Appendix A

Primary Care Principles for Child Mental Health

Primary Care Principles for Child Mental Health

Version 2.0
February, 2010

By Robert Hilt, MD
Program Director, Partnership Access Line
Seattle Children's Hospital

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.

1-866-599-PALS (7257)
www.PALforkids.org

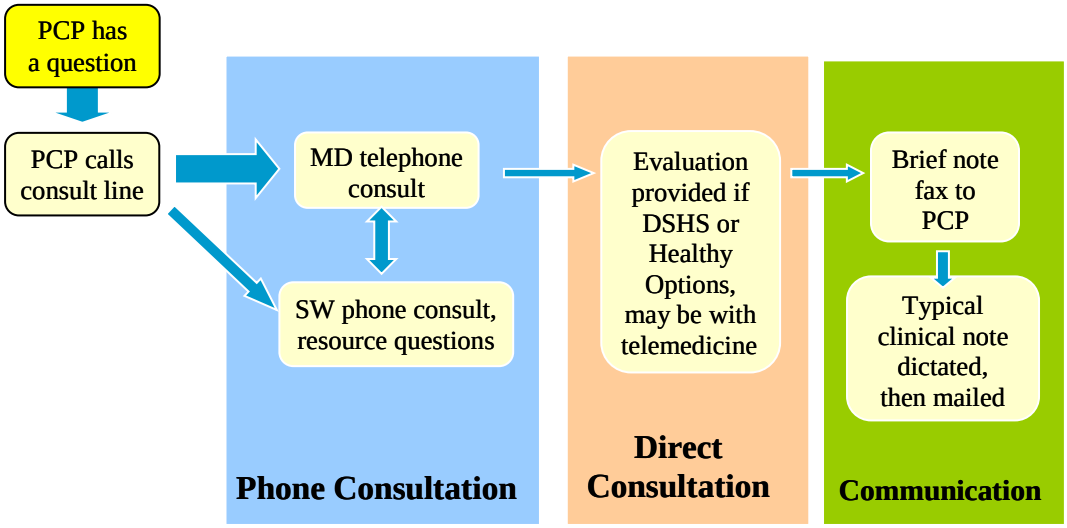
Partnership Access Line
Mental Health Consultation Outreach *for children*

- **PAL is a free consultation program for primary care providers (PCPs). It is funded by the Washington State Legislature and by the Department of Social and Health Services (DSHS)**

- **PCPs may call the PAL toll free number (866-599-7257) during business hours (M-F, 9-5) for *any* type of child mental health advice for *any* child they see**
  - **A program assistant will ask for the provider's name, contact information and basic patient information**
  - **A child psychiatrist then will speak to the provider either immediately, or will schedule a convenient call back time (almost always on the same day)**

- **If the child psychiatrist and PCP determine over the phone that further consultation is needed on a DSHS or Healthy Options client, a rapid consult appointment will be offered with one of our child psychiatrists**

- **Primary care providers may be reimbursed for phone consultations with the PAL psychiatrist regarding DSHS clients (call us for details)**



A study at the University of Washington is being conducted to investigate the effectiveness of the PAL program. You may be contacted by the research team. Your participation in the research is voluntary. You do **NOT** need to participate in the research to participate in the PAL clinical program.

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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 Dr. 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.

General peer review has included:
Child and Adolescent Outpatient Psychiatry Clinic, Seattle Children's Hospital
U. of Washington Division of Public Health and Justice Policy
Eric Trupin, PhD, Professor of Psychiatry & Behavioral Sciences, U. of Washington
Bryan King, MD, Professor of Psychiatry & Behavioral Sciences, U. of Washington
Matt Speltz, PhD, Professor of Psychiatry & Behavioral Sciences, U. of Washington
John Dunne, MD, Child and Adolescent Psychiatrist

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. Sceinces, 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
Eating Disorder:
Rose Calderon, PhD, Associate Professor of Psych. & Beh. Sciences, U. of Washington
Cora Breuner, MD, Associate Professor of Pediatrics, U. of Washington
Oppositional/Conduct:
Terry Lee, MD, Acting Assistant Professor, U of Washington

Endorsed by Washington State Agencies including:
Department of Social and Health Services
Children's Administration
DSHS Regional Area Medical Directors
Washington State Chapter of the American Academy of Child and Adolescent Psychiatry

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 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 between December 2007 and March 2008 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 in particular the bibliography of a recent textbook, *Pediatric Psychopharmacology Fast Facts* by DF Connor and BM Meltzer (2006).

For this current version 2.0 update, additional Medline topic searches for papers published between March 2008 and November 2009 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.

Psychosocial treatment guidance was formulated in consultation with the named section reviewers, and with members of the steering committee. Expert consultations and review of online CAMHD Hawaii Department of Health information (included herein) and review of a WA DSHS report from the Children's Evidence Based Practices Expert Panel, dated December 15, 2006 yielded evidence based psychosocial treatment recommendations.

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, state-of-the-art 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

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 7 common childhood disorders.
- Free- to- reproduce rating scales for assistance with diagnosis and follow up
- Organized, current evidence based medication information
- Community resource guide for DSHS clients for social, behavioral and family support
- Free- to- reproduce patient handouts
- Reference information that will be consistent with advice given out by PAL program psychiatrists

Washington State
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Public Mental Health Overview

DSHS/Medicaid contracts for mental health services via three avenues:

- Contracts with the Regional Support networks (RSNs)
- Contracts with Healthy Options Managed Care Organizations (MCO)
- Individual Core 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 Healthy Options MCO or eligible for care through the Regional Support Networks.

Regional Support Networks

The RSNs subcontract with local community mental health clinics which provide the services. Assessments are available to all Medicaid covered individuals who request them, and emergency services are available 24/7. However, ongoing care is determined on the basis of severity, using the "Access to Care Standards."

Summary of the DSHS/RSN Access to Care Standards

An individual must meet all of the following before being considered for a level of care assignment with a RSN:

- The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the list of Covered Childhood Disorders. That list, maintained on the DSHS website listed below, contains most major Axis I and Axis II disorders. The covered diagnosis list does not include Autism, Aspergers Disorder and PDD.
- Some mental health diagnoses require some additional criteria documenting that there is a high level of impairment in order to qualify for services.
- The individual's impairment(s) and corresponding need(s) must be the result of a mental illness.
- The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- The individual is expected to benefit from the intervention.
- The individual's unmet need would not be more appropriately met by any other formal or informal system or support.
- Children under the age of six may not readily fit diagnostic criteria. For them eligibility is determined on the basis of functional impairment related to the symptoms of an emotional disorder.

Functional Criteria: Children's Global Assessment Scale (CGAS)

There must be demonstrated functional impairment including a C-GAS score of less than 60, and requiring assistance to meet the need in at least one life domain for Brief Services (up to 6 months, or low intensity for 12 months). For Community Support services (up to 12 months) there must be a C-GAS score of less than 50 and requiring assistance to meet the need in at least one life domain.

CGAS is generally not considered valid for children under the age of six, therefore these children are exempt from such Axis V scoring. A "DC:0-3" rating score may be substituted for that evaluation. Functional impairment for very young children is further described in the published Access to Care Standards.)

Life domains for the Access to Care Standards include:

- Health & Self-Care, including the ability to access medical, dental and mental health care to include access to psychiatric medications
- Cultural Factors
- Home & Family Life Safety & Stability
- Work, school, daycare, pre-school or other daily activities
- Ability to use community resources to fulfill needs

To read more detailed information about the Access to Care Standards, visit DSHS on-line at: http://www1.dshs.wa.gov/Mentalhealth/publications.shtml

Requesting Services from the RSN System

If your patient presents as having serious emotional disturbance, such that more intensive mental health services are warranted for more than the 20 hours per year provided through Healthy Options or Fee-For-Service, you should refer the child to the local RSN for assessment.

Crisis mental health services are provided upon request, 24-hours a day, 7 days a week and are available to anyone who needs them regardless of ability to pay. All RSNs publish a toll free crisis number in local phone books.

To refer someone for crisis intervention services, you or the family should call the appropriate crisis line listed below.

RSNs ensure an intake evaluation is made available within 10 business days of the request for routine mental health services, unless an intake evaluation has been provided in the last 12 months, that establishes Medical necessity based upon the Access to Care Standards. This is true no matter how the request for services is made. To view a map of the RSN's, go to http://www.dshs.wa.gov/mentalhealth/rsnmap.shtml

Requests for RSN services may be made to an RSN or to an RSN contracted provider via:

- A telephone call
- An in person request for services by family
- A written request for services by family
- Through a written EPSDT referral (Early and Periodic Screening, Diagnosis and Treatment)

Unless the individual requests a later appointment date or the scheduled clinician is unexpectedly unavailable, the individual will be seen by their assigned provider within 28 days of their intake assessment.

RSN Name	Counties Serviced	Address & Phone Number	Ombudsman Services	Crisis Lines
Clark County www.clark.wa.gov/mental-health	Clark	PO Box 5000 Vancouver, WA 98666-5000 360-397-2130 or 800-410-1910	866-666-5070	800-626-8137
Grays Harbor www.ghphss.org/page.aspx?id=99590	Grays Harbor	2109 Sumner Ave Suite 203Aberdeen, WA 98520-3699 360-532-8665x285 or 800-464-7277	888-816-6546	800-685-6556

RSN Name	Counties Serviced	Address & Phone Number	Ombudsman Services	Crisis Lines
Greater Columbia Behavioral Health www.gcbh.org	Asotin Benton Columbia Franklin Garfield Kittitas Klickitat Skamania Walla Walla Whitman Yakima	101 N Edison Street Kennewick, WA 99336-1958 509-735-8681 or 800-795-9296	800-257-0660	Asotin: 888-475-5665 Benton 800-548-8761 Columbia: 800-734-9927 Franklin: 800-548-8761 Garfield: 888-475-5665 Kittitas: 509-925-9861 Klickitat: 509-733-5801/ 800-572-8122 Skamania: 509-427-9488 Walla Walla: 509-522-4278 Whitman: 866-871-6385 Yakima: 509-575-4200/ 800-572-8122 Yakima Children: 509-576-0934, or 800-671-5437
King County http://www.kingcounty.gov/healthServices/MHSA.aspx	King	821 Second Avenue, Suite 610 Seattle, WA 98104 206-296-5213 or 800-790-8049	800-790-8049	866-427-4747 TDD: 206-461-3219
North Central Washington	Adams Ferry Grant Lincoln Okanogan Pend Oreille Stevens	119 Basin Street SW Ephrata, WA 98823-1855 509-754-6577 or 800-251-5350	800-346-4529	Adams (collect):509-488-5611 Ferry 866-268-5105 Grant: 877-467-4303 Lincoln: 888-380-6823 Okanogan: 866-826-6191 Pend Oreille: 866-847-8540 Stevens: : 888-380-6823
North Sound Mental Health www.nsmha.org	Island San Juan Skagit Snohomish Whatcom	117 N. 1st Street Suite 8 Mount Vernon, WA 98273-2858 800-684-3555 or 888-693-7200	888-336-6164	800-584-3578
Peninsula	Clallam Jefferson Kitsap	614 Division Street, MS 23 Port Orchard, WA 98366-4676 360-337-4886 or 800-525-5637	888-377-8174	East Jefferson County: 360-385-0321 or 800-659-0321, East Clallam County: 360-452-4500 Kitsap County: 800-843-4793 or 360-479-3033 West Jefferson and West Clallam County: 360-374-5011 (Non Business Hours: 360-374-6271)
Pierce County http://www.co.pierce.wa.us/pc/services/health/mental/services.htm	Pierce	3580 Pacific Ave Tacoma, WA 98418-7915 253-798-4500 or 800-531-0508	800-531-0508	800-576-7764
Southwest http://www.co.cowlitz.wa.us/humanservices/mental_health_services.html	Cowlitz	1952 9th Ave Longview, WA 98632-4045 800-803-8833 or 800-347-6092	360-414-0237	800-803-8833
Spokane www.spokanecounty.org/mentalhealth	Spokane	312 West 8th Avenue 4th Floor; Spokane, WA 99204-2506 509-477-5722 or 800-273-5864	866-814-3904	877-678-4428

RSN Name	Counties Serviced	Address & Phone Number	Ombudsman Services	Crisis Lines
Thurston-Mason http://www.co.thurston.wa.us/health/ssrsn/index.html	Thurston Mason	412 Lilly Road NE Olympia, WA 98506-5132 360-786-5830 or 800-658-4105 TDD 360-786-5602 or 800-658-6384	800-658-4105	800-754-1338
Timberlands	Lewis Pacific Wahkiakum	PO Box 217 Cathlamet, WA 98612-0217 360-795-3118 or 800-392-6298	888-662-8776	Lewis: 800-559-6696 Pacific: 800-884-2298, Wahkiakum: 800-635-5989

Future updates to these RSN listings:
Crisis line number updates can be found at http://www.dshs.wa.gov/Mentalhealth/crisis.shtml

RSN contact information updates can be found at
http://www1.dshs.wa.gov/mentalhealth/rsndirectory.shtml

Healthy Options

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

Plan	Phone Number	Medicaid Provider ID Number
Asuris Northwest Health Plan P.O. Box 91130 Seattle, WA 98111-9230	1-866-240-9560	7502685
Columbia United Providers 19120 SE 34th Street, Suite 201 Vancouver, WA 98683	1-800-315-7862	7500416
Community Health Plan 720 Olive Way, Suite 300 Seattle, WA 98101	1-800-440-1561	7502453
Group Health Cooperative 320 Westlake Ave. N., Suite 100 Seattle, WA 98109-5233	1-888-901-4636	7502602
Molina Healthcare of Washington, Inc. Post Office Box 4004 Bothell, WA 98041-4004 21540 – 30th Dr. SE, Suite 400 Bothell, WA 98021	1-800-869-7165	7520158
Regence BlueShield 1501 Market Street, MS: MK510 Tacoma, WA 98402	1-800-669-8791	7502677

For an updated list of currently contracted Healthy Options providers,
http://hrsa.dshs.wa.gov/healthyoptions/newho/client/planlinks.htm

Not all Healthy Options plans serve all counties. To obtain more information about Healthy Options and all other managed care programs, visit DSHS on line at:
http://hrsa.dshs.wa.gov/HealthyOptions/

Fee-For-Service

If your patient is *not* enrolled with a Healthy Options plan and is not likely to meet medical necessity (per the Access to Care Standards), you may contact DSHS by calling **1-800-562-3022 (TTY: 1-800-848-5429)** to find a mental health provider who will accept payment from DSHS to provide mental health services to your patient on a "fee-for-service" basis.

Washington State
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Mental Health Benefit Expansion!

Dear Provider:

Knowing where to refer individuals with mental health needs can be challenging. DSHS is working to support you in your efforts to find the right services for your patients. In fact, recent legislation has allowed DSHS to expand the number of sessions available and the number of providers eligible to accept mental health referrals for children age 18 and younger who receive medical benefits from DSHS (and are Medicaid eligible). The intention of this expansion is to increase access to mental health services for children and youth who do not meet the RSN Access to Care Standards.

As of July 1, 2008:

- ✓ The number of outpatient mental health treatment hours, including evaluation, that may be paid in a calendar year for individuals under age 19 is being increased from 12 to 20, and

- ✓ The type of provider who may bill for these services, previously limited to psychiatrists, is being expanded to include the following:
    - Licensed Psychologists
    - Licensed Psychiatric Advanced Registered Nurse Practitioners
    - Licensed Independent Clinical Social Workers
    - Licensed Advanced Social Workers
    - Licensed Marriage and Family Therapists
    - Licensed Mental Health Counselors

These expanded resources are available to individuals with Medicaid who are enrolled in a DSHS contracted Managed Care Program under the Health Options program or who see a individual provider who accepts payment from DSHS on a fee-for-service basis.

To learn more about these services and how you may bill for them for dates of service on and after July 1, 2008, visit DSHS on or after May 19, 2008 at:

http://hrsa.dshs.wa.gov/download/BI.html

Where do I call if I have questions?

You may call any of the numbers listed on the tool kit, or you may call provider relations at 1-800-562-3022. Providers wishing to enroll as a DSHS reimbursable provider as above should call the Provider Relations number or access http://hrsa.dshs.wa.gov/providerenroll/

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Additional Tools from DSHS

12 Month Service History Reports

In order to provide a comprehensive medical history for you regarding your patients, DSHS has developed a rolling 12-month client medical profile. It includes prescriptions, emergency room usage and other services. To obtain a profile:

- Fax patient's signed release form to 360-725-1328 Attn: Carolyn Geimer. You may use your own release or the DSHS release.
- Include on the request: Your return fax and phone numbers, including area code, and the client's name and DSHS identification number.

Requests are processed Monday through Friday, 8am to 5pm and will be sent to you within 24-48 hours. The client will also be sent a notification to their last known address.

To obtain a 12 month history of Rx, ER and other services, visit DSHS on line at:
http://hrsa.dshs.wa.gov/pharmacy/ToolKit.htm

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 DSHS at: (360) 725-1780 (Calls are returned within 24 hours) or visit DSHS on line at:
http://hrsa.dshs.wa.gov/PRR/

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 may be changing in the near future, but historically 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

HRSA's Division of Alcohol and Substance Abuse (DASA) oversees the provision of substance abuse treatment for adolescents in Washington State.

To learn more about DASA, visit: http://www.dshs.wa.gov/dasa/default.shtml

Drug and Alcohol Treatment for Adolescents

Adolescents who need alcohol/drug treatment should be referred to the Teen Line 1-877-345-TEEN to arrange for an assessment, to locate a treatment agency, and to verify that they are eligible for state-funded services.

- **Adolescent Chemical Dependency Treatment 24-Hour Referral: 1-877-345-TEEN**
- For help screening patients in need of alcohol/drug treatment, providers can access a Screening and Referral Pocket Card found at http://www.dshs.wa.gov/pdf/hrsa/dasa/PocketScreeningGuide.pdf
- Information on youth treatment services: Referral & Resource Guide for Adolescent Chemical Dependency Treatment found at http://www.dshs.wa.gov/pdf/hrsa/dasa/youthreferralguide.pdf
- Regional treatment managers are available Monday-Friday from 8-5 for assistance placing youth or updates on services. The web address for reaching them is: http://hrsa.dshs.wa.gov/pharmacy/DASA%20Region%20Treatment%20Administrators%20listed%20by%20County.doc
- For additional information about chemical dependency and support services for pregnant women go to: http://www.dshs.wa.gov/pdf/hrsa/dasa/PregnantWomenGuide.pdf
- Recently updated DASA youth residential treatment bed availability can be found at http://www.theteenline.org/dasa_youth_residential_treatment.htm

Youth Residential Treatment Providers

- **Full descriptions of each facility below can be found via web links at** http://www.theteenline.org/dasa_youth_residential_treatment.htm

Inpatient Facilities

Fresh Start
Healing Lodge of the Seven Nations
Sundown M Ranch
Daybreak
Excelsior Youth Center
Lakeside Milam
Providence St. Peter
Ryther Child Center
SeaMar Visions
SeaMar Renacer

Recovery House

Skagit Recovery (John King)

Youth Detox/Stabilization Facilities

Lakeside Milam Recovery Center- Kirkland
Recovery Centers of King County- Seattle
Tacoma Detoxification Center- Tacoma
Skagit Recovery Center- Mount Vernon
Community Detox Services- Spokane
Providence St. Peter- Lacey
Dependency Health Services- Yakima

Reduce Underage Drinking

Find resources parents can use to prevent underage drinking at Start Talking Now, the Washington State Coalition to Reduce Underage Drinking (RUaD Coalition) website. That web address is: http://www.starttalkingnow.org/stateefforts/index.shtml

Fact Sheet: ADHD Drug Utilization Review Program:

http://maa.dshs.wa.gov/Pharmacy/

Washington State Department of Social & Health Services

What: HRSA is interested in the safe and effective use of ADHD medications in children. Specific areas include use of medication in children between the ages of 0-4 and appropriate dosing limits in the prescribing of these medications. This program is being implemented to assure prescriptions covered by HRSA are within the guidelines established in collaboration with the members of the Mental Health Stakeholder Workgroup.

When:

- Patient is < 5 years of age: *Requires prior authorization & HRSA approved second opinion*
- Methylphenidate (generics, Metadate CD, Concerta, Methylin ER Ritalin SR/LA, Metadate ER) *for age 5 and older doses @ >120mg/day*
- Methylphenidate DAYTRANA transdermal *for age 5 and older doses @ >30mg/day*
- Dexmethylphenidate- (generics, Focalin /XR) *for age 5 and older @ >60mg per day*
- Amphetamines (generics, Adderall /XR, Dexedrine SA, Dextrostat, Liquadd, Procentra) *for age 5 and older doses @ > 60mg/day*
- Lisdexamfetamine (Vyvanse*) for age 5 & older doses @ >70mg/day*
- Atomoxetine (Strattera) *for age 5 and older doses @ >120mg/day*
- Combinations of medications in 2 or more categories:

	Methylphenidate	Dexmethylphenidate	Amphetamines	Atomoxetine
Methylphenidate		X	X	X
Dexmethylphenidate	X		X	X
Amphetamines	X	X		X
Atomoxetine	X	X	X	

- New orders for ADHD medications should not exceed these guidelines recommended by the Mental Health Stakeholders Workgroup
- Anyone under 18 years of age requires a second opinion if the prescription exceeds these limitations

Why: Of the 16,115 of clients receiving ADHD medications in 2009:

- 258 clients <5 years of age
- 432 clients exceed dosage limits
- 248 clients with combinations that have no effectiveness evidence

How: Prescriptions exceeding the Age and Dose Limitations:

- Will be authorized **only** for continuation of therapy (same medication/same dose) until a final decision can be made by HRSA.
- Will require a consult by a member of HRSA's second opinion network for clients under 18 years of age.
  - *Providers are encouraged to consult with a physician member of HRSA's second opinion network before initiating a prescription that exceeds these limits. Contact Children's Hospital Psychiatry Department to initiate a review.*

Who: Seattle Children's Hospital
Child Psychiatry: 4800 Sand Point Way NE, Mail-Stop W3636, Seattle, WA 98105-3916
Phone: 206-987-1771, Fax: 206-987-2246

Note: **If you participate in a phone consult with the second opinion network provider, you may be reimbursed for this service by billing with procedure code 99371**

Washington State
Department of Social
& Health Services

DSHS Drug Utilization Review Program-Antipsychotics

The following safety guidelines regarding other child psychiatric medications were agreed upon by the by the DSHS Pediatric Advisory Group, and community practice consensus in 2009. The DSHS second opinion review program which was previously restricted to just ADHD medications now reviews these other safety standards.

Child in crisis: Unlike with ADHD medications, 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 records that same information on the prescription.

Drug	**Dosing Limits****		
	Age 3-5 years*	**Age 6-12 years**	**Age 13-17 years**
Abilify® (aripiprazole)	0	20 mg per day	30 mg per day
Clozaril®, Fazaclo® (clozapine)	0	600 mg per day	900 mg per day
Geodon® (ziprasidone)	0	80 mg per day	160 mg per day
Haldol® (haloperidol)	0	10 mg per day	15 mg per day
Invega® (paliperidone)	0	0	0
Risperdal®/M-Tab® (risperidone)	2 mg per day	4 mg per day	8 mg per day
Seroquel®/XR (quetiapine)	0	300 mg per day	600 mg per day
Trilafon® (perphenazine)	0	12 mg per day	24 mg per day
Zyprexa®/Zydis® (olanzapine)	2.5 mg per day	10 mg per day	20 mg per day

*A zero indicates the need for a DSHS-approved second opinion.
**Prescriptions exceeding dosing limitations for age require a DSHS-approved second opinion.

Other criteria accepted by the DSHS Pediatric Advisory Group as appropriate reasons to initiate a required second opinion review of a psychiatric medication include:

1	Absence of a DSM-IV diagnosis in the child's claim record
2	Five (5) or more psychotropic medications prescribed concomitantly after 60 days
3	Two (2) or more concomitant antipsychotic medications after 60 days
4	Three (3) or more concomitant mood stabilizer medications {i.e. defined as not including the AAP/AP class} for a mental health diagnosis (i.e. no seizure diagnosis in a claim file) after 60 days.
5	The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed
6	Psychotropic poly-pharmacy for a given mental disorder is prescribed before utilizing psychotropic mono-therapy as new start noted from pharmacy claims data
7	Psychotropic medications are prescribed for children of very young age, including children receiving an antipsychotic in less than five (5) years of age

Washington State
Department of Social
& Health Services

Generics First for New Starts of Psychiatric Medications

Effective for dates of service on and after October 1, 2009, DSHS 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

Note: 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. DSHS is not requiring clients who are established and doing well on a drug to be changed to a generic product. See DSHS Memo 09-61 found at http://maa.dshs.wa.gov/ for more details.

Atypical antipsychotic generics (as of 11/09) *that may be prescribed first* include:

risperidone

Attention Deficit Hyperactivity Disorder generics (as of 11/09) *that may be prescribed first* include:

amphetamine salt combo
amphetamine salt combo XR
dexmethylphenidate
dextroamphetamine
dextroamphetamine SA
methylphenidate
methylphenidate SA
Methylin® (*methylphenidate HCl*) tablet
Methylin ER® (*methylphenidate HCl*)

Clinical Care Recommendations
From the PAL team

General Evaluation and Treatment

Basic screening tools

Specific problem based advice

ADHD
Anxiety
Autism
Bipolar
Depression
Eating disorder
Oppositional/conduct disorder
Sleep Hygiene

General Assessment

11 Mental Health Assessment Principles for Primary Care Providers:

1) *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.

2) *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).

3) *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.

4) *Seek to interview the child alone*, especially if an internalizing problem like depression or anxiety is suspected, to obtain a more thorough history.

5) *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.

6) *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 (i.e. like the "12 month service history" from DSHS on page 13)

7) *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.

8) *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.

9) *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.

10) *Put it all together into your best clinical judgment, 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.

11) *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 an RSN contracted mental health provider to obtain a care assessment and take advantage of the state's mental health benefits.

What can you do if <u>everything</u> looks like a problem?

1) *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 externalizing behavior. In that case, review the steps of our aggression/disruptive behavior decision tree. The child's sleep problems and intermittent anxiety can be explored further at a future appointment.

2) *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. The DSHS resource guide describes how to obtain claims histories. Remember our first assessment principle; you don't have to figure this all out in one visit.

3) *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:
   - *a.* PSC-17 (free, included in this guide)
   - *b.* 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: http://www.sdqinfo.com/b1.html
   - *c.* 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: http://www.aseba.org/products/forms.html
   - *d.* BASC-2 (Behavior Assessment Scale for Children, 2nd 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: http://ags.pearsonassessments.com/Group.asp?nGroupInfoID=a30000

4) *Discuss the scenario with a specialist*. PAL psychiatrists would like to talk about any tricky situations with you, and are available to do this Monday through Friday from 9am to 5pm.

5) *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.

6) *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).

7) *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 <u>very</u> important to not simply stack medicines one upon another without demonstrating a clear benefit to the child.

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

(This is not intended to be an all-inclusive list.)

1) *Peer reviewed care guidelines from a professional association:*
    a. American Academy of Pediatrics, Clinical Practice Guidelines
        a) http://aappolicy.aappublications.org/
    b. American Academy of Child and Adolescent Psychiatry, Practice Parameters
        a) http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters

2) *Peer reviewed care guidelines from a State sponsored workgroup*
    a. Partnership Access Line(PAL) in Washington
        a) http://www.palforkids.org
    b. CMAP project in Texas
        a) http://www.dshs.state.tx.us/mhprograms/CMAP.shtm
    c. Evidence based service guide in Hawaii
        a) http://hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html

3) *Federal agency publications*
    a. National Institute of Mental Health
        a) http://www.nimh.nih.gov
    b. Substance Abuse & Mental Health Service Administration
        a) http://www.samhsa.gov

4) *Collaborative guidance from respected organizations*
    a. www.parentsmedguide.org --from AACAP and APA
    b. www.nami.org --from the National Alliance for the Mentally Ill

5) *New original research, particularly if a randomized controlled trial design is used*
    a. Pub Med provides free Medline searches
        a) http://www.ncbi.nlm.nih.gov/pubmed/

6) *State pharmaceutical policy reviews (which review the current evidence base)*
    a. Independent reviews of medications performed by OHSU Center for Evidence-Based Policy (Oregon EPC), used by Washington Pharmacy and Therapeutics (P&T) committee:
        a) http://www.ohsu.edu/ohsuedu/research/policycenter/DERP/about/final-products.cfm
    b. Washington State P&T committee transcripts, processes and decisions
        a) http://www.rx.wa.gov

Special Issues for Foster Care Children

Post Traumatic Stress Disorder

Children in foster care frequently have past traumatic experiences like witnessing violence or being abused themselves, which might lead them to develop a long lasting anxiety stress disorder called PTSD. *Nightmares* (that are atypical for their age), *flashbacks* (suddenly feeling like one is re-experiencing a trauma), and *hyperarousal* (hypervigilance, irritability, exaggerated startle) that are still occurring more than one month after the traumatic experience are the three hallmarks to look for when diagnosing PTSD. While checking for PTSD, it is not advisable to ask a foster child to recount to you their exact past traumatic experiences within a 10 minute office visit—the child is likely to experience this as "re-traumatizing." Instead, simply ask the child about any current symptoms of PTSD: if they are having nightmares, if they feel very jumpy if someone walks in the room, if they ever find themselves re-experiencing difficult events from their past in a sudden way.

Primary care providers suspecting that a child has PTSD should address these things:
1) The child's current and future physical and emotional safety must be assured. No one recovers from PTSD if abuse is ongoing.
2) The child needs to understand what the plans are for their living situation, where they will be, and for how long. Not understanding where they will live day to day is very stressful and enhances their fear of returning to an unsafe environment.
3) The child should be referred for counseling support with a licensed mental health professional, and the Trauma Focused Cognitive Behavioral Therapy (TF-CBT) technique is preferred where available.
4) Recognize that there is no "PTSD medication." As per the anxiety treatment guideline, SSRI's are the medications most commonly recommended when symptoms of PTSD are severe. Sometimes medications like clonidine are given at bedtime to help with nightmares that are not improving via other treatments.

Attachment Concerns

Children in foster care may have difficulties with attachment to caregivers. These difficulties may manifest in a variety of ways depending on a child's age. Very young children may be difficult to soothe when they are upset. Slightly older children may not turn to their caregivers for comfort in the same way other children do. The degree of attachment issues may vary from very minor to relatively extreme.

On the far end of the attachment spectrum is Reactive Attachment Disorder, which is characterized by pervasively impaired social relationships. It is defined in DSM-IV TR as "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years" and may involve either inhibited or disinhibited behavior. Assessment, according to APSAC Attachment task Force Recommendations, must look at the child's patterns of behavior over time to avoid over-interpreting the child's adjustment to new or stressful circumstances. By gathering information from teachers, day care providers, peers, and from prior living situations one can understand the child's attachment pattern more accurately. Cultural issues are important, especially with cross-cultural or international placements or adoptions. Overly broad, nonspecific, or unproven checklists should not be the basis of an evaluation. Care should be taken to rule out conditions such as autism spectrum disorder, pervasive developmental disorder, childhood schizophrenia, genetic syndromes, or other conditions (for example, Conduct disorder, ADHD) before making a diagnosis of an attachment disorder.

There are several core elements of treatment for attachment problems ,including securing a nurturing and safe environment for the child, working directly with the child's caretakers to teach them appropriate parenting skills, focusing on the child and family's coping, and maintaining the child in the least restrictive and intrusive level of care. With Reactive Attachment Disorder the need for these treatments is multiplied. No specific pharmacotherapy is recommended. Play therapy and cognitive behavioral therapy addressing the child's symptoms of fear, anxiety, and posttraumatic stress may be of benefit. Coercive or holding therapies are not recommended as they have been associated with harming the child.

PEDIATRIC SYMPTOM CHECKLIST-17

Caregiver completing this form: _____

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:
PSC17--I $\geq$ 5
PSC17--A $\geq$ 7
PSC17--E $\geq$ 7
Total Score $\geq$ 15

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

PSC-17 may be freely reproduced.
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

PSC-17 scoring

The PSC-17 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 aide. 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	0.16	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 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.

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 can not 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 SAFE-WA (www.safewashington.org) and Youth 'N Action (www.youthnaction.org).

Families wishing to learn more about Evidence Based Treatments for children are encouraged to look at a brochure on the subject from NAMI, the National Alliance on Mental Illness. That document called "A Family Guide: What Families Need to Know about Evidence-Based Practices" can be found by going to: http://www.nami.org/template.cfm?section=child_and_teen_support and selecting the header appearing on the upper right, "For Parents, Caregivers, & Youth."

The following table shows, based on the best available evidence, examples of which psychosocial practices are recognized to work for particular problem areas. This table was prepared by a workgroup in the State of Hawaii, and is reproduced here due to its recent updating and their formalized process for making treatment categorizations.

"Blue Menu" - Evidence-Based Child and Adolescent Psychosocial Interventions

This tool has been developed to guide teams (inclusive of youth, family, educators and mental health practitioners) in developing appropriate plans using psychosocial interventions. Teams should use this information to prioritize promising options. For specific details about these interventions and their applications (e.g., age setting, gender) see the most recent Evidence Based Services Committee Biennial Report (http://www.hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html).

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- NO SUPPORT
Anxious or Avoidant Behaviors	Cognitive Behavior Therapy, **Cognitive Behavior Therapy and Medication**, Education, Exposure, Modeling	Assertiveness Training, Cognitive Behavior Therapy for Child and Parent, Cognitive Behavior Therapy with Parents, **Family Psychoeducation**, Hypnosis, Relaxation	**Contingency Management, Group Therapy**	Biofeedback, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy	**Attention**, Client Centered Therapy, EMDR, Relationship Counseling, Teacher Psychoeducation [poorly tested: CBT with Parents Only]
Attention and Hyperactivity Behaviors	Behavior Therapy and Medication, Contingency Management, Self Verbalization	Biofeedback, Education, **Parent Management Training (alone, with Problem Solving, or with Teacher Psychoeducation)**, Physical Exercise, Relaxation and Physical Exercise, Social Skills and Medication, Working Memory Training	None	Parent Management Training and Social Skills, Relaxation, **Self-Verbalization and Contingency Management**, Social Skills	**Attention**, Client Centered Therapy [poorly tested: **Cognitive Behavior Therapy, Cognitive Behavior Therapy and Anger Control, Parent Coping/Stress Management**, Parent Management Training and Self-Verbalization, Self Control Training, Self Verbalization and Medication, Skill Development]
Autistic Spectrum Disorders	Intensive Behavior Therapy, Intensive Communication Training	None	None	None	[poorly tested: Auditory Integration Training]
Delinquency and Disruptive Behavior	Assertiveness Training, Cognitive Behavior Therapy, Contingency Management, Multisystemic Therapy, Parent Management Training, Social Skills	Anger Control, Client Centered Therapy, Communication Skills, Functional Family Therapy, Multidimensional Treatment Foster Care, Parent Management Training and Problem Solving, Problem Solving, Rational Emotive Therapy, Relaxation, Transactional Analysis	Attention, Outreach Counseling, Peer Pairing, Self Control Training	**Parent Management Training and Self-Verbalization**, Physical Exercise, Stress Inoculation	**CBT with Parents**, Education, Exposure, Family Systems Therapy, Group Therapy (!!), Life Skills, Project CARE (!!),Skill Development [poorly tested: **CBT and Anger Control**, Catharsis, Collaborative Problem Solving, Family Empowerment, Psychodynamic Therapy, Self Verbalization]
Depressive or Withdrawn Behaviors	Cognitive Behavior Therapy, Cognitive Behavior Therapy and Medication, **Family Therapy**	Client Centered Therapy, Cognitive Behavior Therapy with Parents, Expressive Writing/Journaling/Diary, **Interpersonal Therapy**, Relaxation	None	Self Control Training, Self Modeling	Attention, Counselors Care, Counselors Care and Anger Management, Psychodynamic, Life Skills, **Social Skills** [poorly tested: Problem Solving]
Eating Disorders	None	Cognitive Behavior Therapy, Family Therapy, Family Systems Therapy	None	None	**Client Centered Therapy, Education, Goal Setting**
Substance Use	None	Cognitive Behavior Therapy, Contingency Management, Goal Setting/Monitoring, Purdue Brief Family Therapy, Family Therapy, Family Systems Therapy	None	**Goal Setting, Motivational Interviewing/Engagement**	Client Centered Therapy, Education, Group Therapy (!!), Project CARE (!!), Twelve Step Program
Traumatic Stress	Cognitive Behavior Therapy with Parents	Cognitive Behavior Therapy	None	Play Therapy, Psychodrama	Client Centered Therapy, Cognitive Behavior Therapy with Parents Only [poorly tested: **Cognitive Behavior Therapy and Medication**, EMDR]

Note: Level 5 refers to treatments that were tested and found ineffective. Risk of harm is noted by the symbol (!!), which indicates that at least one study found negative effects on the main outcome measure. The risk of using such treatments should be weighed against potential benefits.

Above table reproduced with permission from State of Hawaii CAMHD, from http://hawaii.gov/health/mental-health/camhd/library/webs/ebs/ebs-index.html,
Table last updated 4/1/09, and downloaded 11/1/09

ADHD

Considering ADHD diagnosis?
Problem from inattention/hyperactivity?

Consider comorbidity or other diagnosis:
- Oppositional Defiant Disorder
- Conduct Disorder
- Substance Abuse
- Language or Learning Disability
- Anxiety Disorder
- Mood Disorder
- Autistic Spectrum Disorder
- Low Cognitive Ability/Mental Retardation

Diagnosis:
Preschoolers have some normal hyperactivity/impulsivity: recommend skepticism if diagnosing ADHD in this group. (Note that DSHS will require a medication review if prescribing and child age <5)
If rapid onset symptoms, note this is not typical of ADHD

Use DSM-IV TR criteria:
- Must have symptoms present in more than one setting
- Symptom rating scale strongly recommended from home and school
  - Vanderbilt ADHD Scale (many others available, for a fee)
- If unremarkable medical history, neuro image and lab tests not indicated
- If significant concern for cognitive impairment, get neuopsychological testing

Treatment: If diagnose ADHD

Mild impairment, or no medication per family preference

Psychosocial Treatment:
Behavior therapy
Behavior management training (essentially more effective time outs and rewarding positive behavior)
Social skills training
Classroom support/communication

Give parent our resource list to explain the above treatments (the parent handout in this guide)

Significant impairment, or psychosocial treatments not helping

Active substance abuse?

yes → Treat substance abuse, consider atomoxetine trial

no → Monotherapy with methylphenidate or amphetamine preparation.

Titrate up every week until maximum benefit (follow-up rating scales help)

If problem side effects or not improving, switch to other stimulant class

If problem side effects, or not improving, switch to atomoxetine or alpha2 agonist monotherapy

If no improvement, reconsider diagnosis. Medication combinations like alpha-2 agonist plus stimulant may be reasonable at this stage.

Primary References:

AACAP: "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention Deficit/Hyperactivity Disorder."*JAACAP* 46(7):July 2007:894-921

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

Vanderbilt ADHD Teacher Rating Scale (page 1 of 2)

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 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 (page 2 of 2)

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	Problematic		Average		Above Average
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 Parent Rating Scale was developed by Mark L. Wolraich, MD.
Reproduced and format adapted by R. Hilt MD and Washington's PAL with permission.

Vanderbilt ADHD Parent Rating Scale (page 1 of 2)

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 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 misbehaviors	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 (page 2 of 2)

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	Problematic		Average		Above Average
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 19-26: _____

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

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

Number of questions scored as 1 or 2 in questions 48-49: _____

Vanderbilt ADHD Diagnostic Parent Rating Scale was developed by Mark L. Wolraich, MD. Reproduced and format adapted by R. Hilt MD and Washington's 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.

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	Usual Starting Dose	FDA max daily dose	DSHS maximum before a review
methylphenidate (Ritalin, Methylin)	4-6 hours	5, 10, 20mg	5mg BID ½ dose if 3-5yr	60mg	120 mg
dextroamphetamine (Dexedrine DextroStat Dexedrine SA)	4-6 hours	5, 10 mg	5mg QD-BID ½ dose if 3-5yr	40mg	60 mg
amphetamine salt combo (Adderall)	4-6 hours	5, 7.5, 10, 12.5, 15, 20, 30mg	5mg QD-BID ½ dose if 3-5 yr	40mg	60 mg
dexmethylphenidate (Focalin)	4-6 hours	2.5, 5, 10mg	2.5mg BID	20 mg	60 mg

Extended Release Stimulants

Drug Name	Duration	Dosages	Stimulant Class	Usual Starting Dose	FDA max daily dose	DSHS maximum before review	Editorial Comments
Methylin ER Methylphenidate SR Metadate ER	4-8 hours	10 or 20mg tab	Methyl.	10mg QAM	60mg	120 mg	Generic available. Uses wax matrix. Variable duration of action
Concerta	10-12 hours	18, 27, 36, 54 mg	Methyl.	18mg QAM	72mg	120 mg	Osmotic capsule
Adderall XR	8-12 hours	5, 10, 15, 20, 25, 30 mg	Dextro.	5mg QD	30mg	60 mg	Generic available. Beads in capsule can be sprinkled
Metadate CD (30% IR)	~8 hours	10,20,30, 40,50, 60 mg capsules	Methyl.	10mg QAM	60mg	120 mg	Beads in capsule can be sprinkled
Ritalin LA (50% IR)	~8 hours	10,20,30, 40 mg capsules	Methyl.	10mg QAM	60mg	120 mg	Beads in capsule can be sprinkled
Focalin XR	10-12 hours	5, 10, 15, 20 mg	Methyl.	5mg QAM	30 mg	60 mg	Beads in capsule can be sprinkled
Daytrana patch	Until 3-5 hours after patch removal	10,15,20, 30mg Max 30mg/9hr	Methyl.	10mg QAM	30 mg	n/a (no PO dose equivalence)	Rash can be a problem, slow AM startup, has allergy risk
Lisdexamfetamine (Vyvanse)	~10 hours	30,50,70 mg	Dextro.	30 mg QD	70 mg	70mg	Conversion ratio from dextroamphetamine is not established

Versions of all of the above medications (except Ritalin LA) are on WA preferred drug list, http://rx.wa.gov

NON-STIMULANT MEDICATIONS FOR ADHD

	Duration	Dosages	Usual Starting Dose	FDA max daily dose	Editorial Comments
Atomoxetine (Strattera)	All day	10,18,25,40, 60,80,100 mg	0.5mg/kg/day (1 to 1.2 mg/kg/d usual full dosage)	Lesser of 1.4mg/kg/day or 100mg (DSHS limit is 120mg/day)	usually lower effectiveness than stimulants; has GI side effects
Clonidine (Catapres)	12 hour ½ life	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
Guanfacine (Tenex)	14 hour ½ life	1, 2mg	0.5mg QHS if <45kg, otherwise 1mg QHS	(Not per FDA) 27-40kg 2mg 40-45kg 3mg >45kg 4mg	Often given to help sleep, also treats tics, can have rebound BP

			Caution if <5 yr.		effects
Guanfacine XR (Intuniv)	16 hour ½ life	1, 2, 3, 4mg	1mg QD if over 6 years old (full dosage 0.05 to 0.12mg/kg)	4mg daily	May have more even duration of action than regular Tenex

Reference: AACAP ADHD Practice Parameter (2007), Micromedex 2009

Versions of all the above medications, except Intuniv, are on WA preferred drug list, http://rx.wa.gov

Effect size of all stimulants ~1.0
Effect size of atomoxetine ~0.7
Effect size of guanfacine ~0.65

Medication net costs to DSHS:

Strattera
Vyvanse
Daytrana
Concerta
Adderall XR
Focalin XR
dextroamphetamine SA
amphetamine salt combo
dextroamphetamine
methylphenidate SR
methylphenidate

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.

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:

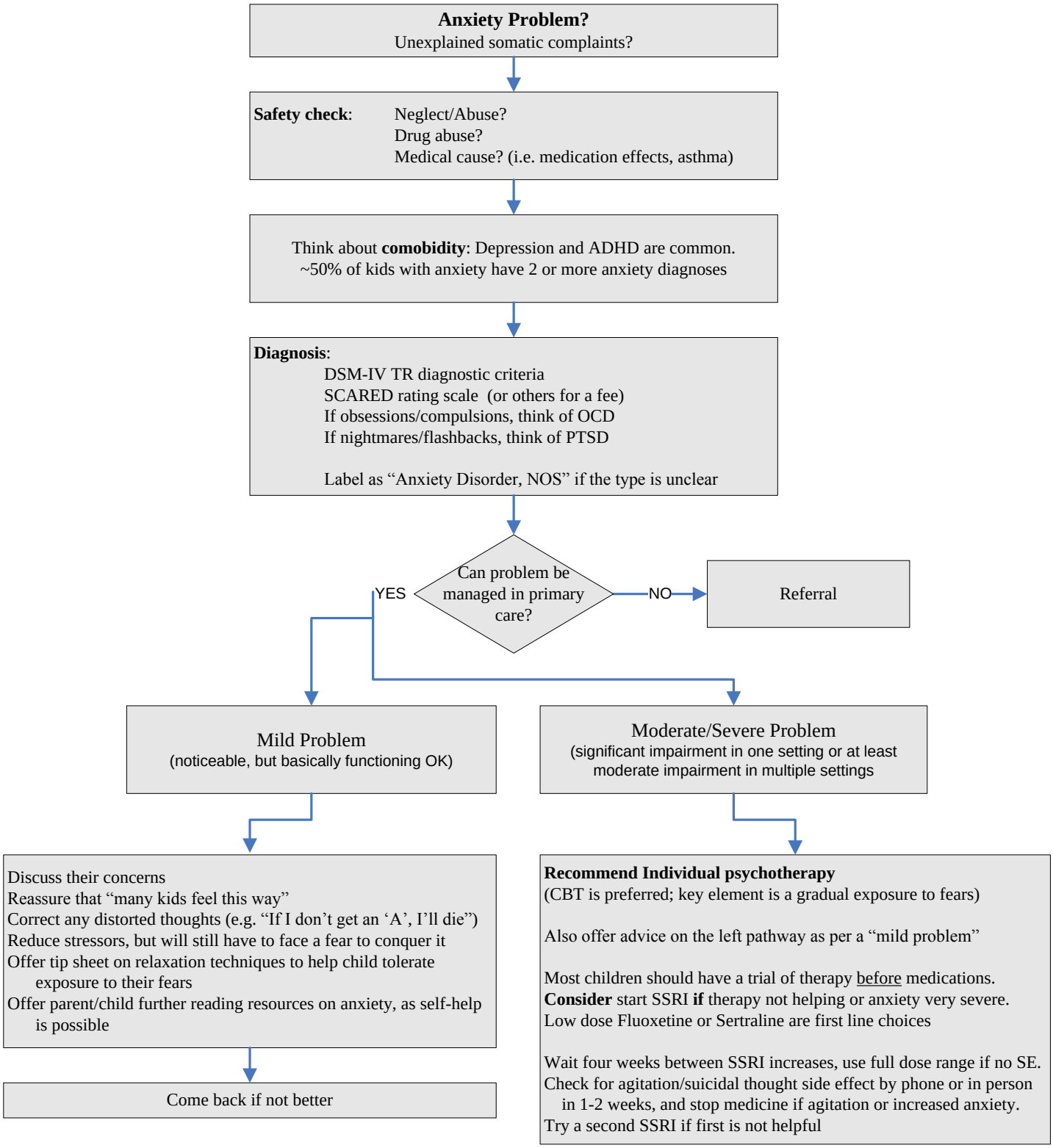
www.chadd.org (support groups, information resource)
www.teachadhd.ca (teaching advice for ADHD kids)
www.parentsmedguide.org (quality information about medications for ADHD)
www.dshs.state.tx.us/mhprograms/CMAPadhdED.shtm (CMAP family information)

More book and other information recommendations can be found at parentsmedguide.org
Change link to: http://www.psych.org/share/parents-med-guide.aspx

"Behavior Management Training" and "Behavior Therapy" are 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. The principle elements of these treatments are:

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

Anxiety



Reference:
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:

1. 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.
2. 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.
3. Now practice making your breath smooth, like a wave that inflates and deflates.
4. 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.

1. Lie down in a quiet room and take slow breaths, try Breathing Control as above.
2. 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.
3. 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.
4. 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.
5. 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.

6. 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

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

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 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.	○	○	○

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Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.	○	○	○
22. When I get frightened, I sweat a lot.	○	○	○
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.	○	○	○

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 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**.

**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, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

SCARED Rating Scale Scoring Aide

Question	**Panic/Somatic**	**General Anxiety**	**Separation**	**Social**	**School Avoidance**	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
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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	Total Anxiety ≥ 25

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

Child 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).

	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)	10,20,40 mg 20mg/5ml	5-10 mg/day (60 max)*	10-20mg**	Yes	Yes (For OCD>7yr)	Long ½ life, no SE from a missed dose
Sertraline (Zoloft)	25,50,100mg 20mg/ml	25 mg/day (200 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)	25,50,100 mg	25 mg/day (300 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, 37.5 mg CR forms	5-10 mg/day (60 max)*	10-20mg**	Yes	No	Not preferred if child also has depression. Can have short ½ life
Citalopram (Celexa)	10,20,40 mg 10mg/5ml	5-10 mg/day (40 max)*	10-20mg**	Yes	No	Very few drug interactions
Escitalopram (Lexapro)	5,10,20mg 5mg/5ml	2 ½ to 5 mg/day (20 max)*	5-10mg**	No	No	No generic form. Active isomer of citalopram

Highlighted generics are on WA preferred drug list, http://rx.wa.gov

* 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

DSHS Costs: citalopram<fluoxetine<mirtazapine<paroxetine<bupropion<bupropion SR<venlafaxine<EffexorXR

Anxiety Disorder Resources—Patient Information

Books that parents may find helpful:

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

Helping Your Anxious Child (2008), by R Rapee PhD., A Wignall DPsych, S Spence PhD., V Cobham PhD., and H Lyneham, PhD.

Worried No More, 2nd Ed (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 that children may find helpful:

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.

Websites that 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/cs/root/facts_for_families/the_anxious_child

US Department of Health
http://mentalhealth.samhsa.gov/publications/allpubs/CA-0007/default.asp

Autism
and Autism Spectrum Disorders

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

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-IV TR diagnostic criteria which include presence of:
A. Impairments in Social Interaction—including impairments in non-verbal behaviors, developmentally-appropriate peer relationships, spontaneous sharing interests, and/or social or emotional reciprocity.
B. Impairments in Communication—including a delay or lack of spoken language without use of alternative modes of communication, a marked impairment in starting and sustaining conversation, a lack of developmentally-appropriate pretend or social imitative play, and/or stereotyped, repetitive, or idiosyncratic language
C. Restrictive, repetitive, stereotyped behaviors, interests, and activities—including abnormally intensely focused and restricted interests, inflexible adherence to non-functional routines, stereotyped and repetitive motor mannerisms (finger or hand flapping or twisting), and/or persistent preoccupation with parts of objects.

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 www.firstsigns.org/downloads/m-chat.PDF
CAST (Childhood Autism Spectrum Test) for age 4-11 years. Found at www.autismresearchcentre.com/tests
AQ (Autism Quotient) for age 12-15 years. Found at www.autismresearchcentre.com/tests
(many others are available for a fee)

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 Infant Toddler Early Intervention Program (http://www.dshs.wa.gov/iteip). 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 to address core deficits associated with autism and to reduce maladaptive behaviors. Applied 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—for Families and Care Providers."
--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 a 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."

Treating Maladaptive Behavior 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 system (such as 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 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 Maladaptive Aggression."

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

Psychiatric Medication Considerations in Children with Autism

1. Medications do not improve core autism features; *i.e. there is currently no "autism medication."*

2. 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.

3. Use a single medication appropriate to a diagnosis or target symptom. Start low and increase slowly.

4. Track the target symptom's response to interventions.

5. 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.

6. If an intervention isn't reducing symptoms, taper and remove the medication, then re-evaluate. Be vigilant about stopping any medication that is not clearly helpful

7. 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.

8. 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.

<u>Some medications to consider include:</u>

<u>Risperidone</u>: 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 (see page 55).

<u>Aripiprazole</u>: 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 5-10mg/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.

Autism Resources--for Families and Care Providers

Books that 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:
http://wwww.autismspeaks.org (advocacy, diagnostic, treatment and support resources)
http://depts.washington.edu/uwautism (advocacy, diagnostic, treatment and support resources)
http://www.arcwa.org/parent_to_parent.htm (parent peer mentorship program)

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, M.D., (Future Horizons.)
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.)
www.do2learn.com (free games that teach about feelings and facial expressions.)

Picture Exchange Communication System (PECS) resource
www.do2learn.com (has pictures that can be printed out for arranging a visual daily schedule)

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.

In an ideal world, 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
- Asperger 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 at RSN to evaluate/treat Bipolar I or II (also called "narrow phenotype" bipolar)

Maybe

Is this Bipolar Disorder NOS?

- This is label used for bipolar symptoms that cause impairment, but severity or duration criteria for bipolar I or II not met.
- Diagnosis is controversial.
- Most irritable, moody, irrational, hyperactive kids do NOT have a bipolar disorder.

More likely Bipolar Disorder NOS if:
Episodic patterns of mood changes 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 Disorder NOS if:
Younger age (such as <10)
Rages only after frustrations
Symptoms only in 1 setting (i.e. home)
High expressed emotion in household (think ODD)

→ Reconsider oppositional defiant disorder, ADHD, or other reasons for behaviors

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
6. Follow up frequently, perhaps weekly until stabilizing
7. Ensure adequate sleep hygeine.

Primary References:

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

DSM-IV TR June 2000, American Psychiatric Publishing, Inc. 4th edition

Bipolar Disorder Medications—Page 1

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

Atypical Antipsychotics

	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)	Generic forms. More dystonia risk than rest
Aripiprazole (Abilify)	2,5,10,15, 25,30mg 1mg/ml	2mg QD	+	+	+/-	Yes	Yes (Age >10)	Long ½ life, can take weeks to build effect
Quetiapine (Seroquel)	25,50,100, 200,300, 400mg	25mg BID	++	+	+/-	Yes	Yes (Age >10)	Pills larger, could be hard for kids to swallow.
Ziprasidone (Geodon)	20,40,60, 80mg	20mg BID	+	+	+/-	No	No	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)	Greatest risk of weight gain, ↑cholesterol

Table + and – from Fedorowicz VJ. Fombonne E. (2005), Lublin, H; et al (2005), and Correll CU et al (2009)

All of the above are currently on the WA preferred drug list, http://rx.wa.gov

DSHS relative costs: Risperdal < < Seroquel, Geodon, Abilify, Zyprexa

Monitoring for all atypical antipsychotics:

1. *Weight checks and fasting glucose/lipid panel roughly every Q6months.*
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—Page 2

Other Medication Options

	Bipolar (+) RCT evidence in kids	FDA bipolar approved children?	Monitoring	Editorial Comments
Lithium	Yes	Yes (over age 12)	Baseline EKG, BUN/creat,TSH,CBC. Lithium level after 5 days. Q3month Lithium level. 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	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 ovary syndrome
Carbamazepine	No	No	CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed	Aplasia and rash risk. Note a negative result trial with kids and oxcarbazepine & bipolar
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

ABNORMAL INVOLUNTARY MOVEMENT SCALE
(AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS. MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

CODE 0 = NONE
1 = MINIMAL, MAY BE EXTREME NORMAL
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					
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 NOS" 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:

Websites

American Academy of Child and Adolescent Psychiatry, Practice Parameter on Bipolar Disorder, updated in 2007. This is a very detailed review of our current state of knowledge and a review of currently available treatments.
http://www.aacap.org/galleries/PracticeParameters/JAACAP_Bipolar_2007.pdf

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

National Alliance for the Mentally Ill:
www.nami.org

American Academy of Child and Adolescent Psychiatry, then select "Facts for Families":
www.aacap.org

Child and Adolescent Bipolar Foundation
www.bpkids.org

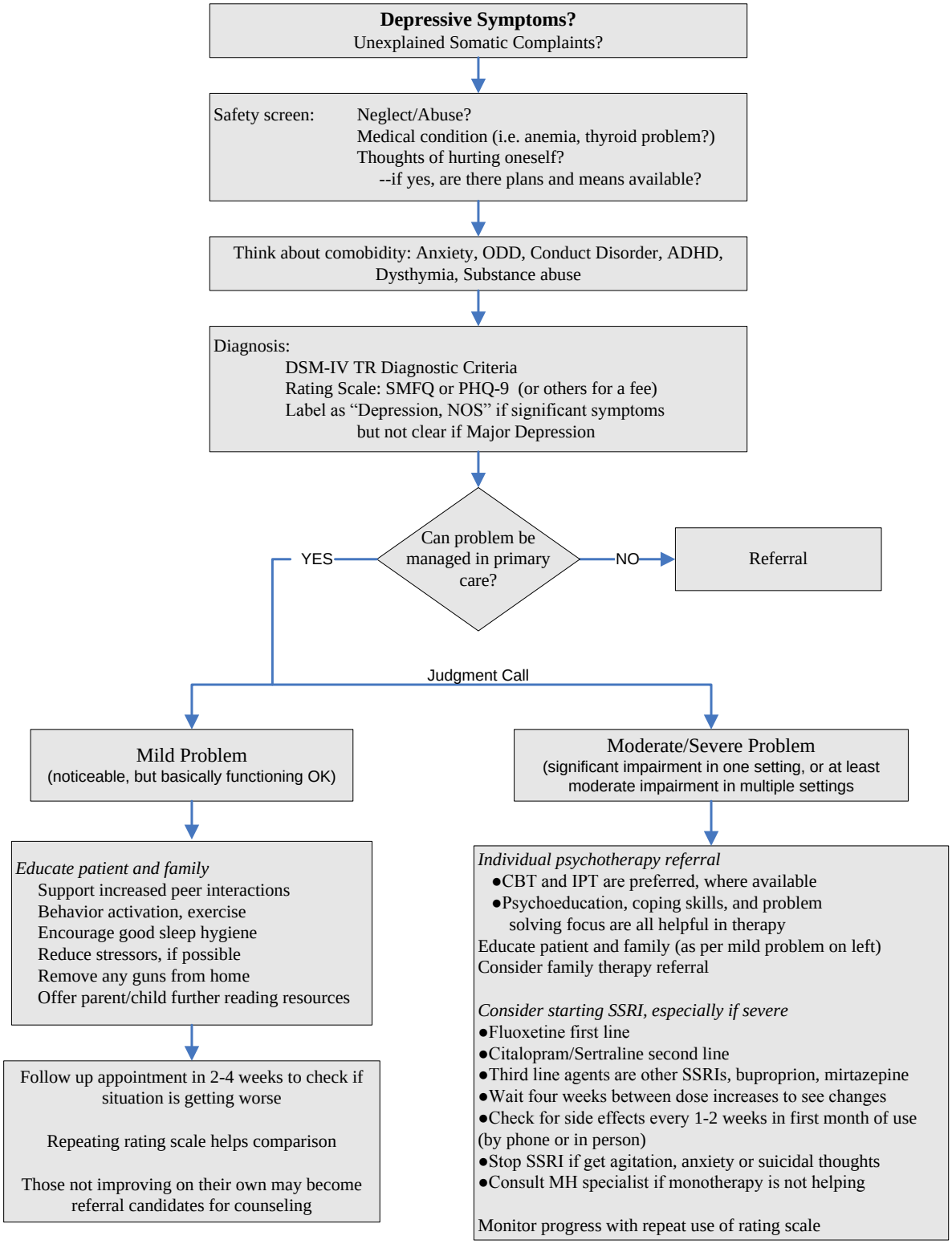
Books

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)

Depression



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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

Self Report Version

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.

		TRUE	SOME TIMES	NOT 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	☐	☐	☐

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Parent Report Version

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.

		TRUE	SOME TIMES	NOT 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	☐	☐	☐

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Scoring for the SMFQ
(Short Mood and Feelings Questionnaire)

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 aide 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 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** _____

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PHQ-9

Scoring Instructions*

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 aide 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.

Child Depression Medications

	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)	10,20,40 mg 20mg/5ml	10 mg/day (60 max)*	10-20mg**	Yes	Yes (over age 8)	Long ½ life, no side effect from a missed dose
Fluoxetine considered first line due to stronger evidence base in children						
Citalopram (Celexa)	10,20,40 mg 10mg/5ml	10 mg/day (60 max)*	10-20mg**	Yes	No	Few drug interactions
Sertraline (Zoloft)	25,50,100mg 20mg/ml	25 mg/day (200 max)*	25-50mg**	Yes	No	May be prone to side effects when stopping
Escitalopram (Lexapro)	5,10,20mg 5mg/5ml	5 mg/day (20 max)*	5-10mg**	Yes (for adolescents)	Yes	No generic form. Active isomer of citalopram
Citalopram (escitalopram) and Sertraline considered second line per the evidence base in children						
Buproprion (Wellbutrin)	75,100 mg 100,150,200 mg SR forms	75 mg/day (later dose this BID) (400mg max)*	75-100mg**	No	No	Can have more agitation risk. Also has use for ADHD treatment.
Mirtazepine (Remeron)	15,30,45 mg	15 mg/day (45 max)*	15mg**	No	No	Sedating, increases appetite
Venlafaxine (Effexor)	25,37 ½ ,50, 75,100mg 37.5,75,150 mg ER forms	37 ½ mg/day (225 max)*	37 ½ to 75mg **	No (May have higher SI risk than others for children)	No	Only recommended for older adolescents. Withdrawal symptoms can be severe.
Others above considered third line treatments per the evidence base in children						

For highlighted items, the generic form is on WA DSHS preferred drug list
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.

DSHS Cost: citalopram<fluoxetine<mirtazapine<paroxetine<bupropion<bupropion SR<venlafaxine<EffexorXR

Child Depression Resources

Information for Families

Books for Adults:

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

Books for Kids:

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)

Crisis Hotlines:

TeenLink
Seattle based teenagers with professional training and support, 6-10PM daily
1-866-TEENLINK

National Hotline
1-800-784-2433

Find local line number on http://suicidehotlines.com/washington.html

Websites families may find helpful:

Guide to depression medications from multiple professional organizations:
www.parentsmedguide.org

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

American Academy of Child and Adolescent Psychiatry:
www.aacap.org

CMAP patient and family information:
www.dshs.state.tx.us/mhprograms/CMAPmddED.shtm

Excellent consumer guide to childhood depression from NAMI:
www.nami.org/Content/ContentGroups/CAAC/Family_Guide_final.pdf

Eating Disorder

Possible Eating Disorder?

Consider other causes of symptoms:

- Malignancy
- GI disorder like Crohn's disease
- Endocrine disorder like diabetes mellitus
- Depression
- Obsessive compulsive disorder
- Chronic infection or disease
- Superior mesenteric artery syndrome
- History of sexual abuse

Safety check: Suicidality?
Medically unstable? (hospital criteria below)

Diagnosis:
EAT-26 rating scale can be helpful for screening
DSM-IV TR criteria for anorexia nervosa and bulimia nervosa
Note > half of all youth with eating disorders do not fully meet specific criteria and are then diagnosed "eating disorder, NOS"
Record highest stable weight and current weight
Body image concerns: "Do you like your body?"
Inquire about all restrictive and purging habits
(including exercise, laxative, vomiting, caffeine/nicotine or other substance abuse)

Management:

1. Initial lab: CBC, electrolytes, LFT, UA, TSH, baseline EKG
2. Establish plan for frequent weight check, HR, BP, temp. Follow-up weekly if low weight.
3. Referral to a nutritionist, preferably one with eating disorder experience
3. Referral to therapist, eating disorder experience preferred
   Family based approach best supported if <16 years old or illness < 3 year.
   Group therapy with anorexic children is not recommended.
4. Medications:
   consider SSRI like fluoxetine for binge/purge of bulimia, or if anorexic with weight > 85%ile to decrease rate of relapse
   (not good evidence for use of other medications)
5. Consider hospital admission if:

HR < 40	Intractable vomiting
Weight < 75 percentile of ideal	Orthostatic hypotension
Severe dehydration	Precipitous weight loss
Acute food refusal	Severe electrolyte imbalance
Suicidality	Hypothermia
EKG changes	

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	Some times	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.

Eating Attitudes Test© (EAT-26): Scoring and Interpretation

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 the first 25 questions:		
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 for Parents:

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

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

Effective Meal Support: A Guide for Family and Friends, by British Colombia Children's Hospital and Seattle Children's Hospital, order info at 604-875-2260 or mcatamo@cw.bc.ca

Off the C.U.F.F. (Calm, Unwavering, Firm and Funny) by Duke Eating Disorders Program, order info at http://eatingdisorders.mc.duke.edu/parent_training.htm or 919-668-7301

Books for Youth:

Eating Disorders by Trudi Strain Trueit (2003)

No Body's Perfect by Kimberley Kirberger (2002)

Suggested web sites:

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

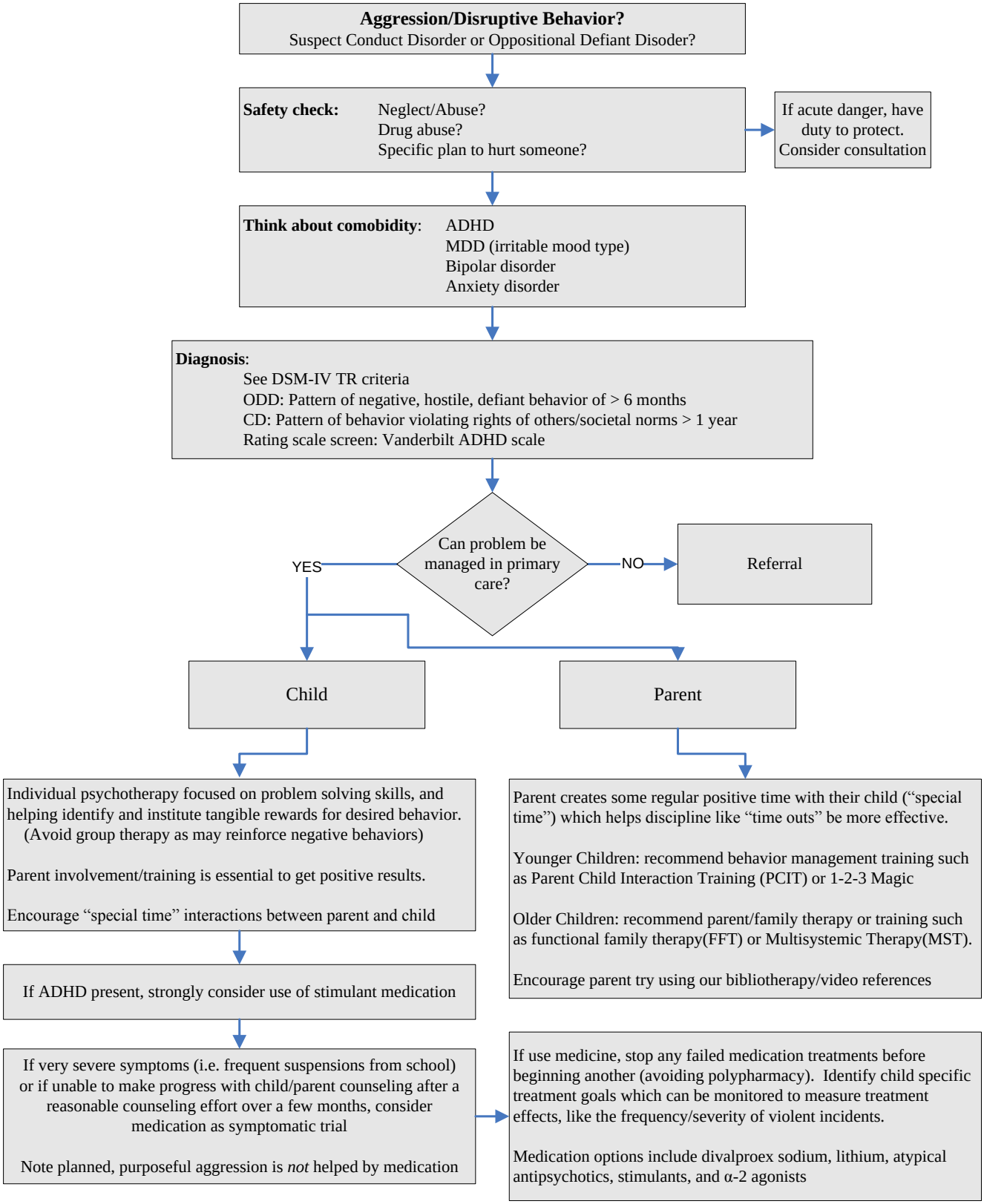
Parent guide to an evidence based, outpatient treatment for anorexia
http://www.maudsleyparents.org

Academy for Eating Disorders, professional organization
www.aedweb.org

Recovery support site
www.somethingfishy.org

Triage information regarding severe symptoms:
Seattle Children's Hospital Adolescent Medicine Consulting Nurse Line: 206-987-3005

Oppositional Defiant Disorder and Aggression



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 (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. 2005.

Non-Specific Medications for Maladaptive Aggression

1. If used, choosing a single medication is strongly recommended over polypharmacy
2. Establish a specific target to treat, and measure the response over time (such as anger explosion frequency, duration)
3. Aggression is not a diagnosis—continue to look for and treat what may be the cause, usually prescribing psychotherapy

	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	0.25 mg QHS	+	+	+	Yes	Most researched med in kids of the group
Aripiprazole (Abilify)	2,5,10,15, 25,30mg 1mg/ml	2 mg QD	+	+	+/-	No	Long ½ life, takes weeks to build effect
Quetiapine (Seroquel)	25,50,100, 200,300, 400mg	25 mg QHS	++	+	+/-	No	Pills larger, could be hard for kids to swall.
Ziprasidone (Geodon)	20,40,60, 80mg	20 mg QHS	+	+	+/-	No	Greater risk of QT lengthen, EKG check
Olanzapine (Zyprexa)	2.5, 5,7.5, 10,15,20 mg	2.5 mg QHS	++	++	+/-	No	Greatest risk of weight gain,↑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 risk. Weight checks, fasting glucose/lipid panel Q6months at minimum.*

(DSHS relative costs: Risperdal < Seroquel < Geodon < Abilify < Zyprexa)

Other Medication Options

	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 risks, 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
Carbamazepine	Anti-seizure	No	CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed	Aplasia and rash risk. Note a negative result trial with kids and oxcarbazepine & bipolar d/o
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 which is approved for irritability/aggression treatment in autism.

All of the above medications are currently on the WA preferred drug list, http://rx.wa.gov

ABNORMAL INVOLUNTARY MOVEMENT SCALE
(AIMS)

INSTRUCTIONS: COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS. MOVEMENT RATINGS: RATE HIGHEST SEVERITY OBSERVED, RATE MOVEMENTS THAT OCCUR UPON ACTIVATION ONE LESS THAN THOSE OBSERVED SPONTANEOUSLY.

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

1. ***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.

2. ***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.

3. ***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.

4. ***Time outs should occur <u>immediately</u> 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.

5. ***If giving a warning before use of time out, make it count***. For instance saying "one more time and you will get a time out" needs to be followed up by actually bringing the child calmly to time out if they do "it" one more time.

6. ***Remember that kids enjoy making a splash***. Like throwing rocks in the water, triggering a parent to lose their cool can be interesting or satisfying for a child. Keeping your cool when setting limits keeps from inadvertently reinforcing their behavior to occur again.

7. ***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, having your child apologize to you). Simply "resume business as usual" or congratulate them on regaining personal control. *Actively look for the next positive behavior to praise*.

Procedure summary by Robert Hilt, MD

Special Time

Sometimes called '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. Families often find that time-outs work better after initiating special time.

How to do special time:

1. Important to be done regularly, every day is optimal, but two or three times a week consistently is OK. Siblings should receive equal opportunity.
2. Child picks 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.
3. Parent picks time of day.
4. Label it "special time."
5. Pick a time short enough that it can be done reliably as scheduled, usually 15-30 minutes.
6. Do it no matter how good or bad the day was.
7. One on one without interruption.
8. End on time: may use a timer to help. Remind child when the next special time will be. May play with the child more after a break from each other.
9. If the child refuses at first, tell the child that you will just sit with him/her for a while, and/or that you will continue to invite the child to participate when next special time is scheduled.
10. Parent also needs to have some special time for him/herself. This is often a prerequisite for the parent to do special time with the child.

Procedure summary by Robert Hilt, MD

Oppositional Defiant Disorder Resources

Information for Families

Books parents may find helpful to help their oppositional children:

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

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

1-2-3 Magic (2004), by Thomas Phelan, PhD

How to Raise 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.

Videos that parents may find helpful:

1-2-3 Magic, 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:

American Academy of Child Psychiatry oppositional defiant disorder resources
http://www.aacap.org/cs/ODD.ResourceCenter

The Incredible Years training programs (based in Seattle)
http://www.incredibleyears.com/

DSHS explanation of Wraparound Services
http://www.dshs.wa.gov/mentalhealth/guidetotailoredcare.shtml

Sleep Hygiene for Children

1. Keep consistent bedtimes and wake times every day of the week. Late weekend nights or sleeping-in can throw off a sleep schedule for days.

2. Avoid spending lots of non-sleep time in bed—spending hours lying on a bed doing other activities before bedtime keeps our brains from associating the bed with sleep time.

3. Child's bedroom should be cool, quiet and comfortable. Those children who stare at clocks should have their clocks turned away from them.

4. Bedtime should follow a predictable sequence of events, such as brushing teeth and reading a story.

5. Avoid high stimulation activities just before bed, such as watching television, playing videogames, communication with friends, or exercise. Do not do these things during a nighttime awakening either. It is best not to have videogames, televisions, computers or phones in the child's bedroom.

6. Having physical exercise as a part of the day often helps with sleep time many hours later.

7. Relaxation techniques such as performing deep, slow abdominal breaths or imagining positive scenes like being on a beach can help a child relax.

8. Avoid caffeine (sodas, chocolate, tea, coffee) in the afternoons/evenings. Even if caffeine doesn't prevent falling asleep it can still lead to shallow sleep or frequent awakenings.

9. If child is awake in bed tossing and turning, it is better for them to get out of bed to do a low stimulation activity, (i.e. reading) then return to bed later. This keeps the bed from becoming associated with sleeplessness. If still awake after 20-30 minutes, spend another 20 minutes out of bed before lying down again.

10. Worry time should not be at bedtime. Children with this problem can try having a "worry time" scheduled earlier when they are encouraged to think about and discuss their worries with a parent.

11. Children should be put to bed drowsy, but still awake. Letting them fall asleep other places forms habits that are difficult to break.

12. Security objects at bedtime are often helpful for children who need a transition to feel safe and secure when their 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.

13. When checking on a child at night, checks should be "brief and boring." The purpose is to reassure the child you are present and that they are okay.

14. If your child is never drowsy at the planned bedtime, you can try a temporary delay of bedtime by 30 minute increments until the child appears sleepy, so that they experience falling asleep more quickly once they get into bed. The bedtime should then be gradually advanced earlier until the desired bed time is reached.

15. Keep a sleep diary to keep track of naps, sleep times and activities to find patterns and target problem areas when things are not working.

Robert Hilt, MD
Primary reference: A Clinical Guide to Pediatric Sleep by Jodi Mindell and Judith Owens