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Virginia Chapter
Incorporated in Virginia
American Academy of Pediatrics

VIRGINIA MENTAL HEALTH ACCESS PROGRAM

Guide for Promoting Child and Adolescent Behavioral and Mental Health in Primary Care

VERSION 2.0

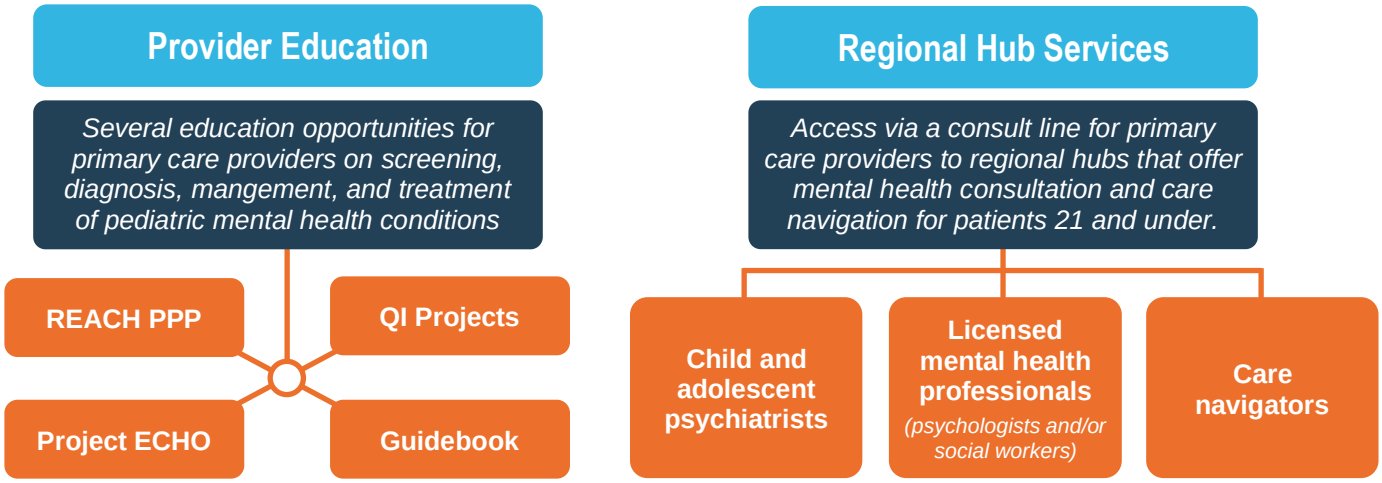
VMAP

What is VMAP?

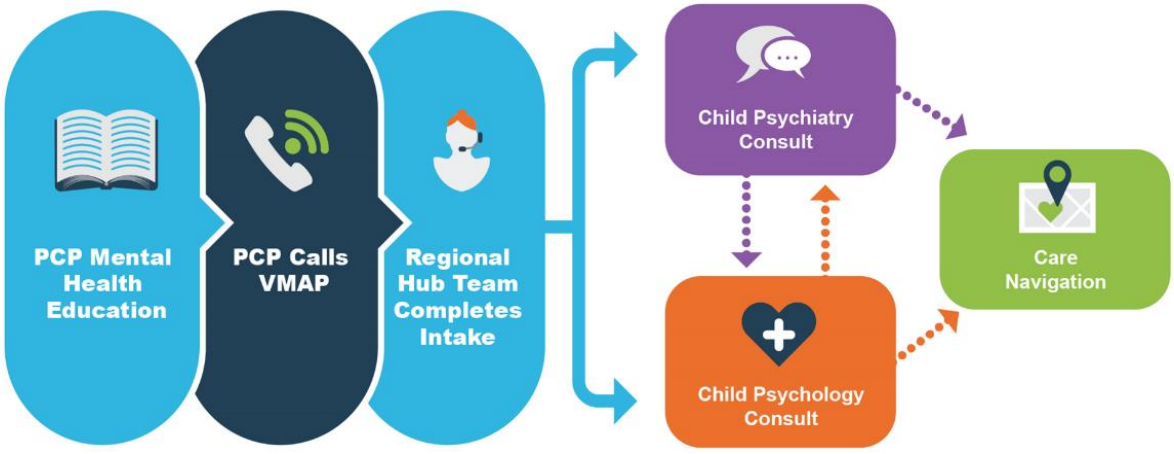
The **Virginia Mental Health Access Program (VMAP)** is a statewide initiative to support primary care providers in meeting the increased needs of children and adolescents with mental health conditions through both increasing provider educational opportunities and provider access to child psychiatrists, psychologists, social workers, and care navigators.

WHAT VMAP DOES

VMAP ensures that more children in the Commonwealth have increased access to screening, diagnosis, management, and treatment of mental health needs. This is accomplished through primary care provider education and expert consultation and care navigation.



HOW DOES VMAP WORK?



HOW CAN I GET STARTED WITH VMAP?

If you're a primary care provider caring for Virginia pediatric patients aged 0 to 21, we're open for your calls and invite you to participate in our educational offerings! Register at vmap.org

PCP Call Line: (888) 371-VMAP (8627) or request a consult at bit.ly/VMAP-Consult

Monday to Friday, 9 am to 5 pm

vmap.org

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Acknowledgements & Gratitude

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Methods & Peer Review

The *Virginia Mental Health Access Program Guide for Promoting Child and Adolescent Behavioral and Mental Health in Primary Care* ("VMAP Guidebook") is informed by up-to-date evidence-based mental health assessment and treatments in children, as well as practical experience of primary care providers. It is developed to offer a synopsis of current knowledge into focused actions and knowledge points practical for the primary care provider. The guidance presented may serve as an accompaniment to provider consultation and provider education available through VMAP.

This guide has utilized peer review from a variety of mental health experts and has benefited from the guidance of statewide entities, including VMAP, the Virginia Department of Behavioral Health and Developmental Services, the Virginia Department of Health, the Virginia Department of Medical Assistance Services, the Medical Society of Virginia, and the Virginia Chapter of the American Academy of Pediatrics.

Virginia subject matter experts drafted initial section-specific topics and received multiple peer review edits, as identified in the contributor listing. Peer reviewers were tasked with verifying the validity of the information and guiding the content of the final product.

Screening tools, scales, resources, and patient/caregiver handout information chosen for inclusion in the guide was selected based on the clinical experiences of editors, contributors, and reviewers.

The process of developing practice pathways included in the care guides was based on the practical experience of subject matter experts, review of current literature and relevant practice guidelines, and the recommendations of the VMAP Education Advisory Group.

Medication advice and dosing was established by pharmacy and VMAP child psychiatry consultation providers, as well as up-to-date medical guidance in the literature and national publications (including American Academy of Child and Adolescent Psychiatry medication guidance). *Note: all medication information should be verified using current PDR.*

Evidence-based behavioral intervention recommendations were developed and reviewed by pediatric psychologists, LCSWs, and other contributors, in addition to established guidance maintained by the Commonwealth of Virginia Commission on Youth as identified in its *Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs.*

This guide will evolve in the coming years. Future editions may cover additional topics in child health, as well as additional tools and resources.

As a practicing primary care provider, you are part of the peer review process. To suggest topics for future editions or specific edits, visit vmap.org/guidebook.

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This resource of the Virginia Mental Health Access Program (VMAP) is being made available by the Medical Society of Virginia Foundation (MSVF) to the general public and is for informational purposes only. The views expressed in this resource should not necessarily be construed to be the views or policy of MSVF, the Virginia Chapter of the American Academy of Pediatrics, or any partners in this work.

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In addition, this resource is not a substitute for the exercise of providers' independent professional judgment, which shall be exercised in the sole discretion of the provider.

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1.1 How to Use This Guide

The Virginia Mental Health Access Program (VMAP) is a statewide initiative to support and guide health care providers in their primary care of children and adolescents with mental health conditions. This guidebook is developed to supplement VMAP psychiatric consultation and other educational activities and resources.

WHAT THIS GUIDE IS AND IS NOT…

This guide **IS** a just-in-time resource for pediatric primary care providers (PCPs) to access when a "how to" question arises — how to recognize, how to assess, how to refer, how to support the patient and family with resources and education. It is a compilation of evidence-based practices, up-to-date resources, and practical knowledge.

This guide **IS NOT** intended to represent or establish a standard of care. It is not an exhaustive or comprehensive resource. It is intended to be used in collaboration with provider experience, education, and specialty consultation.

This guide **IS** another tool for the PCP's toolbox. It can help point the PCP and their team in the right direction.

HOW THIS GUIDE IS ORGANIZED…

- **Section 1: Pediatric and Adolescent Mental Health in Primary Care**
  Foundational materials, including one-page tools that can serve as just-in-time resources in busy office practices.
- **Section 2: Child Mental Health Care in Virginia**
  A quick overview and listing of Virginia-specific resources for pediatric patients with mental health conditions and their caregivers.
- **Section 3: VMAP Care Guides**
  Each Care Guide is organized with a suggested decision-making pathway for a specific concern or diagnosis, a free screener for the topic, summary of evidence-based behavioral interventions, summary of medication guidance, provider tips, and family resources. These modules can be downloaded individually or as the whole section.
- **Section 4: Building Competency in Caring for Important Populations**
  Considerations and perspectives for ensuring care meets the specific needs of an individual and their caregivers.

Pages bordered in green are available as downloadable handouts at vmap.org/guidebook

HOW TO USE THIS GUIDE…

Print it out in its entirety, or download and keep it handy. Individual handouts, many in multiple languages, and modules are available at vmap.org/guidebook. *Note that the embedded links work best when downloaded as a whole guide versus individual modules.*

It can be difficult to incorporate this information into busy practices serving a vast array of patient needs. Here are some tips that have worked for others:

- Maintain an easily accessible accordion file with preprinted screening tools in each exam room.
- Develop a protocol for safety planning — who in the practice will do what and under what conditions.
- Print out the embedded one-page handouts and make accessible to families.
- Remember that VMAP is an EVERY DAY resource. Schedule a consult with a pediatric mental health expert at vmap.org.

WHAT'S NEXT…

This guide will be updated every one to two years. Future iterations of this guide will include additional topics and resources, and will be available in additional formats and languages. Have an idea? We're here to help: vmap.org.

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1.2 Why and How to Do Assessments

THE PRIMARY CARE MENTAL HEALTH ASSESSMENT OF CHILDREN AND ADOLESCENTS

WHY is it important to BOOST primary care visits with mental health strategies?

- 10 to 15% of children/youth have an impairing mental health disorder (but 85 to 90% don't!).
- 2 out of 3 children/youth with significant mental health problems are NOT recognized by their parents, teachers, or health care providers.
- 90% of youth who commit suicide have a mental health disorder.
- PCPs are trained to be FIRST AND FREQUENT health care providers, and offer a trust-filled continuum of care for children/youth and can integrate individual/family strengths and recognize risk factors (ACES, SDOH).

BEFORE the visit

1. Do you use a **Behavioral Health Questionnaire**?
2. Access completed **general mental health screening tools**, such as:
   - Pediatric Symptom Checklist-17 (PSC-17) for ages 4 to 17 (parent and child forms)
   - Early Childhood Screening Assessment (ECSA) for ages 2 to 6 (parent form)
3. Consider using the **Mental Health Card** for interview of patient/caregiver.
4. Be ready to explain to caregiver that recognizing and responding to mental health problems often takes more than one visit.
5. Be ready to offer a follow-up appointment (e.g., end of day, one day next week) to move from general assessment to more specific assessment/recommendations found in each care guide.

THE 4 Rs DURING THE VISIT: RECOGNIZE, RESPOND, (KNOW YOUR) RESOURCES, REFER

Recognize: Children present to clinicians with a wide range of somatic complaints or behaviors that may be linked to mental health concerns. Learning the important questions to ask is also part of the RECOGNIZE step.

Respond: Use of broad-range and/or specific screening tools IS a respectful response to listening carefully to patient/family concerns and determining the degree of mental health distress. Discussing settings where problems are most concerning and helping to identify if patient and family is safe IS a form of response. At the provider level, determining degree of distress is part of the RESPOND step (mild/moderate/severe). Reviewing ways to optimize safety, sleep, eating, screen time, schedules, and exercise are first steps toward improvement.

Resources: When level of distress is more than MILD, usually a PCP needs collateral information and community resources. Have contact or referral forms for common local support systems.

Refer: Knowing when to refer a patient to the next level of care or when to seek additional consultation. For mental health problems, this step often centers on the provider, family and patient concerns for safety. Fortunately, we now have VMAP for psychiatry and licensed mental health provider consultation and care navigation support.

VMAP PCP Call Line: (888) 371-VMAP (8627)
vmap.org

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DURING THE VISIT: THE 4 Rs
SUGGESTED WORKFLOW BY PATIENT AGE

Take advantage of time BEFORE the visit; using a tool, like the provided sample BHQ, can help gather important information to review during the visit

	0—5 Years	6—11 Years	12 Years and Older
Before the Visit	Behavioral Health Questionnaire (BHQ)	Consider BHQ, Parent PSC-17	Consider BHQ, Youth PSC-17
Structure of Visit	• Observe caregiver-child interaction	• Caregiver-child interview • Then optional 5 min with child alone	• Youth interview • Then caregiver interview
Recognize **using the Mental Health Card**	• Behaviors (e.g., anger, aggression, avoidance) driven by emotions, thoughts • Ask clarifying questions (**ABCs***) • Safety in home? • Determine severity of symptoms	• Externalizing, internalizing, or both? • Safety concerns? • Impairing at home/school? • Determine severity of symptoms	• Use **HEEADDSSSSSS*** • Safety, SI, NSSI, CRAFFT, aggression? • School problems? • Determine severity of symptoms
Respond **see table of screening tools that follows**	• Screen for ACEs, SDOH, ECSA, parental depression, M-CHAT-R/F, general development; see *Bright Futures* for guidance • Optimize sleep, eating, caregiving • Review BHQ and screen • Offer **HELLPPP*** • Discuss specific interventions next visit	• Specific rating scales? • Review BHQ and screen; see *Bright Futures* for guidance • Gather collateral information • Optimize sleep, eating, screen time, exercise • Discuss specific interventions next visit	• Youth PHQ-A • Specific rating scales? • Gather collateral info • Review BHQ and screen; see *Bright Futures* for guidance • Optimize sleep, eating, screen time, exercise • Discuss specific interventions next visit
Know local, age-specific Resources	• Infant Toddler Connection (0-3) • Early Childhood Special Ed (2-5) • Head Start (3-5)	• IEP? School counselor? • Offer self- and caregiver-led resources or training	• IEP? School counselor? • Offer self- and caregiver-led resources or training
When to Refer	If UNSAFE BEHAVIORS or severe mental health problem	If UNSAFE BEHAVIORS or severe mental health problem	If UNSAFE BEHAVIORS or screen positive for SI or severe mental health problem

Glossary of Terms

ACEs = Adverse Childhood Experiences

SDOH = Social Determinants of Health

IEP = Individualized Education Plan

SI = suicidal ideation

NSSI = non-suicidal self-injury

*Mnemonic Definitions

ABCs

Antecedent
Behavior
Consequence

HELLPPP

Hope
Empathy
Language
Loyalty
Permission
Partnership
Plan

HEEADDSSSSSS

Home
Education, **E**ating
Activities
Drugs, **D**epression
Sex, **S**exuality
Self-harm, **S**uicidality
Safety, **S**ocial media

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BEHAVIORAL HEALTH CAREGIVER QUESTIONNAIRE

By completing this form, you are providing important information that will allow us to focus on your primary concerns during today's visit and also archive past medical history for future visits. If you do not know the answer to any of the questions below, please note with "?". Thank you for taking the time to provide this information.

Background Information

Child's name: _____ Age: _____ Today's date: _____

Name of person completing this form: _____ Relationship to child: _____

Primary Concerns

Please list the concerns you have about this child, with highest concern listed first.

Concern 1: _____

Concern 2: _____

Concern 3: _____

Birth History

Where was this child born?

How much did this child weigh at birth? _____ pounds _____ ounces Length of pregnancy? _____ weeks

Did the mother use any substances or medications during the pregnancy? *(Check all that apply)*

☐ Beer / Wine ☐ Tobacco ☐ Vaping ☐ Alcohol ☐ Marijuana ☐ Methamphetamine (Crystal / Ice)

☐ Cocaine ☐ Other _____ ☐ Any prescription medication _____

Were there any problems during pregnancy? ☐ Yes ☐ No ☐ ? ☐ Specify: _____

Were there any problems during labor / delivery? ☐ Yes ☐ No ☐ ? ☐ Specify: _____

Was this child born by Caesarean / C-Section? ☐ Yes — planned ☐ Yes — emergency ☐ No ☐ ?

Did this child remain in the NICU for any problems after birth? ☐ Yes ☐ No ☐ ? ☐ Specify: _____

Was this child:

- Sitting up by 8 months? ☐ Yes ☐ No ☐ ?
- Walking by 15 months? ☐ Yes ☐ No ☐ ?
- Using 2-word phrases by 2 years? ☐ Yes ☐ No ☐ ?
- Speaking so strangers could understand by 3 years? ☐ Yes ☐ No ☐ ?
- Staying dry during the day by 4 years? ☐ Yes ☐ No ☐ ?
- Reading simple words by 6 years? ☐ Yes ☐ No ☐ ?

Was this child adopted? ☐ Yes ☐ No ☐ ?

Is this child in foster care? ☐ Yes ☐ No ☐ ?

Health History

Any major health problems? ☐ Yes ☐ No ☐ ?

Any hospitalizations? ☐ Yes ☐ No ☐ ?

Any surgery? *(including sedated dental, ear tubes)* ☐ Yes ☐ No ☐ ?

Any head injury, loss of consciousness? ☐ Yes ☐ No ☐ ?

Any vision or hearing loss? ☐ Yes ☐ No ☐ ?

Any seizures? ☐ Yes ☐ No ☐ ?

Any heart-related problems? ☐ Yes ☐ No ☐ ?

Any serious or chronic illness or injury? *(including poisoning, ingestion)* ☐ Yes ☐ No ☐ ? Specify: _____

Strengths

What are strengths you see in this child? _____

What are your goals for this child? _____

Medications

Please list all medications this child currently takes (including vitamins / supplements):

_____ _____

_____ _____

_____ _____

School Information *(if over 3 years of age)*

Current school: _____ Length of time at this school: _____ Current grade: _____

Has this child:

- Repeated a grade? ☐ Yes ☐ No ☐ ?
- Received special education services? ☐ IEP ☐ 504 Plan ☐ Yes ☐ No ☐ ?
- Received disciplinary action? *(detention/suspension/expulsion)* ☐ Yes ☐ No ☐ ?

Family Mental Health History

Have any of the child's biological relatives experienced: *(Check one)*	If yes, how is the person related to this child?
ADHD / ADD *(attention problems)* ☐ Yes ☐ No ☐ ?	
Learning or reading disability ☐ Yes ☐ No ☐ ?	
Anxiety ☐ Yes ☐ No ☐ ?	
Depression ☐ Yes ☐ No ☐ ?	
Suicide ☐ Yes ☐ No ☐ ?	
Bipolar Disorder / Manic Depression ☐ Yes ☐ No ☐ ?	
Autism Spectrum Disorder ☐ Yes ☐ No ☐ ?	
Other developmental delays or genetic condition ☐ Yes ☐ No ☐ ?	
Schizophrenia / Psychosis ☐ Yes ☐ No ☐ ?	
Alcohol / Substance use problems ☐ Yes ☐ No ☐ ?	
Incarceration *(biological parent only)* ☐ Yes ☐ No ☐ ?	
Eating disorder ☐ Yes ☐ No ☐ ?	
Tics or Tourette syndrome ☐ Yes ☐ No ☐ ?	

Child Mental Health History

Has this child ever had a mental health diagnosis?	☐ Yes ☐ No ☐ ?	Specify: _____
Who diagnosed this condition? _____		When? _____
Has this child ever taken medications for mental/behavioral/emotional concerns?	☐ Yes ☐ No ☐ ?	Specify: _____
Has this child ever received mental health counseling?	☐ Yes ☐ No ☐ ?	Specify: _____

Cultural History

Does child hear more than one language at home?	☐ Yes ☐ No ☐ ? If yes, specify: _____
Has child experienced discrimination, racism, or other disadvantage?	☐ Yes ☐ No ☐ ?
Has child had housing or food insecurity?	☐ Yes ☐ No ☐ ?

Social History

Please list all people currently living in the household with this child:

Name	Relationship to Child	Age	Education (adults)	Employment (adults)

Are there any immediate family members who do not live with this child (biological mother/father or siblings)? ☐ Yes ☐ No

The child's biological parents are currently (please check one):

☐ married to each other ☐ divorced from each other ☐ never married to each other

☐ separated from each other ☐ deceased ☐ don't know/other:_____

Have there been any major changes or stresses in this child's life, especially in the last 6 months (e.g., marital problems, a move, change of school, birth of a brother/sister, death of a pet)? ☐ Yes ☐ No

If yes, please specify: _____

Has this child experienced or seen any traumatic events (e.g., domestic violence, physical or sexual abuse, other violence, bullying, natural disaster, separation from primary caregiver for more than 1 month) that you would like to discuss? ☐ Yes ☐ No

If yes, please specify: _____

Would you like to discuss these issues separate from child? ☐ Yes ☐ No

Are there any major changes or stresses expected in the near future? ☐ Yes ☐ No

If yes, please specify: _____

Has CPS ever been involved with your family? ☐ Yes ☐ No

If yes, please specify: _____

Comments: Is there anything else you want to share that is not already listed here?

1.3 Table of Screening Tools and Rating Scales

GENERAL SCREENING TOOLS AND RATING SCALES REFERENCED IN CARE GUIDES							
Tool or Scale		**Focus**	**Ages**	**Reporters**	**Length**	**Notes**	**Languages**
PSC-17	Pediatric Symptom Checklist	Attention, internalizing, externalizing behaviors	4-17 yrs	Parent/Caregiver Youth ≥ 11 yrs	17 items <5 min Scoring: 2 min	Best if parent completes.	numerous
BPSC	SWYC: Baby Pediatric Symptom Checklist	Social-emotional health, behavior	up to 18 mths	Parent/Caregiver	12 items 5 min	NEW!	English, Spanish, Khmer, Burmese, Nepali, Portuguese, Haitian-Creole, Arabic, Somali, Vietnamese
PPSC	SWYC: Preschool Pediatric Symptom Checklist		18-65 mths	Parent/Caregiver	18 items 5 min	NEW!	
SWYC	Survey of Well-being of Young Children	Cognitive, language, and motor development	up to 65 mths	Parent/Caregiver	10 items 5 min	Age-specific forms. Training resources available.	
ECSA + Brief ECSA	Early Childhood Screening Assessment	Emotional and behavioral development, caregiver distress	18-60 mths	Parent/Caregiver	40 items Brief = 22 items 5-10 min Scoring: <1 min	Addresses parent stress and child behaviors.	English, Spanish, Romanian
FOCUSED SCREENING TOOLS AND RATING SCALES (embedded in care guides)							
Tool or Scale		**Focus**	**Ages**	**Reporters**	**Length**	**Notes**	**Languages**
SMFQ	Short Mood and Feelings Questionnaire	**Depression**	≥ 6 yrs	Patient Parent/Caregiver	13 items <5 min		numerous
ASQ **Suicide Risk**	Ask Suicide-Screening Questions	**Suicidality**	10-24 yrs	HCP administers	4 items 20 seconds	See toolkit for scripts, follow-up, etc.	numerous
SCARED + SCARED brief	Screen for Childhood Anxiety Related Emotional Disorders	**Anxiety** **PTSD**	≥ 8 yrs	Patient Parent/Caregiver	41 items 5 min Scoring: 1-2 min		numerous

(Table continues on the next page)

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FOCUSED SCREENING TOOLS AND RATING SCALES (embedded in care guides)							
Tool or Scale		**Focus**	**Ages**	**Reporters**	**Length**	**Notes**	**Languages**
PHQ-9 + PHQ-A	Patient Health Questionnaire-9 + PHQ-9 Modified for Teens	**Depression, Maternal Depression**	11-17 yrs	Parent/Caregiver	9 items <5 min Scoring: <3 min	Can be administered by provider. Can be used for initial and monitoring decision making.	numerous
GAD-7	General Anxiety Disorder 7-item	**Anxiety**	11-17 yrs	Patient	7 items + 1 if (+) ≤7 min		numerous
CATS	Child and Adolescent Trauma Screen	**Trauma**	Caregiver: 3-17 yrs Self-report: 7-17 yrs	Patient Parent/Caregiver	10 min Scoring: <1 min		Spanish German, Norwegian, Swedish, Arabic, Dari, Farsi, Paschtu, Tigrinya, Turkish available by request
Vanderbilt	Vanderbilt ADHD Diagnostic Rating Scale	**ADHD**	6-12 yrs	Parent/Caregiver Teacher	Two-sided 5-10 min Scoring: 3-4 min	Symptoms and impairment assessed.	Spanish — parent Spanish — teacher
Prime-PC	PRIME Early Psychosis Screening Test	**Psychosis**	12-25 yrs	Patient	12 items Scoring: 3-4 min		
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble	**Substance use**	12-21 yrs	HCP administers	4-9 items 1-2 min if responses negative	Provider administers. Very helpful administration guidance and scripts available at crafft.org/.	numerous
SCOFF	Sick, Control, One, Fat, Food	**Eating disorder**	11+ yrs	Patient	5 items 1 min Scoring: 1 min	Provider administers.	
EAT-26	Eating Attitudes Test	**Eating disorder**	Adolescents and Adults	Patient	26+ items 2 min		
BEARS	BEARS Sleep Screening Tool	**Sleep**	2-12 yrs	Patient Parent/Caregiver	5 items 5 min	B = bedtime issues E = excessive daytime sleepiness A = night awakenings R = regularity and duration of sleep S = snoring	

(Table continues on the next page)

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OTHER SCREENING TOOLS AND RATING SCALES							
Tool or Scale		Focus	Ages	Reporters	Length	Notes	Languages
AIMS	Abnormal Involuntary Movement Scale	Observing and documenting drug-induced involuntary movement	All	HCP administers	5 min	Administer q 6 months when patients are on anti-psychotics.	
Columbia	Columbia-Suicide Severity Rating Scale	Suicide risk	Adolescents	Patient	6 items 5 min	Requires training to administer.	
EPDS	Edinburgh Postnatal Depression Scale	Maternal depression	Peripartum women	Parent/Caregiver	10 items <5 min Scoring: 5 min		numerous
M-CHAT-R/F	Modified Checklist for Autism in Toddlers	Autism	16-30 mths	Parent/Caregiver	20 items 5-10 min Scoring: 5 min	Includes follow-up questions when moderate risk is present.	numerous
SEEK	A Safe Environment for Every Kid Questionnaire	Maternal depression, SDOH	0-5 yrs	Parent/Caregiver	15 items 2 min Scoring: <1 min	Affirmative answer warrants follow-up. Caregiver handouts available in English and Spanish.	English, Spanish, Italian, Chinese, Portugue, French, Nepali
Spence	The Spence Children's and Preschool Anxiety Scales	Anxiety — preschool Anxiety — children	Preschool and Children	Patient Parent/Caregiver Teacher	28 items (preschool) 44 items (children) 10 min		numerous
Y-BOCS	Yale-Brown Obsessive Compulsive Scale	Obsessive Compulsive Disorder symptoms	6-17 yrs	Parent and child	Checklist and semi-structured interview	Provider administers. Rates symptom severity; not a diagnosis.	

SDOH: Social Determinants of Health

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1.4 Mental Health Card

CHIEF CONCERN
If not specific, consider starting with school and social history, or use a general screener like PSC-17 or ECSA

SYMPTOM-SPECIFIC HISTORY
Description: What is it? Get concrete examples, including **OPQRST**

- **O:** ONSET
- **P:** PALLIATIVE and PRECIPITATING factors — What triggers it?
- **Q:** QUALITY — What does it look like? Specific behaviors (talking back, verbal aggression, physical aggression)?
- **R:** RELATIONSHIPS and REGION — What contexts (relationships and places) do the behaviors happen in?
- **S:** SEVERITY — level of intensity, risk of injury, actual injury
- **T:** TIMING — time of day, days of week, duration of the behavioral events

Response:

- How do you deal with it?
- Is there anything that YOU do that makes it better?
  - Adaptive skills?
  - ETOH? Self-medicating?
- Is there anything that YOU do that makes it worse?

Impairment:

- Tell me how bad it gets/got… describe it to me (time, place, situation)
- What's the worst it ever got?
  - Depression?
  - Suicidal thoughts?
  - Aggression?
- What does it stop you from doing?

Safety:

- Danger to self or others? If YES, address degree of risk and SAFETY PLAN

REVIEW OF SYSTEMS (e.g., mood, sleep, appetite, energy, concentration, anxiety, aggression, etc.)

BIRTH, DEVELOPMENTAL, AND BEHAVIORAL HISTORY

RELEVANT MEDICAL HISTORY
- include cardiac history, seizures, vision or hearing loss, concussion, meds/OTC

SCHOOL HISTORY
- Academics? Behavior? Extra services? Recent changes?
- May need to get parental permission to communicate with school

SOCIAL HISTORY
- Living environment
- **Trauma history (ACEs)**, including witnessed domestic violence
- Friends (changes, new, withdrawal, bullying)
- Substance use
- Functioning, strengths, interests, goals

TARGETED FAMILY HISTORY

LAB VALUES/SCREENING OR RATING TOOLS

ASSESSMENT/DIAGNOSIS (Mild, Moderate, Severe symptoms)

TREATMENT OPTIONS (consider guidelines for decision making)

Adapted from the VMAP REACH Training materials.

To learn more about REACH and register for this in-depth learning experience, visit vmap.org/reach.

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ANXIETY

Presenting Concerns:
- Chest pain, shortness of breath/trouble breathing, racing heart
- Headache, dizziness
- Nausea, abdominal pain
- Change in school performance

PSC-17 (General) **SCARED** or **GAD-7** (Focused)

Treatment Options:
Psycho-education, environmental changes, active monitoring with reassurance/counseling; Medication; Referral (for CBT and/or meds)

Additional considerations: Dealing with anxious parents; developmental issues, specifically speech and language deficits. Context specific: consider social phobia. Intermittent and episodic: consider panic. **Consider:** Sleep. Eating Disorder. ACEs. NSSI. SI. Autism.

Differential:
- Medical causes (thyroid, cardiac, migraine)
- Abuse/threatening environment/bullying
- Substance use
- Depression
- Adjustment disorder
- Medication side effects (stimulants, withdrawal)
- Caffeine
- Pregnancy
- Autism

Anxiety Questions: (for kids)
- Do you worry a lot? Do you think about scary things a lot? Can you stop?
- Do you get sleepy, feel like you've got to move around a lot, or have trouble paying attention when you're supposed to?
- Have you ever gotten really scared all of a sudden when there isn't anything scary around? (trouble breathing? heart pounding? shaking? sweaty palms?)
- Do you stay away from people or things because you're afraid or worried?

AGGRESSION (Young child ≤10)
(Youth ≥11, coming soon)

Presenting Concerns:
- Aggressive behavior (property damage, hurting others)
- Dysregulated anger, severe irritability
- Defiance

PSC-17 (General) **ECSA or PPSC** (2-5 years, General)
Vanderbilt (Focused) Request **School Functional Behavioral Assessment**

Treatment Options:
- Treat primary mental health disorder and optimize sleep
- Behavioral interventions — supervision and structure first
- Assess patient response
- Continue psychosocial tx even if medication initiated
- If response to above limited, consider atypical antipsychotic
- Consider referral to mental health professional

Differential:
- ADHD
- Adjustment
- Oppositional Defiant Disorder
- Major Depressive Disorder (MDD)
- Anxiety
- Posttraumatic Stress Disorder (PTSD)
- Autism
- Medical causes
- Medication side effect
- Psychosocial
- Abuse/bullying/ACEs

Aggression Questions: (for parent and child)
- **O:** Onset
- **P:** Palliative and Precipitating factors — *What triggers it?*
- **Q:** Quality — *What does it look like? Specific behaviors (talking back, verbal aggression, physical aggression)?*
- **R:** Relationships and Region — *What contexts (relationships and places) do the behaviors happen in?*
- **S:** Severity — *Level of intensity, risk of injury, actual injury*
- **T:** Timing — *Time of day, days of week, duration of the behavioral events*
- What is the last time that you got very angry? What happened?
- What's the angriest you ever got?
- What's the worst fight you ever got into?
- Are you so angry at ____ that you want to hurt him/her now? Do you plan to?
- Have you ever done anything to hurt yourself?
- Do you want to hurt yourself right now? How about anyone else?
- Have you ever stolen property? Have you broken things or destroyed property?

DEPRESSION

Presenting Concerns:
- Sadness
- Parent-child conflict
- Irritability
- School problems
- Stomachaches, fatigue, increased sleep

PSC-17 (General) **SCARED** or **GAD-7** (Focused)
SMFQ (Focused) **ASQ** (if suicidal ideation)

Treatment Options:
Cognitive behavioral therapy; interpersonal therapy for adolescents; SSRIs; if severe — ER.

Additional considerations: Suicide risk and assessment. Co-occuring substance use or anxiety common. Gender and/or sexuality issues. Eating disorder. Sleep, exercise. Family history.

Differential:
- Medical: thyroid, acquired brain injury, pregnancy, EBV
- Trauma/abuse/ACEs
- Substance use
- Anxiety, DMDD
- Bereavement/grief

Depression Questions: (SIGECAPS)
- How has your mood been lately? **OR** Do you ever feel down, depressed, or blue? Have little things made you angry?
- How have you been **sleeping**? Compared to normal?
- Have you lost **interest** in usual things you used to enjoy?
- Are you feeling **guilty** or blaming yourself for things?
- Have you noticed a decrease in your **energy** level?
- Have you been having trouble **concentrating**?
- Has there been any change in your **appetite** or weight?
- **Psychomotor**: Have you been feeling fidgety or had problems sitting still?
- Have you felt slowed down, like moving in slow motion or stuck in mud?
- **SI:** Have you felt that life is not worth living or that you'd be better off dead?
- Sometimes when a person feels down or depressed they might think about dying. Have you been having any thoughts like that?
- How would you describe yourself to someone you had never met before?

ADHD

Presenting Concerns:
- Inattention/short attention span
- Motor hyperactivity
- Impulsivity, risk-taking
- Aggression, irritability, defiance
- Poor school performance

PSC-17 (General) **ECSA** (General)
Vanderbilt (Focused) **GATHER COLLATERAL INFORMATION**

Treatment Options:
- Parent activation in chronic illness model
- Parent Behavior Management Training
- Medication (stimulants, ATX, etc.)
- Behavioral methods, parent support groups, daily report card

Additional considerations:
- CBC with differential, iron panel including ferritin, Lead (Pb) level
- History of concussion
- Family history of ADHD
- Tics
- Cardiac conditions

Differential:
- Learning disability
- Hearing, vision problems
- Anxiety disorders, incl. PTSD
- Depressive disorders
- Medication side effects (anti-asthmatics)
- Trauma, deprivation, abuse, neglect
- Acquired brain injury
- Seizure disorder

ADHD Questions:
- Ever pay really good attention?
- When, where, why, and for how long?
- Does well in some classes but not others?
- For some teachers but not others?
- Able to complete homework?
- Listen to or read a storybook?
- How about home vs. school, or caregiver specific?
- How about for something fun, like a game?

Adapted from the VMAP REACH Training materials.
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1.5 Culture and Mental Health Care

One's culture, values, race, language, and religious beliefs affect how one perceives and experiences both physical and mental health. Cultural beliefs can influence how medical advice is perceived, what treatments are accepted, and future compliance. It is essential that culture, race, language, and religion are addressed when mental health care is discussed. Tailoring mental health care to each individual patient while considering cultural beliefs has been shown to improve outcomes.

IMPORTANT DEFINITIONS

- **Culture:** Integrated pattern of human behaviors including thoughts, communication, actions, customs, beliefs, values; can include racial, ethnic, religious, and social constructs
- **Ethnicity:** Historical or geographic heritage shared by a group of people
- **Race:** Social classification system based on external physical characteristic
- **Acculturation**: Process of assimilation to a culture, typically the dominant one or the majority
- **Immigrant:** Someone who comes to live permanently in a foreign country
- **Refugee:** Someone who has been forced to leave their country in order to escape war, persecution, or natural disaster
- **Cultural Competence:** Set of behaviors, attitudes and polices found in a system which allows professionals to work within the context of cultural differences
- **Cultural Humility:** A process of reflection and lifelong inquiry which involves self-awareness of one's own personal biases, with awareness and sensitivity to the cultural differences of others

CULTURAL CONTRIBUTORS AND CONSIDERATIONS

- **Stigma of discussing/addressing mental health conditions**
- **Mental health viewed differently than physical health/ailments**
- **Unconscious bias on the part of the health care provider**
  - Importance of keeping an open mind and exhibiting humble curiosity can help build rapport
- **Cultural bias**
  - Mental health/ailments viewed as *not real* or a *weakness*
  - Mental health/ailments can be described as a somatic symptom
  - Fear of child getting "labeled"
- **Religious beliefs**
  - Medication not needed, healing through rituals
- **Familial**
  - Role of the father or eldest male when addressing patient or family
  - Patriarchal hierarchy or matriarchal hierarchy

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- **Linguistic barriers**
  - Certain languages may describe mental health conditions differently (i.e., mal de nervios)
  - Certain languages do not have words that correlate to the words used in the English language to describe mental health ailments (i.e., Urdu, Hindi)
- **Gender**
  - Must consider gender of provider when discussing sensitive health information. In some cultures:
    - A male health care provider may not be permitted to discuss or examine a female patient
    - A female health care provider may be viewed with less respect or viewed as less knowledgeable by male patient
  - Must be aware of gender of translator (electronic and in-person) who will also be in the exam room
    - Family members should not serve as interpreters
    - If possible, ask patient/caregiver their comfort level with available interpreter
- **Immigrant experiences of parents**
  - Mental health may be viewed as less important than physical health
  - Due to sacrifices of immigrant parents, children are often not allowed to *feel sad/bad*
  - What the children may be experiencing is *not as bad* as what parents have experienced previously
  - Children may feel guilty and/or ungrateful
- **Traumatic events**
  - Awareness of traumatic events experienced in the immigration journey
    - Approaching these families with a trauma-informed perspective
  - Fear on the part of the patient and/or caregiver may prevent engagement/honesty with the health care provider
  - Discuss how their child has acclimated to a new country and environment. Doing so gives the caregiver an opportunity to verbalize their concerns about their child and the challenges they face.
- **Generational trauma**
  - Oftentimes unrecognized in patient care; also referred to as intergenerational or transgenerational trauma
  - Used to describe the impact of a traumatic experience not on just one generation but on subsequent generations after the event
  - Common symptoms include low self-esteem, anger, insomnia, depression, anxiety
  - Should be considered when working with immigrant and refugee families

Awareness of current events and cultural experiences is important when working with immigrant and refugee families, as well as those who identify as BIPOC (Black, Indigenous, and People of Color)

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CULTURALLY APPROPRIATE CARE: THINGS TO CONSIDER

Printed materials (handouts, intake sheets, patient information, flyers/posters)

- Literacy levels
  - Patient education materials should be at a 6th grade or lower reading level
  - Visual representations may be helpful for those with limited literacy
- Culturally appropriate
  - Documents should not be a strict translation from English
  - Translation should account for cultural nuances and linguistic differences

Interpreter services

- Culturally appropriate
- Gender considerations
  - In-person vs. virtual vs. telephonic
- There can be differences in terms used and differences in accents
  - It is important to explore vague terms until provider has a clear understanding of what is being described
  - Example: “falling out” can have a variety of cultural contexts and meanings

Cultural differences

- Consider usage of terms based on dialect, or geographic, or regional differences
  - Important to explore unclear terms to understand what is being described by patient/caregiver
- Gender considerations
- In-person vs. virtual vs. telephonic

A shared language does not mean the cultural beliefs and values are the same between patients.

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THE 4 Cs OF CULTURE

1. What do you **CALL** the problem?
   - Ask patient what they are concerned or fearful about the condition and/or treatment. This can be helpful with starting the conversation and establishing rapport.
   - Ask patient what they think is wrong. Ask for their understanding of the disease, treatment plan, etc.
   - Similar symptoms can have different meanings in different cultures, affecting compliance with treatment.
2. What do you think **CAUSED** the problem?
   - Ask patient what they believe is the source of the problem. Ask what they think would address the problem.
   - Important to consider that if the patient does not believe the cause is addressed and treated, patient may feel that they have not been cured.
3. How do you **COPE** with the condition?
   - Ask the patient what they have done to help them feel better.
   - Physician must ask in non-judgmental manner so patient feels safe to tell them of any treatments/medications that can interact with further medical treatment.
4. What **CONCERNS** do you have about the condition and treatment?
   - Ask patient what they are concerned or fearful about the condition and/or treatment.
   - Ask patient what brought them to the doctor: were they referred or did they notice a problem and wanted to be seen?
   - This will lead to improved compliance by addressing their concerns in a way that addresses their cultural beliefs.

TREATMENT CONSIDERATIONS

- Cultural beliefs and values
- Behavioral management therapies, and other remedies such as herbal supplements that incorporate cultural values and beliefs
- Involving local communities
  - Are cultural navigators, religious leaders, or local trusted medical providers present?
  - Allows for cultural values, religious beliefs, and linguistic barriers to be considered
- Who to involve in treatment plan
  - Parents/caregivers/guardians
    - Considerations for elderly family members, patriarchal society
  - Religious leaders, if appropriate
  - Joint family system, extended family
    - Consider household structure

PROVIDER RESOURCES

- AAP Culturally Effective Care Toolkit (aap.org): practice management tool to help clinicians learn more about providing culturally effective care to their patients and families
- DSM-5 Cultural Formation Interview (apa.org): interview tool that asks questions about cultural identity, explanations of illness, and queries for cultural factors related to psychosocial environment and level of functioning
- EthnoMed: offers information about cultural beliefs, medical issues, and other topics relevant to the health care of US immigrants, including refugees fleeing war-torn parts of the world

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1.6 Psychopharm: The Basics

CHECKLIST BEFORE PRESCRIBING PSYCHOTROPIC MEDICATIONS TO CHILDREN

Assessment

GREAT RESOURCES!
- Take the VMAP REACH course
- AACAP Parent Med Guides
- SwitchRx.com

- ☐ Is the medical assessment complete?
- ☐ What is the primary working diagnosis and possible co-occurring conditions?
- ☐ Any signs of self-harm, suicidality, abuse, trauma? **Address first.**
- ☐ Does the new symptom or complaint warrant additional medication or dosage adjustment? Is this a side effect of a currently prescribed medication?
- ☐ Is behavioral therapy or cognitive behavioral therapy (CBT) an option for first-line treatment?
- ☐ Any baseline screening tools to be completed?

Current ROS

- ☐ Are there any co-occurring medical conditions impacting the patient's symptom presentation or that may limit use of a medication?
- ☐ Any use of over-the-counter, nicotine, vape, or illicit substances that may be contributing to the patient's symptoms or may interact with the prescribed medication? TIP: Don't forget to ask about antihistamines and birth control.
- ☐ Could current medications result in the presenting symptom? If so, does the current medication need to be adjusted or discontinued?

Medication Use *(Great questions to discuss with a VMAP psychiatrist!)*

VMAP PCP Call Line:
(888) 371-VMAP (8627)
vmap.org

- ☐ Are the symptoms likely to be managed with medication?
- ☐ Are the symptoms severe enough to treat with a medication?
- ☐ Have you decided which medication would be effective and the safest to try first (e.g., clonidine vs. an antipsychotic for aggressiveness)? Which medications are FDA approved for pediatric patients?
  - *Please note: many medications are effective in clinical trials but never get FDA approval (e.g., PATS showed methylphenidate worked in children under 6 but it is not FDA approved).*
- ☐ Any baseline labs or monitoring required before initiating pharmacotherapy?
- ☐ Has the caregiver and child/adolescent been informed of the expected benefits and medication side effects (common, severe, permanent, etc.)?
- ☐ Have you provided caregiver and patient education including starting dose, titration, and duration of therapy?
- ☐ Did you consider giving caregiver the appropriate AACAP Parent Medication Guide (i.e., ADHD, anxiety, depression)?
- ☐ Are you able to complete a prior authorization, if necessary?

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Classes of Psychotropics	DX	General Rules	Cautions
Stimulants (methylphenidates, amphetamine salts)	ADHD	About 80-90% of children will respond to either MPH or AS.	^CARDIAC Decreased appetite, weight loss, tics Sleep changes (most kids have poor sleep to begin with)
Non-Stimulants SNRI (atomoxetine, viloxazine)	ADHD, often with co-occurring anxiety and/or depression	Weight-based dosage — could be first choice in substance use disorder or when stimulants are not tolerated.	*BOX WARNING
SSRI (fluoxetine, sertraline, etc.) SSNRI (venlafaxine, duloxetine)	Depression, Anxiety, OCD	Start with a low dose, increase in about 4 weeks as tolerated. Fluoxetine usually given qAM; other SSRIs often given qhs, more sedating.	*BOX WARNING Paroxetine — avoided in children and adolescents due to increased activation, prolonged withdrawals, and highest risk of withdrawal syndrome even after 1 missed dose Rare: Serotonin Syndrome
Alpha agonist (guanfacine, long-acting form is Intuniv; clonidine, long-acting form is Kapvay)	Aggression, ADHD, hyperarousal due to trauma history, sleep problems	Start with low dose, increase with bid, tid. Long-acting forms.	Hypotension, sedation, rebound hypertension with rapid withdrawal Tolerance can occur
Other anti-anxiety (benzodiazepines and buspirone)	Anxiety, agitation	Benziodiazepines not for long term use generally.	Benzodiazepines — addiction potential Paradoxical activation
Anti-histamine (hydroxyzine)	Anxiety, sleep problems	Not for long-term use generally.	Can cause sedation.
Melatonin	Sleep problems	Try sleep hygiene first. Short and long acting. Also effective in use with autism and sleep problems.	Usually does not work at doses above 6-10mg nightly
Trazodone	Sleep problems	Start with 25-50mg.	Tolerance can occur Rare: Serotonin Syndrome, Priapism
Other atypical anti-depressants (bupropion, mirtazapine)	Depression, Anxiety, ADHD in setting of substance use	Start with a low dose, increase in about 4 weeks as tolerated. Mirtazapine sometimes used for sleep onset disorders.	*BOX WARNING Buproprion — don't use in Bulimia or seizures Mirtazapine — weight gain, sedation
2nd generation anti-psychotics (risperidone, aripiprazole)	Bipolar/irritability/psychosis ID/ASD — aggression	**Start low. Go slow.** Increased appetite so monitor weight.	#Monitor movement (AIMS) and labs regularly Weight gain with most

Note: all medication information should be verified using current PDR

SSRI = selective serotonin reuptake inhibitors, SNRI = selective norepinephrine reuptake inhibitor, SSNRI = selective serotonin-norepinephrine reuptake inhibitor

Note: Some medications in each category may not be FDA approved for this diagnosis and/or this age group (although some clinical studies have shown benefit) and are therefore considered an "off-label" use of the medication. This should be discussed with the guardian/patient.

*BOX WARNING: 2004: FDA Warning pooled studies of antidepressants in children and adolescents, which showed that approximately 4% of adolescents (on meds) compared to 2% (Placebo) had suicidal ideation. NO completed suicides. Monitor 1 week with call, and 2 weeks after being seen.

^CARDIAC SCREEN FOR STIMULANTS — consider EKG in children with cardiac symptoms, hx of murmurs, or a family hx of early cardiac problems or death. Sample checklist available here.

#ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) AND LABS FOR anti-psychotic use. See next page.

For General Psychopharmacology Reference:
McVoy M, Stepanova E, Findling RL; Clinical Manual of Child and Adolescent Psychopharmacology, Fourth Edition. American Psychiatric Association Publishing, 2024.

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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. Do teeth 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.)
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 of forehead, eyebrows, periorbital area, cheeks), including 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) and athetoid movements (i.e., slow irregular, complex serpentine). Do not include tremor (i.e., repetitive, regular, rhythmic)	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes); e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot	0 1 2 3 4
Trunk Movements:	7. Neck, shoulders, hips (e.g., rocking, twisting, squirming, pelvic gyrations)	0 1 2 3 4
Global Judgments:	8. Severity of abnormal actions	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

☐ Not applicable: Patient has no history of treatment with neuroleptics for one month or more.

☐ Examination completed

Physician signature: _____ Date of examination: _____

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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.

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THE SENTINEL PSYCHOTROPIC STUDIES: EVIDENCE FOR PROVIDERS TO SHARE WITH FAMILIES

MTA: Multimodal Treatment Study of Children with ADHD

579 school-age youth with ADHD

Compared stimulant, behavioral, combination (stimulant + behavioral) and (routine) community care in 579 children over 14 months.

Results: Medications alone and the combination treatment worked well initially and were superior to the other treatments and persisted over 24 months, but when these intensive treatments were less rigorous or stopped after 14 months, symptoms returned.

PATS: The Preschool ADHD Treatment Study

Two phase study with a crossover titration trial followed by a placebo-controlled, parallel trial in 303 preschoolers followed for 70 weeks with 3 and 6 year follow-ups.

Results: Original study demonstrated significant improvement in ADHD symptoms for all methylphenidate doses (2.5, 5, 7.5mg three times daily). Two-thirds were still on ADHD medications at 3-year follow-up, and 71% at 6 years. Note: 10% were on antipsychotics and 25% were on more than 1 medication. The results show that preschoolers may benefit from low doses of medication when it is closely monitored, but the positive effects are less evident and side-effects are somewhat greater than previous reports in older children

TADS: Treatment for Adolescent Depression Study

439 subjects aged 12-17 years with major depressive disorder (MDD) (30% had suicidal ideation, 2% severe) for 12 weeks

Compared fluoxetine, fluoxetine + CBT, CBT alone or placebo

Results: 43% CBT responded, 61% fluoxetine responded, 71% of combination (SSRI+CBT) responded. CBT alone did not separate from placebo. Suicide was attempted in 1.6% (n=7) of 439 subjects. Extended study to 36 weeks had similar findings (SSRI+CBT better than either alone). Suicidal events more common in fluoxetine therapy than combination therapy or CBT alone (14.7% vs. 8.4% vs. 6.3%, respectively)

TORDIA: Treatment of Resistant Depression in Adolescents

334 subjects ages 13-18 years with MDD unresponsive to 8 weeks SSRI (at $\geq$ fluoxetine 40mg equivalent) followed for 12 weeks. Treatment included: switch to new SSRI, switch to venlafaxine, SSRI + CBT, or venlafaxine + CBT. Additional 24 week extension study.

Results: 39% subjects achieved remission by week 24. Remission was more likely and achieved faster if improvement seen by week 12. There were no significant differences between groups.

TOSCA: The Treatment of Severe Childhood Aggression Study

Nine-week randomized trial with 168 children (6-12 years) with ADHD and oppositional defiant disorder or conduct disorder treated with parent training, a stimulant, or placebo. For those who did not have reduced aggressiveness after several weeks on the stimulant, risperidone (enhanced treatment) was added and carefully titrated along with 9 sessions of parent training.

Results: adding risperidone and parent training was moderately more effective than placebo for reducing aggressiveness and irritability, as well as teacher-rated ADHD symptoms.

CAMS: The Child/Adolescent Anxiety Multimodal Study

Twelve-week study comparing 488 youth (7-17 years) with anxiety disorders (SAD, GAD, Soc Phobia) treated with CBT, sertraline, combination (CBT+sertraline) or placebo.

Results: All active treatments were better than placebo, and the combination was better than either alone. 81% of children and adolescents receiving combination treatment improved, 60% of those receiving CBT only improved, 55% of those receiving antidepressant medication improved, and only 24% of those receiving only placebo improved. At weeks 24 and 36, combined treatment remained more effective than CBT or sertraline monotherapy.

Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS)

Eight-week double-blind, randomized controlled trial comparing olanzapine, risperidone, and molindone + benztropine in 119 subjects 8-19 years of age.

Results: Risperidone and olanzapine were not superior to molindone for early-onset schizophrenia and schizoaffective disorder. Response was observed in 50% of molindone treated subjects, 34% for olanzapine, and 46% for risperidone. The olanzapine group showed more weight gain, risperidone showed more hyperprolactinemia, and molindone subjects had more akathisia.

Treatment of Early Age Mania (TEAM)

Eight-week, randomized, controlled trail comparing lithium divalproex, and risperidone for manic or mixed bipolar disorder I in medication-naïve outpatients ages 6-15 years.

Results: More risperidone subjects demonstrated improvement than lithium or divalproex treated subjects. The risperidone group experienced more weight gain, hyperprolactinemia, and increased BMI. Lithium subjects experienced more abdominal pain, nausea, and vomiting. All groups had a decrease in suicidality.

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PSYCHOTROPIC MEDICATIONS: QUICK REFERENCE (not exhaustive; all medication information should be verified using current PDR)

Class	Generic (Brand)	Indication (Bold = FDA Pediatric Approval)	Common Adverse Effects	Monitoring
Selective serotonin reuptake inhibitors (SSRI)	citalopram (Celexa)	MDD	• Constipation, diarrhea, nausea, vomiting, weight gain • Drowsiness/sedation or insomnia • Activation or irritability, mood changes, anxiety • Dizziness, headache, tremor • Blurry vision, dry mouth • Palpitations	Box warning — Increased risk of suicidal thoughts and/or behaviors Citalopram — QTc prolongation risk Paroxetine — avoided in children and adolescents due to increased activation, prolonged withdrawals, and highest risk of withdrawal syndrome even after 1 missed dose
	escitalopram (Lexapro)	**MDD** GAD		
	fluoxetine (Prozac)	**MDD, OCD** PMDD, panic disorder, bulimia nervosa, binge eating		
	fluvoxamine (Luvox)	**OCD**		
	paroxetine (Paxil)	GAD, MDD, OCD, panic disorder, PMDD, PTSD, social anxiety disorder		
	sertraline (Zoloft)	**OCD**, MDD, panic disorder, PMDD, PTSD, social anxiety disorder		
Selective serotonin norepinephrine reuptake inhibitor (SSNRI)	desvenlafaxine (Pristiq)	MDD	• Constipation, decreased appetite, dry mouth, nausea, vomiting • Dizziness, insomnia or sedation/somnolence • Sexual dysfunction • Increased blood pressure and/or heart rate, palpitations	Box warning — Increased risk of suicidal thoughts and/or behaviors
	duloxetine (Cymbalta)	**GAD** MDD		
	levomilnacipran (Fetzima)	MDD		
	venlaxfaxine (Effexor)	GAD, MDD		
Miscellaneous antidepressants	bupropion (Wellbutrin, Zyban)	MDD, seasonal affective disorder, smoking cessation	Activation, anxiety, dry mouth, headache, increased blood pressure/heart rate, insomnia, seizures	Box warning — Increased risk of suicidal thoughts and/or behaviors Seizure
	mirtazapine (Remeron)	MDD	Dry mouth, increased appetite, sedation, weight gain	Box warning — Increased risk of suicidal thoughts and/or behaviors
	trazodone (Desyrel)	MDD	Blurry vision, constipation, diarrhea, dizziness, headache, orthostatic hypotension, priapism, sedation/ somnolence, sexual dysfunction	Box warning — Increased risk of suicidal thoughts and/or behaviors
	vilazodone (Viibryd)	MDD	Diarrhea, dry mouth, nausea, sexual dysfunction	Box warning — Increased risk of suicidal thoughts and/or behaviors
	vortioxetine (Trintellix)	MDD	Diarrhea, dry mouth, nausea, sexual dysfunction	Box warning — Increased risk of suicidal thoughts and/or behaviors

(Chart continues on next page. Click here to see table key.)

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PSYCHOTROPIC MEDICATIONS: QUICK REFERENCE (not exhaustive; all medication information should be verified using current PDR)

Class	Generic (Brand)	Indication (Bold = FDA Pediatric Approval)	Common Adverse Effects	Monitoring
Stimulant medications — Methylphenidates	dexmethylphenidate (Focalin IR and XR)	ADHD (≥6)	• Decreased appetite, nausea, weight loss • Insomnia, sleep disruption, dizziness, lightheadedness • Increased blood pressure/heart rate • Irritability, rebound symptoms • Tics or atypical movements	• Weight • Cardiac monitoring • Box warning — Risk of abuse/dependence
	methylphenidate (Ritalin IR and LA, Metadate ER and CD, Aptensio XR)	ADHD (≥6)		
	methylphenidate (Quillichew ER, Quillivant XR suspension)	ADHD (≥6)		
	methylphenidate (Concerta, Relexxii)	ADHD (≥6)		
	methylphenidate (Adhansia XR)	ADHD (≥6)		
	methylphenidate (Cotempla XR-ODT)	ADHD (≥6)		
	serdexmethylphenidate/ dexmethyphenidate (Azstarys)	ADHD (≥6)		
	methylphenidate (Jornay PM)	ADHD (≥6)		
	methylphendiate (Daytrana Patch)	ADHD (≥6)		
Stimulant medications — Amphetamine Salts	dextroamphetamine (Dexedrine IR and ER, Procentra, Zenzedi)	ADHD (≥3 for IR; ≥6 for XR)		
	mixed amphetamine salts (Adderall IR and XR)	ADHD (≥3 for IR; ≥6 for XR)		
	amphetamine sulfate (Evekeo IR and Dyanavel XR)	ADHD (≥3 for IR; ≥6 for XR)		
	amphetamine sulfate (Adzenys ER and XR-ODT)	ADHD (≥6)		
	mixed salts of single entity amphetamine (Mydayis)	ADHD (≥13)		
	lisdexamfetamine (Vyvanse)	ADHD (≥6)		
	dextroamphetamine (Xelstrym patch)	ADHD (≥6)		

(Chart continues on next page. Click here to see table key.)

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PSYCHOTROPIC MEDICATIONS: QUICK REFERENCE (not exhaustive; all medication information should be verified using current PDR)

Class	Generic (Brand)	Indication (Bold = FDA Pediatric Approval)	Common Adverse Effects	Monitoring
Non-stimulants	atomoxetine (Strattera) *Do NOT open capsule	ADHD (weight-based approval for children and adolescents)	Gastrointestinal discomfort, headache, insomnia, irritability, loss of appetite, dry mouth, fatigue, nausea, vomiting, somnolence	Box warning — Increased risk of suicidal thoughts and/or behaviors Hepatotoxicity Changes in behavior
	viloxazine (Qelbree)	ADHD (≥6)	Decreased appetite, fatigue, insomnia, irritability, nausea, somnolence, vomiting, somnolence	Suicidality, changes in behavior
	clonidine ER (Kapvay)	ADHD (≥6)	Abdominal pain, decreased blood pressure/heart rate, headache, fatigue, sedation/somnolence	Cardiac
	guanfacine ER (Intuniv)	ADHD (≥6)		
Second generation antipsychotics	aripiprazole (Abilify)	**Schizophrenia (≥13 yrs); Bipolar I disorder (≥10 yrs); MDD adjunct; Tourette's disorder (≥6 yrs); agitation/irritability associated with autism (≥6 yrs)**	Sedation, orthostatic hypotension, weight gain, lipid abnormalities, increased blood glucose, extrapyramidal symptoms Risperidone/paliperidone — hyperprolactinemia	Metabolic labs, weight, abnormal movements Risperidone/paliperidone — prolactin
	asenapine (Saphris)	**Bipolar I disorder (≥10 yrs)** Schizophrenia		
	lurasidone (Latuda)	**Schizophrenia (≥13 yrs); Depressive episodes with bipolar disorder (≥10 yrs)**		
	olanzapine (Zyprexa)	**Schizophrenia (≥13 yrs); Bipolar I disorder (≥13 yrs**		
	paliperidone (Invega)	**Schizophrenia (≥12 yrs)** Schizoaffective disorder		
	quetiapine (Seroquel)	**Schizophrenia (≥10 yrs); Bipolar I disorder (≥10 yrs)** Bipolar disorder, depressive episodes; MDD adjunct		
	risperidone (Risperdal)	**Schizophrenia (≥13 yrs); Bipolar I disorder (≥10 yrs); agitation/ irritability associated with autism (≥5)**		
	ziprasidone (Geodon)	Schizophrenia; Bipolar I disorder		

(Chart continues on next page. Click here to see table key.)

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PSYCHOTROPIC MEDICATIONS: QUICK REFERENCE (not exhaustive; all medication information should be verified using current PDR)

Class	Generic (Brand)	Indication (Bold = FDA Pediatric Approval)	Common Adverse Effects	Monitoring
Mood stabilizers	carbamazepine (Tegretol, Carbatrol, Equetro)	Acute manic and mixed episodes in bipolar I disorder	Nausea, dizziness, somnolence, tremor, agranulocytosis, aplastic anemia, hypernatremia, rash, Stevens-Johnson Syndrome	Carbamazepine level — 4-12mg/dL Sodium, complete blood count
	divalproex sodium (Depakote)	Acute manic and mixed episodes in bipolar I disorder; Migraine headache	Nausea, diarrhea, thrombocytopenia, alopecia, weight gain, increased LFTs	Valproic acid level — 50-120mg/dL Platelets, hepatic function
	lamotrigine (Lamictal)	Maintenance treatment of bipolar I disorder	Nausea, sedation, dizziness, diarrhea, rash, Stevens-Johnson Syndrome	
	lithium (Eskalith, Lithobid)	**Manic episodes of bipolar disorder (≥12); Maintenance treatment of bipolar disorder (≥12)**	Nausea, diarrhea, somnolence, tremor, hypokalemia, hypothyroidism, hypernatremia, increased serum creatinine, weight gain	Lithium level 0.5-1 mEq/L Electrolytes, thyroid, renal function

Key:

ADHD = attention deficit/hyperactivity disorder

GAD = generalized anxiety disorder

MDD = major depressive disorder

OCD = obsessive-compulsive disorder

PMDD = premenstrual dysphoric disorder

PTSD = posttraumatic stress disorder

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SIDE EFFECT INFORMATION FOR FAMILIES: SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs)

SERTRALINE (Zoloft), FLUOXETINE (Prozac), CITALOPRAM (Celexa), ESCITALOPRAM (Lexapro), FLUVOXAMINE (Luvox), PAROXETINE (Paxil)

NAME of medication: _____

DOSE of medication: _____

USED for the treatment of the following conditions:

- Depression or mood disorder
- Anxiety disorder
- Obsessive-compulsive disorder
- Eating disorders
- Disruptive mood dysregulation disorder

SIDE EFFECTS of these medications include but are not limited to:

- Nausea, vomiting, constipation, diarrhea, weight gain
- Drowsiness/sedation or insomnia
- Activation (especially Prozac)
- Dizziness, tremor, headache
- Dry mouth, blurry vision (anticholinergic symptoms)
- Mood changes, anxiety
- Skin problems (rash, itching)
- Racing heart

RARE but SERIOUS side effects include but are not limited to:

- **Serotonin syndrome (fever, agitation, sweating, tremor, seizures)**
- Worsening depression, elevated mood/hypomania
- Increased risk of bruising
- **Adverse heart (cardiovascular) events — (especially Celexa)**

  Please tell your provider if there is a personal or family history of heart disease, including abnormal heart rhythms (prolonged QTc syndrome), in which case screening is indicated prior to starting this medication.
- Suicidal ideation (very unlikely and studies did not report any attempts)

Administration:

- For children with autism spectrum disorder, these medications are often effective at lower doses. Therefore, the dose is started lower and then titrated upward as needed.
- These medications do not need to be taken with food. However, if there is any stomach upset, it may help to take the medication with food.
- **This medication must be taken regularly. Abrupt discontinuation may lead to withdrawal symptoms (nausea, fatigue, chills, muscle aches, agitation). Please tell your provider if you want to stop the medication and we can help to taper it down.**

Other Information:

- Generally, there is no need to pre-screen patients to start this medication unless there is a family or personal history of cardiac disease or the patient is taking other medications which may prolong the QTc interval. Please tell your provider if there is a family history of heart problems.
- While there may be some effect from the medication during the first week, it will take between 2 to 8 weeks for the medication to have its full therapeutic effect.
- Side effects will be monitored at upcoming visits. **Please contact us sooner if you have any questions or concerns about potential side effects**.

SIDE EFFECT INFORMATION FOR FAMILIES: STIMULANTS

Methylphenidate derivatives and amphetamine derivatives

NAME of medication: _____

DOSE of medication: _____

USED for the treatment of the following conditions:

- ADHD (Attention Deficit and Hyperactivity Disorder) or ADD

SIDE EFFECTS include but are not limited to:

- Decreased appetite with associated weight loss or failure to gain weight
- Nausea or belly pain
- Sleep disruption — difficulty falling asleep or staying asleep
- Dizziness/lightheadedness
- Rebound effect (increased hyperactivity/impulsivity when the stimulant wears off)
- New emotional and/or behavioral symptoms (anxiety, mood changes, irritability)
- Increase in blood pressure, increase in heart rate
- Tics or atypical movements (in children who are predisposed to tic disorders)

RARE but SERIOUS side effects include but are not limited to:

- **Adverse heart (cardiovascular) events.** *If there is a personal or family history of heart disease, including abnormal heart rhythms (prolonged QTc syndrome) or structural heart disease (in particular early sudden death due to cardiac/heart reasons), in which case screening is indicated prior to starting this medication.*
- Psychotic symptoms (hallucinations, delusional thinking, or mania)
- Severe allergic reaction including anaphylaxis
- Angioedema (swelling of the skin usually on the face around the lips and eyes)
- Priapism (erection lasting longer than 4 hours)
- Growth delay for long-term use
- Reynaud's phenomenon

Administration:

- To avoid trouble sleeping, the last dose should be given several hours prior to bedtime unless using delayed release form (Jornay PM).
- The immediate release preparations should be taken at least 30 minutes prior to a meal.
- **Immediate Release Tablets:** swallow whole or may be crushed and mixed in a small amount of food such as yogurt, honey, applesauce, or jam
  - includes Ritalin, Focalin, Adderall
- **Oral Solution:**
  - includes Methylin (grape flavor), Procentra (bubblegum flavor), Quillivant XR (banana flavor), Dynavel XR (bubblegum flavor)
- **Chewable Tablets:** must be chewed before swallowing
  - includes Methylin chewable, QuilliChew ER, Vyvanse
- **Orally Disintegrating Tablets (ODT)**:
  - includes Adzenys XR-ODT (orange flavor), Cotempla XR-OCT

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- **Extended Release Tablets:** Must be swallowed whole. Do not crush, chew, or divide tablet as the medication will not work effectively
  - includes Concerta, Metadate ER, Jornay PM; note: Strattera, non-stimulant
- **Extended Release Capsules:** Swallow whole or open capsule and sprinkle medication on applesauce
  - includes Focalin XR, Metadate CD, Ritalin LA, Adderall XR, Aptensio XR, Vyvanse (may dissolve in water); note: Qelbree (non-stimulant)

Other Information:

- Stimulant medications are classified into two groups:
  - Methylphenidate derivatives:
    - IR (immediate release, short-acting): Ritalin, Focalin, Methylin
    - ER (extended release, intermediate acting): Metadate CD/ER, Ritalin LA/SR
    - XR (extended release, long-acting): Aptensio XR, Adhansia XR, Concerta, Cotempla XR-ODT, Daytrana patch, Focalin XR, Jornay PM, Quillichew ER, Quillivant XR
  - Amphetamine/dextroamphetamine derivatives:
    - IR: Adderall, Evekeo, Procentra, Zenzedi
    - XR: Adderall XR, Adzenys XR-ODT/ER, Dynavel XR, Mydayis, Vyvanse
- The immediate release medications start to work within 20 to 60 minutes and generally have an effect for 3 to 6 hours.
- The intermediate release medications start to work within 20 to 60 minutes and generally have an effect of 6 to 8 hours.
- The extended release medications start to work within 20 to 60 minutes and generally have an effect for 8 to 12 hours and some up to 24 hours.
- The delayed release medication (Jornay PM) starts to work in 8 to 12 hours for morning ADHD control.
- Due to the short-acting nature of these medications, they do not “build up” in the system and they are in and out of the body in 1 day. Once they are discontinued, the side effects should stop as well.
- These medications are considered first line treatment for ADHD, with or without behavioral therapy/interventions.

SIDE EFFECT INFORMATION FOR FAMILIES: NEUROLEPTICS/SECOND GENERATION ANTIPSYCHOTICS

RISPERIDONE (Risperdal), ARIPIPRAZOLE (Abilify), QUETIAPINE (Seroquel), OLANZAPINE (Zyprexa), ZIPRASIDONE (Geodon), PALIPERIDONE (Invega), LURASIDONE (Latuda)

NAME of medication: _____

DOSE of medication: _____

USED for the treatment of the following conditions:

- Aggression and irritability, especially in children with autism
- Self-injurious behaviors
- Tic disorders and stereotypies
- Bipolar disorder
- Schizophrenia or psychosis

SIDE EFFECTS include but are not limited to:

- Sedation, drowsiness, confusion, memory problems
- Headache
- Dry mouth, blurry vision (anticholinergic effects)
- Constipation or diarrhea
- Increased appetite and weight gain with risk of developing "metabolic syndrome" (metabolic syndrome includes diabetes, high cholesterol, and high triglycerides)
- Anxiety or restlessness
- Dystonic reactions (involuntary muscle contractions of the head/neck/trunk/extremities/eyes)
- Orthostatic hypotension (a drop in blood pressure when standing up) with dizziness, tachycardia (fast heartbeat) or syncope (fainting)
- Absence of menses (periods) in females due to elevated prolactin
- Galactorrhea (nipple discharge) due to elevated prolactin
- Gynecomastia (increased breast tissue in males) due to elevated prolactin

RARE but SERIOUS side effects include but are not limited to:

- **Tardive dyskinesia:** involuntary and repetitive movements of the face and body which can occur after prolonged use of medication (e.g., eye blinking, lip smacking, etc.)
- **Adverse heart (cardiovascular) events:** *Please tell your provider if there is a personal or family history of heart disease, including abnormal heart rhythms (prolonged QTc syndrome), in which case screening is indicated prior to starting this medication.*
- Neuroleptic malignant syndrome (NMS): muscle rigidity, fever, delirium, changes in heart rate
- Changes in white blood cell count
- Liver injury with abnormal liver function tests
- Seizures
- Cataracts
- Hypersensitivity reaction (severe allergic reaction)

Other Information:

- These medications tend to work quickly with positive effect being seen within 1 to 2 weeks.
- It is important to take the medication daily to achieve desired effect.
- **Do not discontinue the medication without speaking to your medical provider due to the risk of withdrawal symptoms.**

(Continues on the next page)

- Prior to starting the medication, the following lab work may be obtained
  - Fasting Lipid Panel and glucose
  - Hemoglobin A1c, if glucose level is high
  - Complete Metabolic Panel (CMP)
  - Complete Blood Count with Differential (CBC with Diff)
- A Lipid Panel and glucose may be obtained every 6 months thereafter
- CMP and CBC with Diff may be obtained every 1 year thereafter
- Prolactin may be elevated in asymptomatic patients, and prolactin level measurement is reserved if symptoms are present.

Side effects will be monitored at upcoming visits. Please contact us sooner if you have any questions or concerns about potential side effects.

SIDE EFFECT INFORMATION FOR FAMILIES: ALPHA-2 AGONISTS

CLONIDINE (Catapres), EXTENDED RELEASE CLONIDINE (Kapvay), GUANFACINE (Tenex), EXTENDED RELEASE GUANFACINE (Intuniv)

NAME of medication: _____

DOSE of medication: _____

USED for the treatment of the following conditions:

- ADHD (Attention Deficit and Hyperactivity Disorder) or ADD
- Hyperactive/impulsive behaviors
- Outbursts and temper tantrums
- Tic disorders (decrease in motor tics)
- Sleep problems
- High blood pressure

SIDE EFFECTS include but are not limited to:

- Sedation
- Decreased heart rate and/or blood pressure
- Headache
- Dry mouth
- Dizziness
- Constipation
- Rebound hypertension upon abrupt discontinuation of the medication ***(do not stop abruptly)***

RARE but SERIOUS side effects include but are not limited to:

- Extreme decrease in heart rate or blood pressure, particularly of concern in an overdose situation ***(please keep out of reach of children)***

Administration:

- If unable to swallow, the immediate release preparations (Catapres, Tenex) can be crushed and mixed with a small amount of soft food like yogurt, honey, applesauce, or jam that needs to be eaten right away.
- The long-acting forms of these medications (Kapvay, Intuniv) last for 10 to 12 hours. The extended release preparations must be swallowed whole.

Other Information:

- It may take 1 to 2 weeks or longer to achieve desired effects, and the dosage of medication may need to be titrated upward weekly until desired effect is achieved.
- **These medications must be tapered when discontinuing to avoid rebound hypertension (high blood pressure).**

Side effects will be monitored at upcoming visits. Please contact us sooner if you have any questions or concerns.

SIDE EFFECT INFORMATION FOR FAMILIES: ATOMOXETINE (STRATTERA)

DOSE of medication: _____

USED for the treatment of the following conditions:

- ADHD (Attention Deficit and Hyperactivity Disorder) or ADD
- Often used when there are significant side effects to stimulants or if there is co-existing anxiety

TYPE of medication: Selective Norepinephrine Reuptake Inhibitor (SNRI)

SIDE EFFECTS include but are not limited to:

- Weight loss, decreased appetite
- Nausea, vomiting, belly pain
- Headache
- Dizziness
- Irritability
- Sedation, fatigue
- Increased blood pressure, increased heart rate
- Tics or atypical movements

RARE but SERIOUS side effects include but are not limited to:

- **Adverse heart (cardiovascular) events including sudden death.** *Please tell your provider if there is a personal or family history of heart disease, including abnormal heart rhythms (prolonged QTc syndrome) or structural heart disease (in particular early sudden death due to cardiac/heart reasons), in which case screening is indicated prior to starting this medication.*
- Liver injury (indications would be itchy skin, yellowing of the skin or whites of the eyes, dark urine, right upper abdominal pain/tenderness, unexplained “flu-like” symptoms)
- Priapism (erection lasting longer than 4 hours)
- Change in mood or irritability
- **Change in thought patterns with increased risk of suicidal thinking**

Administration:

- This medication comes in a capsule form and should be swallowed whole. It is effective if taken in the morning or the evening but is generally more effective if taken in the morning. Strattera works for at least 10 to 12 hours.
- It takes time to build up to an effective dose and, while some effect may be seen in 1 to 4 weeks, it may take between 6 to 12 weeks to achieve desired effect. **Therefore, it is important to take every day.**
- Please tell your provider if you wish to discontinue the medication. It is best to wean off to avoid withdrawal symptoms.

Side effects will be monitored at upcoming visits. Please contact us sooner if you have any questions or concerns about potential side effects.

1.7 Coding for Pediatric and Adolescent Mental Health

2021 CODING FOR BILLING GUIDELINES

- Allows for coding based on “time” or “medical decision making” (MDM)
- Look at both — use whichever one is beneficial (though it is hard to get enough “complexity” to bill 99205 or 99215 by MDM, so using time-based billing is best for >40 minute visits)
- Will likely code mental health visits both ways depending on the situation and nature of the visit

- **Sign-up for AAP coding newsletters**
- **See the Nov 2023 AAP newsletter for important SDOH updates**

WHAT CHANGED WITH THE 2021 GUIDELINES?

- Not dependent on “bullet points” of HPI, ROS, PE
- Document HPI, ROS, PE, etc. as it is pertinent to the patient's care and risk management
- Billing documentation is focused on MDM **OR** Time

TIME-BASED BILLING

- Total time on day of service (calendar date, not a 24-hour clock) spent on PATIENT. Can only be billing PROVIDER's work. Time does not need to be continuous. Not limited to counseling and coordination of care. AS LONG AS IT IS ON THE DAY OF SERVICE, examples include, but are not limited to:
  - **Non face-to-face pre-visit review of chart,** tests, separately obtained history, and communications
  - **Face-to-face visit** including medically appropriate history and physical exam
  - **Counseling and education** of the patient and family or caregivers
  - **Non face-to-face ordering medications**, tests, or procedures
  - **Non face-to-face referring and communicating** with other health care professionals (who are not in the same specialty **and** practice)
  - **Documentation** in the medical record
  - Independently interpreting test results (documentation required in note) and communicating them
  - **Coordination of care**
  - **Letter writing**
  - **Form completion**
  - Personally calling a pharmacy
  - Calling the VMAP consult line
- Sample statement that can be used with many elements:

  My total time on this date and for this encounter was XX minutes which included the following activities: preparing to see the patient; obtaining and/or reviewing separately obtained history; performing a medically necessary exam and/or evaluation; counseling and educating the patient/family/caregiver; ordering medications, tests, or procedures; referring to and communicating with others; documenting clinical information in the medical record; independently interpreting results and communicating results to patient/family/care; and care coordination. This time is independent and non-overlapping.

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- Time that does not count:
  - Performance of services that have already been completed and reported
  - Travel
  - Teaching of families, etc. that is general and not required for the management of the specific patient
  - Staff time (such as administering screening tool, obtaining vitals)
  - Time during which you are caring for another patient while awaiting conclusion of an issue
- Billing for a "split visit":
  - Total time of 2 practitioners operating SERIALLY can be summed under one. For example: seen by a Nurse Practitioner or Physician Assistant who comes to physician with management questions. Physician provides consultation and sees the patient. Physician can bill for the mid-level provider AND the physician time in a split visit. The mid-level provider cannot bill separately. Only one can bill for the total time spent.
  - **If patient seen in parallel by more than 1 provider → both can bill their time independently**. For example: a counselor and a provider are in the office and see a patient simultaneously. Both can bill professional services for their time.
- **Note, you may not "round up" if you hit the midway point between times**
- **You must hit the bottom of a range for a code in order to bill that code based on time**

New Patients	
Code	**Time (in minutes)**
99201	10-14
99202	15-29
99203	30-44
99204	45-59
99205	60-74

Established Patients	
Code	**Time (in minutes)**
99211	not applicable
99212	10-19
99213	20-29
99214	30-39
99215	40-54

- ***NEW*** services code 99417
  - Only applies to time-based billing
  - Can only be used in addition to "level 5" visit: new or established
  - 15-minute increments
  - Coverage for this code varies by insurer

Total Duration of New Patient Services (minutes)	Code	Total Duration of Established Patient Services (minutes)	Code
74 or less	No 99417 reported	54 or less	No 99417 reported
75-89	99205 x 1, 99417 x 1	55-69	99215 x 1, 99417 x 1
90-104	99205 x 1, 99417 x 2	70-84	99215 x 1, 99417 x 2
105 or more	99205 x 1, 99417 x 3 or more for each 15 minutes	85 or more	99215 x 1, 99417 x 3 or more for each 15 minutes

Source: *Coding for Pediatrics 2022, 27th ed.,* American Academy of Pediatrics Committee on Coding and Nomenclature (COCN).

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BILLING BASED ON MEDICAL DECISION MAKING (MDM)

- Based on
  - Number and complexity of problems
  - Data analyzed
  - Risk of management
- Documentation requirements
  - NOT dependent on “bullet points” of HPI, ROS, PE
  - Document HPI, ROS, PE with what is pertinent to patient management/risk management
- Number and complexity of problems
  - For mental health care — mostly acute and chronic
  - Exacerbation vs. stable (a problem that is not at its treatment goal is in exacerbation, even if unchanged from prior visit)
  - Side effects of treatment increases the complexity New or established problem
  - Risk inherent in a problem is distinct from risk in management (see below)
- Amount and complexity of data analyzed
  - Don’t double count: cannot count ordering a point of care AND analyzing a point of care test in the same encounter.
  - Number of elements
    - Tests
    - Data sources
    - Communication with outside professionals/subspecialists
    - Communication with appropriate sources
    - Independent historian
    - Independent interpretation of a test
- Risk of management
  - Risk can simply be defined in documentation **as minimal, low, medium, or high/extensive**.
  - Risk is defined as **inherent to the current encounter**. For example, one cannot consider resolved past suicidality as high risk unless it is germane to the current encounter.
  - **Risk of complications/morbidity/mortality of patient management**. Distinct from the risk of the condition. However, the underlying problems may DRIVE the risk of management.
    - **Example:** Depression with suicidality as a problem which then may lead to consideration of hospitalization in management. This would be high-risk as hospitalization is a high-risk intervention and risk of death is a high-risk consequence.
  - Risk involves decision making related to the need to initiate vs. forego further testing, treatment, and/or hospitalization. The action itself does not need to be taken. However, decision making related to **consideration of the option** defines risk. Documentation should address consideration of the intervention in order to support billing based on risk of an intervention not performed.
  - Care affected by **social determinants of health** affects decision making in risk.
  - **Drug therapy requiring intensive monitoring for toxicity** is high risk.

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CHOOSING YOUR LEVEL OF SERVICE BASED ON MDM: EXAMPLE LEVELS

Based on 2 of 3 elements of MDM

Problems (applicable to mental health)		
Code	**Number and Complexity of Problem**	**Examples**
99211	Not applicable	Not applicable
99202 / 99212	Minimal (Straightforward) Self-limited or minor problem	Not generally applicable for mental health
99203 / 99213	Low • 1 stable chronic illness	Follow up of mental health problem — i.e., normal function in the classroom and social settings in a child with ADHD AND no side effects of tx

99204 / 99214	Moderate
	• 1 or more chronic illness with exacerbation/progression/side effect
	OR
	• 2 or more stable chronic illnesses
	OR
	• 1 undiagnosed new problem with uncertain prognosis
		• Evaluation of a mental health problem which is new or longstanding (even if not previously diagnosed) or expected to be more than a year in duration
		• Longstanding mental health problem not at treatment goal (normalized functioning in all domains), no suicidal ideation
		• Depression/Anxiety improved, but still symptomatic — needing counseling
		• 2 mental health problems (e.g., ADHD and Anxiety) at treatment goal
		• Mental health problem with side effect of treatment:
		  ◦ Treatment of ADHD and weight loss, insomnia
		  ◦ Use of an SSRI with side effects
		  ◦ Weight gain on anti-psychotic
		• Undiagnosed new problem with uncertain prognosis:
		  ◦ Initial evaluation of somatic complaint, and medical etiology on differential
		  ◦ Weight loss with a past history of anorexia in remission

99205 / 99215	High • 1 or more chronic illness with **severe** exacerbation, progression, or side effect of treatment	• **Mental health problem with suicidal ideation** • Severe aggression as a presentation, or worsening of, an underlying MH condition • Safety issues (e.g., **elopement** risk from school/parents with significant risk) • Life-threatening side effect of MH medication

GLOSSARY: Related to Problems (definitions limited to pertinent components for MH care)

- **Problem**: disease, condition, symptom, or complaint addressed at the encounter, with or without a diagnosis being established at the time of the encounter. This may be an underlying condition if it contributes to the risk of the presenting problem.
- **Problem addressed**: addressed or managed in that encounter. Includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit or pt/family choice. Referral without evaluation **does not** count as management of a problem.
- **Stable chronic illness**: problem with **expected duration** of at least 1 year. Stable is defined by treatment goals — if AT goal, then stable. If not AT treatment goal, not stable — even if unchanged from prior visit.
- **Chronic illness with exacerbation, progression, or side effects of therapy:** chronic illness that is worsening, not at treatment goal, or progressing, or side effect of the intervention.
- **Chronic illness with severe exacerbation, progression, or side effect of therapy:** significant risk of morbidity and may require hospital level of care.
- **Undiagnosed new problem with uncertain prognosis:** problem with a Differential Diagnosis which may include a highly morbid condition.

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Data (applicable to mental health)		
Code	**Amount and Complexity of Problem**	**Examples**
99211	Not applicable	Not applicable
99202 / 99212	Minimal or none	History limited to the patient. No information from parent or corroborating sources.

99203 / 99213	Limited
	• Independent historian
	OR
	• Any 2 of the following:
	  ◦ Review of prior external notes
	  ◦ Ordering of a unique test
		• Discussion of pt/obtaining hx from an independent historian
		  ◦ Parent present in visit and provides relevant information
		  ◦ Parent sends a written note with the child
		  ◦ Parent sends a message electronically prior to the visit or after the visit and is pertinent
		  ◦ Review of teacher documentation
		  ◦ Each individual source is counted, not number of notes
		• 2 unique laboratory tests ordered
		• Reviewed 1 note and ordered 1 test
		• Parent present who provided a portion of the history

99204 / 99214	Moderate (1 of 3 Categories):
	• Category 1 (can mix and match) any 3 of the following:
	  ◦ Review of prior external notes
	  ◦ Review of unique test results
	  ◦ Ordering of each unique test
	  ◦ Independent historian(s)
	• Category 2: Independent test interpretation
	• Category 3: Discussion of management or test interpretation with external physician, qualified health care professional, or appropriate source within several days of the visit
		Category 1:
		• Review of one external note(s), history from parent, **and** one lab test
		Category 2:
		• In office EKG with interpretation, (not o/w billed)
		Category 3:
		• Discussion of patient with counselor
		• Discussion of patient with CPS or teacher
		• Discussion of patient with a child psychiatrist (VMAP)
		• Discussion of patient with ER physician

99205 / 99215	High/Extensive (2 of 3 Categories):
	• Category 1 (can mix and match) any 3 of the following:
	  ◦ Review of prior external notes
	  ◦ Review of unique test results
	  ◦ Ordering of each unique test
	  ◦ Independent historian(s)
	• Category 2: Independent test interpretation of tests
	• Category 3: Discussion of management or test interpretation with external physician, qualified health care professional, or appropriate source
		Category 1:
		• Review of one source's external note(s), history from parent, **and** one lab test
		Category 2:
		In office EKG with interpretation, not o/w billed
		Category 3:
		• Discussion of patient with counselor
		• Discussion of patient with cps or teacher
		• Discussion of patient with a child psychiatrist
		• Discussion of patient with ER physician

(Continues on the next page)

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GLOSSARY: Related to Data

- **Analyzed:** process of using data as a part of MDM. May be a discrete data point which is not subject to analysis but is included in thought process for diagnosis, evaluation, or treatment. (e.g., TSH value)
- **External qualified source:** non health care professionals who may be involved in patient management — e.g., school, police, CPS, lawyer, case manager. **Family, babysitters, and informal relationships do not apply**.
- **Independent historian:** surrogate historian who can provide history in addition to a history provided by the patient or because confirmatory history is judged to be needed. This history does not need to be in person. It may be in written form. It must be directly from the independent historian.
- **Tests:** imaging, lab, psychometric or physiologic data; things for which a CPT code is available. Screeners and rating scales cannot be counted as tests or data.
- **Unique:**
  - For tests defined by CPT code set: multiple results of the same unique test (e.g., serial blood sugars) analyzed in a single encounter count as one test.
  - For sources: physician or qualified health care professional in a distinct group or different specialty. Each source counts as one data point. Therefore 3 notes from the same person/source are one element. A psychologist embedded in a primary care practice would count as a unique source as they are a different specialty or subspecialty from the primary care provider.
- **Independent interpretation:** interpretation of a test for which there is a CPT code and interpretation or report is customary. This cannot be counted if you are ALSO separately reporting and billing this service. A form of the interpretation should be documented but need not conform to usual standards of a complete report.
- **Appropriate source:** includes non-health care professionals, but who may be involved in the management of the patient (e.g., lawyer, case manager, teacher). Not family or informal caregivers.
- **Discussion:** an interactive exchange of information which is direct and not through intermediaries. **It does not need to be on the dates of the encounter**. It is counted only once and only when it is used in the decision making of the encounter. **It may be asynchronous (i.e., electronic), but must be initiated and completed within a short time period (i.e., within a day or 2)**. Sending visit notes does not qualify as an interactive exchange.

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Risk of Patient Management (Complications and/or Morbidity or Mortality) (Applicable to mental health)		
Code	**Level of Risk**	**Examples**
99211	Not applicable	Not applicable
99202 / 99212	Minimal or no risk from additional diagnostic testing or treatment	Not generally applicable for mental health
99203 / 99213	Low risk from additional diagnostic testing or treatment	Not generally applicable as conditions generally cause functional impairment for a substantial amount of time

99204 / 99214	Moderate risk from additional diagnostic testing or treatment	• Prescription drug management
		• Discussion of therapeutic options, including medication, therapy
		• Diagnosis or treatment significantly limited by social determinants of health
		  ◦ Homelessness
		  ◦ Inability to afford treatment
		• Involvement of Child Protective Services

99205 / 99215	High risk from additional diagnostic testing or treatment	• Decision making regarding need to escalate care (ER or admission) • **Suicidal ideation with safety planning** • MH condition with significant risk factors for suicide ◦ e.g., LGBTQ+, past suicidal ideation, significant self harm and impulsivity • Aggression with potential need to involve law enforcement

GLOSSARY: Related to Risk

- Risk:
  - Based on probability and/or consequences of an event. Affected by the nature of the possibility of the event and not necessarily how likely it is to occur. For example, while most suicidal thinking does not result in death, the nature of death is severe; therefore, management of suicidal ideation is high risk. Alternatively, the risk of a side effect such as abdominal pain - which is much more likely - would result in lower risk designation as abdominal pain is a lower risk event.
  - The level of risk is based upon the usual behavior and thought processes of a physician or other qualified health care professional **in the same specialty**.
  - Based on consequences of the problem at the encounter, when appropriately treated.
  - May be driven by presenting problem, but is distinct from the risk of the condition. It is the risk of the decision/treatment decisions needed to address the problem.
  - MDM related **to the need to initiate or forego** further testing, treatment and/or hospitalization.
- Morbidity: state of illness or functional impairment that is expected to be of substantial duration. It may impair function, quality or life or cause possible organ damage that may not be transient.
- Social determinants of health:
  - Economic and social conditions that influence the health of people and communities (e.g., food or housing insecurity).
  - Split households or unstable living situations may be a SDOH for a child whose care is affected by it.
- Intensive monitoring for toxicity:
  - Therapeutic agent that has the potential to cause serious morbidity or death.
  - The monitoring should be for the toxicity, not the therapeutic effect.
  - May be short- or long-term:
    - Short-term may be for an antipsychotic like Clozaril that can cause agranulocytosis or EKG monitoring after initiation of needed pharmacologic therapy
    - Long-term monitoring is at least quarterly. This may apply to monitoring of atypical antipsychotics.
  - Monitoring may be via laboratory test, physiologic test, or imaging. History, physical exam, and vital signs/growth parameters **do not qualify**.

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1.8 While You Wait For Services: Tips For Families

Deciding to seek mental health services for your child is the first step toward helping them to feel better. It can be frustrating and discouraging when therapists are not available right away, but there are things you can do in the meantime. These strategies are not a replacement for therapy, but can be helpful to implement while you wait.

TALKING WITH YOUR CHILD ABOUT THEIR MENTAL HEALTH

Many parents and caregivers feel unsure of how to talk about mental health with their children. Starting a conversation will let your child know that you care, that you support them, and that you are willing to have difficult conversations with them. Make sure that you have private, uninterrupted time when everyone's emotions are calm to begin the conversation.

- **Start the conversation:**
  Use open-ended, "I" statements such as, "I've noticed that you are spending more time alone lately," or "I'm worried that you seem really upset."
- **Maintain open communication:**
  Reflect back any emotions or experiences that they share with you without expressing judgment or disagreeing with what they say. If they describe a situation, saying things like, "that sounds really hard" or just rephrasing what they have told you can be helpful. This helps children and teens feel heard and understood.
- **Schedule daily check-ins:**
  For older children and teens, an easy 1 to 10 rating can be a nice way for children to quickly communicate to parents how they are feeling. Ask what they need in that moment and offer some ideas (e.g., a hug, just to sit quietly together, to talk or walk, a fun distraction).

Encourage Routine and Self-Care

Changes in appetite, sleep, and activity level are common in people experiencing mental health difficulties such as anxiety or depression. Do what you can to help your child stick to a usual routine. Writing down the daily schedule and hanging it on a wall can help everyone to know the plan. It is equally important that caregivers take time for self-care so that you are able to support your child.

- **Healthy eating:**
  Keep snacking and mealtimes at relatively consistent times.
- **Ensure enough sleep:**
  Not getting enough sleep can lead to even more difficulties with mood and behavior. Try to ensure that your child is getting enough sleep. This can be difficult, but encouraging usual wake-up times and avoiding daytime sleep can actually help with maintaining better nighttime sleep.
  - Keeping a sleep log may help you better understand how much sleep your child is getting.
  - The American Academy of Sleep Medicine offers age-based tips on improving sleep for children and teens (sleepeducation.org/sleep-faqs).
  - It is best to have children and teens sleep in a quiet, dark room, and to keep distractions such as phones and tablets unavailable and in another room during sleep hours

- **Engage in positive and enjoyable activities:**
  Creating and encouraging small doses of movement and activity a few times a day can really make a difference for your child.
  - Think of them as activity 'snacks' – brief 10 minute periods of doing something.
  - Create a "menu" of activity choices together with your child. Activities could include going for a walk, taking a pet outside, playing a game together, coloring, baking, building with toys, using playdough, listening to music with someone, or going on a bike or scooter.
  - Write down when the activities will occur each day so that they become a part of the daily routine and do not get overlooked.

Teach and Model Coping Skills

There are many strategies you can begin to use with your child or teen that are known to have positive effects on mental health. There are many free apps that can help guide your child: *Smiling Mind* (younger children), *Mindful Powers* (older children), *Insight Timer*, *Let's Meditate*, *eQuoo*, *MindDoc.* Or, you can use these simple ideas to guide your child through these practices together. Practice these strategies every morning and night when your child is not having big emotions. The more they are practiced, the easier they will be to use when your child is feeling distressed.

- **Relaxation breathing:**
  Personalize relaxation breathing for your child: their belly is a balloon to be filled and then deflated; breathing in a peaceful color and slowly breathing out the stressful color; breathing in and breathing out enough air to blow out 100 birthday candles; smell a cookie and blow to cool it off.
- **Progressive muscle relaxation:**
  Ask your child to tightly squeeze their fists as if they were squeezing a lemon. Then, ask them to drop the lemons as they let all their muscles in their arms relax. Repeat this three times. Have your child close their eyes and think about all the muscles in their body, noticing if any of them feel tense. For each part of the body, imagine tightening the muscles and then letting them relax. For younger children, have them use their imaginations (e.g., squeezing lemons in their fists, biting on a jawbreaker, pretending they are a turtle and shrugging their shoulders).
- **Guided imagery:**
  Think of a peaceful, relaxing scene with your child. Help them to go that place in their mind by guiding them to imagine what they can hear, see, smell, taste, and feel in that relaxing place. Spend 5 minutes focusing on the characteristics of that place while also slowing breathing.

The Caregiver-Child Relationship

- **Special time:**
  Special time is one way that caregivers can connect with their children in a positive way. Schedule 5 minutes for special time that will not be interrupted by distractions or other demands. Provide age-appropriate creative, constructive toys (e.g., blocks, coloring, dolls, modeling clay, crafts) that do not have rules or instructions. Follow the child's ideas in play, as long as they are appropriate and safe.
- **Encourage desirable behavior:**
  Be sure to "catch your child being good" by paying attention and giving praise when good behavior occurs, no matter how small - "thank you for helping me," "I'm proud of you for staying calm." By catching these small moments, you may begin to change how a child or teen feels about themselves.

If you or someone you know is thinking about suicide, contact the Suicide & Crisis Lifeline at 988, or contact the Crisis Text Line by texting "START" to 741-741.

ADDITIONAL RESOURCES FOR FAMILIES:

Web Resources

- The Cooperation Chart: thecooperationchart.com
- The 5-minute Daily Playtime Ritual That Can Get Your Kids to Listen Better (npr.org)
- Mayo Clinic's Anxiety Coach and Cooperation Coach: anxietycoach.mayoclinic.org
- While You Wait mental wellness tools: onoursleeves.org

Books

- *What To Do Guides for Kids* series (example: *What To Do When You Worry Too Much*)
- *Breaking Free of Child Anxiety and OCD: A Scientifically Proven Program for Parents,* by Eli R. Lebowitz (2021)

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1.9 Brief Intervention: Addressing Treatment Reluctance & Refusal

Mental health treatment reluctance is common and can be difficult for providers to navigate. This can be especially true in pediatrics, where clinicians, patients, and caregivers may have differing goals or beliefs related to mental health. Time limitations of primary care visits can further fuel frustration around treatment reluctance. When helping patients and families engage in any type of treatment, it is important to hear the concerns and explore reasons for ambivalence. Motivational interviewing can be a helpful tool when navigating these situations and ***collaborating*** with patients and families on a treatment plan.

What do I do if my patient refuses or is resistant to medication and/or therapy

#1

Be **kind** and **calm**. **Listen**. Resist the urge to lecture or persuade.

Tips for starting the conversation to understand reasons for resistance:

"What are your/your family's/your culture's beliefs about mental health/therapy/medication?
"When you think about starting a medication for this, what do you worry about?"
"Other patients have mentioned concerns about X, Y, and Z. Are any of these worries that you have?
"What might get in the way of reaching out to a therapist/taking this medication?"

#2

Spend some time identifying **reasons for resistance**. Reasons can include:

- Worry about potential side effects
- Cultural beliefs about mental health and/or mental health treatment
- Perceived barriers
- Hopelessness
- Negative or unhelpful experiences in the past
- Stigma or embarrassment
- Lack of knowledge

#3

Empathize.

- "*I hear that you're having a really tough time — and the treatment options we talked about don't feel like good options for you right now*."
- "*You're annoyed that everyone seems to be making decisions for you. You don't feel like this is something that needs to be addressed right now*."
- if family did not follow through with recommendations from last visit: *"Navigating the mental health system is hard, and the plan we talked about last time was overwhelming."*

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#4

Explore the patient's/family's **values and goals**. Identify discrepancies between their values and current behavior.

- "*What's important to you? How are these symptoms getting in the way of those things?*"
- "*If you felt better, what would you be doing?*"
- "*Let's ignore what your parents and doctors want for a second. What are **you** hoping for right now? How do **you** wish your life were different?*"

#5

Reflect concerns and ask permission to **educate**.

- "*I see a lot of kids who are struggling with similar things. Can I share with you a few of the things they have found helpful?*"

#6

Collaborate on a plan. You may need to compromise. Your ideal treatment plan may differ from what the patient/family feels they can do right now. Facilitate the next step in the plan.

- "*We've talked about a couple of different options today. What feels like a good place to start?*"
- "*I hear that medication feels like too big of a step right now. I'm so happy you are willing to reach out to the therapist. What day/time can you call them?* Our office will touch base with you by the end of the week to check in on how things are going.

#7

Follow-up and make changes to the plan as needed. Some patients may need more frequent follow-up with you. Do not feel like you need to utilize every motivational interviewing skill and come away with a concrete plan after one appointment; this will be an ongoing conversation for many families.

Unless your patient is in crisis, no one can force them to get mental health treatment. In fact, without their buy-in to treatment, it is unlikely to be helpful.

- Roll with the resistance, empathize, and educate where appropriate.
- If a teen is refusing to engage in therapy, consider talking with caregivers about parent training or other parent only treatment options.
- Let the teen know that you care about them and will continue revisiting the conversation because you care.

If safety is a concern and your patient refuses to engage in treatment, refer to VMAP Guidebook Section 2.3: "Understanding the Emergency Custody Order (ECO) and Temporary Detention Order (TDO) Process for Minors & Young Adults."

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Patient Concern	What You Can Do	How You Can Say It
"I've already tried it and didn't like it." (therapy or medication)	• Go further upstream - recognize the problem or barriers and identify potential solutions. • Offer choices.	*"What were you hoping to accomplish with medication/treatment?"* *"Tell me about your last experience with X, Y, Z."* *"There may be other options we can consider. Would it be okay if I tell you about some of those?"* *"Finding a good therapist can be like shopping for a comfortable pair of shoes; sometimes you have to try on a few before you find a good fit."*
Worried about side effects	• Assess what they know, normalize appropriate worry, and then ask permission to educate. • Provide psychoeducation materials if appropriate.	*"Tell me what you know about this medication."* *"Is it okay if I tell you a little bit about the medication and its side effects?"* *"Starting a new medication can feel scary. Can I share with you why I think it could be really helpful for you?"*
Cultural beliefs around mental health treatment	• **Listen, empathize, and validate.** Identify what the family values and try to connect a treatment plan to those values. • If a family doesn't 'believe in medication' for mental health, **meet them where they are**. Discuss other options and identify how you will know if it's working or if other options should be considered. Get creative. • **Language matters.** Use terms acceptable to the family (ex: nerves/worry vs. anxiety).	*"I hear that X, Y, Z are really important to you and your family. Let's work together to find someone who understands that and can incorporate that into your work together."* "*We both really care about *pt name* and are worried about them. Therapy and medication don't feel like the right answer for you. What are you thinking may be helpful? Can I share with you why I think X,Y,Z could be really helpful?"* "*How will we know if what we are doing right now isn't working and more support is needed*?"
Stigma (therapy or medication)	• Listen to the fear. • And then normalize and educate.	*"What do you imagine therapy would be like?"* *"Therapy isn't like you see in the movies; you don't really lay on a couch and talk about your deepest, darkest secrets. You and your therapist will work together on goals that are important to YOU. If that's not happening, let me know and we can find you someone else."* *"Think about a therapist like you would a coach or teacher. They will help you learn some new skills and strategies that will hopefully help you feel better. You'll practice those skills, get really good at them, and eventually you won't need the coach anymore. Or maybe you'll only need to see the coach every now and then to refresh your skills."*
Too many barriers (financial, transportation, hours, language differences, etc.)	• Educate about the options and then offer choices. • Prioritize services and take a stepwise approach. • Remember the hierarchy of needs. Get social work support/community resources in place if needed. • Request VMAP Care Navigation services!	*"We talked about doing X,Y, and Z. Which of those things feels like a doable first step? Okay, great. Let's start there and follow up in a couple of weeks."* *"What might get in the way of making that phone call/getting that prescription filled/etc.?"*

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Patient Concern	What You Can Do	How You Can Say It
Denial of a problem	• Instill power/control for teens. • Verbalize your concern and let them know you care. • Offer choices! (choice of therapist, choice of schedule, choice of format) • Query extremes.	*"I'm worried about you and am hopeful we can work together to get a plan that feels good to you. Can I share some ideas of what I think could be helpful?"* *"Here are some things I think could be helpful. Which of them sounds like something you might consider?"* *"What is worst case scenario if you try X, Y, Z treatment? Best case scenario?"*

Resources for Providers

- American Academy of Pediatrics Motivational Interviewing resources (aap.org)
- *Motivational Interviewing in Health Care*, by Rollnick, Miller, and Butler (2022)
- *Motivational Interviewing: A Guide for Trainees*, by Douaihy, Kelly, and Gold (2015)
- Motivational Interviewing Strategies to Facilitate Adolescent Behavior Change (etsu.edu)
- 6 Culturally Sensitive Ways to Approach Mental Health (qualityinteractions.com)

Resources for Teens and Families

Medication

American Academy of Child and Adolescent Psychiatry Parents' Medication Guides (aacap.org)
Guides as of Nov. 2023 include: ADHD, ADHD in Youth with ASD, Anxiety Disorders, Autism Spectrum Disorder, Depression, Impairing Emotional Outbursts, Sleep Disorders

Taking Your Child to a Mental Health Provider

- Therapy to Improve Children's Mental Health (cdc.gov)*
- Taking Your Child to a Therapist (kidshealth.org)*
- Going to a Therapist (kidshealth.org)*
- Understanding the Different Types of Mental Health Professionals (foundcare.org)
- Helping Resistant Teens into Treatment (childmind.org)*
- Culture and Mental Health (nami.org)

For Teens

- How You Can Ask for Help (nami.org)

* Resource available in English and Spanish

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2.1 Virginia Resources: Quick Links

General Information

Virginia Dept. of Social Services: dss.virginia.gov/

Virginia Dept. of Behavioral Health and Developmental Services: dbhds.virginia.gov/

Virginia Children's Health Insurance: coverva.org/en/famis

Community Services Boards Directory: dbhds.virginia.gov/community-services-boards-csbs

Bridge2Resources: bridge2resourcesva.org/

Accessing a Mental or Behavioral Health Therapist

Virginia Mental Health Access Program (VMAP): vmap.org/ or (888) 371-8627
PCP can call to connect families with care navigators

Psychology Today Directory: psychologytoday.com/us/therapists

Medicaid information, including directories, case management, and contact information: dmas.virginia.gov/for-members
If you have private insurance, you may also contact your insurance company for a list of providers.

Crisis Services

Suicide and Crisis Lifeline: free and confidential emotional support to people in suicidal crisis or emotional distress 24/7

- Call 988; Text 988; Chat at 988lifeline.org
- En Espanol: Text AYUDA to 988; 988lifeline.org/es
- For Deaf & Hard of Hearing: 988lifeline.org/help-yourself/for-deaf-hard-of-hearing/
- For Veterans: Text 838255 to 988

Crisis Textline: for any crisis; 24/7 connection with live, trained crisis counselors.

- Text HOME to 741-741; crisistextline.org/

REACH (Regional Education Assessment Crisis Services Habilitation): 24/7 crisis supports for individuals with developmental disability

- **Region I (western Virginia):** (888) 908-0486
- **Region II (northern Virginia):** (855) 897-8278
- **Region III (southwest Virginia):** (855) 887-8278
- **Region IV (central Virginia):** (833) 968-1800
- **Region V (eastern Virginia):** (888) 255-2989

Developmental Disabilities Resources

The Arc of Virginia: thearcofva.org/

Center for Family Involvement: centerforfamilyinvolvementblog.org

Information on Medicaid Waivers: thearcofva.org/introduction-to-medicaid-waivers

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Family Support Organizations

National Alliance on Mental Illness (NAMI) Virginia: namivirginia.org/programs

United Methodist Family Services: umfs.org/

Parent-to-Parent: p2pusa.org/

Home Visiting Programs (Early Impact Virginia): earlyimpactva.org/directory/

Virginia Post Adoption Consortium: umfs.org/rpacs/

Families Forward Virginia: familiesforwardva.org/

Parent Educational Advocacy Training Center: peatc.org

Juvenile Justice Resources

Dept. of Juvenile Justice Family Resources: djj.virginia.gov/
Visit the section "For Our Families."

LGBTQ+ Resources

Side by Side Virginia: sidebysideva.org/

- **Youth support line:** Call (888) 644-4390 or Text (804) 793-9999

Trevor Project: thetrevorproject.org

- **24-hour national hotline:** (866) 488-7386 or Text START to 678-678

Military Family Resources

Virginia Dept. of Veteran Services & Family Support: dvs.virginia.gov/virginia-veteran-and-family-support-2

Serving Together: servingtogetherproject.org/
Serves primarily Northern Virginia, Washington DC, and Maryland.

Substance Use Disorder Services

Addiction Recovery Support Warmline: (833) 4PEERVA (473-3782)

Alcoholics Anonymous: aa.org/

Families Anonymous: familiesanonymous.org

Narcotics Anonymous: na.org/

Treatment Locator: findtreatment.samhsa.gov/

Warm Lines

NAMI Teen and Young Adult HelpLine: offers a direct connection with another young person who shares similar experiences; offers information, resources, and support; Monday to Friday, 10 a.m. to 10 p.m.
Call (800) 950-6264; Text FRIEND to 62640; E-mail helpline@nami.org

Mental Health America of Virginia Warm Line: peer-run warm line for mental health and substance use

- Call (866) 400-MHAV (6428); Monday to Friday, 9 a.m. to 9 p.m.; Saturday, Sunday, Holidays, 5 p.m. to 9 p.m
- Spanish Services: Call or Text (866) 400-MHAV (6428); Fridays and Saturdays, 5 p.m. to 9 p.m.
- Text (866) 400-MHAV (6428), Wednesdays, Fridays and Saturdays, 5 p.m. to 9 p.m.

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2.2 Virginia Resources for Pediatric Mental Health

WHAT IS THE ROLE OF COMMUNITY SERVICES BOARDS?

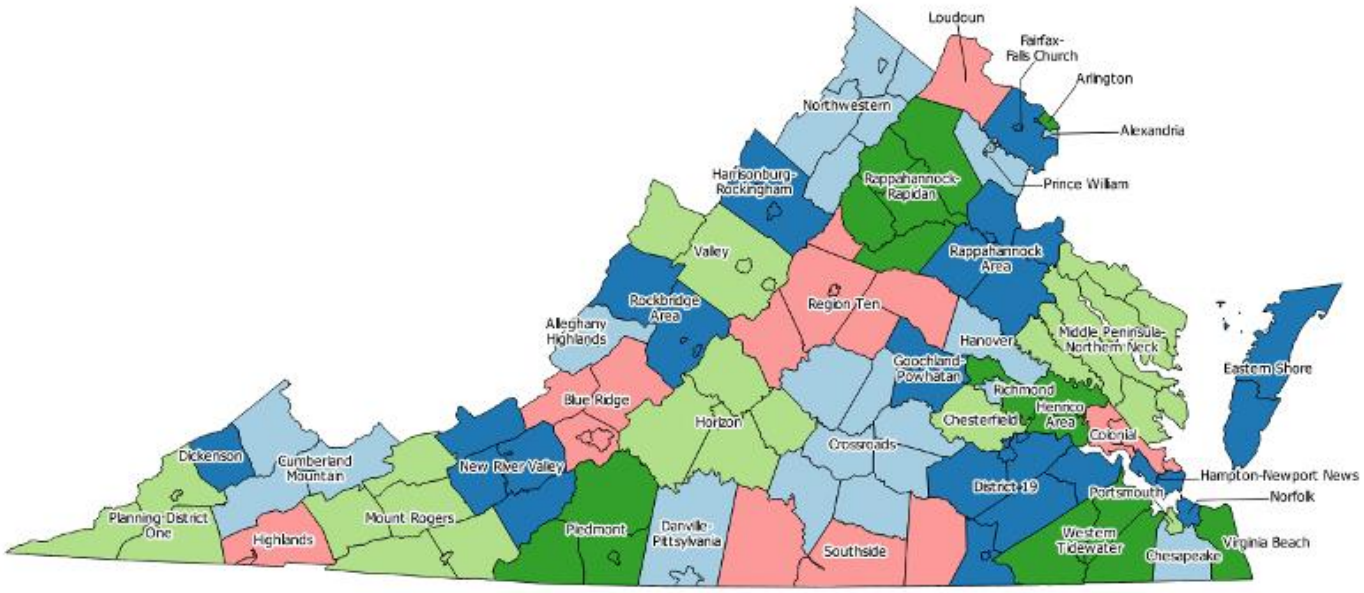
Community services boards (CSBs) serve localities (regional and sometimes by county) across Virginia in providing mental health services and resources to families by locality. In addition to mental health services, they also provide services for individuals with intellectual disabilities and people with substance use disorder.

There are 41 CSBs throughout Virginia. Each CSB is funded by state and local government, and is managed locally. For this reason, there is a great deal of variation in the number and types of services offered by each CSB.

HOW DO I FIND THE CSB THAT SERVES MY PATIENTS?

Use the map or follow the link below to determine your local CSB and information on local services and operating hours: dbhds.virginia.gov/community-services-boards-csbs

CSBs in Virginia



WHAT IS SAME DAY ACCESS?

The purpose of Same Day Access (SDA) is to provide a clinical assessment to any individual on the day they come to the CSB during open access hours. The intention is to reduce wait times and streamline the process for access to services. ***However, SDA hours vary by CSB and some locations do not provide assessments for children and adolescents***. Families should check the website for their local CSB for more details about SDA availability.

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WHAT IS THE CONTACT INFORMATION FOR THE CSBs THAT SERVE MY PATIENTS?

Go to dbhds.virginia.gov/community-services-boards-csbs to search for CSB by locality.
Fill in the blanks below so you have quick access to the CSBs that align with your patients' localities.

Locality	CSB that serves this area	Primary phone number	Local crisis number (if different)

COMMON SERVICES AVAILABLE THROUGH A CSB

Level of Need	Services That May Be Available (varies by locality)
Urgent-Crisis	• Crisis intervention services, counseling, safety planning and referrals • Mobile crisis and/or crisis stabilization • Screening and referral for hospitalization when needed • REACH* program — regional crisis stabilization for individuals with developmental disabilities
Mild to Moderate Mental Health Needs (outpatient services)	• Individual and family therapy for mental health and substance use • Case management
Individuals with Developmental Disabilities	• Case management • Day support for adults (can include vocational training and support) • Residential services (group homes) • Medicaid waiver eligibility
Early Intervention	• Screening and services for children under age 3 • Some Infant and Toddler Connection programs operate out of the CSBs itcva.online/central-directory **800-234-1488**

** REACH is a regional crisis service and in this instance does not refer to the VMAP-sponsored provider training of the same name*

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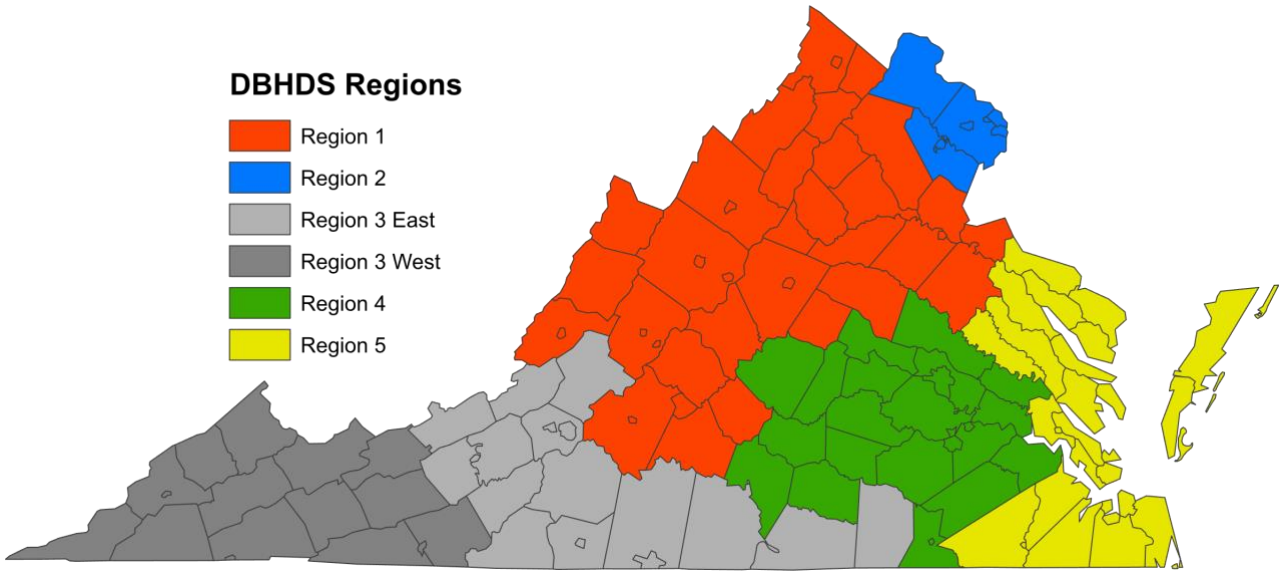
REGIONAL CRISIS INFORMATION

In Virginia, crisis services vary by region. It is good to know which Virginia Department of Behavioral Health and Developmental Services (DBHDS) region the families you serve reside in (see map below). Local crisis resources and contacts are available on each community services board (CSB) website. Follow the link below to determine your local CSB and access its respective website. dbhds.virginia.gov/community-services-boards-csbs



Virginia participates with 9-8-8, the national 3-digit crisis number. When calling this number, a specialist will be able to work with a family to direct them to:

- Over the phone support
- Home visitation provided by a Mobile Crisis Responder
- Community-based stabilization services
- Crisis Receiving Centers
- Referral to community-based services and resources

REACH: Regional crisis system of care for special populations, including children and adolescents and individuals all ages with intellectual or developmental disabilities. REACH services are available regionally:

- 24/7 crisis assessment and intervention
- Post-crisis mobile/community-based prevention services
- Brief residential crisis therapeutic services at an Adult or Youth REACH Crisis Therapeutic Home
- Creation of an individualized Crisis Education and Prevention Plan
- Individualized training to clients and their support system
- Connections to other community supports
- Training and education to the broader community

Alongside these changes, the state has adopted the MARCUS Alert system, which will limit the involvement of law enforcement in mental health crises, diverting individuals to clinical resources and supports instead. Each locality is developing its own implementation of the MARCUS Alert system; however, the 9-8-8 phone number will assist in its functionality.

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CHILDREN'S SERVICES ACT (CSA) AND FAPT FUNDING

What do PCPs need to know about CSA and FAPT (Family and Assessment Planning Team) funding?

These government funds support community-based, family-centered, and cost-effective care for youth with significant educational or emotional needs. In order to access CSA funding, families must connect with a FAPT or Community Policy and Management Team (CPMT) in their locality. These multi-disciplinary teams meet regularly to assess initial and ongoing funding needs for specific services. ***Families can self-refer at their Department of Social Services, but often families connect to this process through a school or other social service case manager.***

- The Children's Services Act (formerly Comprehensive Services Act) is a Virginia law that allows state and local agencies to draw on government funds to provide services for at-risk youth. The most frequently funded services include: private school placement for special education, residential treatment, and specialized therapy.
- Services frequently funded through CSA or FAPT/CPMT are typically for the following populations:
  - Youth who require placement in a private school for special education as determined by their IEP
  - Youth in foster care or who are eligible for foster care services
  - Youth who are eligible for services through a Child in Need of Services or Child in Need of Supervision (CHINS; a court-designated status for children whose behavior, conduct or condition presents a risk to safety and well-being and/or to address truancy and runaway behaviors) parental agreement
  - Youth with significant emotional or behavioral challenges, particularly if at risk of residential placement or requiring multiple services

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COMMUNITY-BASED & SCHOOL-DELIVERED SERVICES

Child Age	Birth to 3 years	3 to 17 years	18 years and older
Services Available	• Early Intervention (DBHDS) • Home Visiting (VDH) • Early Childhood Special Education (ECSE); accessed through local school district (for age 2+)	• Individualized Education Plan (IEP) • 504 plan (accommodations) • Response to Intervention (RTI) support services	Individuals with an IEP may qualify for special education services and transition services **up to age 22**. A child with a disability whose 22nd birthday is after September 30 remains eligible for the remainder of the school year.
Where Services May Be Provided	Home or daycare settings	• Preschool or Head Start • Public school • Private or specialty school • Residential program • Home-based instruction (Based on need determined through assessment and re-evaluated at least annually)	• Public school • Specialty school • Residential program • Vocational training centers
First Point of Contact for Family	Local Infant & Toddler Connection (varies by locality) itcva.online/central-directory **800-234-1488**	Child's home school; family should request a meeting in writing to initiate child study process.*	If adult needs accommodations in college or post-high school training, updated evaluations may be required.
Role of PCP	May provide initial referral to services based on screening or diagnosis.	• May provide initial referral to services based on screening or diagnosis. • Medical records and/or diagnosis can be considered but are usually not the only determining factor of eligibility for services. ***Diagnosis alone does not determine eligibility. Impact on the child's learning in their environment must be considered.***	May support family with discussions on guardianship or conservatorship.This usually requires additional consultation with an attorney.

WHAT IS CHILD FIND?

Under federal law, public schools must look for, find, and evaluate kids who need special education. This is called Child Find, and it covers kids from birth through age 21. It applies to all kids, including those who are homeschooled or in private schools, plus kids who are migrants or without homes.

Parents and caregivers can request an evaluation via written request; understood.org has template letters that families can utilize for this purpose.

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Legal requirements for educational services

- Federal special education law (IDEA) covers youth ages 3-21 to receive specialized support and instruction through an individualized education plan (IEP) when determined eligible.
- Additional legislation covers early intervention services (birth to 3) for in-home, community-based services and support through an individualized family services plan (IFSP).
- Children not eligible for an IEP may qualify for accommodations under a 504 plan (part of the Federal Rehabilitation Act). While an IEP does not need to be honored in a private school, a 504 plan usually does.
- A 504 plan (or IEP) can provide:
  - Testing or assignment modifications
  - Behavior management support
  - Regularly scheduled visits to a school nurse
  - Other environmental modifications as indicated by the child's need
- Resource for families: Virginia Department of Education's Understanding Special Education (available in multiple languages) doe.virginia.gov/programs-services/special-education/information-for-families

INVOLUNTARY MENTAL HEALTH HOSPITALIZATION

See Section 2.3 for additional information.

- **Temporary Detention Order (TDO)** — a legal document requiring an individual to receive immediate hospitalization until a commitment hearing can be arranged. Typically, this is only used in cases of safety concerns to self/others and lack of consent (see below). TDOs cannot last longer than 72 hours for adults or 120 hours for a minor.
- Legal age of consent in Virginia:
  - The legal age of consent for hospitalization is 14 in Virginia. However, medical treatment still requires parent/guardian consent for individuals under the age of 18.
  - If the teen does not consent to care but the parent/guardian does, a TDO will be required for hospitalization.
  - If the individual is younger than 14, consent for admission and treatment for mental health services are the responsibility of a parent or guardian.
- Who to contact if you think involuntary hospitalization is necessary?
  - If the family is working with a mental health professional (counselor, psychiatrist, etc.), they should be the first point of contact to discuss options.
  - The next best point of contact is the closest community services board (CSB). Regional mobile crisis services can support this but services vary based on region. Call the closest CSB and ask for an immediate appointment for someone in a mental health crisis. dbhds.virginia.gov/community-services-boards-csbs
    - 9-1-1 is always an option for an assessment by a Crisis Intervention Team officer.

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TIERED SERVICES OF SUPPORT AVAILABLE IN VIRGINIA

This section briefly describes supports for mental and behavioral health services that are typically available to children and families in Virginia. ***It is important to know that some services are restricted based on payment options (Medicaid, FAPT, etc.) or other qualifying criteria.***

What are considerations for home visiting?

Who is eligible for home visiting?

Home visiting is typically covered for eligible children under age 3. You can refer a family for home visiting services.

What can a home visitor provide?

Trained professional home visitors (e.g., Early Head Start, Resource Mothers, Parents As Teachers, CHIP of VA, Healthy Families, Family Spirit, Healthy Start, Nurse Family Partnership) provide parenting and education support designed to provide in-home support to:

- Monitor children's health, mental health, and development
- Assist women with keeping health and mental health appointments
- Follow up with the caregiver on follow-through for referrals to needed health, mental health and social services
- Promote positive parent-child relationships

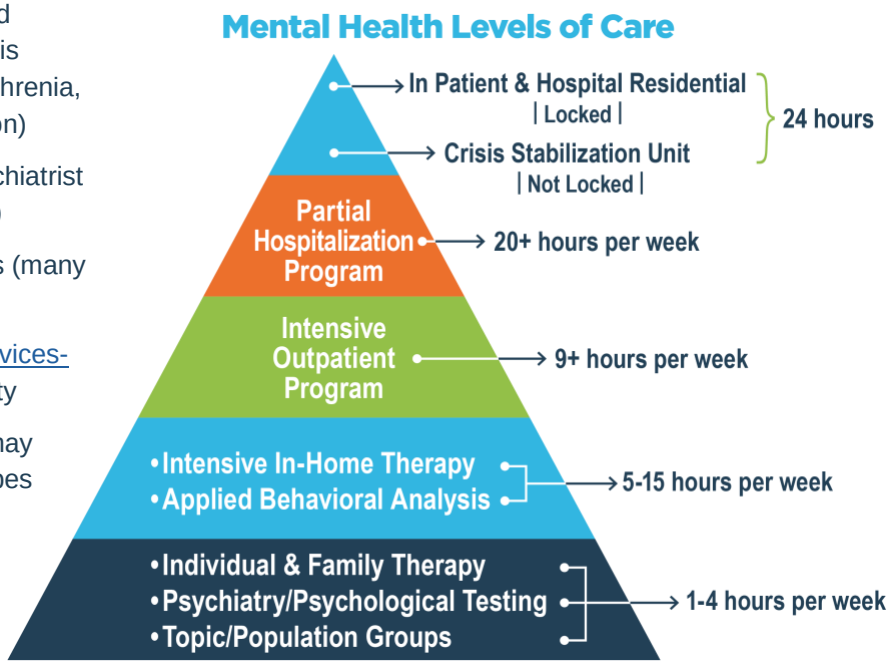
To find contact information for home visiting programs in your area, use the following link earlyimpactva.org/directory/ and then choose a city or county from the drop-down menu.

What are considerations for outpatient therapy?

- Typically provided by a licensed mental health provider (PsyD, LPC, LMFT, or LCSW)
- Provides a behavior-based approach to care using various therapeutic techniques, cognitive behavioral therapy (CBT), psychometric assessment, or testing for IQ and learning disabilities
- Go to dbhds.virginia.gov/community-services-boards-csbs to search for CSB by locality
- Funded by insurance; some providers may not bill or only take certain insurance types

What are considerations for psychiatry management?

- Typically more focused on diagnosis and treatment, particularly when medication is needed (e.g., anorexia, bulimia, schizophrenia, PTSD, bipolar disorder, major depression)
- Provided by a child and adolescent psychiatrist or a psychiatric nurse practitioner (PNP)
- Be certain to ask for any age restrictions (many providers don't see children under 12)
- Go to dbhds.virginia.gov/community-services-boards-csbs to search for CSB by locality
- Funded by insurance; some providers may not bill or only take certain insurance types



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WHAT OPTIONS ARE AVAILABLE FOR MORE INTENSIVE MENTAL HEALTH SERVICES?

Service Type	Brief Description	How is it funded?	What is the PCP's role?
Intensive In-Home Services	• Provides intensive family counseling and behavioral intervention therapy in the home setting, usually 3-10 hours per week for up to 26 weeks. • Often a step-down service from crisis or acute hospitalization OR offered to prevent hospitalization.	• Typically funded through Medicaid or FAPT; very few private insurances cover this service	• Communication with therapists providing services will support a continuum of care.
Partial Hospitalization or Intensive Outpatient (PHP/IOP)	• Provides intensive mental health services during the day, 20-30 hours per week. Children go home at night. • Includes psychiatry oversight and individual/family therapy services.	• Funded by insurance (Medicaid and private)	• For PHP/IOP: speak with someone in admissions to discuss case; refer for admission if program allows. • For IP hospitalization: refer for CSB emergency services evaluation via Same Day Access program or recommend ED for evaluation. • After discharge, providing step-down or interim medication management until patient is able to connect with an outpatient psychiatrist (may have a lag time of 2-3 months). • VMAP can help support the medication management piece through consultation. • If youth is over 14, they must consent for hospitalization or PCP can initiate TDO process.
Inpatient Psychiatric Hospitalization: Acute	• Psychiatric stabilization, often resulting from crisis. Often includes starting or adjusting medication and intensive therapy focused on safety and stabilization. • Families often cannot self-admit; requires admission through emergency room or other community crisis services. Average stay is 5-7 days; discharged to community services or inpatient/residential depending on patient need.	• Funded by insurance (Medicaid and private)	
Longer Term or Residential Psychiatric Hospitalization	• Often a next step after inpatient acute psychiatric stay. May vary in type of program (locked unit, specialty area). Can be as short as 30 days or as long as 6 months. • May vary in type of program and length (locked unit, specialty area, days or months). • Usually includes educational services while admitted.	• Medical component may be funded by insurance. Private insurance coverage is usually more limited than Medicaid. • Child may qualify for Medicaid services after 30 days of inpatient stay. • Can also be funded by FAPT/CSA.	

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2.3 For PCPs: Understanding the Emergency Custody Order (ECO) and Temporary Detention Order (TDO) Process For Minors & Young Adults

A "responsible person" thinks help is needed

- Legal guardian may admit minors ages 13 and under; this is not considered involuntary hospitalization.
- If the individual in crisis is 14 or older, they have to agree to hospitalization. If they don't agree, then the process to detain must be followed.

Mobile Crisis/Co-Responder Team (police + CSB worker)

Responsible Person (e.g., family, PCP, therapist)

Law Enforcement Officers (LEO)

Petition for Emergency Custody Order (ECO):
"Responsible person" with most firsthand information about the individual's crisis — CSB worker, family member, friend, roommate, medical provider — petitions the magistrate for **E**mergency **C**ustody **O**rder

Paperless ECO:
If LEO feels confident that the individual meets criteria of §37.2-808 (e.g., has a mental illness, is in imminent danger of harm)

Contact or go in-person to local magistrate for petition to complete — notarize and return (can fax)

Magistrate reviews petition to determine if it meets criteria (§37.2-808)

ECO **not** granted

ECO **granted**

Assigned to LEO for transport

Note: Restraint may be used

Transport to ED/Hospital

CSB therapist evaluates for **T**emporary **D**etention **O**rder

CSB applies for TDO with magistrate

If granted, bed search initiated (patient is in ED)

Admitted for up to 72 hrs before a hearing

TDO hearing outcome options:
- Court-Mandated Admission (has to stay in hospital)
- Voluntary hospitalization
- Dismissed/released with mandatory outpatient treatment
- Dismissed/released

PCP can initiate ECO/TDO/Medical TDO process:

Requirements for issuance of ECO/TDO: evidence that the person suffers from a mental illness; that, as a result of mental illness, the person will, in the near future, cause serious physical harm to self or others or will suffer serious harm due to a lack of capacity to protect against harm or to provide for basic human needs; that hospitalization or treatment is required, and, for an adult, that he or she is unable or unwilling to consent to treatment.

Medical TDO: a similar process **that a PCP may want to consider** if the risk to the individual's life and safety stems from the individual being incapable of making an informed decision to accept necessary medical treatment (e.g., for diabetes, heart condition).

Magistrate: a judge available on an around-the-clock basis, conducting hearings to issue arrest warrants, search warrants, emergency custody orders, etc.

Need Assistance?

Contact VMAP for help understanding this process

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2.4 Virginia Medicaid and Behavioral Health

MEDICAID OVERVIEW

The Virginia Medicaid program, administered by the Department of Medical Assistance Services (DMAS), celebrated its 50th anniversary in 2019. DMAS plays an essential role in the Commonwealth's health care system by offering lifesaving coverage to 1 in 5 Virginians, including more than 500,000 newly eligible adults who gained access to care when the program expanded in 2019. Both state and federal funding contribute to the Medicaid budget. Medicaid and FAMIS are Virginia's medical assistance programs to help pay for medical care for qualifying individuals. To be eligible for medical assistance, an individual must have limited income or meet some other eligibility criteria. This overview will focus on youth populations given the focus of VMAP.

CARDINAL CARE TRANSITION

DMAS branded as Cardinal Care on January 1, 2023. Cardinal Care encompasses all health coverage programs, including Medicaid, Family Access to Medical Insurance Security (FAMIS), and Plan First.

On October 1, 2023, Virginia combined its two existing managed care programs – Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0 – into one unified managed care program known as Cardinal Care Managed Care (CCMC).

Commonwealth Coordinated Care Plus Home and Community-Based Services (HCBS) Waiver program will continue to operate as the CCC Plus HCBS Waiver.

The following table summarizes the types of Medicaid programs for children, the basic eligibility criteria, and information on how they may apply for enrollment:

Program	Eligibility	Application Instructions
FAMIS	Children from birth to age 19 whose family income is between 143% - 200% (+ 5% income disregard) of the Federal Poverty Level (FPL) limit.	Call the Cover Virginia Call Center at **1-855-242-8282** (TDD: **1-888-221-1590**) Complete an online application at Common Help: commonhelp.virginia.gov Complete an online application at The Health Insurance Marketplace: healthcare.gov Mail or drop off a paper application to your local Department of Social Services (mailing may take longer than other methods of applying). Find your nearest local department of social services by visiting: dss.virginia.gov/localagency/index.cgi Call the Virginia Department of Social Services Enterprise Call Center at **1-855-635-4370** if you also want to apply for other benefits.
FAMIS Plus *Children's Medicaid*	Children from birth to age 19 whose family income is at or below 143% of the Federal Poverty Level (FPL) limit.	

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Program	Eligibility	Application Instructions
FAMIS Select	FAMIS-enrolled children may choose between FAMIS coverage or FAMIS Select, a program that offers a small monthly subsidy to help families pay the monthly premium for employer-sponsored health insurance. Children in FAMIS Select are enrolled in their employer-sponsored plan for all benefits but can receive wraparound coverage of childhood immunizations if not covered by the private plan.	Once enrolled in FAMIS, apply for FAMIS Select online: coverva.org/en/famis-select and complete and submit an application to the FAMIS Select Unit. Call FAMIS Select directly at **1-888-802-5437** or **804-786-1024**. FAMIS Select will mail you a packet that includes an application, instructions to complete the application and a program brochure. Applying for FAMIS Select is voluntary. Once enrolled in FAMIS Select, you have the choice to drop FAMIS Select and go back to FAMIS at any time during the child's 12-month coverage.
NOTE: Eligibility for Youth in Foster Care and Former Foster Youth All youth in foster care are eligible for Medicaid health care coverage. Medicaid coverage is also available to eligible former foster care youth who were receiving Medicaid and foster care services in any state at the time of their 18th birthday and are currently under age 26.		

WHAT HAPPENS AFTER A MEMBER ENROLLS IN MEDICAID?

Members initially enroll in fee-for-service for a short time until they select enrollment in one of the six managed care plans. During that brief fee-for-service period, the fee-for-service service authorization contract, Kepro/Acentra, provides coverage for both mental health and addiction and recovery treatment services.

Initial Enrollment In Fee-for-Service
always covers residential services, even after the transition to MCO

Choose Managed Care Plan
for all behavioral health services except residential

Providers may contact Kepro/Acentra directly via email at VAproviderissues@kepro.com or by phone at **1-888-827-2884.** The Kepro/Acentra website is https://dmas.kepro.com/.

Most Medicaid and FAMIS members get care through a health plan. Each health plan has a network (group) of primary care providers (PCPs), specialists, hospitals and other health care providers.

These are the health plans Medicaid and FAMIS members may choose from:

Managed Care Organization	Phone Number	Website
Aetna Better Health	**(800) 279-1878**	aetnabetterhealth.com/virginia
Anthem HealthKeepers Plus	**(800) 901-0020**	anthem.com/vamedicaid
Molina Healthcare	**(800) 424-4518**	molinahealthcare.com
Sentara Community Plan ***in Northern Virginia, members may be with Kaiser Permanente***	**(800) 881-2166** ***(855) 249-5025***	sentarahealthplans.com
UnitedHealthCare Community Plan	**(844) 752-9434**	**For existing members:** uhccommunityplan.com/va **For non-members looking for info on UHC plans:** uhc.com/communityplan/virginia

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CO-PAY INFORMATION

Most members do not pay a co-payment for services covered by Medicaid. For children covered in the FAMIS program, a small co-payment may be required for some services.

BEHAVIORAL HEALTH SERVICES

Over the past 5 years, Virginia Medicaid has worked to expand and enhance its behavioral health program with the goal of building a continuum of services that are high-quality, evidence-based, trauma-informed, person-centered and prevention-oriented. This effort began in 2017 with the implementation of the Addiction and Recovery Treatment Services (ARTS) program. The work has continued into 2021 with the launch of enhancements to mental health services through an initiative called Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes). The following section provides some answers to the most common questions about these programs.

What mental health services are included in Medicaid?

The Virginia Medicaid mental health services program includes a variety of services across all levels of care from outpatient counseling/psychotherapy to inpatient acute psychiatric hospitalization.

Other services currently covered include the following, listed roughly by level of intensity of the service:

Service	Adult Service	Youth Service
Case Management	✓	✓
Outpatient Counseling/Psychotherapy	✓	✓
Outpatient Psychiatric Medical Care	✓	✓
Applied Behavioral Analysis**	X	✓
Intensive In-Home Services	X	✓
Multisystemic Therapy**	X	✓
Functional Family Therapy**	X	✓
Therapeutic Day Treatment	X	✓
Mental Health Skill Building	✓	X
Psychosocial Rehabilitation	✓	X
Assertive Community Treatment*	✓	X
Intensive Outpatient Programs*	✓	✓
Partial Hospitalization Program*	✓	✓
Mobile Crisis Response**	✓	✓
Community Stabilization**	✓	✓
23-Hour Crisis Stabilization**	✓	✓
Residential Crisis Stabilization**	✓	✓
Therapeutic Group Homes***	X	✓
Psychiatric Residential Treatment Facilities***	X	✓
Acute Psychiatric Hospitalization	✓	✓

** These services became available for reimbursement on July 1, 2021.*

*** These services became available for reimbursement on December 1, 2021.*

**** PRTF services for mental health are currently only covered for youth age 18 and under.*

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What is Early and Periodic Screening, Diagnostic and Treatments (EPSDT)?

The EPSDT benefit is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to ensure that health problems are diagnosed and treated as early as possible. EPSDT specialized services are medically necessary treatment services for children that are not routinely covered by Virginia Medicaid; a letter of medical necessity or provider order may be required. The 6 most common services requested include:

- assistive technology
- hearing aids
- private nurse
- behavioral therapy
- personal care
- medical formulas

For provider inquiries, contact (804) 786-6134 or EPSDT@dmas.virginia.gov.

What is the ARTS (Addiction and Recovery Treatment Services) program?

The ARTS program benefit provides treatment across the levels of care defined by the American Society of Addiction Medicine (ASAM) for members with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS and FAMIS MOMS, including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

- Information on the ARTS program is available here: dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/.
- The Managed Care Organizations have ARTS Care Coordinators what can support connection to these services.

A Google Map of ARTS providers is available here: dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/.

RESIDENTIAL SERVICES FOR YOUTH

Are residential placements covered by Medicaid?

Residential treatment services for youth (Therapeutic Group Home and Psychiatric Residential Treatment Facilities) are “carved out” of managed care, and covered and managed by Kepro/Acentra through fee-for-service. This means that they are indeed covered, but when a youth is enrolled with a Managed Care Organization and it is determined that they may need evaluation for or placement in a residential level of care, their mental health care is temporarily managed by Kepro/Acentra. Their medical coverage remains with the Managed Care Organization.

How do members determine if they are eligible for residential treatment?

Each youth seeking admission to residential services will receive the support of the local Independent Assessment, Certification and Coordination Team (IACCT) in each locality to assess the child’s needs. The IACCT is organized by contractors working with Kepro/Acentra and will include the child, the child’s family/legal guardian and clinical professionals from the child’s community. ***Whenever possible, a primary care physician or psychiatrist who knows the child’s history will be involved in the assessment.*** A Kepro/Acentra Intensive Care Manager (ICM) will assist with care coordination for the IACCT. A Kepro/Acentra Family Support Coordinator (FSC) with lived experience as the parent of a child receiving behavioral health services will connect with the family throughout the course of treatment to offer continuity of care. After the IACCT completes the assessment, the team will develop an appropriate plan of care to meet the individualized needs of the child and family. Plans may include residential or community-based services.

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How can families initiate the IACCT process for their youth?

Providers or families may initiate the IACCT process by submitting an inquiry form through the Kepro/Acentra website.

What does Medicaid pay for during residential treatment for youth mental health problems?

Medicaid is allowed to pay for all of the health care services, including behavioral health and physical health interventions, that a person participates in during their residential placement. Some of those interventions are included in the "per diem" (daily rate) for the services, and others can be reimbursed in addition to the daily rate. The chart below provides an overview of what is covered in the two types of residential treatment services.

Per Diem Component*	Psychiatric Residential Treatment Facilities	Therapeutic Group Home
Room and Board	✓	X
Daily Supervision	✓	X
Treatment Planning	✓	✓
Skills Restoration and ADL Restoration Interventions	✓	✓
Care Coordinator	✓	✓
Crisis Response	✓	✓

**Cannot be reimbursed separately from or in addition to the per diem.*

The Children's Services Act (CSA) provides funding that is available to cover the educational costs for youth during residential treatment. These funds are managed by the local Family Assessment and Planning Teams (FAPT) within each locality, and educational costs are considered in the initial coordination between the FAPT teams and the IACCT assessor. More information on accessing CSA funds can be found at csa.virginia.gov/.

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VIRGINIA'S HOME- AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

Virginia Medicaid provides two types of waivers:

1. Developmental Disability Waivers

Virginia has three waivers for individuals with a developmental disability:

- Building Independence for individuals 18 and older
- Family & Individual Support
- Community Living

Virginia Medicaid administers DD Waivers jointly with the Virginia Department of Behavioral Health and Developmental Services (DBHDS). There is a tiered priority waiting list for these waivers, and the slots are assigned based on urgency of need. To apply for DD Waiver services, contact the local Community Services Board (CSB): vacsb.org/csb-bha-directory/.

Eligibility

- The individual must meet diagnostic eligibility consistent with Virginia's Definition of Developmental Disability.
- The individual must meet the functional criteria for the Virginia Individual Developmental Disability Eligibility Survey (VIDES) ; these critera are available on the Virginia DBHDS website and are differentiated by life stage — VIDES Adult, VIDES Child, VIDES Infant.
- The individual must meet financial eligibility. A child does not have to apply or be enrolled in Medicaid when being screened for a waiver. Medicaid waiver eligibility for children is not dependent on parental income once they receive approval for a waiver slot. To receive waiver services, an individual must apply and qualify for Medicaid unless already enrolled in the Medicaid program.

Apply

To apply for Developmental Disability Waiver services, contact the local CSB. The CSB staff will determine if the child:

- meets the definition of someone with a developmental disability; and
- meets the functional criteria as assessed on the VIDES screening tool.

Covered Services

Employment & Day Supports

- Community Engagement
- Community Coaching
- Group Day Services
- Supported Employment

Crisis Supports

- Community-Based Crisis Supports
- Center-Based Crisis Support Services
- Residential Options
- Shared Living

Additional Services

- Assistive Technology
- Benefits Planning Services
- Employment & Community Transportation
- Environmental Modifications
- Electronic Home-Based Services
- Personal Emergency Response System
- Community Guide
- Transition Services
- Peer Mentor Supports

2. Commonwealth Coordinated Care (CCC) Plus Waiver

The CCC Plus Waiver serves all ages and does not have a waiting list. The waiver provides (for individuals with nursing level needs) care in the home and community rather than in a nursing facility or other specialized care medical facility. The CCC Plus Waiver provides supports and service options for successful living, nursing, respite, assistive technology, and environmental modifications.

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The Department of Medical Assistance Services (DMAS) oversees the Medicaid Long-term Services and Supports Screening Process in Virginia to evaluate what services may be available to an individual, including services through the CCC Plus waiver.

Eligibility

The following individuals may be eligible:

- Someone who meets the nursing facility level of care criteria (i.e., they are functionally dependent and have a medical nursing need)
- Individuals who are dependent upon technological support and require substantial, ongoing skilled nursing care
- Individuals who rely on a nurse personal care aide to maintain health, safety, and welfare in their home
- Individuals determined to be at imminent risk of nursing facility placement
- Individuals who are able to remain in their home rather than being placed in a nursing facility because of the community-based care services they receive under the waiver

Apply

To apply for CCC Plus Waiver services, contact the local Department of Social Services. The local Department of Social Services will complete a screening to determine eligibility for the waiver services. If eligible, the individual will then apply for Medicaid (if not already enrolled).

Covered Services

- Personal Emergency Response System
- Respite Services (Agency- and Consumer-Directed
- Service Facilitation
- Transition Services
- Adult Day Health Care
- Assistive Technology
- Environmental Modifications
- Personal Care Services (Agency- and Consumer-Directed)
- Private Duty Nursing (RN and LPN)

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2.5 Confidentiality of Minors in Mental Health Care: Frequently Asked Questions

Below are several FAQs addressing the impact of Virginia law on access to medical records of adolescent patients. Please note that while these FAQs summarize Virginia law, they do not apply it to any particular circumstances that a provider may encounter in the course of practicing. Furthermore, a provider's course of action in any given circumstance should also comply with any applicable policies and procedures of the provider's organization, as they may prescribe additional or more stringent standards than what is required by law.

Q *What is a "minor" under Virginia law?*

Persons under the age of 18 are considered minors under Virginia law. *(Va. Code § 1-207)*.

Q *What is the general rule under Virginia law on parental access to medical records of their minor children?*

Generally, parents of minors have the right to provide consent to minors' medical treatment and the corresponding right to access the medical records related to that treatment, although there are limited exceptions. *(Va. Code § 32.1-127.1:03; Va. Code § 20-124.6)*.

Q *What are the exceptions to the general rule?*

1. ***Access that is reasonably likely to cause substantial harm to the minor or another person.*** *(Va. Code § 20-124.6; Va. Code § 32.1-127.1:03)*
   - If a minor's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor *has made a part of the minor's record* a written statement that, in the exercise of his or her professional judgment, the furnishing to or review by the requesting parent of such health records would be reasonably likely to cause substantial harm to the minor or another person.
   - If a parent is denied access to, or copies of a minor's health record on this basis, the entity denying the request must inform the parent of his or her right to designate, or to request that the denying entity designate (at its expense) another reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor. The designated reviewing physician, clinical psychologist, clinical social worker, or licensed professional counselor shall make a judgment as to whether to make the health record available to the individual.
2. ***Minors' access to records when they are deemed adults when consenting to medical or health services.*** *(Va. Code § 54.1-2969)*. **A minor is deemed an adult for the purpose of consenting to:**
   - Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;
   - Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;
   - Medical or health services needed in the case of outpatient care (but not inpatient), treatment or rehabilitation for substance abuse[1]; or

[1] "Substance abuse" means the use of drugs enumerated in the Virginia Drug Control Act without a compelling medical reason or alcohol that (i) results in psychological or physiological dependence or danger to self or others as a function of continued and compulsive use or (ii) results in mental, emotional, or physical impairment that causes socially dysfunctional or socially disordering behavior and (iii), because of such substance abuse, requires care and treatment for the health of the individual. This care and treatment may include counseling, rehabilitation, or medical or psychiatric care. Va. Code § 37.2-100.

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- Medical or health services needed in the case of outpatient care (but not inpatient), treatment or rehabilitation for mental illness or emotional disturbance.
- Note that minors' access to records in the situations listed above are not exclusive, meaning that while a minor has the right to access records relating to the services described above, so will their parents, provided that the disclosure of records to the parent would not be reasonably likely to cause substantial harm to the minor or another person. Specifically, Subsection K of Va. Code § 54.1-2969 entitles a parent to the results of a minor's nondiagnostic drug test when the minor is not receiving care, treatment or rehabilitation for "substance abuse," as well as other health records, except when the minor's treating physician, clinical psychologist, clinical social worker, or licensed professional counselor has determined, in the exercise of professional judgment, that the disclosure would be reasonably likely to cause substantial harm to the minor or another person.

3. ***Access by emancipated minors.*** *(Va. Code § 16.1-334)*
   - Under Virginia law, an emancipated minor is treated as an adult for purposes of making health care decisions which include providing consent to medical treatment and accessing medical records. A minor must be emancipated by court order. Once the court issues an emancipation order, the emancipated minor may consent to medical, dental, or psychiatric care without parental consent, knowledge, or liability.
4. ***Access by married and pregnant minors.*** *(Va. Code § 54.1-2969)*
   - Two other subsections of Va. Code § 54.1-2969 provide specific direction on minors' access to records. Subsection F provides "[e]xcept for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment." This is an interesting provision in light of the laws (explained above) regarding the emancipation of minors because if a minor is or has been married, this statute provides the right to consent to medical treatment (and presumably to access medical records) even if the court has not issued an order granting the minor emancipation status. In addition, Subsection G provides that a pregnant minor is deemed an adult for the purpose of providing consent for herself and her child "to surgical and medical treatment relating to the delivery of her child when such surgical or medical treatment is provided during the delivery of the child or the duration of the hospital admission for such delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child." Therefore, pregnant minors can access both their medical records that are related to the delivery of their children and their post-partum care and can also access the records of their children.

Q *Do minors have access to their treatment records associated with a psychiatric inpatient admission?*

Generally, no. The Psychiatric Treatment of Minors Act set forth at Va. Code §§ 16.1-335 et seq. contains provisions giving the right to minors who are 14 years of age and older consent to (and object to) an inpatient admission at a psychiatric hospital. However, there is no provision that would provide those minors access to the records associated with their treatment during such admission. Va. Code § 54.1-2969.E allowing a minor to consent to outpatient behavioral health (but not inpatient behavioral health as noted above), suggests that the lack of such a provision is intentional.

Q *Can clinicians interfere with access, exchange or use of electronic health information (EHI) in an adolescent teen's electronic health record?*

The Cures Act defines practices that constitute impermissible "information blocking," while also establishing several exception. Under the Cures Act, "information blocking" occurs when a provider engages in a practice that is likely to interfere with access, exchange, or use of EHI, and the provider knows that the practice is unreasonable, and thus is likely to interfere with such access, exchange, or use. Providers should consult their

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policies and procedures and compliance and/or privacy officers before taking measures that may constitute “information blocking” under the Cures Act.

The Cures Act includes an exception under 45 C.F.R. § 171.201 in order to prevent harm. For the exception to apply: (i) the actor must hold a reasonable belief that the practice will substantially reduce a risk of harm; (ii) the actor’s practice must be no broader than necessary; (iii) the risk of harm must either by determined on an individualized basis in the exercise of professional judgment by a professional with a current or prior clinician-patient relationship or arise from data that is known or reasonably suspect to be misidentified, mismatched, corrupt due to technical failure or erroneous; (iv) the type of harm meets one of the conditions outlined in the regulations; and (v) the practice must satisfy the condition concerning a patient right to request review of an individualized determination of risk of harm. To reiterate, before taking any action that could implicate the Cures Act, providers should consult the appropriate personnel within their organization.

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3.1 Depression

SURVEILLANCE FOR **DEPRESSION**:

- Screen routinely, all patients ages 12+ annually
- Children and youth presenting with sadness, irritability, somatic complaints, school problems, parent-child conflict
- Additional risks include: family hx of depression; trauma; SUD; chronic disease; mental health comorbidity; bereavement

VALIDATED SCREENING TOOLS:

- Short Mood and Feelings Questionnaire (SMFQ) — age 6+ (positive ≥ 8)
- PHQ-A — age 12+ (10-14: moderate; 15+ and/or Q9 positive: severe)

PHQ-A:
Pay attention to
Question 9!

NEGATIVE SCREEN

Clinician concerned?

YES → Active follow-up with scheduled recheck, repeat screening and assessment

NO → Continue annual screening

POSITIVE SCREEN

- Interview patient alone
- Interview parent/caregiver
- Complete PE with labs as needed
- Use motivational interviewing to form a treatment alliance
- Pay attention to response on PHQ-A Q9

ASSESS FOR SAFETY

- Hx of suicide attempt or self-harm?
- Suicidality present? (suicide-risk screening tool; see care guide)
- Mania or psychosis? (see care guides)

Save A Life: Look for SIGECAPS

Sleep changes; lack of
Interest;
Guilt; decreased
Energy;
Concentration difficulties;
Appetite increase/decrease;
Psychomotor retardation/agitation;
Suicidal ideation

Safety concern?

YES → **EMERGENCY MENTAL HEALTH ASSESSMENT**
See 3.2: Suicidality Care Guide

NO

Mild depression:
PHQ-A score 5-9
Moderate depression:
PHQ-A score 10-14
SMFQ score > 8

- Active follow-up
- Psychoeducation, team formation and goal setting
- Evidence-based psychotherapy and/or medication
- If not successful, assess and screen for comorbid mental health conditions

Moderately severe:
PHQ-A score 15-19
SMFQ score > 8
Severe depression:
PHQ-A score 20+

- Psychoeducation, evidence-based therapy, medication
- Assess and screen for co-occurring mental health conditions
- Safety plan — see Suicidality Care Guide

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PHQ-9: MODIFIED FOR TEENS (PHQ-A)

Name: _____ **Clinician:** _____ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you feel okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

If you have had thoughts that you would be better of dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Office use only: **Severity score:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

PHQ-9 MODIFIED FOR TEENS (PHQ-A) SCORING GUIDANCE

When collecting the measure, please pay special attention to item #9. **If an individual responds to item #9 with a 3, immediately assess safety.** If an individual replies to item #9 with a 1 or a 2, assess for safety and consider VMAP consultation or specialist referral.

Scores Represent		
0-4	=	no or minimal depression
5-9	=	mild depression
10-14	=	moderate depression
15-19	=	moderately severe depression
20-27	=	severe depression

USING THE PHQ-9 TO ASSESS PATIENT RESPONSE TO TREATMENT

Initial Response After 4 Weeks of an Adequate Dose of an Antidepressant		
PHQ-9	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline	Possibly Inadequate	May warrant an increase in antidepressant dose.
Drop of 1 point or no change or increase	Inadequate	Increase dose; augmentation; switch; informal or formal psychiatric consultation; circle back and confirm therapy is occurring.

Initial Response After 6 Weeks of Psychological Counseling		
PHQ-9	**Treatment Response**	**Treatment Plan**
Drop of ≥ 5 points from baseline	Adequate	No treatment change needed. Follow-up in four weeks.
Drop of 2-4 points from baseline	Possibly Inadequate	Probably no treatment change needed. Share PHQ-9 with psychotherapist.
Drop of 1 point or no change or increase	Inadequate	If depression-specific psychological counseling (CBT, PST, IPT *) discuss with therapist, consider adding antidepressant. For patients dissatisfied with current counseling, review community options.

Source: MacArthur Initiative on Depression and Primary Care (2009)

**CBT = Cognitive Behavioral Therapy; PST = Problem Solving Treatment; IPT = Interpersonal Therapy*

SMFQ SCORING GUIDANCE

Not True = 0; Sometimes = 1; True = 2

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

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SHORT MOOD AND FEELINGS QUESTIONNAIRE (PARENT REPORT ON CHILD)

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

For each question, please check (✓) how s/he has been feeling or acting **in the past two weeks**.

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

	NOT TRUE	SOMETIMES	TRUE
S/he felt miserable or unhappy.	☐	☐	☐
S/he didn't enjoy anything at all.	☐	☐	☐
S/he felt so tired that s/he just sat around and did nothing.	☐	☐	☐
S/he was very restless.	☐	☐	☐
S/he felt s/he was no good anymore.	☐	☐	☐
S/he cried a lot.	☐	☐	☐
S/he found it hard to think properly or concentrate.	☐	☐	☐
S/he hated him/herself.	☐	☐	☐
S/he felt s/he was a bad person.	☐	☐	☐
S/he felt lonely.	☐	☐	☐
S/he thought nobody really loved him/her.	☐	☐	☐
S/he thought s/he could never be as good as other kids.	☐	☐	☐
S/he felt s/he did everything wrong.	☐	☐	☐

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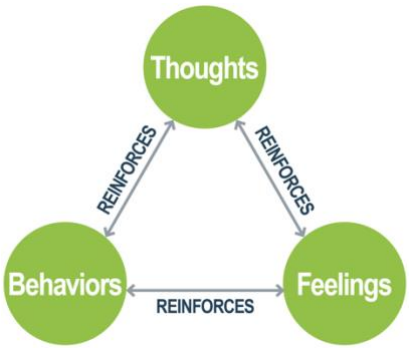
EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR DEPRESSION

Cognitive Behavioral Therapy (CBT) — bidirectional relationship between feelings, thoughts, and behavior to identify patterns of thinking that influence behavior and contribute to depressed mood



Treating Mild/Moderate Depression in Teens

Dose of therapy matters! Strive for minimum of 8 weeks of CBT.

- 5 to 8 sessions – some improvement
- 12 weeks CBT – 43% improvement
- 12 weeks CBT + SSRI – 70% improvement
- Maintain medication 6-12 months after symptom remission

Interpersonal psychotherapy — explores relationship difficulties with family and friends that can exacerbate depressed mood; teaches problem-solving skills

Family therapy — involves family members together to promote alliances, connection, and strengths

Dialectical Behavioral Therapy (DBT) — may be helpful for patients who experience very strong negative emotions but know few skills to manage them and resort to suicidal/self-injurious behavior

Does depression need to be treated? Will it just get better?

- More than 60% of children and adolescents with depressive disorders do not get diagnosed or treated
- Single episode of untreated depression can last 6-9 months — a whole school year!
- Serious consequences — increased risk for suicide, substance misuse, eating disorders
- Impairment in functioning at school, home, work and with peers has long-term implications/consequences
- Lack of treatment increases risk for future relapse and worsening depression which can be harder to treat

How can caregivers help children and teens with depression?

- **Safety planning:** talk about suicide and self-harm seriously, remove lethal means, monitor and listen carefully
- **Symptom improvement:** requires encouragement; reduce family conflict, increase support
- **Ensure:** sleep, hygiene, exercise, healthy diet; consider reducing screen time
- **Enhance protective factors:** one caring adult, stop substance misuse, attend therapy, be a coach regarding new ways of thinking/coping
- **Provide hope:** be a sounding board for the child/youth

What if therapy is not working?

- Reassess diagnosis, co-occurring conditions, treatment plan, and compliance
- Consider medication evaluation
- Consider consultation with VMAP

988 SUICIDE & CRISIS LIFELINE

People can call or text 988 or chat 988lifeline.org 24/7 for themselves or if they are worried about a loved one who may need crisis support.

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MEDICATION GUIDANCE: COMMONLY PRESCRIBED ANTI-DEPRESSANTS (not an exhaustive list)

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
SSRI	fluoxetine	Prozac	• 20mg/5ml • Tabs 10/20/40/60mg	***Initial dose:** 5-10mg **Max dose:** 60mg **Typical effective dose:** 20mg **Duration:** 24 hours	When switching meds tapering is not usually required due to very long half-life of active metabolite (avg 9.3 days) Common side effects and risk of serotonin syndrome ++	Common first line, FDA approved for MDD age 8+, OCD age 7+, PMDD
SSRI	escitalopram	Lexapro	• 5mg/5ml • Tabs 5/10/20mg	***Initial dose:** 5mg **Max dose:** 20mg **Typical effective dose:** 10mg **Duration:** 24 hours	Contraindicated in known congenital long QT syndrome Common side effects and risk of serotonin syndrome ++	Common first line, FDA approved for MDD age 12+, GAD
SSRI	sertraline	Zoloft	• 20mg/ml • Tabs 25/50/100mg	**Initial dose:** 12.5mg **Max dose:** 200mg **Typical effective dose:** 100mg **Duration:** 24 hours	Drowsiness and sleep disturbance more common in adults than children Common side effects and risk of serotonin syndrome ++	Evidence based for MDD, OCD age 6+, PMDD, PTSD.
SSNRI	duloxetine	Cymbalta	• Caps 20/30/60mg • Sprinkle 20/30/40/60mg	**Initial dose:** 30mg for at least 2 weeks **Max dose:** 120mg **Typical effective dose:** 40-60mg for MDD, up to 120mg for GAD **Duration:** 24 hours	Common side effects: abd pain, dec appetite, nausea, vomiting, dry mouth, drowsiness, headache. Sexual side effects, sleep disturbance, and weight loss can be seen.	MDD; FDA approved GAD age 7+, consider after two SSRIs have been tried, juvenile fibromyalgia age 13+
NDRI	bupropion	Wellbutrin	Multiple forms Short and longer acting	Dosing depends upon the release of the med	NOT first line therapy for depression — may consider for refractory depression or co-occurring conditions; consider psychiatry consultation	Not first line for ADHD but may be considered for MDD with co-occurring ADHD

Note: all medication information should be verified using current PDR

SSRI = selective serotonin reuptake inhibitor, SNRI = selective serotonin-norepinephrine reuptake inhibitor, NDRI= norepinephrine and dopamine reuptake inhibitor

* Initial dose, max dose, typical effective dose are half for age 8-11.

++ Common SSRI side effects: nausea, diarrhea, dry mouth, drowsiness, insomnia, decreased libido, ejaculatory dysfunction.

Serotonin syndrome is an emergency and is a clinical diagnosis. KNOW all of patient's medications (rx, other substances and supplements) and symptoms of serotonin syndrome: tachycardia, hypertension, hyperthermia, agitation, ocular clonus, dilated pupils, tremor, akathisia, hyperreflexia, clonus, flushed skin, diaphoresis.

Consider **switchrx.com** for guidance on medication switch

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PROVIDER TIPS & CLINICAL PEARLS: PCP MANAGEMENT OF DEPRESSION

Careful History

- Functioning in all domains
- Trauma and triggers
- Somatic and mood complaints
- Co-occurring and/or family hx of psychiatric diagnoses
- Substance misuse
- History of mania
- Peer relationships
- Sexual identity, gender identity
- Perfectionism

Presentation

- **Younger children:** withdrawal, temper tantrums, persistent boredom, school avoidance, failure to gain weight appropriately
- **Teens:** irritability or anger, reckless or hostile behavior, low self-esteem, new academic issues, withdrawal from activities and peers, substance abuse and risk-taking behaviors

Medical Work-Up and Differential Diagnosis

- Complete PE, weight change and appetite
- Hx of traumatic brain injury, recurrent concussion
- Consider labs if clinically indicated:
  TSH, CBC, urine drug screen, pregnancy test
- Consider possible differential diagnoses:
  - Adjustment disorder
  - Bereavement
  - PTSD
  - Bipolar Disorder
  - DMDD
  - Substance induced depression
  - Anemia
  - Thyroid dysfunction
  - Adverse effect of medication
  - Substance use
  - Mononucleosis

Psychoeducation

- Message to patient: “We are glad you’re here. We are on the same team!”
- See **Suicidality Care Guide** for safety planning
- Self-care is power! Strong bodies make strong minds; encourage sleep, exercise, nature.
- Patients with residual symptoms have an increased risk of relapse
- GLAD-PC is free to download: screeners, medication guidelines, family handouts

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PREVALENCE OF DEPRESSION

Estimates: 2-4% in children, 4-8% in adolescents

Increases by a factor of 2-4 after puberty, especially in females

Screening and Diagnostic Criteria

- 5 or more of symptoms (with one of these * nearly daily):
  - Depressed, sad, or irritable mood*
  - Significant loss of interest or pleasure in activities*
  - Significant weight loss/gain or appetite changes
  - Difficulty falling/staying asleep or sleeping too much
  - Restlessness, unable to sit still (psychomotor agitation), being slowed down (psychomotor slowing)
  - Fatigue or loss of energy
  - Feelings of worthlessness, excessive/inappropriate guilt
  - Concentration/decision-making difficulties
  - Constant thoughts of death, suicidal thinking, or a suicide attempt
- Symptoms have lasted for at least 2 weeks, affecting performance at school, at work, with family, or with friends
- Symptoms are not caused by medication, drug abuse, or alcohol and are not the result of another medical or mental illness

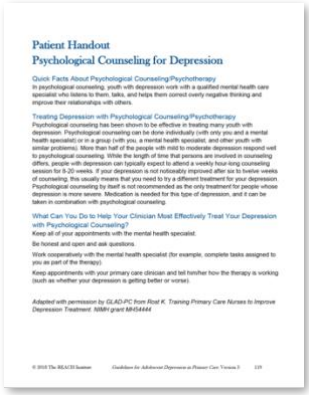
GLAD-PC Toolkit published in 2018 for primary care providers

Download the entire document for free, and consider these handouts for families:


OLDER TEEN

Antidepressant Medication and YOU

Self-Care *(p.117-118)*


Patient Handout

Psychological Counseling for Depression

Sleep *(p.119)*


Self-Care Success!

Things you can do to help yourself.

Therapy *(p. 120)*


How Can You Help with Sleep Problems

Meds *(p. 123)*

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PROVIDER TIPS: EVIDENCE-BASED PHARMACOTHERAPY FOR DEPRESSION

PCP checklist before starting meds:

- ✓ careful assessment, including trauma and triggers
- ✓ family hx and success with medications
- ✓ alliance with family
- ✓ setting goals for treatment
- ✓ safety planning
- ✓ active follow-up and/or therapy have not resulted in improvement
- ✓ depression is moderately severe or severe

SSRIs (selective serotonin reuptake inhibitors) are first line:

1. FDA-approved medications:
   Fluoxetine: age 8+
   Escitalopram: age 12+
2. Evidence-based medication for depression:
   Sertraline

See Medication Dose Chart

This is not intended to be an exhaustive overview of antidepressants, but rather a starting point for providers to become familiar with the evidence-base for general practice with pediatric patients.

Review SSRI side effects:

Common Usually resolve with time	Less Common May require med change		Rare But Notable Emergency
• Insomnia	• Agitation	• Constipation	• New Suicidality
• Sedation	• Restlessness	• Dizziness	• Serotonin syndrome
• Appetite change (up ≈ down)	• Impulsivity	• Tremor	• Easy bleeding
• Nausea	• Irritability	• Diarrhea	• Hyponatremia
• Dry mouth	• Silliness		• Mania
• Headache			• Prolonged QT interval
• Sexual dysfunction			

Review Box Warning: Monitor carefully for suicidal thoughts, especially in early treatment phase

- 2004 FDA review of 24 clinical trials (4,400 children and teens prescribed antidepressants for MDD, anxiety, OCD). **No completed suicides in any trials.**
- See guidebook module on Psychopharmocology Basics

Initial treatment phase: medication effect might not be felt until 4-6 weeks

- **Week 1-2:** start SSRI at initial test dose to assess for adverse effects; contact family to assess after Week 1
- **Week 2-4:** if no adverse effects and residual symptoms, increase to target dose
- **Week 4:** recheck in person or via telehealth and use a rating scale to support assessment

Continuation phase: goal is remission by 8 weeks

- AACAP recommends monitor monthly for 6 months after full remission
- If partial improvements, side effects, or maximum dose — consider contacting VMAP or psychiatry referral

Remission phase: 6-12 months of successful treatment

- If score < cut-point without impairment, then consider tapering antidepressant medication according to the following schedule: decrease daily dose by 25% every 2-4 weeks (or more slowly!) to starting dose, then discontinue.

VMAP psychiatrists and care navigators are only a phone call away!
1-888-371-VMAP (8627) | vmap.org

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DEPRESSION ACTION PLAN

My important contacts: parents, caregivers, PCP, therapist, neighbor, teacher, friend!

Put all in your phone now! Take a picture of this plan!

Contacts	Daytime Phone	Evening Phone	E-mail Address
Name:			
Name:			
Name:			
PCP:			
Therapist:			
Emergency Contact:			

Call or Text 988: Suicide & Crisis Lifeline
Text "HOME" to 741-741: Crisis Text Line

How to use this plan:

GO — Continue current plan

Green Zone: depression symptoms under control → What to do?

You are feeling well, functioning well in school and work, enjoying relationships at home and with peers.

Personal Goals:

1. _____

2. _____

What to do?

- **Continue current plan:** Therapy? PCP visits? Medication?
- **Self-care:** Do these areas need more focus?
  - – Sleep
  - – Diet
  - – Exercise
  - – Fun
  - – Activities
- **Continue progress on two goals**

CAUTION — Reach out and reassess

Yellow Zone: depression symptoms NOT in remission → What to do?

You are not feeling as well, experiencing at least 3 of the following, and you are **NOT harming yourself, wishing you were dead, thinking about or planning to kill yourself:**

- Sleep is off
- Energy level is off (fatigue)
- Slow or agitated feeling
- Little interest or pleasure
- Concentration is off
- Recurrence of previously improved symptoms
- Guilt or worthlessness
- Appetite changes
- New triggering event that is causing distress

What to do?

REACH OUT (to a parent, therapist, PCP, emergency contact, school counselor, or a hotline) and say: **I NEED HELP!** Get near someone who is your support person, and together plan next steps with your care team.

DANGER — Immediately get help

Red Zone: DANGER → What to do?

You are really down with more than 3 of the above symptoms **AND/OR you are thinking about suicide now:** wishing you were dead, feeling that family would be better off, planning a suicide attempt, previous suicide attempt.

What to do?

IMMEDIATELY GET HELP:
You are loved! Call the above contacts right away! Remember your call and text hotline numbers are in your phone!

ADDITIONAL LINKS FOR CAREGIVERS AND PATIENTS

What is depression?

- AACAP Facts for Families: Depression in Children and Teens (aacap.org)
- National Alliance on Mental Illness (NAMI): 'About Mental Illness: Major Depression' (nami.org)
- Adolescent Depression: What Parents Can Do To Help - HealthyChildren.org
  defines depression and action steps for parents

Guidance about depression diagnosis, therapy and medication:

- Depression: Parents' Medication Guide (American Academy of Child & Adolescent Psychiatry, aacap.org)
- effectivechildtherapy.org (Society of Clinical Child & Adolescent Psychology)

Self-care for depression

- For extensive family information including parent guides visit: *Families for Depression Awareness* at familyaware.org/ *(covers the role of the caretaker and self-care for caretakers)*
- **Apps:** Headspace, Calm, Breathe, CBT Companion

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3.2 Suicidality

SURVEILLANCE FOR **SUICIDE RISK**:

Clinician should use **EVERY teen visit to obtain:**

- Routine PHQ-A and specifically look at Q9. Current or history of + answer.
- Concerning behavior (incl. suspected attempt), statement (suicidal/homicidal ideation?) or symptoms (NSSI?).
- Within 3 months of discharge from a psychiatric facility.
- New patient data with symptoms of any mental/emotional disorder.

Age recommendations for screening:

- **Ages 12+:** universal screening
- **Ages 8-11:** when clinically indicated
- **Under 8:** screening not indicated; assess for suicidal thoughts/behaviors if warning signs present

IF YES

Screen for suicide risk using **ASQ suicide risk screening tool** (valid for ages 8-24)

SEVERITY

NEGATIVE SCREEN
Patient answers "NO" to all questions AND clinical presentation is unremarkable

- Screening is negative
- Consider follow-up in 2-4 weeks
- Psychoeducation
- Address any underlying mental health concerns identified in surveillance

Patient answers "NO" to all questions BUT **clinical presentation is concerning**

Complete **ASQ Brief Suicide Safety Assessment**

POSITIVE SCREEN
Patient answers "YES" to any screening question **OR** clinical presentation is obviously critical

In office, keep patient under direct observation; remove dangerous items

- Complete ASQ Brief Suicide Safety Assessment

OR

- Send immediately to ED for extensive mental health evaluation

Assess **DEGREE** of possible suicide risk. **ENGAGE CAREGIVERS**/adult supports in safety planning (especially in restricting access to dangerous items and behaviors that increase risk).

Low Risk	Possible Risk	Imminent Risk
No further evaluation needed at this time.	Further evaluation of risk is necessary.	Patient is at imminent risk for suicide (current suicidal plan and/or intent).
Recommend non-urgent mental health provider appointment.	Mental health referral needed as soon as possible.	Emergency mental health evaluation required.
Review safety plan and send home with a mental health referral. Continue medical care.	Consider VMAP consultation. Create a safety plan, review with caregivers, send home with referral list of mental health crisis services to access immediately, follow up with family in 24-48 hours.	Keep patient under direct observation, remove dangerous items, follow practice policies regarding alerting staff. Send to ED for thorough mental health evaluation to determine level of mental health care needed. Safe transport to ED; if not agreeing, call Emergency Services (911).

Note that high/imminent suicide risk negates privacy for all patients, even adults.

The 2021 Youth Risk Behavior Survey reported that **22.2% of high school students in the U.S. had seriously considered suicide**, and **10.2% actually attempted suicide** in the last year.

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SCREENING FOR SUICIDE RISK

Suicide and suicidal behavior among youth and young adults is a major public health crisis. Suicide is the 2nd leading cause of death among young people age 10-24 in the United States, and rates have been rising for decades.

In 2022 the American Academy of Pediatrics and the American Foundation for Suicide Prevention released the *Blueprint for Youth Suicide Prevention*.

Age Recommendations for Suicide Risk Screening	
Youth ages 12+	Universal screening
Youth ages 8-11	Screen when clinically indicated: • When presenting with behavioral health chief complaint • If the patient or caregiver raises a concern • If reported history of suicidal ideation or behavior • If the patient displays warning signs of suicide
Youth under age 8	Screening not indicated. Assess for suicidal thoughts and behaviors if warning signs or caregiver report of suicidal behaviors are present. Examples include, but aren't limited to: • Talking about wanting to die or wanting to kill oneself • Actions such as grabbing their throat in a "choking" motion, or placing their hands in the shape of a gun pointed toward their head • Engaging in self-harming behaviors • Acting with impulsive aggression • Giving away treasured toys or possessions

Asking kids about suicide is:

- Safe
- Very important for suicide prevention
- Not harmful
- Does not put thoughts or ideas into their heads

The ASQ Brief Suicide Safety Assessment offers sample statements!

IMPORTANT RESOURCE:

The AAP **Blueprint for Youth Suicide Prevention** (2022) includes Strategies for Clinical Settings for Youth Suicide Prevention

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NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary *(*Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "**No**" to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

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asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

What to do when a pediatric patient screens positive for suicide risk:

WORKSHEET

Patient name:_____ **DOB:** _____

Interviewer name: _____ **Assessment date:**_____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the asQ

❑ Frequency of suicidal thoughts

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

❑ "Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

National Institute of Mental Health

asQ Suicide Risk Screening Toolkit

7/1/2020

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asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

WORKSHEET

2 Assess the patient Review patient's responses from the asQ

❑ Symptoms Ask the patient about:

- ❑ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ❑ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ❑ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ❑ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ❑ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ❑ **Isolation:** "Have you been keeping to yourself more than usual?"
- ❑ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ❑ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- ❑ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ❑ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

❑ Social Support & Stressors *(For all questions below, if patient answers yes, ask them to describe.)*

- ❑ **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"
- ❑ **Family situation:** "Are there any conflicts at home that are hard to handle?"
- ❑ **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- ❑ **Bullying:** "Are you being bullied or picked on?"
- ❑ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

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asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

WORKSHEET

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- ❑ Sad or depressed?" ❑ Anxious?" ❑ Impulsive? ❑ Reckless?" ❑ Hopeless?" ❑ Irritable?"
- ❑ Unable to enjoy the things that usually bring him/her pleasure?"
- ❑ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ❑ Sleeping pattern?" ❑ Appetite?"

"Does your child use drugs or alcohol?" ❑ Yes ❑ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

_____

"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ❑ Yes ❑ No

"Are you comfortable keeping your child safe at home?" ❑ Yes ❑ No

_____

_____

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

_____

_____

4 Make a safety plan with the patient Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call_____."

- ❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- ❑ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
- ❑ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

Comments _____

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asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

WORKSHEET

5 Determine disposition

For all positive screens, follow up with patient at next appointment.

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

❑ **Emergency psychiatric evaluation:** **Patient is at imminent risk for suicide (current suicidal thoughts).**
Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).

❑ **Further evaluation of risk is necessary:**
Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).

❑ **Patient might benefit from non-urgent mental health follow-up:**
Review the safety plan and send home with a mental health referral.

❑ **No further intervention is necessary at this time.**

Comments _____

6 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

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EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR SUICIDALITY

1. Currently there are no interventions that have been deemed evidence-based. It is difficult to design ethical research for individuals experiencing suicidal ideation. Despite limitations in the literature, there is research to support the use of some techniques over others.
2. There is good evidence supporting use of Safety Planning and Lethal Means Restriction to reduce both suicide attempts and deaths from suicide.

   - **SAFETY PLANS**
   - **LETHAL MEANS RESTRICTION**
   - **DIRECT OBSERVATION** (line of sight, no locked doors, buddy)
   - **MENTAL HEALTH THERAPY**

3. Selective serotonin reuptake inhibitors (SSRIs) may help reduce suicidal ideation; however, in some individuals they may cause suicidal ideation.

   Box Warning: Monitor carefully for suicidal thoughts, especially in early treatment phase.

   - 2004 FDA review of 24 clinical trials (4,400 children and teens prescribed antidepressants for MDD, anxiety, OCD). **No completed suicides in any trials.**
   - See Module 1.4 on Psychopharmacology Basics

4. Cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) have both shown promise in reducing suicidal ideation in some youth when paired with appropriate medication therapy.
5. Address sleep.
6. When lethal means are made less available or less deadly, suicide rates decline.
   - Keeping firearms locked and eliminating unsupervised exposure to firearms may decrease the likelihood of youth suicide involving firearms.
   - During routine evaluations and where consistent with state law, ask whether firearms are kept in the home and discuss with caregivers the increased risk of adolescent suicide with the presence of firearms.
   - Specifically for adolescents at risk for suicide, advise caregivers to remove guns and ammunition from the house, keep razors and other sharp objects locked away, and secure supplies of prescription and over-the-counter medications.

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PROVIDER TIPS & CLINICAL PEARLS

- Suicide is the second leading cause of death for youth ages 10-24.
- Adolescents and young adults: leading method of **completed** suicide is the use of firearms; over 80% of US youth under 18 who died by suicide used a gun.
- Children ages 10-14: most likely to **complete** suicide by strangulation or hanging.
  - Discuss with caregivers the need for direct (REMAIN IN LINE-OF-SIGHT) observation and uncompromising intervention if this method has been considered or prior attempts included these methods.
- The most common method of attempted suicide is overdose/poisoning with medications, street drugs or alcohol, or chemical ingestions. However, the LETHALITY of suicide attempts is much greater with firearms (90%) versus other means (10%).
- **Short-term risk:** same day to 2 weeks
  - Recent breakup
  - Recent exposure to suicide
  - Stressful life event
  - Sleep disturbance
- **Psychiatric hospitalization is almost always indicated** for children and adolescents with suicidal attempt, plan/intent, or immediate high risk of suicide.
- **Protective factors:**
  - Access to effective physical and behavioral health care
  - Strong connection to family, friends, and/or community
  - Optimism for the future (e.g., looking forward to college)
  - Constructive use of leisure time
  - Fear of death and dying

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FAMILY HANDOUT

Your child's health and safety is our #1 priority. We use a screening tool created by the National Institute of Mental Health specifically for youth and children called the *ASQ: Ask Suicide-Screening Questions*. You can find more information about this screening at nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

Suicide is the 2nd leading cause of death for youth. Please note that asking youth questions about suicide is safe and is very important for suicide prevention. Research has shown that asking youth about thoughts of suicide is not harmful and does not put thoughts or ideas into their heads.

Although attempting and completing suicide is more common in youth with depression and other mood disorders, impulsive suicide attempts can occur in those with no known history of mental illness. Families can make homes safer, helping to protect children and teens. Although it is not possible to make a home perfectly safe, following these suggestions can help reduce the risks and chance for a suicide attempt.

Even if you have made your home safer, if your child is talking about thoughts or plans of suicide, they should be urgently evaluated by a qualified mental health provider.

Sources of Risk in the Home

Weapons

- Research shows that having a gun or weapon in the home increases the risk of dying by suicide.
- Guns should be stored unloaded in a locked safe. Bullets should be also locked, but in a separate place.
- Gun safe keys or combination to the lock should be kept only by the adults in the house.
- Consider purchasing trigger locks for guns.
- When children and teens go to friends' or relatives' homes, ask about gun ownership and storage.
- Lock away knives, razor blades, and other sharp objects from children and teens.

Medications

- Keep all medications, both prescribed and non-prescribed (over-the-counter), in a locked box.
- An adult should hand out and control all prescribed and over-the-counter medications to children and adolescents.
- Keep track of all bottles of medication as well as the number of pills in each container, including those prescribed as over-the-counter medications (such as pain relief, allergy pills, vitamins, and supplements, etc.) for every person and any pets in the home.
- Dispose of all expired and no-longer-used prescribed medications by bringing them to your local pharmacy or fire station.
- Ask the parents of your child's friends how their medications are stored in their home.

Other substances

- If substances that can be abused are kept in the home, they should be monitored and locked.
- Keep track of bottles of alcohol and lock them away. It is not enough to put these items "out of reach."
- If marijuana is kept in the home, lock all forms of it in a lock box that only adults in the house have the key or combination to.
- Talk with the parents of your child's friends about how they store alcohol or marijuana in the home.

Other items can be used for self-harm and suicide

- Keep your vehicle keys with you at all times or consider locking them in a lock box.
- Lock away all toxic household cleaners, pesticides, and industrial chemicals.
- Consider limiting ropes, electrical wire, and long cords within the home or lock them away.
- Secure and lock high-level windows and access to rooftops.

Online activities

- Parents and caregivers should monitor the online activities of their children, watching for:
  - Researching methods of suicide.
  - Purchasing of any materials or items that could be used for self-harm.
  - Spending time in chat rooms or social media sites dedicated to self-harm or suicide.
  - Receiving texts or direct messages from peers about suicide, calls for help or peer bullying.

The risk of dying by suicide can be decreased when families and caregivers reduce access to ways children can harm themselves. Following these steps can help to improve safety in your home.

Additional resources:

- Suicide & Crisis Lifeline: Call or Text 988 or Chat at 988lifeline.org/chat
- Crisis Text Line: Text "HOME" to 741-741
- American Foundation for Suicide Prevention, Virginia Chapter: afsp.org/chapter/virginia

INDIVIDUAL SAFETY PLAN (for youth to complete)

Make the environment safe: remove access ex: lock up medications	1. _____ 2. _____ 3. _____
Warning signs and vulnerabilities ex: not getting my homework done	1. _____ 2. _____ 3. _____
Things I can do on my own to distract me ex: listen to favorite band	1. _____ 2. _____ 3. _____
People who can help distract me ex: my brother	1. _____ 2. _____ 3. _____
Adults I can ask for help ex: my parent, my neighbor	1. _____ 2. _____ 3. _____
Future goals and things I'm looking forward to	1. _____ 2. _____ 3. _____

Professionals I can ask for help:

My therapist: _____ Phone: _____

My provider: _____ Phone: _____

My psychiatrist: _____ Phone: _____

If my health care provider is not available and I find myself preparing for suicide, I'll call

_____ (person/agency) at _____ (number) for emergency help.

If I feel that I can't control my suicidal behavior, I'll go to the nearest emergency department or call 911.

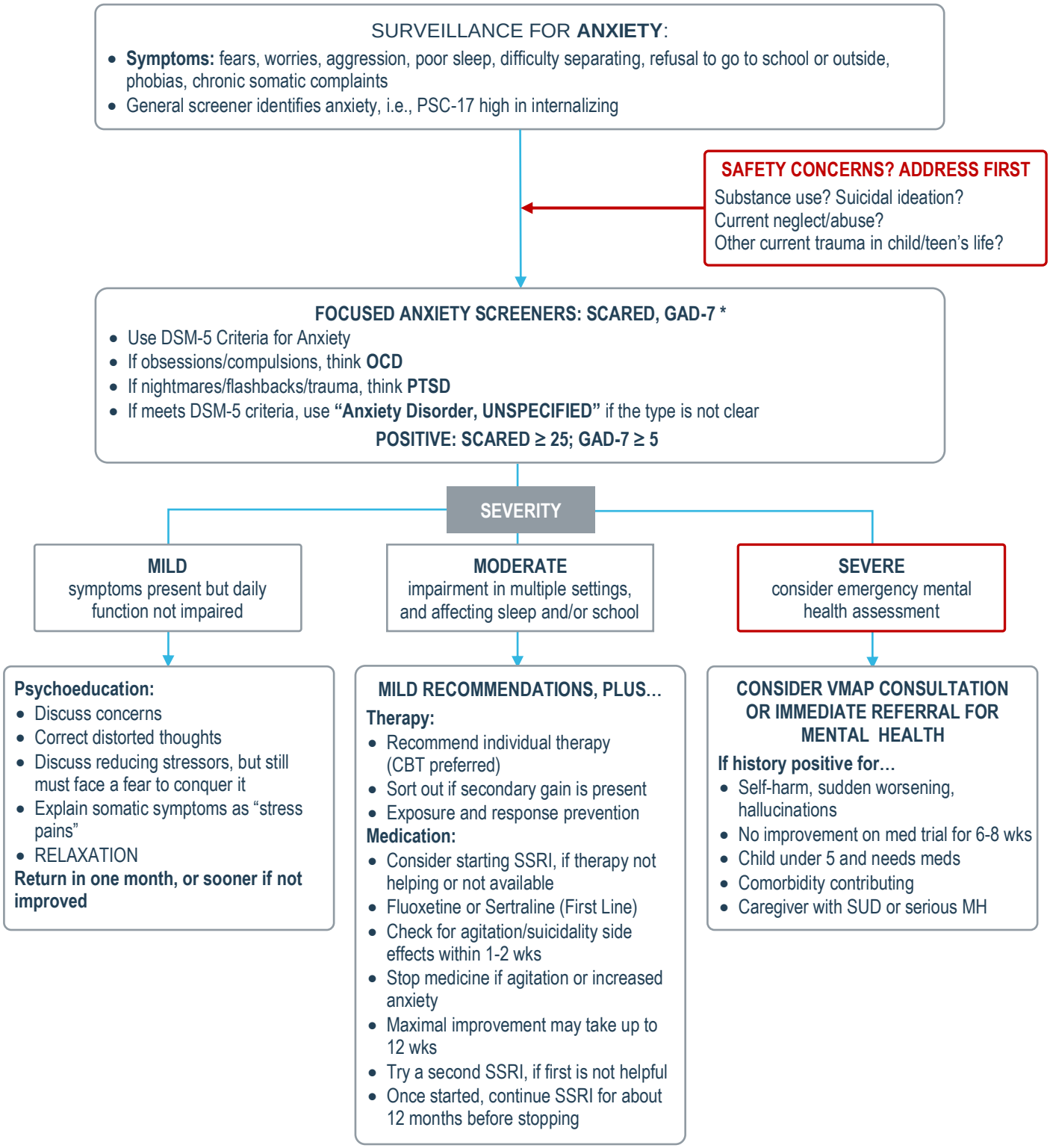
24-Hour Crisis Hotlines

- Crisis Text Line — **Text:** HOME to 741-741
- National Suicide Prevention Hotline — **Phone or Text:** 988
- National Hopeline Network — **Phone:** 1-800-SUICIDE (784-2433)

Local Emergency Room or call 911

Adapted from: GMU Center for Psychological Services

3.3 Anxiety



* Many providers offer both the PHQ-A and GAD-7 for all kids ages 12 and older (combined tool provided in this module)

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SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

CHILD version — Page 1 of 2 (to be filled out by the CHILD)
For children and adolescents ages 8 and older; kids 8 to 11 may need help completing

Name: _____ Date: _____

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, check (✓) the box that corresponds to the response that seems to describe you **for the last 3 months**.

Symptom	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.				PA/SO
2. I get headaches when I am at school.				SCH
3. I don't like to be with people I don't know well.				SOC
4. I get scared if I sleep away from home.				SEP
5. I worry about other people liking me.				GA
6. When I get frightened, I feel like passing out.				PA/SO
7. I am nervous.				GA
8. I follow my mother or father wherever they go.				SEP
9. People tell me that I look nervous.				PA/SO
10. I feel nervous with people I don't know well.				SOC
11. I get stomachaches at school.				SCH
12. When I get frightened, I feel like I am going crazy.				PA/SO
13. I worry about sleeping alone.				SEP
14. I worry about being as good as other kids.				GA
15. When I get frightened, I feel like things are not real.				PA/SO
16. I have nightmares about something bad happening to my parents.				SEP
17. I worry about going to school.				SCH
18. When I get frightened, my heart beats fast.				PA/SO
19. I get shaky.				PA/SO
20. I have nightmares about something bad happening to me.				SEP

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

CHILD version — Page 2 of 2 (to be filled out by the CHILD)

Symptom	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.				GA
22. When I get frightened, I sweat a lot.				PA/SO
23. I am a worrier.				GA
24. I get really frightened for no reason at all.				PA/SO
25. I am afraid to be alone in the house.				SEP
26. It is hard for me to talk with people I don't know well.				SOC
27. When I get frightened, I feel like I am choking.				PA/SO
28. People tell me that I worry too much.				GA
29. I don't like to be away from my family.				SEP
30. I am afraid of having anxiety (or panic) attacks.				PA/SO
31. I worry that something bad might happen to my parents.				SEP
32. I feel shy with people I don't know well.				SOC
33. I worry about what is going to happen in the future.				GA
34. When I get frightened, I feel like throwing up.				PA/SO
35. I worry about how well I do things.				GA
36. I am scared to go to school.				SCH
37. I worry about things that have already happened.				GA
38. When I get frightened, I feel dizzy.				PA/SO
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).				SOC
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.				SOC
41. I am shy.				SOC

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.

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED); a replication study. Journal of the American Academy of Child and Adolescent Psychiatry, 38(10), 1230-6.

The SCARED is available at no cost at pediatricbipolar.pitt.edu/ under resources/instruments.

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

PARENT version — Page 1 of 2 (to be filled out by the PARENT)

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 your child. Then, for each sentence, check (✓) the box that corresponds to the response that seems to describe your child ***for the last 3 months***. Please respond to all statements as well as you can, even if some do not seem to concern your child.

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

SCREEN FOR CHILD ANXIETY RELATED DISORDERS (SCARED)

PARENT version — Page 2 of 2 (to be filled out by the PARENT)

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

The SCARED is available at no cost at pediatricbipolar.pitt.edu/ under resources/instruments.

January 19, 2018

SCARED RATING SCALE SCORING AIDE Use with parent and child versions

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

0 = not true or hardly true

1 = somewhat true or sometimes true

2 = very true or often true

Scoring

A total score of **≥ 25** may indicate the presence of an **Anxiety Disorde**r. Scores higher than 30 are morespecific.

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 Symptom**s.

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**.

Total axiety ≥ 25

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PATIENT HEALTH QUESTIONNAIRE AND GENERAL ANXIETY DISORDER (PHQ-9 AND GAD-7)

Date: _____ Patient Name:_____ Date of Birth:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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 the score for each column				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one) **Not difficult at all** **Somewhat difficult** **Very difficult** **Extremely difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores):_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one) **Not difficult at all** **Somewhat difficult** **Very difficult** **Extremely difficult**

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR ANXIETY

Sub-Clinical to Mild Anxiety:

Interventions in this category may be guided or explained by the clinician and/or the caregiver can assist self-management in the home with:

- Psychoeducation (see handout for online parent/child resources)
- Relaxation (see handout for parent/child resources)
- Cognitive Behavior Therapy (CBT): CBT is first-line treatment in children and youth. Can try self-led or parent-led CBT first.

  CBT is a diverse group of therapeutic interventions targeting the three primary dimensions of anxiety: cognitive (thoughts), behavioral (e.g., avoidance of school), and physiological (e.g., abdominal pain, sweating, racing heart rate). It usually involves "homework" and an average of 8 to 12 sessions.

Moderate Anxiety:

(Or for unsuccessful self-management of mild anxiety)

- Refer to therapist-led Cognitive Behavior Therapy (CBT) and consider medication if not improved with interventions, or having difficulty accessing therapist-led CBT
- Anxiety treatment includes exposure therapy and minimizing unintended reinforcers of behaviors

Severe Anxiety:

Refer to therapist-led therapy (CBT preferred) **AND** initiate pharmacotherapy

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MEDICATIONS FOR TREATMENT OF PEDIATRIC ANXIETY

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
SSRI	fluoxetine	Prozac	• 20mg/5ml • Tabs 10/20/40/60mg	**Initial dose:** 5-10mg **Max dose:** 60mg **Typical effective dose:** 5-20mg for use under age 12, and 10-60mg for use over age 12 **Duration:** 24 hours	Often dosed in morning. Can cause vivid dreams. When switching meds tapering is not usually required due to very long half-life of active metabolite (avg 9.3 days). Peak effect 4-6 weeks.	First line per evidence. FDA approved for MDD age 8+, OCD age 7+. Side effects rare if dose missed, due to long half-life. **See side effect handout: most mild, but know serotonin syndrome, and BOX Warning.**
SSRI	sertraline	Zoloft	• 20mg/1ml • Tabs 25/50/100mg	**Initial dose:** 12.5-25mg **Max dose:** 200mg **Typical effective dose:** 50-100mg **Duration:** 24 hours	Drowsiness and sleep disturbance more common in adults than children, but may be better dosed at bedtime.	First line per evidence. Evidence-based for MDD, OCD age 6+, PMDD, PTSD. Peak effect 12 weeks.
SSRI	escitalopram	Lexapro	• 5mg/5ml • Tabs 5/10/20mg	**Initial dose:** 2.5-5mg **Max dose:** 20mg **Typical effective dose:** 10mg **Duration:** 24 hours	Contraindicated in known congenital long QT syndrome.	Common first line, FDA approved for MDD age 12+, GAD. Peak effect 12 weeks.

MDD (major depressive disorder), OCD (obsessive compulsive disorder)
Note: all medication information should be verified using current PDR

Consider starting all medications at a LOW DOSE for the first 1-2 weeks for anxiety disorders. Titrating medication from low to typical effective dose over a few weeks often mitigates child's experience with side effects.

Starting Medication: General Principles of Utilizing Pharmacotherapy for Pediatric Anxiety

Initial treatment phase:

- Evidence-based medications for anxiety: fluoxetine (Prozac), sertraline (Zoloft)
- Start daily test dose for 1-2 weeks (e.g., fluoxetine 5mg or sertraline 12.5mg)
- If test dose tolerated over one week, increase daily dose (e.g., fluoxetine 10mg or sertraline 25mg
- Monitor weekly for agitation, suicidality, and other side effects
- If severe agitation or suicidal intent/plan, refer immediately for emergency evaluation

Continuation phase:

- Monitor weekly x 4 weeks, then every other week for 2 months utilizing SCARED or GAD-7 to help guide the treatment strategy
- Once therapeutic dose is achieved, consider call to VMAP if patient's screening tools are not improving AND/OR anecdotal evidence suggests patient is not improving. Sometimes others notice improvement before the patient!

Remission phase:

- Even if patient feels much better after a few months, continue maintenance dose for "two seasons" or about 6 months after weaning off

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PROVIDER TIPS & CLINICAL PEARLS

BEFORE deciding an Anxiety diagnosis is correct, ask a few more questions:

HPI: Presenting Concerns	**TRAUMA**	Has this child/teen experienced a traumatic event? Examples: domestic violence, abuse, natural disaster, motor vehicle accident.
	TRIGGERS	What are the specific situations or factors that trigger the anxiety symptoms? What unexpected "benefits" does the child experience from their anxiety symptoms (e.g., school refusal and parent thus staying home from work)?
	CO-OCCURRING DEPRESSION, ADHD	Are there any accompanying signs of depression? Consider PHQ-9. **Severe anxiety disorders may be complicated by major depression and/or suicide.** **ASK about suicidal thoughts/homicidal thoughts. Look at the PHQ.** ADHD symptoms? Consider Vanderbilt Rating Scales.
	SEVERITY	Does the anxiety seem appropriate for the developmental stage of the child? **Again, severe anxiety disorders may be complicated by major depression and/or suicide.** **ASK about suicidal thoughts/homicidal thoughts. Look at the PHQ.** Is there a prior history of self-harm or intent?
	IMPAIRMENT	Does the anxiety impair the child's daily functioning such as school attendance, grades, friend or family relationships?
	CONSTITUTIONAL SX	What impact is the child's symptoms having on their appetite, sleep, focus/attention? Is the child complaining of abdominal pain, headache, muscle tension, fatigue?
Family Hx		Is there a family history of anxiety disorders? Has anyone ever had to stay in a hospital because of mental health issues?
Review of Systems	**Rule out medical causes of the anxiety symptoms**	• Asthma, and its medications • Substance use and abuse • Other chronic illnesses (diabetes, chronic pain, SLE) • Caffeinism • Seizure disorders • Thyroid disorders • Hypoglycemia • Cardiac arrhythmia • Migraine headaches • Brain tumor • Pheochromocytoma

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DURING VISIT: USE 4 Rs: RECOGNIZE, RESPOND, KNOW WHEN TO REFER, KNOW RESOURCES

RECOGNIZE: Use screening tools AND interview	Some children AVOID certain activities or circumstances that trigger their anxiety. This may result in patients with moderate or severe anxiety to reporting they are "free" of subjective feelings of anxiety.
Assess for current or prior suicidal thinking or behaviors	Anxiety disorders can be associated with suicidal ideation with or without comorbid depression. Use Suicide Screening Tool if unsure.
Observe for common mental status findings	The clinician may observe problems with separation, behavioral inhibition, selective mutism, or hyperactivity.
Consider differential diagnoses	1. Adjustment reactions: Rarely require pharmacological intervention; refer to therapy. 2. Bullying: Children who are victims of bullying may present with avoidance and anxiety symptoms. 3. Bipolar Disorder: Can be complicated in terms of assessment; consider VMAP consultation — rare before mid-adolescence. 4. Substance Use Disorders: Patients with anxiety disorders may self-medicate with other substances and present with anxiety symptoms related to withdrawal. 5. Autism spectrum disorder: Patients with ASD frequently report anxiety symptoms. Consider VMAP consultation for help in clarifying the diagnoses.
RESPOND: Conduct a general medical exam	Consider a general exam for any child with anxiety symptoms to rule out medical conditions and to examine extent of any chronic medical conditions or other medications being used.
Know when to REFER for VMAP consultation or child psychiatry	Consider referring if child/youth: • Experiences only partial response to medication **AND** a second medication is being considered • Requires/asks for PRN meds for severe distress • Reports agitation, suicidality, or demonstrates increased self-harming behaviors • Reports active suicidal planning or intent or recent suicidal behavior • Has multiple co-occurring diagnoses such as ADHD, depression, substance use disorders • Demonstrates or reports symptoms of bipolar disorder, specifically mania • Has co-occurring autism spectrum disorder
RESOURCE for families	AACAP Parents' Medication Guide: Anxiety

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Family Resources

Websites

- AACAP Anxiety Disorders Resource Center
  aacap.org/aacap/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx
- Anxiety and Depression Association of America
  adaa.org/
- WorryWiseKids
  worrywisekids.org/
- On Our Sleeves: How to Help Kids Manage Anxiety
  onoursleeves.org/mental-wellness-tools-guides/help-kids-manage-anxiety
- Coping Cat Parents
  copingcatparents.com
- Anxiety in Teens is Rising: What's Going On? (healthychildren.org)
  This parenting website from the AAP has great handouts
- School Avoidance: Tips for Concerned Parents (healthychildren.org)

Handouts & Guides

- Children's Mental Health Matters Facts for Families: Anxiety Disorders
  childrensmentalhealthmatters.org/files/2021/03/Anxiety-Disorders-2021.pdf
- American Academy of Child and Adolescent Psychiatry: Anxiety Disorders Parents' Medication Guide
  aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/anxiety-parents-medication-guide.pdf

Apps

App Name	Ages	Description	Cost
Breathe, Think, Do with Sesame	2-5	Teaches skills such as problem-solving, self-control, planning, and task persistence	Free IOS, Android
Chill Outz	4-10	Animated stories teaching children proven techniques to stay mindful and relaxed anywhere, anytime	$4.99 IOS
Monster Meditation	2-6	Meditation, relaxation (from Sesame Street and Headspace)	Free on YouTube
Calm	Ages 9+	Meditation, relaxation (kids pack unlocks for ages 5-8)	Free to try; upgrade for fee IOS, Android
Dreamy Kid	Ages 4+	Meditation, guided visualization, and affirmations	Free IOS, android
Headspace	Ages 9+	Guided meditation (kids pack unlocks for age 5 and under)	Free to try; upgrade for free IOS, Android
Smiling Mind	7-18	Mindfulness meditation techniques, targeted at different ages including one for ages 7-9	Free IOS
MindShift CBT	Ages 11+	CBT strategies, including thought journals, belief experiments, fear ladders, comfort zone challenges	Free IOS

Books — for Caregivers

- *Helping Your Anxious Child: A Step-by-Step Guide for Parents* (2008), by Ronald Rapee, et al.
- *Parent-Led CBT for Child Anxiety: Helping Parents Help Their Kids* (2016), by C. Creswell, M. Parkinson, K. Thirtwall, and L. Willetts
- *Freeing Your Child from Anxiety, Revised and Updated Edition: Practical Strategies to Overcome Fears, Worries, and Phobias and Be Prepared for Life — from Toddlers to Teens* (2014), by Tamar E. Chansky
- *Freeing Your Child from Negative Thinking: Powerful, Practical Strategies to Build a Lifetime of Resilience, Flexibility, and Happiness* (2008), by Tamar E. Chansky
- *Monsters Under the Bed and Other Childhood Fears: Helping your Child Overcome Anxieties, Fears, and Phobias* by Stephen W. Garber, PhD, Robyn Freedman Spizman, and Marianne Daniels Garber (1993)

Books — for Kids

- *What to Do When Mistakes Make You Quake: A Kid's Guide to Accepting Imperfection* (2015), by Claire A. B. Freeland and Jacquelline B. Toner
- *The Anxiety Workbook for Kids: Take Charge of Fears and Worries Using the Gift of Imagination* (2016), by R. Alter and C. Clarke
- *The Relaxation and Stress Reduction Workbook for Kids: Help for Children to Cope with Stress, Anxiety, and Transitions* (2009), by L. Shapiro and R. Sprague
- *What to Do When You Worry Too Much: A Kid's Guide to Managing Anxiety*, by Dawn Huebner, PhD
- *Outsmarting Worry: An Older Kid's Guide to Managing Anxiety*, by Dawn Huebner, PhD
- *What to Do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD*, by Dawn Huebner, PhD

3.4 Trauma and PTSD

SURVEILLANCE FOR **TRAUMA & ACES**:

- **For parents/caregivers:** "Has anything really scary or upsetting ever happened to your child or anyone else in your family?"
- **For kids ages 7-17:** "Has anything really scary or upsetting happened to you or your family?"

IF YES

GATHER DETAILS AND ASSESS FOR SAFETY

- If concern for recent or current abuse/neglect: call CPS/Police
- If concern for imminent danger to self or others: refer to ED or CSB Crisis Team for emergency assessment

SCREEN TO ASSESS FOR ADVERSE CHILDHOOD EVENTS/TRAUMA and PTSD SYMPTOMS

- Consider using the Child & Adolescent Trauma Screen (CATS) — OR —
- **PEARLS** screens for ACES (Part 1) and additional adversities (Part 2):
  available in: caregiver-completed tools for children (ages 0-11) and adolescent (ages 12-19); adolescent self-report tool (ages 12-19)

SEVERITY

Normal to Mild
Noticeable but basically functioning okay

CATS ages 3-6: score <12
CATS ages 7-17: score <15

- Discuss caregiver concerns
- Explain neurodevelopmental model of stress
- Reassure, normalize feelings
- Correct distorted thoughts
- Reduce stressors
- Offer caregiver and youth self-help resources (videos, books, workbooks, relaxation scripts)
- Provide anticipatory guidance for specific behaviors
- Assist family in obtaining needed social, legal services

Moderate
Moderate trauma-related stress

CATS ages 3-6: score 12-14
CATS ages 7-17: score 15-20

- Assess for co-occurring depression
- Monitor for suicidal ideation, self-injurious behavior
- Trauma education
- Consider referral for trauma-focused therapy
- Schedule follow-up visit in 4-6 weeks to evaluate symptom recovery
- Inquire about how parents/caregivers are coping utilizing self-care and availability of supports

Severe (possible/probable PTSD)
Significant impairment in one setting or moderate impairment in multiple settings

CATS ages 3-6: score 15+
CATS ages 7-17: score 21+

Re-check safety
Offer office-based interventions for mild and moderate **PLUS**

- Recommend trauma-focused therapy
- Consider VMAP consultation
- Consider PTSD

Screen for PTSD
SCARED PTSD Brief Assessment
If positive, refer to specialist for further assessment and treatment

When to Refer:

- Impairment > 2 weeks or trauma secondary to abuse
- If suicide or homicide involved, or if impairment > 4-8 wks after other loss
- Preoccupation with death
- Playing out elements of the trauma
- New behavioral disturbances — especially in specific contexts
- New onset sleep problems and nightmares
- New school or childcare problems
- Caregiver distress

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CHILD AND ADOLESCENT TRAUMA SCREEN (CATS) — CAREGIVER REPORT (AGES 7-17 YEARS)

Child's Name: _____ Date: _____

Caregiver Name: _____

Stressful or scary events happen to many children. Below is a list of stressful and scary events that sometimes happen. Mark YES if it happened to the child to the best of your knowledge. Mark NO if it didn't happen to the child.

Event	Yes	No
1. Serious natural disaster like a flood, tornado, hurricane, earthquake, or fire.	☐	☐
2. Serious accident or injury like a car/bike crash, dog bite, sports injury.	☐	☐
3. Robbed by threat, force or weapon.	☐	☐
4. Slapped, punched, or beat up in the family.	☐	☐
5. Slapped, punched, or beat up by someone not in the family.	☐	☐
6. Seeing someone in the family get slapped, punched or beat up.	☐	☐
7. Seeing someone in the community get slapped, punched or beat up.	☐	☐
8. Someone older touching his/her private parts when they shouldn't.	☐	☐
9. Someone forcing or pressuring sex, or when s/he couldn't say no.	☐	☐
10. Someone close to the child dying suddenly or violently.	☐	☐
11. Attacked, stabbed, shot at or hurt badly.	☐	☐
12. Seeing someone attacked, stabbed, shot at, hurt badly or killed.	☐	☐
13. Stressful or scary medical procedure.	☐	☐
14. Being around war.	☐	☐
15. Other stressful or scary event? Describe: _____	☐	☐

Which one is bothering the child most now? _____

If you marked "YES" to any stressful or scary events for the child, then go to the next page and answer the next questions

CATS (cont'd)

Mark 0, 1, 2 or 3 for how often the following things have bothered the child in the last two weeks 0 — NEVER 1 — ONCE IN A WHILE 2 — HALF THE TIME 3 — ALMOST ALWAYS				
1. Upsetting thoughts or images about a stressful event. Or re-enacting a stressful event in play.	0	1	2	3
2. Bad dreams related to a stressful event.	0	1	2	3
3. Acting, playing or feeling as if a stressful event is happening right now.	0	1	2	3
4. Feeling very emotionally upset when reminded of a stressful event.	0	1	2	3
5. Strong physical reactions when reminded of a stressful event (sweating, heart beating fast).	0	1	2	3
6. Trying not to remember, talk about or have feelings about a stressful event.	0	1	2	3
7. Avoiding activities, people, places or things that are reminders of a stressful event.	0	1	2	3
8. Not being able to remember an important part of a stressful event.	0	1	2	3
9. Negative changes in how s/he thinks about self, others or the world after a stressful event.	0	1	2	3
10. Thinking a stressful event happened because s/he or someone else did something wrong or did not do enough to stop it.	0	1	2	3
11. Having very negative emotional states (afraid, angry, guilty, ashamed).	0	1	2	3
12. Losing interest in activities s/he enjoyed before a stressful event. Including not playing as much.	0	1	2	3
13. Feeling distant or cut off from people around her/him.	0	1	2	3
14. Not showing or reduced positive feelings (being happy, having loving feelings).	0	1	2	3
15. Being irritable. Or having angry outbursts without a good reason and taking it out on other people or things.	0	1	2	3
16. Risky behavior or behavior that could be harmful.	0	1	2	3
17. Being overly alert or on guard.	0	1	2	3
18. Being jumpy or easily startled.	0	1	2	3
19. Problems with concentration.	0	1	2	3
20. Trouble falling or staying asleep.	0	1	2	3

Total Score	
Clinical =	15+

Please mark "YES" or "NO" if the problems you marked interfere with:

	YES	NO
1. Getting along with others	☐	☐
2. Hobbies/fun	☐	☐
3. School or work	☐	☐
4. Family relationships	☐	☐
5. General happiness	☐	☐

Child's Name: _____ Date: _____

SCARED BRIEF ASSESSMENT

Posttraumatic Stress Symptoms

Here is a list of sentences that describe how people feel. 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, choose the answer that seems to describe you for the last 3 months.

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

Muris, P, Merckelbach, H., & Korver, P., & Meesters, C. (2000)

PTSD: 6+ = clinical Score _____

EVIDENCE-BASED THERAPIES: TRAUMA-FOCUSED

Name	Description	Resource
Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)	Ages 3-21, focuses on building skills for emotional and behavioral regulation, strengthening relationships, and processing traumatic events	tfcbt.org/
Child-Parent Psychotherapy (CPP)	Ages 0-5, focuses on strengthening parent-child attachment	childparentpsychotherapy.com/providers/training
Parent-Child Interaction Therapy (PCIT)	Ages 2-7, therapist coaches parent to change parent-child interaction patterns	pcit.org/
Attachment Regulation & Competency Therapy (ARCT)	Ages 2-21, provides a framework for working with children and adolescents with multiple, prolonged traumas	arcframework.org/what-is-arc/

Resources to learn more

- Trauma-Informed Care: Implementation Resource Center
  traumainformedcare.chcs.org/what-is-trauma-informed-care/
- The National Child Traumatic Stress Network
  nctsn.org/
- American Academy of Pediatrics Trauma Toolbox for Primary Care
  aap.org/traumaguide
- Pediatric Medical Traumatic Stress Toolkit for Health Care Providers
  nctsn.org/resources/pediatric-medical-traumatic-stress-toolkit-health-care-providers
- National Council for Behavioral Health: Fostering Resilience and Recovery Change Package
  thenationalcouncil.org/fostering-resilience-and-recovery-a-change-package/
- Center for Health Care Strategies: Implementing Trauma-Informed Care in Pediatric & Adult Primary Care
  chcs.org/resource/implementing-trauma-informed-care-pediatric-adult-primary-care-settings/
- SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
  ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

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PROVIDER TIPS & CLINICAL PEARLS

To understand more about trauma, review AAP Trauma Toolbox for Primary Care	
Ask open-ended questions	• Has anything bad, sad, or scary happened to your child or to you (older child) recently? • Has your home life changed in any significant way? • Are there any behavior problems with your child?
Follow up close-ended questions	• Do you have any concerns that your child is being exposed to stress or something frightening? • Does your child feel safe?

Child's Response to Trauma: Bodily Functions

Symptom(s)	Function	Central Cause
• Difficulty falling asleep • Difficulty staying asleep • Nightmares	Sleeping	Stimulation of reticular activating system
• Rapid eating • Lack of satiety • Food hoarding • Loss of appetite • Other eating disorders	Eating	Inhibition of satiety center, anxiety
• Constipation • Encopresis • Enuresis	Toileting	Increased sympathetic tone, increased catecholamines

Child's Response to Trauma: Misunderstood Causes

Response	More Common In	Misunderstood Cause
• Detachment • Numbing • Compliance • Fantasy	• Females • Young children • Children with ongoing trauma/pain • Children unable to defend themselves	• Depression • ADHD inattentive type • Developmental delay
• Hypervigilance • Aggression • Anxiety • Exaggerated response	• Males • Older children • Witnesses to violence • People able to fight or flee	• ADHD • ODD • Conduct disorder • Bipolar disorder • Anger management difficulties

Child's Response to Trauma: Developing and Learning

Age	Effect: Working Memory	Effect: Inhibitory Control	Effect: Cognitive Flexibility
0-4	• Difficulty acquiring developmental milestones	• Frequent severe tantrums • Aggressive with other children	• Easily frustrated • Difficulty with transitions
5-12	• Difficulty with school skill acquisition • Losing details can lead to confabulation (others view as lying)	• Frequently in trouble at school and with peers for fighting and disrupting	• Organizational difficulties • Can look like learning problems or ADHD
13+	• Difficulty keeping up with material as academics advance • Trouble keeping school work and home life organized • Confabulation increasingly interpreted by others as integrity issue	• Impulsive actions which can threaten health and well-being • Actions can lead to involvement with law enforcement and increasingly serious consequences	• Difficulty assuming tasks of young adulthood which require rapid interpretation of information (e.g., driving, functioning in workforce)

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Symptom	How Family Can Respond	
Sleep disturbance	• Consistent bedtime schedule • Soothing bedtime routine (bath, reading books, dim light, brief cuddling/snuggling) • No screen time 1 hour before bed	• Accept and empathize with child's fears, help reassure child • Transitional item: stuffed animal, blanket, pillow (may tell story of item being scared, needing child to feel safe/secure)
Eating disturbance	• Consistent schedule: 3 meals + 3 snacks • Calm, pleasant meals • Sit down to eat all meals and snacks	• Expect experimentation and messiness • Give a chewable multivitamin with iron and zinc
Food refusal	• No force-feeding, cajoling, or reprimands • Set up rewards for each step toward eating item (e.g., having item on plate, smelling item, putting item to lips, tasting item, taking a bite, swallowing item)	• Offer 2 desired foods + 1 non-preferred food at each sitting • High-calorie/high-protein diet if underweight • Follow growth weekly or monthly with primary care
Overeating and hoarding	• Set up reward system for "asking for food items" and "eating item when given" (instead of sneaking/hiding item) • Offer plenty of water throughout the day • Frequent checks for hidden foods and reward system for "bedroom free of food" • Keep a bowl of high-fiber snacks (e.g., carrots, apples). Refill bowl every 30 minutes and gradually increase time between fillings. Praise child for saving some and progress.	
Encopresis, constipation	• Bowel clean out as necessary (taking steps to minimize additional trauma) • Eliminate any negative associations around toileting • Reward system for sitting on toilet (may need a graduated reward system for small steps toward sitting on the toilet, e.g., pooping in pullup while in bathroom, pooping in pullup while standing next to toilet, pooping in pullup while sitting on closed toilet seat, pooping in pullup while sitting on open toilet seat, pooping in toilet) • Game or activity that can only be used in the bathroom	
Urinary incontinence (day)	• Treat constipation if present • Timed voiding (every 2 hours)	• Reward incentive for remaining dry during set intervals and adhering to voiding schedule
Functional abdominal pain	• Consider diet change: increase fiber, decrease lactose • Clarify whether each bout is "same" or "different" • Relaxation techniques (deep breathing)	• Distraction • Cognitive coping skills (positive self-talk)
Tension headaches	• "What do you think might be causing this headache?" • Visual imagery with progressive relaxation exercises • Drink lots of water	• Visual images of anatomic structures like blood vessel contracting/dilating and accompanying pain sensors • Headache diary to identify triggers
Anxiety, fears, avoidance	• Acknowledge and respect the fear • Do not belittle, exaggerate, or cater to the fear • Provide information about the fear	• Read a book about the feared concern • Watch reassuring television programs, movies, videos • Practice active listening
Trouble with self-regulation	**Techniques for the parent/caregiver:** • Do not take the behavior personally • Calm and gentle; lower the tone and intensity in voice • Get down to child's eye level to speak • Give directions that are positively stated, simple, and direct, without use of strong emotions • Anticipate a reactive response and use redirection before child's emotions are out of control	**Techniques to try with the child:** • Practice child calming skills (e.g., breathing techniques, relaxation skills or exercises) when child is not upset • Caregiver to model skills to child when caregiver is upset • Gently remind child to use skills when upset; caregiver may suggest they use a skill together • Use of strategic ignoring for behaviors that can be ignored can help children learn to self-calm

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Symptom	How Family Can Respond
Difficulty expressing feelings	• Have caregiver label own emotions/response throughout day, e.g., "Mom is really frustrated sitting in traffic right now." • Have caregiver help child label child's emotions, e.g., "It looks like you are upset that you have to wait your turn." • Encourage child to label his own emotions throughout the day to practice, e.g., "How are you feeling right now?"
Irritable, aggressive behavior	• Have caregiver help child understand caregiver's facial expression, tone of voice • Remind caregiver to be aware of emotional response to child's behavior • Do not take the behavior personally • Be consistent and calm when disciplining • Avoid yelling, aggression • Give messages that say child is safe, capable, worthwhile • Spend extra-special time playing with child • Praise desired and neutral behavior

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After the Trauma: Helping My Child Cope

THINGS PARENTS CAN DO AND SAY

Six things you can do to help your child after a trauma.

1. **Let your children know they are safe.** Younger children may need extra hugs (as well as your teens).

2. **Allow children to talk about their feelings and worries if they want to.** Let them know that being a little scared and upset is normal. If they don't want to talk, they could write a story or draw a picture.

3. **Go back to everyday routines.** Help your child get enough sleep, eat regularly, keep up with school, and spend time with friends.

4. **Increase time with family and friends.** Children who get extra support from family and friends seem to do better after upsetting events. Try reading, playing sports or games or watching a movie together.

5. **Take time to deal with your own feelings.** It will be harder to help your child if you are worried or upset. Talk about your feelings with other adults, such as family, friends, clergy, your doctor, or a counselor.

6. **Keep in mind that people in the same family can react in different ways.** Remember, your child's feelings and worries might be different from yours. Brothers and sisters can feel upset too.

What should I expect after a trauma? In the first few days after a trauma, your child might feel confused, upset, jumpy or worried. This is normal. Most children just need a little extra time to feel better.

What are common changes in my child? After a trauma, changes you might notice are:

- **Young children:** thumb sucking, bed wetting, clinging to parents, being afraid of the dark.
- **School age children:** getting easily upset or angry, clinging to parents, nightmares, not paying attention, not wanting to go to school or play with friends.
- **Teens:** changes in sleeping and eating, new problems in school, arguing with friends or family, complaining of feeling sick.

When and how should I get help for my child? If these changes do not clear up, seem to be getting worse, or there are other things that worry you, talk to your child's doctor or school counselor to find out the best way to help your child and family.

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Things other parents have found helpful.

YOUNGER CHILDREN:

"You're safe now."

"Why don't you draw a picture about your time in the hospital."

OLDER CHILDREN:

"You can still spend time with your friends."

"When I'm upset, I find someone to talk to."

Do: Allow your child to talk about what happened, if he or she wants to.

Say: *"A lot has happened. Is there anything you're worried or confused about?"*

Do: If your child doesn't want to talk about what happened, encourage him or her to draw a picture or write a story about it.

Say: *(To younger children) "Can you draw a picture about what happened and tell me a story about it?" (To teenage children) "Can you write a story about what happened and how you're feeling?"*

Do: Keep in mind that brothers and sisters could also feel upset or worried.

Say: *"How are you doing? Is there anything you are worried about?"*

Do: Keep up with regular meal and bed times for you child. If sleep is a problem for your child, try a bedtime story and a favorite stuffed animal for younger children, some quiet time and relaxing music for teens.

Say: *(To younger children) "Let's read your favorite book before going to bed." (To teenage children) "How about listening to music that helps you relax?"*

Do: Talk to another adult if you are feeling upset about what happened to your child. Also, talk to your child's doctor if you are concerned about how he or she is dealing with the trauma.

Say: *"I'm feeling a little overwhelmed. It would help to have someone to talk to."*

A PARTNER IN NCTSN The National Child Traumatic Stress Network

Developed by The Center for Pediatric Traumatic Stress at The Children's Hospital of Philadelphia and Nemours / Alfred I. duPont Hospital for Children

www.healthcaretoolbox.org

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3.5 ADHD

SURVEILLANCE FOR **ADHD**:

- EXCESSIVE activity for developmental level, and/or interrupts/intrudes, distractibility, fails to finish work, gets overly excited/upset, fearless, inconsistent performance, unsafe, aggressive
- Symptoms are present in 2 or more settings and cause impairment

- Is child younger or older than ages of 6-12?
- Has child had significant traumatic changes (e.g., foster care, death) in last 6 months?
- Is there an existing diagnosis (e.g., Autism, ID, seizures, visual or hearing impairment)?

YES → **See special circumstances on next page:** preschool, adolescent, Autism or DD, seizures

FOCUSED SCREEN FOR ADHD:

Vanderbilt rating scales to caregiver(s) and teacher

POSITIVE SCREEN ON VANDERBILT =

- score of 2/3 on 6 of 9 items on Q1-9 **and/or** Q10-18; **AND**
- evidence of impairment

NEGATIVE SCREEN

CONSIDER OTHER DIAGNOSES

- Hearing, vision, lead level, learning problems or dev delays, brain injury, seizure disorder, primary sleep disorder, history of extreme prematurity, prenatal substances, anxiety/depression is primary problem, early ACES, or trauma in last 6 months
- Consider more general screener (PSC-17, PHQ-9)
- Treat as if "MILD" if parent concerns; provide psychoeducation

POSITIVE SCREEN

SEVERITY

MILD / PRESCHOOL AGE
not impairing in school; or only single setting problem; or does not meet DSM-5

- Parent Behavior Management Training (PBMT)
- School interventions: daily report card
- Parent: education (see chadd.org/)
- Child: skills of self-regulation, social skills
- Review non-med approaches below

MODERATE / SEVERE
with no evidence of substance use in caregiver or patient

All items in Mild PLUS:

- Behavior therapy
- Discuss medication: parentsmedguide.org
- Start medication: titrate up to treat target symptoms
- Med follow-up in 2-4 weeks

MODERATE / SEVERE WITH SUBSTANCE USE IN CAREGIVER OR PATIENT
(see special circumstances)

All items in Mild PLUS:

- Behavior therapy
- Discuss medication: parentsmedguide.org
- If concerned for diversion, see special circumstances
- Consider VMAP consult or psychiatry referral

NON-MED APPROACHES

- nccih.nih.gov/
- Omega-3 (mild + effect)
- Limit dyes (min + effect)
- Improve sleep
- Exercise
- Parent education, behavior therapy
- Self-regulation
- Mindfulness
- Daily report cards at school

IMPROVED?

- Monitor every 3-6 months: HT, WT, BP, HR, tics, side effects
- Consider ADHD monitoring forms

NOT IMPROVED?

- Repeat Vanderbilts
- Trial of other stimulant or XR version of immediate release **OR** trial of non-stimulant
- Monitor trials with rating scales
- Reconsider dual diagnosis
- Consider VMAP consult or psychiatry referral

SIDE EFFECTS of medication?

See provider tips

- Decreased appetite
- Insomnia
- Tics
- Irritability
- Wears off too fast
- Consider VMAP call if persists

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ADHD SPECIAL CIRCUMSTANCES

Dual diagnoses increase complexity: VMAP Consultation Line can help with your complex ADHD questions

PRESCHOOL: Under age 4, unlikely to meet full criteria for DSM-5. Sub-Types of ADHD — primary inattentive type (PIT), hyperactive type (HA), combined type (CT) — not reliable under age 6. Usually hyperactivity-impulsive behaviors. Behavioral management first. Consider specialist referral.

- Based on evidence in preschoolers, consider trial of MPH-IR: 2.5-5mg after breakfast and titrate to 2.5-5mg bid after breakfast and lunch. Target dose is often 7.5-10mg bid.
- May consider alpha agonist (e.g., guanfacine) for impairing behaviors (i.e., aggression, dysregulated anger): start at 0.5mg nightly, increase to 0.5mg bid/1mg nightly. Generally, total dose is less than 3-4mg/24hr. May crush immediate release guanfacine but not extended release guanfacine.

ADOLESCENCE (age 12-18): symptoms should have been present and impairing under age 12. Strongly consider a psychologist referral/neuropsychometric or psychoeducational testing if initial presentation is after age 12. Screen for Anxiety, Depression, Substance Use, Learning Disability, Autism. Gather collateral information from school: time management, organization difficulties, and inconsistency are common. May start with a long-acting stimulant. If starting with a short-acting stimulant, switch to long-acting formulation to reduce misuse and diversion risk.

AUTISM or other Developmental Disability: Dual diagnosis permitted since DSM-5 (2013). Typically follow PRESCHOOL model of START LOW and GO SLOW. Children with autism may have inattentive and distracted behavior due to their autism. They may have hyperactivity due to their stereotypies and sensory needs. If they have co-existing and impairing IMPULSIVITY, pursue dual diagnosis of ADHD in setting of Autism.

With ANXIETY: Anxiety and ADHD often co-exist (30%). Vanderbilts have anxiety questions that will help.

- Initiating BEHAVIOR THERAPY first may be a good choice, then treat residual ADHD symptoms with medication.
- MOST OFTEN, children present with impairing ADHD symptoms and some anxiety symptoms, and starting a ADHD medication helps both! Sometimes starting stimulants can aggravate anxiety symptoms. A second line medication is Atomoxetine for ADHD + Anxiety (though it often works best in kids with minimal hyperactivity symptoms).

SUBSTANCE USE or diversion concerns in patient or family: 15% of youth with ADHD have a co-occurring SUD. If using a stimulant, use a long-acting formulation with parent or school administration/supervision. Trial of non-stimulant such as atomoxetine or bupropion (Wellbutrin) may be appropriate for youth, along with SUD therapy. Frequent requests to change meds, add additional doses, losing scripts, etc. should increase suspicion. Counsel older youth on risks of sharing meds. Check Virginia PDMP (+/- multi-state search) regularly.

TICS: 20% of kids with ADHD have tics. 50% of kids with tics have ADHD. ADHD meds do not cause or worsen tics. Guanfacine and clonidine can sometimes decrease tics and, added to ADHD medication, may help. Learn more: ADHD and Tics: Is There a Connection? (understood.org)

SEIZURES: Taking ADHD medication does not increase risk of seizures in patients with/without epilepsy. Use of stimulant medication with seizure medication is appropriate. It may be advisable to use once daily anti-convulsant in PM and once daily stimulant in AM.

INTEREST IN MILITARY SERVICE: While ADHD alone does not disqualify a person from military service, the Department of Defense (DoD) places significant enlistment restrictions on individuals with an ADHD diagnosis and/or prior treatment with stimulant medication. In 2018, ADHD was considered a DoD disqualifying condition if an applicant: was prescribed medication to treat ADHD in the last two years; was recommended or prescribed an IEP or 504 Plan, or work accommodations after age 14; has a history of comorbid mental disorders; has documentation of adverse academic, occupational, or work performance. Individuals with ADHD need a medical waiver to be able to enlist if they meet these points, with the branches typically requiring that applicants be off medication for several months and have evidence they can function at school or in a job without impairment off medication.

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VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child's Name: _____ Parent's Name:_____

Today's Date: _____ Date of Birth:_____ Age:_____

Directions: 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.

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

Behavior	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, books)	0	1	2	3
8. Is easily distracted by noises or other 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 too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play games	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' conversations and/or activities	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 go along 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 wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (i.e., "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
32. Has stolen things that have 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

Behavior	Never	Occasionally	Often	Very Often
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 or 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

Academic & Social Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (e.g., teams)	1	2	3	4	5

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1. **Motor Tics:** Rapid, repetitive movements such as eye-blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, rapid kicks.
   ☐ No tics present ☐ Yes, they occur nearly every day, but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.
2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffling, snorting, screeching, barking, grunting, repetition of words or short phrases.
   ☐ No tics present ☐ Yes, they occur nearly every day, but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.
3. If **YES** to 1 or 2 → Do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)?
   ☐ No ☐ Yes

Previous Diagnosis & Treatment	NO	YES
1. Has the child been diagnosed with ADHD or ADD?	☐	☐
2. Is he/she on medication for ADHD or ADD?	☐	☐
3. Has the child been diagnosed with a Tic Disorder or Tourette's Disorder?	☐	☐
4. Is he/she on medication for a Tic Disorder or Tourette's Disorder?	☐	☐

For Office Use Only

Total number of questions scored 2 or 3 in questions 1-9: _____
Total number of questions scored 2 or 3 in questions 10-18: _____
Total symptom score for questions 1-18: _____
Total number of questions scored 2 or 3 in questions 19-26: _____
Total number of questions scored 2 or 3 in questions 27-40: _____
Total number of questions scored 2 or 3 in questions 41-47: _____
Total number of questions scored 2 or 3 in questions 48-55: _____
Average Performance Score: _____

VANDERBILT ADHD DIAGNOSTIC TEACHER RATING SCALE

Child's Name: _____ Teacher's Name: _____

Today's Date: _____ School: _____ Age:_____

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

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

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

Behavior	Never	Occasionally	Often	Very Often
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

Academic & Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Writing	1	2	3	4	5
38. Mathematics	1	2	3	4	5
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Tic Behaviors: To the best of your knowledge, please indicate if this child displays the following behaviors:

1. **Motor Tics:** Rapid, repetitive movements such as eye-blinking, grimacing, nose twitching, head jerks, shoulder shrugs, arm jerks, body jerks, rapid kicks.
   ☐ No tics present ☐ Yes, they occur nearly every day, but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.
2. **Phonic (Vocal) Tics:** Repetitive noises including but not limited to throat clearing, coughing, whistling, sniffling, snorting, screeching, barking, grunting, repetition of words or short phrases.
   ☐ No tics present ☐ Yes, they occur nearly every day, but go unnoticed by most people. ☐ Yes, noticeable tics occur nearly every day.
3. If **YES** to 1 or 2 → Do these tics interfere with the child's activities (like reading, writing, walking, talking, or eating)?
   ☐ No ☐ Yes

Previous Diagnosis & Treatment	NO	YES
1. Has the child been diagnosed with ADHD or ADD?	☐	☐
2. Is he/she on medication for ADHD or ADD?	☐	☐
3. Has the child been diagnosed with a Tic Disorder or Tourette's Disorder?	☐	☐
4. Is he/she on medication for a Tic Disorder or Tourette's Disorder?	☐	☐

For Office Use Only	
	Total number of questions scored 2 or 3 in questions 1-9: _____
	Total number of questions scored 2 or 3 in questions 10-18: _____
	Total symptom score for questions 1-18: _____
	Total number of questions scored 2 or 3 in questions 19-28: _____
	Total number of questions scored 2 or 3 in questions 29-35: _____
	Total number of questions scored 2 or 3 in questions 36-43: _____
	Average Performance Score: _____

EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR ADHD

The positive effects of behavioral therapies tend to persist, but the positive effects of medication cease when medication stops. "Behavior Management Training" and "Behavior Therapy" and "Parent Management Behavior Therapy (PMBT)" are all terms used for children and caregivers who receive counseling for their ADHD; this type of counseling is offered by pediatric psychologists and licensed mental health providers, including LCSWs. Almost always, caregivers need to have time alone with counselor to discuss compliance and discipline.

GUIDE TO ADHD PSYCHOEDUCATION

What is ADHD?

Attention Deficit Hyperactivity Disorder is a neurodevelopmental condition with symptoms existing along a continuum from mild to severe. It occurs across the life span.

How is ADHD Treated?

Treatment should be **multimodal.** Incorporating different interventions, such as education, medication, and behavioral modifications/motivational interviewing/ psychotherapy, produces a better outcome.

Treatment must be collaborative among the physician, the patient, and the family. It should be targeted to each individual's needs and goals, which may change over time.

Two important components of a multimodal approach:

PSYCHOEDUCATION

Psychoeducation should be the first intervention. Educating the family/ patient about ADHD (symptoms, functional impairment, possible comorbidities and treatment) will ensure a more successful outcome.

PSYCHOSOCIAL INTERVENTIONS

Psychosocial interventions can reduce impairments associated with ADHD symptoms and improve overall quality of life. Interventions can be **cognitive** or **behavioral**.

PSYCHOEDUCATION

Discover
- What does the individual/ family know about ADHD?

Demystify
- Myths about ADHD
- Diagnosis and assessment processes

Instill Hope
- Evidence-based treatments and interventions **do** exist and **will** promote a positive outcome

Educate
- Importance of combining pharmacological and psychosocial interventions
- Risks and benefits

Empathize
- Acknowledge feelings of discouragement, grief, and frustration.

Encourage
- A strength-based approach
- Make more positive than negative comments
- Discourage criticisms

Recognize
- Appropriate behavior, whether observed or reported
- Goals achieved

Be Sensitive
- Ethnic, cultural and gender issues may shape the perception and beliefs about ADHD and its treatment

Motivate
- Nurture strengths and talents
- Encourage skills

Promote
- Regular exercise
- Consistent sleep hygiene
- Healthy nutrition routine

Humour


Humour can defuse awkward, tense situations and avoid or reduce conflict

Give Resources
- Websites
- Local community resources
- Book lists

CADDRA

For further information, please refer to the Psychosocial Interventions and Treatments chapter, Canadian ADHD Practice Guidelines at caddra.ca

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Parent Behavior Management Training

Parent Behavior Management Training (PBMT) is designed for children ages 2-17 and focused primarily on caregivers, though children may participate in some sessions. Caregivers are taught skills to more effectively manage challenging behaviors through modeling and role-playing. Between sessions, caregivers practice at home with their children. Training programs typically include at least 10 sessions.

PBMT has been shown to be effective in decreasing oppositional, aggressive, and antisocial behavior, with strong post-intervention results. For more information, visit the FACTs Sheet template (chadd.org); it includes links to behavior management in preschoolers, parent training, and 12 behavior programs that work in children with ADHD.

Parent AND Child Behavior Management Training (evidence-based): 10-20 sessions to teach psychoeducation, psychosocial strategies, and specific interventions for ADHD.

Preschool	School Age	Adolescent
Parent Behavior Management Training (PBMT) to decrease oppositional behavior, aggression. Improve positive parenting and parent self-efficacy and decrease negative parenting and coercive parenting.	PBMT to decrease oppositional behavior, aggression. Improve positive parenting and parent self-efficacy and decrease negative parenting and coercive parenting. Set up homework completion strategies, family function.	PBMT to establish appropriate token economy for compliance, rules to minimize risk-taking behaviors. Teens with ADHD are typically 2 years behind their peers socially and with respect to responsibility. Consider family therapy for older adolescents.
Child behavioral therapy to increase prosocial skills, decrease aggression, improve self-regulation.	Child behavior therapy to increase adaptive behavior, social skills.	Teen learning peer pressure strategies, organizational skills training. Cognitive Behavior Therapy (CBT) is effective for ADHD after about age 10 (to learn time management, etc.).
Teacher/childcare interventions include visual strategies, structure and routine in supervised settings.	Teacher to implement strong communication with daily report card, strategies for organization, improve academic productivity, peer interactions.	Social skills interventions (often done by schools), organizational skills/time management coaching, driving safety education.

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MEDICATION GUIDANCE: ADHD

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
Stimulant	methylphenidate: short acting	Ritalin (IR) Focalin Methylin	Ritalin tab (5,10,20mg) Focalin* tab (2.5,5,10mg) Methylin • chew (2.5,5,10mg) • soln (5mg/5ml, 10mg/5ml)	**Initial dose:** 2.5-5.0mg bid **Max dose:** Usually 60mg/day except Focalin* 30mg/day **Typical effective dose:** 15-20mg/day <6y 25-40mg/day 6-12y 30-60mg/day >12y **Duration:** 3-4 hours	**SEE SIDE EFFECT HANDOUT** for full list **Common:** loss of appetite, sleep disturbance **Less common/rare:** All other symptoms Except for children under 6 — more side effects than school-age children and adolescents Monitor HT, WT, BP, Pulse	*Focalin is twice as concentrated as Ritalin — use ½ doses FDA approved for 6+, but research under age 6, used MPH (PATS study) Best to titrate with IR and switch to longer acting
	methylphenidate: intermediate acting	Ritalin LA Metadate CD	Ritalin LA capsule can be sprinkled (10-40,60mg) Metadate CD capsule can be sprinkled (10-60mg)	**Duration:** 6-8 hours		FDA 6+
	methylphenidate: long acting	Concerta Metadate ER Quillivant XR Focalin XR Aptensio XR Contempla XR-ODT Daytrana^patch	Concerta (18,27,36,54mg) Metadate ER (10,20mg) Quillivant XR • chew 20,30,40mg • soln 25mg/5cc Focalin XR caps can sprinkle (5,10,15,20,25,30mg) Aptensio (10,15,20,30,40,50,60mg) Contempla XR-ODT (8.6,17.3,25.9mg) ^Daytrana patch (10,15,20,30mg)	**Initial dose for >6 years:** 18-27mg Concerta or 20mg Quillivant XR, or others **Max dose:** Usually 60mg for all drugs, except: Focalin XR: 30mg; Concerta: 72mg; Contempla XR: 51.8mg **Duration:** 8-12 hours **Peak effects vary:** 2-5 hours		^For Daytrana Patch information FDA 6+ Do not crush Concerta OROS capsule Other new meds on the market in MPH long acting group: • Jornay PM, taken night before • Azstarys is a long acting MPH with a combination of MPH+prodrug for action

Note: all medication information should be verified using current PDR

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Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
Stimulant	amphetamine (mixed salts and/or dextroamphetamine): short acting	Adderall Dexedrine Evekio Zenzedi Procentra	Adderall (5,7.5,10,12.5,15, 20,30mg) Evekio (5,10mg) Zenzedi (2.5,5,7.5,10,15,20,30mg) Procentra (5mg/5ml)	**Initial dose:** 2.5mg for 3-5 year old, 5mg BID for 6+ **Max:** Usually 40mg **Typical effective:** 5mg bid for <6; 10-15mg bid for >6+ **Duration:** 4-6 hours	**SEE SIDE EFFECT HANDOUT** for full list **Common:** loss of appetite, sleep disturbance **Less common/rare:** All other symptoms Except for children under 6 — more side effects than school-age children and adolescents. Monitor HT, WT, BP, Pulse	FDA approved for ages 3+, but less researched than MPH
Stimulant	amphetamine (mixed salts and/or dextroamphetamine): intermediate or long acting	Adderall XR Vyvanse Dexedrine spansules Adzenys XR ODT Adzenys ER Dyanavel XR Mydayis	Adderall XR caps can be sprinkled (5-30mg) Vyvanse may open cap and dissolve in water (20-70mg) Dexedrine spansules (5-15mg) †Adzenys • XR ODT (3.1,6.3mg, etc.) • ER (1.25mg/1ml) †Dyanavel XR (2.5mg/1ml) †Mydayis cap (12.5,25,37.5mg)	**Initial dose:** 5mg daily >6+ **Max:** 40mg **Typical effective:** 20-30mg **Duration:** 8-12 hours		†Adzenys is dosed for ODT and liquid. Starting dose is 6.3mg for 6+. †Dyanavel XR is liquid with initial dose of 2.5-5mg for >6+ †Mydayis dosed for teens only
SNRI	atomoxetine	Strattera	Capsule 10,18,25,40,60,80, 100mg Do not open	Initial 0.5mg/kg/day for <70kg and >6+; for >70kg start with 40mg **Max:** 100mg **Typical effective:** 40-60mg **Duration:** 18-24 hours	Needs 2-4 weeks for effect BOX WARNING like SSRI **SEE SIDE EFFECT HANDOUT**	Other new SNRI on the market for ADHD is viloxazine (Qelbree)

Relative Effect Size of ADHD Medication Choices
Effect size of all stimulants ~1.0
Effect size of atomoxetine ~0.7
Effect size of guanfacine ~0.65 (using Cohen's d-statistic)

Stimulant Relative Potencies
Methylphenidate 10mg ≈ dexmethylphenidate 5mg
Methylphenidate 10mg ≈ dextroamphetamine 5mg

Note: all medication information should be verified using current PDR

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PROVIDER TIPS & CLINICAL PEARLS

What do I do with ADHD medication side effects?

PRINT OUT AACAP PARENT MEDICATION GUIDE: ADHD (2020) and review with family

- There is a table with STRATEGIES FOR STIMULANT SIDE EFFECTS
- There is a table with STRATEGIES FOR NON-STIMULANT SIDE EFFECTS
- Of note, if you ask BEFORE starting medications, a lot of children have picky eating, poor sleeping, and afternoon irritability at baseline, so medications may IMPROVE, HAVE NO EFFECT, OR WORSEN symptoms.
- 75% of children with ADHD improve with first stimulant tried, and another 10-15% improve if you have to go to second class of stimulants (MPH and AMP). So only about 10% of children don't improve or have so many side effects to STOP stimulant therapy in setting of ADHD.
- ADHD-Primary Inattentive Type (PIT) is missed more often and responds differently to meds than the Combined Type and the Hyperactive Type. If daydreaming is IMPAIRING, without other ADHD symptoms, look harder for a learning problem or autism Level 1.

What do I do if the screening results do not agree?

Parent Screener	Teacher Screener	Likely Outcome
+	+	ADHD ++ (often ODD, anxiety, etc.)
+	—	Explore concerns in the home, parent mental health status, parent-child relationship, stress
—	+	Likely ADHD or, if new concern this school year, consider teacher-child mismatch

Significant oppositional behaviors are common in setting of untreated ADHD, so treat as "impulsivity" symptoms first.

What about need for EKG before medications?

- AAP does not recommend EKG or cardiology consultation, unless strong family history of cardiac problems (death under age 35-40) or underlying cardiac problems are present in patient. **Monitor at each visit: HR, BP, weight, height, and any new symptoms that could be cardiac-related (syncope, palpitations).**

What if I need to use medication in a child between ages 3-5?

- START LOW AND GO SLOW.
- Consider guanfacine short-acting, and if not working, trial of MPH IR is best studied (though not FDA approved in preschoolers). The PATS Study identified total daily dose for ages 3-5 at 14-20mg/day, MUCH LESS THAN SCHOOL-AGE KIDS.

What about poor sleep at baseline causing behavior problems?

- Sleep onset latency insomnia is a HUGE problem for kids with ADHD. Consider 1-3mg of melatonin before considering other meds. Research shows it works in at least 50% of kids. Higher than 5-6mg is not recommended. Don't forget: good sleep hygiene is considered first line for insomnia.
- Separately, lack of sleep can mimic ADHD symptoms. Consider treating sleep first to see if symptoms improve.

What should I monitor during regular 3-6 month medication checks?

- With stimulant or atomoxetine treatment, follow vital signs, sleep, mood lability, appetite, growth, and cardiac symptoms with treatment.
- With alpha agonist treatment, follow vital signs, symptoms of orthostasis, sedation, agitation, and for depressed mood.

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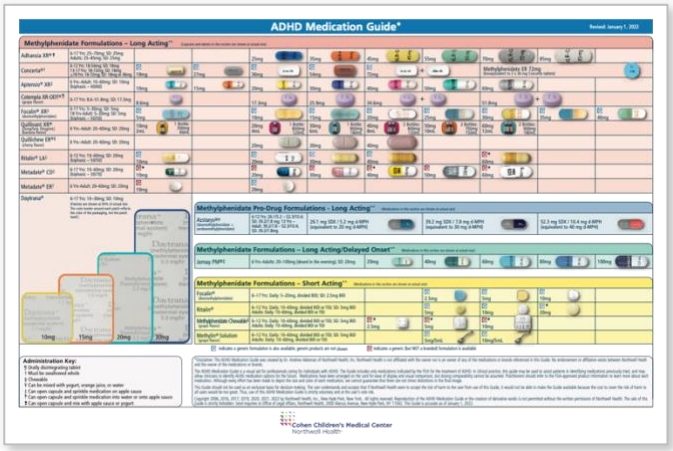
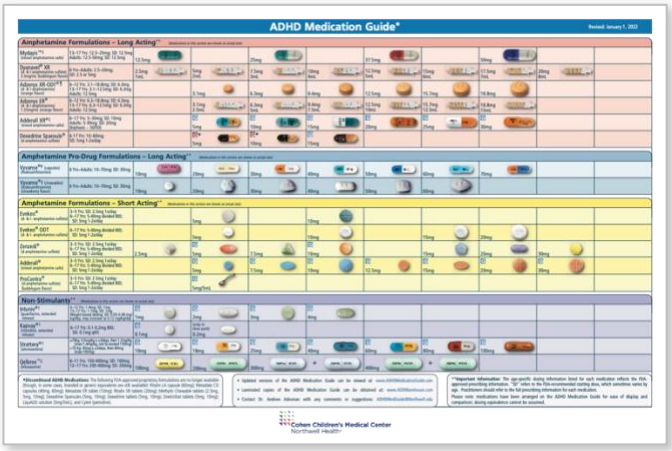
ADHD resources for providers

- *AAP Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents* (2019) by Wolraich et al.
- *Society for Developmental & Behavioral Pediatrics Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder* (2020)
- Cohen Children's Medical Center The ADHD Medication Guide© is available for download at adhdmedicationguide.com/





ADHD web resources for patients and caregivers

- CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder): chadd.org/
- Understood: understood.org/hub
- ADDitude Magazine: additudemag.com/
- CDC child and family resources including videos, games, and fun facts about ADHD
- Harvard University Center on the Developing Child: age-based activity guide for building executive function skills
- American Academy of Child and Adolescent Psychiatry ADHD Parents Medication Guide

ADHD books for patients and caregivers

- *Taking Charge of ADHD: Complete Authoritative Guide for Parents* by Russell Barkley, PhD
- *How to Talk So Kids Will Listen and Listen So Kids Will Talk* by Adele Farber & Elaine Mazlish
- *Parenting the Strong-Willed Child* by Rex Forehand, PhD & Nicholas Long, PhD
- *Smart But Scattered* (child and teen version) by Peg Dawson, EdD & Richard Guare, PhD
- *1-2-3 Magic* by Thomas Phelan, PhD
- *Raising Boys with ADHD; Raising Girls with ADHD* by James Forgan & Mary Anne Rich

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FOR FAMILIES: WHAT IS ATTENTION DEFICIT HYPERACTIVITY DISORDER?

Attention deficit hyperactivity disorder, also called ADHD, is a common behavior problem seen in school-aged children. With ADHD, your child may be overactive and restless most of the time. They may also have a hard time paying attention, concentrating, and controlling their actions. These may make it difficult for your child to do well at home or in school. ADHD may also cause your child to have problems getting along with their friends and relatives. You may notice that your child's behavior may seem different from other children of their age. ADHD usually starts before your child is seven years of age and is more common among boys. With proper treatment and care, your child's ADHD may be controlled and their quality of life improved.

Helpful websites:

- Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD): chadd.org or help4adhd.org
  - Spanish: chadd.org/understanding-adhd/recursos-en-espanol/
- American Academy of Child & Adolescent Psychiatry: aacap.org and go to "Families and Youth" Section
- Child Mind Institute: childmind.org (available in Spanish)
- Understood: understood.org
- Parent Resources/Blogs:
  - Thriving with ADHD: thrivingwithadhd.com.au/
  - Tilt Parenting: tiltparenting.com/recommended-resources/

Additional resources:

The following resources can be helpful for you as you make decisions about your child's care after a diagnosis of ADHD. We recommend that parents try books that they think will be helpful to them, but none of these are required reading!

- The ADHD Parent Medication Guide is an overview of ADHD and information on different treatment options. It can be found online at tinyurl.com/Med-Guide.
- The following books can be helpful for parents of children with ADHD.
  - *Smart but Scattered Series*, by Drs. Peg Dawson and Richard Guare
  - *Taking Charge of ADHD: The Complete, Authoritative Guide for Parents*, by Russell A. Barkley, PhD
  - *Driven to Distraction: Recognizing and Coping with Attention Deficit Disorder from Childhood through Adulthood,* by Edward Hallowell and John Ratey.
  - *Mindful Parenting for ADHD: A Guide for Cultivating Calm, Reducing Stress, and Helping Children Thrive,* by Dr. Mark Bertin
  - *The Family ADHD Solution: A Scientific Approach to Maximizing Your Child's Attention and Minimizing Parental Stress,* by Dr. Mark Bertin
  - *What Your ADHD Child Wishes You Knew: Working Together to Empower Kids for Success in School and Life,* by Dr. Sharon Saline
  - *Boy Without Instructions: Surviving the Learning Curve of Parenting a Child with ADHD,* by Penny Williams
  - *What to Expect When Parenting Children with ADHD: A 9-Step Plan to Master the Struggles and Triumphs of Parenting a Child with ADHD,* by Penny Williams
  - *The Insider's Guide to ADHD: Adults with ADHD Reveal the Secret to Parenting Kids with ADHD, by Penny Williams*

  - *Faster Than Normal: Turbocharge Your Focus, Productivity, and Success with the Secrets of the ADHD Brain, by Peter Shankman*
  - *The Everything Parent's Guide to Children with Executive Functioning Disorder: Strategies to help your child achieve the time-management skills needed to succeed in school and life, by Rebecca Branstetter*
  - *Helping Students Take Control of Everyday Executive Functions: The Attention Fix, by Paula Moraine*
  - *SOAR Study Skills; A Simple and Efficient System for Getting Better Grades in Less Time, by S. Kruger*
- The following podcasts and YouTube channels also have useful information:
  - Parenting ADHD Podcast with Penny Williams
  - Parenting your Challenging Child by Dr. Ross Greene
  - Distraction by Dr. Ned Hallowell
  - ADHD Dude: Free videos (including ones for kids!) highlighting different topics related to ADHD in boys and young men. youtube.com/c/ADHDDudeRyanWexelblattLCSW
- The following books can be useful resources for children. We recommend that parents try books that they think will be helpful to them, but none of these are required reading!
  - *The Survival Guide for Kids with ADHD,* by John F. Taylor Ph.D.
  - *Learning To Slow Down & Pay Attention,* by Kathleen Nadeau
  - *The ADHD Workbook for Kids: Helping Children Gain Self-Confidence, Social Skills, and Self-Control,* by Lawrence Shapiro, Ph.D

Consider these non-medication treatments and strategies for ADHD. While medications are considered first-line therapy, many parents find that additional strategies can be helpful in treating their child's ADHD.

- **Behavioral Therapy:** Multiple modalities of behavioral therapy have been found to be effective in treating children with ADHD. These include cognitive behavioral therapy, parent-child interaction therapy, and parent management training. You can talk with your provider to find resources in your area.
- **Sleep:** It is beneficial for children to get enough sleep to focus and learn well during the day.
- **Exercise:** Regular physical activity is associated with decreased ADHD behaviors and improved executive functioning.
- **Green Therapy:** Being outside and moving or playing significantly reduces ADHD symptoms compared to being indoors.
- **Yoga:** Yoga reduces hyperactivity, impulsivity, mild mood swings, and severity of ADHD symptoms.
- **Limiting Screen Time:** Screen time harms attention.
- **Nutrition:** Children who eat healthy foods and a nutritious breakfast pay better attention in school.

3.6.1 Disruptive Behavior & Aggression in Children Ages 2 to 10

SURVEILLANCE OF **DISRUPTIVE BEHAVIOR & AGGRESSION** IN AGES 2-10:
Symptoms: defiance, aggression towards self or others, anger

SAFETY CHECK
- Assess for risk of self-harm or harm of others
- Assess for safety of patient (maltreatment)
- If concerned, consider emergency evaluation (risk of harm by patient) or Child Protective Services evaluation

- **SCREEN BROADLY:** PSC-17 (positive ≥ 15), PPSC (positive ≥ 9), Brief ECSA (positive ≥ 9)
- Then **FOCUSED SCREEN**: Vanderbilt, PTSD, Anxiety

CONSIDER THE CAUSE OF THE BEHAVIOR
- ADHD
- Adjustment reaction
- Developmental delays or autism
- Mood disorder (depression or DMDD)
- Anxiety, OCD, PTSD, or chronic trauma exposure
- Sleep impairment
- Medication or supplement effect
- Unmet basic needs (e.g., food, parenting, appropriate daycare)
- Caregiver depression or other MH needs

POSITIVE SCREEN

MILD TO MODERATE
aggression isolated to home setting

- Reduce attention for mildly oppositional/disruptive behavior
- Schedule frequent follow-ups
- Monitor with PSC-17 regularly
- Consider peer mentors, patient and family communication skills therapy, Triple P, PMT, PCIT

Preschool age:
- Consider referral for home visiting, Head Start (if eligible), Early Intervention (Infant Toddler Connection)

School age:
- Identify provocative behaviors
- Safe consequences for disruptive behaviors
- Relaxation skills ("Monster Meditations," mindfulness apps)

SEVERE
violent or occurs in multiple settings

Mild to Moderate PLUS

Preschool age:
- Parent behavior management training (ages 3-11), PCIT (ages 2-7)

School age:
- Request school Functional Behavior Assessment (FBA)
- Parent training/child behavior therapy focused on communication, problem-solving skills, effective parenting skills
- Consider medications for maladaptive, impulsive aggression to treat underlying cause: stimulants, alpha agonists, atypical antipsychotic agents, and mood stabilizers have evidence

Medications do not treat proactive, planned aggression

See 3.6.2 for guidance regarding aggression in youth ages 11+

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SCREENERS

General Surveillance and Screening

- Behavioral Health Questionnaire
- Brief Early Childhood Screening Assessment (ages 18-60 months)
- Preschool Pediatric Symptom Checklist (ages 18-65 months)
- Pediatric Symptoms Checklist-17, parent (ages 4-17)

Focused Screening and Rating Tools

- Vanderbilt, parent and teacher (over age 4)
- CATS
- SCARED, parent and child (over age 8)
- PTSD

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EVIDENCE-BASED BEHAVIORAL INTERVENTIONS

Parent training programs

Focus on teaching parent and caregiver skills to promote positive behaviors by:

- Shaping child behavior through positive reinforcement, increased attention to positive behaviors
- Planned ignoring (decreased attention to low levels of negative behaviors)
- Using clear, effective directions
- Implementing clear, consistent, safe consequences for unsafe or unacceptable behaviors

Family-focused problem-solving treatments

- Support healthy problem solving and coping strategies for youth and caregivers
- Focus on effective communication strategies across the family and school settings
- Help caregivers understand behaviors as a sign of a problem, rather than the main problem
- Address family basic needs

Individual therapy with caregiver involvement

- Individual therapy focused on problem solving
- Generally not as effective unless co-occurring stressors, anxiety, and/or depression
- Focus on developing coping skills

Treatment Modality	Ages (yrs)	Program Name	Website/Resources
Parent training programs	3-13	Parent Management Training (PMT)	parentmanagementtraininginstitute.com/
	0-8	Incredible Years Series	incredibleyears.com/
	2-7	Parent Child Interaction Therapy (PCIT)	pcit.org/
	0-13	Triple P — Positive Parenting Program	triplep.net/
Family-focused interventions that include problem solving	0-18	Collaborative and Proactive Solutions	cpsconnection.com
	10-18	Functional Family Therapy	fftllc.com/fft
	12-18	Multisystemic Therapy	mstservices.com
Individual treatment	All ages	Cognitive Behavioral Therapy	Best for children with co-occurring anxiety and/or depression

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MEDICATIONS FOR CHILDREN WITH DISRUPTIVE BEHAVIORS

Medications are not first line treatments for children with disruptive behaviors.

- **First line intervention should be behavioral interventions that focus on either mitigating stressors** (educational supports, caregiver depression treatment) **or increasing a child's coping capacity.**
- Pharmacotherapy may be considered when behavioral interventions are ineffective or unavailable, or when treating co-occurring mental health concerns. Generally, stimulants and alpha agonists are considered before other classes due to safety profiles. Understanding where the aggression is coming from is paramount to deciding what to use, although these medications and their safety profiles make them good choices if the clinical scenario is unclear.
- If disruptive behaviors and aggression are present in a child with autism, see autism guidance, Section 4.5.

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information + SE	Comments
Alpha Agonist	clonidine, clonidine ER	Catapres, Kapvay	**Tablets:** 0.1mg, 0.2mg, 0.3mg **Transdermal patch:** (0.1-0.4mg)	**Initial dose:** 0.05-0.1mg **Max dose:** 0.4mg in 24 hours **Therapeutic dose range:** 0.1-0.4mg nightly or divided up to TID **Duration:** 3-6 hours (patch 1-5 days) **PEAK:** 3-4 hours	**Common:** sedation, rash, dizziness, constipation Major side effects include hypotension, mood changes Potential for rebound hypertension with abrupt discontinuation, especially if given >0.1mg/day	FDA approval for ADHD for Kapvay in children over age 6. Also may be effective for tics. Monitor P, BP Kapvay tablets should not be crushed or cut Wean 0.1mg/day q7+ days **SEE SIDE EFFECT HANDOUT IN SECTION 1**
	guanfacine, guanfacine ER	Tenex, Intuniv	**Tablets:** 1mg, 2mg **ER:** 1-4mg	**Initial dose:** 0.5 (1/2 tab) -1.0mg **Max dose:** 3-4mg in 24 hours (6-12yo), 7mg (13+) **Therapeutic dose range:** 1-2mg BID or divided up to TID, or if using long acting, nightly **Duration:** 12-24 hours, peak effect 4-8 hours for Tenex	**Common:** sedation, dizziness, constipation. Major side effects include hypotension, sedation, mood changes. Potential for rebound hypertension with abrupt discontinuation, especially if given >1.0mg/day.	FDA approval for ADHD for Intuniv in children over age 6. Also may be effective for tics. Monitor P, BP Wean 1mg/day q 3-7 days Intuniv should not be crushed or cut **SEE SIDE EFFECT HANDOUT IN SECTION 1**

Note: all medication information should be verified using current PDR

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PROVIDER TIPS: RETHINKING DISRUPTIVE BEHAVIOR PROBLEMS

Disruptive behavior patterns are a non-specific presenting problem like pain. Using a pneumonic developed for pain can help organize the history for a child presenting with disruptive behavior patterns.

O: ONSET
P: PALLIATIVE and PRECIPITATING factors — What triggers it?
Q: QUALITY — What does it look like? Specific behaviors (talking back, verbal aggression, physical aggression)?
R: RELATIONSHIPS and REGION — What contexts (relationships and places) do the behaviors happen in?
S: SEVERITY — level of intensity, risk of injury, actual injury
T: TIMING — time of day, days of week, duration of the behavioral events

Differential Diagnosis: **The key to effective intervention for disruptive behaviors is identifying the underlying problem driving the aggression or difficulty with following rules:**

Driver of Disruptive Behavior?	Important Considerations	IMPORTANT: Evidence-based behavioral interventions are FIRST LINE	
		Non-pharmacologic intervention(s)	If medication is needed… *
Typical behaviors	Behaviors are problematic for family or classroom, but are typical for the child's developmental level. Consider caregiver stress, mood problems, or anxiety.	Functional behavioral analysis, education consult, social skills therapy (if appropriate)	
ADHD	Impulsivity and inattention prominent. Child shows genuine remorse.	Parent Management Training (3-11yo), PCIT (2-7yo), 1-2-3 Magic (2-12yo), Triple P (birth-16yo) Combination of therapy and meds for children over 6 years.	Stimulant or alpha agonist See ADHD Care Guide (3.5)
Adjustment reaction	Adjustment disorder should be considered when changes in behavior are sudden or context-specific.	Psychotherapy	
Anxiety disorders	Disruptive behaviors may represent a way of avoiding the anxiety trigger or because of overwhelming fears/emotions that spill out as anger and frustration.	Psychoeducation Child-parent psychotherapy (CPP) CBT can be effective in children over age 4 years	SSRI (sertraline or fluoxetine common first choices) See Anxiety Care Guide (3.3)
Autism, developmental delays	Disruptive behaviors may develop in the context of excessive developmental demands.	Early Intensive Behavior Intervention (including ABA, communication strategies, addressing sensory)	Research supports risperidone or other anti-psychotic but developmental behavioral peds is usually involved See Autism Care Guide (4.5)
Learned behavior	Children learn from the people around them.	Positive role models, mentorship programs	
Mood disorder	Prominent mood symptoms (depression, irritability), behavioral difficulties decrease when mood normalizes, problems with sleep, appetite, concentration, energy.	Child-parent psychotherapy (CPP) Family focused therapy CBT (as children get older, behavioral intervention may be most effective in combo with medication)	SSRI (fluoxetine or escitalopram common first choices) See Depression Care Guide (3.1)

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Driver of Disruptive Behavior?	Important Considerations	IMPORTANT: Evidence-based behavioral interventions are FIRST LINE	
		Non-pharmacologic intervention(s)	If medication is needed… *
OCD	Compulsions and obsessions can present as disruptive behaviors when a child's internal "rule" from the OCD is broken or conflicts with adults' rules and expectations.	Psychoeducation CBT (exposure and response prevention therapy)	Assess with Y-BOCs and consider referral to psychologist first for confirmation, because SSRI may be needed at higher doses for OCD than anxiety
Posttraumatic stress disorder	Includes irritability, distress, and avoidance of reminders (some of which may result in avoiding activities the adults expect a child to participate in). Dissociation patterns (brain turning off in response to reminders) may look like intentional ignoring.	Trauma-focused therapy, such as CBT, CPP Narrative therapy	Alpha agonist See Trauma Care Guide (3.4)
Sleep disturbance	Sleep deprivation results in mood symptoms and easy frustration. R/o other sleep disorders.	Parent Management Training CBTi (for insomnia)	Melatonin, alpha agonist See Sleep Challenges Care Guide (3.11)
Unmet basic needs	Food insecurity, instability of housing, and other unmet basic needs put stress on all elements of life, including coping strategies.	Connect to social services/other resources to help meet basic needs	

*** IMPORTANT NOTE**

If medication is needed, identify prominent target symptom complex.
If more than one, pick the most impairing symptoms to focus on first.

Source: Gleason MM, Goldson E, Yogman MW; COUNCIL ON EARLY CHILDHOOD; COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH; SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS. Addressing Early Childhood Emotional and Behavioral Problems. Pediatrics. 2016 Dec;138(6):e20163025. doi: 10.1542/peds.2016-3025. PMID: 27940734.

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PROVIDER TIPS: DISCUSSION GUIDE FOR FAMILIES

Disruptive behaviors generally represent a dysregulated emotional and behavioral response to stressors and usually are a sign that a patient's coping skills are not sufficient for the challenging stressors they face.

Emotional and behavioral coping capacity < Dysregulating force OR stressors

Indicators of need for specialty referral

- Extreme, unsafe behaviors (use of weapons, aggressive behaviors)
- Unresponsive to primary care interventions
- Extreme family distress/parental mental health problems

Online intervention supports

- Monster Meditations — Sesame Street Muppets teach mindfulness (available free on youtube.com)
- Pocket PCIT — pocketpcit.com/ (experimental intervention)
- Triple P Online
- Teen mindfulness and CBT Apps (Calm, Breath2Relax, Woebot, for example)

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FAMILY RESOURCES: TIPS FOR MANAGING YOUR CHILD'S BEHAVIOR

- **Use specific praise:** Be very clear and specific! You should describe the behavior that you are seeing, that you like that behavior, and that you want to see more of that good behavior. Example: "Oh, thank you! I love it when you pick up your toys!"
- **Catch your child being good!** You should give labeled praise more than you correct. Aim for a goal of 4 labeled praises for every 1 time you respond to misbehavior.
- **Give clear and calm instructions:** Be sure to have your child's full attention, be at their eye level, and give a simple, calm instruction. Your child should be given 5 seconds to comply and praised for compliance. If your child is non-compliant, repeat the instruction and give another 5 seconds to follow through. Do not give the instruction more than twice. If they do not follow through with your instruction, it should be followed by an immediate logical consequence.
- **Teach your child to label their emotions:** If your child looks upset, say something like "It looks like you are upset that you have to wait your turn." Encourage your child to label their emotions throughout the day by asking "How are you feeling right now?" This can help to reduce tantrums, meltdowns, aggression, and destructive behavior over time.

Parenting children with aggression often requires specific training!

There are research-based Parent Management Training strategies available that caregivers can self-train in and/or seek the support of a Child Behavioral Counselor/Therapist.

- Child Mind Institute's Complete Guide to Managing Behavior Problems: childmind.org/guide/parents-guide-to-problem-behavior/
- Center for Effective Parenting: parenting-ed.org/parenting-information-handouts/early-childhood/
- CDC Parenting Essentials for Toddlers and Preschoolers: cdc.gov/parents/essentials/
- Empowering Parents: empoweringparents.com/
- Lives in the Balance: livesinthebalance.org/

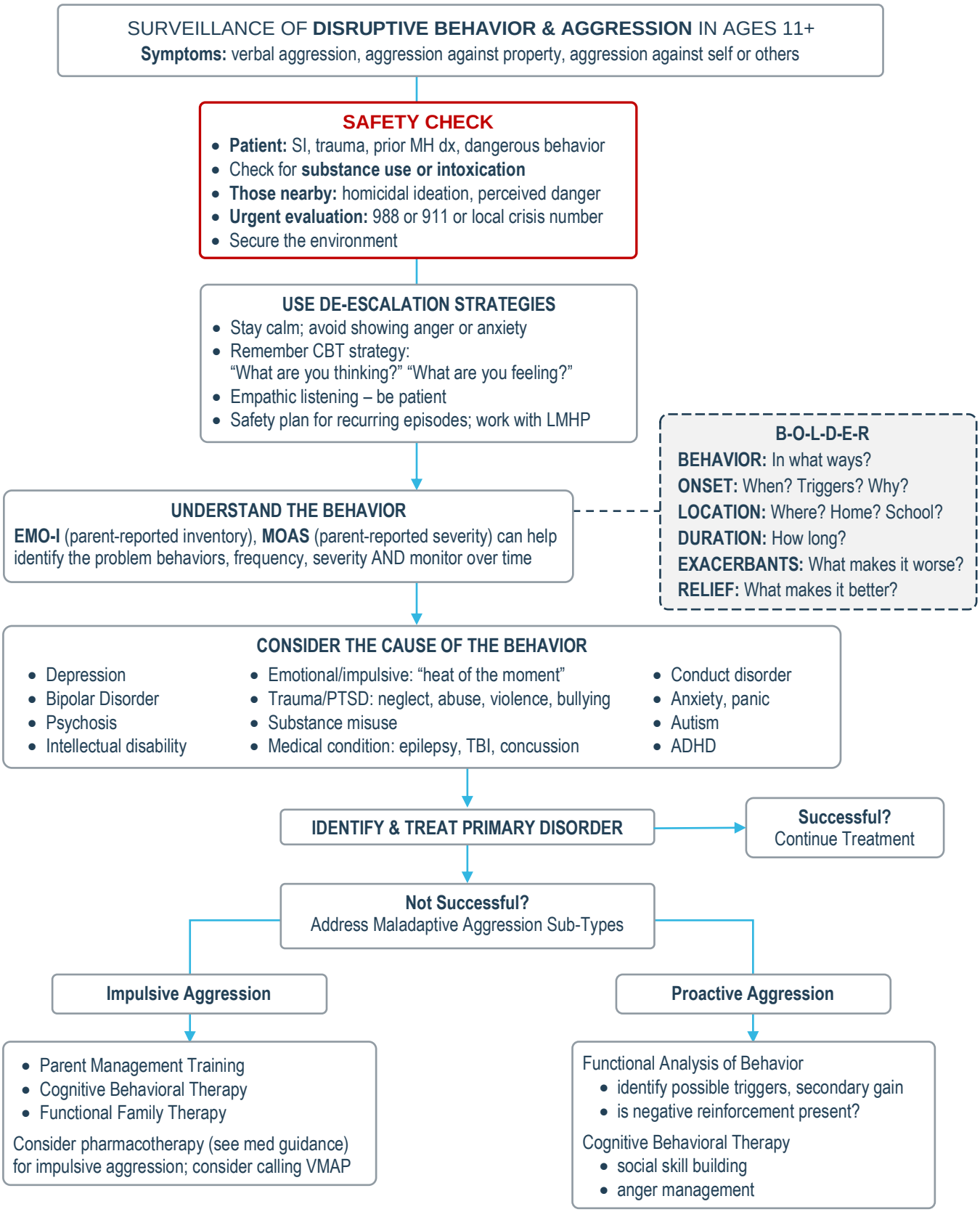
Websites and books for kids

- Self-care for kids: 6 ways to self-regulate (understood.org)
- Sesame Street in Communities (sesameworkshop.org/resources)
- *The Kid's Guide to Staying Awesome and In Control* (2014), by Lauren Brukner
- *Train Your Angry Dragon* (2018), by Steve Herman
- *Anger Management Workbook for Kids* (2018), by Samantha Snowden
- *Social Skills Activities for Kids* (2019), by Natalie Daniels

Websites and books for caregivers

- zerotothree.org/resources/for-families
- American Academy of Child Psychiatry Oppositional Defiant Disorder resource center (aacap.org)
- *Your Defiant Child: Eight Steps to Better Behavior* (2013), by Russell Barkley, PhD
- *The Difficult Child* (2000), by Stanley Turecki, MD and Leslie Tonner
- *SOS Help for Parents* (2006), by Lynn Clark, PhD
- *1-2-3 Magic* (2016), by Thomas Phelan
- *Parenting Children with ADHD* (2014), by Vincent Monastra
- *How to Talk So Kids Will Listen & Listen So Kids Will Talk* (2002), by Adele Faber and Elaine Mazlish
- *The Explosive Child* (2001), by Ross Greene, PhD

3.6.2 Aggression in Youth Ages 11+



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PRIMARY CARE ASSESSMENT: UNDERSTANDING THE BEHAVIOR

Aggression is a behavior that can be a cry for help; all behavior serves a function for the teen or young adult. The first step is to understand more about the behavior.

Antecedent: what is the trigger?

Behavior: impending behaviors might be intense anger, temper or "blow ups," frustration, irritability, or impulsivity

Consequence: exclusion from school or work, juvenile justice system, relationship deterioration

PAUSE AND CONSIDER REFRAME from "what is wrong with you?" to **"what is happening within you?"**

START with a careful history, including medical conditions and family history

- Remember cultural humility: "I don't know your world and I need you to show me and share with me when you are ready."

ASSESS AND DEFINE TARGET SYMPTOMS AND BEHAVIORS

from *"Treatment of Maladaptive Aggression in Youth"* (free, downloadable at thereachinstitute.org)

- Assess the behavior of the youth, towards him/herself and others.
- Determine the frequency and intensity of the symptoms, and how the youth experiences them.
- Identify symptom triggers and coping mechanisms the youth uses to counter the symptoms.
- Identify the symptoms of aggression that are most likely to respond to a specific treatment.
- Include the family's input to ensure their participation throughout treatment and management planning.

B– O – L– D– E– R

BEHAVIOR: In what ways does the youth exhibit aggression?

ONSET: When does it happen? What triggers it, and why?

LOCATION: Where do the symptoms occur – home/school?

DURATION: How long does it last?

EXACERBANTS: What makes it worse?

RELIEF: What makes it better?

IDENTIFY the primary mental health condition:

- **Trauma:** CATS or PEARLS screen
- **Substance misuse:** CRAFFT screen
- **ADHD:** NICHQ Vanderbilt ADHD Diagnostic Rating Scale
- **Anxiety or panic disorder:** SCARED
- **PTSD:** SCARED brief assessment
- Suspected **Bipolar Disorder:** Young Mania Rating Scale, consider VMAP consultation
- Suspected **Psychosis:** consider VMAP consultation

SCALES specific for aggression:

The Emotional Outburst Inventory (EMO-I)

The emotional outburst inventory helps with understanding triggers for anger which can lead to aggressive behavior. There is no cut off score; this is just for information.

The Modified Overt Aggression Scale (MOAS)

The MOAS is an inventory of behaviors. There is not a "cut off" score, and it can be used to track improvement over time. The MOAS begins with less serious behaviors, such as verbal aggression, and is weighted more heavily for aggression against property, against self or against others.

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EMOTIONAL OUTBURST INVENTORY (EMO-I)

Questions about your child's irritability and anger

Name: _____ Date: _____

1. How easy is it for him/her to get angry? (Please check the box of the **ONE BEST** answer)

- ☐ S/he is rarely irritable or angry.
- ☐ S/he is mostly reasonable but has days at a time where s/he is very touchy and gets very angry very easily.
- ☐ S/he rarely gets angry but when s/he does, the explosion is huge compared to the incident that provoked it.
- ☐ S/he has always been cranky and easily angered.

2. What causes him/her to get angry? (Please check **ALL** that apply)

☐ S/he feels s/he is being criticized.	☐ S/he can't handle change in routine.
☐ S/he misunderstands what others are saying.	☐ S/he is frustrated because s/he can't do something (task or activity).
☐ Her/his demands must be met immediately.	☐ S/he is hungry, tired, or pre-menstrual.

3. Which of the following does your child usually do? (Please check **ALL** that apply)

	No	A little	A lot
Expresses anger in an appropriate way	☐	☐	☐
Argues, whines or sulks	☐	☐	☐
Becomes verbally insulting, swears, shouts	☐	☐	☐
Threatens	☐	☐	☐
Slams doors, punches walls, makes a mess, destroys property	☐	☐	☐
Self-mutilates, bangs head, or otherwise takes it out on self	☐	☐	☐
Throws things	☐	☐	☐
Hits, kicks, bites, spits	☐	☐	☐
Needs physical restraint	☐	☐	☐

(Please check the BEST RESPONSE to each question below)

4. How often does a serious tantrum or outburst occur?

☐ Never ☐ Rarely ☐ Several times a month ☐ Weekly ☐ At least 3 times a week ☐ Daily

5. How long does a tantrum or outburst last?

☐ A few minutes ☐ Up to 15 minutes ☐ Up to half an hour ☐ Up to an hour ☐ Up to half a day

6. Is your child angry or irritable between outbursts?

☐ Not at all ☐ Sometimes ☐ Often ☐ Very often

7. How does your child understand the outburst?

☐ Remorseful ☐ Forgets or denies it ☐ Blames others ☐ Spiteful

8. Where does your child have outbursts?

☐ At home/with parents ☐ At school ☐ Both home and school ☐ Home, school, public _____

9. What helps your child calm down?

Carlson, Silver and Klein, Stony Brook University, **updated 2021**

MODIFIED OVERT AGGRESSION SCALE (MOAS)

INSTRUCTIONS:

Rate the patient's aggressive behavior over the past week. Select as many items as are appropriate.

SCORING:

1) Add items within each category; 2) In the scoring summary, multiply sum by weight and add all the weighted sums for total weighted score. Use this score to track changes in level of aggression over time.

VERBAL AGGRESSION: *Verbal hostility, statements or invectives that seek to inflict psychological harm on another through devaluation/degradation, and threats of physical attack*

_____	**0**	No verbal aggression
_____	**1**	Shouts angrily, curses mildly, or makes personal insults
_____	**2**	Curses viciously, is severely insulting, has temper outbursts or deliberately (e.g., to gain money or sex)
_____	**3**	Impulsively threatens violence toward others or self
_____	**4**	Threatens violence toward others or self repeatedly
_____	**SUM VERBAL AGGRESSION SCORE**	

AGGRESSION AGAINST PROPERTY: *Wanton and reckless destruction of ward paraphernalia or others' possessions*

_____	**0**	No aggression against property
_____	**1**	Slams door angrily, rips clothing, urinates on floor
_____	**2**	Throws objects down, kicks furniture, defaces walls
_____	**3**	Breaks objects, smashes windows
_____	**4**	Sets fires, throws objects dangerously
_____	**SUM PROPERTY AGGRESSION SCORE**	

AUTOAGGRESSION: *Physical injury toward oneself, self-mutilation, or suicide attempt*

_____	**0**	No autoaggression
_____	**1**	Picks or scratches skin, pulls hair out, hits self (without injury)
_____	**2**	Bangs head, hits fists into walls, throws self on floor
_____	**3**	Inflicts minor cuts, bruises, burns, or welts on self
_____	**4**	Inflicts major injury on self or makes a suicide attempt
_____	**SUM AUTOAGGRESSION SCORE**	

PHYSICAL AGGRESSION: *Violent action intended to inflict pain, bodily harm, or death*

_____	**0**	No physical aggression
_____	**1**	Makes menacing gestures, swings at people, grabs at clothing
_____	**2**	Strikes, pushes, scratches, pulls hair of others (without injury)
_____	**3**	Attacks others, causing mild injury (bruises, sprains, welts, etc.)
_____	**4**	Attacks others, causing serious injury (fracture, loss of teeth, deep cuts, loss of consciousness, etc.)
_____	**SUM PHYSICAL AGGRESSION SCORE**	

Category	Sum Score	Weights	Weighted Sum
Verbal Aggression		X1	
Aggression Against Property		X2	
Autoaggression		X3	
Physical Aggression		X4	
TOTAL WEIGHTED SCORE			

*Modified from Kay, S. R., Wolkenfeld, F., & Murrill, L.M. (1988). Profiles of aggression among psychiatric patients: I. Nature and prevalence. *Journal of Nervous and Mental Disease, 176*(9), 539–546.

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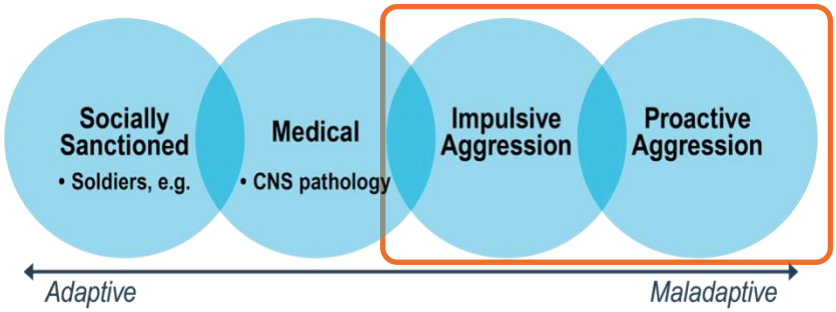
EVIDENCE-BASED BEHAVIORAL INTERVENTIONS

Initial Treatment + Management Planning

- Conduct a risk assessment; consider referral to mental health specialist or crisis
- Partner with family in developing an acceptable treatment plan
- Provide psychoeducation and help families form realistic expectations about treatment
- Help the family to establish community and social supports

The Aggression Continuum



Impulsive aggression: aggression in context of frustration or social threat

- Parent management training (usually better for ages 3 to 11)
- Functional family therapy
- Cognitive Behavioral Therapy (CBT)
- Other therapy to address the purpose of the behavior

Proactive aggression: aggression in service of a tangible goal

- Identify the function of the behavior
- CBT: anger management, social skill building

Treating aggression/impulsivity often requires a team-based approach!

- Aggression is a symptom, not a diagnosis
  - The primary goal is to understand the primary disorder and develop a treatment plan
- You are not alone! Bring together the “team”: family, peers, community resources, teachers, coaches, trusted adults
  - Consider 504 plan to address school-based triggers
- Therapy for primary condition
  - Find a trusted therapist who can help the family understand the “why”
- Psychoeducation when calm: warning signs, strengths, calming and coping strategies
  - Don’t underestimate the influence of your relationship with the patient
- Consider contacting VMAP to help you identify resources

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MEDICATION GUIDANCE

1. The most important point is the collaboration of the team: patient, parents, school, therapist, community resources.
2. Second, treat the primary disorder with medication and therapy, with an adequate dose and trial of medication.
3. Consider VMAP consult. If considering antipsychotics, prescribe for the shortest possible interval at the lowest possible dose to control symptoms. **Start low, go slow.**
4. If antipsychotic is prescribed, monitor for metabolic side effects. See Module 1.6 for additional information.

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information + SE	Comments
Alpha Agonist	clonidine, clonidine ER	Catapres, Kapvay	**Tablets:** 0.1mg, 0.2mg, 0.3mg **Transdermal patch:** 0.1-0.4mg	**Initial dose:** 0.05-0.1mg **Max dose:** 0.4mg in 24 hours **Therapeutic dose range:** 0.1-0.4mg nightly or divided up to TID **Duration:** 3-6 hours (patch 1-5 days) **PEAK:** 3-4 hours	**Common:** sedation, rash, dizziness, constipation Major side effects include hypotension, mood changes Potential for rebound hypertension with abrupt discontinuation, especially if given >0.1mg/day	FDA approval for ADHD for Kapvay in children over age 6. Also may be effective for tics. Monitor P, BP Kapvay tablets should not be crushed or cut Wean 0.1mg/day q7+ days **SEE SIDE EFFECT HANDOUT IN SECTION 1**
	guanfacine, guanfacine ER	Tenex, Intuniv	**Tablets:** 1mg, 2mg **ER:** 1-4mg	**Initial dose:** 0.5 (1/2 tab) -1.0mg **Max dose:** 3-4mg in 24 hours (6-12yo), 7mg (13+) **Therapeutic dose range:** 1-2mg BID or divided up to TID, or if using long acting, nightly **Duration:** 12-24 hours, peak effect 4-8 hours for Tenex	**Common:** sedation, dizziness, constipation Major side effects include hypotension, sedation, mood changes Potential for rebound hypertension with abrupt discontinuation, especially if given >1.0mg/day	FDA approval for ADHD for Intuniv in children over age 6. Also may be effective for tics. Monitor P, BP Intuniv should not be crushed or cut Wean 1mg/day q 3-7 days **SEE SIDE EFFECT HANDOUT IN SECTION 1**

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Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
Second generation antipsychotic (SGA)	risperidone	Risperdal	tabs, disintegrating tabs, oral suspension (1mg/ml), XR injection	**Initial:** 0.25-0.50mg **Max:** 6mg **Titration:** q3-4 days **Typical effective dose:** 1-2mg in child, 2-4mg in adolescent, 3-6mg psychosis	**For agitation or dysregulated mood, or psychosis:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** usually once daily **Peak effect:** 10-15 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring
	aripiprazole	Abilify	tabs, disintegrating tabs, oral suspension (1mg/1ml), XR injections	**Initial:** 2.5-5mg **Max:** 30mg **Titration:** q2-7 days **Typical effective dose:** 5-10mg in child, 5-15mg adolescent, 5-30mg psychosis	**For agitation or dysregulated mood, or psychosis:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** daily **Peak effect:** 7-10 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring
	olanzapine	Zyprexa	tabs, disintegrating tabs, injection, XR injections	**Initial:** 2.5-5.0mg **Max:** 20mg **Titration:** 5mg/week	**For psychosis:** EPS, weight gain, increased prolactin, drowsiness, metabolic syndrome **Schedule:** once a day **Peak effect:** 7-10 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring

Note: all medication information should be verified using current PDR

AIMS: Abnormal Involuntary Movement Scale; see Section 1

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PROVIDER TIPS & CLINICAL PEARLS

- **Treatment reluctance:**
  If the youth won't participate in therapy, at least get the parent/caregiver therapy supports.
- **Psychosocial approaches:**
  - Involve the family system
  - Involve other psychosocial supports (school, religious/cultural institutions)
- **Likely medication course:**

If medication was started for **aggression specifically**…	• Taper after 6 months' stability (i.e., aggression improved)
	• Taper slowly and monitor closely
	  ◦ No set discontinuation guidelines
	  ◦ Example: decrease by no more than 25%, every 2 to 4 weeks
	  ◦ Stop taper or increase dose if behaviors return

If medication was started for an **underlying cause**...	• Continue the medication until underlying cause is controlled ◦ Use screening tools (e.g., PHQ, SCARED, GAD) to monitor for medication effect • Can try discontinuing antidepressant for depression/anxiety after 6 to 12 months of remission • Can try discontinuing ADHD meds if symptoms are no longer impairing (i.e., school/work performance)

Driver of Aggression?	Important Considerations	Non-Pharmacologic Intervention(s)	If medication is needed …
Neurodevelopmental disorders (e.g., intellectual disability, autism)	• If words are not options, aggression = communication • Address the function of aggression; avoid reinforcing it	Try behavior therapy first (e.g., ABA)	• Identify and treat comorbidities (e.g., ADHD + ASD) • THEN, try meds for the aggression and/or impulsivity itself

MDD	• Irritability is common in children/adolescents with MDD
	• Keep an eye out for bipolar disorder:
	  ◦ Younger onset MDD sx = higher risk for bipolar disorder
	  ◦ Watch for sleep-deprived energy enhancement (e.g., sleeping 4 hours or less and still has energy)
		• Cognitive Behavioral Therapy (CBT)
		• Family therapy
		• Dialectical Behavioral Therapy (DBT)
			See depression module

ADHD	• ODD is comorbid in about 60% • CD is comorbid in about 20% • Treat with meds + psychotherapy	• Behavior Management Training • Parent Management Behavior Training	See ADHD module

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PAUSE. CONSIDER UNCONSCIOUS BIAS WHEN DIAGNOSING YOUTH AGGRESSION.

- Try to assume *impulsive aggression* first. Look for and treat drivers.
- Did we consider PTSD, trauma, violence, abuse? Youth exhibiting aggressive behaviors may be victims themselves.
- Consider *cultural context*. Language and cultural differences may factor into what we each perceive as a societal "norm."
  - Is the youth experiencing mental and emotional injury caused by encounters with racial bias, ethnic discrimination, racism and/or related microaggressions?
- Did we consider SDOH before assuming it is aggression?
  - Symptoms may stem from a lack of felt safety (e.g., food, housing insecurity).
- "Nationally and in Virginia, students of color and students with disabilities are disproportionately suspended compared to their white and non-disabled peers."[1]
  - School exclusion leads to decreased high school graduation rates and subsequent long term consequences.
- While 13.2% of Virginia students have a disability, they receive:
  - 25.8% of short term out-of-school suspensions
  - 25.0% of expulsions
- Curiosity and respect for youth is the antidote for bias. Search for strengths.

[1]*2022 Assessment of Virginia's Disability Services System: The School to Prison Pipeline, Virginia Board for People with Disabilities.*

Toolkits for Providers and Families

T-MAY: Treatment for Maladaptive Aggression in Youth (2010)

TRAAY: Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (2003)

AACAP Parents' Med Guide on Impairing Emotional Outbursts (2021)

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DIFFUSING THE SITUATION: TIPS FOR FAMILIES

Understanding aggression

There isn't a simple reason to explain why someone behaves aggressively. However, we do know that it takes a team to support youth and families who are struggling with aggressive behavior.

SAFETY FIRST

Get help as quickly as possible if a young person threatens to damage or destroy property; or hurt or kill himself or herself or someone else.

Getting help

Maybe you suspect that your young person may have an aggression problem requiring special help. Your primary care provider can help with assessment or referral to a mental health provider for additional support. There are many strategies proven to help.

Tips for diffusing the situation

- **Control your body language and tone of voice.** Make sure your body language and tone of voice do not contradict your verbal message.
- **Stay calm.** Focus on letting the person know that you care about him or her, are concerned about what is happening and are there to help. Don't try to solve the problem in the moment while the young person is acting aggressively toward you.
- **Offer a way out.** Give clear choices, with safe limitations. In this way, you allow the young person to retain a feeling of control along with his or her self-esteem.
- **Discourage bystanders.** When a young person is acting out, ask peers who may be watching to leave the setting and continue with their activities.
- **Don't make threats.** Don't give warnings about consequences that you are not prepared to follow through on or that are unreasonably severe.
- **Don't make generalizations.** Saying, "You always do this when …" reinforces negative behaviors.
- **Wait for the right moment.** Wait until after an incident involving aggression is over, when everyone has calmed down, to talk to a young person about inappropriate behaviors.
- **Maintain safety.** Make sure that everyone present during an incident is safe at all times. If you can't control the situation, call for help.
- **Deal appropriately with threats made by youth.** In most cases, children or youth who make threats don't carry them out. Your main goal will be to get a young person making threats to focus on the way he or she is feeling, and to keep them away from any target of aggression.

When is aggression a concern?

If you are trying to determine if your loved one has a serious problem with aggression, ask yourself the following questions:

- Does this behavior occur regularly (every day, every week or every month)?
- Has it been happening for a long time?
- Are you concerned about the young person's behavior for any other reasons besides aggression?
- Does the aggression persist or appear to be getting worse?
- Do explosions happen at times that don't bother other young people—or for no **obvious** reason?
- Is it difficult to calm the young person down after an outburst?
- Has the young person injured himself or herself or anyone else?
- Does the behavior lead to conflicts with parents, siblings, peers or teachers? Do friends also behave aggressively or anti-socially?

The earlier a young person with an aggression problem is identified and receives help, the greater the chance that the chosen treatment will have lasting benefits

Source: Adapted from camh.ca/en/health-info/guides-and-publications/aggressive-behaviour-in-children-and-youth

3.7 Bipolar Disorder

SURVEILLANCE OR QUESTIONS ABOUT **BIPOLAR DISORDER?**

STOP: Unlikely to be a Bipolar Disorder if…

- Young age (< 10-12 years old)
- Mania symptoms only present in one setting (e.g., only at home)
- Persistently irritable mood between frequent behavioral or emotional episodes (suggestive of DMDD or ODD)

SEE TABLE BELOW

Strongly consider other possible reasons for the symptoms in children and youth under age 12:

- ADHD
- Disruptive Mood Dysregulation Disorder (DMDD)
- Oppositional Defiant Disorder (ODD)
- Conduct Disorder
- Substance Use Disorder
- Autism Spectrum Disorder
- Major Depression
- ACES or PTSD
- Anxiety or OCD
- Medical causes of mania (e.g., hyperthyroidism)

TREAT THE OTHER CAUSES OF SYMPTOMS
especially if you are unsure of a
Bipolar Disorder diagnosis

ENSURE PATIENT SAFETY

- Suicidal and homicidal ideation
- Experience of current abuse or neglect
- Substance abuse
- Other risky behavior (sexual, financial, antisocial, etc.)

IF STILL CONCERNED ABOUT BIPOLAR DISORDER:

Consider VMAP consult and refer to a mental health specialist for further evaluation and treatment

- Has patient had a clear, distinct period of mania for 4+ consecutive days?
- History of psychosis or suicidality?
- Ever hospitalized for mania?

KEY QUESTIONS: MANIA SYMPTOMS

Abnormally elevated, expansive, or irritable mood + increased goal-directed activity

- Inflated self-esteem; grandiosity
- Decreased need for sleep; wakes feeling rested after very little sleep
- More talkative than usual; pressured speech
- Flight of ideas; racing thoughts; peers say “slow down”
- Poor decision-making; episodic delinquent behavior
- Excessive silliness
- Increase in goal-oriented activity
- Excessive involvement in activities that have a high potential for painful consequences (e.g., sexual indiscretions, physically risky behaviors that indicate sense of invincibility)

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Mania Symptoms		Elevated, expansive mood	Irritability	Increased energy	Inflated self-esteem; Grandiosity	Decreased need for sleep	More talkative; Pressured speech	Flight of ideas; Racing thoughts	Distractibility	Increase in goal-directed behavior; Psychomotor Agitation	Involvement in activities with a high potential for painful consequences
Other Conditions to Consider ↑ Always consider medical explanations for mania	**ADHD**	Brief, extreme excitement is common	Poor frustration tolerance is common	Hyperactivity	—	Chronic sleep difficulties are common	Hyperactivity	Hyperactivity	Inattention	Hyperactivity	Impulsivity
	ODD	—	"Often loses temper;" "Touchy or easily annoyed"	—	Defiance can resemble this	—	—	—	—	—	—
	DMDD	—	Persistently irritable or angry mood	Behavioral outbursts can resemble this	Behavioral outbursts can resemble this	—	—	—	—	Behavioral outbursts can resemble psychomotor agitation	—
	MDD	Recovery from depressed mood misinterpreted as euphoria	Irritable mood rather than sad mood	—	—	Insomnia is common	—	—	Difficulties with concentration	Psychomotor agitation is common	Self-harm
	Anxiety	—	Irritability is common	—	—	Sleep difficulties are common	—	Worry can be experienced as racing thoughts	Anxiety impairs concentration	Psychomotor agitation is common	—
	SUD	Euphoric mood while on substance	Irritability while on substance or during withdrawal from substance	Increased energy while on substance	Brief improvement in self-esteem	Decreased need for sleep while on substance	More talkative while on substance	Racing thoughts while on substance	Concentration difficulties while on substance	Increased goal-directed behavior while on substance	Impulsivity while on substance
	ASD	—	Behavior dysregulation resembling irritability	Behavior dysregulation resembling irritability	—	—	—	—	—	—	Impulsivity can resemble this

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EVIDENCE-BASED INTERVENTIONS FOR BIPOLAR DISORDER

Pharmacotherapy is essential for the successful treatment of bipolar disorder (Murray, 2017).

Adjunctive behavioral health treatment is effective in optimizing stable mood to prevent relapse. At this time, no behavioral interventions have been found to be effective at reducing acute mania symptoms (Reinares, 2014).

Refer to Mental Health specialist to help with:

First Line Treatments	
Psychoeducation	Provision of information about the nature, causes, course, treatments, and key coping strategies for Bipolar Disorder to the patient and family. The goal is to optimize their detection of prodromes of depression and mania, ongoing stress management, and adherence to medication and psychosocial treatments. Psychoeducation may be delivered individually or in group settings.
Second Line Treatments	
Cognitive Behavioral Therapy (CBT)	CBT works to identify and adjust thoughts and behaviors that contribute emotional distress mood symptoms. Applied to Bipolar Disorder, CBT helps the patient address depressive symptoms and feelings of guilt/shame about manic episodes. Patients also engage in practical problem solving and learn coping strategies to manage strong emotions.
Family-Focused Therapy (FFT)	FFT is based on the idea that patient outcomes are improved with support of family, particularly in families with high expressed emotion. FFT focuses on optimizing communication styles between patients and their family members with the goal of improving relationship functioning.
Third Line Treatments	
Interpersonal and Social Rhythm Therapy (IPSRT)	IPSRT focuses on helping patients regulate their social and sleep rhythms through improving structure of daily routines and emphasizing sleep hygiene practices. It is unclear whether IPSRT represents a “stand-alone” therapy for Bipolar Disorder or if it is better conceptualized as Psychoeducation and behavioral strategies that can be found as essential parts of the therapies listed above.
Peer Interventions	Peer interventions such as peer support groups or individual support have been found to be helpful in reducing stigma of the illness and social isolation. There may be risks if the peers delivering the intervention are not properly trained.

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MEDICATION MANAGEMENT: ROLE OF PCP WHEN PARTNERING WITH CHILD PSYCHIATRY

- Prioritize sleep promotion: Consider a medication choice that is more sedating for a child with increasing manic symptoms.
- Follow closely for symptom progression. Sleep is a useful measure for tracking symptom change over time.
- Collateral information from family is important, since insight gets impaired in active mania.
  - **Medication guidelines will focus on treating mania or hypomania.**
  - **When treating depression in a person with bipolar disorder, avoid using antidepressants without a mood stabilizer. Treating with antidepressants alone can precipitate mania. Maintain communication with psychiatry and/or psychology.**

Name of drug	Starting dose	Target dose	Maximum dose/day	Increase	Monitoring	Considerations (incl. FDA approval age)
Risperidone	0.25mg	2.5mg	6mg	0.25-0.5mg every 3 days	• Weight, fasting lipids and glucose • AIMS (Abnormal Involuntary Movement Scale) • Increases Prolactin level • Can cause priapism • Tardive Dyskinesia	Most risk of extrapyramidal side effects (10+)
Aripiprazole	2mg	10mg	30mg	2mg every 3 days		Akathisia, weight gain more common than with adults (10+)
Lurasidone	20mg	20-40mg	80mg	20mg every 3 days		**Take with 350+ calories of food** (10+)
Asenapine	2.5mg twice daily	2.5-10mg twice daily	20mg	2.5mg every 3 days		Sublingual, twice daily dosing (10+)
Quetiapine	25mg twice daily	up to 400mg daily, divided BID	800mg	25-50mg every 3 days		Orthostatic hypotension and sedation can be notable (10+)
Olanzapine	2.5mg	10mg	20mg	2.5-5mg every 3 days		Most prominent weight gain, very sedating (13+)
Lithium*	300mg, 3 times daily (>30kg), 300mg, 2 times daily (<30 kg)	**Maintenance:** titrate to 0.8 mEq/L serum concentration	**Maintenance:** 1.0 mEq/L **Acute:** 1.2 mEq/L	>30kg: 300mg every 3 days	CBC, TSH, BMP, lithium level (12hr after last dose/right before next dose) HcG test	It works well, but weight gain, increased thirst, renal damage, thyrotoxicity risks exist. Narrow therapeutic range — careful with heat/avoid dehydration, ensure hydration, avoid NSAIDs. Reduces suicide risk. Can worsen acne.

Note: all medication information should be verified using current PDR

*Other mood stabilizers: carbamazepine, lamotrigine, oxcarbazepine, Divalproex Sodium — significant side effects, requires lab testing.

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PROVIDER TIPS & CLINICAL PEARLS

Epidemiology

- **Average age of onset (USA): 20 years old**
- Prevalence: 2.4% (lifetime), 1-2% (adolescents)

Diagnosis of Bipolar Disorder (DSM-5)

At least one episode of mania is required for diagnosis; see DSM-5 for full criteria. This mania episode must be **distinct** and a **clear departure** from the youth's baseline functioning.

Treatment of Bipolar Disorder

- Consider consultation or immediate referral to a mental health specialist, especially if in an active state of mania and/or there are safety concerns. → Refer to nearest emergency department (voluntarily or involuntarily).
- Consider possible medical, substance, or medication causes of mania (e.g., hyperthyroidism, recent substance ingestion, initiation of new psychotropic or other medication).
- Refer for behavioral health intervention.
- Medication trial will likely prioritize **sedation** and **mood stabilization** (decrease of mania).
- Request a sleep log to monitor sleep time as evidence of symptom improvement/worsening.
- Ensure appropriate sleep hygiene and routinized daily schedule of activities.
- Follow up frequently until mood has stabilized.

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ASSESSMENT QUESTIONS TO HELP IDENTIFY POSSIBLE BIPOLAR DISORDER

Assessment Question	Increased Risk for Bipolar Disorder
Is there a family history of bipolar disorder or schizophrenia?	"Yes" to either significantly increases chances of the youth having bipolar disorder.
When did you first notice the symptoms and did they come on suddenly?	Sudden onset within 1-2 days is a more "classic" bipolar presentation.
Did the mania symptoms seem to be a distinct episode with a clear beginning and a clear ending?	An answer of "yes" is more "classic" bipolar presentation.
Is this type of manic mood state common for the youth?	To be bipolar disorder, mania should not be common; it should be a clear departure from baseline behavior.
Did the episode of mania include true elation and euphoria?	Elation during mania is common for children and adolescents; be skeptical of presentations that only include irritability.
Can the youth and family identify 2-3 distinct mood states (i.e., manic/euphoric, baseline/euthymic, depressed/irritable)?	Many individuals with a long history of depression forget what their baseline mood feels like and then mistake their happiness, absence of anhedonia, and renewed energy for mania when the depression episode ends. Depression is not necessary to diagnose a bipolar disorder, but it is common.
Has the youth had a depressive episode? More than one? What were they like?	Most individuals with Bipolar Disorder have at least one major depressive episode before experiencing mania for the first time. Individuals with early age of onset of depression and highly recurrent depressive episodes are more likely to go on to have a bipolar disorder (Schaffer, 2010). Individuals who have depression with psychotic features, psychomotor agitation, and/or atypical depressive symptoms such as hypersomnia and hyperphagia are more likely to go on to have a bipolar disorder (Mitchell, 2008).
If an anti-depressant medication was ever prescribed, did the onset of mania symptoms coincide with initiation of that medication? Did the mania symptoms stop when the medication was discontinued?	Mania symptoms must be present after medication is fully discontinued to warrant concern for a bipolar disorder.

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TIPS FOR CAREGIVERS: BIPOLAR DISORDER

What is Bipolar Disorder?

Bipolar disorder is a condition characterized by extreme changes in a person's mood, energy, thinking, and behavior. Children with bipolar disorder have episodes of mania and many also experience episodes of depression.

An episode of mania is where a person's mood is elevated (overly happy), expansive, or very irritable and the person also has increased energy at the same time. These symptoms are present most or all of the day for at least four consecutive days. These symptoms should be a very clear change from the child's normal mood and behavior.

Other mania symptoms may include:

- Unrealistic highs in self-esteem or perceived ability and importance
- Significant increase in energy
- Decreased need for sleep; being able to go with little or no sleep for days without feeling tired
- Increase in talking, including increased rate of speech and difficulty interrupting their talking
- Distractibility — the child's attention jumps frequently from one thing to the next
- Racing thoughts or ideas — for example, thoughts are coming so fast they are hard to describe
- Excessive increase in goal-oriented activity
- Repeated high risk-taking behavior, such as abusing alcohol and drugs, reckless driving, or sexual promiscuity

Diagnosis

The diagnosis of bipolar disorder in children and teens is complex. The symptoms listed above are often part of other conditions, such as Attention-Deficit/Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Oppositional Defiant Disorder (ODD), anxiety, and substance abuse. This is why it is important to have a psychiatric or mental health specialist involved in diagnosis of Bipolar Disorder.

What causes Bipolar Disorder?

There is no single known cause of Bipolar Disorder. It is likely the case that many factors work together to cause the illness for any given individual. Research suggests that genetics plays a big role in the cause of Bipolar Disorder because the conditions runs strongly in families. Having a parent with Bipolar Disorder makes a child 4-6 times more likely to develop the illness themselves; however, genetics are not the only cause. Clinical experience suggests that trauma or stressful life events can trigger the onset of Bipolar Disorder for people who are genetically vulnerable.

Treatment

Bipolar Disorder can be effectively treated for children and teenagers. Treatment typically includes education for the patient and family about the condition, mood stabilizing medications, and psychotherapy. Medications often help decrease the occurrence of manic episodes and may also help with depression. Psychotherapy helps the patient learn more about stressors that contribute to mood changes, strategies to cope with strong emotions, and ways to improve self-esteem and relationships.

What is the caregiver's role in treatment?

Parents and other caregivers play an essential role in a child's treatment for Bipolar Disorder. Parents must learn about and consider the full range of treatment options. Once a treatment plan is selected, the parent can help their child stay committed to the plan. This may involve providing and overseeing the child taking their medication, scheduling and attending psychotherapy sessions, and regularly checking in with the child's medical doctor about any new symptoms or side effects of medications.

Where can I learn more about bipolar disorder?

Families should start learning about Bipolar Disorder with the following books and websites that provide high-quality, evidence-based information.

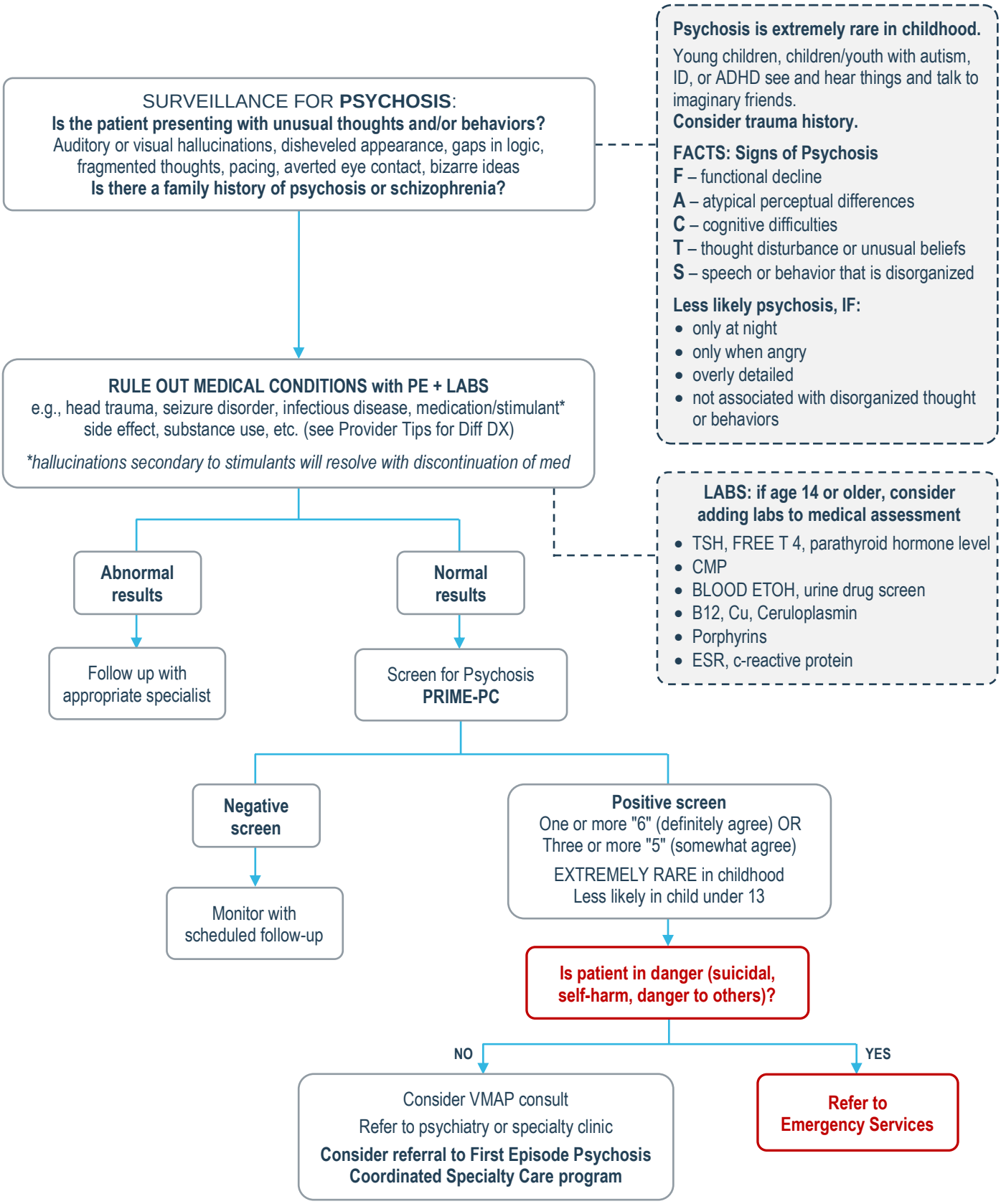
Books:

- *The Bipolar Workbook: Tools for Controlling Your Mood Swings*. Second Edition. (2015) By Monica Ramirez Basco (An excellent, practical guide to managing the disorder; based on CBT principles)
- *The Bipolar Teen: What you can do to help you child and your family*. (2007) By David Miklowitz and Elizabeth George (A parent guide to helping their child)
- *An Unquiet Mind.* (1995) By Kay Redfield Jamison. (A memoir written by a bipolar disorder researcher who has the illness herself)

Web resources:

- American Academy of Child and Adolescent Psychiatry Parents' Medication Guide:
  Information including treatments and ways family members can be helpful to their children
- American Academy of Child and Adolescent Psychiatry Bipolar Disorder Resource Center:
  Video clips and many other resource links for families and children
- National Institute of Mental Health — Bipolar Disorder Section
- National Alliance on Mental Illness: nami.org/
- Depression and Bipolar Support Alliance: dbsalliance.org/

3.8 Psychosis



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PRIME-PC SCREEN

Date: _____ Age:_____ Gender:_____

Please read the attached information sheet before completing this questionnaire.

The following screen asks about your personal experiences. It asks about your sensory, psychological, emotional, and social experiences. Some of these questions may seem to relate directly to your experiences and others may not.

Based on your experiences within the past year, please indicate how much you agree or disagree with the following statements. Read each question carefully and circle the answer that best describes your experience. Please answer all questions.

Within the past year:	Definitely disagree	Somewhat disagree	Slightly disagree	Not sure	Slightly agree	Somewhat agree	Definitely agree
1. I think that I have felt that there are odd or unusual things going on that I can't explain	0	1	2	3	4	5	6
2. I think that I might be able to predict the future.	0	1	2	3	4	5	6
3. I may have felt that there could possibly be something interrupting or controlling my thoughts, feelings, or actions.	0	1	2	3	4	5	6
4. I have had the experience of doing something differently because of my superstitions.	0	1	2	3	4	5	6
5. I think that I may get confused at times whether something I experience or perceive may be real or may be just part of my imagination or dreams.	0	1	2	3	4	5	6
6. I have thought that it might be possible that other people can read my mind or that I can read other's minds.	0	1	2	3	4	5	6
7. I wonder if people may be planning to hurt me or even may be about to hurt me.	0	1	2	3	4	5	6
8. I believe that I have special natural or supernatural gifts beyond my talents and natural strengths.	0	1	2	3	4	5	6
9. I think I might feel like my mind is "playing tricks" on me.	0	1	2	3	4	5	6
10. I have had the experience of hearing faint or clear sounds of people or a person mumbling or talking when there is no one near me.	0	1	2	3	4	5	6
11. I think that I may hear my own thoughts being said out loud.	0	1	2	3	4	5	6
12. I have been concerned that I might be "going crazy."	0	1	2	3	4	5	6

The questionnaire was developed by the PRIME Group at Yale University Medical School.

SCORING THE PRIME-PC

- A positive result on the PRIME Screen is defined as **one or more scores of "6"** (definitely agree) or **three or more scores of "5"** (somewhat agree).
- A screen result is not the same thing as a diagnosis.
- People who have a positive screen should consider going for a diagnostic evaluation if they are concerned or distressed.

PSYCHOSIS SCREENING IN PEDIATRIC PRIMARY CARE

The Center for Early Detection, Assessment, and Response to Risk toolkit for PCPs (psychosisscreening.org) to:

- know the signs
- find the words
- make the connection

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EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR PSYCHOSIS

If the youth is determined to have psychosis through the PRIME screening tool and there is deterioration in functioning, they should be referred for treatment. Mild and transient symptoms suggest the youth may be at Clinical High Risk for Psychosis (CHR-P). If the youth presents with more severe and persistent symptoms with functional decline, they may be in a First Episode of Psychosis (FEP). The PCP does not need to diagnose the psychiatric condition but **should refer the individual to a mental health professional skilled in diagnosis immediately.**

Clinical High Risk for Psychosis (CHR-P) treatment

The preferred treatment for children at high risk for psychosis is a specialty mental health program offering stepped care. Unfortunately, there is currently only one program in Virginia, in Fairfax, offering this treatment. The primary clinical component of the stepped care programs for CHR-P is Cognitive Behavioral Therapy for Psychosis (CBTp). There are many practitioners in Virginia providing CBT and a subset trained in CBTp. VMAP will help PCPs locate a practitioner in your community.

These services are based on evidenced-based practices and are very effective. They help the child manage symptoms and arrest the slide of diminishing functioning. There is evidence that these services also reduce conversion to a diagnosed psychosis.

First Episode Psychosis (FEP) treatment

Once an individual has been first diagnosed with a psychotic disorder they are eligible for an evidence-based service known as Coordinated Specialty Care (CSC). There are currently 11 CSC programs in Virginia and VMAP will help PCPs locate a local program. These services have been highly researched and are proven effective in reducing the intensity of symptoms and improving functioning while managing the patient on low-dose medications.

If a CSC program is not available in the local community, seek out an outpatient psychiatrist who has treated FEP. Use VMAP Care Coordination resources.

Virginia's First Episode Psychosis Programs	
TRAILS Mental Health Program (Alexandria) • City of Alexandria residents • Ages 15 to 30	**LINC Program** (Loudoun CSB) • Loudoun County residents • Ages 16 to 30
Fairfax-Falls Church CSB Turning Point • Fairfax County, cities of Fairfax and Falls Church residents • Ages 16 to 30 for FEP; 14 to 25 for high-risk of psychosis	**YACC: Young Adult Coordinated Care Program** • Residents of Culpeper, Fauquier, Madison, Orange, Rappahannock counties • Ages 15 to 25
Henrico CSB InSTRIDE • Residents of Henrico, Charles City, New Kent counties • Ages 16 to 25	**GetOnTrack** (Prince William CSB) • Prince William county residents
NAVIGATE (Highlands CSB) • Residents of City of Bristol, Washington County	**Life Management Program** (Western Tidewater CSB) • Residents of Isle of Wight and Southampton counties, cities of Franklin and Suffolk • Ages 16 to 25

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MEDICATION GUIDANCE

- Antipsychotic medications are not indicated for young people who are determined to be clinically high-risk for psychosis. If needed, medications can be prescribed for anxiety, depression, or sleep disorders. Please see those modules in the guidebook.
- If the individual has First Episode Psychosis (FEP), antipsychotic medications are indicated following a “low and slow” regimen. A Coordinated Specialty Care (CSC) program or outpatient psychiatrist trained in FEP will know how to provide proper medication management. The following medication table provides information on the top three recommended medications for FEP.

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
Second generation antipsychotic (SGA)	risperidone	Risperdal	tabs, disintegrating tabs, oral suspension (1mg/ml), XR injection	**Initial:** 0.25-0.50mg **Max:** 6mg **Titration:** q3-4 days **Typical effective dose:** 1-2mg in child, 2-4mg in adolescent, 3-6mg psychosis	**For agitation or dysregulated mood, or psychosis:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** usually once daily **Peak effect:** 10-15 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring **Rare:** Tardive dyskinesia or dystonic reaction
SGA	aripiprazole	Abilify	tabs, disintegrating tabs, oral suspension (1mg/1ml), XR injections	**Initial:** 2.5-5mg **Max:** 30mg **Titration:** q2-7 days **Typical effective dose:** 5-10mg in child, 5-15mg adolescent, 5-30mg psychosis	**For agitation or dysregulated mood, or psychosis:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** daily **Peak effect:** 7-10 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring **Rare:** Tardive dyskinesia or dystonic reaction
SGA	quetiapine	Seroquel IR Seroquel XR	**IR:** tabs starting at 25mg, can be crushed **XR:** starting at 50mg, cannot be chewed or crushed	**Initial:** 12.5mg in child, 25mg in adolescent **Max:** 600-800mg **Titration:** q18-30 days; 25-50mg up to 150mg, can split 2 x times daily **Typical effective dose:** 300-600mg	**For schizophrenia and bipolar disorder over age 10-13 years:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** daily **Peak effect:** 30-60 days.	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring **Rare:** Tardive dyskinesia or dystonic reaction

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Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
SGA	lurasidone	Latuda	Tabs starting at 20mg, do not cut or crush 40, 60, 80, 100, 120mg	**Initial:** 20mg **Max:** 120-160mg **Titration:** 20mg every 1-2 weeks **Typical effective dose:** 40-80mg	**For agitation or dysregulated mood, or psychosis:** EPS, weight gain, increased prolactin, sedation, metabolic syndrome **Schedule:** daily, with high fat meal (>350 calories) **Peak effect:** 7-10 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring Dizziness, light headed ness **Rare:** Tardive dyskinesia or dystonic reaction
SGA	olanzapine	Zyprexa	tabs, disintegrating tabs, injection, XR injections	**Initial:** 2.5-5.0mg **Max:** 20mg **Titration:** 5mg/week	**For psychosis:** EPS, weight gain, increased prolactin, drowsiness, metabolic syndrome **Schedule**: once a day **Peak effect:** 7-10 days	AIMS, weight monitoring, prolactin monitoring (levels if symptomatic), lipid/blood sugar monitoring

Note: all medication information should be verified using current PDR

AIMS: Abnormal Involuntary Movement Scale; see Section 1

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PROVIDER TIPS & CLINICAL PEARLS

How do I identify psychosis?

- As a PCP treating children and adolescents you will see instances of unusual thinking and behaviors. You should be prepared to identify the symptoms of psychosis and rule out non-psychiatric causes.
- Under age 13, think twice! Psychosis is rare. 65% of kids under 7 have imaginary friends. **THINK TRAUMA FIRST**.
- Diagnosable illnesses of thought disorders often first present in adolescence and young adulthood and should be treated immediately.
- Symptoms of psychosis in children and adolescents may have many causes. See table on next page.

How should I ask about hallucinations?

- Symptoms of psychosis may emerge as auditory or visual hallucinations. **Patients should be asked if they are hearing unusual sounds or voices that others do not hear.** This should be confirmed with the patient's caregivers. The patient may complain of voices or sounds occurring either internally or externally. Likewise, visual hallucinations may take the form of shapes, shadows, or fleeting colors. They may also consist of fully formed images.
- Less common manifestations of hallucinations may be somatic or tactile. Patients should be asked if they are experiencing unusual feelings within their body (like a cancer or parasite) or if they feel something "under or on" their skin. Again, this should be confirmed with caregivers.

How can I identify delusional thinking?

- Delusions are thoughts, often well formed, that are unusual and have no basis in reality. You may find that patients are reticent about sharing unusual thoughts.
  - **Paranoid** delusions are most common and consist of thoughts that the patient is being watched or monitored, and appears guarded or suspicious. Caregivers may be able to provide additional information.
  - A patient may also have **grandiose** delusions. They may share that they have special powers, or have been chosen for a special mission, or are being controlled by another being.

Is there a tool that will screen for psychosis?

- The PRIME PC Screen should be administered by the PCP by asking each question as written.
- If there is one response rated "6" or three responses rated "5" the child can be considered at clinically high-risk for psychosis. This does not mean that the child will develop a psychotic illness. Generally, only 25% of children with early symptoms of psychosis develop a schizophrenia spectrum disorder.
- Changes in functioning can be best determined through dialogue with the youth and caregivers about specific CHANGES IN ACTIVITIES OF DAILY LIVING.

You do not need to diagnose the psychiatric condition but you should refer the individual as soon as possible to a mental health professional skilled in diagnosis.

What should I say to the parents/family?

- They should be informed that very few individuals with symptoms of psychosis develop a psychotic disorder.
- They should also be assured that there is highly effective treatment available for individuals who are at clinical high-risk as well as those who have experienced a first episode of psychosis.

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Some medical causes associated with psychosis-like episodes

Cause	Tests to Consider
Neurologic (migraine, seizures, tumor, autoimmune or infectious encephalitis, head injury)	MRI, EEG, LP
Metabolic (thyroid, para-thyroid, adrenal, thiamine def, electrolyte)	CMP, TFT, PTH, etc.
Genetic (including metabolic, Wilson D)	CMA, blood and urine tests, ceruloplasmin, urine porphyrins, eye exam
Other nutritional deficiencies	CBC, Magnesium, Vit A, D, Bs
Sleep disorders	Polysomnogram
Medication (steroids, stimulants*) ** hallucinations secondary to stimulants will resolve with discontinuation of med*	Overdose?
Drug use and abuse (substances, alcohol)	Urine drug screen
Toxins (carbon monoxide, heavy metal)	CarboxyHgB, mercury or lead levels

From the American Academy of Pediatrics June 2021 Clinical Report: "Collaborative Care in Identification and Management of Psychosis in Adolescents and Young Adults"
publications.aap.org/pediatrics/article/147/6/e2021051486/180278/Collaborative-Care-in-the-Identification-and

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PSYCHOSIS FACT SHEET FOR FAMILIES

Your health care provider has determined that your child may have symptoms of psychosis. This sheet will provide basic information of what this is and your options for treatment.

What is psychosis?

Psychosis refers to an array of symptoms and is not a diagnosis. For example, when someone is told they have a fever they are informed of the presence of a symptom. Fever usually indicates the presence of a illness. Sometimes it can be treated and goes away without a condition being diagnosed. The same can be true of psychosis.

Psychotic symptoms refer to disorders in thinking. These may emerge as hallucinations such as hearing voices or sounds that others do not hear. Other times they may be seeing shapes or images that, likewise, are not seen by others. Often these can be frightening and disruptive. Another type of psychotic thinking is having delusions, or thoughts that are unusual or not connected to actual events. This includes paranoia, thoughts that others have plans to do harm to the individual or others. Thoughts may be grandiose, believing that the individual has special powers. These thoughts may also include that the person has a special relationship with another. At times, delusions may involve perceptions of the body. This includes thoughts that there is something wrong with the body, such as an undiagnosed illness or parasite within the body. These beliefs are often accompanied by unusual sensations or pain.

What causes psychosis?

Symptoms of psychosis can have many causes. They may emerge under stress or from lack of sleep. Resolving these causes will usually resolve the symptoms. At other times they could emerge due to another condition. This includes use of illegal substances or even prescribed medications. Again, stopping the use of substances or adjusting medications will resolve or diminish the symptoms.

Sometimes psychosis will occur in relation to another medical condition, such as a head trauma or seizure disorder. In these instances your physician will treat the psychotic symptoms in conjunction with treatment for the medical condition.

Psychosis may be related to an emerging mental health condition. These include schizophrenia, bipolar disorder, and some types of depression. Posttraumatic stress disorder will often include some symptoms of psychosis. These conditions require specialist psychiatric treatment. Your health care provider will discuss options with you.

What are treatment options for psychosis?

Psychotic symptoms may be mild or fleeting. Your child may be distressed but the symptoms do not result in a significant disruption in your child's life. In this instance, your health care provider will want to monitor the symptoms to determine whether they are resolving or worsening.

If, however, there is a decrease in your child's functioning or a significant change in behavior your doctor will want to refer your child to specialized treatment. A change in functioning may be related to school performance, worsening sleep or eating habits, a decrease in concentration or attention, worsening personal hygiene, or increasing isolation and decreasing interaction with family and friends.

The emergence of mild symptoms of psychosis accompanied by a decrease in functioning may indicate that your child is at a clinical high-risk for psychosis. This can only be determined by a specialist mental health provider. Early identification and treatment provide effective outcomes for this condition. If your health care provider suspects that your child may be at clinical high-risk for psychosis, they will discuss treatment options with you. The most effective treatment is Cognitive Behavioral Therapy for Psychosis (CBTp).

If the psychotic symptoms are more severe and functioning is significantly impaired, your child may be experiencing a first episode of psychosis. This generally means that there is an emerging, diagnosed psychiatric illness, such as schizophrenia, bipolar disorder, or major depression. It is essential that your child receives early treatment for these conditions. Specialized programs, known as Coordinated Specialty Care for First Episode Psychosis, are in many communities in Virginia. Ask your health care provider if one of these programs is available for your child. They are very effective in reducing symptoms and in addressing the deterioration in functioning. If one of these programs is not available, your child should be seen by a psychiatrist as soon as possible. If your child makes suicidal or self-harm statements or threatens others with violence they should be evaluated at the emergency room or at local mental health emergency services immediately.

Medications for psychosis

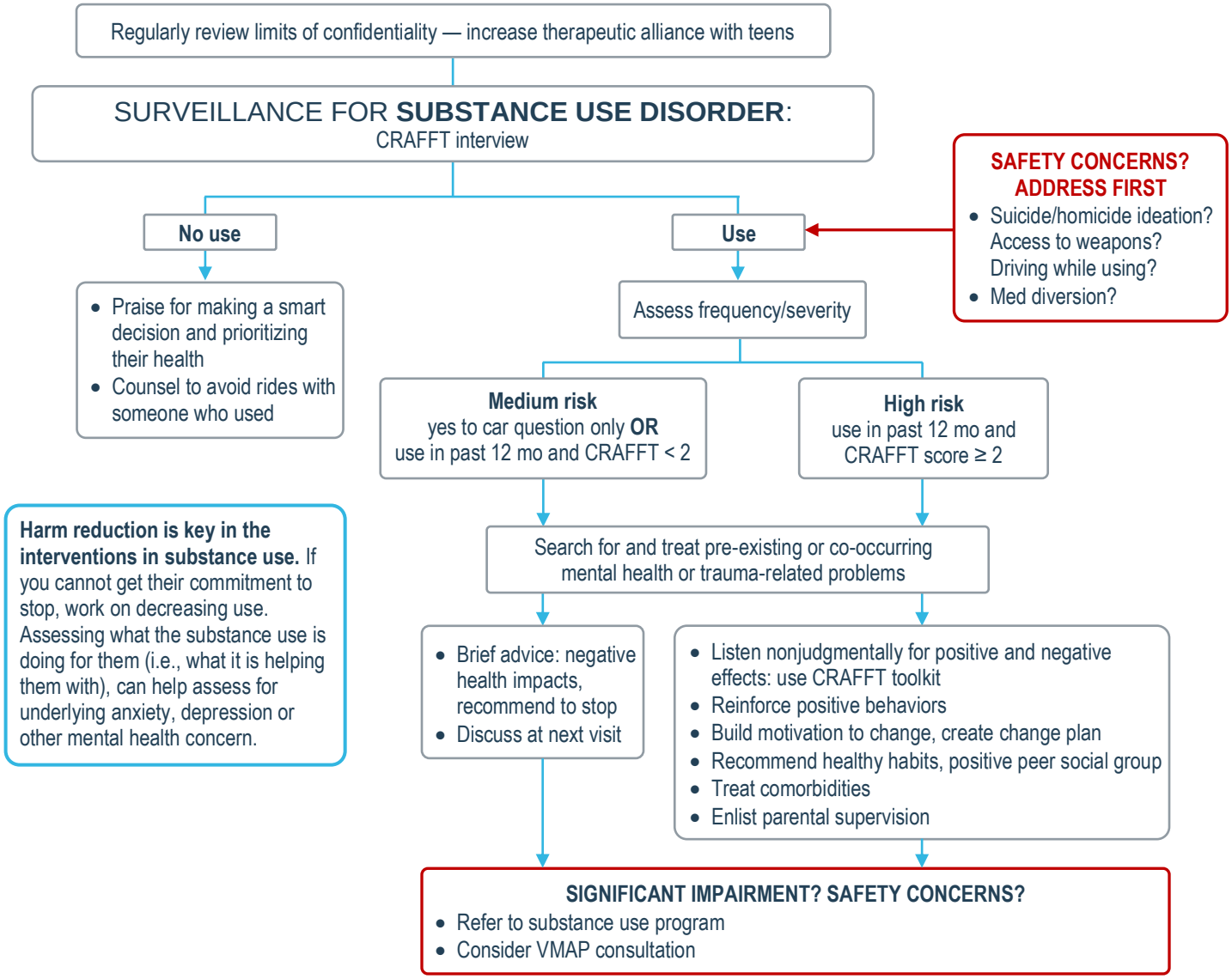
If your child is determined to be at clinical high-risk for psychosis, antipsychotic medications are generally not indicated. Symptoms are generally mild and can be effectively managed with CBT. Your doctor may want to prescribe medications for associated symptoms, such as depression, anxiety, or sleep disturbances. Discuss all options with your health care provider.

If it is determined that your child is having a first episode of psychosis, antipsychotic medications will likely be needed. There is a specific protocol for prescribing medication to these individuals. Psychiatrists in a Coordinated Specialty Care program will know how to medicate your child. If you see a psychiatrist not affiliated with a Coordinated Specialty Care program, discuss the approved protocols for medicating an individual with first episode psychosis.

Additional resources

- "Watching for Signs of Psychosis in Teens" (childmind.org)
- "Psychosis (Schizophrenia) in Children and Youth" (mhanational.org)
- National Institute of Mental Health Understanding Psychosis patient and family resources (nimh.nih.gov)
- Understanding a First Episode of Psychosis (samhsa.gov)

3.9 Substance Use Disorder



Risk Level	CRAFFT Score	Clinical Action
LOW	No use in past 12 months and CRAFFT score of 0	Provide information about risks of substance use and substance use-related riding/driving; offer praise and encouragement
MEDIUM	No use in past 12 months and "Yes" to car question only; **OR** Use in past 12 months and CRAFFT score < 2	Provide information about risks of substance use and substance-use related riding/driving; brief advice; possible follow-up visit
HIGH	Use in past 12 months and CRAFFT score ≥ 2	Provide information about risks of substance use and substance-use related riding/driving; brief advice; follow-up visit; possible referral to counseling/treatment
For additional guidance in using this tool, visit: crafft.org/wp-content/uploads/2021/10/CRAFFT_2.1_Provider-Manual_2021.10.28.pdf		

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THE CRAFFT QUESTIONNAIRE (VERSION 2.1)

To be completed by the patient

Please answer all questions **honestly**; your answers will be kept **confidential**.

During the past 12 months, how many days did you:	
1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	# of days: _____
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles), or **"synthetic marijuana"** (like "K2," "Spice")? Put "0' if none.	# of days: _____
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject)? Put "0" if none.	# of days: _____

READ THESE INSTRUCTIONS BEFORE CONTINUING:

- **If you put "0" in ALL of the boxes above, ANSWER QUESTION 4, THEN STOP.**
- **If you put "1" or higher in ANY of the boxes above, ANSWER QUESTIONS 4-9.**

	Circle One	
4. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	**No**	**Yes**
5. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	**No**	**Yes**
6. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	**No**	**Yes**
7. Do you ever FORGET things you did while using alcohol or drugs?	**No**	**Yes**
8. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	**No**	**Yes**
9. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	**No**	**Yes**

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

THE CRAFFT QUESTIONNAIRE (VERSION 2.1)

To be verbally administered by the clinician

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

PART A: During the PAST 12 MONTHS, on how many days did you:	
1. Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Say "0" if none.	# of days: _____
2. Use any **marijuana** (cannabis, weed, oil, wax, or hash by smoking, vaping, dabbing, or in edibles), or **"synthetic marijuana"** (like "K2," "Spice")? Say "0' if none.	# of days: _____
3. Use **anything else to get high** (like other illegal drugs, pills, prescription or over-the-counter medications, and things that you sniff, huff, vape, or inject? Say "0" if none.	# of days: _____

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

YES → **Ask 1st question only in Part B, then STOP**

NO → **Ask all 6 questions in Part B**

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

***Two or more YES answers in Part B suggests a serious problem that needs further assessment. See next page for further instructions**

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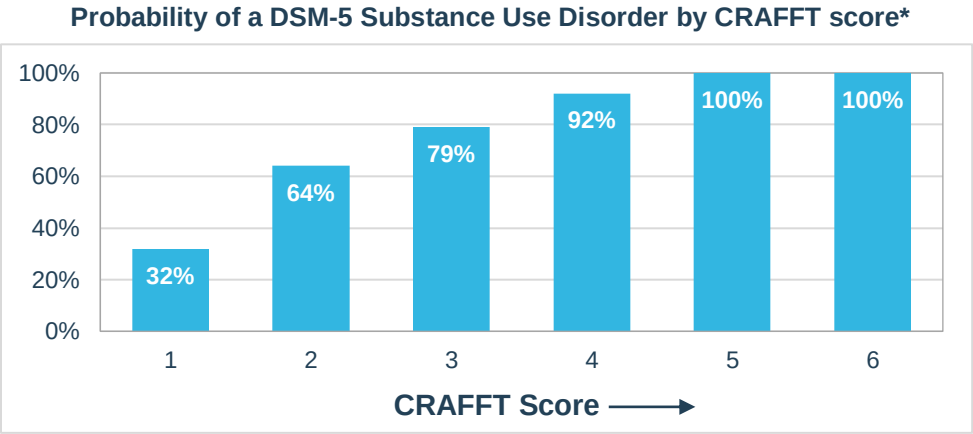
CRAFFT SCORE INTERPRETATION



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

USE THE 5 R'S TALKING POINTS FOR BRIEF COUNSELING.

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

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."

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

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

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

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

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crafft@childrens.harvard.edu | crafft.org
For more information and versions in other languages, see crafft.org.

EVIDENCE-BASED THERAPEUTIC INTERVENTIONS

Therapy is the mainstay of treatment in adolescents with substance use disorder.

Outpatient therapy for adolescent SUD

- Cognitive Behavioral Therapy (CBT)
  - Individual
  - Individual + parent + family
- Adolescent Community Reinforcement Approach
  - CBT and emphasis on identification and engagement in prosocial activities
  - Individual + family
- Family Based Therapies
  - Functional Family Therapy (FFT)
  - Multi-Dimensional Family Therapy (MDFT)
  - Multisystemic Therapy (MST)
- Motivational Interviewing or Enhancement + CBT
- Contingency Management + CBT or Family Based Therapies
- 12-step approaches specifically for adolescents (with EBT elements)

Levels of care

- Early brief intervention
  - Screening, Brief Intervention, and Referral to Treatment (SBIRT)
- Outpatient treatment — see above
- Intensive Outpatient and Partial Day Hospitalization
- Residential or Inpatient Treatment
- Medically Managed Intensive Inpatient Treatment

Referral resources

- Virginia's **Community Services Boards** (CSB) provide treatment for substance use and addiction (in addition to mental health issues, and intellectual and developmental disabilities). To locate a CSB by locality, click here.
- **Virginia Medicaid** offers members with substance use disorder enhanced behavioral health and addiction services, including community-based, inpatient detoxification, and residential treatment. More information is available at dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/.
- The federal **Substance Abuse and Mental Health Services Administration (SAMHSA)** treatment locator website includes provider search by type and zip code.
- **VMAP** (vmap.org/) can assist providers with identifying resources local to their patients.

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MEDICATION GUIDANCE

- The only FDA-approved medication for any substance use disorder in adolescents is buprenorphine, for ages 16 and up, for opioid use disorder.
  - **SAMHSA-approved certification required to prescribe**; see SAMHSA website for additional information.
- For marijuana use disorder in adolescents and young adults below around age 21, a substance use program may consider use of n-acetylcysteine 1200mg twice daily which has been shown to decrease marijuana use in this population, but this is not FDA approved.
- Other medications that may be prescribed in an inpatient setting or treatment program may include:
  - Clonidine for acute opioid withdrawal
  - Benzodiazepines for alcohol withdrawal
  - Vivitrol (injectable) for opioid dependence and alcohol dependence

Substance of abuse	Medication	FDA approved?	Works?	Dosing
Opioid use disorder	buprenorphine	Yes, age 16+	Yes	4-8mg, up to 16mg
Marijuana use disorder	n-acetylcysteine	No	Yes — adolescents to early 20s	1200mg twice daily

- Naloxone (Narcan, Evzio) is a medicine that rapidly reverses an opioid overdose.
  - It works by temporarily blocking the effects of opioids and helps the person to breathe again.
  - By standing order written for the general public, Virginia allows pharmacists to dispense naloxone without requiring an individual prescription.
  - Anyone can access naloxone by:
    - Getting a prescription from their doctor; or
    - Using the standing order written for the general public; or
    - Virginia's Local Health Departments and some Community Services Boards at no cost
  - Virginia offers trainings for lay rescuers through REVIVE! dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/

Fast Facts: Substance Use Among Teens

In 2021, Virginia high schoolers reported...

- 8.8% rode with a driver who had been drinking alcohol
- 14.3% currently use electronic vapor products
- 15.5% currently smoke cigarettes, cigars or use smokeless tobacco and/or electronic vapor products
- 14.0% had their first drink before 13 years of age
- 19.4% currently drink alcohol
- 10.5% currently binge drink
- 13.3% currently use marijuana

Source: Virginia High School Youth Risk Behavior Survey, 2021

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CLINICAL PEARLS & RECOMMENDED RESOURCES

Family tips

- Substance use disorder impacts the individual and the family. Family support (e.g., support groups like Al-Anon or Nar-Anon) can be helpful.
- Families should set expectations for their child's behaviors, including not using substances.
- Therapy that incorporates the family should be a part of treatment plan. This will help set expectations and boundaries to support harm reduction.
- Families should consider seeking psychiatric treatment if concerned about medical complications or concerning responses to intoxication.
- Families should call the police if the individual is engaging in dangerous behaviors. This can be difficult for families to do, but can also be important for safety. Programs such as CHINS (Children in Need of Services) through the state courts are available to help when a child or youth's behavior threatens his or her well-being and physical safety.

Provider tips

- Motivation changes frequently for adolescents. Follow up frequently. Use motivational interviewing techniques such as exploring life goals (e.g., career) or shorter-term goals (e.g., sports team) can give clinician a starting point and promote continued commitment to change.
- Parent involvement is often crucial for keeping a child engaged in treatment. It can be helpful to reinforce the child's willingness to have open and honest communication with their parents about substance use.

What about uring drug screens?

- see clinical report, 2014
- Blood, breath, saliva, sweat, hair and urine (and in neonates, meconium) are used for drug assays.
- Urine testing is common in PCP offices. Used for emergent clinical care, assessment of behavioral/MH symptoms, monitoring of therapy program, school clearance. MOST PCPs do not use is for universal screening.
- False positive when co-occurring antibiotics or ADHD meds.
- False negatives when tampering (dilution, substitution, masking urine). MOST PCPs do not ensure accuracy of collection with direct observation or temperature monitoring of urine.
- MOST PCPs decline involuntary drug testing, unless acute risk of harm where breaching confidentiality is required.

References and resources

- **SAMHSA National Helpline: 1-800-662-HELP (4357)**
  A free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders
- **SAMHSA Behavioral Health Treatment Services Locator:** findtreatment.samhsa.gov/
- **SBIRT: Screening, Brief Intervention, and Referral for Treatment for Substance Use** clinician tools: sbirt.care/tools.aspx
- **healthychildren.org substance use resources for families:** healthychildren.org/English/ages-stages/teen/substance-abuse/
- American Academy of Pediatrics Section on Tobacco Control resources:
  - E-Cigarettes and Vaping: What Clinicians Need to Know
  - E-Cigarettes and Vaping: What Parents Need to Know
- Chung, T. & Bachrach, R.L. (2019). *Substance use problems*. In Prinstein, M.J., Youngstrum, E., Marsh E.J., & Barkley (Eds), *Treatment of Disorders in Childhood and Adolescence*. New York, NY: Guilford Press.

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PATIENT TOOLS

Prescription for Change

Date: _____

Goal: _____

_____

_____

Steps:

1. _____
2. _____
3. _____

Next appointment: _____

Contact: _____

_____

3.10 Eating Disorders

SURVEILLANCE FOR **EATING DISORDERS**:

- Body image dissatisfaction?
- Preoccupation with weight?
- Others suspect disordered eating? Unexplained weight loss?
- Failed PHQ
- Compensatory behaviors? (e.g., starving, purging, over-exercising)

Consider Risk for Eating Disorder:
Use screening tool such as
EAT-26 or **ChEAT, SCOFF, CHEAT-6**

S: Do you make yourself **SICK** because you feel uncomfortably full?
C: Do you worry you have lost **CONTROL** over how much you eat?
O: Have you recently lost more than **ONE** stone (15 lbs) in a 3-month period?
F: Do you believe yourself to be **FAT** when others say you are too thin?
F: Would you say **FOOD** dominates your life?

"YES" to > 1: may have an eating disorder and should be referred for further evaluation and treatment

- Other medical, developmental or psychiatric etiology present? **Treat first.**
- Screen for SI and other MH disorders.
- Eating nonfoods? Consider Pica and medical work-up.

NEGATIVE SCREEN

Schedule follow-up as needed

POSITIVE SCREEN

Provisional Diagnosis of Eating Disorder (ICD-10 Eating Disorder, unspecified F50.9) and **REFER TO SPECIALIST ***

*** CONSIDER HOSPITALIZATION**

For Anorexia: if HR < 50 bpm in daytime or <45 bpm when asleep, SYS BP <90 mm HG. Orthostatic changes, arrhythmia, temperature <96F, failure to respond to outpatient treatment, refusal to eat.

For Bulimia: if syncope, serum potassium <3.2 mmol/L, serum chloride <88 mmol/L, esophageal tears, arrhythmias (including prolonged QTc), hypothermia, suicide risk, intractable vomiting, hematemesis, failure to respond to outpatient treatment.

Measuring Orthostatic BP

1. Have the patient lie down for 5 min.
2. Measure BP and pulse rate.
3. Have the patient stand.
4. Repeat BP, pulse rate after standing 1 and 3 min

A drop in BP of ≥20 mm Hg, or in diastolic BP of ≥10 mm Hg, or experiencing lightheadedness or dizziness is considered abnormal.

Common Eating Disorders

Anorexia Nervosa	Atypical Anorexia Nervosa	Bulimia Nervosa	ARFID
• Restricted intake leading to significant weight loss • Fear of weight gain • Poor body image • Subtypes: – AN-R (restricting) – AN-BP (binge/purge behaviors plus restricting)	All of the criteria for Anorexia Nervosa are met except that despite significant weight loss, weight is within or above the "normal" range	• "Average" weight • Binge eating • Compensatory behaviors present ~1/wk ≥ 3 mo • Poor body image	Restricted intake due to: • Lack of interest in food • Avoidance based on sensory characteristics of food • Concern for aversive consequences of eating Resulting in: • Weight loss/faltering growth • Significant nutritional deficiency • Dependence on enteral feeding or supplements No body image concerns

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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:

Birth Date:_____ **Gender:** _____ **Height:** Feet_____ Inches _____ **Current Weight:** _____

Highest Weight (excluding pregnancy): _____ **Lowest Adult Weight:**_____ **Ideal Weight:**_____

Part B: Please check a response for each of the following statements.	Always	Usually	Often	Sometimes	Rarely	Never
1. I am terrified about being overweight.	☐	☐	☐	☐	☐	☐
2. I avoid eating when I am hungry.	☐	☐	☐	☐	☐	☐
3. I find myself preoccupied with food.	☐	☐	☐	☐	☐	☐
4. I have gone on eating binges where I feel that I may not be able to stop.	☐	☐	☐	☐	☐	☐
5. I cut my food into small pieces.	☐	☐	☐	☐	☐	☐
6. I am aware of the calorie content of foods that I eat.	☐	☐	☐	☐	☐	☐
7. I particularly avoid food with a high carbohydrate content (i.e., bread, rice, potatoes, etc.).	☐	☐	☐	☐	☐	☐
8. I feel that others would prefer if I ate more.	☐	☐	☐	☐	☐	☐
9. I vomit after I have eaten.	☐	☐	☐	☐	☐	☐
10. I feel extremely guilty after eating.	☐	☐	☐	☐	☐	☐
11. I am preoccupied with a desire to be thinner.	☐	☐	☐	☐	☐	☐
12. I think about burning up calories when I exercise.	☐	☐	☐	☐	☐	☐
13. Other people think that I am too thin.	☐	☐	☐	☐	☐	☐
14. I am preoccupied with the thought of having fat on my body.	☐	☐	☐	☐	☐	☐
15. I take longer than others to eat my meals.	☐	☐	☐	☐	☐	☐
16. I avoid foods with sugar in them.	☐	☐	☐	☐	☐	☐
17. I eat diet foods.	☐	☐	☐	☐	☐	☐
18. I feel that food controls my life.	☐	☐	☐	☐	☐	☐
19. I display self-control around food.	☐	☐	☐	☐	☐	☐
20. I feel that others pressure me to eat.	☐	☐	☐	☐	☐	☐
21. I give too much time and thought to food.	☐	☐	☐	☐	☐	☐
22. I feel uncomfortable after eating sweets.	☐	☐	☐	☐	☐	☐
23. I engage in dieting behavior.	☐	☐	☐	☐	☐	☐
24. I like my stomach to be empty.	☐	☐	☐	☐	☐	☐
25. I have the impulse to vomit after meals.	☐	☐	☐	☐	☐	☐
26. I 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
1. Gone on eating binges where you feel that you may not be able to stop? *	☐	☐	☐	☐	☐	☐
2. Ever made yourself sick (vomited) to control your weight or shape?	☐	☐	☐	☐	☐	☐
3. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	☐	☐	☐	☐	☐	☐
4. Exercised more than 60 minutes a day to lose or to control your weight?	☐	☐	☐	☐	☐	☐
5. Lost 20 pounds or more in the past 6 months.		☐ Yes			☐ No	
6. Have you ever been treated for an eating disorder?		☐ Yes			☐ No	

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

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

SCORING THE EATING ATTITUDES TEST© (EAT-26)

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

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

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

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

EAT-26 score

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

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

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

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EVIDENCE-BASED THERAPEUTIC INTERVENTIONS

Individuals with eating disorders may require hospitalization. There are also step-down programs for treatment of eating disorders, including PHPs (Partial Hospital Programs), IOPs (Intensive Outpatient Programs), and outpatient treatment. If a patient requires a higher level of care than an inpatient facility can provide, they may be transferred to a RTC (Residential Treatment Center) for longer-term care once they are no longer acutely ill or medically unstable. It is recommended that individuals with eating disorders are followed by a multidisciplinary team knowledgeable in eating disorders that includes a licensed mental health provider, Registered Dietitian, and a medical provider.

Types of evidence-based therapeutic interventions

Recommended for all eating disorders

- **FBT (Family Based Therapy, also known as The Maudsley Method):** It is a specialized form of family therapy in which the focus is on the importance of food as medicine, and an agnostic approach is taken regarding the cause of the eating disorder. Parents take control over managing the patient's eating, which alleviates the food decision-making burden on the patient. Over time, the patient works to regain control over their eating and mealtime decisions.

Additional evidence-based therapies for Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder

- **CBT (Cognitive Behavioral Therapy):**
  CBT is a form of therapy that helps individuals identify and change detrimental thought patterns. It also focuses on the link between thoughts, feelings, and behaviors. Use in addition to FBT, for best results. *Recommended for AN, BN, BED.*
- **IPT (Interpersonal Psychotherapy):**
  IPT is a short-term type of therapy that focuses on creating strong attachments and improving interpersonal relationships. *Recommended for BN, BED.*
- **DBT (Dialectical Behavior Therapy):**
  DBT is a modified form of CBT that helps individuals learn to live in the moment, develop healthy coping strategies, regulate emotions, and better interact with others. It is an emerging therapy for eating disorders. It is *traditionally used for patients with borderline personality disorder*, the symptoms and diagnosis of which can frequently co-occur in patients with eating disorders, such as AN or BN, for example.

Recommended specifically for Avoidant Restrictive Food Intake Disorder (ARFID)

- **CBT (Cognitive Behavioral Therapy).** CBT interventions for ARFID include:
  - Regular eating using self-monitoring and/or enlisting caregivers to take control over managing the patient's eating. Caregivers are coached to increase patient's dietary volume and dietary variety.
  - **Food chaining or flavor mapping** where patients choose a new food that is similar to one that they already like, but is a different brand, slightly different flavor, somewhat different texture, etc. (i.e., If they eat one brand of vanilla yogurt well, try an alternate brand or try smooth strawberry yogurt in the preferred brand.)
  - Exposure and response involves graduated exposure to feared foods and situations in which choking, vomiting, or other feared consequence may occur.
- Depending on the age and presenting issues, patients may work therapeutically with a speech therapist, occupational therapist, behavioral therapist (ABA), pediatric psychologist, LCSW, developmental behavioral pediatrician and/or psychiatrist.

AN = Anorexia Nervosa
BN = Bulimia Nervosa
BED = Binge Eating Disorder
ARFID = Avoidant Restrictive Food Intake Disorder

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MEDICATION GUIDANCE

The mantra in treatment of feeding and eating disorders is: “Food is medicine.”

There are no medications specifically to treat pediatric eating disorders.

- **Antidepressants** — These can be used to target symptoms of obsessionality, anxiety, and depression in AN and BN. They can also target the binge eating and purging symptoms in these illnesses. Note: if the patient is significantly underweight, Selective Serotonin Reuptake Inhibitors (SSRIs) will not be effective, as the body is not capable of producing enough Serotonin for the medication to have an effect. Fluoxetine is approved for BN in adults. The SSRIs that are FDA-approved for use in children and adolescents, in general, are fluoxetine (ages 7+), sertraline (ages 6+), and escitalopram (ages 12+).
- **Atypical antipsychotics** — These medications can be helpful in targeting the rigid thinking, body image distortion, weight-gain fears, and anxiety. Consult with psychiatrist.
- **Stimulants** — Lisdexamfetamine (Vyvanse) was the first medication to be FDA-approved to treat Binge Eating Disorder in adults. It is thought that this medication decreases the patient’s impulsivity, thereby decreasing the frequency of binge eating.
- **Anti-epileptics** — Topiramate (Topamax) can also be helpful in treatment of BED by suppressing the appetite. Unfortunately, it can cause brain fog and memory issues.
- **Anxiolytics** — Antihistamines such as hydroxyzine pamoate (Vistaril) and hydroxzine hydrochloride (Atarax) can sometimes be useful prior to mealtimes in individuals who are highly anxious about eating. Hydroxyzine is less sedating than diphenhydramine (Benadryl), so it is preferred in this context. Antihistamines are preferred overall over benzodiazepines because the latter can cause a dissociative effect which interferes with the therapeutic goals of eating.
- **Appetite stimulants** — Cyproheptadine (Periactin) has shown to have improvements in weight gain in some children with ARFID. Efficacy has shown to wane over time with cyproheptadine. Appetite stimulants are generally not recommended for the other eating disorders.

Note: all medication information should be verified using current PDR

AN = Anorexia Nervosa
BN = Bulimia Nervosa
BED = Binge Eating Disorder
ARFID = Avoidant Restrictive Food Intake Disorder

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PROVIDER TIPS & RECOMMENDED RESOURCES

History	• Screen for PTSD, Anxiety, Depression, SI • Substance use? • Youth with Type-1 Diabetes — may manipulate their insulin for weight loss **(very dangerous)** • Maintaining/restoring menses alone is not a good indicator of health in a patient who is severely underweight. Menses can persist despite significant weight loss, sometimes due to use of exogenous hormone.
Vitals	• Check orthostatics: including temperature, BP, HR • Post-void weight without shoes, sweater, baggy/heavy accessories every time. Patient should face away from scale to prevent seeing their weight, unless plan in place to disclose weight.
Exam	• Blood-streaked saliva with a halo of blood at the end of a purge is diagnostic for a Mallory Weiss tear • Look for calluses on the backs of fingers (Russel's sign) which may be indicative of purging • Parotid enlargement with purging • Dental erosion with purging
Labs	• Amenorrhea for >6 months, may result in bone density loss. Consider DEXA scan. • Unsure about menstruation, measure estradiol (if <20, amenorrheic) • Elevated TSH with normal free T4 can be seen in eating disorder; also called "sick euthyroid syndrome" • Low Serum K+ means potassium levels are critically low intra-cellularly • Consider obtaining UA prior to weigh-ins and monitor the specific gravity to check for excessive water intake as patients may attempt to artificially elevate weight for check-ins (called "water loading").
Clinic	• Whenever possible, talk about "health" instead of weight or body size. • Avoid terms such as "ideal body weight" and "goal weight". "Minimum safe weight" is preferred because it indicates that this is the lowest safe weight, and higher weights can also be safe.

NOTE: *"Minimum Safe Weight" (or "MSW") is the lowest medically safe weight for that individual. The MSW is usually determined by the nutritionist, PCP, and/or psychiatrist based on the child or adolescent's pre-eating disorder growth charts.*

Web resources

- The National Eating Disorders Association (NEDA): nationaleatingdisorders.org/
- National Association of Anorexia Nervosa and Associated Disorders: anad.org/
- Families Empowered and Supporting Treatment for Eating Disorders: feast-ed.org/
- What is Health At Every Size? asdah.org

Books for families and caregivers

- *How to Nourish Your Child Through an Eating Disorder* (2018), by Casey Crosbie and Wendy Sterling
- *Survive FBT: Skills Manual for Parents Undertaking Family Based Treatment (FBT) for Child and Adolescent Anorexia Nervosa* (2016), by Mari Ganci
- *Skills-based Caring for a Loved One with an Eating Disorder: The New Maudsley Method* (2016), by Janet Treasure, Grainee Smith, and Anna Crane
- *Help Your Teenager Beat an Eating Disorder, Second Edition* (2015), by James Lock and Daniel Le Grange
- *Health At Every Size (2010),* by Linda Bacon
- *ARFID Avoidant Restrictive Food Intake Disorder: A Guide for Parents and Carers* (2019), by Rachel Bryant-Waugh
- *When Your Child Won't Eat or Eats Too Much: A Parents' Guide for the Prevention and Treatment of Feeding Problems in Young Children* (2012), by Dr. Irene Chatoor

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TEEN & CAREGIVER HANDOUT: WHAT ARE EATING DISORDERS?

Eating disorders are problems with the way people eat. They can harm a person's health, emotions, and relationships. There are several types of eating disorders. It's important to know that anyone can develop an eating disorder, no matter their gender, race, ethnicity, or socio-economic status.

Anorexia

People with anorexia:

- eat very little on purpose. This can lead to a very low body weight, but sometimes, in atypical anorexia, weight loss does not lead to this because of starting with an elevated body weight. It's still dangerous and can lead to severe medical complications and even death.
- have an intense fear of weight gain.
- have a distorted body image. They do not see themselves accurately and may see themselves very differently than others see them. Individuals with anorexia often do not recognize the severity of their malnutrition.

People with anorexia are very strict about what and how much they will eat. They may think about food or calories almost all the time. To lose weight, some people with anorexia fast or exercise too much. Others may use laxatives, diuretics (water pills), or enemas.

Bulimia

People with bulimia:

- overeat and feel out of control to stop. This is called binge eating.
- do things to make up make up for overeating. They may make themselves throw up on purpose after they overeat. This is called purging. To prevent weight gain they may use laxatives, diuretics, weight loss pills, fast, or exercise a lot.
- judge themselves based on body shape and weight.

People with bulimia eat much more (during a set period of time) than most people would. If a person regularly binges and purges, it may be a sign of bulimia. Unlike people with anorexia who are very low weight, people with bulimia may be thin, average weight, or overweight. People with bulimia often hide their eating and purging from others.

Binge Eating

People with binge eating disorder:

- feel a loss of control when eating and overeat. This is called binge eating.
- eat large amounts even when they are not hungry.
- may feel upset or guilty after binge eating.
- often gain weight, and may become very overweight.

Many people with binge eating disorder eat faster than typical. They may eat alone so others don't see how much they are eating. Unlike people with bulimia, those with binge eating disorder do not make themselves throw up, use laxatives, or exercise a lot to make up for binge eating. If a person binge eats at least once a week for 3 months, it may be a sign of binge eating disorder.

ARFID (Avoidant/Restrictive Food Intake Disorder)

People with ARFID are extremely picky eaters and have little interest in food. They:

- eat a limited variety of preferred foods.
- may be turned off to foods due to the taste, feel, smell, temperature, or look of the food.
- may be fearful of eating due to a traumatic event.
- are not afraid of gaining weight.
- do not have a poor body image.

People with ARFID may be afraid that they will choke or vomit. They don't have anorexia, bulimia, or another medical problem that would explain their eating behaviors.

How are eating disorders diagnosed?

Health care providers and mental health professionals diagnose eating disorders based on history, symptoms, thought patterns, eating behaviors, and an exam. The doctor will check weight and height and compare these to previous measurements on growth charts. The doctor may order tests to see if there is another reason for the eating problems and to check for problems caused by the eating disorder.

How are eating disorders treated?

Eating disorders are best treated by a team that includes doctors, dieticians and therapists. Treatment includes nutrition counseling, medical care, and talk therapy (individual, group, and family therapy). The doctor might prescribe medicine to treat binge eating, anxiety, depression, or other mental health concerns.

The details of the treatment depend on the type of eating disorder and how severe it is. Some people are hospitalized because of extreme weight loss and medical complications.

How do eating disorders affect health and emotions?

Anorexia can lead to health problems caused by undernutrition and low body weight; people with anorexia may find it hard to focus and have trouble remembering things. Health and emotional problems may include:

- low blood pressure
- slow or irregular heartbeats
- feeling tired, weak, dizzy, or faint
- constipation and bloating
- irregular periods
- weak bones
- delayed puberty and slow growth
- feeling alone, sad, or depressed
- anxiety and fears about gaining weight
- thoughts of hurting themselves

Bulimia can lead to emotional problems, as well as health problems caused by vomiting, laxatives, and diuretics:

- low blood pressure
- irregular heartbeats
- feeling tired, weak, dizzy, or faint
- blood in vomit or stool
- tooth erosion and cavities
- low self-esteem, anxiety, and depression
- alcohol or drug problems
- thoughts of hurting themselves
- swollen cheeks (salivary glands)

Binge eating can lead to weight-related health problems, as well as emotional challenges:

- diabetes
- high blood pressure
- high cholesterol and triglycerides
- fatty liver
- sleep apnea
- have low self-esteem, anxiety, or depression
- feel alone, out of control, angry, or helpless
- have trouble coping with strong emotions or stressful events

ARFID may lead to health problems that stem from poor nutrition, similar to anorexia.

If you think you may have an eating disorder

Tell someone. Tell a parent, teacher, counselor, or an adult you trust. Let them know what you're going through. Ask them to help.

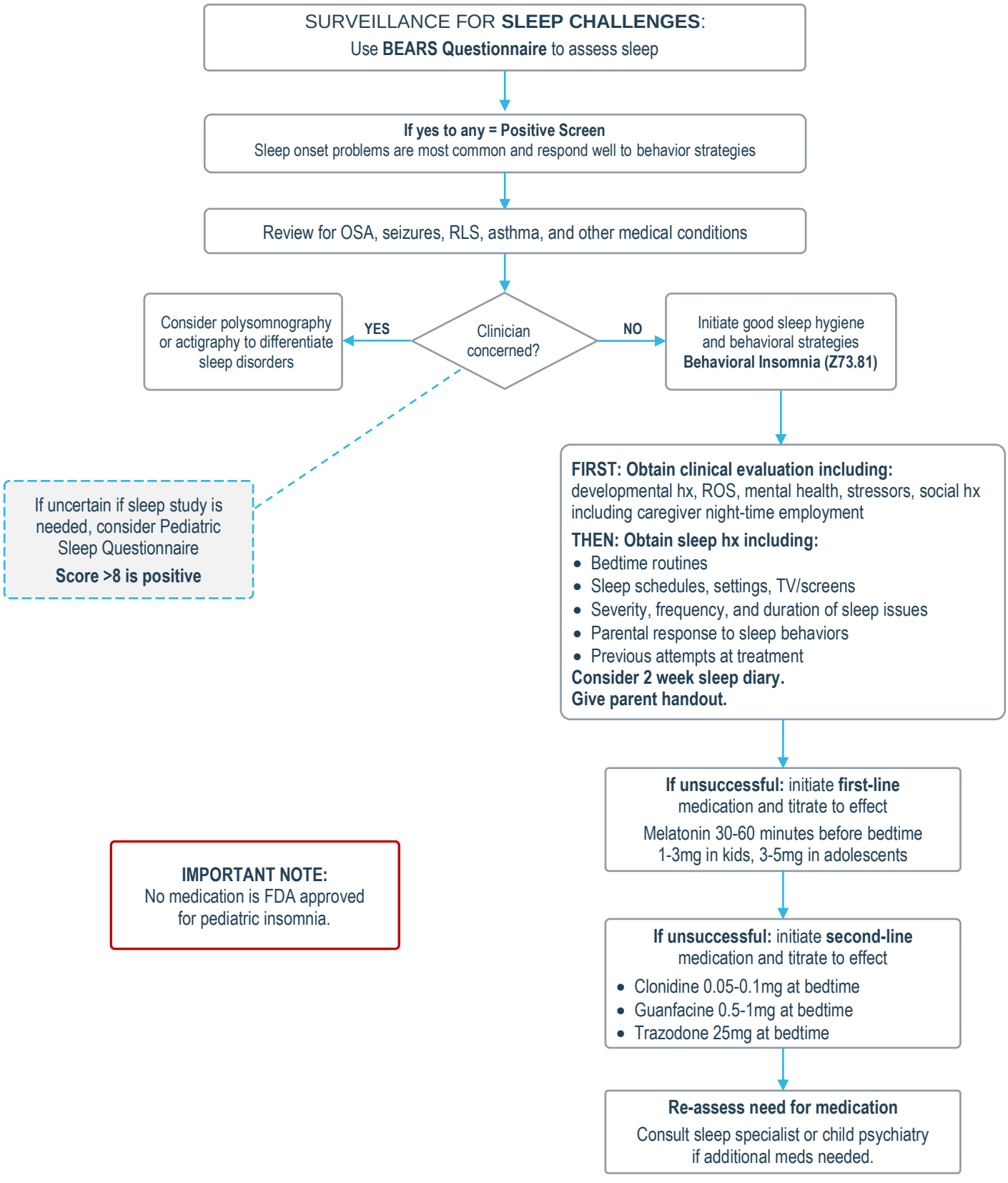
Get help early. When an eating disorder is caught early, a person has a better chance of recovery. Make an appointment with your doctor or an eating disorders specialist.

Go to all appointments. Treatment takes time and effort. Work hard to learn about yourself and your emotions. Ask questions any time you have them.

Be patient with yourself. There's so much to learn, and change happens a little at a time. Take care of yourself and be with people who support your recovery, health and well-being.

Adapted from: kidshealth.org/en/teens/eat-disorder.html

3.11 Sleep Challenges



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Types of Sleep Disorders in Children and Adolescents
Sleep-related breathing disorders • Snoring • Sleep Related Hypoventilation Syndrome/Obesity Hypoventilation Syndrome (OHS) • Obstructive Sleep Apnea (OSA) • Central Sleep Apnea (CSA) • Upper Airway Resistance Syndrome (UARS) • Nocturnal Asthma, or other medical problems like GERD
Parasomnias *(unusual, but benign sleep behaviors)* • Sleep walking/talking • Sleep terrors/night terrors — episodes of screaming, intense fear, and flailing while asleep. The child is typically inconsolable/difficult to wake and has no recollection of it. • Sleep related eating disorder (SRED) — episodes of eating while asleep • Sleep paralysis — temporary inability to move or speak that occurs during transition between sleep and wakefulness. Some individuals experience hallucinations or feel a sense of choking or suffocating, which can be very frightening. • REM sleep behavior disorder — episodes of physically acting out vivid, often unpleasant dreams with vocal sounds and sudden arm and leg movements during REM sleep

Insomnia *(can have mix of types)*
• Acute insomnia — brief difficulty sleeping often caused by a stressful life event or change
• Chronic insomnia — difficulty falling asleep or staying asleep > 3x/week for > 3 months
• Sleep onset insomnia — trouble initiating sleep
• Maintenance insomnia — difficulty staying asleep, going back to sleep, or waking early
• Behavioral insomnia of childhood (can have mix of types)
  ◦ Sleep onset association type — unable to self-soothe, often requires caregiver presence when falling asleep or very particular conditions to fall asleep
  ◦ Limit setting type — noncompliance at bedtime — stalling or refusing to go to sleep and insufficient limits set by caregiver

Hypersomnia
Circadian rhythm sleep disorders • Delayed sleep phase syndrome — sleep > 2 hours past acceptable/conventional bedtime • Irregular sleep-wake rhythm disorder — inconsistent sleep patterns without stable rhythm
Sleep-related movement disorders • Restless legs syndrome (RLS) — unpleasant sensations in the legs that cause an uncontrollable urge to move and tends to occur at night when sitting or lying down • Periodic limb movement disorder (PLMD) — frequent limb movements during sleep • Nocturnal bruxism — jaw clenching and/or teeth grinding
Sleep/nocturnal enuresis
Nocturnal seizures
Narcolepsy
Night eating syndrome — different from SRED — individual is awake and fully aware of eating

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BEARS SLEEP SCREENING TOOL

	Toddler/Preschool (2-5 years)	School-Aged (6-12 years)	Adolescent (13-18 years)
Bedtime problems	Does your child have any problems going to bed? Falling asleep?	Does your child have any problems at bedtime? (P) Do you have any problems going to bed? (C)	Do you have any problems falling asleep at bedtime? (C)
Excessive daytime sleepiness	Does your child seem overtired or sleepy a lot during the day? Does she still take naps?	Does your child have difficulty waking in the morning, seem sleepy during the day, or take naps? (P) Do you feel tired a lot? (C)	Do you feel sleepy a lot during the day? In school? While driving? (C)
Awakenings during the night	Does your child wake up a lot at night?	Does your child seem to wake up a lot at night? Any sleepwalking or nightmares? (P) Do you wake up a lot at night? (C) Have trouble getting back to sleep? (C)	Do you wake up a lot at night? Have trouble getting back to sleep? (C)
Regularity and duration of sleep	Does your child have a regular bedtime and wake time? What are they?	What time does your child go to bed and get up on school days? Weekends? Do you think he/she is getting enough sleep? (P)	What time do you usually go to bed on school nights? Weekends? How much sleep do you usually get? (C)
Snoring	Does your child snore a lot or have difficulty breathing at night?	Does your child have loud or nightly snoring or any breathing difficulties at night? (P)	Does your teenager snore loudly or nightly? (P)
If you answered "yes" to any of these questions, your child may have a sleep problem that should be discussed with your pediatrician or pediatric sleep specialist.			

P = parent or caregiver question
C = child or youth question

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EVIDENCE-BASED INTERVENTIONS FOR BEHAVIORAL INSOMNIA OF CHILDHOOD

- Non-pharmacologic treatment is effective and the standard of care.
- No medication is FDA approved for pediatric insomnia.
- Bedroom environment must be optimized for sleep (e.g., comfortable, quiet, dark, cool, no screens).
- Free relaxation apps can be a good resource; see Anxiety Care Guide.
- Bedtime routine and sleep/wake time should be consistent (e.g., bath, PJs, brush teeth, stories).
- The routine should not involve a parent being in the room when the child falls asleep. This may also include a transitional object (e.g., stuffed animal or blanket).
- Explain the “silent return”: “If you talk, ask me questions, or yell, I’m not going to respond because it’s time for sleep. If you leave your room, I’m going to take you back to bed so we can all get good rest.” (e.g., “It’s time for sleep. I’ll see you in the morning.”)

Cognitive behavioral therapy for insomnia (CBTi) — therapist

- Multi-component, evidence-based approach of 6-8 sessions appropriate for adolescents
- Involves:
  - Psychoeducation — sleep hygiene tips, sleep needs, relationship between thoughts, feelings, behaviors, and sleep
  - Cognitive restructuring — changing inaccurate or unhelpful thoughts about sleep
  - Behavioral interventions — relaxation training (e.g., deep breathing, body scan, progressive muscle relaxation), stimulus control, sleep restriction or compression to help establish healthy sleep habits

Biofeedback

- Uses technology to help monitor certain processes in the body such as brain waves, heart rate, breathing, and body temperature
- Can include electromyogram (EMG) and electroencephalogram (EEG)
- Aids in control of physiologic variables through auditory and visual feedback to decrease somatic arousal
- Typically combined with relaxation techniques

Light therapy

- Used to treat delayed sleep phase disorders with exposure to light on awakening
- Use caution with bipolar disorder because of risk of mania

Chronotherapy

- Gradually shifting bedtime and wake time each day until the desired sleep time is reached

Motivational interviewing

- Can be helpful for adolescents to facilitate behavior changes around sleep (e.g., decreasing screen usage before bedtime, eliminating afternoon naps)

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MEDICATION GUIDANCE

Class	Generic	Brand Name	Available Forms/Doses	Dosing Information	Other Information	Comments
Neurohormone	melatonin		**Immediate-release tablets:** 0.5, 1, 3, 5mg **Prolonged-release tablets:** 5mg **Oral liquid:** 1mg/ml Chewable avail	**Initial:** 0.5-3mg/day **Max dose:** 10mg/day **Typical effective dose:** 3-6mg/day **Peak effect:** 45-60 minutes **Duration:** 4 hours	**More common side effects (SE):** headache, dizziness **Rare SEs:** morning sleepiness, enuresis, possible decreased seizure threshold, suppression of the hypothalamic-gonadal axis, liver damage in overdose	**Indication:** sleep-onset insomnia Administer 30-60 minutes prior to bedtime
Alpha2-agonist	clonidine	Catapres IR, Kapvay ER	**Immediate-release tablets:** 0.1, 0.2, 0.3mg **Extended-release tablet:** 0.1, 0.2mg	**Initial:** 0.05-0.1mg/day **Max dose:** 0.3mg/day **Typical effective dose:** 0.1-0.2mg/nightly **Peak effect:** 2-3 hours **Duration:** 4-5 hours	**Common SEs:** sedation (clonidine > guanfacine) **Rare SEs:** hypotension, bradycardia, irritation, anticholinergic effects, REM suppression Administer 1 hour before bedtime Wean 0.1mg/day q7 days (clonidine) or 1mg/day q3-7 days (guanfacine) to prevent rebound hypertension	**Indication:** sleep disturbances Monitor blood pressure and heart rate for hypotension and bradycardia Sedative effect diminishes over time Limited evidence for use in pediatrics
	guanfacine	Tenex IR, Intuniv ER	**Immediate-release tablets:** 1, 2mg **Extended-release tablet:** 1, 2, 3, 4mg	**Initial:** 0.5-1mg/day **Max dose:** 4mg/day **Typical effective dose:** 1-4mg/day **Peak effect:** 3-5 hours **Duration:** 8-10 hours		
Antihistamine	hydroxyzine	Atarax, Vistaril	Tab (10, 25, 50mg) Soln (10mg/5ml)	**Initial:** 5mg nightly, increase to 0.6mg/kg/day for >6+ to max **Max dose:** 50mg (<6), 50-100mg (>6) **Typical effective dose:** 25mg **Peak effect:** 30 min-2 hours **Duration:** 3-4 hours	**Common SEs:** dry mouth, dizziness, drowsiness, constipation **Rare SEs:** tremor, difficulty urinating, irregular or fast heart beat, agitation	Also approved for anxiety treatment such as 10mg tid
Atypical reuptake inhibitor (SARI)	trazodone	Desyrel	**Tablets:** 50, 100, 150, 300mg	**Initial:** 25mg/day **Max dose:** 400mg/day **Typical effective dose:** 50mg **Peak effect:** 30-90 min	**Common SEs:** dry mouth, nausea, vomiting, drowsiness, dizziness, headache, blurry vision, hypotension, morning hangover effect **Rare SEs:** priapism **Box warning (BW):** increased risk of suicidal thoughts	**Indication:** sleep-onset insomnia and night awakenings Administer 30 minutes prior to bedtime. Antidepressant effects at doses 150-400mg. Limited evidence-based studies in pediatrics.

Note: all medication information should be verified using current PDR

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PROVIDER TIPS: SPECIAL POPULATIONS AND CO-OCCURRING SLEEP PROBLEMS

Population	Common Sleep Problems	Treatment Options (not necessarily in rank order)
Attention-deficit/hyperactivity disorder (ADHD)	• Insomnia (acute or chronic insomnia; sleep onset and/or sleep maintenance insomnia) • Behavioral insomnia of childhood • Sleepiness on awakening • Night eating syndrome	• Behavioral therapy and/or pharmacotherapy for ADHD • Psychoeducation on ADHD, sleep hygiene and behavioral strategies • Consider melatonin or sleep medications as a temporary intervention
Depression	• Insomnia (acute or chronic; onset, maintenance, or both) • Hypersomnia • Excessive daytime fatigue • Night eating syndrome	• CBT for depression including psychoeducation on depression and sleep hygiene • Pharmacotherapy for depression and/or melatonin • Consider sleep medication as a temporary intervention
Bipolar disorder	• Insomnia (acute or chronic; onset, maintenance, or both) • **Decreased need for sleep** (common during manic episodes — person does NOT feel tired) • Hypersomnia (common during depressive periods)	• Confirm correct diagnosis • Pharmacotherapy for bipolar disorder (by or in consultation with psychiatrist) • Child and family focused psychoeducation and CBT for bipolar disorder including sleep hygiene
Anxiety	• Insomnia (acute or chronic; onset, maintenance, or both) • Behavioral insomnia of childhood • Nightmares • Bedtime refusal, co-sleeping, inflexible nighttime rituals • Night eating syndrome	• CBT for anxiety including psychoeducation on anxiety, sleep hygiene, and sleep-related cognitions • Pharmacotherapy for anxiety and/or melatonin • Consider sleep medication as a temporary intervention
Acute stress disorder and posttraumatic stress disorder (PTSD)	• Insomnia (acute or chronic; onset, maintenance, or both) • Behavioral insomnia of childhood • Nightmares • Auditory/visual hallucinations • Regression (e.g., bed wetting)	• TF-CBT including psychoeducation on trauma and sleep • Consider melatonin and/or sleep medication as a temporary intervention • Pharmacotherapy for comorbid conditions
Autism spectrum disorders	• Insomnia (acute or chronic; onset, maintenance, or both) • Behavioral insomnia of childhood • Circadian rhythm dysfunction	• Behavioral therapy • Sleep toolkit: autismspeaks.org/tool-kit/atnair-p-strategies-improve-sleep-children-autism • Consider melatonin or sleep medications as a temporary intervention

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SLEEP HYGIENE TIPS FOR CAREGIVERS

Understanding sleep problems in children and teens

All children and teens should have healthy sleep habits. Parents should provide support for healthy sleep habits. Reaching the recommended amount of sleep for each child's or adolescent's age helps with focus, behavior, memory, mood, quality of life, and mental and physical health.

Age	Recommended Hours of Sleep Every 24 Hours
Infants 4-12 months	12-16 hours including naps
Children 1-2 years	11-14 hours including naps
Children 3-5 years	10-13 hours including naps
Children 6-12 years	9-12 hours
Teenagers 13-18 years	8-10 hours

Some sleep problems that affect children and teenagers are:

- Frequent awakenings at night
- Talking during sleep
- Trouble falling asleep
- Waking up crying
- Feeling sleepy during the day
- Having nightmares
- Bedwetting
- Teeth grinding and clenching
- Sleepwalking
- Waking up early

Most sleep problems are because of poor sleep habits or anxiety at bedtime about falling asleep. Separation anxiety and nightmares are common in childhood. With regular bedtime routines most sleep problems decrease.

Good sleep hygiene habits

- Set a regular bedtime routine and waking time with a clear schedule for all days of the week.
  - Provide warnings about approaching bedtime.
  - Predictable bedtime routine such as bath time or picking out clothes for the next day, brushing teeth, and story time.
  - Bedtime should occur when drowsy but while still awake. Falling asleep in other places could create bad habits that are difficult to eliminate.
  - Delays of 15-30 minutes may be used if the child is not drowsy at bedtime. Gradually advance the bedtime if this occurs.
- The bedroom should be cool, quiet, and comfortable.
  - Eliminate "screens" or "blue light" from the bedroom. Teens charge cell phone in another room; might need an alarm clock that is not a phone.
  - Only use the bedroom for sleep, not for punishment.
  - A white noise machine or sound machine may be helpful to have on throughout the night.
  - Minimize light coming into the room (e.g., use blackout curtains, eliminate lights on at night, or reduce to one dim night light even if this has to be done gradually).
- Increase physical activity during the day.

- Do relaxing activities before bedtime.
  - Turn off all screens 1-2 hours before bedtime.
  - Avoid stimulating activities before bedtime such as video games, exercise, or rowdy play.
  - Relaxation techniques may be helpful such as deep breathing or positive imagery.
- Avoid chocolate, caffeine, and heavy food or drinks before bedtime.
- Parents should not be in room when child falls asleep. There are 3 main ways to go about removing parents from the room:
  - **Extinction:** Put the child to bed, leave, ignore inappropriate behavior.
  - **Graduated extinction with check-ins:** Put the child to bed, leave, provide periodic check-ins (short intervals at first that gradually get longer). You can say, "I'll come back in X minutes." Or you can make up a boring reason to leave: "I'm going to go brush my teeth. I'll be right back."
  - **Graduated extinction with slow removal:** Put the child to bed and gradually move further away from the bed each night or every few nights.
- Worry time should not be at bedtime. If worries persistently come up at bedtime, try having a designated "worry time" earlier in the day to talk about concerns with parents or journal.
- Keep a sleep diary including naps, sleep, wake times, and activities for a minimum of 2 weeks to find patterns and problem areas to target.

Sleep Tips for Children	Sleep Tips for Adolescents
• Comfort objects may help with feeling secure and safe when parent or caregiver is not present. • Check-ins should be brief and boring with the goal to reassure the child they are okay and the parent is present. • Bedtime pass: can be exchanged for one "free" trip out of bed or one parent visit after bedtime. If the pass is not used, then could be exchanged for a positive reward (positive reinforcement).	• Avoid alcohol, tobacco, sleep aids, and marijuana that can interfere with your natural sleep cycle. • If you are awake and tossing and turning, get out of bed and complete a low-stimulating activity until feeling tired. This prevents the bed from being associated with sleeplessness. • Avoid daytime napping, such as sleeping after school.

Book recommendations

- *What To Do When You Dread Your Bed: Kid's Guide to Overcoming Problems with Sleep* by Dawn Huebner, PhD
- *The Sheep Who Wouldn't Sleep — A Story That Teaches Self-Soothing and Mindfulness* by Susan Rich Brooke
- *It's Never Too Late to Sleep Train: The Low-Stress Way to High-Quality Sleep for Babies, Kids, and Parents* by Craig Canapari, MD
- *Become Your Child's Sleep Coach: The Bedtime Doctor's 5-Step Guide, Ages 3-10* by Lynelle Schneeberg, PhD
- *Healthy Sleep Habits, Happy Child, 4th Edition: A Step-by-Step Program for a Good Night's Sleep* by Marc Weissbluth, MD
- *Solve Your Child's Sleep Problems* by Richard Ferber

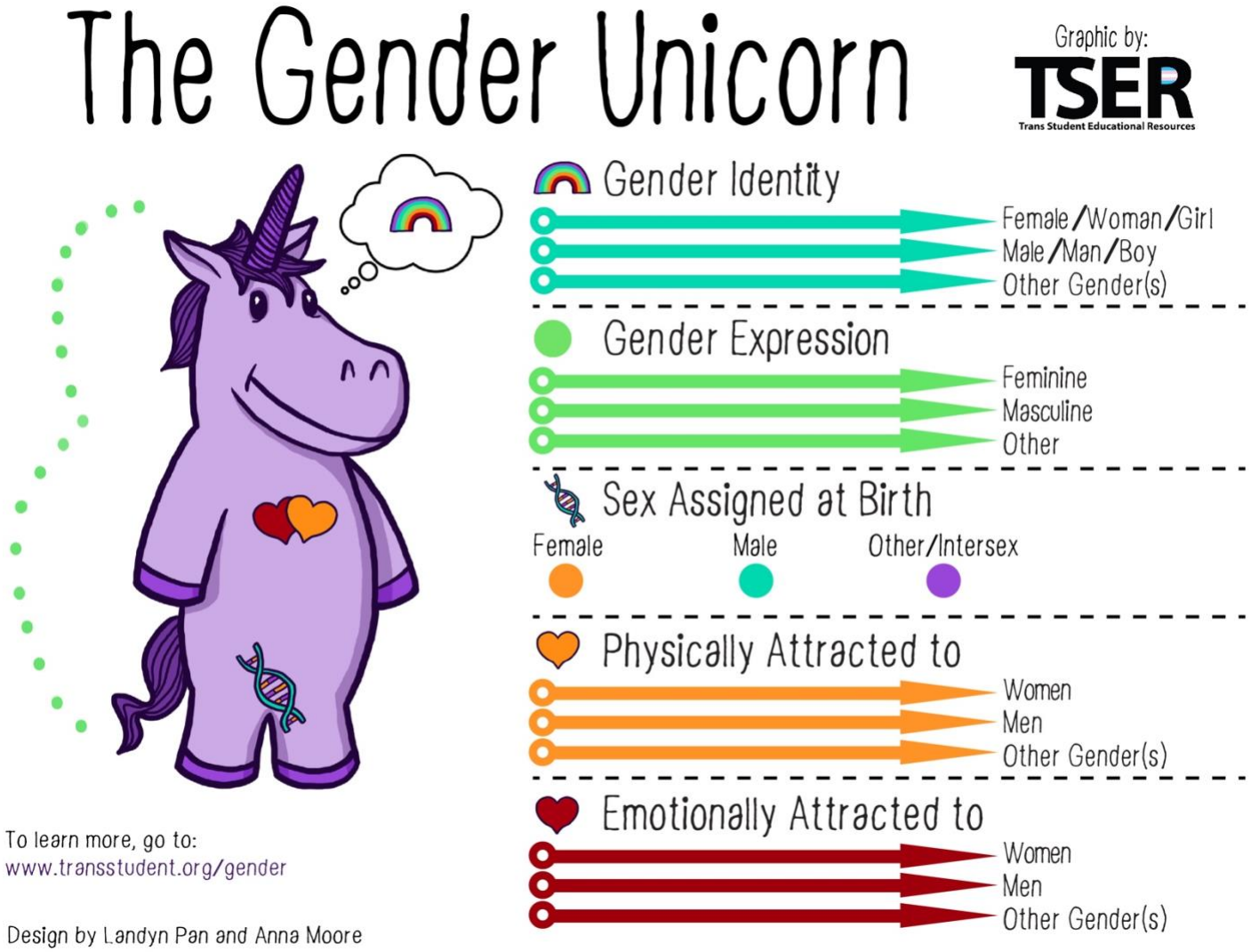
IMPORTANT TERMINOLOGY: GENDER

Your LBGTQ+ Patients:
Knowing who they are matters

- **Natal gender:** the sex assigned at birth usually based on external genitalia
- **Cisgender:** gender identity is congruent with that assigned at birth
- **Transgender:** gender identity different than that assigned at birth
- **Misgender:** to use pronouns incongruent with an individual's gender identity
- **Gender fluid:** describes a person whose gender identity fluctuates at varying times and degrees between two or more genders
- **Nonbinary:** describes genders that don't fall into the "gender binary" of male or female
- **Sex:** maleness or femaleness as it relates to sex chromosomes, gonads, genitalia, secondary sex characteristics, and relative levels of sex hormones

IMPORTANT TERMINOLOGY: SEXUAL ORIENTATION

- **Sexual orientation:** describes an enduring physical and emotional attraction to another group; sexual orientation is distinct from gender identity



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BACKGROUND: HISTORICAL NOTES

1973: Homosexuality was declassified as a mental illness

1980: Transgender individuals were classified as having **Gender Identity Disorder**

2013: Gender Identity Disorder was changed in the DSM-5 to read **Gender Dysphoria**

2013: AAP releases Policy Statement on Office-Based Care for Lesbian, Gay, Bisexual,Transgender, and Questioning Youth

2018: AAP releases Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

2023: HHS releases fact sheet on Gender-Affirming Care and Young People

15.6% of patients identify as LGBTQ+ and 1.8% identify as transgender

The average pediatrician cares for 1,500 patients:
~230 patients are LGBTQ+ and ~27 patients are transgender

TALKING TO PARENTS ABOUT GENDER DIVERSE EXPRESSION IN CHILDREN

Children are very perceptive. They discover who they are at a surprisingly young age. They test out their self-perception to see what others think of them. Along the way, they make changes in their behavior so that they move into adulthood with a minimum of adversity. Sometimes they hide traits that make up their authentic selves and simultaneously perform behaviors that are rewarded, even if those behaviors feel unnatural to them. Hiding and keeping secrets requires constant attention to protecting what is hidden and steals valuable resources from every other area of development. **As child-serving primary care providers, we can help our patients to hide less and thrive more.**

IDENTIFYING YOUR PATIENTS

It's important that we identify our LGBTQ+ patients in our practices.

Patients and their caregivers are less likely to disclose information about gender and sexuality if an office is not projecting an openness to their family.

This begins with educating staff at the front desk and having forms that are inclusive.

Know your patients and their mental health risks:

- 41% of LGBTQ+ young people seriously considered attempting suicide in the past year, including 50% of transgender and nonbinary youth
- 14% of LGBTQ+ youth attempted suicide in the past year, including nearly 1 in 5 transgender and nonbinary youth

Source: The Trevor Project's 2023 U.S. National Survey on the Mental Health of LGBTQ Young People

By age 2…	• Children become aware of the physical differences between the sexes.
By age 3…	• Most children can easily label themselves as boy or girl.
By age 4…	• Most children have a stable sense of their gender identity. • Children who are highly discordant between their gender identity and their birth sex will notice this discrepancy and state it plainly to their parents or caregivers. • Many of these children will be persistent, insistent, and consistent about this self-observation, and this increases the likelihood that this individual is, in fact, transgender.
By age 7…	• Gender dysphoria tends to start before puberty, with an average age of onset of 7 years. • Gender dysphoria worsens as a child becomes aware of the impending changes their body will undergo with the onset of puberty.

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Conversation starters with youth

- Are you happy with how your life is going?
- Would you change anything about yourself or your life?
- Are other children being mean to you? What kinds of mean things do other children say to you?
- Are you happy with your body?
- Have you ever questioned your sexuality or your gender?
- Are you attracted to boys, girls, both, or neither?

OPPORTUNITIES TO HELP A CHILD FEEL MORE COMFORTABLE ABOUT THEIR GENDER AND SEXUALITY

- If your office has pictures of people, try to choose pictures that represent diversity of culture, sexuality, and gender expression.
- Create restrooms that are affirming of patients on the gender spectrum.
- Place stickers in the exam room to signal that you are open to discussions about gender and sexuality. Some providers wear pins or stickers with their name badge.
- Be open about sexuality and gender when speaking to the family, without putting a child on the spot about theirs.
- Offer a teen questionnaire that asks about sexuality and gender (see resources for examples).
- Talk to your patients one-on-one by age 13 or sooner, if appropriate.
- Use questions to mirror teen's own words when talking one-on-one.
- If a patient discloses to you, thank them, affirm them, and offer resources. See provider resources.

HELPING CAREGIVERS SUPPORT GENDER IDENTITY IN YOUTH

The following interventions show the youth that their caregivers are supportive of their identity, and offer an approach that allows for fluidity in a reversible manner.

- Affirm clothing and hairstyle
- Use a chosen name and pronouns
- Allow youth to present as their affirmed gender at home and in public when they are ready
- Collaborate with the youth to define public disclosure of gender identity
- Stand up for child when they are being mistreated
- Make it clear that slurs or jokes based on gender, gender identity, or sexual orientation are not tolerated (including at home and with siblings)
- Connect child with LGBTQ+ organizations

PROVIDER RESOURCES

- Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know (aafp.org)
- Creating an Inclusive Environment for LGBT Patients (National LGBT Health Education Center, 2017)
- Adolescent and Young Adult Health Questionnaire: a youth (ages 11-20) self-report tool that incorporates questions regarding general health, safety, sexual health, substance use, and more. Also available in Spanish.
- The Safe Zone Project: trainings to learn about LGBTQ+ identities, gender, and sexuality
- Coming Out: Information for Parents of LGBTQ Teens (healthychildren.org)

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TIPS FOR PRIMARY CARE: SUPPORTING LGBTQ+ YOUTH

TIP #1

Sometimes, a parent will raise concerns about their child's gender expression or their social habits around their peers. Our job, in these moments, is to help parents revise their expectations so that they don't unintentionally shame their child about behavior that feels very natural to the child. **Avoid persuasion and shame.**

TIP #2

PCPs should be aware that gender identity becomes known to a child at a young age and the expression of their gender needs to be supported. "**Gender expression** can be influenced by exposure to stereotypes and their identification with people in their lives. The internal sense of being a girl, boy, in between, or something else **(gender identity)** cannot be changed." This is not to say that once a child presents as discordant with their sex assigned at birth, they will never change their presentation. However, it can be harmful to try and persuade a child to change their presentation. **Avoid persuasion and shame.**

TIP #3

PCPs can help caregivers cope with a child who displays gender diverse expression in a way that supports their child and avoids creating shame between the ages of 3 and 10. All of the interventions in this timeframe are easily reversible if the child decides to change their expression.

TIP #4

When a child begins to show signs of gender dysphoria, this is a good time to initiate therapy with an affirming therapist. Often, these therapists are listed with LGBTQ+ Support Centers.

TIP #5

Most PCPs make a point of talking with their patients in a one-on-one setting by the time they are 13 years old. However, if a child is showing signs of depression, anxiety, or other behavioral concerns that are not easily explained, it makes good sense to have this conversation at a younger age, with parental assent. During this conversation, you can begin to explore the possibility that gender or sexuality may be an element of a child's distress.

TIP #6

If you are able to identify gender dysphoria in a prepubertal child, and parents have come to understand their child's gender identity, most pediatricians may choose to refer to an affirming endocrinologist who can discuss interventions, such as puberty blocking. Often this begins between ages 10 and 12. This intervention is generally not chosen for the many gender diverse children who do not display gender dysphoria. For children presenting without distress regarding their gender diverse expression, social transition is the primary intervention.

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UNDERSTANDING GENDER-AFFIRMING TREATMENTS

Self-awareness of sexuality and gender identity take huge leaps when the body starts releasing elevated sex hormones. This is precisely the moment when a provider should be introducing affirming statements about gender and sexuality, without raising a child's anxiety in the process, if possible. See provider tips for evidence-based interventions, including social, emotional, and family supports in addition to the medical interventions below.

Hormone therapy

Puberty Blocking is often the first medical intervention for gender diverse patients and is reversible. This generally takes place at the onset of puberty, specifically and most appropriately at a sexual maturity rating of Tanner 2. The use of puberty blocking agents is associated with improvements in mental health outcomes. It can also be a useful tool to allow more time for an adolescent to develop emotionally before starting gender affirming hormone therapy. If the patient ultimately decides to forego this therapy, puberty blockade can be stopped and puberty will begin.

GnRH analogs may be administered in a variety of forms, including injections and implants. Many adolescents start with the histrelin insert (effective for two years) or with intramuscular leuprolide injections every three months. The dose of the injection may be titrated to adequately suppress puberty by patient report, physical examination, and/or laboratory values. Monitoring of height, weight, pubertal progression, and bone health are an important aspect of pubertal suppression and must be carefully considered if this is done outside of the guidance of a gender clinic. Ideally, GnRH analogs would be used until a patient has had gonadectomy, but this is not often the case because of cost concerns and insurance coverage. Instead, these products are stopped after 1-2 years, preferably to coincide with onset of affirming hormone therapy.

Examples of gender-affirming hormone therapy

For transfeminine patients, exogenous 17-beta estradiol is necessary for feminization of birth-designated males. The addition of androgen blockers (e.g., spironolactone) assists in reducing testosterone activity and/or male-pattern hair. Estradiol can be administered in a variety of methods, though many patients choose to have injections every one to two weeks.

For transmasculine patients, exogenous testosterone is necessary for masculinization of birth-designated females. Testosterone is available as an injection (subcutaneous or intramuscular) or topically (e.g., patch, gel, cream). It is most commonly given subcutaneously on a weekly schedule. Subcutaneous administration is used by many providers because it is better tolerated, less painful, and as efficacious as intramuscular injection. Transmasculine youth who are starting gender-affirming hormones in early or middle adolescence may not necessarily desire profuse body hair, so they may benefit from starting at a low dose and increasing slowly. On the other hand, too slow or too low a dose may not be sufficient to suppress endogenous estrogen and may allow continued and undesired menstruation or breast development.

Before starting gender-affirming hormone therapy, patients need to be provided informed consent because many of the changes that ensue will be irreversible and they have to be given reasonable expectations of timing. There is also a commitment to be made on monitoring of hormone levels and other health markers. The most consistently used resource for gender-affirming hormone therapy is available from the World Professional Association for Transgender Health (wpath.org).

Surgery

Although most surgical intervention is pursued during adulthood, chest reconstruction for transmasculine individuals is one intervention that may be considered and waiting for adulthood may not be in the patient's best interest.

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VIRGINIA RESOURCES FOR LGBTQ+ YOUTH

Organization	Location	Website	Notes
PFLAG	• Hampton Roads • Williamsburg • Richmond • Charlottesville • Floyd • Washington, DC	• pflag.org	Support and community for families and friends of LGBTQ+ individuals. All ages welcome.
LGBTQ+ Center	• Hampton Roads • Richmond • Staunton • Roanoke	• lgbtlifecenter.org • diversityrichmond.org • shenlgbtqcenter.org • roanokediversitycenter.com	Wide range of support for all ages.
GLSEN	• High schools	• glsen.org	Gender and Sexuality student groups in high schools and some middle schools.
Equality Virginia	• Richmond	• equalityvirginia.org	Statewide advocacy.
He She Ze and We	• Richmond/Virtual	• heshezewe.org	Weekly support and education meetings for parents, caregivers and adult family members of transgender and gender-diverse children of all ages. Trainings for businesses, schools, etc.
Gender Clinics	• Carilion Clinic Gender Care • CHKD LGBTQ+ Services • Children's National Gender Development Program • UVA Children's Gender Health Clinic • VCU CHOR Gender-Affirming Care		Medical support usually starting at puberty.
Trevor Project	• Online/Text/Phone • Available 24/7, 365 days a year	• thetrevorproject.org • Text "START" to 678-678 • Call 1-866-488-7386 • Chat online thetrevorproject.org/get-help	Support for LGBTQ+ individuals in crisis. Good resource for teens and adults.
It Gets Better	• Online	• itgetsbetter.org	Affirming videos for teens and adults.
VDH	• Online	• vdh.virginia.gov/disease-prevention/disease-prevention/transgender-health-services-support/	Finding services and affirming providers statewide.

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4.2 Military-Connected Children

RECOGNIZE: Unique Experiences for Military-Connected Children

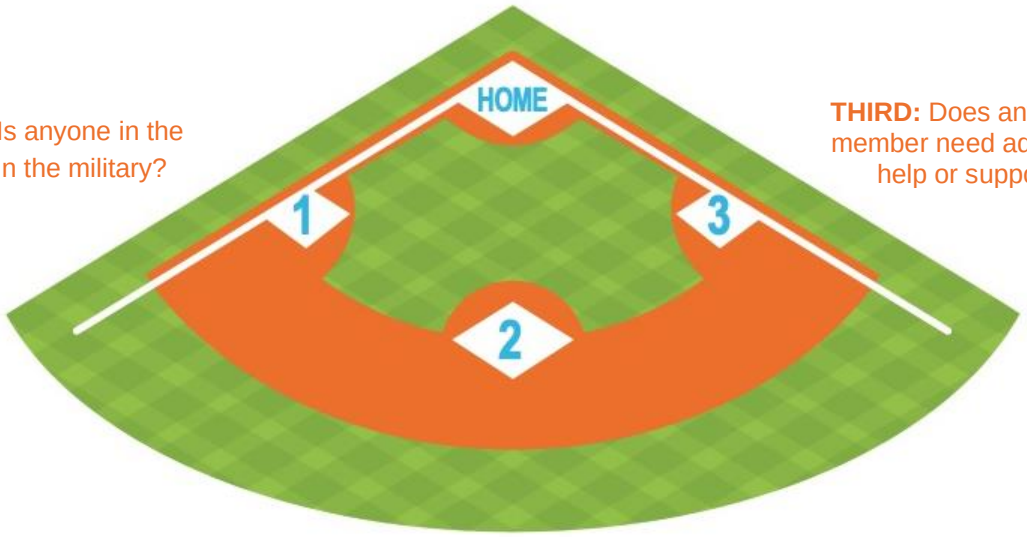
- Frequent relocations, including fragmented care or schooling
- Parent deployment (three stages of deployment with unique challenges in each)
  - Pre-deployment preparation
  - During deployment
  - Post-deployment/reunification
- Parent injury or death during military service
- Selected Reserve families are often living in civilian communities and may feel isolated from the military community and resources

RESPOND: Consider a broad screener (PSC-17 or 35 or ECSA) at well-child visits

RESPOND: "Cover the Bases" and ask additional questions for military-connected children

HOME: Is everyone safe at home?

FIRST: Is anyone in the family in the military?



THIRD: Does any family member need additional help or support?

SECOND: Is anyone in the family showing signs of distress?

RESPOND: Based on information from the PSC and above questions, PCP determines whether the child and family require only psychoeducational materials or referral for mental health services

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KNOW WHEN TO REFER: When to consider referral to mental health professional

- For the parent:
  - After 2 visits using reassurance or helping the parent cope using a psychoeducational intervention or supportive counseling
  - If PCP feels uncomfortable with their own counseling or psychoeducational skills
- Child behavior becomes more extreme or persists for 1-3 months after parent has returned home from a lengthy deployment
- Significant change in child's behavior or drop in school performance
- Injury or death of a deployed parent

RESOURCES: Unique resources for military-connected children

- Military One Source: free 24/7 resource for military families
  - New MilParent: offers free, individualized, confidential support for expecting and new military parents of children up to age 5
  - Exceptional Family Members Program (EFMP): helps with identification and support of a family member with special medical or educational needs
- Military and Family Life Counseling Program: free resource for service members and loved ones
- Military Kids Connect: online community for military kids ages 6 to 17
- Babies on the Homefront: web resource and app created by ZERO to THREE to support military and veteran parents with their baby or toddler
- TRICARE Humana Military: **1-800-444-5445**
- FOCUS (Families Overcoming Under Stress) Resilience Training for military families:
  - FOCUS Quantico
  - Naval Station Norfolk
  - Fort Story
- Operation Homefront: offers military families in-need short-term financial assistance, recurrent family support, and help with long-term stability including mortgage-free homes and veteran caregiver support
- Navy Fleet and Family Support Program: includes family supports, counseling, advocacy, and prevention programs
- National Call Center for Homeless Veterans: **1-877-4AID-VET (424-3838)**
- Virginia Veteran & Family Support Program: **1-877-285-1299**
  Operated statewide by the Virginia Department of Veterans Services; provides outreach, connection, and support to veterans and their families as they address the challenges of military service, transition, deployments, posttraumatic stress, or other behavioral health concerns as well as traumatic brain injuries and physical injuries.

If you're concerned about **a veteran in crisis**, the **Veterans Crisis Line (dial 988 then press 1; text 838255)** has caring, qualified VA responders standing by to provide free and confidential support — 24 hours a day, 7 days a week, 365 days a year. Responders will work with the individual to get through **any** personal crisis.

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RESOURCES TO SUPPORT MILITARY FAMILIES

For Providers

- AAP Section on Uniformed Services (aap.org/en/community/aap-sections/uniformed-services/)
- Center for the Study of Traumatic Stress (centerforthestudyoftraumaticstress.org/)
- Military OneSource (militaryonesource.mil/)

For Parents/Caregivers

- American Red Cross (redcross.org)
- Ginsburg KR, Jablow MM. *Building Resilience in Children and Teens: Giving Kids Roots and Wings*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2014 (shop.aap.org/)
- Military OneSource (militaryonesource.mil/)
- National Military Family Association (militaryfamily.org/)
- ZERO to THREE “Military Family Projects” (zerotothree.org/our-work/military-families/)
- TAPS: Tragedy Assistance Program for Survivors (taps.org/)

Education

- Military K-12 partners (Department of Defense Education Connections)
- Military Interstate Children’s Compact Commission (mic3.net/)
- Military Child Education Coalition (militarychild.org/)
- Specialized Training of Military Parents (STOMP) (wapave.org/stomp)

For Child

- Operation Purple through the National Military Family Association (militaryfamily.org/programs/operation-purple/)

Service Related

- Air Force (af.mil/)
- Air Force Reserve Command (afrc.af.mil/)
- Army Community Services programs for families (armymwr.com/programs-and-services/personal-assistance)
- Army Reserve Family Programs (usar.army.mil/ARFP/)
- Coast Guard (uscg.mil/mwr)
- Marine Corps Family Team Building (mccscp.com/mcftb)
- Marine Forces Reserve MFR Family Readiness (marforres.marines.mil/FamilyReadinessOffice.aspx)
- National Guard Family Program (militaryonesource.mil/national-guard/national-guard-family-program/)
- Naval Services FamilyLine (nsfamilyline.org/)

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PHASES OF DEPLOYMENT AND THE ROLE OF THE PROVIDER

Factors With Increased Risk of Mental Health Stress/Trauma

- Length of deployment (longer increases risk)
- Older adolescent children (15-17 years, especially girls)
- Young children of single parents (usually Active Duty mothers) at greatest risk of maltreatment (most frequently neglect)
- Pre-existing child anxiety
- Combat-related deployment and/or PTSD in service member (compared to non-combat related tour)
- Children of National Guard families may be more isolated from supports

Pre-deployment: From Notification of Deployment to Actual Departure

- Often intense preparation of military units; requires extensive time away from family.
- Decisions made about careers, financial adjustments, legal issues, and child care.
- Experience with previous deployments may interfere with preparation for new deployment.
- Can be confusing to children, who may not understand why separation is necessary and have no concept of what this change means.
- Children at various developmental ages experience excitement, denial, worry, fear, and anger. Emotional withdrawal is not uncommon immediately before deployment.
- Last-minute or recurrent goodbyes often increase tension.
- Teens can be angry at the "selfish" nature of a service member's job that takes the adult away from his or her role as parent, coach, and supporter.

Primary Care Assessment	Primary Care Anticipatory Guidance
Assess for preexisting: • Family dysfunction • Mental health issues in parent • Children with special needs • Recent family relocation • Recent divorce or remarriage • Previous problems during a deployment	• Discuss responsibilities and expectations of each family member during upcoming deployment. • Make plans and goals for family rather than "put lives on hold." • Prepare for communication strategies and expectations, perhaps avoiding everyday contact with deployed service member. • Plan to maintain rules, rituals, and routines.

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Deployment: Typically Lasts Between 3 and 15 Months

- Usually begins with a tearful going-away ceremony, followed by a period (usually 1-6 weeks) of emptiness and loss.
  - The intensity leading up to a goodbye can be overwhelming.
  - The sense of relief that the deployment has actually started can be confusing.
- After about 6 weeks, most families try to establish and settle into a new routine.
- The "midtour" R&R leave:
  - Is when the deployed service member can come home for 2 weeks
  - Is often a difficult time for children
  - May occur during the school year
  - Is when children are often distracted by anticipation, excitement, and a short period of visitation and then have to say goodbye all over again
- Many families describe deployment as "surviving, not thriving" despite trying to find resilience and strength.
- For the month or two before homecoming:
  - There may be worry as well as excitement as new independence or self-reliance may have emerged into a "new normal."
  - Family members are unsure of how to reintegrate a deployed parent.

Primary Care Assessment	Primary Care Anticipatory Guidance

• Assess at-home parent and children for:
  ◦ Adjustment (1-6 weeks after deployment)
  ◦ Sleep regularity
  ◦ School attendance
  ◦ Mood problems
• Spend time in private conversation with adolescents to assess:
  ◦ Adjustment
  ◦ School performance
  ◦ Mood
  ◦ Risk-taking
  ◦ Role in family
	• Discuss responsibilities and expectations of each family member during deployment.
	• Make plans and goals for family rather than "put lives on hold."
	• Prepare for communication strategies and expectations, perhaps avoiding everyday contact with the deployed service member during deployment.
	• Plan to maintain rules, rituals, and routines.

Post-deployment (Re-deployment)

- Often begins with "honeymoon" period of happiness and putting off the chores of the day.
- Happiness of reuniting is mixed with needing to get reacquainted and deciding how to share the time lost.
- "Block leave" is 30 days of vacation time given to the post-deployment unit, sometimes delayed after the actual return.
  - May not coincide with when family members have availability to leave school or work.
  - At-home spouse often wants some much-needed respite after a year of "full-time" parenting.

Primary Care Assessment	Primary Care Anticipatory Guidance
Assess family for: • Readjustment (1-6 weeks) • Parental mood • PTSD • Substance use • Marital discord • Increased screen time, especially violent video games	• Take time to communicate and to get to know each other. • Spend time talking with each other. • Take time to make decisions and to discuss changes in routine. • Lower holiday expectations. • Keep plans simple and flexible. • Don't try to schedule too many things during the first few weeks. • Let absent parent "back into" the family circle.

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4.3 Children and Youth in Foster Care and Adoption

When the child welfare system becomes involved with a family, the primary area of focus is providing support to stabilize the family to prevent any type of removal or out-of-home placement. If out-of-home placement must occur to protect the safety of the child, then initial efforts are targeted around returning them to the home environment as soon as safely possible.

All children who have experienced family disruption have experienced trauma, regardless of timing or circumstances. See 3.4 Trauma + PTSD Care Guide for additional resources.

What is foster care?

- Intended to be a *temporary* placement for a child removed from their biological family or home.
- Reasons for removal may involve neglect, abuse, abandonment, family crisis, or other health/safety issues.
- The foster placement may be with a relative or non-relative.
- The foster family works with local department of social services (DSS), biological family, child (when able), and any other community partners involved.
- Support and training are provided to foster parents to support the needs of children in their care (physical, emotional, cultural).
- Visitations with biological family often continue to occur.
- **The agency and the parents have at a minimum 12 months to correct the problems that caused the child to come into foster care.** Parents may be ordered to seek substance use treatment, mental health treatment, employment assistance, housing, etc. If reasons for removal are not corrected and the child has been in foster care continuously for 15 of the last 22 months, federal and state law require that a petition for termination of parental rights be filed or an exception to filing a petition for termination be documented in the child's foster care plan. If parental rights are terminated, Virginia law requires consideration of permanent placement with a relative, including transferring legal custody to the relative.

What is adoption?

- The social, emotional, and legal process of a child who will not be raised by their birth parent(s) to become full and permanent members of another family.
- Biological parent(s) relinquish their parental rights. The terms "open" and "closed" adoption may have different definitions for different families and situations.

What is permanency?

- The importance of finding safe, permanent homes for children as quickly as possible.
- Achieved through: (1) reunification; (2) placement with, or custody transfer to, a relative (kinship care); or (3) adoption.
- It is important to establish permanency so that the child can establish and nurture a family connection. One secure attachment to a caregiver during childhood can lead to better mental health outcomes throughout the individual's life.

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What is reunification?

- Reunification is the process that occurs when a former foster youth returns to his or her family of origin.
- Reunification is the primary goal for children in foster care in Virginia.
- Research supports that children do better when raised in their biological families, if possible.

What is TPR (termination of parental rights)?

- Termination can be voluntary or involuntary.
- Voluntary termination of parental rights may occur when a parent chooses to make an adoption plan for the child.
- Involuntary termination of parental rights requires a court to determine that the parent is unfit and that severing the parent-child relationship is in the child's best interest.
- Resource: Grounds for Involuntary Termination of Parental Rights (childwelfare.gov)

What is kinship care?

Kinship care is placement of a child with a relative or someone who has a significant emotional relationship with a child not born to them. Kinship care is sought when children must be separated from their parents, either voluntarily or by court order, and is often preferred over foster care.

- **Informal Kinship Care:** the child is not in the custody of the local department of social services.
- **Formal Kinship Care:** the child is in the custody of the local department of social services and living with a relative who is an approved foster parent.

Kinship Care Resources:

- For providers: Needs of Kinship Care Families and Pediatric Practice (AAP Policy Statement, 2017)
- For kin: GrandFamilies.org

Resources for Providers

- Promoting Protective Factors for Children and Youth in Foster Care: A Guide for Practitioners (childwelfare.gov)
- Helping Foster and Adoptive Families Cope with Trauma (aap.org)
- Parenting a Child Who Has Experienced Trauma (childwelfare.gov)
- Mental and Behavioral Health Needs of Children in Foster Care (aap.org)
- Foster Care Friendly Tip Sheet for Health Care Professionals (aap.org)

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Evidence-Based and Evidence-Informed Therapeutic Interventions

Early Intervention (EI) in Virginia: Young children ages 0-3 may be eligible for EI through Infant and Toddler Connection of Virginia (itcva.online) due to "effects of toxic exposure including fetal alcohol syndrome, drug withdrawal"

- **Attachment and Biobehavioral Catch-up (ABC):** tailored toward infants who have experienced early adversity; 10-session home visiting program for enhancing parental sensitivity and children's attachment security and regulatory capabilities.
- **Attachment, Regulation & Competency (ARC):** for youth and families who have experienced multiple and/or prolonged traumatic stress (complex trauma) by building attachment, self-regulation, and competency with the caregiver and child.
- **Child-Parent Psychotherapy (CPP):** for trauma-exposed children ages 0-5, with a goal of supporting and strengthening the caregiver-child relationship.
- **Circle of Security (COS):** teaches parents the fundamentals of attachment theory and children's use of parents as a secure base.
- **Coping Cat:** a cognitive-behavioral treatment for anxious children, ages 7-13 and for those with separation anxiety disorder. There also is a version for adolescents known as the C.A.T. Project.
- **Dyadic Developmental Psychotherapy (DDP):** developed for children who failed to experience the dyadic (reciprocal) interaction between a child and parent that is necessary for normal development; incorporates attitudes based on playfulness, acceptance, curiosity, and empathy.
- **Eye Movement Desensitization and Reprocessing (EMDR):** can be an effective therapeutic tool with older youth who have experienced trauma or have a diagnosis of PTSD.
- **Incredible Years:** is an evidence-based parenting program designed to work jointly to promote emotional, social, and academic competence and to prevent, reduce, and treat behavioral and emotional problems in young children.
- **Multisystemic Therapy (MST):** intensive family- and community-based treatment program focuses on addressing all environmental systems that impact these youth — family, school, neighborhood, and friends.
- **Parent-Child Interaction Therapy (PCIT):** for young children with emotional and behavioral problems with the goal to improve parent-child interaction patterns, teach parents nurturing skills, increase prosocial behavior, and decrease negative behavior.
- **Parenting with Love and Limits (PLL):** involving group, family, and individual therapy for children and adolescents with severe emotional and behavioral problems and their parents. It seeks to teach families how to reestablish adult authority through consistent limits, while reclaiming a loving relationship.
- **Positive Parenting Program (Triple P):** evidence-based parenting program that includes a range of parenting interventions with varying intensity.
- **Theraplay:** structured play therapy for children with a range of externalizing behaviors or interpersonal problems and their parents. The goal is to enhance attachment, self-esteem, trust in others, and joyful engagement.
- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT):** reduces emotional and behavioral responses resulting from trauma for children, adolescents, and their caregivers. The treatment is based on learning and cognitive theories and addresses distorted beliefs and attributions related to the abuse, and provides a supportive environment in which children are encouraged to talk about their traumatic experience.
- **Trust-Based Relational Intervention (TBRI):** attachment-based, trauma-informed intervention that uses Empowering Principles to address physical needs, Connecting Principles for attachment needs, and Correcting Principles to disarm fear-based behaviors.

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Virginia Resources for Families

Family First Virginia, through Virginia Department of Social Services (DSS), offers prevention services for children at risk of out-of-home placement; includes mental health treatment, substance use disorder prevention and treatment, and in-home parent skill building. familyfirstvirginia.com/

Kinship Navigator Programs (available in some regions) offer assistance to kinship caregivers:

- Arlington DSS (Arlington, Alexandria, Fairfax, Prince William, Loudoun)
- Bedford DSS (Amherst, Appomattox, Bedford, Campbell, Lynchburg, Nelson)
- Dickenson DSS (Dickenson, Buchanan, Russell, Tazewell, Lee, Wise, Scott, City of Norton)
- James City County DSS (James City County, Williamsburg, York-Poquoson)
- Virginia Beach DSS (Virginia Beach, Chesapeake, Portsmouth, Suffolk, Norfolk)
- Smyth DSS (Bland, Bristol, Carroll, Galax, Giles, Grayson, Montgomery, Pulaski, Radford, Smyth, Washington, Wythe)

Promoting Safe and Stable Families: designed to assist children and families to resolve crises, connect with necessary and appropriate services, and remain safely together in their own homes whenever possible. Families access services through their local Department of Social Services. dss.virginia.gov/family/pssf.cgi

Independent Living Program for foster care youths ages 14 — 21 years: educational, vocational, daily living skills, counseling, service coordination, and other support available to help with the transition from foster care to independent living. dss.virginia.gov/family/fc/independent.cgi

Regional Post Adoption Consortium Services for adoptive families with children under the age of 18: referrals, case management, education, training, peer support, planned respite activities, and crisis support.
Central & Eastern Virginia | Northern Virginia | Piedmont & Western Virginia

Web Resources for Families

Complex Trauma: Facts for Caregivers (National Traumatic Stress Network)

Parenting a Child Who Has Experienced Trauma (childwelfare.gov)

AAP Parenting After Trauma: A Guide for Foster and Adoptive Parents (English)

AAP Parenting After Trauma: A Guide for Foster and Adoptive Parents (Spanish)

AAP Safe and Sound: Helping Children Who Have Experienced Trauma and Adversity

Formed Families Forward: nonprofit organization supporting foster, kinship, and adoptive families of children with disabilities and other special needs (formedfamiliesforward.org)

Bibliotherapy for Kids

- *Kids Need to Be Safe: A Book for Children in Foster Care* by Julie Nelson
- *Finding the Right Spot: When Kids Can't Live with Their Parents* by Janice Levy and Whitney Martin
- *A Family for Leanne* by Shelby Timberlake
- *How It Feels to Be Adopted* by Jill Krementz
- *Families Change: A Book for Children Experiencing Termination of Parental Rights* by Julie Nelson
- *Rosie's Family, An Adoption Story* by Lori Rosove
- *The Invisible String* by Patrice Karst

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Neonatal Abstinence Syndrome (NAS)

- A withdrawal syndrome that can occur in newborns exposed to certain substances, including opioids, during pregnancy. Withdrawal symptoms can begin within 24 hours post-delivery up to weeks after; most typically occur within 72 hours post-delivery.
- Symptoms depend on type of substance used, frequency of use, time of last use, how the mother's body breaks down the drug, and age of baby at birth.

Common signs/symptoms

- Dehydration
- Diarrhea
- Stuffy nose or sneezing
- Fussiness
- Excessive crying
- High-pitched crying
- Poor feeding
- Inability to suck
- Slow weight gain
- Breathing problems, including rapid breathing
- Body shakes (tremors)
- Overactive reflexes (twitching)
- Seizures (convulsions)
- Sleep problems and lots of yawning
- Tight muscle tone
- Fever or unstable body temperature
- Sweating or blotchy skin
- Vomiting

Beyond initial withdrawal symptoms, babies with NAS are at increased risk of:

- Low birthweight
- Jaundice
- Seizures
- Sudden infant death syndrome (SIDS)

It is important to identify and treat these symptoms as soon as possible to reduce significant harm and long-term effects, which may include:

- Sleep problems
- Ear infections
- Vision problems
- Problems with nutrition and growth
- Developmental delays (not meeting milestones)
- Motor problems
- Behavior and learning problems (impulsivity, short attention span, hyperactivity)
- Speech and language problems
- Impaired cognition (poor memory, analytical skills, lower IQ)
- Poor speech and language development

NAS Resources for Providers

Neonatal Abstinence Syndrome Campaign Toolkit (aap.org)

NAS Resources for Families

March of Dimes: Neonatal Abstinence Syndrome

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Fetal Alcohol Spectrum Disorders (FASD)

- A group of conditions that can occur when a fetus has been exposed to alcohol before birth.
- The effects of FASD can range in severity and have lifelong impact on the individual to include physical, mental, behavioral, and/or learning disabilities.
- Early intervention is key.
- Consider genetic testing for alternative etiology if dysmorphic features are present (e.g., cornelia de lange syndrome).
- Diagnostic terms under the FASD umbrella are:
  - Fetal Alcohol Syndrome (FAS)
  - Partial Fetal Alcohol Syndrome (PFAS)
  - Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (ND-PAE)
  - Alcohol-Related Neurodevelopmental Disorder (ARND)

Common signs/symptoms

- Low body weight
- Poor coordination
- Hyperactive behavior
- Difficulty with attention
- Poor memory
- Difficulty in school (especially with math)
- Learning disabilities
- Speech and language delays
- Intellectual disability or borderline IQ
- Poor reasoning, judgment skills
- Sleep, sucking problems as a baby
- Vision or hearing problems
- Problems with the heart, kidneys, or bones
- Shorter-than-average height
- Small head size
- Abnormal facial features, such as a smooth ridge between the nose and upper lip (philtrum)

FASD Resources for Providers

AAP Fetal Alcohol Spectrum Disorders toolkit (aap.org)

Treatment: FASD (cdc.gov)

FASD Resources for Families

FASD Fact Sheet for Families (cdc.gov)

FASD United: fasdunited.org/

SAMHSA Substance Abuse Treatment Facility Locator: findtreatment.samhsa.gov/

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4.4 Families New to the U.S.

In the U.S., 1 in 4 children have parents or caregivers who are immigrants

In Virginia:

- **23%** of parents of children ages 0-4 are immigrants
- **24%** of parents of children ages 5-10 are immigrants

THE LANGUAGE OF U.S. IMMIGRATION

- **Refugees:** Individuals outside of their country who are unable or unwilling to return home because they fear serious harm and are outside the U.S. when they seek protection.
- **Secondary migration**: Refugees who voluntarily move within the U.S. after U.S. resettlement (this movement may occur before or after public health screening).
- **Asylees**: Individuals who fit the definition of a refugee, however, they seek protection at a point of entry or once they are within the U.S.
- **Unaccompanied children (UAC):** Individuals under age 18 without lawful legal status in the U.S. and without a legal guardian in the U.S. to provide care or physical custody.
- **Unaccompanied refugee minors (URM):** Refugee children under age 18 meeting definition above of 'refugees' without a parent or guardian and living with foster family with protection of the Office of Refugee Resettlement (ORR).
- **Undocumented immigrant children**: Children without lawful legal status in the U.S. with a legal guardian in the U.S.
- **Special Immigrant Visa:** Qualifies for a green card (permanent residence) under the U.S. Citizenship and Immigration Services (USCIS) special immigrant program (most often Aghani and Iraqi families that worked for the U.S. military).
- **Immigrant visaholders:** Other children with various legal visa statuses including green cards obtained through "family-based" program and green card lottery.

Refugees, Asylees, UAC, and URM are required to have some form of public health screening and a civil surgeon medical examination in order to continue their green card eligibility process.

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THE IMPORTANCE OF UNDERSTANDING THE IMMIGRANT EXPERIENCE

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred. These traumatic events may occur while the refugees are in their country of origin, during displacement from their country of origin, or in the resettlement process here in the U.S. While in their country of origin, immigrant and refugee children may have experienced traumatic events or hardships including:

- Violence (as witnesses, victims, and/or perpetrators)
- War
- Lack of food, water, and shelter
- Physical injuries, infections, and diseases
- Torture
- Forced labor
- Sexual assault
- Lack of medical care
- Loss of loved ones
- Disruption in or lack of access to schooling

During displacement, migrant and refugee children often face many of the same types of traumatic events or hardships that they faced in their country of origin, as well as new experiences such as:

- Living in refugee camps
- Separation from family
- Loss of community
- Uncertainty about the future
- Harassment by local authorities
- Detention

Sources of stress experienced by immigrant and refugee youth are not limited to pre-resettlement trauma and often include daily stressors in the resettlement context such as.

- Discrimination and alienation
- Lack of social support
- Lack of access to food, housing, employment
- Poverty
- Economic or financial strain
- Acculturative stress (e.g., the challenges associated with learning a new language and norms of a new culture)

Family immigration status represents an important and often-neglected social determinant of health, and careful assessment of the family's needs will be critical for optimizing outcomes.

Primary care providers working with families new to the United States will first need to establish relationships with families with different languages and cultures than their own. Understanding the family's migration history is an important step towards building this rapport.

See 1.5 Culture and Mental Health Module and 3.4 Trauma + PTSD Care Guide for additional information and resources

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Migration-Related Screening

Refugees receive a medical examination overseas prior to arrival in the U.S., and a comprehensive domestic Refugee Medical Screening as soon as possible after arrival. Parasite infections, dental caries, growth abnormalities, and nutritional deficiencies and disorders (iron, calcium) are among the most common health problems of immigrant children, particularly refugees and adoptees.

Pre-Migration Medical Screening	Documentation from the overseas medical examination is provided to state and local health officials through the Electronic Disease Notification system.
Domestic Medical Screening	• Purpose is to identify and eliminate health-related barriers to successful resettlement and protect the health of the U.S. population. Health issues are addressed and refugees are referred to local PCPs. • Conducted by local health departments in a refugee's county of residence under VDH's Virginia Newcomer Health Program.
Refugee Health Screener 15 (RHS-15)	• The Commonwealth of Virginia has adopted this screener to address mental health needs during the initial refugee screening. It assists with identification of **post-traumatic stress disorder, depression, anxiety, and adjustment disorders**. • The RHS-15 is a brief screening tool validated for youth age 14 and older. It is available in multiple languages. It may be administered using the English version and a telephonic interpreter if needed. • A referral to an appropriate mental health provider is recommended if a respondent's overall score on the 15-item measure is greater than or equal to 12, or if the distress thermometer is greater than or equal to 5.

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GUIDANCE FOR PRIMARY CARE

The American Academy of Family Physicians (AAFP) summarizes the components practices should have in place when caring for refugees.

Refugee Health Checklist for Comprehensive Primary Care	
Clinician knowledge of refugee health conditions (at least one practice champion)	Established collaboration with Department of Public Health and VOLAG (voluntary agencies that work with the U.S. State Department to provide reception and placement services for refugees)
Established partnerships with and access to local resources, especially behavioral health, dental, and vision services	Links to social service organizations (e.g., medico-legal, housing, etc.)
Interpreter services	Administrative support for flexible scheduling
Staff buy-in	Access to labs and radiology
Staff cultural competency training	Familiarity with RHS-15
Vaccine supply chain	Access to mental and behavioral health services

Source: AAFP

Tips for the Initial Visit

- Utilize the conceptual framework of **cultural humility**: a set of practices that deter from the idea that there is a set of specific guidelines for understanding culture (which can lead to stereotyping) and reflects instead fluid changes in the provider's own self-awareness, attitudes, and behavior towards diverse populations and more culturally effective relationships with families.
- Evaluate the current problem and assess the patient and family's understanding and beliefs about the described health concerns.
  - Consider that the concepts of health promotion and preventative medicine may be new to the family.
- Consider variables that might interfere with providing appropriate medical care (e.g., compromised trust, fear, conceptualization of disease/pain, language proficiency of the help-seeking family)

Factors for PCPs to Consider When Caring for Immigrant Children		
Individual	**Family**	**Society**
Individual health (infectious, congenital, etc.)	Intergenerational conflict	Poverty
Nutrition and obesity	Acculturation	Health disparities
Oral health	Linguistic isolation	Language barriers
School readiness	Parental education	Educational opportunity
Mental health	Immigration status	Immigration policy
Medications (home country, alternative therapies)	Traditional parenting practices	Transportation (access, driver's license)
Fear of parental deportation	Deportation	Unemployment
Abuse	Domestic violence	Fear and stigma
Health insurance status	Mobility or migration	Health policy
Federal benefit eligibility	Food or housing insecurity	Federal benefit eligibility

Source: Sisk B, Green A, Chan K, Yun K. Caring for Children in Immigrant Families: Are United States Pediatricians Prepared? Acad Pediatr. 2020 Apr;20(3):391-398. doi: 10.1016/j.acap.2019.11.015. Epub 2019 Nov 30. PMID: 31790799.

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Assessing English Proficiency
The following questions can be asked to quickly assess language proficiency at the initial visit: 1. Does this person speak a language other than English at home? ☐ Yes ☐ No ← *stop here; person is considered English proficient* 2. What is the language? _____ 3. How well does this person speak English? ☐ Very Well ☐ Well ☐ Not Well ☐ Not At All
Guideline: Person has LEP (limited English proficiency) if reply is anything other than "very well", and therefore requires medical interpreter or bilingual provider. Detailed information on improving language access in health care is available in the *Office of Minority Health's A Patient-Centered Guide to Implementing Language Access Services in Healthcare Organizations* (2005).

Source: Shetgiri, Geltman, & Flores, 2019

Migration History Template

The below template can provide an outline to guide the conversation regarding a family's migration history. This key component of the social history can be difficult to approach if not completed in the first meeting.

The National Immigrant Law Center recommends that a patient's immigration status not be documented in the medical record.

Location of birth:	
# of years in the U.S.:	
Preferred language:	
Country of birth:	
Path to U.S.: (additional countries inhabited prior to U.S. immigration as needed to guide public health decision making)	
Location lived in during migration: (e.g., refugee camp, urban settlement, w/ family or friends, own apartment, etc.)	
# of years of migration:	
School attendance during migration:	
Health care access during migration:	
Overseas presumptive treatment? (International Organization for Migration/CDC)	☐ YES ☐ NO If yes, which types:
Location of first residence in U.S.:	
Public health screening location:	
Members of family who traveled during migration:	

Source: embedded Epic note @ see.regimmigrantvisitnote

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Mental Health Evaluation

- Immigrant children are at higher risk for not being screened for behavioral and developmental disorders (and waiting longer for referrals to specialists).
- Depression and PTSD are fairly common among newly arriving immigrant and refugee youth.
- Assessment and evaluation for mental health needs is critical; however, it is also important to not assume that all immigrant children will develop psychiatric disorders.

CDC Recommended Action Plans Based on Patient's Mental Health Symptoms		
Symptom Severity	**Characteristics**	**Recommendations for Physicians**
Chronic/serious or acute mental illness	Psychotic break, severe functional limitations, suicidal or homicidal ideation	Identify potentially unstable patients; refer immediately for psychiatric evaluation; consider inpatient behavioral health services
Less acute mental illness or symptoms	Decreased interest in usual activities, difficulties with sleeping and concentration, irritability	Screen to identify those not previously diagnosed with mental illness; establish ongoing care with primary care physician; ensure that mental health resources are available if necessary
No identified mental illness	Demonstrate resilience when discussing past trauma; may have some transient symptoms	Coordinate care with local resettlement agencies; if treatment is available, screen for depression and posttraumatic stress disorder

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Provider Resources

- AAP Immigrant Child Health Toolkit (aap.org): practice management tool to help clinicians learn more about providing culturally effective care to their immigrant patients and families
  - AAP Policy Statement: Providing Care for Immigrant, Migrant, and Border Children (aap.org)
  - How to Identify, Understand, and Unlearn Implicit Bias in Patient Care (aafp.org)
- DSM-5 Cultural Formation Interview (apa.org): interview tool that asks questions about cultural identity, explanations of illness, and queries for cultural factors related to psychosocial environment and level of functioning
  - Online training is available for providers at: nyculturalcompetence.org/
- CDC Refugee Health Profiles: These country-specific profiles include specific interventions for specific groups being resettled in the United States. Each profile consists of six components: priority health conditions, background, population movements, healthcare and nutrition in camps/urban settings, medical screening of U.S.-bound refugees, and general health information.
- EthnoMed: offers information about cultural beliefs, medical issues, and other topics relevant to the health care of U.S. immigrants, including refugees fleeing war-torn parts of the world
- Evidence-Based Preventative Care Checklist for New Immigrants and Refugees: eLearning knowledge translation tool, based upon immigrant's region-of-origin, designed for primary care physicians to help integrate the Canadian Immigrant Health Guidelines into practice
- Office of Refugee Resettlement: offers general information about refugee health
- North American Society of Refugee Healthcare Providers

Virginia-Specific Resources

Virginia DSS Office of New Americans: dss.virginia.gov/family/ons/index.cgi

Virginia's Resettlement Agencies

- Catholic Charities Diocese of Arlington — Migration and Refugee Services
- Church World Service
- Commonwealth Catholic Charities
- Ethiopian Community Development Council
- International Rescue Committee (Charlottesville)
- International Rescue Committee (Richmond)
- Lutheran Social Services

Unaccompanied Refugee Minor Foster Care Programs

- Commonwealth Catholic Charities — Richmond
- Lutheran Social Services — Fairfax
- Office of Refugee Resettlement URM Program Overview

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4.5 Children and Youth with Autism Spectrum Disorder

SURVEILLANCE: Signs of AUTISM are present

deficits in social communication and interaction, along with presence of rigid and restrictive interests and behaviors

SEE CHECKLIST BELOW

AGE OF CHILD

TODDLERS & PRESCHOOLERS

For ages 16-30 months: M-CHAT-R/F (Modified Checklist of Autism in Toddler, Revised, with Follow-up)
mchatscreen.com/

PRE-K & SCHOOL-AGED

For >30 months there are no validated screening tools. Consider the following questionnaires which may help determine which children need full assessment.

Ages 4-11 yrs: CAST (Childhood Autism Spectrum Test)

Ages 12-15 yrs: AQ (Autism Quotient)

FAIL SCREENER OR PROVIDER CONCERN?
"Act Now" interventions are available even before formal diagnosis

ACT NOW INTERVENTIONS	
Birth to 3 yrs	Infant & Toddler Connection of VA often offers SLP, OT, and/or PT in-home visits
>2 yrs through teen	Parents can contact their public school district to request an evaluation and to determine eligibility for special education services.
Focused interventions for ALL AGES	• **Speech/language deficits:** consider referral to speech/language therapist • **Motor deficits:** consider referral to physical therapist • **Adaptive or sensory processing deficits:** consider referral to occupational therapist • **Social skills deficits:** consider social skills groups or speech/language therapist • **Maladaptive behavior affecting function:** (e.g., severe tantrums) consider referral to psychologist, psychiatrist, developmental pediatrician, or behavioral specialist

FIRST: question underlying medical issues (e.g., constipation, GERD, otitis media, dental concerns, seizures, headaches, fractures)

Some Signs That Indicate a Child Should Be Screened for ASD

DOMAIN	SIGNS AND SYMPTOMS COMMONLY NOTED BY CAREGIVERS		
Social Differences	• Doesn't smile when smiled at • Has poor eye contact • Seems to prefer to play alone • Gets things for him/herself only	• Is very independent for age • Seems to be in "own world" • Seems to tune people out • Is not interested in other children	• Doesn't point out interesting objects by 14 months of age • Doesn't like to play "peek-a-boo" • Doesn't try to attract his/her parent's attention
Communication Differences	• Does not respond to his/her name by 12 months • Cannot explain what he/she wants • Doesn't follow directions	• Seems to hear sometimes, but not other times • Doesn't point or wave "bye-bye" • Used to say a few words or babble, but now does not	
Behavioral Differences	• Gets "stuck" doing the same things over and over and can't move on to other things • Shows unusual attachments to toys, objects, or routines (e.g., always holding a string or having to put on socks before pants) • Spends a lot of time lining things up or putting things in a certain order • Repeats words or phrases over and over		

Source: National Institutes of Health, nichd.nih.gov/health/topics/autism/conditioninfo/symptoms

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REFER: TO AUTISM SPECIALISTS

- Individual clinician (developmental pediatrician, child neurologist, child psychiatrist, or child psychologist)

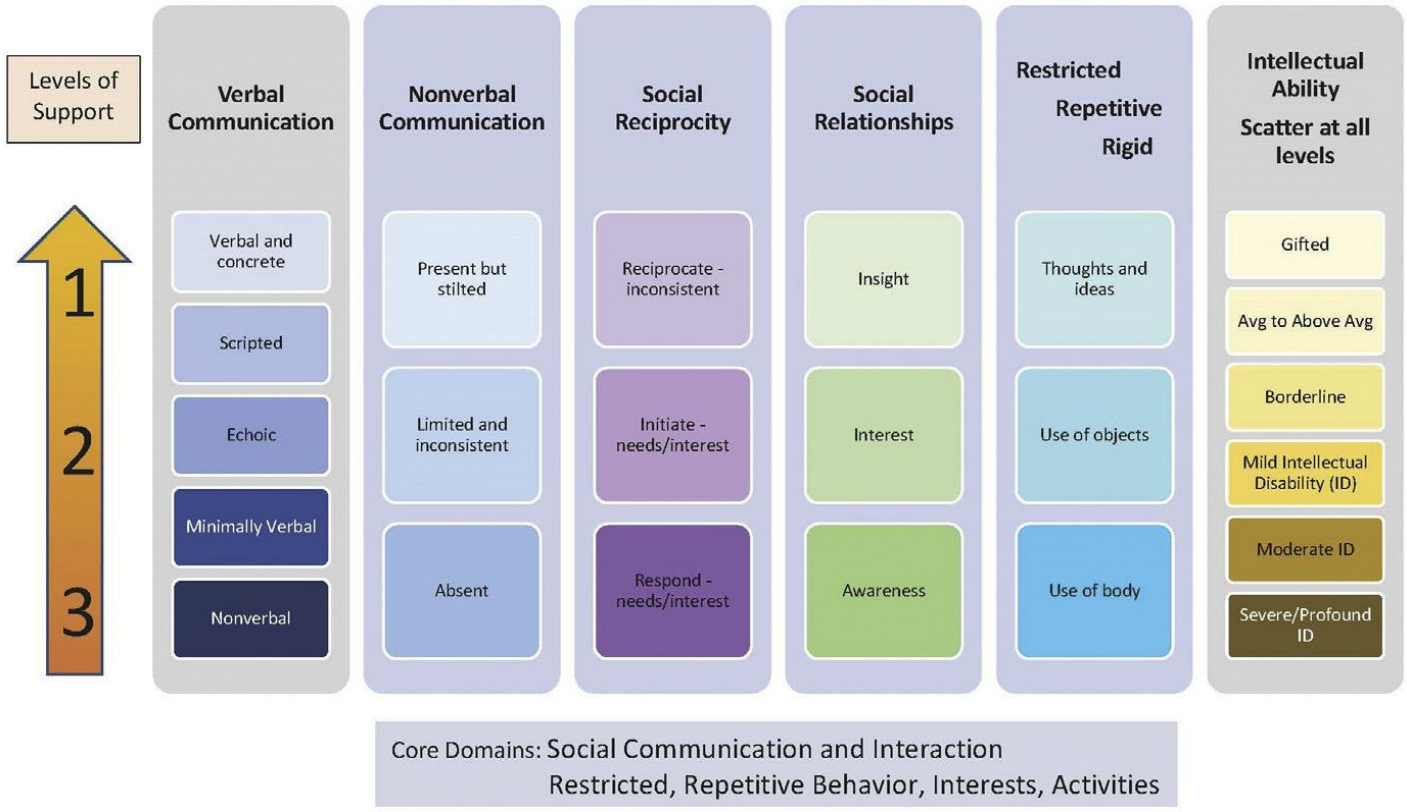
  OR

- Multi-disciplinary diagnostic autism team
  - Call VMAP for care navigation support
  - See UVA Autism Drive (autismdrive.virginia.edu) for resources

Referral considerations: with or without…

- Intellectual impairment
- Language impairment
- Syndromic features (such as Fragile X, Down Syndrome)

AUTISM SPECTRUM PHENOTYPE MATRIX



Courtesy of C.E. Rice, PhD, Atlanta, GA

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AFTER DIAGNOSIS

1. **Provide psychoeducation and caregiver support**
2. **REFER FOR: Autism-specific evidence-based interventions** (in addition to the "Act Now" interventions listed on the first page of this module)
   - Early Intensive Behavioral Interventions (EIBI) — e.g., ABA therapy
   - Naturalistic Developmental Behavioral Interventions (NDBI) — e.g., Early Start Denver
3. **Monitor for challenging behaviors and co-occurring disorders/conditions**
   - Severe disruptive behavior/tantrums (aggression, unsafe, elopement)
   - Medical issues (constipation, dental problems, seizures, food allergies, GERD, sensory)
   - Sleep disorders
   - Psychological disorders (ADHD, anxiety, depression)
   - Neurodevelopmental disorders (cognitive impairment, language impairment, tics)
   - Hearing or vision impairment
   - Feeding disorders (ARFID)
   - Genetic condition or CMA mutation (genetics referral for new diagnosis of ASD is recommended)
4. **Medications**

   There are no medications to treat the core features of ASD. Medications may be used to treat the co-occurring behaviors or mental health disorders. See **Medication Guidance** in this module for full details.

Disorders and Conditions that Commonly Co-Occur with ASD

CATEGORY	CO-OCCURRING DISORDER OR CONDITION
Neurodevelopmental disorders	• Intellectual disability • Language disorder • Attention-Deficit/Hyperactivity Disorder (ADHD) • Motor disorders
Psychological disorders	• Obsessive-Compulsive and Related Disorders (OCRD) • Anxiety disorders (including social phobia and specific fears or phobias) • Depressive disorders • Trauma- and stressor-related disorders
Medical conditions	• Epilepsy • Sleep disorders • Constipation or other digestive disorders
Other conditions	• Hyperactivity • Obsessive-compulsive behaviors • Self-injury • Aggression • Stereotypies (repetitive or ritualistic movements, postures, or utterances), tics, and affective symptoms • Extreme and limited food preferences

Source: Virginia Commission on Youth's Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs — 8th Edition, 2021.

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SCREENING TOOLS

For ages 16-30 months: M-CHAT-R/F

(Modified Checklist of Autism in Toddlers, Revised, with Follow-Up™)

mchatscreen.com/

SCORING: For most items, YES is a typical response, and NO is an at-risk response. HOWEVER, items 2, 5, and 12 are reverse scored, meaning that NO is a typical response and YES is an at-risk response. To score the M-CHAT-R/F, add up the number of at-risk responses, and follow the algorithm below:

- **Total Score 0-2:** The score is LOW risk. No follow-up needed. Child has screened negative. Rescreen at 24 months if the child is younger than 2 years old (or after 3 months has elapsed) and refer as needed if developmental surveillance or other tools suggest risk for ASD.
- **Total Score 3-7:** The score is MODERATE risk. Administer the M-CHAT-R/F Follow-Up items that correspond to the at-risk responses. Only those items which were scored at risk need to be completed. If 2 or more items continue to be at-risk, refer the child immediately for (a) early intervention and (b) diagnostic evaluation.
- **Total Score: 8-20**: The score is HIGH risk. It is not necessary to complete the M-CHAT-R/F Follow-Up at this time. Bypass Follow-Up, and refer immediately for (a) early intervention and (b) diagnostic evaluation.

For children older than 30 months, there are no validated screening tools available or recommended by the AAP.

PEARL: Many providers use MCHAT-R/F for any age child who is non-speaking after a hearing assessment has been completed. Also, consider the following which may help with deciding on which children need more definitive evaluation.

For ages 4-11 years: CAST (Childhood Autism Spectrum Test)

autismresearchcentre.com/tests/childhood-autism-spectrum-test-cast/

SCORING: A scoring key is included on the website. Autism relevant responses are underlined and score '1.' Maximum score possible is 31, cut-off currently is 15 for possible autism or related social-communication difficulties. Questions that are not underlined are controls.

For ages 12-15 years: AQ (Autism Quotient)

autismresearchcentre.com/tests/autism-spectrum-quotient-10-items-aq-10-adolescent/

SCORING: Only 1 point can be scored for each question. Score 1 point for Definitely or Slightly Agree on each of items 1, 5, 8, and 10. Score 1 point for Definitely or Slightly Disagree on each of items 2, 3, 4, 6, 7, and 9. If the individual scores 6 or above, consider referring them for a specialist diagnostic assessment.

PEARL: Often, clinical psychologist is best professional to assess school-age child or youth.

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PROVIDER TIPS & CLINICAL PEARLS

Evaluating challenging behaviors in children with autism spectrum disorders

1. **Consider the ABCs**

   Antecedent: what happens *before* the behavior?

   Behavior: frequency, intensity, duration, settings, situations

   Consequence: what happens *after* the behavior?

2. **Safety first!**
   - Aggression towards others
   - Self-injurious behaviors
   - Wandering/elopement
   - Pica

3. **Medical etiology?**
   - Constipation
   - Dental concerns
   - Headaches/sinus discomfort
   - Otitis media
   - Seizures
   - Fractures
   - Eczema

4. **Sleep problems** (most often behavioral sleep association problem), **feeding challenges** (including nutritional deficiencies such as iron or vitamin-D)

5. **Psychosocial circumstances** (transitions between activities, adjustment to new caregivers or teachers or environments)

6. **Co-occurring mental health conditions** (anxiety, depression, ADHD)

Stepwise checklist before starting a medication

☐ Rule out medical causes

☐ Evaluate sleep (behavioral insomnia is more common than sleep-disordered breathing)

☐ Evaluate caregiver stress

☐ Behavioral specialist evaluation at home and school to understand the ABCs

☐ Evaluate for co-occurring mental health or behavioral condition (e.g., ADHD)

Medication

(see AACAP Autism Spectrum Disorder: Parents' Medication Guide)

1. Have visual strategies and therapy been optimized?
2. Address aggression
   - Irritability and Problem Behavior in Autism Spectrum Disorder: A Practice Pathway for Pediatric Primary Care, 2016
3. Manage sleep
   - Practice guideline: Treatment for insomnia and disrupted sleep behavior in children and adolescents with autism spectrum disorder: Report of the Guideline Development, Dissemination, and Implementation Subcommittee of the American Academy of Neurology, 2020
4. Look for and treat mood/irritability
5. Then, look for and treat anxiety/depression
   - Assessment and Treatment of Anxiety in Youth With Autism Spectrum Disorders, 2016
6. Then, if impairing symptoms include impulsivity and hyperactivity, consider ADHD
   - AACAP ADHD in Youth with ASD: Parents' Medication Guide

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Consider medical evaluation every 6-12 months

- Check hearing and vision. Check on dental status.
- Assure routine medical care, health supervision, immunizations.
- Consider evaluation for seizures based on symptoms, decline in functioning, or co-occurring GDD/ID.
- Genetic evaluation completed (chromosomal microarray analysis, Fragile X analysis).
- Monitor closely for other treatable medical problems which can exacerbate behavior problems (e.g., constipation, headaches, dental caries, otitis media, sleep problems, feeding problems, wandering, pica, eczema).
- Consider co-occurring mental health conditions (ADHD, anxiety, depression).

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EVIDENCE-BASED THERAPEUTIC INTERVENTIONS

Overarching goals

1. **Minimize core deficits** in social communication and interaction, and restrictive or repetitive behaviors and interests
2. **Facilitate learning** and acquisition of adaptive skills to maximize functional independence
3. **Eliminate, minimize, or prevent problem behaviors** that may interfere with functional skills

Guiding principles

1. Intervention should **start as early** as possible, beginning even before formal diagnosis, in toddlerhood or infancy
2. Intervention should be **intensive** (25-40 hours per week for over a year or longer)
3. Intervention should be **comprehensive** (target broader development rather than specific skills)

What Works: Established Interventions	
Established Interventions have sufficient evidence to be recommended as first-line treatments for autism. They are effective, are expected to provide positive long-term outcomes, and they do not cause harm.	
Applied behavior analysis (ABA)	Uses principles of learning theory to bring about meaningful and positive change in behavior, build a variety of skills (e.g., communication, social skills, self-control, and self-monitoring), and help generalize these skills to other situations. Also known as early intensive behavioral intervention and comprehensive behavioral treatment for young children (CBTYC).
Positive behavioral interventions	Behavioral interventions analyze the cause of a negative behavior and how it is being reinforced, and then offer techniques targeted to promoting positive behaviors.
Discrete trial teaching or training (DTT)	A behavioral intervention that uses operant learning techniques to change behavior. Also known as the ABC model (action request, behavior, consequence).
Cognitive behavioral intervention package	CBT modified for ASD youth.
Language training	Targets the ability to communicate verbally.
Modeling	Involves demonstrating a target behavior to encourage imitation.
Naturalistic teaching strategies (NTS)	Child-directed strategies that use naturally occurring activities to increase adaptive skills.
Parent training package	Involves training parents to act as therapists.
Peer training package	Involves training peers on how to behave during social interactions with a youth with ASD.
Learning experience: An alternative program (LEAP)	A type of peer training program for peers, teachers, parents, and others.
Pivotal response training (PRI)	Involves targeting pivotal behaviors related to motivation to engage in social communication, self-initiation, self-management, and responsiveness to multiple cues.
Schedules	Used to increase independence for youth with ASD.
Scripting	Provides scripted language to be used as a model in specific situations.
Self-management	Strategies that involve teaching youth to track performance while completing an activity.
Social skills package	Aims to provide youth with the skills (such as making eye contact appropriately) necessary to participate in social environments.
Story-based intervention	Uses stories to increase perspective-taking skills.

Source: Virginia Commission on Youth's Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs — 8th Edition, 2021.

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What Seems to Work: Emerging Interventions	
Emerging Interventions are not generally recommended as first-line treatments for autism, but they are considered promising and warrant serious consideration if Established Interventions were unsuccessful.	
Augmentative and alternative communication devices	Communication systems designed to complement speech (pictures, symbols, communication boards, or other assistive technology, like tablets, text-to-speech programs, etc.).
Developmental relationship-based treatment	Programs that emphasize the importance of building social relationships by using the principals of developmental theory.
Exercise	Uses physical exertion to regulate behavior and help with social, communication, and motor skills.
Exposure package	Involves gradually exposing youth to the non-dangerous situations that they fear, with a focus on having them learn that their anxiety will decrease over time. At the same time the use of maladaptive strategies used in the past is prevented.
Functional communication training	Behavioral method that replaces disruptive or inappropriate behavior with more appropriate and effective communication.
Imitation-based intervention	Relies on adults imitating the actions of a child.
Initiation training	Involves directly teaching individuals with ASD to initiate interactions with their peers.
Language training (production and understanding)	Aims to increase both speech production and understanding of communicative acts.
Massage therapy	Involves the provision of deep tissue stimulation.
Multi-component package	Involves a combination of multiple treatment procedures that are derived from different fields of interest or different theoretical orientations.
Music therapy	Aims to teach individual skills or goals through music.
Picture exchange communication system	Involves the application of a specific augmentative and alternative communication system designed to teach functional communication to youth with limited communication skills.
Reductive package	Relies on strategies designed to reduce problem behaviors without increasing alternative appropriate behaviors.
Sign language instruction	Teaches sign language as a means of communicating.
Social communication intervention	Targets some combination of social communication impairments.
Structured teaching	Relies heavily on the physical organization of setting, predictable schedules, and individualized use of teaching methods.
Technology-based intervention	Presents instructional materials using the medium of computers or related technologies.
Theory of mind training	Aims to teach youth to recognize and identify the mental states of others.

Source: Virginia Commission on Youth's Collection of Evidence-based Practices for Children and Adolescents with Mental Health Treatment Needs — 8th Edition, 2021.

QUESTIONS ABOUT UNESTABLISHED INTERVENTIONS?

- National Center for Complementary and Integrative Health: nccih.nih.gov
- Virginia Commision on Youth's Collection of Evidence-based Practices: vcoy.virginia.gov/collection

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MEDICATION GUIDANCE

There are no medications that improve the core features of autism at this time. Medications are used to treat co-occurring symptoms or disorders.

Guiding principles

- Start low go slow (start at ½ the typical dose, short acting, once a day) and titrate slowly, until benefit or side effect.
- Often need liquids or patches if child cannot swallow pill.
- Consider VMAP consultation.

Evidence-based medication	Guided by cluster of behavioral or target symptoms	Starting dose usually ½ or initial dose	Common side effects more common
Stimulant: Methylphenidates (try first for ADHD)	IMP, HA>INATT, DISTR (inatt is often a core autism symptom, so focus on degree of impulsivity)	2.5-5mg IR after breakfast Find liquid if needed	Decreased appetite, sleep problems, emotional outbursts
Stimulant: Amphetamine salts	IMP, HA>INATT, DISTR (inatt is often a core autism symptom, so focus on degree of impulsivity)	2.5mg IR	Decreased appetite, sleep problems, emotional outbursts
Alpha-agonists	Above, and/or hyperarousal, history of trauma very young child, tics, sleep onset latency	Guanfacine 0.5mg am/pm (first line because it has less sedation than clonidine) Then move to clonidine	Drowsiness, hypotension if on larger dose, constipation. Can cause irritability.
SSRI/SSNRI: escitalopram, fluoxetine, sertraline	Anxiety/depression, ARFID, self-injury	Find liquid if needed ½ starting doses	GI problems, behavioral activation, headaches, sedation or insomnia, BOX warning
Antipsychotic: risperidone (RUPP study), aripiprazole	Aggression, irritability, self-injury	0.25-0.5mg daily	Sleepiness, increased appetite, weight gain

Source: jaacap.org/article/S0890-8567(13)00819-8/pdf

Note: all medication information should be verified using current PDR

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RESOURCES FOR FAMILIES

Autism Speaks Tool Kits include the following:

AutismSpeaks.org

- Strategies to Improve Sleep in Children with Autism
- Pica (eating non-food) Guide for Professionals
- Guide to Managing Constipation in Children with Autism
- Dental Tool Kit
- Guide to Individualized Education Programs (IEP)
- Getting Started with ABA: Asking the Right Questions
- A Friend's Guide to Autism
- A Grandparent's Guide to Autism
- A Parent's Guide to Autism
- A Sibling's Guide to Autism
- Haircutting Training Guide
- Medication Decision Aid

Sensory Processing

- AutismSpeaks.org/sensory-issues

Early Signs of Social Communication Delays

- Firstwordsproject.com
- Firstsigns.org

Early Intervention

- Infant and Toddler Connection of Virginia (itcva.online)
- Navigating Autism: Early Childhood and Beyond (autismdrive.virginia.edu)

Early Parenting Strategies for Development

- Vroom.org
- For video recordings about parent-led ABA: bmc.org/pediatrics-autism-program/parent-training-everyday-aba

School-age Resources

- Virginia Department of Education: Special Education (doe.virginia.gov/programs-services/special-education/specific-disabilities/autism)
- Understood.org
- Lifespan Roadmap for Autism (autismdrive.virginia.edu)

4.6 Children Experiencing Grief

IDENTIFYING LOSS EXPERIENCES in children:
use discussion of loss or death (i.e., death of a pet) to identify risk factors

SAFETY CONCERNS? ADDRESS FIRST
self-harm, SI, access to violent means, concern of harm to self or others

INITIATE THE CONVERSATION

Step 1: Acknowledge loss; express your concern and sympathy; pause and allow for emotional response.
Step 2: Invite discussion: "How are you doing?" "How is your family doing?" Limit sharing own grief experiences.
Step 3: Reassure children/youth of their lack of responsibility related to the death.
Step 4: Identify coping strategies and supports

HOW TO SUPPORT THE GRIEVING CHILD OR ADOLESCENT
see "Grief by Developmental Stage" in this module for specific coping recommendations

- Suggest active participation by the child in the funeral, if applicable
- Maintain routines, including play dates, ballgames, school attendance as much as possible
- Assess and address feelings of guilt
- Address need for social support (including interacting with other bereaved children – groups, camps, etc.)
- Suggest books to read on death and coping, by developmental age
- Address secondary stressors and losses (e.g., school absence, impact on parental stress)
- Provide psychoeducation to caregivers (e.g., grief is not a linear process, reactivation of grief reaction may occur at different developmental stages, etc.)

Typical Grief

Follow-up, PRN

- Assess for risk factors for complicated grief*; offer preventive intervention and monitor, if concerns
- Assess coping strategies and supports
- Provide general info on bereavement, resources

Complicated Grief

Care centered on grieving

- Therapeutic intervention
- Refer for EBI (psychotherapy, support group, family therapy, etc.)
- Close monitoring of child and caregivers

When Grief Triggers a Psychiatric Disorder

Specific care for disorder

- Care appropriate to the psychiatric disorder, psychotherapy/ psychotropic medication if needed
- Traumatic grief can present as PTSD
- Close monitoring

RISK FACTORS FOR COMPLICATED GRIEF		
Situations	• An unexpected or violent death • Death of a child • Close relationship to the deceased person • Social isolation or loss of a support system	• History of depression, separation anxiety, and/or PTSD • Traumatic childhood experiences • Other major life stressors
Symptoms	• Have trouble carrying out normal routines • Isolate from others and withdraw from social activities • Experience depression, deep sadness, guilt or self-blame	• Believe they did something wrong or could have prevented the death • Feel life isn't worth living without loved one • Wish they had died along with loved one

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By age 18 …

- 90-95% of children experience the death of a loved one
- 5% of children experience the death of a parent

UNDERSTANDING GRIEF

	WHAT IT LOOKS LIKE …	HOW LONG IT LASTS …
Anticipatory Grief	Mourning loss of health in a loved one; worry about what life will be like without that person	For years depending on the health status of the loved one
Bereavement	The experience of losing someone important	Often overlaps with grief
Grief *(typical grief)*	• Internal manifestation of a loss (e.g., sadness, loneliness, crying, insomnia, lack of self-care, yearning) • A process of adjustment to the loss, enabling social and affective investment while preserving a connection to the deceased person	Frequently lasts up to one year
Mourning	Personal or public way to grieve (e.g., funerals, wakes, anniversary)	Months to years
Complicated Grief	• Abnormally long, protracted, disabling grief • A grieving process that differs from the norm due to intensity or duration of symptoms and functional interference	Can last for years
Traumatic Grief	When the cause of loss is experienced as horrifying or terrifying and may result in PTSD (e.g., motor vehicle accident, gun violence, war, natural causes)	Can last a lifetime

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GRIEF BY DEVELOPMENTAL AGE: WHAT TO EXPECT & HOW TO SUPPORT

	Understanding of death	Expression of grief	How caregivers can help
Infancy	• No comprehension of death.	• Irritability • Sleep/feeding difficulties connected to routine changes, alterations in parent behaviors	• Maintain routines • Avoid separation • Provide extra attention to comfort the child
Preschool (ages 2-4)	• Lack understanding, but experience loss • Unable to process permanence; seen as reversible – a prolonged absence	• Regression to earlier behaviors like thumb-sucking and bedwetting • Sleep problems • Irritability • Confusion	• Use simple, clear language • Explain loved one has died ("their body stopped working"); "that means we will no longer be able to see them" • There will likely be repeated questions
Kindergarten (ages 5-6)	• May still see death as reversible. • Lots of concrete questions: How did he die? What will happen to him now?	• Nightmares; changes in sleeping/eating • Regression to earlier behaviors • Violent play; role-playing the deceased • Fear that something might happen to people close; separation anxiety	• Encourage expression of the child's feelings through creative tools (play, drawing, story-telling) • Encourage talking about the deceased • Read appropriate books together
Elementary to Early Middle School (ages 7-12)	• A natural, universal phenomenon • Philosophical, religious questions • Specific questions; a desire for detail • Concern for understanding the "right" way to respond, understand/recognize mourning in others	• May fixate on why someone died • Regression, school problems, withdrawal from friends, acting out • Changes in eating and sleeping habits • Somatic symptoms • Thoughts about own safety and death	• Encourage expression of feeling • Explain/offer choices around services • Encourage physical outlets; teams, play • Don't avoid talking about death or answering questions
Late Middle to High School (ages 12-18)	• Clear perception of death • Existential questioning • Abstract reasoning about death	• Possible denial or deferment of grief • Sadness, depression • Anxiety, anger, withdrawal • Risk-prone behaviors • Protective attitudes towards the family • Fear of crying in front of peers	• Encourage them to talk • Utilize support systems in addition to parents (peers, teachers, coaches) • Allow them to mourn, grieve in own way
Adult	• Irreversibility • Finality • Inevitability • Causality	• Understands that all death is permanent, all functioning stops with death, death is universal for all living things, and the cause of death is unknown	• Seek support for children in family who need care or babysitting

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EVIDENCE-BASED INTERVENTIONS

Parents, teachers, and other social supports play a vital role in supporting bereaved children and adolescents. Most bereaved youth will not require intervention for their grief, and most families will not seek formal therapy.

TREATMENT MODALITY	WHO IS IT FOR?	FOCUS OF TREATMENT
Cognitive Behavioral Therapy (CBT)	All ages	CBT and narrative therapy facilitate the development of an in-depth, coherent narrative while eliciting the child's thoughts and feelings, development of positive coping strategies, and making meaning of losses.
Resilient Parenting for Bereaved Families	Broad age range For caregivers of children who have lost a parent	For parents/caregivers of children who have experienced death of a parent. Designed to provide tools to help navigate parenting a grieving child while also grieving. 10 half-hour sessions; self-paced. Available online at bereavedparenting.org.
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	Ages 3-21 and caregivers For children with PTSD, or other problems related to traumatic life experiences	Recognizes that children need to process their grief. Children learn to manage their trauma reactions, write or record "trauma narratives" that help them become desensitized to the traumatic events, and learn skills to help them move forward. Find a provider/learn more at tfcbt.org.
Multidimensional Grief Therapy	Ages 6-16	Recognizes that youth can experience grief reactions in any or all of three domains: separation distress, existential or identity distress, and circumstance-related distress. Learn more at tagcenter.org.
Grief and Trauma Intervention (GTI) for children	Ages 7-12 For those who have witnessed/been victims of violence or a disaster	Goal is to improve symptoms of posttraumatic stress, depression, and traumatic grief. Grounded in CBT and narrative therapy and includes narrative exposure to the trauma (through drawing, discussing, and writing), development of positive coping strategies, and making meaning of losses.
Trauma and Grief Component Therapy for Adolescents (TGCTA)	Ages 12-20 For trauma-exposed or traumatically bereaved youth	Designed to address the complex needs of older children and adolescents contending with trauma, bereavement, traumatic bereavement. Goals include to reduce distress, risky behavior, improve functioning, and promote adaptive developmental progression. Learn more at tgtca.com.

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FREQUENTLY ASKED QUESTIONS

What to advise about attending a funeral or memorial service?

Most children and adults benefit from attending a funeral. Of course, it is up to the individual caregivers.

- Explore caregiver rationale and understanding if one option will work better than another.
- Assign a friend or adult to be with child and be able to leave if needed.
- Caregivers should review the process of the funeral and burial and determine, in advance, scope of exposure (e.g., viewing, casket, burial, grieving adults).

Toolkit: Children and End of Life Memorials and Rituals (nacg.org)

Scripts for discussing with children: good-grief.org

What should I know about specific religious and/or cultural practices?

The experience of grief is universal, and families from different cultures and religious backgrounds may follow specific traditions, rituals, and practices after a death. Rather than attempting to gain knowledge about every culture, what often works best is to simply be present, express your concern, and remain available to provide assistance.

1. *Ask questions.* "Can you help me understand how I can best be of help to you and your family?"
2. *Watch out for assumptions.* Even if you know about the common practices of a culture, this may not accurately predict how a family or individual from that culture will behave.
3. *Be present and authentic.* Even if you don't know about a particular culture's practices concerning death and grief, you can approach the family with an open mind and heart. Be guided by their responses.

Adapted from grievingstudents.org/module-section/cultural-sensitivity/

What can families suggest the school do to support children and youth who are grieving?

During times of grief, children may experience impacts on their time at school or their ability to do schoolwork. Some general tips that educators and school staff can consider to help students feel supported during this time include:

1. Help students return to a normal routine as soon as possible.
2. Watch for signs that a child might be struggling and need extra help.
3. Stay in touch with the caregivers in the days and weeks after the death has occurred.

School accommodations that might be helpful for the grieving child include:

- modify testing, assignments, academic expectations
- review and modify grief and/or trauma sensitive curricula as necessary (consult with parents, guidance counselor)
- be sensitive to events in their environment that may trigger reminders such as trauma, loss, or change
- support consistent school and extracurricular routines (may need alternate transport, etc)

The Coalition to Support Grieving Students (grievingstudents.org/) offers free professional resources specifically for educators and school personnel.

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PROVIDER RESOURCES

- AAP Clinical Report: Supporting the Grieving Child and Family. Committee on Psychosocial Aspects of Child and Family (2016)
- Dougy Center Grief Support and Resources: (dougy.org/grief-support-resources)
  A wide range of resources organized by age and situation to help with grief before and after a death.
- New York Life Foundation Bereavement Resources: (newyorklife.com/foundation/bereavement-support)
  Dedicated online resources for bereaved families and providers who support them, including bereavement around COVID-19.
- National Alliance for Children's Grief: (nacg.org/)
  Toolkits, community resources, and resource library created specifically to support children who are grieving.

SUPPORTING GRIEVING CHILDREN AND YOUTH THROUGH SPECIAL CIRCUMSTANCES

Death by suicide	• NACG Toolkit: Supporting Children Grieving A Death by Suicide (nacg.org)
Substance use related death	• NACG Toolkit: Supporting Children Grieving a Substance-Use Related Death (nacg.org) • Eluna Resource Center: elunanetwork.org/resources/
Death of parent	• *Samantha Jane's Missing Smile: A Story About Coping With the Loss of a Parent*, by Donna Pincus • NACG Toolkit: Grandparents Raising Grandchildren (nacg.org)
Perinatal sibling	• Siblings' Grief After a Pregnancy Loss (prismahealth.org)
Sibling death	• Sibling Death and Childhood Traumatic Grief (ncstn.org)
Helping children through the holidays	• NACG Holiday Toolkit: Supporting Children who are Grieving During the Season of Family (nacg.org)
Child is dying	• Child: Discussing Death with Children (stanfordchildrens.org) • For Parents: Important Decisions to Be Made in the Dying Process (stanfordchildrens.org) • Family: Supporting the Family After the Death of a Child (aap.org) • Clinician: The Physician's Role When a Child Dies Discussion Guide.pdf (aap.org)
Youth in foster care	• LYGHT Resources for Youth in Foster Care (dougy.org)
Military	• Traumatic Grief for Military Children: Information for Families (ncstn.org) • Honoring Our Babies and Toddlers: Supporting Young Children Affected by a Military Parent's Deployment, Injury, or Death (zerotothree.org) • sesamestreetformilitaryfamilies.org
General disaster or traumatic event	• After a Crisis: Helping Young Children Heal (ncstn.org) • Age-Related Reactions to a Traumatic Event (ncstn.org) • Promoting Adjustment and Helping Children Cope (aap.org)

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BIBLIOTHERAPY FOR FAMILIES

From the American Academy of Pediatrics (HealthyChildren.org)

- Five Ways to Help Your Child Remember and Celebrate Loved Ones
- How Children Understand Death & What You Should Say
- Childhood Grief: When to Seek Additional Help

Resources by Age Group

Young Children	• Video series by the Sesame Workshop Group on Childhood Grief sesameworkshop.org/resources/helping-kids-grieve/ • Helping Young Children with Traumatic Grief: Tips for Caregivers nctsn.org/resources/helping-young-children-traumatic-grief-tips-caregivers • *The Invisible String*, by Patrice Karst • *Something Very Sad Happened: A Toddlers Guide to Understanding Death*, by B. Zucker • *I Miss You: A First Look at Death*, by Pat Thomas
School-Age Children	• *Helping School-Age Children with Traumatic Grief: Tips for Caregivers* nctsn.org/resources/helping-school-age-children-traumatic-grief-tips-caregivers • *Everett Anderson's Goodbye,* by Lucille Clifton, about a father's death • *My Grandson Lew,* by Charlotte Zolotow, about a grandparent's death • *When Something Terrible Happens,* by Marge Heegaard • *When Someone Very Special Dies,* by Marge Heegaard • *Good Answers to Tough Questions About Death,* by Joy Berry • *Help Me Say Goodbye: Activities for Helping Kids Cope When a Special Person Dies,* by Janis Silverman
Teens	• Helping Teens with Traumatic Grief: Tips for Caregivers: nctsn.org/resources/helping-teens-traumatic-grief-tips-caregivers • *Weird Is Normal: When Teenagers Grieve*, by J.L. Wheeler
All Ages	• Ten Tips for Supporting Children Who Are Grieving (dougy.org) • *Lifetimes: The Beautiful Way to Explain Death to Children*, by Bryan Mellonie • *The Fall of Freddie the Leaf*, by Leo Buscaglia • *I have a question about Death. Clear answers for all kids, including Children with Autism Spectrum Disorder or other special needs*, by A.G. Gaines, M.E. Polsky • *The Next Place*, by Warren Hansen • *A Complete Book About Death for Kids*, by Earl Grollman • After a Loved One Dies: How Children Grieve and How Parents and Other Adults Can Support Them: newyorklife.com/assets/docs/pdfs/claims/Bereavement-bklet-English.pdf

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