	Bipolar (+) child RCT evidence?	FDA bipolar approved?	Editorial Comments
Risperidone (Risperdal)	0.25, 0.5, 1, 2, 3, 4mg 1mg/ml	0.25mg QHS	+	+	+	Yes	Yes (Age ≥10 acute mixed or manic)	Generic forms. More dystonia risk than rest, prolactin impact
Aripiprazole (Abilify)	2, 5, 10, 15, 25, 30mg 1mg/ml	2mg QD	+	+	+/-	Yes	Yes (Age ≥10 acute mixed or manic)	Generic forms. Long 1/2 life, can take weeks to build effect, more weight gain than for adults
Quetiapine (Seroquel)	25, 50, 100, 200, 300, 400mg	25mg BID	++	+	+/-	Yes	Yes (Age ≥10 acute management)	Generic forms. Pills larger, could be hard for kids to swallow.
Ziprasidone (Geodon)	20, 40, 60, 80mg	20mg BID	+	+	+/-	Yes	No	Generic forms. Greater risk of QT lengthen, EKG check
Olanzapine (Zyprexa)	2.5, 5, 7.5, 10, 15, 20mg	2.5 mg QHS	++	++	+/-	Yes	Yes (Age ≥13 acute mixed or manic) (Age ≥10 depressed in combination with fluoxetine)	Generic forms. Greatest risk of weight gain, increased cholesterol
Asenapine (Saphris)	Sublingual 2.5, 5, 10mg	2.5 mg SL BID	++	+/-	+/-	Yes	Yes (Age ≥10)	Oral paresthesias, must dissolve in mouth
Lurasidone (Latuda)	20, 40, 60 80, 120mg	20 mg QD	+	+	+/-	Yes	Yes (Age ≥10 depressed phase)	Take with food

Monitoring for all atypical antipsychotics:

1. Weight checks and fasting glucose/lipid panel roughly every 6 months.
2. If weight gain is severe, will need to change treatments.
3. AIMS exam at baseline and Q6months due to risk of tardive dyskinesia that increases with duration of use.
4. Review neuroleptic malignant syndrome risk (i.e. severe allergic reaction) before starting medication.
5. Discuss dystonia risk, and explain the use of diphenhydramine if needed as antidote.

Bipolar Disorder Medications

Other Medication Options

Drug Name	Bipolar (+) RCT evidence in kids	FDA bipolar approved children?	Monitoring	Editorial Comments
Lithium	Yes	Yes (Age ≥7 maintenance, acute mixed or manic)	Baseline EKG, BUN/creat, TSH, CBC. Lithium level after 5 days. Q3month Lithium level. Q6mo TSH,BUN/creatinine	Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal. Caution with NSAIDs.
Lamotrigine	No	No	CBC, LFT at baseline, in 2 -4 weeks, then Q6 month. Monitor for rash	Stevens-Johnson rash risk requires slow titration, adult studies support use for bipolar depression
Valproate	No	No	CBC, LFT at baseline, in 3 month, then Q6month. VPA level checks needed	Weight gain, sedation, rare severe toxicity of liver, ↓platelets ↓WBC, risk of polycystic ovarian syndrome. Teratogen.
Carbamazepine	No - not typically recommended	No	CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed	Aplasia and rash risk. Oxcarbazepine bipolar trial with kids had negative results

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

CODE 0 = NONE 1 = MINIMAL, MAY BE EXTREME NORMAL 2 = MILD 3 = MODERATE 4 = SEVERE

MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

EXAMINATION PROCEDURE

EITHER BEFORE OR AFTER COMPLETING THE EXAMINATION PROCEDURE OBSERVE THE PATIENT UNOBTRUSIVELY AT REST (E.G., IN WAITING ROOM). THE CHAIR TO BE USED IN THIS EXAMINATION SHOULD BE A HARD. FIRM ONE WITHOUT ARMS.

1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.
2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW?
3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE. HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.
4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION)
5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.)
6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE.
7. ASK PATIENT TO PROTRUDE TONGUE. OBSERVE ABNORMALITIES OF TONGUE MOVEMENT. DO THIS TWICE.

*8. ASK PATIENT TO TAP THUMB. WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)

9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.)
10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.)

*11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS. AND MOUTH.)

*12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE.

** ACTIVATED MOVEMENTS

FACIAL AND ORAL MOVEMENTS:	1.	MUSCLES OF FACIAL EXPRESSION E.G., MOVEMENTS OP FOREHEAD, EYEBROWS, PERIORBITAL AREA, CHEEKS; INCLUDE FROWNING, BLINKING, SMILING, GRIMACING	0	1	2	3	4
	2.	LIPS AND PERIORAL AREA E.G.. PUCKERING POUTING, SMACKING	0	1	2	3	4
	3.	JAW E.G., BITING CLENCHING, CHEWING, MOUTH OPENING, LATERAL MOVEMENT	0	1	2	3	4
	4.	TONGUE RATE ONLY INCREASE IN MOVEMENT BOTH IN AND OUT OF MOUTH. NOT INABILITY TO SUSTAIN MOVEMENT	0	1	2	3	4
EXTREMITY MOVEMENTS:	5.	UPPER (ARMS, WRISTS HANDS FINGERS INCLUDE CHOREIC MOVEMENTS (I.E., RAPID, OBJECTIVELY PURPOSELESS, IRREGULAR SPONTANEOUS) ATHETOID MOVEMENTS (I.E., SLOW IRREGULAR, COMPLEX SERPENTINE). DO NOT INCLUDE TREMOR (I.E., REPETITIVE, REGULAR, RHYTHMIC)	0	1	2	3	4
	6.	LOWER (LEGS, KNEES, ANKLES, TOES) E.G., LATERAL KNEE MOVEMENT, FOOT TAPPING, HEEL DROPPING, FOOT SQUIRMING, INVERSION AND EVERSION OF FOOT	0	1	2	3	4
TRUNK MOVEMENTS:	7	NECK, SHOULDERS, HIPS E.G., ROCKING. TWISTING, SQUIRMING PELVIC GYRATIONS	0	1	2	3	4
GLOBAL JUDGMENTS:	8	SEVERITY OF ABNORMAL ACTION	0	1	2	3	4
	9	INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0	1	2	3	4
	10.	PATIENT'S AWARENESS OF ABNORMAL MOVEMENTS	0	1	2	3	4
DENTAL STATUS:	11	CURRENT PROBLEMS	0	1	2	3	4
	12	DOES PATIENT USUALLY WEAR DENTURES?	0	1	2	3	4

❑ NOT APPLICABLE: PATIENT HAS NO HISTORY OF TREATMENT WITH NEUROLEPTICS FOR ONE MONTH OR MORE.

❑ EXAMINATION COMPLETED

PHYSICIAN'S SIGNATURE..... DATE OF EXAMINATION.....

REVISED 03/20/97

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Monitoring for all atypical antipsychotics: AIMS exam at baseline and ~Q6months due to risk of tardive dyskinesia. Warn of dystonia risk. Weight checks, fasting glucose/lipid panel ~Q6months at minimum.

Bipolar Disorder Resources

Information for Families

There is no shortage of books written about childhood bipolar disorder. Despite this fact, quality research based and balanced information is hard to find. This reflects the fact that an intense professional debate is currently raging about how bipolar disorder in children is defined, with some authors using "bipolar, unspecified type" as a label for any very irritable child.

Families should start their learning about bipolar disorder with the following websites that provide high quality information and support.

Books families may find helpful:

An Unquiet Mind (1995), by Kay Redfield Jamison, MD (a memoir by a bipolar disorder researcher who had the illness herself — can be helpful for understanding the nature of Bipolar I illness)

Bipolar Disorder for Dummies (2005), by Candida Fink, MD and Joe Craynak (don't be put off by the name of the book, it is balanced and easy to read)

The Bipolar Workbook: Tools for controlling your mood swings (2006), by Monica Ramirez Basco (contains some practical advice, based on CBT principles)

Your Child Does Not Have Bipolar Disorder (2011) by Stuart Kaplan (describes when a bipolar label would not be appropriate, and how we know how to help irritable, angry, explosive children)

The Bipolar Teen: What You Can Do to Help Your Child and Your Family (2007), by David Miklowitz, PhD and Elizabeth George, PhD

Websites families may find helpful:

American Academy of Child and Adolescent Psychiatry, Practice Parameter on Bipolar Disorder. This contains a very detailed review of treatments.
www.aacap.org/App_Themes/AACAP/docs/practice_parameters/JAACAP_Bipolar_2007.pdf

American Academy of Child and Adolescent Psychiatry Bipolar disorder Resource Center, has video clips, "facts for families," and many other resource links

www.aacap.org/aacap/families_and_youth/resource_centers/bipolar_disorder_resource_center/home.aspx

National Institute of Mental Health, bipolar disorder section
www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml

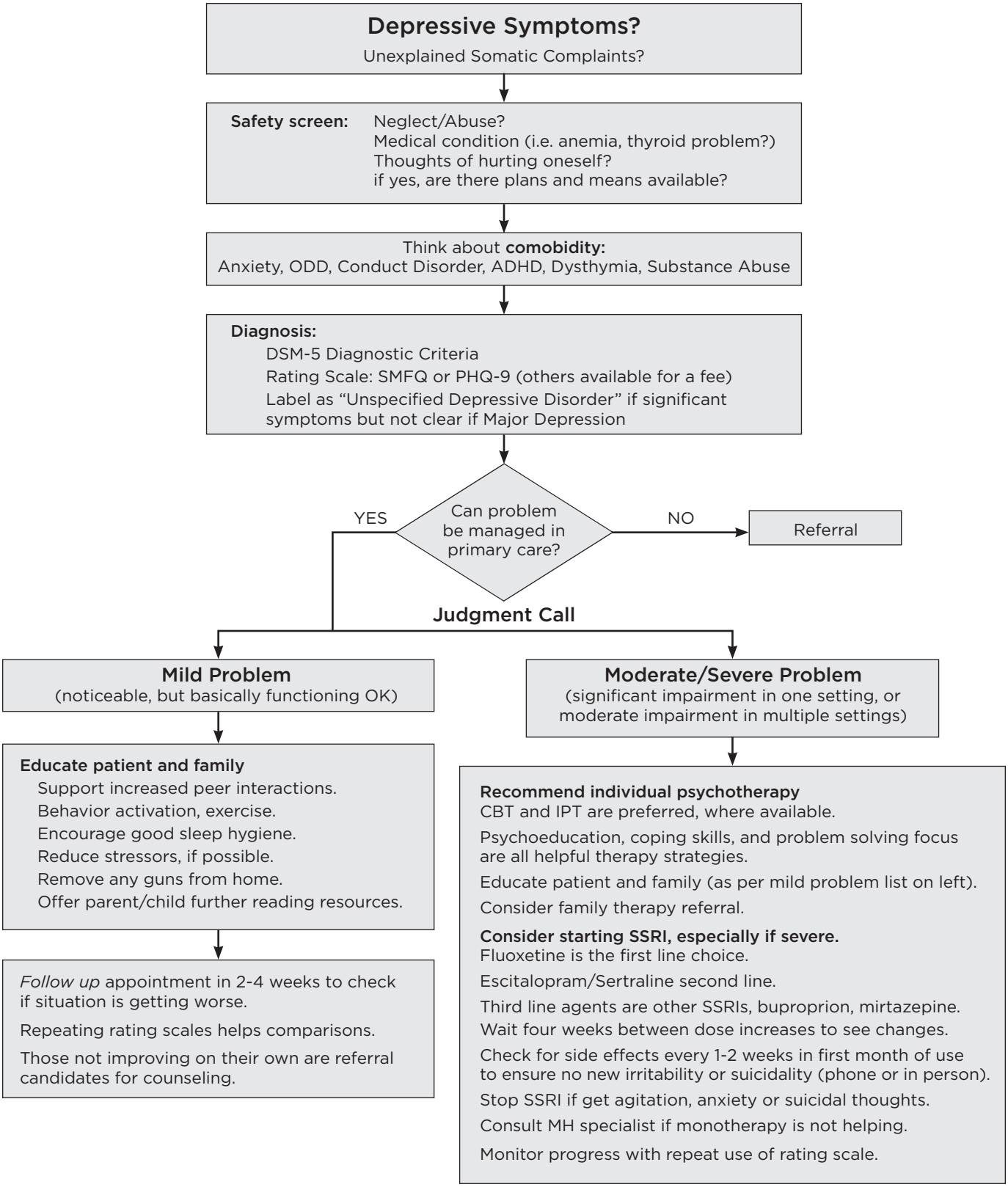
National Alliance for the Mentally Ill
www.nami.org

Depression and Bipolar Support Alliance
www.dbsalliance.org

Parents Med Guide, contains bipolar disorder medication information from American Psychiatric Association and American Academy of Child and Adolescent Psychiatry
www.parentsmedguide.org

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Depression



Primary References:
Jellinek M, Patel BP, Froehle MC eds. (2002): Bright Futures in Practice: Mental Health-Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health: 203-211

Marek JS, Silva S, Vitiello B, TADS team (2006): "The treatment for adolescents with depression study (TADS): methods and message at 12 weeks." JAACAP 45:1393-1403

AACAP (in press): "Practice parameter for the assessment and treatment of children and adolescents with depressive disorders." Accessed 2/08 on www.aacap.org

Zuckerbrot R ed.: "Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit." Columbia University: Center for the Advancement of Children's Mental Health

Short Mood and Feelings Questionnaire

This form is about how you might have been feeling or acting recently.

For each question, please check how much you have felt or acted this way *in the past two weeks.*

If a sentence was true about you most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about you, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. I felt miserable or unhappy	❑	❑	❑
2. I didn't enjoy anything at all	❑	❑	❑
3. I felt so tired I just sat around and did nothing	❑	❑	❑
4. I was very restless	❑	❑	❑
5. I felt I was no good any more	❑	❑	❑
6. I cried a lot	❑	❑	❑
7. I found it hard to think properly or concentrate	❑	❑	❑
8. I hated myself	❑	❑	❑
9. I was a bad person	❑	❑	❑
10. I felt lonely	❑	❑	❑
11. I thought nobody really loved me	❑	❑	❑
12. I thought I could never be as good as other kids	❑	❑	❑
13. I did everything wrong	❑	❑	❑

Short Mood and Feelings Questionnaire

This form is about how your child may have been feeling or acting recently.

For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

If a sentence was true about your child most of the time, check TRUE.
If it was only sometimes true, check SOMETIMES.
If a sentence was not true about your child, check NOT TRUE.

	NOT TRUE	SOMETIMES	TRUE
1. S/he felt miserable or unhappy	❑	❑	❑
2. S/he didn't enjoy anything at all	❑	❑	❑
3. S/he felt so tired that s/he just sat around and did nothing	❑	❑	❑
4. S/he was very restless	❑	❑	❑
5. S/he felt s/he was no good any more	❑	❑	❑
6. S/he cried a lot	❑	❑	❑
7. S/he found it hard to think properly or concentrate	❑	❑	❑
8. S/he hated him/herself	❑	❑	❑
9. S/he felt s/he was a bad person	❑	❑	❑
10. S/he felt lonely	❑	❑	❑
11. S/he thought nobody really loved him/her	❑	❑	❑
12. S/he thought s/he could never be as good as other kids	❑	❑	❑
13. S/he felt s/he did everything wrong	❑	❑	❑

Scoring the SMFQ

Note: the SMFQ has been validated for use in children age 6 years and up.

The SMFQ should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

Add up the assigned values for all 13 questions. Record the total score.

A total score on the child version of the SMFQ of 8 or more is considered significant.

> Sensitivity of 60% and specificity of 85% for major depression at a cut off score of 8 or higher. Source is Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." *International Journal of Methods in Psychiatric Research* (1995), 5:237-249.

Sensitivity/specificity statistics of the parent version is not reported in the literature. If your patient does not complete the child version of SMFQ, repeated administration of the parent version over time should still be useful for symptom tracking.

Patient Health Questionnaire (PHQ-9)

NAME..... DATE.....

Over the *last 2 weeks,* how often have you been bothered by any of the following problems? (*use "✔" to indicate your answer).*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
add columns			+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	**TOTAL:**			

10. If you checked off *any* problems, how *difficult* have these problems made it for you to to do your work, take care of things at home, or get along with other people.

Not difficult at all .....

Somewhat difficult .....

Very difficult .....

Extremely difficult .....

Scoring the PHQ-9

Note: this scale has not been evaluated for use with pre-pubertal children.
A number of studies have used this scale for adolescent patients.

The PHQ-9 should not be used to make a definitive diagnosis of depression. It has usefulness as a screening tool for situations where depression is suspected, and as an aid toward following a child's symptom severity and treatment response over time.

Any positive response to question 9 should be followed up with questions about the child's current safety.

Any immediate plans for suicide require an emergent response.

Question 10 should be noted as at least "somewhat difficult" to be consistent with a diagnosis of depression.

A depression diagnosis requires a functional impairment to be present.

Add up the total number from items 1-9
Estimated depression severity:

0-4	None
5-9	Minimal symptoms
10-14	Possible dysthymia, or mild Major Depression
15-19	Consistent with Major Depression
≥ 20	Consistent with severe Major Depression

* As recommended by Macarthur Foundation and Pfizer, Inc.

Depression Medications

Drug Name	Dosage Form	Usual starting dose for adolescent	Increase increment (after ~4 weeks)	RCT evidence in kids	FDA depression approved for children?	Editorial Comments
Fluoxetine (Prozac)	10, 20, 40mg 20mg/5ml	10 mg/day (60mg max)*	10-20mg**	Yes	Yes (Age ≥8)	Long 1/2 life, no side effect from a missed dose
Fluoxetine considered first line per the evidence base in children						
Sertraline (Zoloft)	25, 50, 100mg 20mg/ml	25 mg/day (200mg max)*	25-50mg**	Yes	No	May be prone to side effects when stopping
Escitalopram (Lexapro)	5, 10, 20mg 5mg/5ml	5 mg/day (20mg max)*	5-10mg**	Yes	Yes (Age ≥12)	The active isomer of citalopram.
Escitalopram and Sertraline considered second line per the evidence base in children						
Citalopram (Celexa)	10, 20, 40mg 10mg/5ml	10 mg/day (40mg max)*	10-20mg**	Yes	No	Few drug interactions, dose maximum 40mg/day due to risk of QT prolongation
Bupropion (Wellbutrin)	75, 100mg 100, 150, 200mg SR forms 150, 300mg XL forms	75 mg/day (later dose this BID) (400mg max)*	75-100mg**	No	No	Can have more agitation risk. Avoid if eat d/o. Also has use for ADHD treatment. Seizure risk limits dose.
Mirtazapine (Remeron)	15, 30, 45mg	15 mg/day (45mg max)*	15mg**	No	No	Sedating, increases appetite
Venlafaxine (Effexor)	25, 37.5, 50, 75, 100mg 37.5,75, 150 mg ER forms	37.5 mg/day (225mg max)*	37.5 to 75mg**	No (May have higher SI risk than others for children)	No	Only recommended for older adolescents. Withdrawal symptoms can be severe.
Duloxetine (Cymbalta)	20, 30, 40, 60mg	30 mg/day (120mg max)*	30mg	No	No	May cause nausea. May help with somatic symptoms.
Citalopram, bupropion, mirtazapine, venlafaxine, and duloxeline considered third line treatments per the evidence base in children						

Starting doses in children less than 13 may need to be lowered using liquid forms

Successful medication trials should continue for 6 to 12 months

* Recommend decrease maximum dosage by around 1/3 for pre-pubertal children

** Recommend using the lower dose increase increments for younger children.

Crisis Prevention Plan Aid

A parent's guide to creating a crisis prevention plan

Crisis Prevention Plans (CPP) are intended to help children/adolescents and their caregivers prevent minor problems from escalating into crisis events. CPPs provide an opportunity for the child/adolescent and the caregiver to logically think through situations by identifying the cause of distress, understanding and discussing options for minimizing difficult situations, and encouraging coping skills to help decrease the distress. Key components of a CPP include understanding triggers, identifying warning signs, and helping to facilitate interactions that will decrease the possibility of further difficulties. A thoughtful and carefully constructed CPP can help families make choices and take actions to diffuse difficult situations.

Steps for creating your own Crisis Prevention Plan:

- **Discuss triggers** — Triggers are things that cause distress for the child/adolescent. Common triggers include peer conflict, homework, chores, feeling sad or angry, and being told "no" or being unable to get their way. The child/adolescent and caregiver should be honest and explicit about the triggers for what is currently causing them the most difficulty.
- **Identify early warning signs** — Warning signs are physical clues the child/adolescent does (sometimes without their knowledge) that show others that they are upset or distressed. Common warning signs include blushing/flushed face, clenching fists, pacing, yelling, or withdrawing/becoming quiet.
- **List interventions the caregiver can do to help the child/adolescent calm down** — Discuss what the child/adolescent would want, and how the caregiver could provide that for them. Examples include giving the child/adolescent space to calm down, reminding them to use a coping skill, talking with them, or offering a hug.
- **List things the child/adolescent can do to help calm themselves** — This typically includes coping skills such as listening to music, talking a walk, doing deep breathing exercises, taking time to themselves (include a mention of how long to let the child/adolescent "cool off" before being expected to reengage with the family), writing, drawing/coloring, or other relaxation techniques.
- **Identify other supports if the above interventions aren't helpful or are unavailable** — for instance, list three people the child/adolescent can contact, beside the caregiver, when distressed. Examples include peers who would have a positive influence, relatives, older siblings, therapists, or teachers/coaches. The child/adolescent and caregiver should agree who are a good resource. Also identify and list the crisis line where you live. A teen hotline such as Teen Link (1-866-833-6546 or https://www.teenlink.org/) is also helpful.

Christina Clark, MD

Crisis Prevention Plan

My triggers are:

1. .....
2. .....
3. .....
4. .....
5. .....

My early warning signs are:

1. .....
2. .....
3. .....
4. .....
5. .....

When my parents/caregivers notice my early warning signs, they can:

1. .....
2. .....
3. .....
4. .....
5. .....

Things I can do when I notice my early warning signs:

1. .....
2. .....
3. .....
4. .....
5. .....

If I am unable to help myself I can call:

1. .....
2. .....
3. .....
4. .....
5. .....

- Your County Crisis Line Phone Number: ..... (you can look it up here: www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines)
- Text HOME to 741741 or visit: https://www.crisistextline.org
- Teen Link Hotline: 1-866-833-6546 or https://www.teenlink.org/
- The National Suicide Hotline: 1-800-273-8255

This Crisis Prevention Plan was created to give your family strategies you can use in your home to help calm your child during an escalation before they reach a crisis point. We do not advise using restraint, such as holding your child down, because you or your child could get hurt. Please call 911 if you or your child is in imminent danger.

General Home Safety Recommendations After a Child Crisis Event

The following safety tips may help to keep things safe right now after an escalated crisis event, and help to reduce further escalations/crises:

1. In the home environment, maintain a "low-key" atmosphere while maintaining regular routines
2. Follow your typical house rules, but pick your battles appropriately, for example:
   - immediately intervene with aggressive or dangerous behaviors
   - if your child is just using oppositional words, it may be wise to ignore those behaviors
3. Provide appropriate supervision until the child's crisis is resolved
4. Make a crisis prevention plan by identifying likely triggers for a crisis (such as an argument), and **plan with your child** what the preferred actions would be for the next time the triggers occur (such as calling a friend, engaging in a distracting activity or going to a personal space)
5. Encourage your child to attend school, unless otherwise directed by your provider
6. Make sure that you and your child attend the next scheduled appointment with their provider
7. Administer medications as directed by your child's medical or psychiatric provider
8. Go into each day/evening with a plan for how time will be spent — this should help prevent boredom and arguments in the moment
9. Secure and lock up all medications and objects your child could use to hurt him/herself and/or use to attempt suicide. When locking up items, ensure your child does not have knowledge of their location, the location of the key, or the combination to any padlock used to secure them. This includes:
   - Sharp objects like knives and razors
   - Materials that can be used for strangulation attempts, such as belts, cords, ropes and sheets
   - Firearms and ammunition (locked and kept in separate/different locations from each other)
   - All medications of all family members, including all over the counter medicines. If your child takes medication of any type, you should administer it for the time being (unless instructed to stop it by your care provider)

In the event of another crisis, please do the following:

- If you believe that you, your child, or another person is no longer safe as a result of your child's behavior, call 911 to have your child transported to the emergency department closest to your home
- Consider calling your local county crisis hotline, which are listed at: www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines
- Consider calling the national suicide hotline: 1-800-273-8255

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Depression Resources

Information for Families

Books families may find helpful:

The Childhood Depression Sourcebook (1998), by Jeffery Miller

The Depressed Child: Overcoming Teen Depression (2001), by Mariam Kaufman

The Explosive Child (2001), by Ross Greene

Helping Teens Who Cut: Understand and Ending Self-Injury (2008), by Michael Hollander

Books children may find helpful:

Taking Depression to School (2002), by Kathy Khalsa (for young children)

Where's Your Smile, Crocodile? (2001), by Clair Freedman (for young children)

Feeling Good: The New Mood Therapy (1999), by David Burns (for adolescents)

My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed (2008), by Sara Hamil (for elementary school students)

When Nothing Matters Anymore: A Survival Guide for Depressed Teens (2007), by Bev Cobain and Elizabeth Verdick

Crisis Hotlines:

National Suicide Prevention Lifeline
1-800-273-8255

Text HOME to 741741
www.crisistextline.org

Websites families may find helpful:

Guide to depression medications from APA and AACAP professional societies
www.parentsmedguide.org

National Institute of Mental Health
www.nimh.nih.gov/health/topics/depression/index.shtml

National Alliance for Mental Illness
https://www.nami.org/Your-Journey/Teens-Young-Adults

American Foundation for Suicide Prevention
https://afsp.org/

American Academy of Child and Adolescent Psychiatry
www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Peripartum Mood and Anxiety Disorders

Nearly 1 in 5 women experience a peripartum mood or anxiety disorder. Untreated peripartum mood or anxiety disorder presents serious risks.

- Risks to mothers: delayed or poor prenatal care, low birth weight, spontaneous abortion, impaired bonding with child, increased substance abuse (including nicotine), psychiatric hospitalization, postpartum psychosis, and suicide.
- Risks to offspring: decreased cognitive abilities, increased risk of affective, anxiety, and conduct disorders, increased risk of ADHD and learning disorders, increased risk of failure to thrive, delayed immunization, decreased car seat safety, and infanticide.

RISK FACTORS: history of traumatic birth, fussy baby, difficulty breastfeeding, unplanned C-section, stressful life events during peripartum period, financial hardship, NICU visit, or history of mental health difficulties in the mother.

SYMPTOMS:

- Sadness, hopelessness, emptiness
- Crying more often than usual for no apparent reason
- Increased worry, anxiety, panic or feeling overwhelmed
- Moodiness, irritability, restlessness, anger, rage
- Oversleeping, or being unable to sleep even when her baby is asleep
- Difficulty concentrating, remembering details, making decisions
- Losing interest in activities that are usually enjoyable
- Physical aches and pains, e.g., frequent headaches, stomach problems, and muscle pain.
- Increased or decreased appetite
- Social withdrawal or avoidance
- Difficulty emotionally attaching to her baby
- Persistently doubting ability to care for her baby
- Thinking about harming herself or her baby

SCREENING: The American Academy of Pediatrics recommends screening of mothers at 1, 2, 4, and 6 months well child visits. The PHQ-2, PHQ-9 and the Edinburgh Postnatal Depression Scale (EPDS) are free, brief rating scales. Patients who screen positive on the PHQ-2 (score ≥ 3) should be further evaluated with the PHQ-9. The EPDS removes some signs of depression that are difficult to distinguish from the average parenting experience, such as diminished sleep. To bill for screening, use the infant's MRN and CPT code 96161.

TREATMENT:

If screening is positive for mild symptoms (PHQ-9 10-14 or EPDS 9-13),

a) Let the mother know that postpartum depression and anxiety are common, treatable, and not her fault.

b) Support parenting through feeding support, sleep training support, etc.

c) Enlist social and community support.

d) Refer to a support group and/or for maternal or dyadic (mother/baby) therapy.

e) Consider referral for medication.

If screening is positive for moderate symptoms (PHQ-9 15-19 or EPDS 14-18) or severe symptoms (PHQ-9>20 or EPDS >19), in addition to above interventions for mild symptoms,

a) Strongly consider medication intervention.

b) Consider hospitalization when safety is a concern.

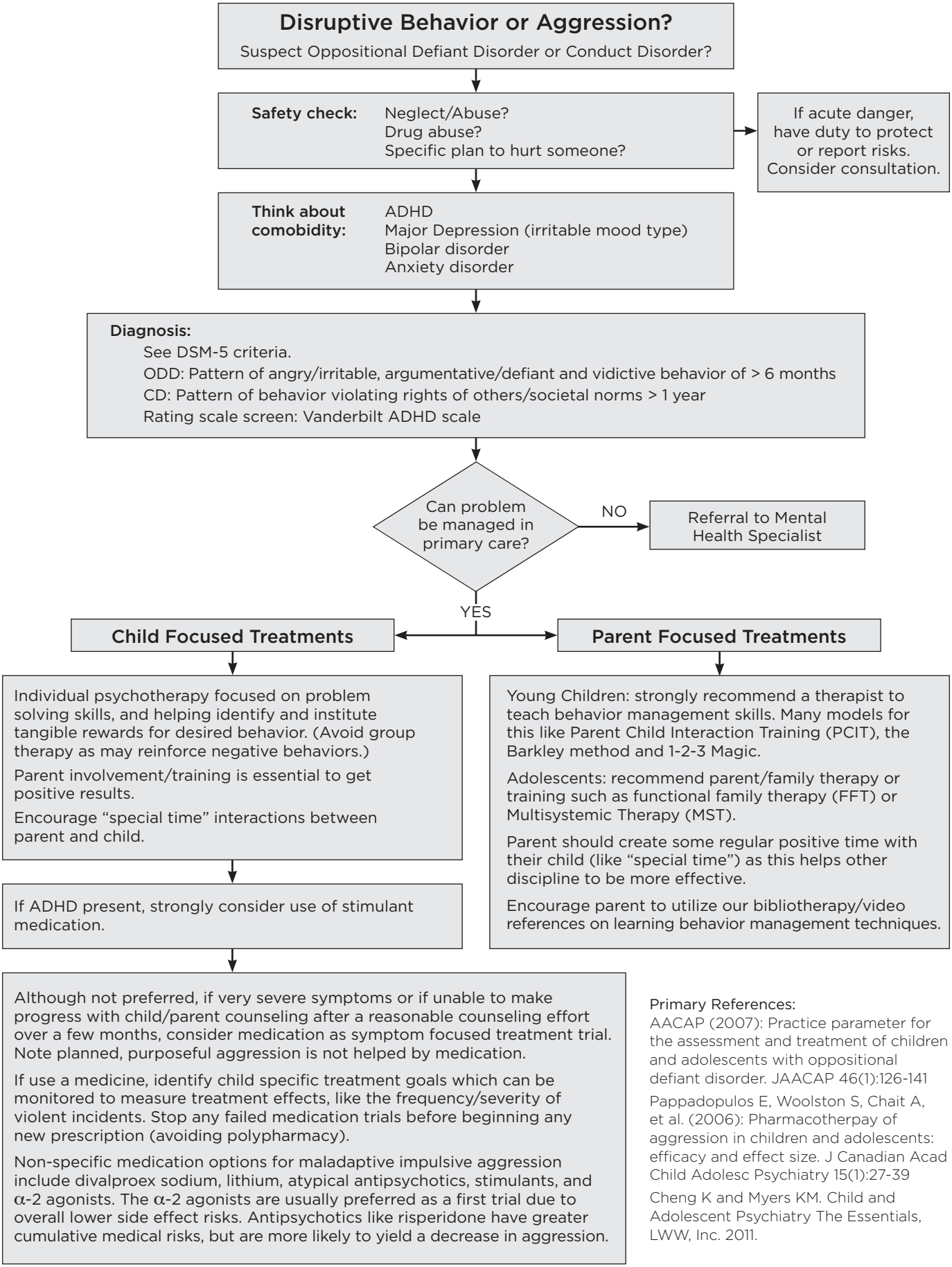
Kisha Clune, MD

Perinatal Psychiatry Consultation Line (PAL for Moms)

- Free phone consultation for healthcare providers
- Monday – Friday 9-5
- Toll Free: 1-877-PAL4MOM (1-877-725-4666)

References:
NIMH, "Postpartum depression facts;" https://www.nimh.nih.gov/health/publications/perinatal-depression/index.shtml
MCPAP for Moms, "Assessment of Depression Severity And Treatment Options;" https://www.mcpapformoms.org/Docs/Assessment%20of%20Depression%20Severity%20and%20Tx%20Options%2009.09.14.pdf,
Maternal depression and child development. Paediatrics & Child Health. 2004;9(8):575-583.

Disruptive Behavior and Aggression



Primary References:
AACAP (2007): Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. JAACAP 46(1):126-141

Pappadopulos E, Woolston S, Chait A, et al. (2006): Pharmacotherpay of aggression in children and adolescents: efficacy and effect size. J Canadian Acad Child Adolesc Psychiatry 15(1):27-39

Cheng K and Myers KM. Child and Adolescent Psychiatry The Essentials, LWW, Inc. 2011.

Non-Specific Medications for Disruptive Behavior and Aggression

- If used, choosing a single medication is strongly recommended over polypharmacy
- Establish a specific target to treat, and measure the response over time (such as anger explosion frequency, duration)
- Aggression is not a diagnosis – continue to look for and treat what may be the cause, such as trauma, autism, OCD, tics, ADHD, conduct, anxiety, depression, bipolar, and sleep disturbances. Usually psychotherapy and behavior management training are the treatments of choice.

Drug Name	Dosage Form	Start Dose	Sedation	Weight Gain	Extra-pyramidal symptoms	(+) RCT evidence in kids?	Editorial Comments
Risperidone (Risperdal)	0.25, 0.5, 1, 2, 3, 4mg 1mg/ml	0.25mg QHS	+	+	+	Yes	Most child research support of the meds in this group
Aripiprazole (Abilify)	2, 5, 10, 15, 25, 30mg 1mg/ml	2mg QD	+	+	+/-	No	Long 1/2 life, takes weeks to build effect.
Quetiapine (Seroquel)	25, 50, 100, 200, 300, 400mg	25mg QHS	++	+	+/-	No	Pills larger, could be hard for kids to swallow.
Ziprasidone (Geodon)	20, 40, 60, 80mg	20mg QHS	+	+	+/-	No	Greater risk of QT lengthen, EKG check
Olanzapine (Zyprexa)	2.5, 5, 7.5, 10, 15, 20mg	2.5 mg QHS	++	++	+/-	No	Greatest risk of weight gain, increased cholesterol

Table + and – from Fedorowicz VJ. Fombonne E. (2005), Lublin, H; et al (2005), and Correll CU et al (2009)
*Pappadopulos E et al., J Cdn. Acad. Child Adol. Psych. (2006)

Monitoring for all atypical antipsychotics: *AIMS exam at baseline and Q6months due to risk of tardive dyskinesia. Warn of dystonia & NMS risks. Weight checks, fasting glucose/lipid panel Q6months at minimum*

Other Medication Options

Drug Name	Description	(+) RCT evidence in kids**	Monitoring	Editorial Comments
Lithium	A salt, is renally excreted	Yes	Baseline EKG, BUN/creat, TSH, CBC. Lithium level after 5 days. Q3month Li. Q6mo TSH,BUN/crt	Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal
Valproate	Anti-seizure	Yes	CBC, LFT at baseline, in 3 month, then Q6month. VPA level checks needed	Sedating, weight gain, rare severe toxicity of liver, ↓platelets
Clonidine, Guanfacine	α-2 agonists	Yes	Pulse, BP	Orthostasis, sedation sign of excess dose, avoid high doses, rebound hypertension if quick stop

**Pappadopulos E et al. (2006) and lit. review

None of the medications on this page are FDA approved for aggression treatment, with the exception of risperidone and aripiprazole which are approved for irritability/aggression treatment in autism.

ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

CODE 0 = NONE 1 = MINIMAL, MAY BE EXTREME NORMAL

MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

2 = MILD 3 = MODERATE 4 = SEVERE

EXAMINATION PROCEDURE

EITHER BEFORE OR AFTER COMPLETING THE EXAMINATION PROCEDURE OBSERVE THE PATIENT UNOBTRUSIVELY AT REST (E.G., IN WAITING ROOM). THE CHAIR TO BE USED IN THIS EXAMINATION SHOULD BE A HARD. FIRM ONE WITHOUT ARMS.

1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.
2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW?
3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE. HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.
4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION)
5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.)
6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE.
7. ASK PATIENT TO PROTRUDE TONGUE. OBSERVE ABNORMALITIES OF TONGUE MOVEMENT. DO THIS TWICE.

*8. ASK PATIENT TO TAP THUMB. WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)

9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.)
10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.)

*11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS. AND MOUTH.)

*12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE.

** ACTIVATED MOVEMENTS

FACIAL AND ORAL MOVEMENTS:	1.	MUSCLES OF FACIAL EXPRESSION E.G., MOVEMENTS OP FOREHEAD, EYEBROWS, PERIORBITAL AREA, CHEEKS; INCLUDE FROWNING, BLINKING, SMILING, GRIMACING	0	1	2	3	4
	2.	LIPS AND PERIORAL AREA E.G., PUCKERING POUTING, SMACKING	0	1	2	3	4
	3.	JAW E.G., BITING CLENCHING, CHEWING, MOUTH OPENING, LATERAL MOVEMENT	0	1	2	3	4
	4.	TONGUE RATE ONLY INCREASE IN MOVEMENT BOTH IN AND OUT OF MOUTH. NOT INABILITY TO SUSTAIN MOVEMENT	0	1	2	3	4
EXTREMITY MOVEMENTS:	5.	UPPER (ARMS, WRISTS HANDS FINGERS INCLUDE CHOREIC MOVEMENTS (I.E., RAPID, OBJECTIVELY PURPOSELESS, IRREGULAR SPONTANEOUS) ATHETOID MOVEMENTS (I.E., SLOW IRREGULAR, COMPLEX SERPENTINE). DO NOT INCLUDE TREMOR (I.E., REPETITIVE, REGULAR, RHYTHMIC)	0	1	2	3	4
	6.	LOWER (LEGS, KNEES, ANKLES, TOES) E.G., LATERAL KNEE MOVEMENT, FOOT TAPPING, HEEL DROPPING, FOOT SQUIRMING, INVERSION AND EVERSION OF FOOT	0	1	2	3	4
TRUNK MOVEMENTS:	7	NECK, SHOULDERS, HIPS E.G., ROCKING. TWISTING, SQUIRMING PELVIC GYRATIONS	0	1	2	3	4
GLOBAL JUDGMENTS:	8	SEVERITY OF ABNORMAL ACTION	0	1	2	3	4
	9	INCAPACITATION DUE TO ABNORMAL MOVEMENTS	0	1	2	3	4
	10.	PATIENT'S AWARENESS OF ABNORMAL MOVEMENTS	0	1	2	3	4
DENTAL STATUS:	11	CURRENT PROBLEMS	0	1	2	3	4
	12	DOES PATIENT USUALLY WEAR DENTURES?	0	1	2	3	4

❑ NOT APPLICABLE: PATIENT HAS NO HISTORY OF TREATMENT WITH NEUROLEPTICS FOR ONE MONTH OR MORE.

❑ EXAMINATION COMPLETED

PHYSICIAN'S SIGNATURE ..... DATE OF EXAMINATION.....

REVISED 03/20/97

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Monitoring for all atypical antipsychotics: AIMS exam at baseline and ~Q6months due to risk of tardive dyskinesia. Warn of dystonia risk. Weight checks, fasting glucose/lipid panel ~Q6months at minimum.

Time Out

"Time out" means taking a specific time away from attention, interesting activities, rewards or other reinforcement. It usually means placing the child in a dull, boring place immediately following an undesired behavior, and having them remain there for a specific amount of time. Time out can also involve a temporary loss of parental attention or interaction in situations where the physical space is limited (like no talking for 5 minutes while riding in a car).

It is often said that the length of time out should be one minute for each year of age, but adjustments need to be made based on developmental level — for instance a developmentally delayed child should have their time out times significantly reduced.

Time outs are simple in concept, but can be hard to implement. Here are some tips for greater success:

- ***Set limits that are consistent*** — if a given child behavior requires a time out one day it should always get that response. Inconsistency leads to more testing of the limits.
- ***Focus on changing only one or two types of misbehavior at a time.*** For instance if hitting a sibling is the main concern, focus your efforts on consistent time outs for that behavior and try to let other things slide for a while until you have results.
- ***When you announce the time out, do not continue to engage verbally with your child.*** This is very important — children that continue to verbally engage with you, bargain, plead, and yell back and forth with you will not receive the benefit from a time out because they are in essence receiving MORE attention from you during a time out rather than less. You can't control what their mouth does, but you can control your own. Remain calm, and refuse to take the bait.
- ***Time outs should occur immediately after misbehavior.*** A time out many minutes later sends a confused message. Delaying a time out by lecturing the child before the time out also hurts the process. The action of being quietly brought to a time out location and having no verbal interaction from you speaks far more loudly than any words can.
- ***If giving a warning before use of time out, make it count.*** For instance saying "do it one more time and you will get a time out" needs to be followed up by actually initiating the time out if they do "it" one more time.
- ***Remember that kids enjoy making a splash.*** Like throwing rocks in the water, triggering a parent to lose their cool can be entertaining or satisfying for a child. Keeping your cool when setting limits avoids inadvertently reinforcing their behavior to occur again.
- ***You determine when the time out is over, not the child.*** Setting a timer can make this seem less arbitrary to the child. Don't be punitive with your child immediately after time out (e.g., lecturing, forcing a child's apology). Simply "resume business as usual" or congratulate them on regaining personal control. *Then actively look for the next positive behavior to praise.*

Robert Hilt, MD

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Special Time

Also known as "Child Directed Play"

A strength based approach to overall child behavior problems.

Goal of this is to establish regular times when parent and child have a positive experience in each other's presence, supporting family self confidence, pleasure and hope. Regular special time together is like money in the bank that lessens times of crisis and re-establishes motivation for positive behaviors. Without regular positive parent/child interactions, corrective discipline is far less effective. For instance, families often find that time-outs work better after initiating special time.

How to do special time:

- Important to be done regularly, every day is optimal, but two or three times a week consistently is OK. Siblings should receive equal opportunity.
- Parent picks time of day.
- Label it "special time."
- Pick a time short enough that it can be done reliably as scheduled, usually 15-30 minutes.
- Do it no matter how good or bad the day was.
- One on one without interruption.
- Child picks the together activity, which needs to be something the parent does not actively dislike doing and which does not involve spending money or completing any task or chore.
  - Examples might include playing together with child's toys, or drawing pictures together.
- End on time: may use a timer to help. Remind child when the next special time will be. You may choose to play with the child more after taking a break from each other.
- If the child refuses at first, tell the child that you will just sit with him/her for that time, and/or that you will continue to invite the child to participate when next special time is scheduled.
- Parents also need to have some special time for him/herself. Parents who feel nurtured themselves find this is easier to do with their child.

Robert Hilt, MD

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Treating Disruptive Behavior and Aggression Using Functional Analysis

Identify the behavior

Character	*(what they do)*
Timing	*(especially noting provoking and reinforcing factors)*
Frequency	*(times per day or per week)*
Duration	*(i.e. 30 minute behaviors are different than 30 second behaviors)*

Analyze and make hypotheses about the function of the behavior

- *Communication.* This is the primary etiology to investigate for young children or if a child lacks communication skills. Maladaptive behavior may communicate physical discomfort like pain, GI distress or illness. It may also communicate *emotional discomfort* like boredom, anxiety, anger, frustration, sadness, or over-excitement.
- *Achieving a goal.* How does performing the behavior benefit the child, what does he/she gain? This might include escaping an undesired situation, avoiding a transition, acquiring attention, or getting access to desired things like toys or food.
- *No function.* If there is no function identifiable for the behavior, this suggests causes like seizures, medication side effects, sleep deprivation, and other medical or psychiatric disorders.

Modify the environment by changing provoking and reinforcing factors.

- Enhance communication — could try naming the thoughts or feelings that you believe the child may be having, like "I see that you want to eat right now."
- Use simple, concrete sentences and questions with child.
- Remain calm since your emotional reaction may reinforce an undesired behavior.
- Increase structure — provide schedule of day's events, use routines, anticipate transitions. Describe an upcoming routine to prepare for new situations. Teach child how to ask for help and how to tell adults when they need a break.
- Modify demands — match the task to their developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

Consult with a behavioral specialist to facilitate process and support family.

- Behavior modification specialists can make tailored suggestions for the family's situation.
- If behavior is at school, consult with the school psychologist for a behavioral intervention.

If strategies are insufficient or behavior is severe, or places child or others at risk of harm, consider augmentation with medications.

- See Care Guide section, "Non-Specific Medications for Disruptive Behavior and Aggression".

A. A. Golombek, MD and Robert Hilt, MD

Bullying: Advice for the Primary Care Clinician

Bullying is aggressive behavior intended to hurt another person, often to gain power. It can be physical, verbal, social, in-person or in cyberspace. Strategies to address this common problem include:

Screening for bullying, especially when there is any acute change in mood, behavior, sleep, or somatic symptoms, or any change in social or academic functioning.

1) With **patients,** screening questions include, "Sometimes I hear about kids getting picked on… Have you been bullied or bullied others? How often? Have you seen bullying? How did you respond? Have you sent or received things electronically that may be bullying?"
2) With **parents,** screening questions include, "Sometimes bullying can really affect kids' health and functioning… Have you seen your child being bullied by other kids? Have you heard about any bullying involving your child? Has your child talked about witnessing bullying at school?"

Educating child and family that bullying is not okay and should be addressed. Create a plan:

With a bullying **victim,** immediate action steps to recommend include:

- Walking away and telling a trusted adult who can be accessed quickly.
- Consider confronting a bully (elevate posture, eye contact, "bullying is not okay").
- Changing the topic. Using humor.
- Accessing peers for support and ideas.

For a bullying bystander, action steps to recommend include:

- Asking adults to help during or even after the event.
- Stepping in to change the situation, label the bullying, using humor, suggesting a compromise.

Working directly with the bully:

1) Inquire about the motivation for bullying. Why is the bully trying to be in control? Talk about both how to lead and how to respond to feeling left out.
2) Bullies may be experiencing trauma in their own lives. Screen for abuse.
3) Discuss what makes a good friend and attempt to build empathy for the victim. Try to engender positive feelings towards making others feel good.
4) Review the potential negative consequences of bullying (friends avoiding, bigger peers may challenge, school policies).

Engage parents, school and other care providers about the bullying:

Parents and school staff should review the use of non-physical and non-shaming behavior management techniques, and set clear expectations for empathic behaviors. Children can be taught by counselors and teachers to use problem solving, emotion regulation, and anger management coping skills and how to make plans for alternative actions. Adults should model treating others with kindness and respect. Adults should monitor their child's social media use. Parents can encourage participation in pro-social activities to build peer networks, enhance social skills, and gain confidence.

Parents and school officials can **learn more** about how to stop bullying at www.stopbullying.gov

Rebecca Barclay, MD and Robert Hilt, MD

Reference: Buxton, Potter, and Bostic. Coping Strategies for Child Bully-Victims. Psychiatric Annals. 2013;3:101-105; stopbullying.gov (4/30/14).

Disruptive Behavior and Aggression Resources

Information for Families

Books parents may find helpful:

Your Defiant Child: Eight Steps to Better Behavior (2013), by Russell Barkley, Phd

The Explosive Child (2001), by Ross Greene, PhD

The Difficult Child (2000), by Stanley Turecki, MD and Leslie Tonner

1-2-3 Magic: Effective Discipline for Children 2-12 (2004), by Thomas Phelan, PhD

Raising an Emotionally Intelligent Child (1998), by John Gottman, PhD

SOS Help for Parents (2006), by Lynn Clark, PhD

Parenting Your Out-of Control Teenager: 7 Steps to Reestablish Authority and Reclaim Love (2001), by Scott P. Sells, PhD

Your Defiant Teen: Ten Steps to Resolve Conflict and Rebuild Your Relationship (2013), by Russell Barkley, Phd

Videos parents may find helpful:

1-2-3 Magic: Managing Difficult Behaviors, by Thomas Phelan, PhD

Managing the Defiant Child, by Russell Barkley, PhD

The Kazdin Method for Parenting the Defiant Child (book with DVD), by Alan Kazdin and Carlo Rotella

Raising an Emotionally Intelligent Child, by John Gottman, PhD

Websites families may find helpful:

American Academy of Child Psychiatry Oppositional Defiant Disorder resource center
www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx

Oppositional Defiant Disorder information from Mayo Clinic
http://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/basics/definition/con-20024559

The Incredible Years training programs
www.incredibleyears.com

Lives in the Balance
www.livesinthebalance.org

Sleep Hygiene for Young Children

- Keep consistent bedtimes and wake times every day of the week. Late nights can cause fatigue that throws off a sleep schedule for days.
- Avoid letting the child spend lots of non-sleep time in bed, which keeps the brain from associating the bed with sleep time.
- Child's bedroom should be cool, quiet and comfortable. There should not be any "screens" (phone, tablets, video console, televisions, computers) in the bedroom.
- Bedtime should follow a predictable sequence of events, such as bath time, brushing teeth and reading a story.
- Avoid high stimulation activities just before bed, such as watching television, playing videogames, or rowdy play or exercise. If there are nighttime awakenings, these same activities should be avoided.
- Physical exercise as a part of the day often helps with sleep time many hours later.
- Relaxation techniques such as performing deep, slow abdominal breaths or imagining positive scenes like being on a beach can help a child relax.
- Avoid caffeine (soda, chocolate) in the afternoons and evenings. Some children's sleep can be impacted by any caffeine at all at any time of day. Even if caffeine does not prevent falling asleep, it can still lead to shallow sleep or frequent awakenings.
- Worry time should not be at bedtime. Children with this problem can try having a "worry time" scheduled earlier when they are encouraged to discuss their worries with a parent and then put them aside.
- Children should be put to bed drowsy, but still awake. Letting a child fall asleep in other places or with a parent present in the room forms habits that are difficult to break.
- A comforting object at bedtime is often helpful for children who need to feel safe and secure when the parent is not present. Try to include a doll, toy or blanket when you cuddle or comfort your child, which may help them adopt the object.
- If you need to check in on your child at night, checks should be brief and boring. The purpose is to reassure the child you are present and that they are okay.
- If your child is never drowsy at the planned bedtime, you can try a temporary delay of bedtime by 15-30 minutes until the child appears sleepy, so that the child experiences falling asleep more quickly once they get into the bed. The bedtime should then be gradually advanced earlier until the desired bed time is reached.
- Keep a sleep diary with naps, sleep and wake times and activities to help you find patterns and problem areas to target. This can be very helpful when discussing sleep challenges with your care team.

Robert Hilt, MD

Primary Reference: A Clinical Guide to Pediatric Sleep, by Jodi Mindell and Judith Owens

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Sleep Hygiene for Teens

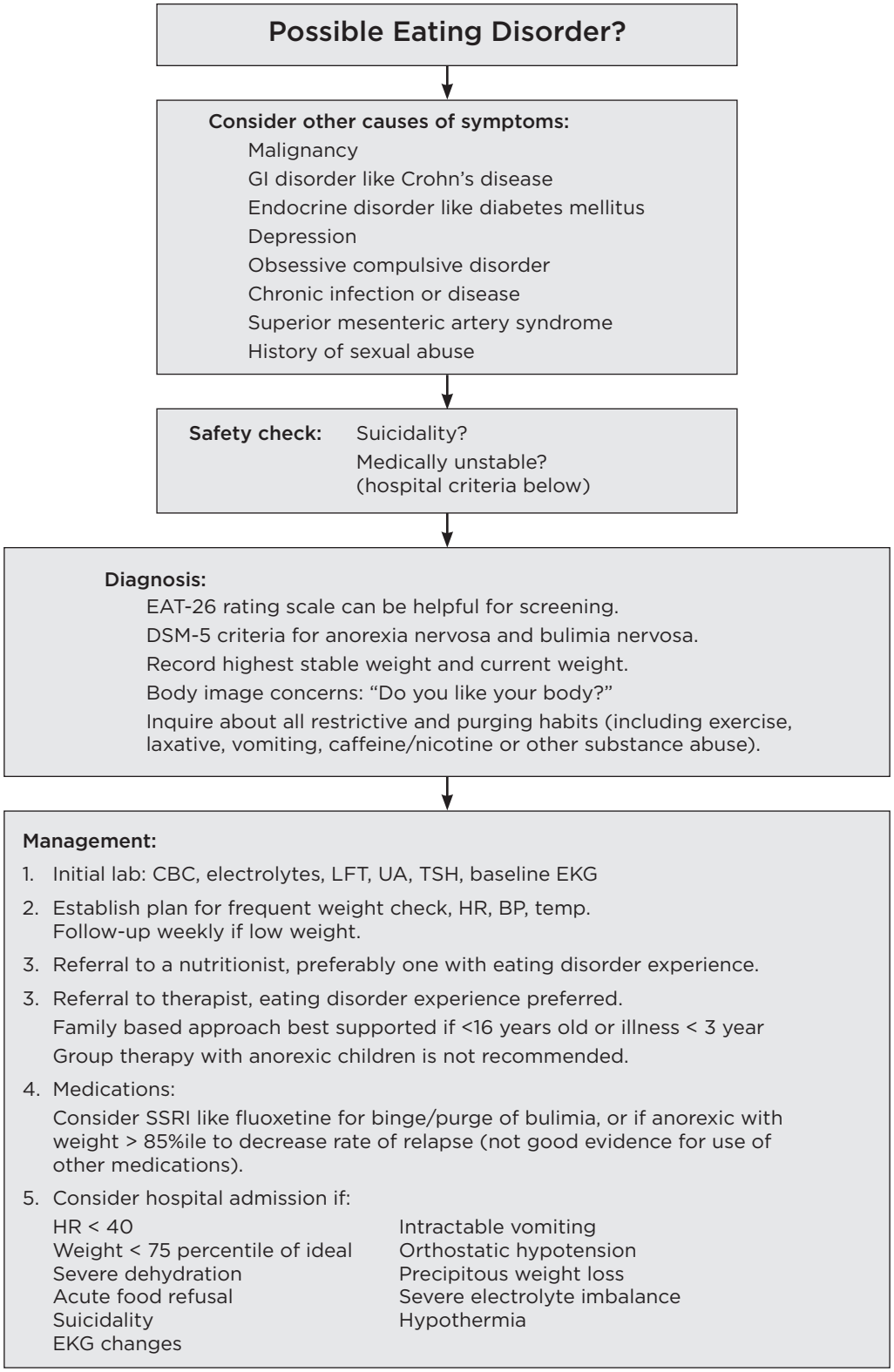
- Keep consistent bedtimes and wake times every day of the week. Late nights or sleeping-in on weekends can throw off a sleep schedule for days.
- The bedroom should be cool, quiet and comfortable. Teens who stare at the clock should have the clock turned away.
  - Restrict use of any "screens" (phone, tablet, video console, television, computer, etc) while in the bedroom. These can all function as sleep prevention devices.
- Bedtime should follow a predictable and non-stressful sequence of events, such as picking out tomorrow's outfit, brushing teeth, and then reading relaxing non-screen material or listening to music.
- Avoid high stimulation activities in the hour before bed, such as watching television, playing videogames, texting with friends, or exercise. Avoid the same during any nighttime awakenings.
- Avoid going to bed hungry or overly full.
- Physical exercise as a part of the day often helps with sleep time many hours later. Getting outside every day, particularly in the morning, may also be helpful.
- Relaxation techniques such as performing deep, slow abdominal breaths or imagining positive scenes like being on a beach can help encourage relaxation.
- Avoid caffeine (soda, chocolate, tea, coffee, energy drinks) in the afternoons/evenings. Some teen's sleep can be impacted by any caffeine at all at any time of day. Even if caffeine doesn't prevent falling asleep it can still lead to shallow sleep or frequent awakenings. Alcohol, tobacco, or sleep aids also can interfere with the natural sleep cycle.
- If the teen awakens in bed tossing and turning, it is better for him or her to get out of bed to do a low stimulation activity, (i.e. non-screen reading) before returning to bed when feeling tired. If sleep still will not come, the teen should spend more time relaxing out of bed before lying down again. This keeps the bed from becoming associated with sleeplessness.
- Worry time should not be at bedtime. A teen may find it helpful to have a "worry time" scheduled when he or she is encouraged to journal about worries or discuss them with a parent or other support, and then put them aside.
- Teens should go to bed drowsy, but still awake. Falling asleep on the couch or in non-bed locations may form sleep associations or habits that are difficult to break.
- If the teen is never drowsy at the planned bedtime, temporarily delay bedtime by 15-30 minutes until the teen is sleepy, so that the teen experiences falling asleep more quickly once in bed. The bedtime should then be gradually advanced earlier until the desired bed time is reached.
- Keep a sleep diary with naps, sleep and wake times and activities to help find patterns and problem areas to target. This can be very helpful when discussing sleep challenges with the care team. There are also apps available that can help with tracking sleep habits.

Robert Hilt, MD

Primary Reference: A Clinical Guide to Pediatric Sleep, by Jodi Mindell and Judith Owens

This resource page is now available in Spanish at www.seattlechildrens.org/pal

Eating Disorder



Primary References:
Jellinek M, Patel BP, Froehle MC eds. (2002): Bright Futures in Practice: Mental Health-Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health: 203-211

AAP Committee on Adolescence (2003): "Policy statement: identifying and treating eating disoders." Pediatrics 111(1):204-211

Eating Attitudes Test© (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no right or wrong answers. All of your responses are confidential.

Part A: Complete the following questions:

1) Birth Date Month: ..... Day: ..... Year: ..... 2) Gender: ❑ Male ❑ Female

3) Height Feet: ..... Inches: .....

4) Current Weight (lbs.): ..... 5) Highest Weight (excluding pregnancy): .....

6) Lowest Adult Weight: ..... 7) Ideal Weight: .....

	Part B: Please check a response for each of the following statements:	Always	Usually	Often	Sometimes	Rarely	Never
1.	Am terrified about being overweight.	❑	❑	❑	❑	❑	❑
2.	Avoid eating when I am hungry.	❑	❑	❑	❑	❑	❑
3.	Find myself preoccupied with food.	❑	❑	❑	❑	❑	❑
4.	Have gone on eating binges where I feel that I may not be able to stop.	❑	❑	❑	❑	❑	❑
5.	Cut my food into small pieces.	❑	❑	❑	❑	❑	❑
6.	Aware of the calorie content of foods that I eat.	❑	❑	❑	❑	❑	❑
7.	Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	❑	❑	❑	❑	❑	❑
8.	Feel that others would prefer if I ate more.	❑	❑	❑	❑	❑	❑
9.	Vomit after I have eaten.	❑	❑	❑	❑	❑	❑
10.	Feel extremely guilty after eating.	❑	❑	❑	❑	❑	❑
11.	Am preoccupied with a desire to be thinner.	❑	❑	❑	❑	❑	❑
12.	Think about burning up calories when I exercise.	❑	❑	❑	❑	❑	❑
13.	Other people think that I am too thin.	❑	❑	❑	❑	❑	❑
14.	Am preoccupied with the thought of having fat on my body.	❑	❑	❑	❑	❑	❑
15.	Take longer than others to eat my meals.	❑	❑	❑	❑	❑	❑
16.	Avoid foods with sugar in them.	❑	❑	❑	❑	❑	❑
17.	Eat diet foods.	❑	❑	❑	❑	❑	❑
18.	Feel that food controls my life.	❑	❑	❑	❑	❑	❑
19.	Display self-control around food.	❑	❑	❑	❑	❑	❑
20.	Feel that others pressure me to eat.	❑	❑	❑	❑	❑	❑
21.	Give too much time and thought to food.	❑	❑	❑	❑	❑	❑
22.	Feel uncomfortable after eating sweets.	❑	❑	❑	❑	❑	❑
23.	Engage in dieting behavior.	❑	❑	❑	❑	❑	❑
24.	Like my stomach to be empty.	❑	❑	❑	❑	❑	❑
25.	Have the impulse to vomit after meals.	❑	❑	❑	❑	❑	❑
26.	Enjoy trying new rich foods.	❑	❑	❑	❑	❑	❑

	Part C: Behavioral Questions. In the past 6 months have you:	Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A.	Gone on eating binges where you feel that you may not be able to stop?	❑	❑	❑	❑	❑	❑
B.	Ever made yourself sick (vomited) to control your weight or shape?	❑	❑	❑	❑	❑	❑
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	❑	❑	❑	❑	❑	❑
D.	Exercised more than 60 minutes a day to lose or to control your weight?	❑	❑	❑	❑	❑	❑
E.	Lost 20 pounds or more in the past 6 months		❑ Yes			❑ No	

• Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control.

EAT-26: Garner et al. 1982, Psychological Medicine, 12, (871 878); adapted/reproduced by D. Garner with permission.

Scoring the Eating Attitudes Test© (EAT-26)

The Eating Attitudes Test (EAT-26) has been found to be highly reliable and valid (Garner, Olmsted, Bohr, & Garfinkel, 1982; Lee et al., 2002; Mintz & O'Halloran, 2000). However the EAT-26 alone does not yield a specific diagnosis of an eating disorder.

Scores greater than 20 indicate a need for further investigation by a qualified professional.

Low scores (below 20) can still be consistent with serious eating problems, as denial of symptoms can be a problem with eating disorders.

Results should be interpreted along with weight history, current BMI (body mass index), and percentage of Ideal Body Weight. Positive responses to the eating disorder behavior questions (questions A through E) may indicate a need for referral in their own right.

EAT-26 Score

Score the 26 items of the EAT-26 according to the following scoring system. Add the scores for all items.

Scoring for Questions 1-25:		
Always	=	3
Usually	=	2
Often	=	1
Sometimes	=	0
Rarely	=	0
Never	=	0

Scoring for Question 26:		
Always	=	0
Usually	=	0
Often	=	0
Sometimes	=	1
Rarely	=	2
Never	=	3

Eating Disorder Resources

Information for Families

Books families may find helpful:

Helping Your Child Overcome an Eating Disorder: What You Can Do at Home (2003), by Teachman, Schwartz, Gordic and Coyle

Help Your Teenager Beat an Eating Disorder (2004), by James Lock and Daniel le Grange

Effective Meal Support: A Guide for Family and Friends, by British Colombia Children's Hospital and Seattle Children's Hospital

Off the C.U.F.F. (Calm, Unwavering, Firm and Funny) by Duke Eating Disorders Program, order info at www.dukehealth.org/treatments/psychiatry/eating-disorders

Life Without Ed: How One Woman Declared Independence from Her Eating Disorder and How You Can Too (2003), by Jenni Schaefer and Thom Rutledge

Books youth may find helpful:

Eating Disorders (2003), by Trudi Strain Trueit

No Body's Perfect (2002), by Kimberley Kirberger

Websites families may find helpful:

National Eating Disorders Association, provides information and referrals
www.nationaleatingdisorders.org

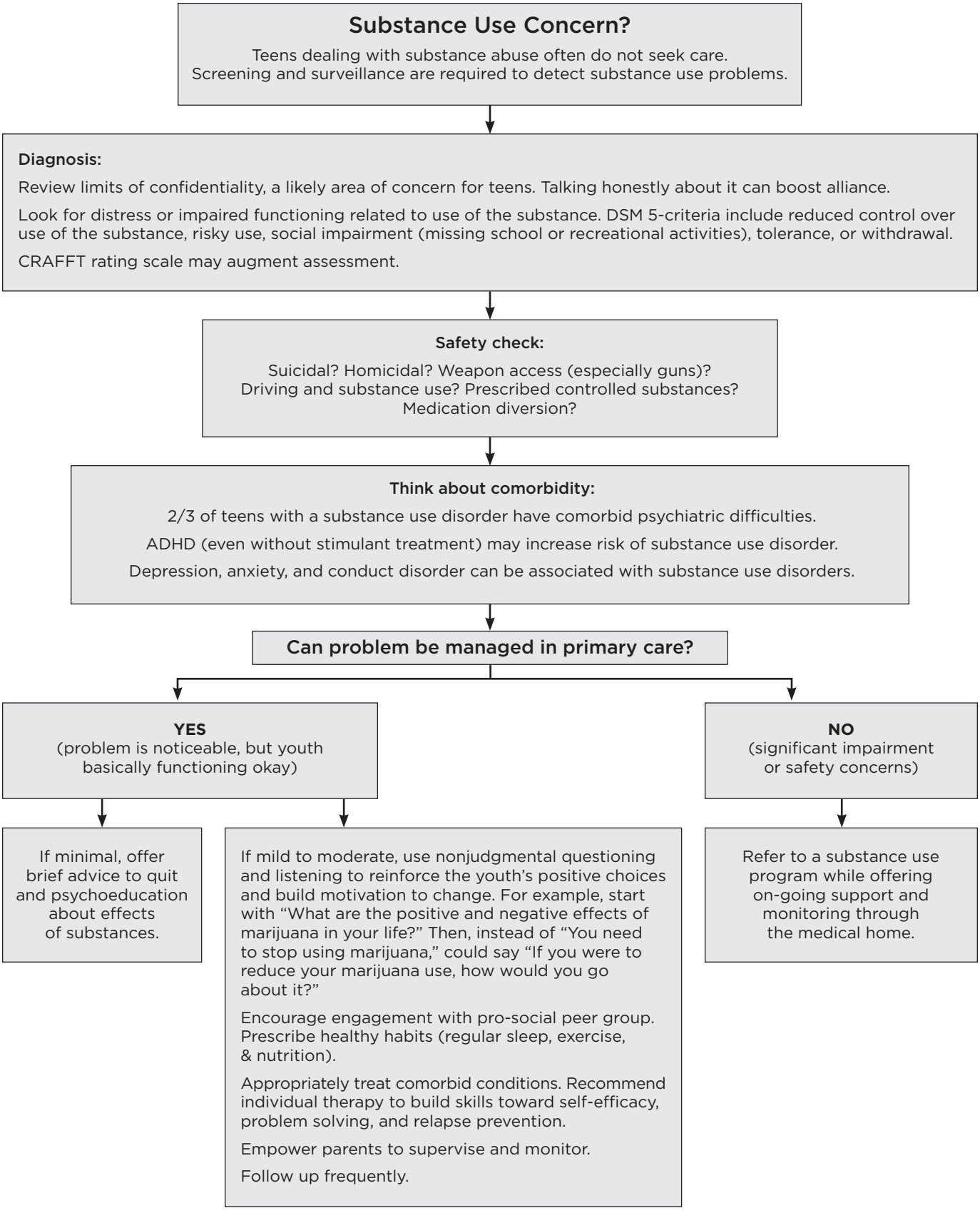
Parent guide to an evidence based, outpatient treatment for anorexia
www.maudsleyparents.org

Academy for Eating Disorders, professional organization
https://www.aedweb.org/home

Recovery support site
http://something-fishy.org

Seattle Children's, Eating Disorder Booklist and Resources
www.seattlechildrens.org/pdf/PE456.pdf

Substance Use



Reference:
Barclay and Hilt. "Integrated Care for Pediatric Substance Abuse."
Child and Adolescent Psychiatric Clinics of North America 2016 October: 769-777.

The CRAFFT Interview (version 2.1)

To be orally administered by the clinician

Begin: ***"I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."***

Part A

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol?** Put "0" if none.	☐ # of days
2.	Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	☐ # of days

Did the patient answer "0" for all questions in Part A?

YES ❑ ↓ **Ask CAR question only, then stop**

NO ❑ ↓ **Ask all six CRAFFT* questions below**

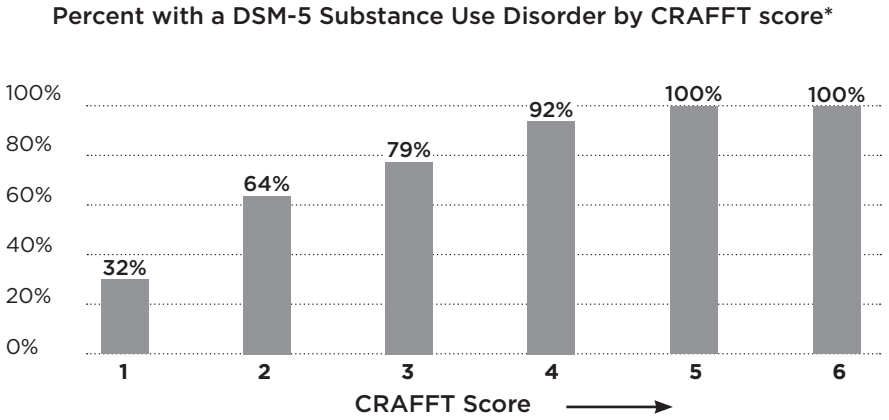
Part B

		NO	YES
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using drugs?	❑	❑
R	Do you ever use alcohol or drugs to **RELAX,** feel better about yourself, or fit in?	❑	❑
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE?**	❑	❑
F	Do you ever **FORGET** things you did while using alcohol or drugs?	❑	❑
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	❑	❑
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	❑	❑

***Two or more YES answers suggest a serious problem and need for further assessment.**

See back for further instructions →

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

2. Use these talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can:

   1) Harm your developing brain;

   2) Interfere with learning and memory, and

   3) Put you in embarrassing or dangerous situations."

3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/ guardians to create a plan for safe rides home."

4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"*
   Users: *"What would be some of the benefits of not using?"*

5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

(617) 355-5433

For more information and versions in other languages, see www.crafft.org.

Substance Abuse Resources

Information for Families

Websites families may find helpful:

A Parent's Guide to Preventing Underage Marijuana Use
www.seattlechildrens.org/pdf/parents-guide-preventing-underage-marijuana-use.pdf

Partnership for Drug-Free Kids
https://drugfree.org

Parent-Teen Driving Agreement
www.healthychildren.org/English/ages-stages/teen/safety/pages/Teen-Driving-Agreement.aspx

Drugs: What You Should Know
https://kidshealth.org/en/teens/know-about-drugs.html

Washington Recovery Helpline (866-789-1511)
www.warecoveryhelpline.org

Start Talking Now
www.starttalkingnow.org

National Institute on Drug Abuse for Parents
https://teens.drugabuse.gov/parents

Websites youth may find helpful:

National Institute on Drug Abuse in Teens
https://teens.drugabuse.gov

Books families may find helpful:

Beyond Addiction: How Science and Kindness Help People Change (2014) by Jeffrey Foote, PhD, Carrie Wilkens, PhD, and Nicole Kosanke, PhD, with Stephanie Higgs

Clean: Overcoming Addiction and Ending America's Greatest Tragedy (2014) and
Beautiful Boy: A Father's Journey Through His Son's Addiction (2009), both by David Sheff

Notes:

Notes:

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