PEDIATRIC BEHAVIOR

HEALTH CARE GUIDES

Florida HEALTH
Children's Medical Services

FLORIDA STATE UNIVERSITY
COLLEGE OF MEDICINE

PROCESS OF CREATING THE GUIDES

This document was created by the Florida State University Center for Behavioral Health Integration (FSU-CBHI: www.med.fsu.edu) in partnership (under contract) with the Florida Department of Health's Office of Children's Medical Services. The Mission of the FSU-CHBI is to serve as a catalyst in the State of Florida for behavioral health research, training and dissemination in order to promote quality integration of behavioral health with primary care. This document was developed and prepared by the following CBHI faculty and staff at the Florida State University College of Medicine:

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SOURCES OF INFORMATION

- Review of existing United States-based Pediatric Behavioral Guides and Recommendations
- Review of clinical and research literature related to evidenced-based detection, treatment and management of pediatric behavioral health conditions
- Review of key association clinical guidelines (American Academy of Pediatrics – AAP; American Psychiatric Association, American Academy of Child and Adolescent Psychiatry)
- Florida Medicaid Medication Management Guidelines
- Validated Pediatric Behavioral Health Screening Tools
- Recommended resources for Pediatric Behavioral Health for parents, children and pediatricians

USE OF THE GUIDES

These guides are intended to serve as a primary resource for Florida Pediatricians and Pediatric Clinicians to use as an "at a glance" way to generally approach suspicion of mental health issues in their patients. This guide should not be used as a substitute for clinical

judgement. Clinicians are encouraged to follow the links provided for additional information that is not detailed within the text of these guides.

KEY ISSUES OVERVIEW:

- These guides include screening tools that are validated, free and downloadable. Information on other relevant and widely used screening tools that require additional permission are listed in the Appendices. A full list of Mental Health Screening and Assessment Tools provided by the American Academy of Pediatrics can be found at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

- These guides provide general guidance on how to approach the most common behavioral health disorders in children including ADHD, Anxiety, Autism Spectrum Disorder, Mood Disorders (Unipolar and Bipolar Depression) and Disruptive Mood Dysregulation Disorder. Clinicians should note the commonality of co-morbidity among the disorders, which is noted throughout the guides.

- In addition, diagnoses must be considered from a developmental perspective, noting that specific symptoms may emerge at a certain developmental stage and context, but may abate, change or worsen over time. All DSM-5 diagnoses require impairment in functioning as a criterion for diagnosis.

- Each guide alerts the clinician's attention to the possibility of substance use as an influence on symptoms and/or a co-morbid condition.

- Given that mental health disorders, especially mood disorders, are a major risk factor for suicide and suicidal behavior, and that suicide is a leading cause of death among certain childhood age groups, it is imperative that pediatric clinicians directly address suicide risk in the presence of behavioral health concerns.

Child's Name _____ Record Number _____
Today's Date _____ Filled out by _____
Date of Birth _____

Pediatric Symptom Checklist

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

			Never (0)	Sometimes (1)	Often (2)
1.	Complains of aches/pains	1	_____	_____	_____
2.	Spends more time alone	2	_____	_____	_____
3.	Tires easily, has little energy	3	_____	_____	_____
4.	Fidgety, unable to sit still	4	_____	_____	_____
5.	Has trouble with a teacher	5	_____	_____	_____
6.	Less interested in school	6	_____	_____	_____
7.	Acts as if driven by a motor	7	_____	_____	_____
8.	Daydreams too much	8	_____	_____	_____
9.	Distracted easily	9	_____	_____	_____
10.	Is afraid of new situations	10	_____	_____	_____
11.	Feels sad, unhappy	11	_____	_____	_____
12.	Is irritable, angry	12	_____	_____	_____
13.	Feels hopeless	13	_____	_____	_____
14.	Has trouble concentrating	14	_____	_____	_____
15.	Less interest in friends	15	_____	_____	_____
16.	Fights with others	16	_____	_____	_____
17.	Absent from school	17	_____	_____	_____
18.	School grades dropping	18	_____	_____	_____
19.	Is down on him or herself	19	_____	_____	_____
20.	Visits doctor with doctor finding nothing wrong	20	_____	_____	_____
21.	Has trouble sleeping	21	_____	_____	_____
22.	Worries a lot	22	_____	_____	_____
23.	Wants to be with you more than before	23	_____	_____	_____
24.	Feels he or she is bad	24	_____	_____	_____
25.	Takes unnecessary risks	25	_____	_____	_____
26.	Gets hurt frequently	26	_____	_____	_____
27.	Seems to be having less fun	27	_____	_____	_____
28.	Acts younger than children his or her age	28	_____	_____	_____
29.	Does not listen to rules	29	_____	_____	_____
30.	Does not show feelings	30	_____	_____	_____
31.	Does not understand other people's feelings	31	_____	_____	_____
32.	Teases others	32	_____	_____	_____
33.	Blames others for his or her troubles	33	_____	_____	_____
34.	Takes things that do not belong to him or her	34	_____	_____	_____
35.	Refuses to share	35	_____	_____	_____

Total score _____

Does your child have any emotional or behavioral problems for which she/he needs help? ( ) N ( ) Y
Are there any services that you would like your child to receive for these problems? ( ) N ( ) Y

If yes, what services?_____

FLORIDA MEDICAID DRUG THERAPY MANAGEMENT TREATMENT GUIDELINES OVERVIEW

The Florida Medicaid Drug Therapy Management Program for Behavioral Health is a program whose goal is to work collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid beneficiaries with a mental illness. The Program information has been developed and is maintained by the University of South Florida College of Behavioral and Community Sciences and is used with permission. More information on the program and additional best practice guidelines can be found at http://www.medicaidmentalhealth.org/.

The Principles of Practice Regarding the Use of Psychotropic Medications (below) provides general guidance on prescribing psychiatric medications in children under age 6, and from ages 6-17. Each behavioral health guide includes the Florida Medicaid Drug Therapy Management Program for Behavioral Health guidelines for each specific behavioral health disorder.

Principles of Practice Regarding the Use of Psychotropic Medications in Children under Age 6

Level 0

Conduct comprehensive multi-informant, multi-modal, multi-disciplinary assessment for those with positive screen. Rule out medical, social, and cognitive causes of behavioral symptoms.

Use validated measures to assess and track psychiatric symptoms and impairment in young children.

Recommended measures of early childhood symptoms include:

- Ages 16–30 months: Modified Checklist for Autism in Toddlers (M-CHAT)
- Ages 2–4 years and 4–11 years: Strengths and Difficulties Questionnaire (SDQ)
- Ages 3–21 years: The Child/Adolescent Psychiatry Screen (CAPS)
- Ages 4–11 years: Home Situations Questionnaire (HSQ)

Links to measures listed above are available at: ***http://medicaidmentalhealth.org/.***

A comprehensive mental health assessment includes:

- A comprehensive assessment of the full range of psychiatric symptoms and disorders, as well as impairment from these symptoms and disorders.
- A full developmental assessment.
- A full medical history, including a sleep history.
- A relevant medical work-up, physical examination and nutritional status evaluation.
- If relevant, an assessment of school functioning including academic, behavioral and social aspects.
- An assessment of family psychiatric history which includes past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parent figures (e.g., step-parent) siblings and other relatives.
- An assessment of family structure and functioning, parent-child relationship and interaction.
- An assessment of environmental risk factors and stressors including any history of abuse (physical, sexual) or neglect, traumatic life events, domestic violence, economic instability, etc.

Notes:

- *Effort should be made to communicate between primary care providers, psychiatrists, case workers, and other team members to ensure integrated care.*
- *Prior to initiating any intervention (e.g., psychosocial, medication), assess and document the risks/benefits of treatment. Education of children should be age-appropriate and targeted to the condition.*
- *Children and parents/legal guardians should be educated about the risks and benefits of treatment, including review of boxed warnings.*
- *Written informed consent should be obtained from the parents/legal guardian (i.e., the individual legally able to consent to medical interventions) and documented in the chart.*

Principles of Practice Regarding the Use of Psychotropic Medications in Children under Age 6 *(continued)*

Level 1

Start with evidence-based psychosocial treatment (e.g., parent training). Parental involvement is essential with involvement by other caregivers or school-based interventions as needed.

- Monitor response to treatment using reliable and valid measures of changes in the target symptoms.
- In mild cases, attempt a course of at least 12 weeks of psychosocial interventions before considering medication.
- In moderate to severe cases, a higher level of intervention may be appropriate.
- Treatment should be individualized.

Level 2

If medications are being considered, first reassess the diagnosis and diagnostic formulation.

Weigh the risks and benefits of initiating treatment with psychotropic medications. The long-term effects of antipsychotic medication use in children is not well studied.

If a decision is made to initiate medication:

- Initiate with monotherapy. Start low, go slow. Take into consideration the pharmacokinetics of the medication (i.e., absorption, distribution, metabolism, excretion).
- Except in rare cases, use monotherapy.
- Continue psychosocial treatment during treatment with medication.
- If possible, monitor effectiveness of interventions with pertinent rating scales.
- Use the lowest effective medication dose.
- Monitor for adverse effects of medications.
- After 6 to 9 months of stabilization, plan down titration trial (i.e., taper or discontinuation trial) to determine whether or not the medication is still needed and effective.
- Continue psychosocial treatment during treatment with medication.
- Use of psychotherapeutic medication in children under the age of 24 months is not recommended unless there are rare and extenuating circumstances.

Dosing Recommendations Regarding the Use of Antipsychotic Medication in Children under Age 6

The use of antipsychotic medications in preschoolers (children under 6 years of age) is generally "off-label", not recommended and should only be considered under the most extraordinary circumstances. Disruptive aggression in autism is one such circumstance. Adequately powered studies have not been conducted in children under age 6.

Before considering pharmacological treatment for children under age 6, the following guidelines are strongly recommended:

1. Patient has developmentally appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented.
2. Patient assessment must include evaluation of parental psychopathology and treatment needs, as well as family functioning.
3. Patient's psychosocial treatments should precede the use of psychotropic medications and should continue if medications are prescribed.

Antipsychotic Dosing Information for Children under Age 6 (Should only be used under rare circumstances).

The dosing information is based on expert opinion and therefore is Level C evidence

Table 1.

Antipsychotic Dosing in Children Under Age 6	
Drug Name	**Dose**
Risperidone	Starting dose: 0.125 mg/day Maximum dose: 1.5 mg/day
Aripiprazole	Starting dose: 1 mg/day Maximum dose: 7.5 mg/day

Principles of Practice Regarding the Use of Psychotropic Medications in Children Ages 6 to 17 Years Old

Level 0

Conduct comprehensive multi-informant, multi-modal, multi-disciplinary assessment for those with positive screen. Rule out medical, social, and cognitive causes of behavioral symptoms.

Use validated measures to assess and track psychiatric symptoms and impairment in young children.

Recommended measures of symptoms in children and adolescents include:

- Ages 4–11 years: Strengths and Difficulties Questionnaire (SDQ)
- Ages 3–21 years: The Child/Adolescent Psychiatry Screen (CAPS)
- Ages 4–11 years: Home Situations Questionnaire (HSQ)

Links to measures listed above are available at: ***http://medicaidmentalhealth.org/.***

A comprehensive mental health assessment includes:

- A comprehensive assessment of the full range of psychiatric symptoms and disorders, as well as impairment from these symptoms and disorders.
- A full developmental assessment.
- A full medical history, including a sleep history.
- A relevant medical work-up, physical examination and nutritional status evaluation.
- An assessment of school functioning including academic, behavioral and social aspects.
- An assessment of family psychiatric history which includes past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, parent figures (e.g., step-parent) siblings and other relatives.
- An assessment of family structure and functioning, parent-child relationship and interaction.
- An assessment of environmental risk factors and stressors including history of abuse (physical, sexual) or neglect, traumatic life events, domestic violence, economic instability, etc.

Notes:

- *Effort should be made to communicate between primary care providers, psychiatrists, case workers, and other team members to ensure integrated care.*
- *Prior to initiating any intervention (e.g., psychosocial, medication), assess the risks/benefits of treatment. Education of children should be age-appropriate and targeted to the condition.*
- *Children/adolescents and parents/legal guardians should be educated about the risks and benefits of treatment, including review of boxed warnings.*
- *Written informed consent should be obtained from the parents/legal guardian (i.e., the individual legally able to consent to medical interventions) and documented in the chart.*

Principles of Practice Regarding the Use of Psychotropic Medications in Children Ages 6 to 17 Years Old *(continued)*

Level 1

Start with psychosocial treatment. Parental involvement is essential, with involvement of other caregivers or school-based interventions as needed.

- Monitor response to treatment using reliable and valid measures of changes in the target symptoms.
- In mild cases, attempt a course of at least 12 weeks of psychosocial interventions before considering medication. In moderate to severe cases, a higher level of intervention may be appropriate as the initial step.

Level 2

If medications are being considered, first reassess the diagnosis and diagnostic formulation. Weigh the risks and benefits of initiating treatment with psychotropic medications.

If a decision is made to initiate medication:

- Initiate with monotherapy. Start low, go slow.
- Except in rare cases, use monotherapy.
- Continue psychosocial treatment during treatment with medication.
- Monitor for suicidality.
- Monitor for adverse effects of medications.
- The use of antipsychotics should be restricted to the diagnoses of schizophrenia (rare in children), mania/bipolar disorder, psychotic depression, drug induced psychosis, Tourette's syndrome and tic disorders, and in some cases, severe aggression as a target symptom.
- On rare occasions, antipsychotics may be used in obsessive compulsive disorder (OCD) after extensive cognitive behavioral therapy (CBT) or failure of two adequate selective serotonin reuptake inhibitor (SSRI) trials.
- Antipsychotics should not be used primarily to target ADHD symptoms or as sedatives in children.
- There may be instances where antipsychotics are used for parasuicidal and severe self-injurious behaviors.

ADHD

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) (5.1.1.1.3.1)

DESCRIPTION

Attention Deficit Hyperactivity Disorder (ADHD) is characterized by a persistent pattern of behavior, present in two or more settings (e.g., school and home). The disturbance causes clinically significant distress or impairment in social, educational, or work settings. Symptom onset is no later than age 12. Symptoms are divided into two categories: inattention and hyperactivity-impulsivity, which include behaviors like failure to pay close attention to details, difficulty organizing tasks and activities, excessive talking, fidgeting, and/or an inability to remain seated in appropriate situations. Children 17 years of age and younger must have at least six symptoms from either (or both) the inattention group of criteria or the hyperactivity-impulsivity criteria. The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) includes no exclusion criteria for people with autism spectrum disorder, since symptoms of both disorders co-occur. However, ADHD symptoms must not occur exclusively during the course of schizophrenia or another psychotic disorder and must not be better explained by another mental disorder, such as a depressive or bipolar disorder, anxiety disorder, dissociative disorder, personality disorder, or substance intoxication or withdrawal.

Source: American Psychiatric Association. (2013). Attention Deficit/Hyperactivity Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

DSM-5 DIAGNOSTIC CRITERIA

A. A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by (1) and/or (2):

A1. Symptoms of Inattention Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic / occupational activities:	A2. Symptoms of Hyperactivity-Impulsivity Six (or more) of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic / occupational activities:
Often fails to give close attention to detail or makes careless mistakes.	Often fidgets with or taps hands and feet, or squirms in seat.
Often has difficulty sustaining attention in tasks or play activities.	Often leaves seat in situations when remaining seated is expected.
Often does not seem to listen when spoken to directly.	Often runs and climbs in situations where it is inappropriate.
Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace.	Often unable to play or engage in leisure activities quietly.
Often has difficulty organizing tasks and activities.	Is often 'on the go', acting as if 'driven by a motor'.
Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort.	Often talks excessively.
Often loses things necessary for tasks or activities.	Often blurts out an answer before a question has been completed.
Is easily distracted by extraneous stimuli.	Often has difficulty waiting their turn.
Is often forgetful in daily activities.	Often interrupts or intrudes on others.

B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.

C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).

D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

SEVERITY CLASSIFICATION

ADHD is specified by the severity based on social, educational or occupational functional impairment: mild (minor impairment), moderate (impairment between mild and severe), severe (symptoms in excess of those required to meet diagnosis; marked impairment).

PREVALENCE

Prevalence rates of ADHD in children and adolescents between the ages of 4-17 range from 5-16%. White children have the highest rates of ADHD among races. ADHD is more frequent in males than in females in the general population. Females are more likely than males to present primarily with inattentive features.

SCREENING, ASSESSMENT, DIAGNOSIS, TREATMENT AND MANAGEMENT OF ADHD (5.1.1.1.3.2)

American Academy of Pediatrics General Recommendations

- Initiate an evaluation for ADHD for any child 4 through 18 years of age with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.
- Alternative causes for symptoms should be considered and ruled out.
- Diagnosis should meet DSM-5 criteria above (including documentation of impairment in more than 1 major setting), with information obtained from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care.
- Conduct assessment for comorbid conditions, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders); developmental (e.g., learning and language disorders or other neurodevelopmental disorders); and physical (e.g., hearing and vision deficit, tics, sleep apnea) conditions.
- Consider children and adolescents with ADHD as children and youth with special health care needs; treat ADHD as a chronic condition using the principles of the chronic care model and the patient centered medical home.

Source: *American Psychiatric Association. (2013). Attention Deficit/Hyperactivity Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.*
Source: *Pastor, Pastor N. et al. (2015). Association between diagnosed ADHD and selected characteristics among children aged 4-17 years: United States, 2011-2013. NCHS data brief, no 201. Hyattsville, MD: National Center for Health Statistics.*
Source: *American Academy of Pediatrics Clinical Practice Guideline. November 2011, Volume 128 / Issue 5 (edited). Retrieved from: http://pediatrics.aappublications.org/content/pediatrics/128/5/1007.full.pdf*

ADHD DECISION TREE

Positive ADHD screen and / or other indication of significant inattention, hyperactivity or impulsivity observed across multiple settings and not developmentally

Assessment / Diagnosis:

- Review DSM-V criteria
- Assess for common co-morbidities (e.g. anxiety, depression)
- Note that diagnosis is based on significant symptoms across multiple settings such as school and home; consider Vanderbilt rating scale completed by parent and teacher
- Consider referral for psychological assessment
- Assess severity / trajectory (worse or better?) and impact on functioning (school, family, sleep)
- Rule out use of substances
- Consider contributing medical and social factors (e.g. prenatal exposures, birth complications, trauma /abuse exposure)

Assess severity, impairment and associated risk issues, including poor self-image

Mild concern / Diagnosis unclear:

1. Psychoeducation for family
2. Regular screening / symptom monitoring
3. Assist with coping skills and task management skills
4. Discuss family coping options for dealing impulsive behaviors
5. Actively address self-esteem

Mild-Moderate severity:

1. Implement all “mild” level interventions
2. Behavioral therapy for child and family
3. Recommend school-based interventions and close communication with school
4. Consider appropriateness of stimulant medication (see medication guidelines) if no substance abuse
5. Consider neuropsychological / cognitive assessment

Moderate – severe; clear ADHD, clear impairment:

1. Home and classroom based behavior therapy
2. Monotherapy with methylphenidate or amphetamine
3. Monitor for treatment response and adjust / augment treatment as needed
4. Monitor for development of depression or other co-morbidities

Manage in primary care; refer based on worsening or increase in risk

Manage in primary care if comfortable and adequately resourced, or refer to specialty care

Refer to specialty care and continue monitoring follow up

DIFFERENTIAL DIAGNOSIS

Additional information on these diagnoses and how they present can be found in *Appendix A*.

Oppositional defiant disorder	Depressive disorders
Intermittent explosive disorder	Bipolar disorder
Other neurodevelopmental disorders	Disruptive mood dysregulation disorder
Specific learning disorder	Substance use disorders
Autism spectrum disorder	Personality disorders
Reactive attachment disorder	Psychotic disorders
Anxiety disorders	Medication-induced symptoms of ADHD

Source: American Psychiatric Association. (2013). Attention Deficit/Hyperactivity Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

VALIDATED SCREENING TOOLS: OVERVIEW, ITEMS AND SCORING INSTRUCTIONS (5.1.1.1.3.3)

The National Institute for Children's Health Quality (NICHQ) Vanderbilt Assessment Scales are used by health care professionals to help diagnose ADHD in children, ages 6 through 12 years. Use and distribution of the 1st Edition of the Vanderbilt Assessment Scales is permitted through a free download on the NICHQ website (https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales). However, access to the 2nd Edition of the Scales is only available by purchase.

The below version is reproduced with the permission of the NICHQ.

Links to additional validated screening tools for ADHD can be found in *Appendix A*.

NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD

NICHQ
National Institute for Children's Health Quality

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

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 the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	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, or 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 activities	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 (ie, "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

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

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

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 (eg, teams)	1	2	3	4	5

Comments:

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 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

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

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

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

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

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

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
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:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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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 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

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

Symptoms	Never	Occasionally	Often	Very Often
1. 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, or 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 activities	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

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised –0303

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HE0352

D5 **NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?** None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

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Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

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

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

Symptoms	Never	Occasionally	Often	Very Often
1. 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, or 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 activities	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

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?** None	Mild	Moderate	Severe
Headache				
Stomachache				
Change of appetite—explain below Trouble sleeping Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying Dull, tired, listless behavior Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

American Academy of Pediatrics General Recommendations for Treatment of Children and Youth with ADHD by Age Group

Preschool-Aged Children (4–5 years of age):

- First line of treatment: Evidence based parent- and/or teacher-administered behavior therapy.
- If evidence based behavioral treatments are not available, weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment.
- May prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function.

Elementary School-Aged Children (6–11 years of age):

- Prescribe medications approved by the US Food and Drug Administration and/or evidence based parent and/or teacher administered behavior therapy; preferably both should be used together.
- Home / school environment, program, or placement is a part of any treatment plan.

For Adolescents (12–18 years of age)

- Prescribe medications approved by the US Food and Drug Administration with the assent of the adolescent; may prescribe behavior therapy as treatment for ADHD; preferably both.
- Screen older children and adolescents diagnosed with ADHD for use of alcohol, marijuana, and other drugs and provide brief intervention or referral to treatment as part of routine visits due to high correlation with substance use and development of substance use disorder.

Source: American Academy of Pediatrics Clinical Practice Guideline. November 2011, Volume 128 / Issue 5 (edited). Retrieved from: http://pediatrics.aappublications.org/content/pediatrics/128/5/1007.full.pdf

FLORIDA MEDICAID DRUG THERAPY MANAGEMENT TREATMENT GUIDELINES

The Florida Medicaid Drug Therapy Management Program for Behavioral Health is a program whose goal is to work collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid beneficiaries with a mental illness. The following information has been developed and is maintained by the University of South Florida College of Behavioral and Community Sciences and is used with permission. More information on the program, and additional best practice guidelines, can be found at http://www.medicaidmentalhealth.org/.

Attention Deficit Hyperactivity Disorder (ADHD) in Children under Age 6

Level 0

Conduct comprehensive assessment and provide psychoeducation about ADHD, including clearly defined treatment expectations. Consider co-morbid developmental language disorder, Specific Learning Disorder or Autism Spectrum Disorder (ASD).

Facilitate family engagement, psychoeducation about ADHD (evidence-based behavioral interventions, educational interventions and medication treatments), and treatment preference assessment. Treatment response should be monitored using rating scales and appropriate health (vital signs, height, weight) and safety assessments. Refer to *General Principles of Practice Regarding the Use of Psychotropic Medications in Children under Age 6* on pg. 6.

→ **Level 1**

Provide parent management/skills training or other behavioral intervention at home and/or school for a minimum of 12 weeks.

→ **Level 2**

Initiate monotherapy with methylphenidate formulation.

→ **Level 3**

If methylphenidate is unsuccessful, could consider monotherapy with atomoxetine (caution: child must be able to swallow medication whole).

→ **Level 4**

Consider amphetamine formulations which have FDA indication for ages 3 to 5 years old, but limited clinical trial evidence base. May also consider alpha-2 agonists, but no published data are available.

- ✦ After 6 months of any sustained improvement on any effective medication treatment, taper in order to determine the lowest effective dose and possibility of discontinuation.

Not Recommended:

- ✦ Antipsychotic medication to treat core symptoms of ADHD.
- ✦ Concurrent use of two or more alpha-2 agonists.

Attention Deficit Hyperactivity Disorder (ADHD) in Children under Age 6 *(continued)*

Table 4.

ADHD Medication Treatment for Children under Age 6	
Drug Name	**Starting Dose Recommendation**
Methylphenidate and Amphetamine preparations	
Short-acting	
Methylphenidate[1]: Short Acting: Ritalin®, Methylin®, Methylin® Chewable Tablets, Methylin® Oral Solution	1.25 mg tid – titrate as needed to doses not exceeding 1 mg/kg/day. *Recommendations extrapolated from the Preschool ADHD Treatment Study (PATS).*
Amphetamine[3]: Short Acting: Mixed amphetamine salts (Adderall®), D-amphetamine (Zenzedi®, ProCentra® Oral Solution). D- & L-amphetamine (Evekeo®)	2.5 mg/day – titrate as needed to doses not exceeding 0.5 mg/kg/day. *Amphetamine target dose is generally one- half to two-thirds of methylphenidate dose.*
Selective norepinephrine inhibitor	
Atomoxetine (Strattera®)[2]	10mg/day – titrate as needed to doses not to exceed 1.4 mg/kg/day. *Recommendations extrapolated from the Kratochvil et al. 2011 study.*
Alpha-2 Agonists4	
Alpha-2 Agonists[4]: **Clonidine** (Catapres®, KAPVAY®) **Guanfacine** (Tenex®, Intuniv®)	Starting dose not to exceed: 0.05 mg/day *(clonidine)* 0.5 mg/day *(guanfacine)* Monitor carefully for excessive sedation, increased irritability. *Recommendations based on expert opinion.*

Notes:

[1] *No FDA indication for children younger than 6 years old; based on Preschool ADHD Treatment Study results (Greenhill et al., 2006).*

[2] *No FDA indication for children younger than 6 years old; based on Kratochvil, C.J., B.S. Vaughan, et al. (2011). A double-blind, placebo controlled study of atomoxetine in young children with ADHD. Pediatrics 127(4):e862-868.*

[3] *FDA indication for ADHD treatment of children 3-5 years old, but no clinical trial study results available.*

[4] *No FDA indication for ADHD except guanfacine extended-release (Intuniv®) and clonidine extended-release (KAPAVY®) in children 6 years and older; no clinical trial study results available for alpha-2 agonist use for ADHD in children below age 6 years old.*

There is no new data on extended release stimulants in preschoolers, but the 2007 American Academy of Child and Adolescent Psychiatry guideline algorithm included extended-release formulations to address compliance concerns (Pliszka et al., 2007).

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old

Level 0

Comprehensive assessment including a detailed developmental and symptom history.

- ADHD Rating Scale-IV.
- Vanderbilt ADHD Diagnostic Parent and Teacher Rating Scales

Links to rating scales available at ***http://medicaidmentalhealth.org/.***

Facilitate family engagement, psychoeducation about ADHD (evidence-based behavior and medication treatments, and educational interventions), and treatment preference assessment.

Ensure that treatment response is monitored using rating scales and appropriate health (vital signs, height and weight) and safety assessments.

Level 1

- Psychostimulant monotherapy (methylphenidate class or amphetamine class, either short or long-acting). If first choice is ineffective, try monotherapy with another stimulant (Refer to Tables 5 and 6 of ADHD medications on pgs. 17–20. If supplementation of long-acting with short-acting psychostimulant required for sufficient coverage, stay within same drug class.

  OR

- Extended-release alpha-2 agonist monotherapy.

Level 2

- Combination of extended-release alpha-2 agonist with psychostimulant.

  OR

- Atomoxetine.

Level 3

Immediate-release alpha-2 agonist (as monotherapy or combination with other ADHD medication classes).

Level 4

Diagnostic reconsideration if none of the above agents result in satisfactory treatment. Consider bupropion or tricyclic antidepressant. Despite limited evidence, these medications may be considered. Desipramine is not recommended due to safety concerns.

Not Recommended:

- Antipsychotic medication to treat core symptoms of ADHD.
- Concurrent use of two or more alpha-2 agonists.
- Concurrent use of two different stimulant classes.
- Desipramine due to safety concerns.

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 5.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Methylphenidate preparations				
Short-acting				Short-acting stimulants often used as initial treatment in children (<16 kg), have disadvantage of bid – tid dosing to control symptoms throughout the day.
Focalin® (dexmethylphenidate hcl tablet)	2.5 mg bid	20 mg	50 mg	
Methylin® (methylphenidate hcl tablet)	5 mg bid	60 mg	>50 kg: 100 mg	
Methylin® Solution (methylphenidate hcl oral solution)	5 mg bid	60 mg	>50 kg: 100 mg	
Methylin® Chewable (methylphenidate hcl chewable tablet)	5 mg bid	60 mg	>50 kg: 100 mg	
Ritalin® (methylphenidate hcl tablet)	5 mg bid	60 mg	>50 kg: 100 mg	
Intermediate-acting				Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep.
Metadate ER® (methylphenidate hcl extended-release tablets)	10 mg qam	60 mg	>50 kg: 100 mg	
Metadate CD® (methlypheidate hcl extended-release capsule)	20 mg qam	60 mg	>50 kg: 100 mg	
Methylin ER® (methylphenidate hcl extended-release tablet)	10 mg qam	60 mg	>50 kg: 100 mg	
Ritalin LA® (methylphenidate hcl extended-release tablet)	20 mg qam	60 mg	>50 kg: 100 mg	
Ritalin SR® (methylphenidate hcl sustained-release tablet)	10 mg qam	60 mg	>50 kg: 100 mg	

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 5 ***(continued).***

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Long-acting				Aptensio XR®,Metadate CD®, Ritalin LA® and Focalin XR® capsules may be opened and sprinkled on soft food for immediate consumption. Beads should not be crushed or chewed. Concerta® should not be crushed, chewed, or broken. Swallow whole with liquids. Non-absorbable tablet shell does not dissolve and may be seen in stool. This is normal. Qillivant XR® is an extended release once-daily suspension. QuilliChew ER® can be broken in half.
Aptensio XR® (methylphenidate hcl extended-release capsule)	Begin with 10 mg qam then titrate by 10 mg at weekly intervals	60 mg	>50 kg: 100 mg	
Concerta® (methylphenidate extended-release tablet)	18 mg qam	72 mg	>50 kg: 108 mg	
Daytrana® patch (methylphenidate transdermal system)	Begin with 10 mg patch qd, then titrate up by patch strength 5 mg qam	30 mg	Not yet known	
Focalin XR® (dexmethylphenidate hcl extended-release capsule)	5 mg qam	30 mg	50 mg	
Quillivant XR® (methylphenidate hcl extended-release oral suspension)	Begin with 20 mg qam, then titrate up by 10-20 mg at weekly intervals	60 mg	>50 kg: 100 mg	
QuilliChew ER® (methylphenidate hcl extended-release chewable tablet)	Begin with 20 mg qam then titrate in increments of 10mg, 15mg or 20mg at weekly intervals	60 mg	>50 kg: 100 mg	

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 6.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Amphetamine preparations				
Short-acting				Short-acting stimulants often used as initial treatment in children (<16 kg), but have disadvantage of bid – tid dosing to control symptoms throughout the day. Note that Adderall®, Procentra Oral Solution®, Eveko® and Zenzedi® have the same dosing recommendations
Adderall® (amphetamine mixed salts tablet)	5 mg qd – bid	40 mg	>50 kg: 60 mg	
Procentra Oral Solution® (d-amphetamine oral solution)	5 mg qd – bid	40 mg	>50 kg: 60 mg	
Evekeo® (d & l amphetamine tablet)	5 mg qd – bid	40 mg	>50 kg: 60 mg	
Zenzedi® (d-amphetamine tablet)	5 mg qd – bid	40 mg	>50 kg: 60 mg	

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 6 ***(continued).***

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Long-acting				Longer acting stimulants offer greater convenience, confidentiality, and compliance with single daily dosing but may have greater problematic effects on evening appetite and sleep. Adderall XR® capsule may be opened and sprinkled on soft foods. Vyvanse® capsule can be opened and mixed with yogurt, water or orange juice. For Dyanavel XR® do not substitute for other amphetamine products on mg-per-mg basis. For Adzenys®, do not substitute for other amphetamine products on mg-per-mg basis. For children and adolescents on Adderall XR®, specific starting doses corresponding to Adderall XR® doses are recommended, ranging from 3.1 mg (for those on 5mg of Adderall XR®) to 18.8 mg (for those on 30mg Adderall XR®).
Dexedrine Spansule® (dextroamphetamine sulfate extended-release capsule)	5–10 mg qd – bid	40 mg	Not yet known	
Adderall XR® (amphetamine extended-release mixed salts capsule)	10 mg qd	6–12 years: 30 mg 13–17 years: 20 mg	>50 kg: 60 mg	
Vyvanse® (lisdexamfetamine capsule)	20–30 mg qd	70 mg	Not yet known	
Dyanavel XR® 2.5mg/mL (amphetamine extended-release oral suspension)	2.5 to 5 mg qd	20 mg	Not yet known	
Adzenys XR-ODT® (amphetamine extended-release orally disintegrating tablet)	6.3 mg qam unless switched from Adderall XR (Refer to conversion schedule)	6–12 years: 18.8 mg 13–17 years: 12.5 mg	Not yet known	

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 7.

FDA Approved ADHD Medications in Children and Adolescents Ages 6 to 17 Years Old				
Generic Class/ Brand Name	**Typical Starting Dose**	**FDA Max Dose/Day**	**Off-Label Max Dose/Day**	**Comments**
Selective norepinephrine reuptake inhibitor				
Strattera® (atomoxetine)	< 70 kg: 0.5 mg/ kg/day for 4 days; then 1 mg/kg/ day for 4 days; then 1.2 mg/kg/ day	Lesser of 1.4 mg/kg or 100 mg	Lesser of 1.8 mg/kg or 100 mg	Not a Schedule II medication. Consider if active substance abuse or severe side effects of stimulants (mood lability, tics).Give qam or divided doses bid (for effects on late evening behavior). Do not open capsule; must be swallowed whole. Monitor closely for suicidal thinking and behavior, clinical worsening, or unusual changes in behavior.
Alpha- adrenergic agonists				
Intuniv® (guanfacine ER)	1 mg qd then titrate up by 1 mg increments once per week	Lesser of 0.12 mg/kg or 4 mg qd (6-12 years) 7 mg q.d. (13-17 years)	Lesser of 0.17 mg/kg or 4 mg qd (6-12 years) 7 mg q.d. (13-17 years)	Not a Schedule II medication. Sedation, somnolence and fatigue are common and tend to decline over time. Consider baseline electrocardiogram (EKG) before starting. Tablets should not be crushed, chewed or broken before swallowing because this will increase the rate of release.
KAPVAY® (clonidine ER)	0.1 mg/day at bed time	0.4 mg/day in divided dose of 0.2 mg bid	0.4 mg/day	Do not administer with high fat meals due to increased exposure. May not see effects for 4-6 weeks. Review personal and family cardiovascular history. Do not abruptly discontinue. Taper the daily dose of Intuniv by no more than 1 mg, and that of Kapvay® by no more than 0.1 mg every 3 to 7 days to avoid rebound hypertension.

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 8.

ADHD Medications NOT FDA APPROVED in Children and Adolescents Ages 6 to 17 Years Old			
Generic Class/ Brand Name	**Typical Starting Dose**	**Max Dose/Day**	**Comments**
Alpha- adrenergic agonists			
Catapres® (clonidine)	<45 kg: 0.05 mg nightly, titrate in 0.05 mg increments two times per day, three times per day, or four times per day. >45 kg: 0.1 mg nightly; titrate in 1mg increments two times per day, three times per day, or four times per day.	27–40.5 kg: 0.2 mg; 40.5–45 kg: 0.3 mg; >45 kg: 0.4 mg	The following applies to both alpha-2 adrenergic agonists: May be used alone or as adjuvant to another medication class for ADHD. Do not combine different alpha-2-adrenergic agents with each other Effective for inattention, impulsivity and hyperactivity; modulating mood level; tics worsening from stimulants; sleep disturbances. Taper the daily dose of Clonidine by no more than 0.1 mg every 3 to 7 days to avoid rebound hypertension.
Tenex® (guanfacine)	< 45 kg: 0.5 mg nightly; titrate in 0.5 mg increments two times per day, three times per day, or four times per day. >45 kg: 1 mg nightly, titrate in 1 mg increments. May dose increments two times per day, three times per day, or four times per day.	27–40.5 kg: 2 mg; 40.5.–45 kg: 3 mg; >45 kg: 4 mg	May not see effects for 4-6 weeks. Review personal and family cardiovascular history. Consider pre-treatment EKG. Taper the daily dose of guanfacine by no more than 1 mg every 3 to 7 days to avoid rebound hypertension.

Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Table 8 ***(continued).***

ADHD Medications NOT FDA APPROVED in Children and Adolescents Ages 6 to 17 Years Old			
Generic Class/ Brand Name	**Typical Starting Dose**	**Max Dose/Day**	**Comments**
Antidepressants			
Wellbutrin®† (bupropion)	Lesser of 3 mg/kg/day or 150 mg/day as 75 mg bid	Lesser of 6 mg/kg or 300 mg/day. Dose should not exceed 150 mg per dose.	Lowers seizure threshold; contraindicated if current seizure disorder, anorexia nervosa or bulimia nervosa. Usually given in divided doses, bid or tid for children and adolescents, for both safety and efficacy.
Wellbutrin SR®† (bupropion SR)	Same as above	150 mg per dose or 400 mg/day	Same as above
Wellbutrin XL®† (bupropion XL)	Not recommended	Not recommended	Not recommended
Tofranil® (imipramine)	1 mg/kg/day	Lesser of 4 mg/kg or 200 mg	Obtain baseline EKG before starting imipramine.
Pamelor® Aventil® (nortriptyline)	0.5 mg/kg/day	Lesser of 2 mg/kg or 100 mg	Obtain baseline EKG before starting nortriptyline.

***Note:** Long-acting formulations of clonidine (Kapvay) and guanfacine (Intuniv) are FDA-approved ADHD medications in children and adolescents 6-17 years old, but short-acting formulations of clonidine (Catapres) and guanfacine (Tenex) are not FDA-approved for ADHD.*

†Bupropion and bupropion SR have more data on off-label use than bupropion XL. Bupropion XL is not recommended in children and adolescents as the safety and efficacy have not been well established in this population.

For a full list of references, visit ***http://medicaidmentalhealth.org/.***

EVIDENCE BASED BEHAVIORAL TREATMENTS FOR ADHD

Treatment	Description	Outcomes
Behavioral Parent Training	Treatment programs provided to parents to modify parenting behaviors and to teach positive reinforcement methods. Implemented in the home.	• Parental implementation of contingency behavioral techniques • Improved compliance with parental commands • Higher levels of parental satisfaction • Increase in positive parent-child interactions
Behavioral Classroom Management	Behavior modification principles and techniques provided to teachers and school staff. Implemented in academic settings.	• Enhanced prosocial behavior • Increase in student engagement • Decrease in discipline problems • Improved attention and work productivity

ANXIETY

ANXIETY DISORDERS (5.1.1.1.3.1)

DESCRIPTION

Anxiety is often characterized as a sense of worry or fear that ranges widely in its spectrum of intensity. For some children and adolescents, anxiety symptoms may cause significant distress, yet may not impair functioning enough to warrant the diagnosis of a disorder. When anxiety significantly affects a child's or adolescent's functioning, it is classified as a disorder rather than as a problem. There are various forms of anxiety disorders, including generalized anxiety disorder, panic disorder, specific phobias, social phobia, separation anxiety, acute stress disorder, posttraumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD) (Bright Futures in Practice). It should be noted that anxiety disorders are among the most common mental health conditions, affecting approximately 15-20% of children / adolescents, with approximately 80% of children un-treated (Beesdo, Knappe, & Pine, 2009; Child Mind Institute Children's Mental Health Report, 2015).

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at https://www.brightfutures.org/mentalhealth/pdf/index.html

Source: Beesdo, K., Knappe, S., & Pine, D.S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. Psychiatr Clin North Am, 32(3): 483-524.

DSM-5 DIAGNOSTIC CRITERIA

GENERALIZED ANXIETY DISORDER

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The individual finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

- **Note: Only one item is required in children.**

1. Restlessness or feeling keyed up or on edge.
2. Being easily fatigued.
3. Difficulty concentrating or mind going blank.
4. Irritability.
5. Muscle tension.
6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

B. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).

D. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Source: American Psychiatric Association. (2013). Generalized Anxiety Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

OBSESSIVE-COMPULSIVE DISORDER

A. Presence of obsessions, compulsions, or both.

- Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.

2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

- Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

    - **Note: Young children may not be able to articulate the aims of these behaviors or mental acts.**

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder (e.g., excessive worries, as in generalized anxiety disorder; preoccupation with appearance, as in body dysmorphic disorder; difficulty discarding or parting with possessions, as in hoarding disorder; hair pulling, as in trichotillomania [hair-pulling

disorder]; skin picking, as in excoriation [skin-picking disorder]; stereotypies, as in stereotypic movement disorder; ritualized eating behavior, as in eating disorders; preoccupation with substances or gambling, as in substance-related and addictive disorders; preoccupation with having an illness, as in illness anxiety disorder; sexual urges or fantasies, as in paraphilic disorders; impulses, as in disruptive, impulse-control, and conduct disorders; guilty ruminations, as in major depressive disorder; thought insertion or delusional preoccupations, as in schizophrenia spectrum and other psychotic disorders; or repetitive patterns of behavior, as in autism spectrum disorder).

Source: American Psychiatric Association. (2013). Obsessive-Compulsive Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SEPARATION ANXIETY DISORDER

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.

8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

B. ***The fear, anxiety, or avoidance is persistent, lasting at least 4 weeks in children and adolescents*** and typically 6 months or more in adults.

C. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning.

D. The disturbance is not better explained by another mental disorder, such as refusing to leave home because of excessive resistance to change in autism spectrum disorder; delusions or hallucinations concerning separation in psychotic disorders; refusal to go outside without a trusted companion in agoraphobia; worries about ill health or other harm befalling significant others in generalized anxiety disorder; or concerns about having an illness in illness anxiety disorder.

Source: American Psychiatric Association. (2013). Separation Anxiety Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SELECTIVE MUTISM

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.

B. The disturbance interferes with educational or occupational achievement or with social communication.

C. The duration of the disturbance is at least 1 month (not limited to the first month of school).

D. The failure to speak is not attributable to a lack of knowledge of, or comfort with, the spoken language required in the social situation.

E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.

Source: American Psychiatric Association. (2013). Selective Mutism. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SPECIFIC PHOBIA

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
    - **Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.**
B. The phobic object or situation almost always provokes immediate fear or anxiety.
C. The phobic object or situation is actively avoided or endured with intense fear or anxiety.
D. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
G. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in obsessive-compulsive disorder); reminders of traumatic events (as in posttraumatic stress disorder); separation from home or attachment figures (as in separation anxiety disorder); or social situations (as in social anxiety disorder).

Source: American Psychiatric Association. (2013). Specific Phobia. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SOCIAL ANXIETY DISORDER (SOCIAL PHOBIA)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people); being observed (e.g., eating or drinking); and performing in front of others (e.g., giving a speech).
    - **Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.**

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing, will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

    - **Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.**

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Source: American Psychiatric Association. (2013). Social Anxiety Disorder (Social Phobia). In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

PANIC DISORDER

A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or “going crazy.”
13. Fear of dying.

- **Note:** Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, “going crazy”).
2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety

disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

Source: American Psychiatric Association. (2013). Panic Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

POSTTRAUMATIC STRESS DISORDER

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

    1. Directly experiencing the traumatic event(s).
    2. Witnessing, in person, the event(s) as it occurred to others.
    3. Learning that a close family member or close friend experienced the traumatic event(s). In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).
        - **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

    1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
        - **Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.**
    2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the traumatic event(s).

- **Note: In children, there may be frightening dreams without recognizable content.**

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
    - **Note: In children, trauma-specific reenactment may occur in play.**
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself / herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify the presence of:

- **Dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

- **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

- **Delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

POSTTRAUMATIC STRESS DISORDER FOR CHILDREN 6 YEARS AND YOUNGER

A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

   1. Directly experiencing the traumatic event(s).

   2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.

      - **Note:** Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

   3. Learning that a parent or caregiving figure experienced the traumatic event(s).

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

      - **Note:** Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

   2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the traumatic event(s).

      - **Note:** It may not be possible to ascertain that the frightening content is related to the traumatic event.

   3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to reminders of the traumatic event(s).

C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

- **Persistent Avoidance of Stimuli**

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

- **Negative Alterations in Cognitions**

1. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).

2. Markedly diminished interest or participation in significant activities, including constriction of play.

3. Socially withdrawn behavior.

4. Persistent reduction in expression of positive emotions.

D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).

2. Hypervigilance.

3. Exaggerated startle response.

4. Problems with concentration.

5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

E. The duration of the disturbance is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.

G. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Source: American Psychiatric Association. (2013). Posttraumatic Stress Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Prevalence

Based on studies of children and adolescents, it is estimated that approximately 15-20% suffer from a lifetime prevalence of “any anxiety disorder.”

Source: Beesdo, K., Knappe, S., & Pine, D.S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. Psychiatr Clin North Am, 32(3): 483-524.

SCREENING, ASSESSMENT, DIAGNOSIS, TREATMENT AND MANAGEMENT OF ANXIETY DISORDERS (5.1.1.1.3.2)

Source: Connolly, S. et al Practice Parameter for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders. J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(2):267Y283; Jellinek M, Patel BP, Froehle MC, eds. 2002. Bright Futures in Practice: Mental Health–Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health

ANXIETY DISORDER DECISION TREE

Positive anxiety screen and / or other source of concern about an anxiety disorder (parent, teacher, clinician; family history of anxiety disorder)

Assessment / Diagnosis:

- Review DSM-V criteria; Assess for key features of specific anxiety disorders (e.g. history of trauma, nightmares-PTSD; ritualistic or repetitive behaviors-OCD)
- Assess for common co-morbidities (e.g. depression, ADHD)
- Consider referral for psychological assessment
- Assess severity / trajectory (worse or better?) and impact on functioning (school, family, sleep)
- Consider other medical, psychiatric or situational factors that may mimic anxiety disorders. Rule out use of substances.

Assess severity and associated risk issues

Mild concern / Diagnosis unclear / low safety risk:

1. Psychoeducation for family
2. Regular screening / symptom monitoring
3. Teach and provide resources for relaxation techniques, deep breathing, exercise, meditation
4. Discuss family coping options for dealing with specific fears
5. Encourage physical activity

Mild-Moderate severity / some safety risk indication:

1. Implement all "mild" level interventions
2. Cognitive Behavioral Therapy (CBT)
3. Consider Family Therapy
4. Assess for suicidal ideation and other suicide risk
5. Consider appropriateness of SSRI's

Moderate – severe; clear anxiety disorder / safety risk:

1. Psychoeducation
2. CBT (Consider combination CBT + SSRI)
3. Directly address suicidal ideation and risk
4. Monitor for treatment response and adjust / augment treatment as needed
5. Monitor for development of depression or other co-morbidities
6. Consider multimodal treatment that engages family, school and / or other supports

Manage in primary care; refer based on worsening or increase in risk

Manage in primary care if comfortable and adequately resourced, or refer to specialty care

Refer to specialty care and continue monitoring follow up

COMORBIDITIES AND DIFFERENTIAL DIAGNOSIS

Anxiety problems and disorders often occur together with depressive and ADHD symptoms in children and adolescents (Bright Futures in Practice). Studies indicate that 30–70% of children and adolescents with anxiety disorders have a depressive disorder, and 15–25% of children and adolescents with anxiety disorders meet the criteria for ADHD (Bernstein and Shaw, 1997). Each disorder's independent contribution to impaired functioning, particularly in school performance, is hard to isolate (Bright Futures in Practice).

Substance use can also co-occur with anxiety disorders. Alcohol or other drugs may be used as a coping mechanism to lessen acute anxiety, but can ultimately worsen symptoms. Drugs such as cocaine and amphetamines can cause anxiety symptoms, so it is important to ask about substance use among this population (Bright Futures in Practice).

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at https://www.brightfutures.org/mentalhealth/pdf/index.html

Source: Bernstein, G., & Shaw, K. (1997). Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders Journal of the American Academy of Child & Adolescent Psychiatry,36(11): 1639-1641.

VALIDATED SCREENING TOOLS: OVERVIEW, ITEMS AND SCORING INSTRUCTIONS (5.1.1.1.3.3)

The Screen for Child Anxiety Related Disorders (SCARED) was developed at the Western Psychiatric Clinic, University of Pittsburgh. It is a brief child and parent self-report screening instrument that targets children ages 8 to 18 years old. The following tools are the SCARED screening for children, the SCARED screening for parents to fill out about their children, and the SCAARED, a tool to assess the parental anxiety, in case it is a contributing factor to the child's anxiety. These tools can be can be found for free online along with multiple language translations on the University of Pittsburgh website at http://pediatricbipolar.pitt.edu/resources/instruments.

An additional validated screening tool for anxiety can be found in *Appendix B.*

The following are reproduced with the permission of the tools' creators.

Screen for Child Anxiety Related Disorders (SCARED)

CHILD Version—Page 1 of 2 (to be filled out by the CHILD)

Name: _____ Date: _____

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

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

Screen for Child Anxiety Related Disorders (SCARED)

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

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. I worry about things working out for me.				GD
22. When I get frightened, I sweat a lot.				PN
23. I am a worrier.				GD
24. I get really frightened for no reason at all.				PN
25. I am afraid to be alone in the house.				SP
26. It is hard for me to talk with people I don't know well.				SC
27. When I get frightened, I feel like I am choking.				PN
28. People tell me that I worry too much.				GD
29. I don't like to be away from my family.				SP
30. I am afraid of having anxiety (or panic) attacks.				PN
31. I worry that something bad might happen to my parents.				SP
32. I feel shy with people I don't know well.				SC
33. I worry about what is going to happen in the future.				GD
34. When I get frightened, I feel like throwing up.				PN
35. I worry about how well I do things.				GD
36. I am scared to go to school.				SH
37. I worry about things that have already happened.				GD
38. When I get frightened, I feel dizzy.				PN
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).				SC
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.				SC
41. I am shy.				SC

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 www.pediatricbipolar.pitt.edu under instruments.

March 20, 2017

Screen for Child Anxiety Related Disorders (SCARED) CHILD Version

TO BE COMPLETED BY CLINICIAN

SCORING:

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

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

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

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

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

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

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 www.pediatricbipolar.pitt.edu under instruments.

March 20, 2017

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 statement, 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.

	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				PN
2. My child gets headaches when he/she am at school.				SH
3. My child doesn't like to be with people he/she does't know well.				SC
4. My child gets scared if he/she sleeps away from home.				SP
5. My child worries about other people liking him/her.				GD
6. When my child gets frightened, he/she fells like passing out.				PN
7. My child is nervous.				GD
8. My child follows me wherever I go.				SP
9. People tell me that my child looks nervous.				PN
10. My child feels nervous with people he/she doesn't know well.				SC
11. My child gets stomachaches at school.				SH
12. When my child gets frightened, he/she feels like he/she is going crazy.				PN
13. My child worries about sleeping alone.				SP
14. My child worries about being as good as other kids.				GD
15. When my child gets frightened, he/she feels like things are not real.				PN
16. My child has nightmares about something bad happening to his/her parents.				SP
17. My child worries about going to school.				SH
18. When my child gets frightened, his/her heart beats fast.				PN
19. He/she child gets shaky.				PN
20. My child has nightmares about something bad happening to him/her.				SP

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version – Page 2 of 2 (to be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
21. My child worries about things working out for him/her.				GD
22. When my child gets frightened, he/she sweats a lot.				PN
23. My child is a worrier.				GD
24. My child gets really frightened for no reason at all.				PN
25. My child is afraid to be alone in the house.				SP
26. It is hard for my child to talk with people he/she doesn't know well.				SC
27. When my child gets frightened, he/she feels like he/she is choking.				PN
28. People tell me that my child worries too much.				GD
29. My child doesn't like to be away from his/her family.				SP
30. My child is afraid of having anxiety (or panic) attacks.				PN
31. My child worries that something bad might happen to his/her parents.				SP
32. My child feels shy with people he/she doesn't know well.				SC
33. My child worries about what is going to happen in the future.				GD
34. When my child gets frightened, he/she feels like throwing up.				PN
35. My child worries about how well he/she does things.				GD
36. My child is scared to go to school.				SH
37. My child worries about things that have already happened.				GD
38. When my child gets frightened, he/she feels dizzy.				PN
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).				SC
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.				SC
41. My child is shy.				SC

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

March 20, 2017

Screen for Child Anxiety Related Disorders (SCARED) PARENT Version

TO BE COMPLETED BY CLINICIAN

SCORING:

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

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

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

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

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

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

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D.,
Western Psychiatric Institute and Clinic, University of Pittsburgh (October, 1995). E-mail: birmaherb@upmc.edu

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.

Screen for Adult Anxiety Related Disorders (SCAARED)

TO BE COMPLETED BY THE PATIENT

Name: _____ Date: _____

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for you. Then, for each sentence, check √ the box that corresponds to the response that seems to describe you now *or within the past 3 months*.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel nervous, it is hard for me to breathe.				PN
2. I get headaches when I am at school, at work or in public places.				PN
3. I don't like to be with people I don't know well.				SC
4. I get nervous if I sleep away from home.				SP
5. I worry about people liking me.				GD
6. When I get anxious, I feel like passing out.				PN
7. I am nervous.				GD
8. It is hard for me to stop worrying.				GD
9. People tell me that I look nervous.				PN
10. I feel nervous with people I don't know well.				SC
11. I get stomachaches at school, at work, or in public places.				PN
12. When I get anxious, I feel like I'm going crazy.				PN
13. I worry about sleeping alone.				SP
14. I worry about being as good as other people.				GD
15. When I get anxious, I feel like things are not real.				PN
16. I have nightmares about something bad happening to my family.				SP
17. I worry about going to work or school, or to public places.				PN
18. When I get anxious, my heart beats fast.				PN
19. I get shaky.				PN
20. I have nightmares about something bad happening to me.				SP

Screen for Adult Anxiety Related Disorders (SCAARED)

	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.				GD
22. When I get anxious, I sweat a lot.				PN
23. I am a worrier.				GD
24. When I worry a lot, I have trouble sleeping.				GD
25. I get really frightened for no reason at all.				PN
26. I am afraid to be alone in the house.				SP
27. It is hard for me to talk with people I don't know well.				SC
28. When I get anxious, I feel like I'm choking.				PN
29. People tell me that I worry too much.				GD
30. I don't like to be away from my family.				SP
31. When I worry a lot, I feel restless.				GD
32. I am afraid of having anxiety (or panic) attacks.				PN
33.I worry that something bad might happen to my family.				SP
34. I feel shy with people I don't know well.				SC
35. I worry about what is going to happen in the future.				GD
36. When I get anxious, I feel like throwing up.				PN
37. I worry about how well I do things.				GD
38. I am afraid to go outside or to crowded places by myself.				PN
39. I worry about things that have already happened.				GD
40. When I get anxious, I feel dizzy.				PN
41. I feel nervous when I am with other people and I have to do something while they watch me (for example: speak, play a sport.)				SC
42. I feel nervous when I go to parties, dances, or any place where there will be people that I don't know well.				SC
43. I am shy.				SC
44. When I worry a lot, I feel irritable.				GD

See: Angulo M, Rooks B, Sakolsky D, Goldstein T, Goldstein B, Monk K, Hickey M, Gill M, Diler R, Hafeman D, Merranko J, Axelson D, Birmaher, B. (In Press). Psychometrics of the Screen For Adult Anxiety Related Disorders (SCAARED)-A New Scale For the Assessment of DSM-5 Anxiety Disorders. Psychiatry Research.

The SCAARED is available at no cost at www.pediatricbipolar.pitt.edu under instruments.
March 2, 2017

Screen for Adult Anxiety Related Disorders (SCAARED)

TO BE COMPLETED BY CLINICIAN

Name: _____ Date: _____

SCORING:

A total score of ≥ **23** may indicate the presence of an **Anxiety Disorder.** TOTAL =

A score of **5** for items 1, 2, 6, 9, 11, 12, 15, 17, 18, 19, 22, 25, 28, 32, 36, 38, 40 may indicate **Panic Disorder** or **Significant Somatic Symptoms.** PN =

A score of **12** for items 5, 7, 8, 14, 21, 23, 24, 29, 31, 35, 37, 39, 44 may indicate **Generalized Anxiety Disorder.** GD =

A score of **3** for items 4, 13, 16, 20, 26, 30, 33 may indicate **Separation Anxiety SOC.** SP =

A score of **7** for items 3, 10, 27, 34, 41, 42, 43 may indicate **Social Anxiety Disorder.** SC =

See: Angulo M, Rooks B, Sakolsky D, Goldstein T, Goldstein B, Monk K, Hickey M, Gill M, Diler R, Hafeman D, Merranko J, Axelson D, Birmaher, B. (In Press). Psychometrics of the Screen For Adult Anxiety Related Disorders (SCAARED)-A New Scale For the Assessment of DSM-5 Anxiety Disorders. Psychiatry Research.

The SCAARED is available at no cost at www.pediatricbipolar.pitt.edu under instruments.
March 2, 2017

EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

Florida Medicaid Drug Therapy Management Guidelines

The Florida Medicaid Drug Therapy Management Program for Behavioral Health is a program whose goal is to work collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid beneficiaries with a mental illness. The following information has been developed and is maintained by the University of South Florida College of Behavioral and Community Sciences and is used with permission. More information on the program, and additional best practice guidelines, can be found at http://www.medicaidmentalhealth.org/.

Anxiety Disorders in Children under Age 6

Level 0

Comprehensive assessment that includes history of stressors, trauma, parental anxiety, and observation of child-parent interactions. Refer to *Principles of Practice* on page 6.

- Rating scales specifically for young children with anxiety symptoms are limited, but the Preschool Anxiety Scale (parent report) is available at ***http://medicaidmentalhealth.org/.***
- Child and parent rating of anxiety symptom severity and impairment with feelings thermometer or faces barometer.

Level 1

Start with psychotherapy for at least 12 weeks that includes the parents and exposure-based cognitive behavioral therapy (CBT) adapted to young children.

- Assess primary caregivers for anxiety disorders and referral for treatment if impacting child's treatment progress.
- Address parental accommodation to child's symptoms of anxiety.

Level 2

If poor or partial response to psychosocial treatment after at least 12 weeks, consider combination treatment with fluoxetine and concurrent psychotherapy for children 4 to 5 years old.

- Review black-box warning with parents and monitor for suicidality.
- 8 to 10-week trial of fluoxetine if well tolerated starting at 1 to 2mg/day.
- Maximum dosing of fluoxetine: 5 to 10 mg/day.
- Increased risk of behavioral activation (e.g., difficulty falling asleep, increased motor activity, increased talkativeness) in young children.
- Discontinuation trial after 6 to 9 months of effective medication treatment with gradual downward titration.

Less than 4 years old, refer to *Principles of Practice in Children under Age 6* on pg. 6.

Level 3

If fluoxetine is not successful, consider sertraline in combination with concurrent psychotherapy. Start with low dosing and monitor closely

Not Recommended for Children Under Age 6 with Anxiety Disorders:

- The use of medication without psychosocial treatment.
- Use of tricyclic antidepressants (TCAs) or alpha-agonists.
- Ongoing use of benzodiazepines. May be used short-term for severe anxiety with medical or dental procedures.

The data for treating anxiety disorders with psychopharmacologic medication in young children is limited. Thus, exercise caution in prescribing pharmacological treatment below age 6.

Note: For dosing recommendations, refer to Table 10 on page 33.

Anxiety Disorders in Children and Adolescents Ages 6 to 17 Years Old

Level 0

A comprehensive assessment includes evaluation of:

- Risk factors including: stressors, trauma, bullying, social support systems, coping skills, learning disorders, and school issues.
- Family coping skills, parenting styles (overprotective or over-controlling), and family accommodations that support child's symptoms.
- Medical conditions and comorbid psychiatric disorders.
- Parental and family history of anxiety disorders and psychiatric treatment.
- Severity of anxiety symptoms and impairment from anxiety disorder.
  - Screening and monitoring for anxiety symptoms with multi-informant, validated rating scales for childhood anxiety (parent and child report) such as Self-Report for Childhood Anxiety Related Disorders (SCARED) and Spence Children's Anxiety Scale (SCAS). Available at ***http://www.medicaidmentalhealth.org/.***
- Baseline somatic symptoms prior to medication trials.

Note: The Anxiety Disorders Interview Schedule for Children (ADIS-C) may assist clinicians to differentiate the specific anxiety disorders (Silverman and Albano, 1996). The ADIS-C is not available on the public domain.

Level 1

If mild to moderate anxiety disorder:

- **1a.** Provide family with psychoeducation regarding anxiety disorders and cognitive behavioral therapy (CBT).
  - Initiate treatment with exposure-based cognitive behavioral therapy.
- **1b.** If CBT is not available, first consider evidence-based psychosocial interventions.
  - Provide family with psychoeducation regarding anxiety disorders and CBT.
  - Train parents to monitor child's anxiety symptoms (e.g. feelings thermometer or faces barometer) and set up behavioral program with positive reinforcement for child's efforts and progress in addressing anxiety symptoms and decreasing avoidance.
  - If parental anxiety disorders interfere with treatment progress, provide referral for parent.

Anxiety Disorders in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 2

If moderate to severe anxiety disorder or inadequate response to CBT alone:

- **2a.** Initiate treatment with fluoxetine or sertraline alone or in combination with CBT.
  - Combination therapy with CBT has been shown to be more effective than medication alone.
  - Review boxed warnings with family and monitor for treatment emergent suicidality and behavioral activation (eg. difficulty falling asleep, increased motor activity, increased talkativeness).
- **2b.** If first SSRI trial with fluoxetine or sertraline is not effective and/or there are treatment-limiting side-effects, switch to the other SSRI not used in Level 2a (fluoxetine or sertraline) and initiate/continue CBT.

Level 3

If moderate to severe anxiety disorder and Levels 1 and 2 are not successful:

- **3a.** Duloxetine alone or in combination with CBT. Monitor height, weight, blood pressure and pulse with duloxetine.
- **3b.** Consider fluvoxamine alone or in combination with CBT.
  - Monitor for treatment emergent suicidality and behavioral activation for either duloxetine or fluvoxamine (see above).

Level 4

If Levels 1, 2 and 3 are not successful, then re-assess diagnosis or refer to a specialist.

If Level 3 is not successful may consider escitalopram, citalopram or venlafaxine in combination with CBT. Monitor for treatment emergent suicidality and behavioral activation. For venlafaxine, monitor height, weight, blood pressure and pulse.

Not Recommended:

- Paroxetine as first or second line treatment (concern about increased adverse effects, eg. insomnia, behavioral activation, decreased appetite, vomiting, discontinuation symptoms, suicidal ideation).
- Benzodiazepines (BZD) as first-line monotherapy for long-term treatment of childhood anxiety disorders.

Notes:

Despite limited evidence, may consider monotherapy or augmentation with other medications if partial or poor response with SSRIs, duloxetine or venlafaxine. Potential agents include: buspirone, alpha-2 agonist, clomipramine, and low dose benzodiazepine. If prescribed, benzodiazepines should be reserved for short-term use only.

For dosing recommendations, refer to Table 10 on page 33.

Medications for the Treatment of Anxiety Disorders

Clinicians should realize that data below age 6 for treating anxiety disorders is limited and caution in using pharmacological treatment below age 6 is warranted.

Table 10.

Medications for the Treatment of Anxiety Disorders			
Drug Name	**Young Child (4 – 6 Years)**	**Child (6 – 12 Years)**	**Adolescent**
***Fluoxetine**			
Starting Dose: Maximum Dose:	1-2 mg/day 5-10 mg/day (limited data)	2.5–5 mg/day 20–40 mg/day	5–10 mg/day 40–60 mg/day
***Sertraline**			
Starting Dose: Maximum Dose:	5-10 mg/day 50-75 mg/day (limited data)	10–12.5 mg/day 100–150 mg/day	25 mg/day 150–200 mg/day
***Fluvoxamine**			
Starting Dose: Maximum Dose:	5 mg/day 50-75 mg/day (limited data)	12.5–25 mg/day 100–200 mg/day	25 mg/day 150–300 mg/day
Escitalopram			
Starting Dose: Maximum Dose:	1-2 mg/day 5 -10 mg (limited data)	2.5 mg/day 10–20 mg/day	5 mg/day 20–30 mg/day
Citalopram			
Starting Dose: Maximum Dose:	No data	5 mg/day 20–40 mg/day	10 mg/day 40 mg/day (check EKG above 40 mg for QTc prolongation)
***Duloxetine**			
Starting Dose: Maximum Dose:	No data	20–30 mg/day 60 mg/day	30 mg/day 60 mg/day
***Venlafaxine**			
Starting Dose: Maximum Dose:	No data	37.5 mg/day 75–112.5 mg/day (25-39 kg)	37.5 mg/day 150 mg/day (40–49 kg) 225 mg/day (>50 kg)

**Indicates placebo-controlled studies in children 6 to 17 years with anxiety disorders.*

Note: The FDA does not currently provide any dosing guidelines for venlafaxine in children or adolescents and does not recommend its use in this population due to mixed results in efficacy trials.

Additional Clinical Information

- May titrate to lowest therapeutic dose once weekly.
- After reaching the lowest therapeutic dose, can increase SSRI or SNRI dose after one month if well tolerated and significant symptoms remain.
- If switching medications, in the absence of side effects, it is preferable to cross-titrate with an overlap of the two medications rather than titrating off one medication before starting the next medication.
- Can consider discontinuation trial of SSRI or SNRI after 12 months of effective medication treatment, during low stress period, and with gradual taper. Monitor for relapse.

Anxiety Disorders and Comorbid Disorders

- ADHD:
  - Stimulant medications can be combined with SSRIs for comorbid ADHD.
  - Non-stimulant medication may be helpful for children with co-morbid anxiety or who cannot tolerate stimulants.
- Depression and bipolar disorder:
  - Fluoxetine is first-line medication for comorbid unipolar depression.
  - For children with comorbid bipolar disorder:
    - The bipolar disorder should be stabilized first. Adding an SSRI or SNRI needs to be considered cautiously after CBT for the anxiety disorder has been tried.
    - Alternatives to SSRI medications for anxiety disorder symptoms may be considered early in treatment, such as guanfacine for autonomic symptoms.
  - Use benzodiazepines with caution as they can increase disinhibition, mood lability, irritability, or aggression and may have potential for abuse.
- Substance use disorder (SUD):
  - Both anxiety disorders and SUD can be treated at the same time. Some substances increase anxiety & panic symptoms complicating treatment.
  - Use caution with benzodiazepines in presence of SUD, especially those with short half-life and increased risk for abuse and dependence.
  - Integrate additional psychotherapy components: Motivational strategies and CBT to identify triggers for cravings, develop alternative coping skills to reduce substance use.
- Autism spectrum disorders (ASD) and developmental disorders (DD):
  - Can modify CBT for anxiety disorders with ASD and/or DD.
  - SSRIs may be used for anxiety/irritability and obsessive-compulsive behaviors distressing to the child, but not all ritualized or repetitive behaviors. Consider when obsessive features, rigidity of thought, perseveration, rituals, anxiety, depression, and/or irritability are impairing.
  - For co-morbid ADHD symptoms, atomoxetine may reduce ADHD and anxiety symptom severity.

EVIDENCE BASED THERAPEUTIC TREATMENTS

Both Cognitive Behavioral Therapy (CBT) and Interpersonal Psychotherapy (IPT) are evidence-based psychotherapeutic treatments for childhood anxiety disorders.

Cognitive Behavioral Therapy (CBT) is an evidence-based psychotherapeutic treatment for depression, anxiety, and a number of other disorders (e.g. pain and insomnia). Trained CBT therapists work in a structured way with the patient to develop an individualized assessment of thoughts and behaviors that serve to maintain or worsen anxiety and/or depression. Ways of thinking that worsen depression are targeted and patients are taught to practice ways of perceiving and thinking about themselves and their environments in ways that improve mood and reduce anxiety. In addition, problematic behaviors, such as avoidance of experiences that would otherwise improve symptoms, are also targeted and shaped in a gradual and systematic way. CBT has been established as a highly effective treatment for childhood and adolescent depression and anxiety, especially for mild-moderate symptoms, and in conjunction with SSRI's for moderate to severe illness (Connolly et al, 2007: USPSTF 2009). A national listing of CBT therapists may be found at www.abct.org.

Interpersonal Psychotherapy adapted for adolescents (IPT-A) has been similarly recommended as a part of guideline-based care for Adolescent depression (USPSTF, 2009). Clinicians trained in IPT-A work with the patient to clearly identify and recognize the link between mood symptoms and interpersonal events, support, and functioning. The therapy works to improve mood by assisting the patient to adjust to social changes (such as school, family, peer, medical and other environmental changes), to cope with interpersonal conflict, and to cope with grief and loss. Access to IPT therapists may be found through inquiry at www.interpersonalpsychotherpy.org.

US Preventive Services Task Force (USPSTF). Screening and Treatment for Major Depressive Disorder in Children and Adolescents: US Preventive Services Task for Recommendations. Pediatrics, April 2009, VOLUME 123 / ISSUE 4

ASD

AUSTIM SPECTRUM DISORDER (ASD) (5.1.1.1.3.1)

DESCRIPTION

The essential features of ASD are persistent impairment in reciprocal social communication and social interaction and restricted, repetitive patterns of behavior, interests, or activities. These symptoms are present from early childhood and limit or impair everyday functioning. The stage at which functional impairment becomes obvious will vary according to characteristics of the individual and his or her environment. Core diagnostic features are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of ASD also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term spectrum. ASD encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

DSM-5 DIAGNOSTIC CRITERIA

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by all of the following, currently or by history (examples are illustrative, not exhaustive; see text):
    - Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
    - Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
    - Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.
    - Specify current severity:
        - Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
    - Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

- Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
- Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
- Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain / temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
- Specify current severity:
    - Severity is based on social communication impairments and restricted, repetitive patterns of behavior.

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

1. With or without accompanying intellectual impairment.
2. With or without accompanying language impairment.
3. Associated with a known medical or genetic condition or environmental factor. (Coding note: Use additional code to identify the associated medical or genetic condition.)
4. Associated with another neurodevelopmental, mental, or behavioral disorder. (Coding note: Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)
5. With catatonia.

Source: American Psychiatric Association. (2013). Autism Spectrum Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SEVERITY CLASSIFICATION

Severity Level	Social Communication	Restricted, Repetitive Behaviors
Level 3 Requiring very substantial support	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted / repetitive behaviors markedly interfere with functioning in all spheres. Great distress / difficulty changing focus or action.
Level 2 Requiring substantial support	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted / repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 Requiring support	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

Source: Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/ncbddd/autism/data.html

Prevalence
According to the Centers for Disease Control and Prevention, Autism and Developmental Disabilities Monitoring Network, about 1 in 68 children has been identified with autism spectrum disorder. ASD occurs in all racial, ethnic, and socioeconomic groups, and males are 4.5 times more likely to be diagnosed than females. Black and Hispanic children continue to receive developmental evaluations later than white children and continue to be diagnosed with autism at lower rates.

Source: Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/ncbddd/autism/data.html

SCREENING, ASSESSMENT, DIAGNOSIS, TREATMENT AND MANAGEMENT OF AUTISM SPECTRUM DISORDERS (ASD) (5.1.1.1.3.2)

American Academy of Pediatrics Clinical Practice Recommendations for Developmental Surveillance and Screening

- Incorporate developmental surveillance at every well-child preventive care visit.
- Promptly address any concerns with standardized developmental screening tests.
- Screening tests should be administered regularly at the 9, 18, and 24 or 30 month visits.
- Children diagnosed with developmental disorders should be identified as children with special health care needs, and chronic condition management should be initiated.
- Identification of a developmental disorder and its underlying etiology may also drive a range of treatment planning, from medical treatment of the child to genetic counseling for his or her parents.

American Academy of Neurology and the Child Neurology Society Clinical Practice Recommendations

- Developmental surveillance should be performed at all well-child visits from infancy through school age, and at any age thereafter if concerns are raised about social acceptance, learning, or behavior.
- Recommended developmental screening tools include:
    - Ages and Stages Questionnaire
    - BRIGANCE® Screens
    - Child Development Inventories
    - Parents' Evaluations of Developmental Status
- The Denver Developmental Screening Test II and the Revised Denver Pre-Screening Developmental Questionnaire are not recommended for appropriate primary care developmental surveillance because of the lack of sensitivity and specificity.
- Further developmental evaluation is required whenever a child fails to meet any of the following milestones:

  - babbling by 12 months
  - gesturing (e.g., pointing, waving bye-bye) by 12 months
  - single words by 16 months
  - two-word spontaneous (not just echolalic) phrases by 24 months
  - loss of any language or social skills at any age
- Siblings of children with autism should be monitored carefully for acquisition of social, communication, and play skills, and the occurrence of maladaptive behaviors.
- Screening should be performed not only for autism-related symptoms but also for language delays, learning difficulties, social problems, and anxiety or depressive symptoms.
- For all children failing routine developmental surveillance procedures, screening specifically for autism should be performed using one of the validated instruments.
- Laboratory investigations, including audiologic assessment and lead screening, are recommended for any child with developmental delay and/or autism. Early referral for a formal audiologic assessment should include behavioral audiometric measures, assessment of middle ear function, and electrophysiologic procedures using experienced pediatric audiologists with current audiologic testing methods and technologies. Lead screening should be performed in any child with developmental delay and pica. Additional periodic screening should be considered if the pica persists.

Source: Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/ncbddd/autism/hcp-recommendations.html

AUTISM SPECTRUM DISORDERS (ASD) DECISION TREE

Positive ASD screen and / or other risk factors (sibling with ASD, parental or other caregiver concern, male). Recommend routine screening starting at 18 months of age at each well-child visit

Assessment / Diagnosis:

- Review DSM-V criteria
- Assess for specific red flags (e.g. eye contact, little or no developmentally expected gestures such as pointing to objects; little or no shared social attention or interest in social interaction)
- Assess for common co-morbidities (e.g. intellectual disability, other speech, language or other communication disorder, hearing or vision impairment, other psychiatric or neurodevelopmental disorder, other psychiatric disorder)
- Complete medical evaluation (hearing / vision / dental, genetic, metabolic; consider Fragile

Any suspicion of ASD should result in referral to a diagnostic assessment so that early intervention can begin as soon as possible in development if indicated by assessment

1. Psychoeducation for family emphasizing importance of early intervention
2. Regular screening
3. Refer to XXXXXX in Florida

Intervention recommendations for ASD

- A list of evidence-based practices can be found at: http://autismpdc.fpg.unc.edu/evidence-based-practices
- Behavioral therapy
- Applied Behavior Analysis
- Individual, relationship-based models such as DIR Floortime
- Educational, school-based interventions
- Speech and language interventions
- Social skills interventions
- Occupational or physical therapy if indicated
- Psychological / psychiatric treatment if indicated, especially if co-morbid psychiatric disorder present

VALIDADED SCREENING TOOLS: OVERVIEW, ITEMS AND SCORING INSTRUCTIONS (5.1.1.1.3.3)

The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F) is a 2-stage parent-report screening tool to assess risk for ASD. The M-CHAT-R/F is a 20-item autism screening tool designed to identify children 16 to 30 months of age who should receive a more thorough assessment for possible early signs of ASD or developmental delay. The American Academy of Pediatrics recommends that all children receive autism-specific screening at 18 and 24 months of age, in addition to broad developmental screening at 9, 18, and 24 months. The M-CHAT-R/F can be administered at these well-child visits.

The online version of the screening can be found here: https://m-chat.org/

Modified Checklist for Autism in Toddlers, Revised, with Follow-Up

(M-CHAT-R/F)™

Diana L. Robins, Ph.D.
Deborah Fein, Ph.D.
Marianne Barton, Ph.D.

Acknowledgement: We thank the M-CHAT Study Group in Spain for developing the flow chart format used in this document.

For more information, please see
www.mchatscreen.com or contact Diana Robins at
mchatscreen2009@gmail.com

Permissions for Use of the M-CHAT-R/F™

The Modified Checklist for Autism in Toddlers, Revised with Follow-Up (M-CHAT-R/F; Robins, Fein, & Barton, 2009) is a 2-stage parent-report screening tool to assess risk for Autism Spectrum Disorder (ASD). The M-CHAT-R/F is available for free download for clinical, research, and educational purposes. Download of the M-CHAT-R/F and related material is authorized from www.mchatscreen.com.

The M-CHAT-R/F is a copyrighted instrument, and use of the M-CHAT-R/F must follow these guidelines:

(1) Reprints/reproductions of the M-CHAT-R must include the copyright at the bottom (© 2009 Robins, Fein, & Barton). No modifications can be made to items, instructions, or item order without permission from the authors.

(2) The M-CHAT-R must be used in its entirety. Evidence indicates that any subsets of items do not demonstrate adequate psychometric properties.

(3) Parties interested in reproducing the M-CHAT-R/F in print (e.g., a book or journal article) or electronically for use by others (e.g., as part of digital medical record or other software packages) must contact Diana Robins to request permission (mchatscreen2009@gmail.com).

(4) If you are part of a medical practice, and you want to incorporate the first stage M-CHAT-R questions into your own practice's electronic medical record (EMR), you are welcome to do so. However, if you ever want to distribute your EMR page outside of your practice, please contact Diana Robins to request a licensing agreement.

Instructions for Use

The M-CHAT-R can be administered and scored as part of a well-child care visit, and also can be used by specialists or other professionals to assess risk for ASD. The primary goal of the M-CHAT-R is to maximize sensitivity, meaning to detect as many cases of ASD as possible. Therefore, there is a high false positive rate, meaning that not all children who score at risk will be diagnosed with ASD. To address this, we have developed the Follow-Up questions (M-CHAT-R/F). Users should be aware that even with the Follow-Up, a significant number of the children who screen positive on the M-CHAT-R will not be diagnosed with ASD; however, these children are at high risk for other developmental disorders or delays, and therefore, evaluation is warranted for any child who screens positive. The M-CHAT-R can be scored in less than two minutes. Scoring instructions can be downloaded from http://www.mchatscreen.com. Associated documents will be available for download as well.

Scoring Algorithm

For all items except 2, 5, and 12, the response "NO" indicates ASD risk; for items 2, 5, and 12, "YES" indicates ASD risk. The following algorithm maximizes psychometric properties of the M-CHAT-R:

LOW-RISK: **Total Score is 0-2**; if child is younger than 24 months, screen again after second birthday. No further action required unless surveillance indicates risk for ASD.

MEDIUM-RISK: **Total Score is 3-7**; Administer the Follow-Up (second stage of M-CHAT-R/F) to get additional information about at-risk responses. If M-CHAT-R/F score remains at 2 or higher, the child has screened positive. Action required: refer child for diagnostic evaluation and eligibility evaluation for early intervention. If score on Follow-Up is 0-1, child has screened negative. No further action required unless surveillance indicates risk for ASD. Child should be rescreened at future well-child visits.

HIGH-RISK: **Total Score is 8-20**; It is acceptable to bypass the Follow-Up and refer immediately for diagnostic evaluation and eligibility evaluation for early intervention.

M-CHAT-R™

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Yes	No
2. Have you ever wondered if your child might be deaf?	Yes	No
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)	Yes	No
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Yes	No
5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Yes	No
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Yes	No
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Yes	No
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Yes	No
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Yes	No
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Yes	No
11. When you smile at your child, does he or she smile back at you?	Yes	No
12. Does your child get upset by everyday noises? (FOR EXAMPLE, does your child scream or cry to noise such as a vacuum cleaner or loud music?)	Yes	No
13. Does your child walk?	Yes	No
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Yes	No
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Yes	No
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Yes	No
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me"?)	Yes	No
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?)	Yes	No
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Yes	No
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Yes	No

M-CHAT-R Follow-Up (M-CHAT-R/F)™

Permissions for Use

The Modified Checklist for Autism in Toddlers, Revised, with Follow-Up (M-CHAT-R/F; Robins, Fein, & Barton, 2009) is designed to accompany the M-CHAT-R. The M-CHAT-R/F may be downloaded from www.mchatscreen.com.

The M-CHAT-R/F is a copyrighted instrument, and use of this instrument is limited by the authors and copyright holders. The M-CHAT-R and M-CHAT-R/F may be used for clinical, research, and educational purposes. Although we are making the tool available free of charge for these uses, this is copyrighted material and it is not open source. Anyone interested in using the M-CHAT-R/F in any commercial or electronic products must contact Diana L. Robins at mchatscreen2009@gmail.com to request permission.

Instructions for Use

The M-CHAT-R/F is designed to be used with the M-CHAT-R; the M-CHAT-R is valid for screening toddlers between 16 and 30 months of age, to assess risk for autism spectrum disorder (ASD). Users should be aware that even with the Follow-Up, a significant number of the children who fail the M-CHAT-R will not be diagnosed with ASD; however, these children are at risk for other developmental disorders or delays, and therefore, follow-up is warranted for any child who screens positive.

Once a parent has completed the M-CHAT-R, score the instrument according to the instructions. If the child screens positive, select the Follow-Up items based on which items the child failed on the M-CHAT-R; only those items that were originally failed need to be administered for a complete interview.

Each page of the interview corresponds to one item from the M-CHAT-R. Follow the flowchart format, asking questions until a PASS or FAIL is scored. Please note that parents may report "maybe" in response to questions during the interview. When a parent reports "maybe," ask whether most often the answer is "yes" or "no" and continue the interview according to that response. In places where there is room to report an "other" response, the interviewer must use his/her judgment to determine whether it is a passing response or not.

Score the responses to each item on the M-CHAT-R/F Scoring Sheet (which contains the same items as the M-CHAT-R, but Yes/No has been replaced by Pass/Fail). The interview is considered to be a screen positive if the child fails any two items on the Follow-Up. If a child screens positive on the M-CHAT-R/F, it is strongly recommended that the child is referred for early intervention and diagnostic testing as soon as possible. Please note that if the healthcare provider or parent has concerns about ASDs, children should be referred for evaluation regardless of the score on the M-CHAT-R or M-CHAT-R/F.

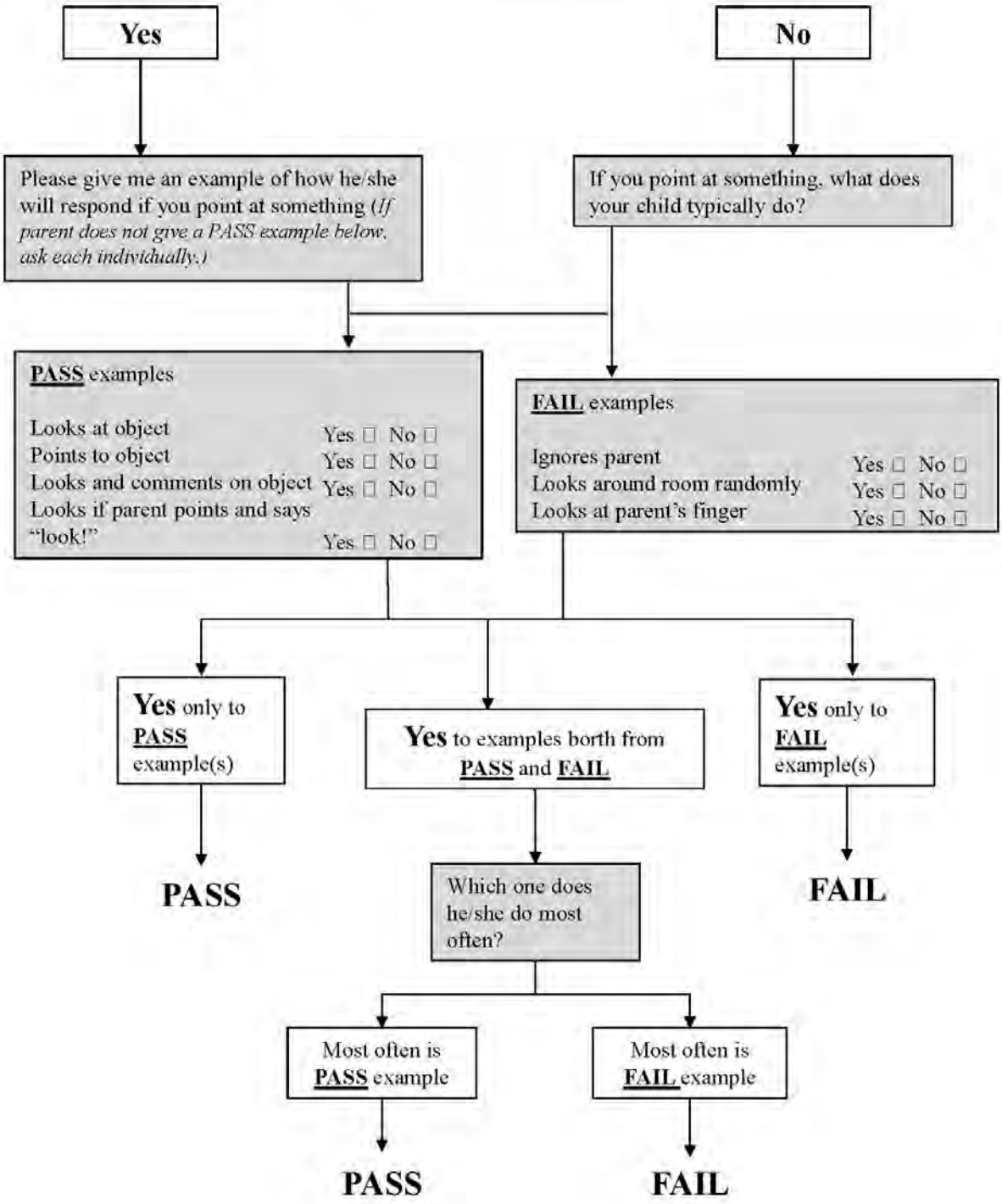
M-CHAT-R Follow-Up™ Scoring Sheet

Please note: Yes/No has been replaced with Pass/Fail

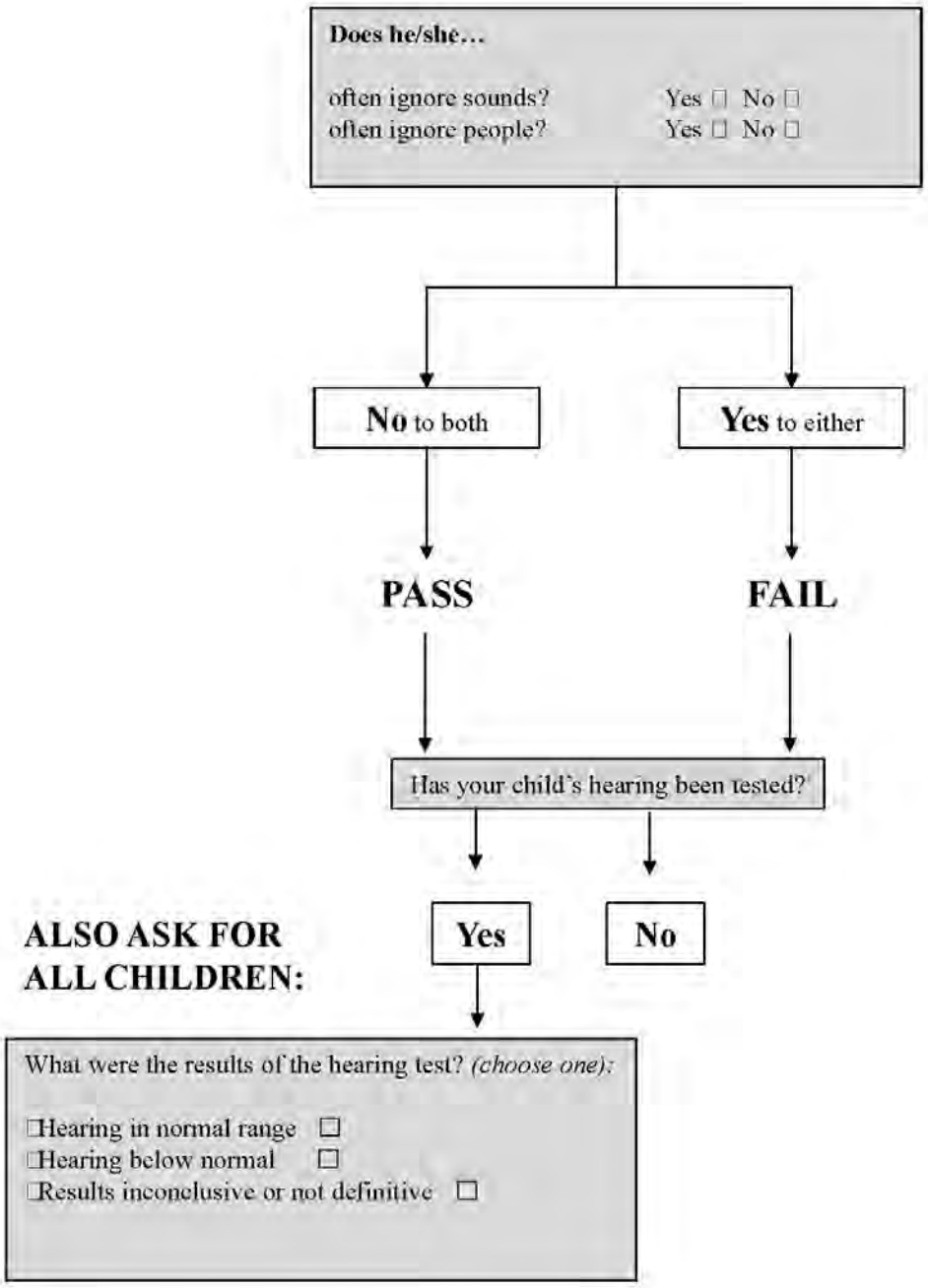
1. If you point at something across the room, does your child look at it? (FOR EXAMPLE, if you point at a toy or an animal, does your child look at the toy or animal?)	Pass	Fail
2. Have you ever wondered if your child might be deaf?	Pass	Fail
3. Does your child play pretend or make-believe? (FOR EXAMPLE, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal)	Pass	Fail
4. Does your child like climbing on things? (FOR EXAMPLE, furniture, playground equipment, or stairs)	Pass	Fail
5. Does your child make unusual finger movements near his or her eyes? (FOR EXAMPLE, does your child wiggle his or her fingers close to his or her eyes?)	Pass	Fail
6. Does your child point with one finger to ask for something or to get help? (FOR EXAMPLE, pointing to a snack or toy that is out of reach)	Pass	Fail
7. Does your child point with one finger to show you something interesting? (FOR EXAMPLE, pointing to an airplane in the sky or a big truck in the road)	Pass	Fail
8. Is your child interested in other children? (FOR EXAMPLE, does your child watch other children, smile at them, or go to them?)	Pass	Fail
9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (FOR EXAMPLE, showing you a flower, a stuffed animal, or a toy truck)	Pass	Fail
10. Does your child respond when you call his or her name? (FOR EXAMPLE, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?)	Pass	Fail
11. When you smile at your child, does he or she smile back at you?	Pass	Fail
12. Does your child get upset by everyday noises? (FOR EXAMPLE, a vacuum cleaner or loud music)	Pass	Fail
13. Does your child walk?	Pass	Fail
14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her?	Pass	Fail
15. Does your child try to copy what you do? (FOR EXAMPLE, wave bye-bye, clap, or make a funny noise when you do)	Pass	Fail
16. If you turn your head to look at something, does your child look around to see what you are looking at?	Pass	Fail
17. Does your child try to get you to watch him or her? (FOR EXAMPLE, does your child look at you for praise, or say "look" or "watch me")	Pass	Fail
18. Does your child understand when you tell him or her to do something? (FOR EXAMPLE, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket")	Pass	Fail
19. If something new happens, does your child look at your face to see how you feel about it? (FOR EXAMPLE, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?)	Pass	Fail
20. Does your child like movement activities? (FOR EXAMPLE, being swung or bounced on your knee)	Pass	Fail

Total Score: _____

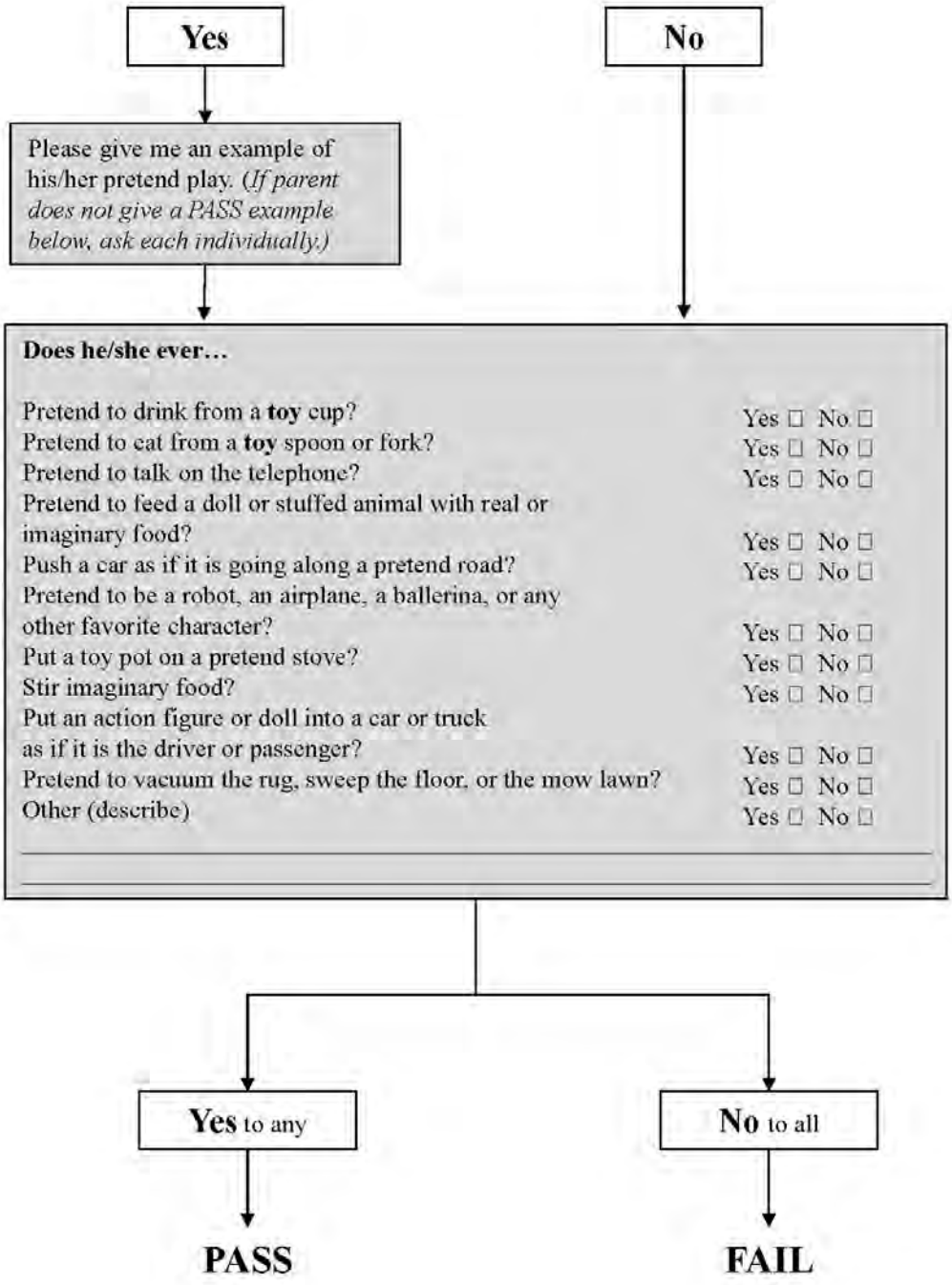
1. If you point at something across the room, does _____ look at it?



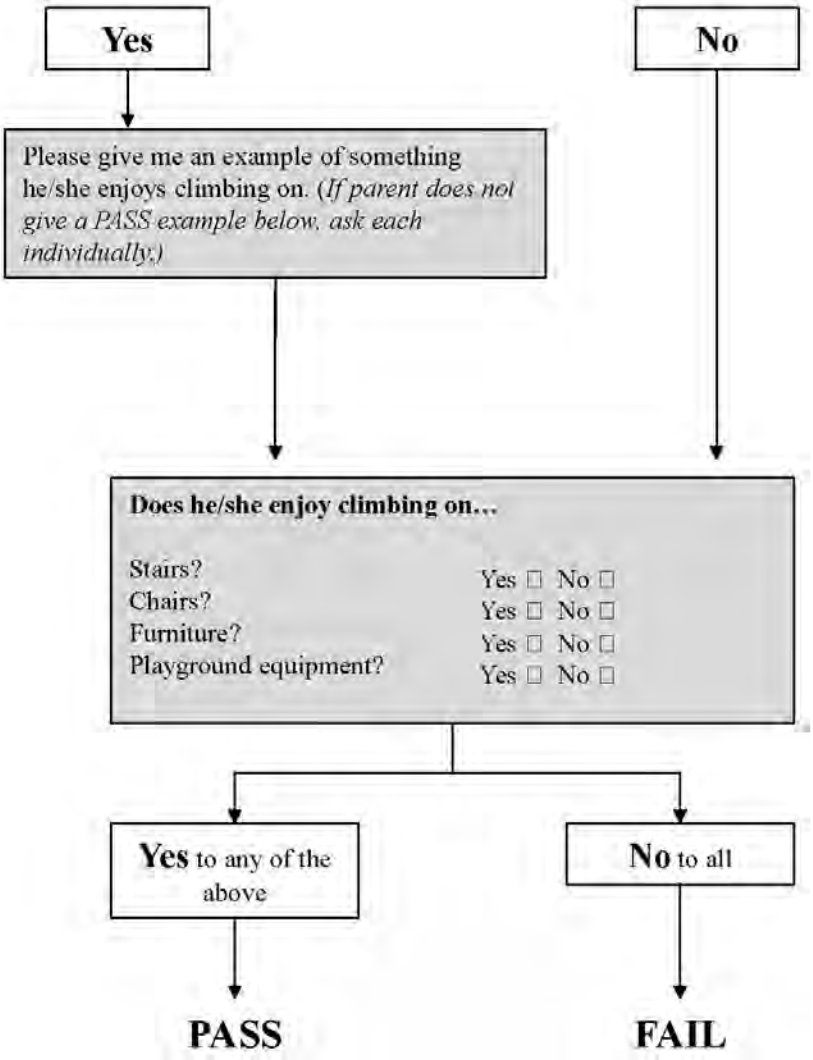
2. You reported that you have wondered if you child is deaf. What led you to wonder that?



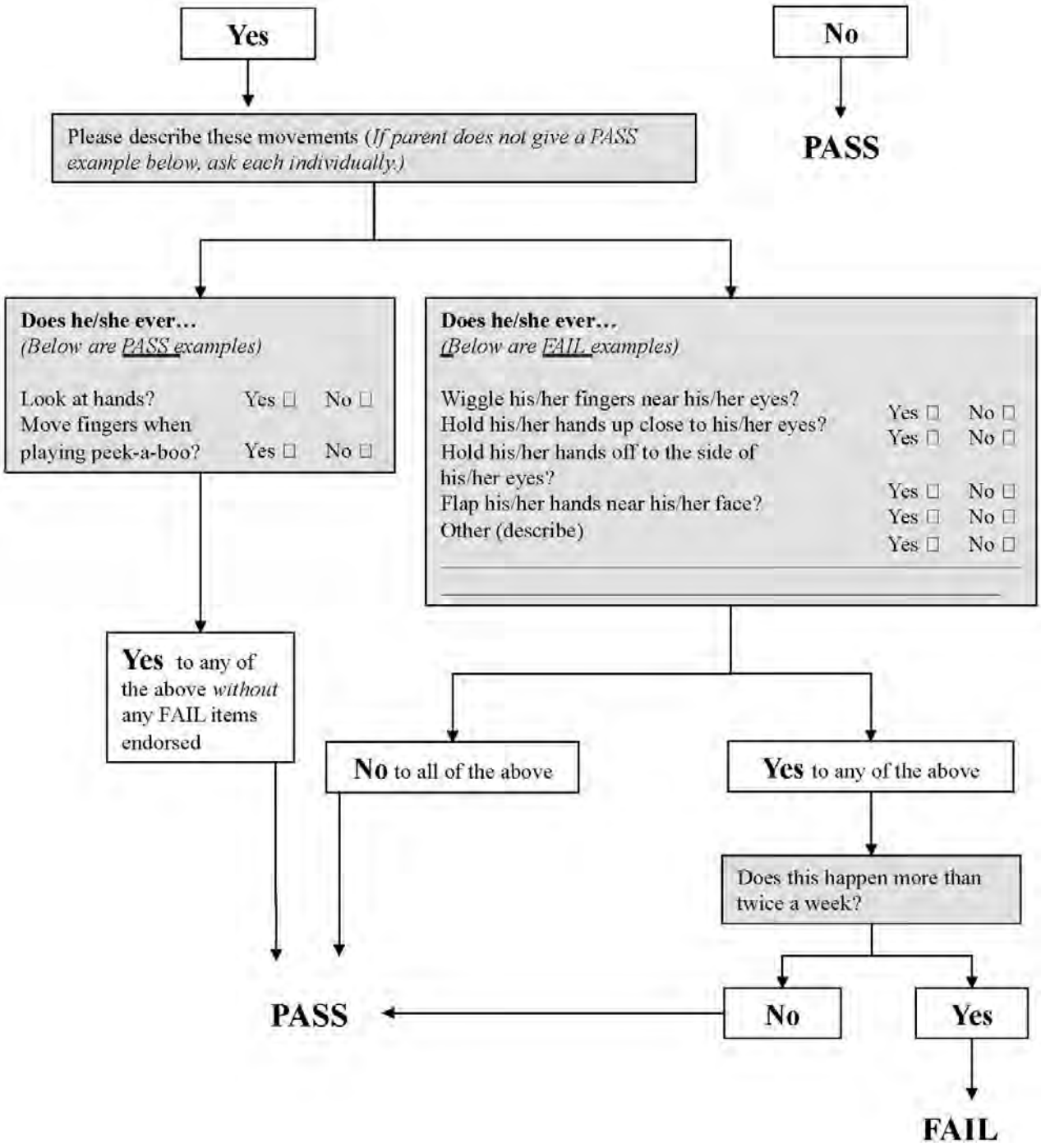
3. Does _____ play pretend or make- believe



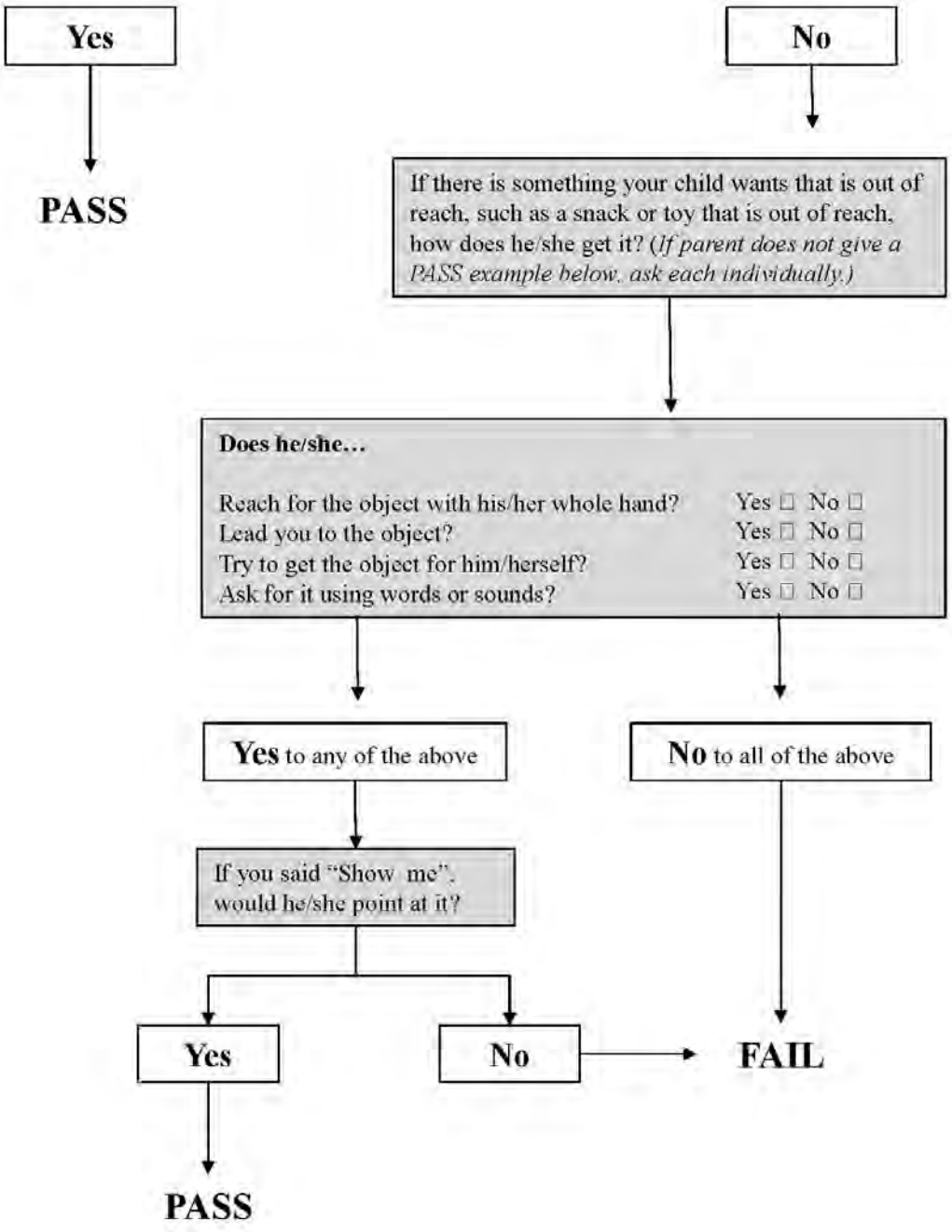
4. Does _____ like climbing on things?



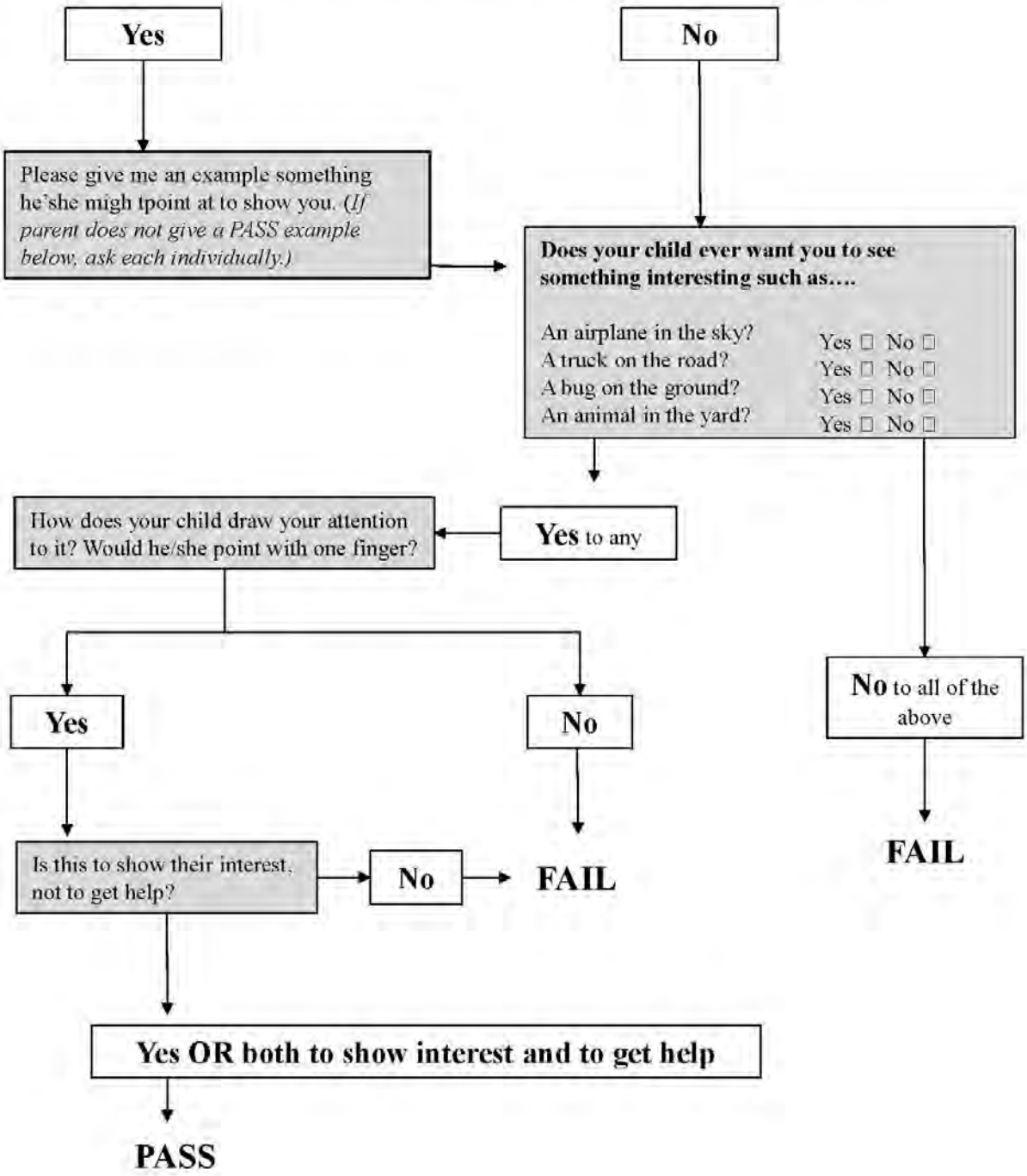
5. Does _____ make unusual finger movements near his/her eyes?



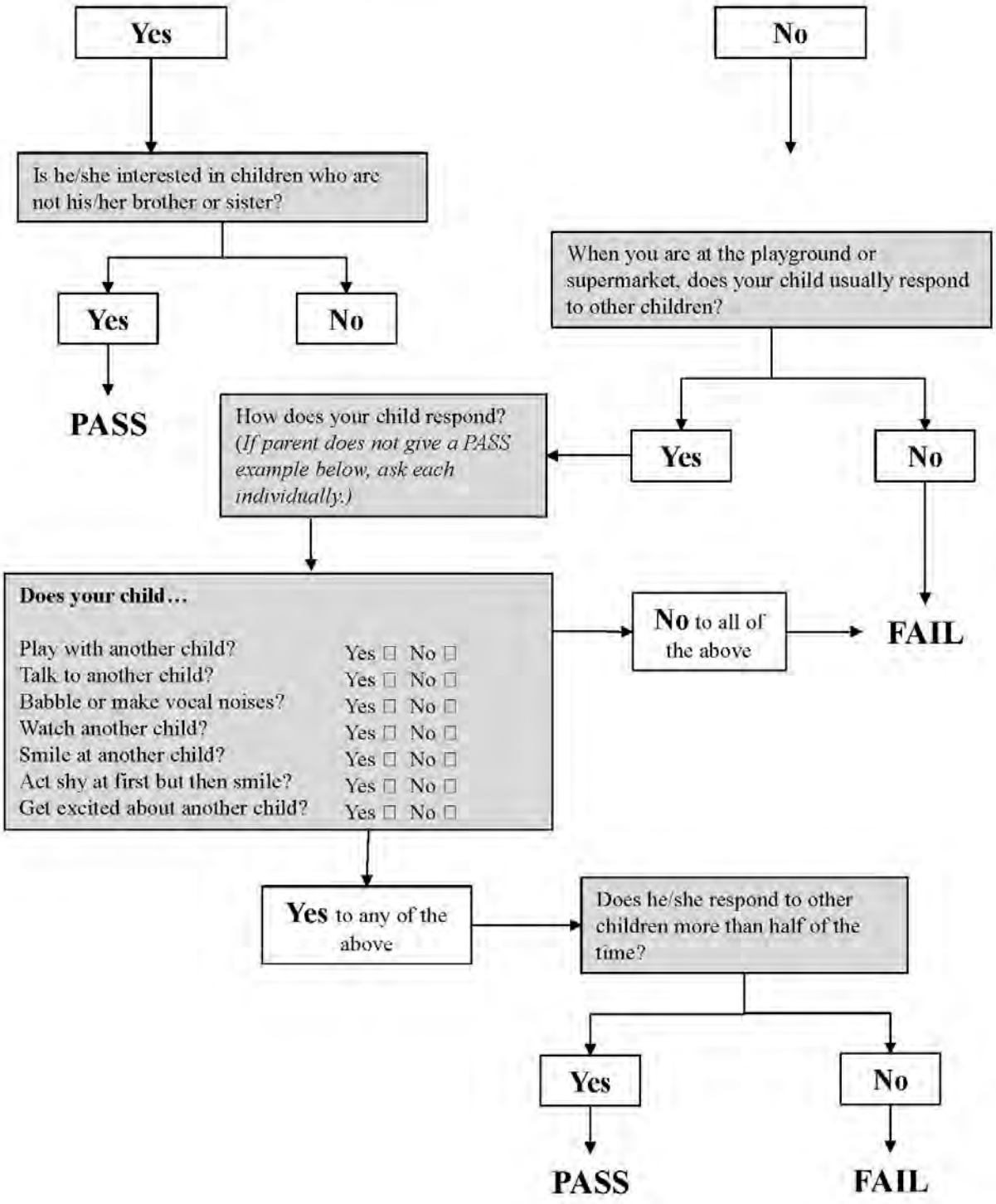
6. Does your child point with one finger to ask for something or to get help?



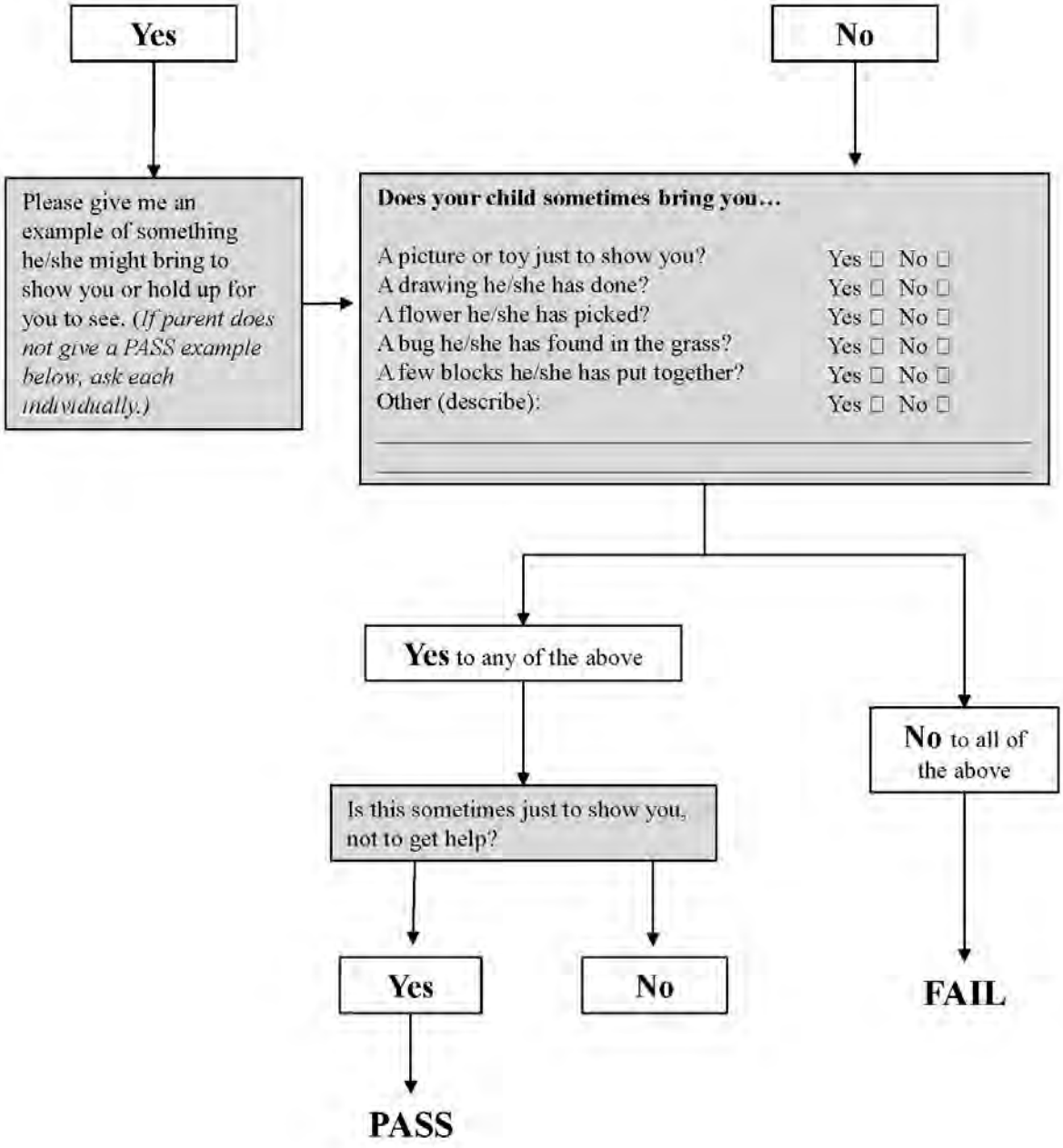
7. * If the interviewer just asked #6, begin here: We just talked about pointing to *ask* for something, ASK ALL → Does your child point with one finger just to show you something interesting?



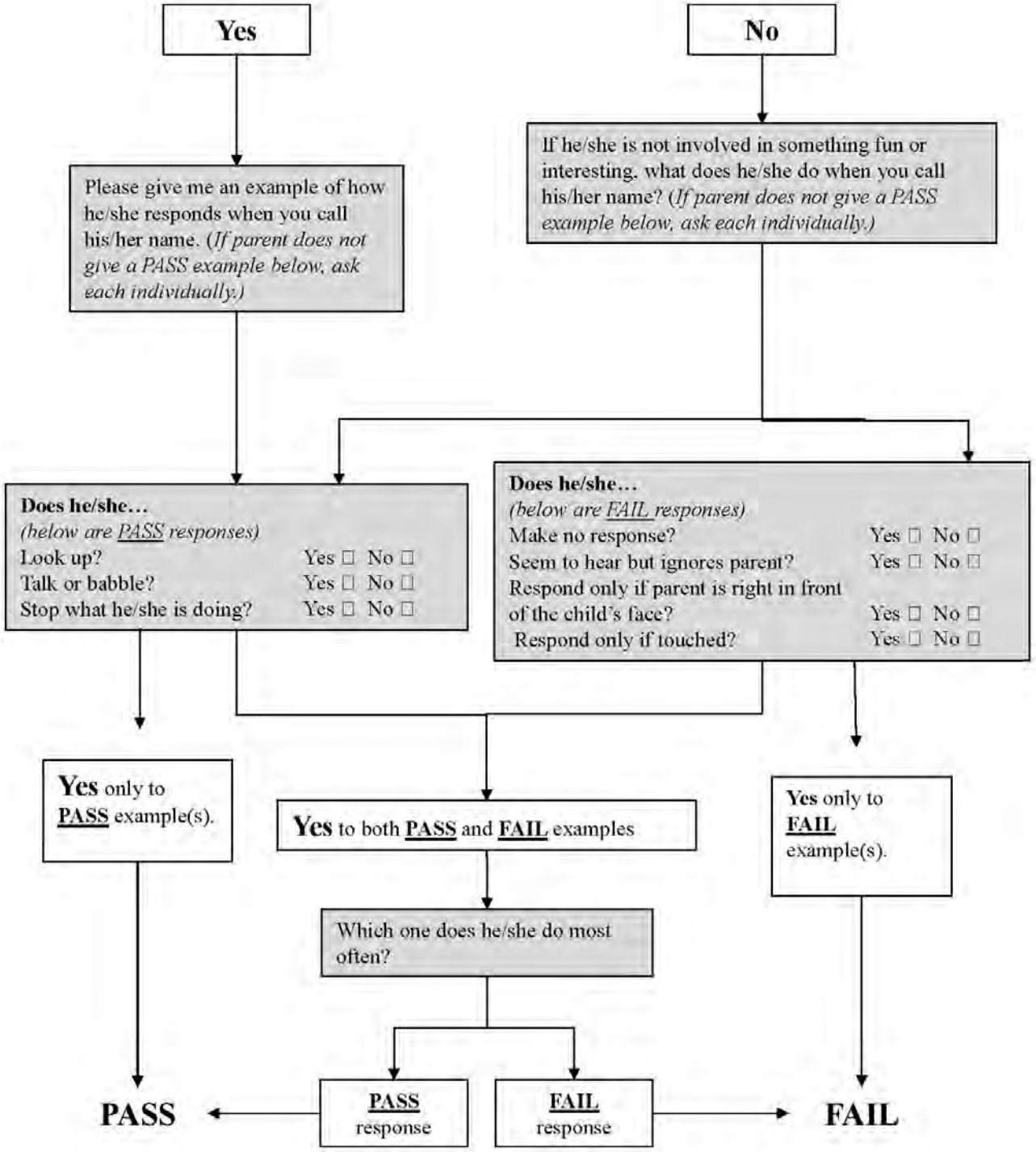
8. Is _____ interested in other children?



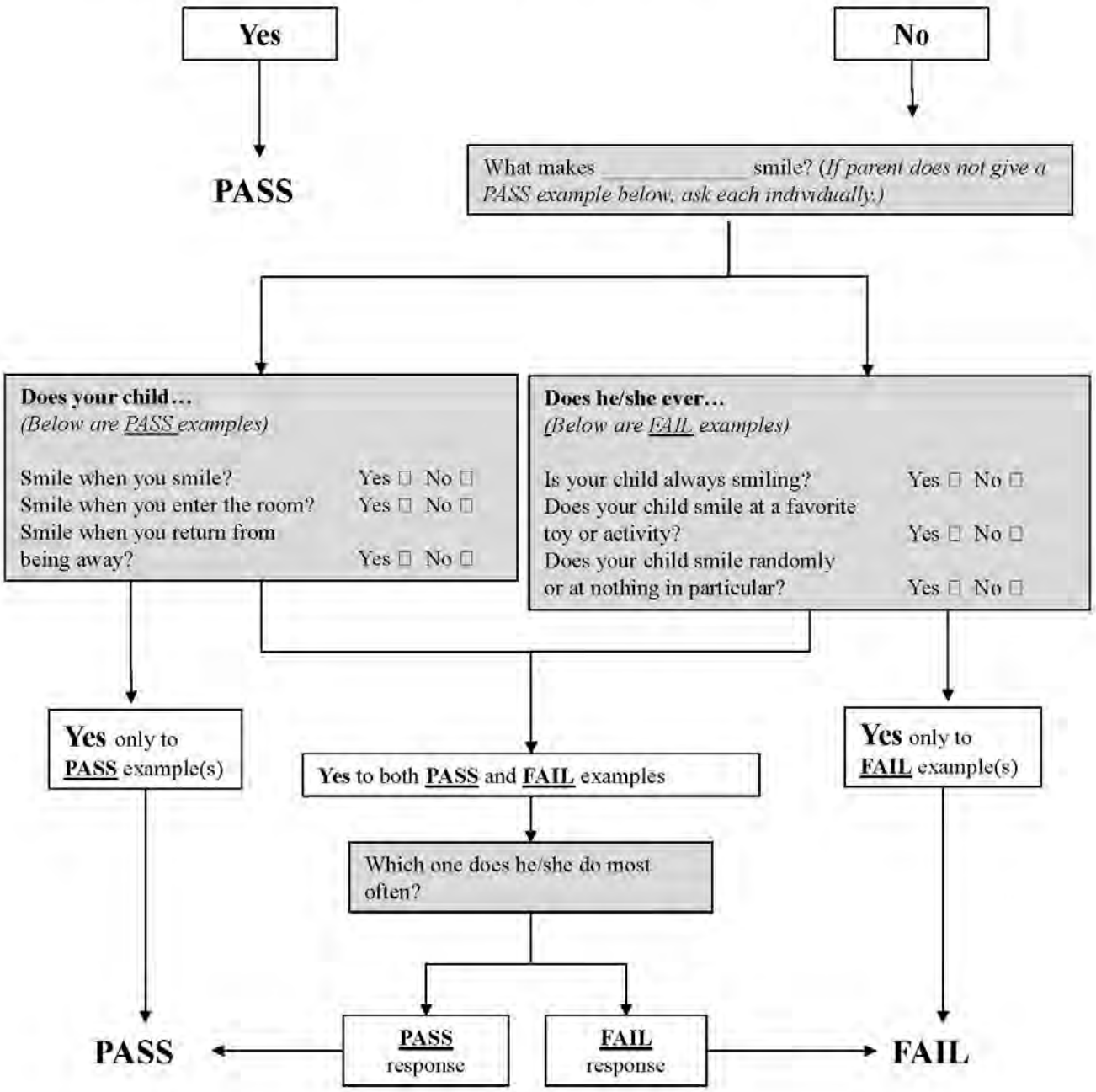
9. Does _____ show you things by bringing them to you or holding them up for you to see? Not just to get help, but to share?

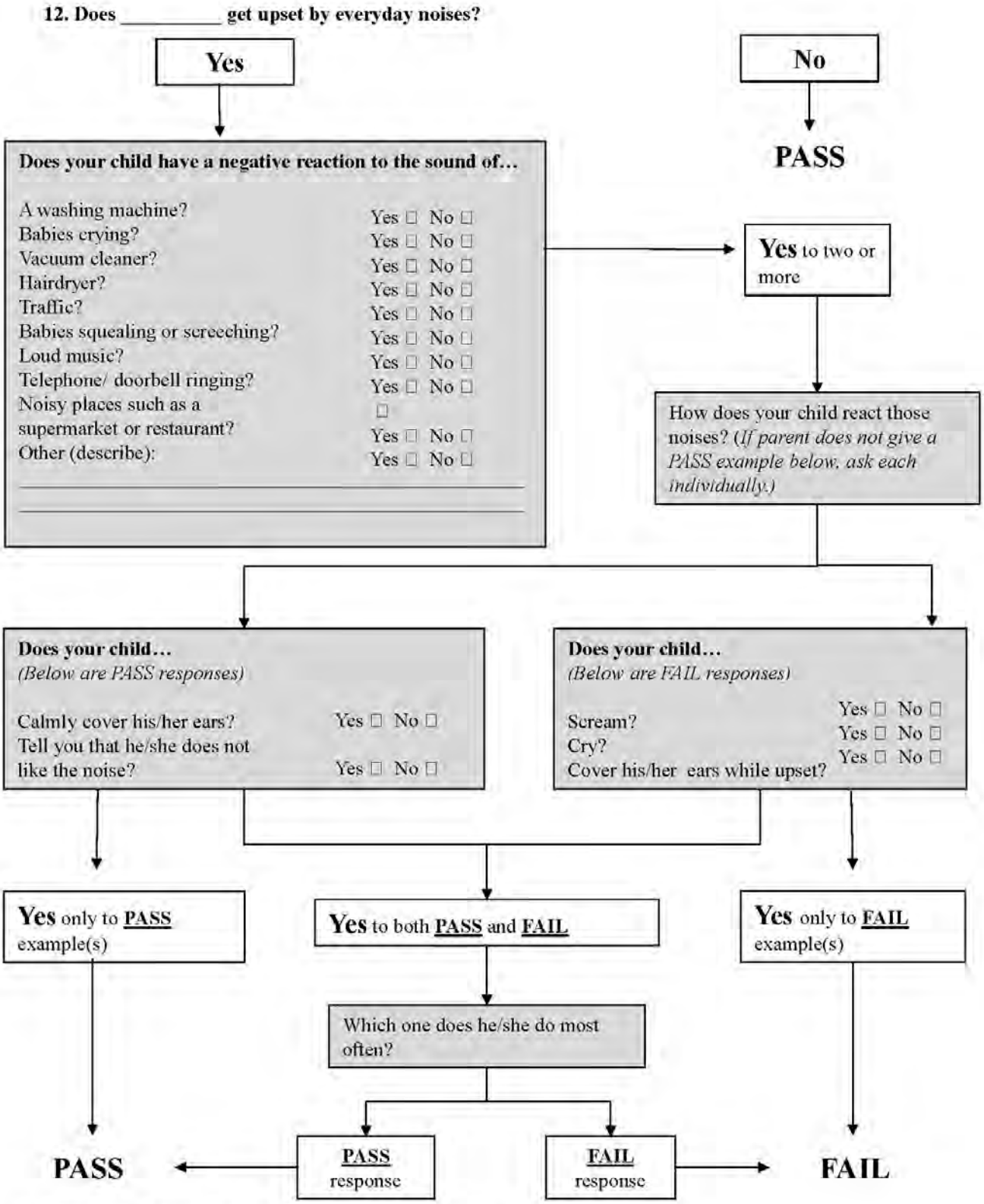


10. Does _____ respond when you call his/her name?

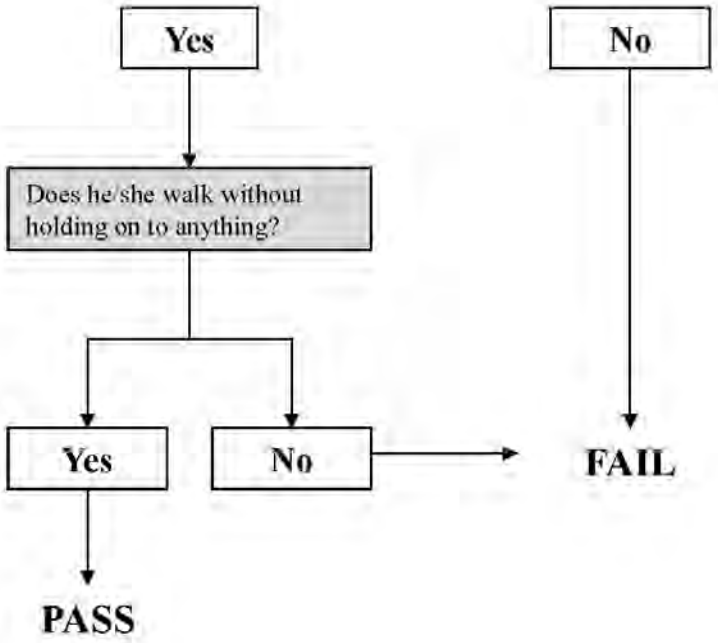


11. When you smile at _____, does he/she smile back at you?

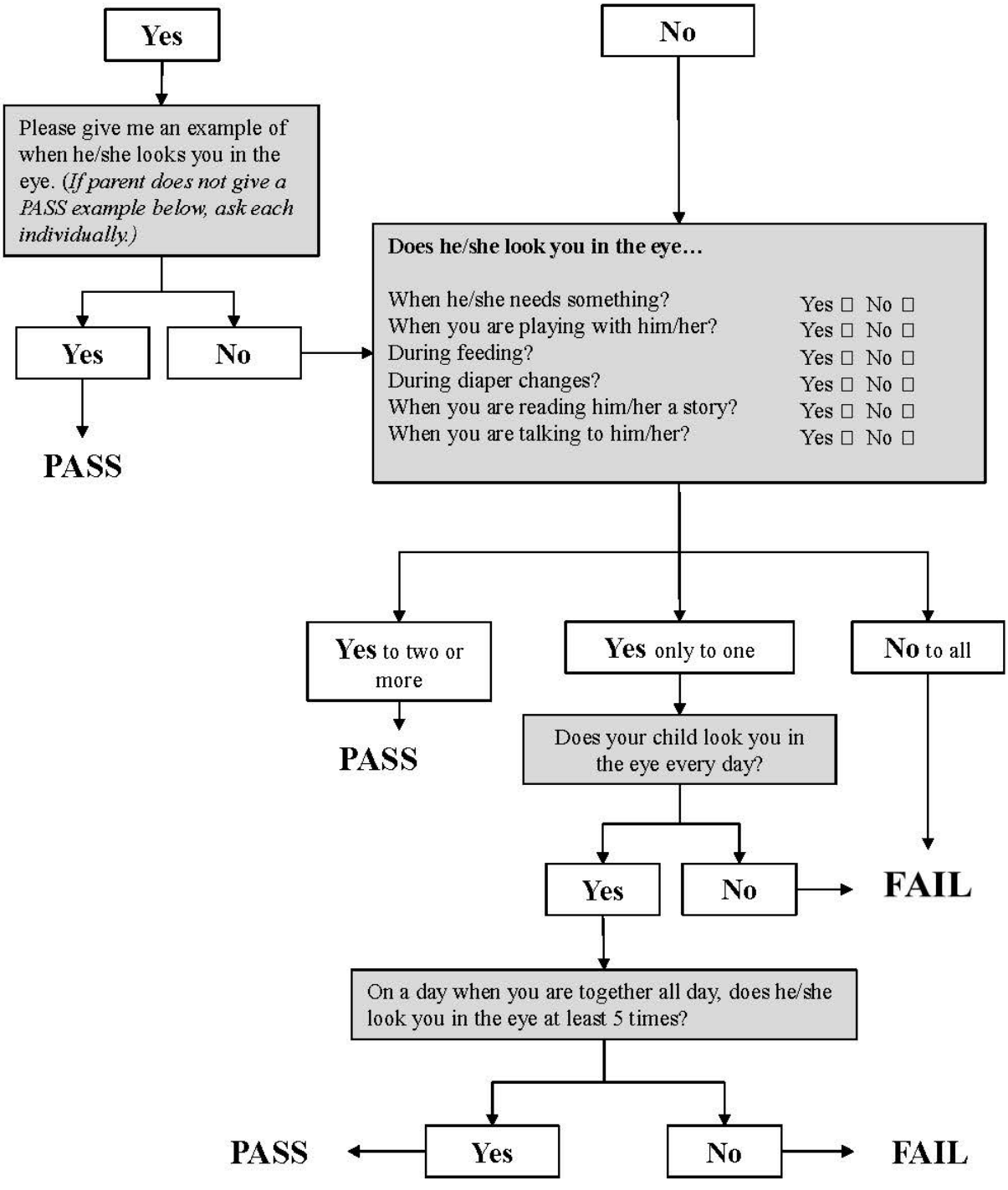




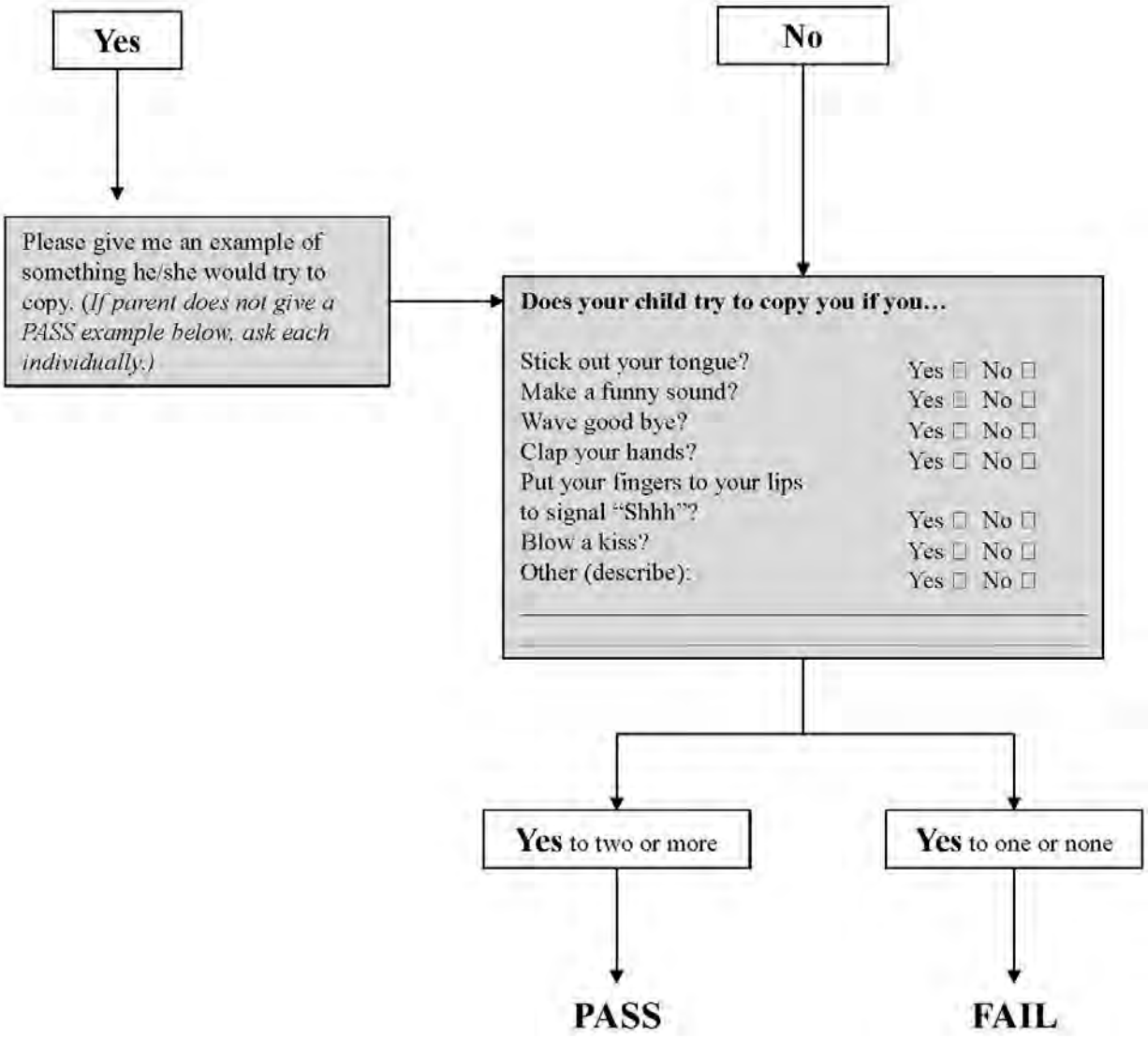
13. Does _____ walk?



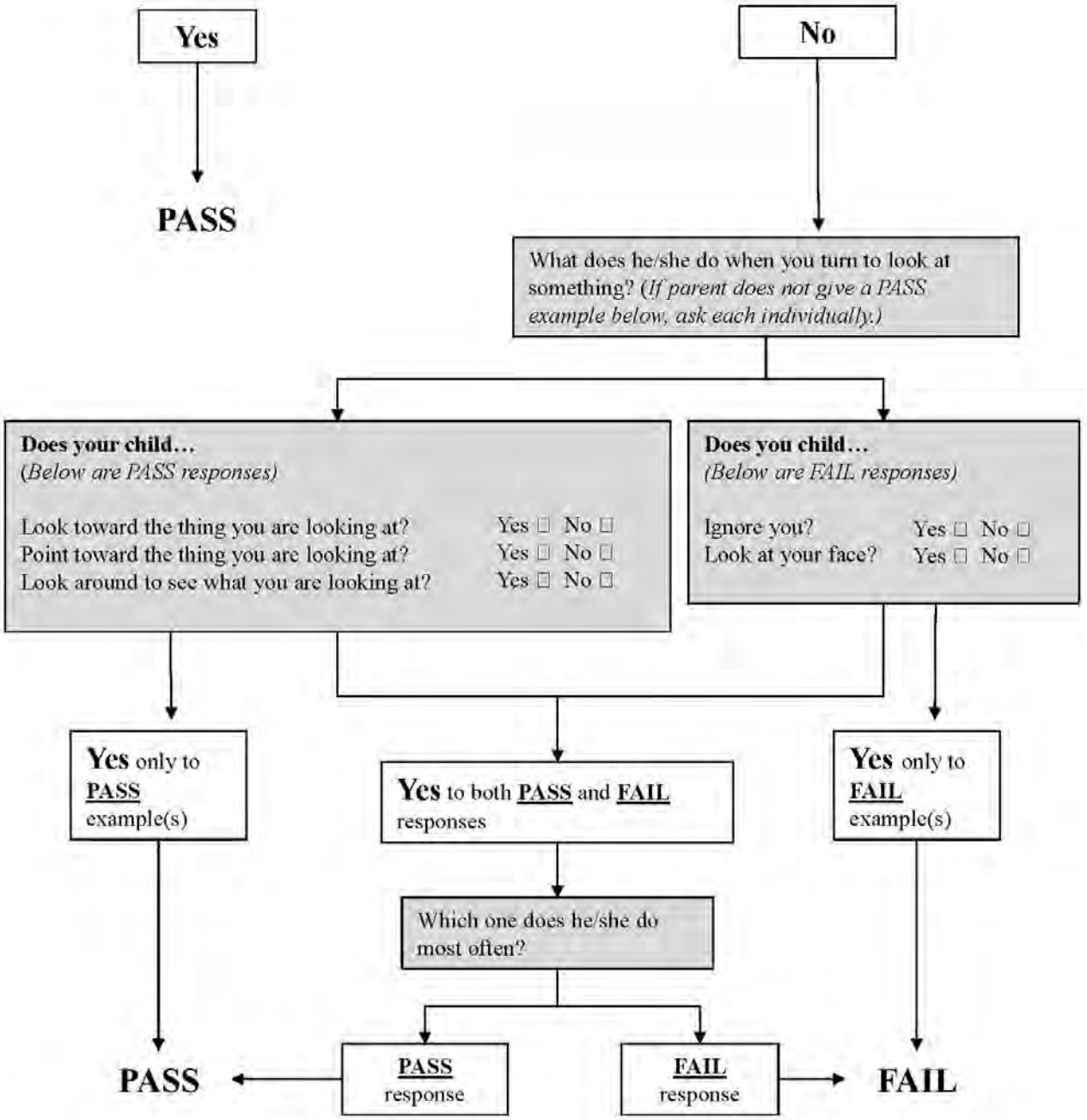
14. Does _____ look you in the eye when you are talking to him/her, playing with him/her, or changing him/her?



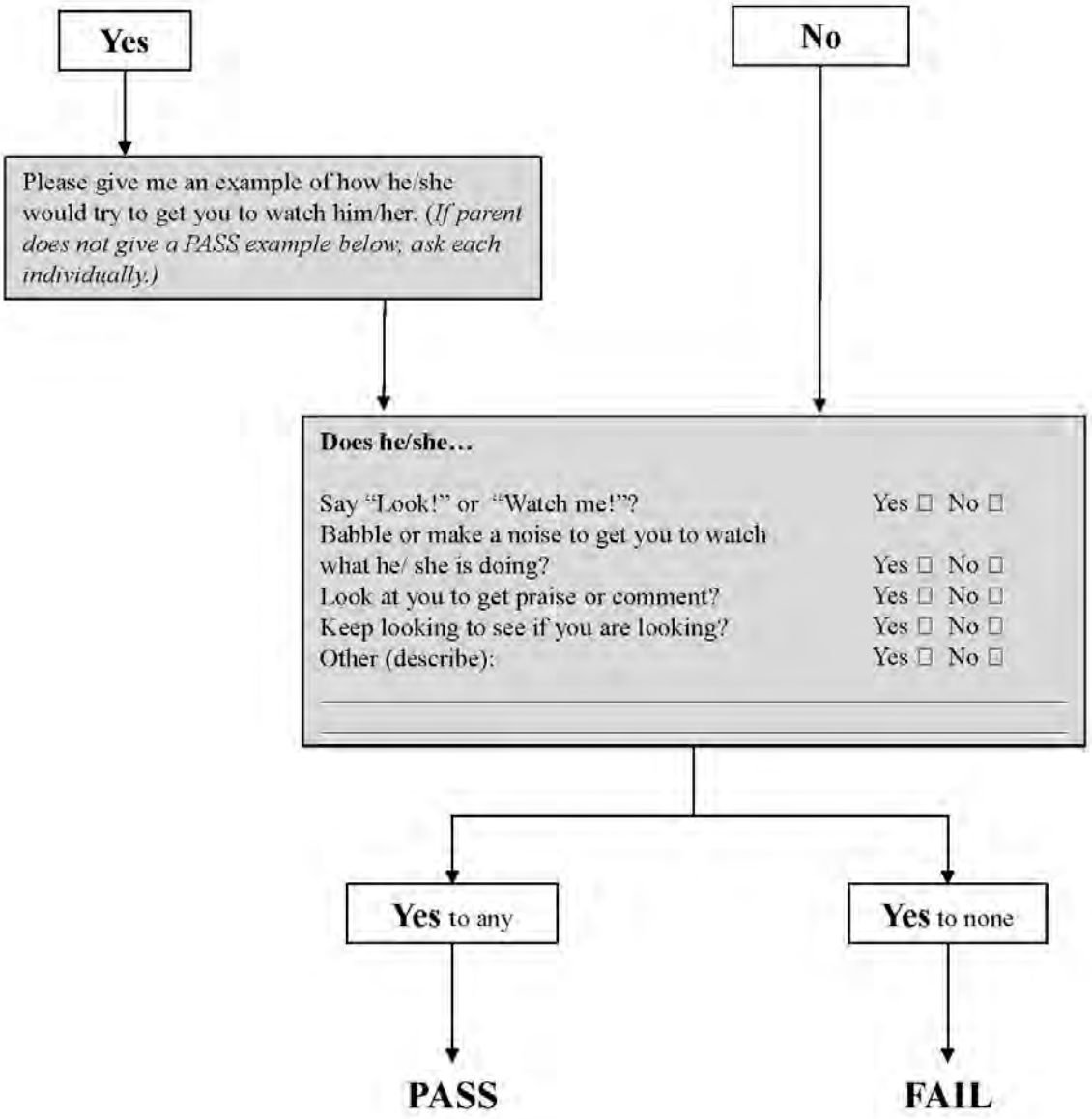
15. Does _____ try to copy what you do?



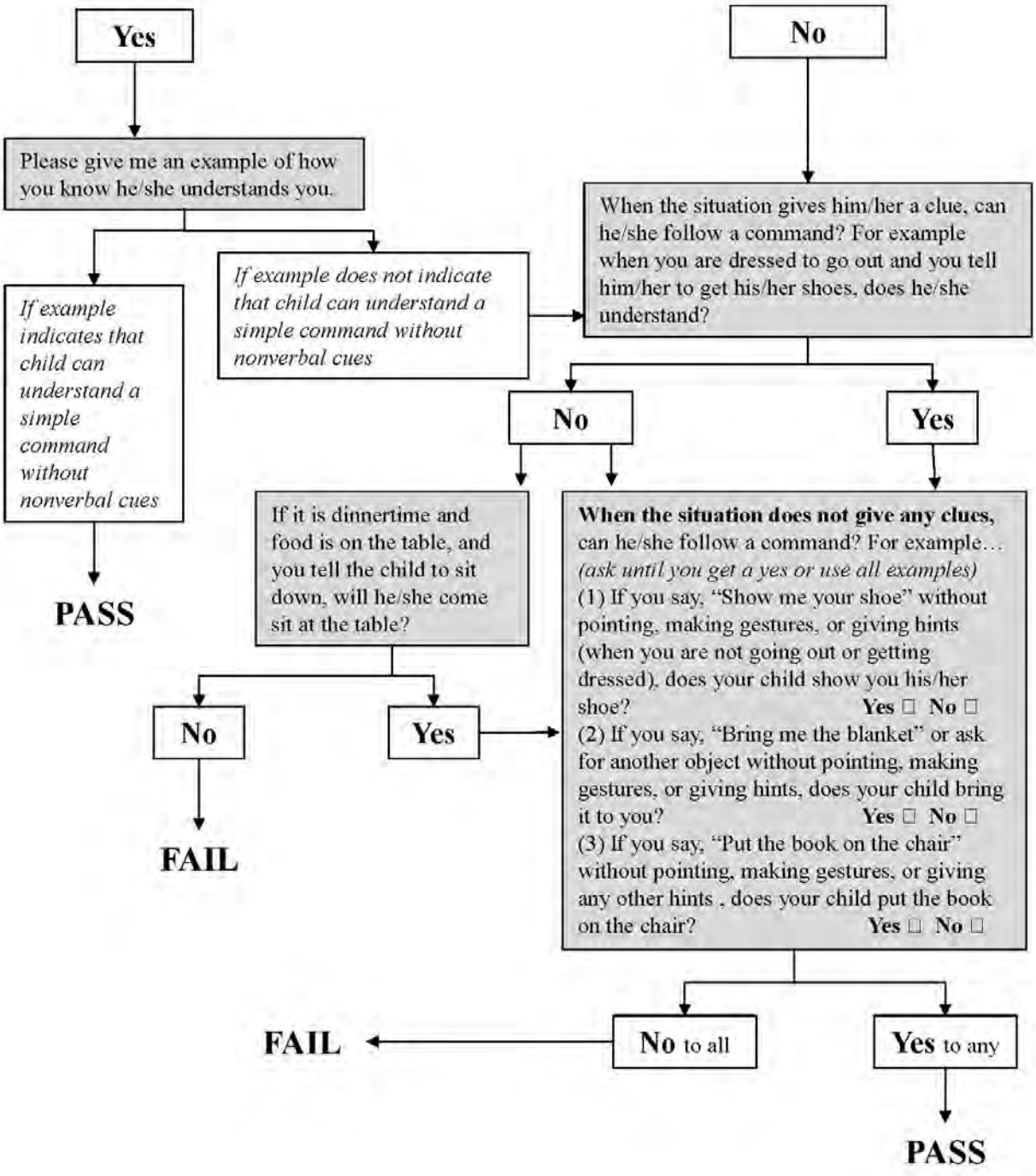
16. If you turn your head to look at something, does _____ look around to see what you are looking at?



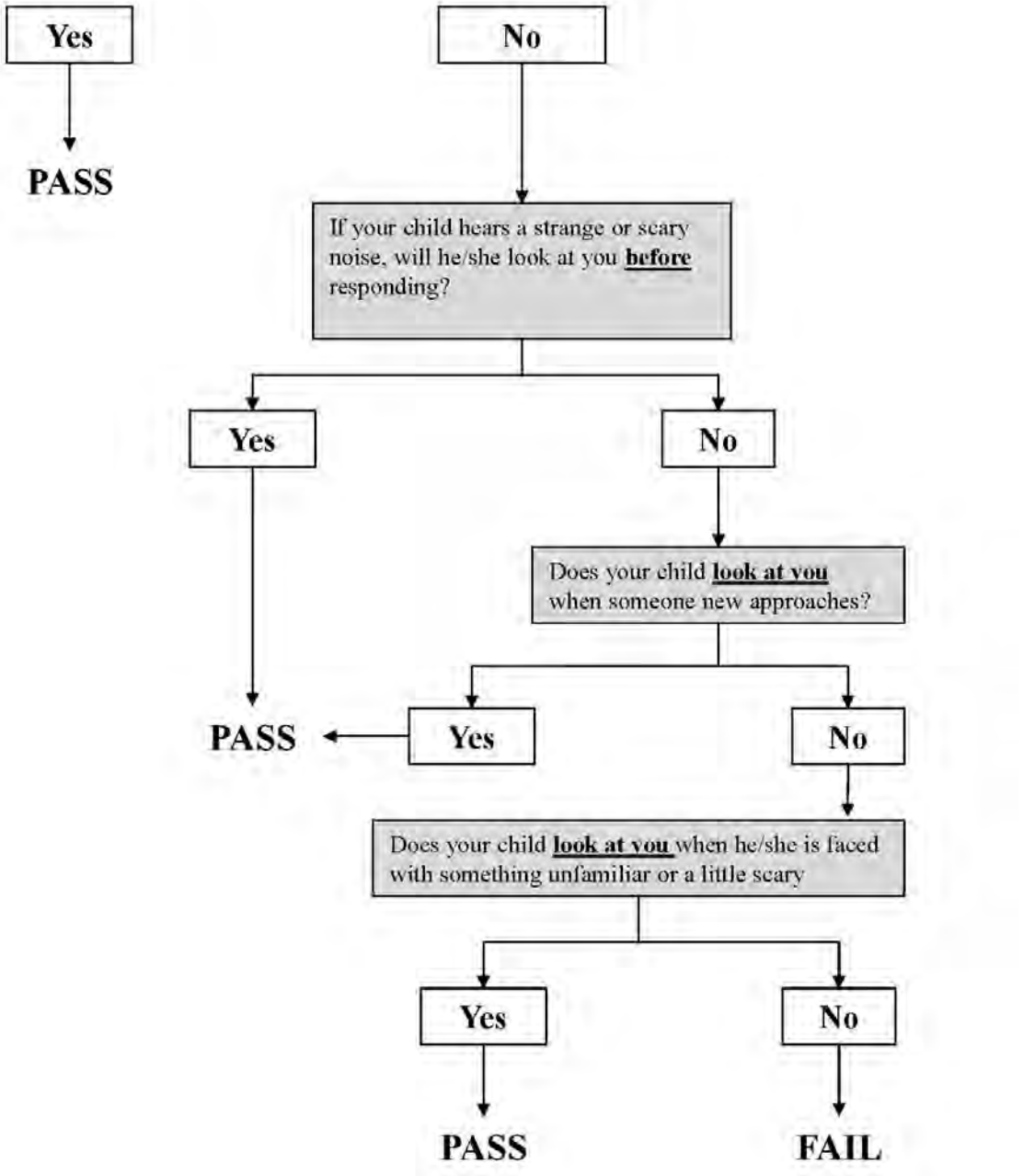
17. Does _____ try to get you to watch him/her?



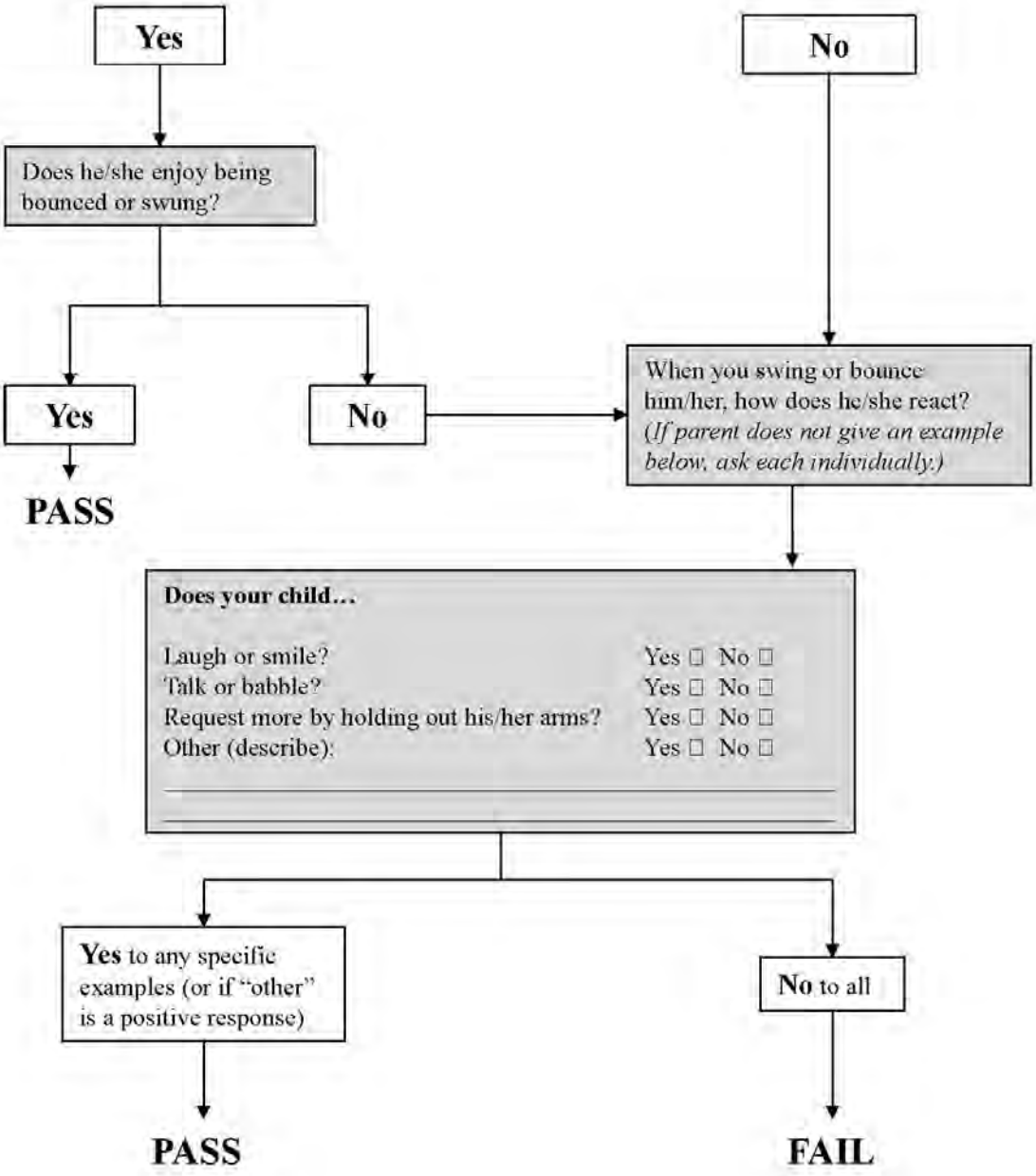
18. Does _____ understand when you tell him/her to do something?



19. If something new happens, does _____ look at your face to see how you feel about it?



20. Does _____ like movement activities?



EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

PSYCHOTHERAPEUTIC MEDICATION TREATMENT GUIDELINES

- There are no current medications to reform autism symptoms / features.
- When dealing with moderate to severe distressed areas of autism that are known to be medically responsive, contemplate employing behavioral or counseling treatments in addition to medications.
- One medication should be applied by way of low to escalated dosages as needed for a single diagnosis or select feature of concern.
- Record the responses to treatments of the select feature under concern.
- Elevating medical treatment amounts continuously past the normal dosage continuum is not recommended or safe. Be judicious concerning medications that feel the necessity of increased dosages after a few weeks of a seemingly successful dose.
- Be aware of any medications with unnoticeable improvements to the symptom; reduce, remove, and reevaluate any treatment that does not seem to be helping.
- Take intermittent trials of reducing dosages of medication if it was helpful in the past, as that does not mean it will consistently aid the patient, and examine if that medicine should be continued.
- Remember that children with autism tend to endure increased detrimental effects to psychotropic medications when compared to others. Please refrain from overstepping the maximum level of a medication for a routinely growing child.

Adapted from Golombek, A., Hilt, R. Primary Care Principles for Child Mental Health, Version 7.1., accessed at: http://seattlechildrens.org/PAL

EVIDENCE BASED THERAPEUTIC INTERVENTIONS

Applied Behavioral Analysis

Applied Behavior Analysis (ABA), a common therapeutic approach for children with autism, focuses on improving specific behaviors, such as social skills, communication, reading, and academics, as well as adaptive learning skills, such as fine motor dexterity, hygiene, grooming, domestic capabilities, punctuality, and job competence. ABA is effective for children in a variety of settings, including schools, workplaces, homes, and clinics. Its focus is on improving social interactions, learning new skills, and maintaining positive behaviors. ABA also helps transfer skills and behavior from one situation to another, controlling situations where negative behaviors arise, and minimizing negative behaviors. ABA is most successful when intensely applied for more than 20 hours a week and prior to the age of 4.

Source: Autism Speaks. Retrieved from: https://www.autismspeaks.org/what-autism/treatment/applied-behavior-analysis-aba

DIR-Floortime

DIR-Floortime is a developmental, individual differences, and relationship-based model that has become the foundation for understanding child development and providing support and intervention that helps children reach their fullest potential. The DIR® Model is also a framework that helps clinicians, parents, and educators conduct comprehensive assessments and develop educational and/or intervention programs tailored to the unique challenges and strengths of each child. DIR-Floortime is most commonly utilized with children with educational, social-emotional, mental health, and/or developmental challenges. DIRFloor-time has become most widely known as an approach to support children with ASD. The objectives of the DIR® Model are to build healthy foundations for social, emotional, and intellectual capacities rather than focusing on skills and isolated behaviors.

Source: The Interdisciplinary Council on Developmental and Learning Disorder (ICDL). Retrieved from: http://www.icdl.com/home

MOOD DISORDERS: UNIPOLAR AND BIPOLAR

BIPOLAR DISORDER (5.1.1.1.3.1)

DESCRIPTION

Bipolar disorder is a type of mood disorder characterized by extreme fluctuations in mood and/or behavior. Bipolar disorder usually begins in late adolescence or early adolescence, but children can also have the condition. A child or adolescent who presents with recurrent depressive symptoms, persistently irritable or agitated / hyperactive behaviors, markedly labile mood, reckless or aggressive behaviors, or psychotic symptoms may be experiencing the initial symptoms of a bipolar disorder.

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at https://www.brightfutures.org/mentalhealth/pdf/index.html

DSM-5 DIAGNOSTIC CRITERIA

BIPOLAR I DISORDER

For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).
B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
    3. More talkative than usual or pressure to keep talking.
    4. Flight of ideas or subjective experience that thoughts are racing.
    5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
    6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
    7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.
    - **Note:** A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis.

Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.
B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
    1. Inflated self-esteem or grandiosity.
    2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
    3. More talkative than usual or pressure to keep talking.
    4. Flight of ideas or subjective experience that thoughts are racing.
    5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
    6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
    7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.
F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition.

- **Note:** A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.

Note: Criteria A–F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
   - **Note:** Do not include symptoms that are clearly attributable to another medical condition.
   1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or hopeless) or observation made by others (e.g., appears tearful). **Note: In children and adolescents, can be irritable mood.**
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
   3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note: In children, consider failure to make expected weight gain.**
   4. Insomnia or hypersomnia nearly every day.
   5. Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down).
   6. Fatigue or loss of energy nearly every day.
   7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
   9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A–C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a major depressive episode it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a major depressive episode is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a major depressive episode. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in a major depressive episode. In grief, self-esteem is generally preserved, whereas in a major depressive episode, feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in a major depressive episode such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A–D under "Manic Episode" above).
B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

Source: American Psychiatric Association. (2013). Bipolar I Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

BIPOLAR II DISORDER

For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode (see criterion above) *and* the criteria for a current or past major depressive episode (see criterion above):

Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A–F under "Hypomanic Episode" above) and at least one major depressive episode (Criteria A–C under "Major Depressive Episode" above).
B. There has never been a manic episode.
C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Source: American Psychiatric Association. (2013). Bipolar II Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Prevalence

According to the National Institute of Mental Health, community studies estimate lifetime prevalence of bipolar spectrum disorders at 0-3% among U.S. adolescents.

Source: National Institute of Mental Health. Bipolar Disorder Among Children. Available at https://www.nimh.nih.gov/health/statistics/prevalence/bipolar-disorder-among-children.shtml

SCREEING, ASSESSMENT, DIAGNOSIS, TREATMENT AND MANAGEMENT OF DEPRESSION (5.1.1.1.3.2)

MOOD DISORDERS DECISION TREE

Positive depression screen and / or other risk factors for mood disorder (family history, history of trauma/ abuse, substance use, anxiety)

Assessment / Diagnosis:

- Review DSM-V criteria; Assess possible bipolar (history of mania or hypomania)
- Assess for common co-morbidities (e.g. anxiety, ADHD, substance abuse)
- Consider referral for psychological assessment
- Assess severity / trajectory (worse or better?) and impact on functioning (school, family, sleep)
- Consider other medical, psychiatric or situational factors that may mimic mood disorders such as recent loss, sleep or thyroid dysfunction. For older children, rule out use of substances
- Directly address suicidal ideation and other risk for self-harm

Assess severity and associated risk issues

Mild concern/Diagnosis unclear/low safety risk:

1. Psychoeducation for family
2. Regular screening / symptom monitoring
3. Address sleep quality/ hygiene
4. Discuss family coping options for dealing with specific fears
5. Encourage physical activity

Manage in primary care; refer based on worsening or increase in risk

Mild-Moderate severity/ some safety risk indication:

1. Implement all “mild” level interventions
2. Cognitive Behavioral Therapy (CBT) or IPT
3. Consider Family Therapy
4. Assess for suicidal ideation and other suicide risk
5. Consider appropriateness of SSRI’s

Manage in primary care if comfortable and adequately resourced, or refer to specialty care

Moderate – severe; clear mood disorder/safety risk:

1. Psychoeducation
2. CBT or IPT (Consider combination psychotherapy + SSRI)
3. Directly address suicidal ideation and risk
4. Monitor for treatment response and adjust/augment treatment as needed
5. Monitor for development of depression or other co-morbidities
6. Consider multimodal treatment that engages family, school and / or other supports

Refer to specialty care and continue monitoring follow up

VALIDATED SCREENING TOOLS: OVERVIEW, ITEMS AND SCORING INSTRUCTIONS (5.1.1.1.3.3)

The Mood Disorder Questionnaire for Parents of Adolescents (MDQ-A) is a validated screening tool for bipolar disorder for adolescents aged 12 to 17 years old. This screening is a self-report screen or one that parents fill out using their observations of their child's behaviors. This tool is available for free online at: *http://bipolarnews.org/wp-content/uploads/2012/08/Mood-Disorder-Questionnaire-for-Parents-of-Adolescents.pdf.*

MOOD DISORDER QUESTIONNAIRE FOR PARENTS OF ADOLESCENTS (MDQ-A)

Name: _____ Date: _____

1. Has there ever been a time for a week or more when your adolescent was not his/her usual self and...

	Yes	No
felt too good or excited?		
felt he/she could do anything?		
needed much less sleep?		
was so easily distracted by things?		
spent too much money?		
used more alcohol or drugs?		
was so irritable that he/she started fights or arguments with people?		
couldn't slow his/her mind down or thoughts raced through his/her head?		
had much more energy than usual?		
was much more active or did more things than usual?		
had many boyfriends or girlfriends at the same time?		
was more interested in sex than usual?		
did many things that were foolish or risky?		

2. If you checked YES to more than one of the above, have several of these ever happened to your adolescent during the same period of time?

Yes No

3. How much of a problem did any of these cause your adolescent--like school problems, failing grades, problems with family and friends, legal troubles?

No problem Minor problem Moderate problem Serious problem

SCORING AND INTERPRETATION: If you checked 5 or more of the 13 behaviors on Question 1, Yes on Question 2, and Moderate or Serious on question 3, investigate a diagnosis of bipolar disorder.

EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

Florida Medicaid Drug Therapy Management Guidelines

The Florida Medicaid Drug Therapy Management Program for Behavioral Health is a program whose goal is to work collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid beneficiaries with a mental illness. The following information has been developed and is maintained by the University of South Florida College of Behavioral and Community Sciences and is used with permission. More information on the program, and additional best practice guidelines, can be found at http://www.medicaidmentalhealth.org/.

Bipolar Disorder (Acute Mania or Mixed Episodes) in Children and Adolescents Ages 6 to 17 Years Old

Level 0

Comprehensive assessment. Use systematic interview covering mania and depression symptoms, family history of psychopathology including depression and mania, and information from teachers if possible to establish duration of manic symptoms over the day.

- Classic bipolar disorder has clear episodes representing a change from usual behavior; DSM-5 symptoms consist of elevated and/or irritable mood and increased energy occurring most of the day, every day; co-occurring symptoms include grandiosity, decreased need for sleep, rapid speech and flight of ideas (no current validity under age 6).
- If ADHD is comorbid with bipolar I or II disorder, symptoms should intensify with the episode. If it is truly comorbid, mania should be treated and stabilized before treating ADHD.
- If the diagnosis of mania cannot be distinguished from ADHD, and especially combined ADHD and Oppositional Defiant Disorder, ADHD should be treated first with discussion with family members about advantages and disadvantages. Refer to ADHD guidelines on pg. 16.
- If rage outbursts are the primary focus of treatment, track the frequency, intensity, number and duration of episodes. Rule out Disruptive Mood Dysregulation Disorder (DMDD).
- If DMDD is present, refer to those guidelines on pg. 40; otherwise, treat the primary disorder first and then treat the aggression, referring to the aggression treatment guidelines.

Level 1

Monotherapy with one of these four agents (FDA approved for youth between the ages of 10-17):

- Aripiprazole
- Risperidone
- Quetiapine
- Asenapine
  - For euphoric mania in adolescents, consider lithium.

Bipolar Disorder (Acute Mania or Mixed Episodes) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 2

If there is partial response to a single atypical antipsychotic, augment with a mood stabilizer (lithium, VPA/divalproex).

If monotherapy with atypical antipsychotic listed in Level 1 is not effective:

- **2a.** Switch to another antipsychotic listed in Level 1 or olanzapine.
- **2b.** Switch to a mood stabilizer (lithium, VPA/divalproex).

Level 3

Monotherapy with antipsychotic (except clozapine) not listed in Level 1 or 2, or combination with mood stabilizer(s).

Level 4

Re-assess the diagnosis. Consider clozapine or ECT in adolescents.

Not Recommended: Two antipsychotics.

Dosing Recommendations for Atypical Antipsychotics in Bipolar Disorder in Children and Adolescents Ages 6 to 17 Years Old*

Clinicians should realize that data below age 10 for treating mania and mixed states are limited and caution in using pharmacological treatment below age 10 is warranted.

Table 11.

Dosing Recommendations for Atypical Antipsychotics and Mood Stabilizers in Bipolar Disorder			
Drug Name	**Starting Dose**	**Maximum Dose**	**FDA Approved Age Range**
Citalopram			
Lithium	300–600 mg/day Goal: acute mania: Blood level 0.8 – 1.2 mEq/L Goal maintenance: Blood level 0.6 – 1 mEq/L	Blood level: 1.2 mEq/L	12–17 years old
Valproate	10–15 mg/kg/day in divided dose Goal: 80 –125 mcg/mL	Dose determined by blood level. Max blood level should be 125 mcg/mL	Not approved in children or adolescents
First generation (typical) antipsychotics			
Haloperidol	Children: 0.25–0.5 mg/day Adolescents: 0.5–1 mg/day	Children: 4 mg/day Adolescents: 10 mg/day	Not approved for pediatric mania
Chlorpromazine	Children: 25–50 mg/day Adolescents: 25–100 mg/day	Children (under 12): 200 mg/day Adolescents: 500 mg/day	Not approved for pediatric mania
Second generation (atypical) antipsychotics			
Aripiprazole	2-5 mg/day	30 mg/day	10–17 years old
Risperidone	Children: 0.25 mg/day Adolescents: 0.5–1 mg bid	Children: 4 mg/day Adolescents: 6 mg/day	10–17 years old
Quetiapine	Children: 12.5 mg bid Adolescents: 25 mg bid	Children: 400 mg/day Adolescents: 600 mg/day	10–17 years old
Asenapine	2.5 mg sublingually twice a day After 3 days, may increase to 5 mg sublingually twice daily, and after an additional 3 days up to 10 mg twice a day, as needed and as tolerated. Avoid food and liquids for at least 10 minutes before and after administration.	10 mg twice a day	10–17 years old
Olanzapine	2.5–5 mg once daily Weekly titration by 2.5–5 mg increments	20 mg/day	13–17 years old

Dosing Recommendations for Atypical Antipsychotics in Bipolar Disorder in Children and Adolescents Ages 6 to 17 Years Old*

Minimizing side effects when switching psychotropic medications:

- Start low. Go slow. Stop slowly. Avoid abrupt stopping, starting, and/or switching to reduce risk of rebound and withdrawal phenomena.
- Do not switch until the primary disorder has been treated according to target disorder guidelines at adequate dose and duration.
- Only stop and/or switch abruptly if a serious adverse effect necessitates it (i.e., severe neutropenia, agranulocytosis, diabetic ketoacidosis, neuroleptic malignant syndrome, acute pancreatitis, lithium toxicity, Stevens-Johnson syndrome, etc.).
- Slow switch using cross-titration is the preferred method; an even slower switch can be done using the plateau-cross titration method, with therapeutic dose overlap of medications (when switching to a less sedating cholinergic medication, or one with a much longer half-life).
- If time permits, do not reduce the first medication by more than 25–50% per 5 half-lives.

Additional considerations:

- When switching medications, the more different the binding affinity for the same receptor (between the two drugs), the greater risk for side effects and rebound and withdrawal phenomena (especially sedating; anti-cholinergic; dopaminergic).
- The more different the half-life of the medications with the same physiological effect (desired or undesired), the greater the risk for rebound and withdrawal phenomena. Withdrawal and rebound phenomena are most likely when discontinuing from a short half-life medication.
- Withdrawal and rebound phenomena are most likely to occur when switching from a strongly antihistaminergic (sedating) or anti-cholinergic medication (i.e., clozapine, olanzapine, quetiapine), to a less strongly binding medication (i.e., haloperidol, molindone, paliperidone, aripiprazole, ziprasidone); or from a strongly binding anti-dopaminergic (i.e. FGA AR risperidone, paliperidone) to a less strongly binding antipsychotic (i.e., clozapine, quetiapine, clozapine); or a full antagonist, to a partial agonist (aripiprazole).
- Insufficient efficacy or increased side effects may occur during a switch when medications metabolized by cytochrome P450 liver enzymes are paired with a medication that affects that same enzyme.
- Never discontinue lithium or clozapine abruptly to avoid potentially severe rebound of mania or psychoses.
- Quetiapine and mirtazapine can lead to more sedation at lower doses (below 250–300 mg for quetiapine and below 15 mg for mirtazapine) because of its high affinity for histamine receptors. This is offset by increased alpha adrenergic activity at higher doses that counteract this.

For a full list of references, visit ***http://medicaidmentalhealth.org/.***

Comorbidities and Other Risk Factors
Among children and adolescents with bipolar disorder, it is estimated that comorbidities associated with ADHD, anxiety disorders, and substance use disorders vary based on the onset of bipolar diagnosis. That is, approximately 90% of children and 30% of adolescents with bipolar disorder are also diagnosed with ADHD. In addition, approximately 30% of children and 10% of adolescents with bipolar disorder are diagnosed with an anxiety disorder. Approximately 10% of children and 40% of adolescents with bipolar disorder also have a comorbid substance use disorder. One in five children / adolescents with bipolar disorder are also diagnosed with conduct disorder. These comorbidities should therefore be considered and assessed accordingly.

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at *https://www.brightfutures.org/mentalhealth/pdf/index.html*

DEPRESSION (5.1.1.1.3.1)

DESCRIPTION

Depression is a mood disorder, and depressed mood falls along a continuum. It is normal for a child / adolescent to experience brief periods of sadness or irritability in response to disappointment / loss, and growing up in a supportive environment should usually resolve this quickly. However, for children / adolescents who experience intense or long-lasting sadness or irritability that interferes with daily activities (e.g., self-esteem, friendships, family life, or school performance), a diagnosis of depressive disorder may be warranted.

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at https://www.brightfutures.org/mentalhealth/pdf/index.html

DSM-5 DIAGNOSTIC CRITERIA

MAJOR DEPRESSIVE DISORDER

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

    - **Note:** Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). **Note: In children and adolescents, can be irritable mood.**
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note: In children, consider failure to make expected weight gain.**
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision

inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode, it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in a major depressive episode it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of a major depressive episode is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of a major depressive episode. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in a major depressive episode. In grief, self-esteem is generally preserved, whereas in a major depressive episode feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in a major depressive episode such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

    - **Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Source: American Psychiatric Association. (2013). Major Depressive Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

PERSISTENT DEPRESSIVE DISORDER (DYSTHYMIA)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

    1. Poor appetite or overeating.
    2. Insomnia or hypersomnia.
    3. Low energy or fatigue.
    4. Low self-esteem.
    5. Poor concentration or difficulty making decisions.
    6. Feelings of hopelessness.

C. During the 2-year period (**1 year for children or adolescents**) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. Criteria for a major depressive disorder may be continuously present for 2 years.

E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.

F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Source: American Psychiatric Association. (2013). Persistent Depressive Disorder (Dysthymia). In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

SUBSTANCE / MEDICATION-INDUCED DEPRESSIVE DISORDER

A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by depressed mood or markedly diminished interest or pleasure in all, or almost all, activities.

B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

    1. The symptoms in criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.

    2. The involved substance / medication is capable of producing the symptoms in Criterion A.

C. The disturbance is not better explained by a depressive disorder that is not substance / medication-induced. Such evidence of an independent depressive disorder could include the following:

    - The symptoms preceded the onset of the substance / medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance / medication-induced depressive disorder (e.g., a history of recurrent non-substance / medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Source: American Psychiatric Association. (2013). Substance/Medication-Induced Depressive Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

PREMENSTRUAL DYSPHORIC DISORDER

A. In the majority of menstrual cycles, at least five symptoms must be present in the final week before the onset of menses, start to *improve* within a few days after the onset of menses, and become *minimal* or absent in the week postmenses.

B. One (or more) of the following symptoms must be present:

    1. Marked affective lability (e.g., mood swings; feeling suddenly sad or tearful, or increased sensitivity to rejection).
    2. Marked irritability or anger or increased interpersonal conflicts.
    3. Marked depressed mood, feelings of hopelessness, or self-deprecating thoughts.
    4. Marked anxiety, tension, and/or feelings of being keyed up or on edge.

C. One (or more) of the following symptoms must additionally be present, to reach a total of *five* symptoms when combined with symptoms from Criterion B above.

    1. Decreased interest in usual activities (e.g., work, school, friends, hobbies).
    2. Subjective difficulty in concentration.
    3. Lethargy, easy fatigability, or marked lack of energy.
    4. Marked change in appetite; overeating; or specific food cravings.
    5. Hypersomnia or insomnia.
    6. A sense of being overwhelmed or out of control.
    7. Physical symptoms such as breast tenderness or swelling, joint or muscle pain, a sensation of “bloating,” or weight gain.

Note: The symptoms in criteria A–C must have been met for most menstrual cycles that occurred in the preceding year.

D. The symptoms are associated with clinically significant distress or interference with work, school, usual social activities, or relationships with others (e.g., avoidance of social activities; decreased productivity and efficiency at work, school, or home).

E. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as major depressive disorder, panic disorder, persistent depressive disorder (dysthymia), or a personality disorder (although it may co-occur with any of these disorders).

F. Criterion A should be confirmed by prospective daily ratings during at least two symptomatic cycles. (**Note:** The diagnosis may be made provisionally prior to this confirmation.)

G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or another medical condition (e.g., hyperthyroidism).

Source: American Psychiatric Association. (2013). Premenstrual Dysphoric Syndrome. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Prevalence

According to the National Institute of Mental Health, around 12.5% of U.S. adolescents reported at least one major depressive episode in the past year in 2015.

Source: National Institute of Mental Health. Major Depression Among Adolescents. Available at https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adolescents.shtml

MOOD DISORDERS DECISION TREE

Positive depression screen and / or other risk factors for mood disorder (family history, history of trauma/ abuse, substance use, anxiety)

Assessment / Diagnosis:

- Review DSM-V criteria; Assess possible bipolar (history of mania or hypomania)
- Assess for common co-morbidities (e.g. anxiety, ADHD, substance abuse)
- Consider referral for psychological assessment
- Assess severity / trajectory (worse or better?) and impact on functioning (school, family, sleep)
- Consider other medical, psychiatric or situational factors that may mimic mood disorders such as recent loss, sleep or thyroid dysfunction. For older children, rule out use of substances
- Directly address suicidal ideation and other risk for self-harm

Assess severity and associated risk issues

Mild concern/Diagnosis unclear/low safety risk:

6. Psychoeducation for family
7. Regular screening / symptom monitoring
8. Address sleep quality/ hygiene
9. Discuss family coping options for dealing with specific fears
10. Encourage physical activity

Manage in primary care; refer based on worsening or increase in risk

Mild-Moderate severity/ some safety risk indication:

6. Implement all "mild" level interventions
7. Cognitive Behavioral Therapy (CBT) or IPT
8. Consider Family Therapy
9. Assess for suicidal ideation and other suicide risk
10. Consider appropriateness of SSRI's

Manage in primary care if comfortable and adequately resourced, or refer to specialty care

Moderate – severe; clear mood disorder/safety risk:

7. Psychoeducation
8. CBT or IPT (Consider combination psychotherapy + SSRI)
9. Directly address suicidal ideation and risk
10. Monitor for treatment response and adjust/augment treatment as needed
11. Monitor for development of depression or other co-morbidities
12. Consider multimodal treatment that engages family, school and / or other supports

Refer to specialty care and continue monitoring follow up

The Patient Health Questionnaire-9 (PHQ-9) is an evidence based diagnostic tool for assessing the presence and severity of depressive disorder. This tool has been modified for use by adolescents and is available as the PHQ-A. Both the PHQ-9 and the PHQ-A are in the public domain.

The PHQ-A is available free online at http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/upload/PHQ-A-Severity-Measure-for-Depression.pdf

For additional depression screening tools, please see Appendix C.

Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A)

Severity Measure for Depression – Child Age 11-17

Name:_____ **Age:** _____ **Sex: Male** □ **Female** □
Date:_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item Score
		(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) 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?					
Total/Partial Raw Score						
Prorated Total Raw Score: (if 1-2 items left unanswered)						

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

INSTRUCTIONS AND SCORING OF PHQ-A

Instructions to Clinicians

The Severity Measure for Depression–Child Age 11-17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9-item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11-17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression.

The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)–Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to Total Raw Score is:

_____(Raw sum x 9)_____

Number of items that were actually answered

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.

EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

Florida Medicaid Drug Therapy Management Guidelines

The Florida Medicare Drug Therapy Management Program for Behavioral Health is a program whose goal is to work collaboratively with prescribers in the Medicaid program to improve the quality and efficiency of the prescribing of mental health drugs, and to improve the health outcomes of Medicaid beneficiaries with a mental illness. The following information has been developed and is maintained by the University of South Florida College of Behavioral and Community Sciences and is used with permission. More information on the program, and additional best practice guidelines, can be found at http://www.medicaidmentalhealth.org/.

Major Depressive Disorder (MDD) in Children under Age 6

Level 0

Comprehensive assessment. Refer to *Principles of Practice* on page 6.

Level 1

Psychotherapeutic intervention (e.g., dyadic therapy) for 6 to 9 months; assessment of parent/guardian depression and referral for treatment if present.

Level 2

If poor response to psychosocial treatment after 6 to 9 months, re-assess diagnosis, primary care giver response to treatment, and/or consider switching to a different or more intensive psychosocial treatment. Consider child psychiatric consultation or second opinion.

Under 3 years, refer to *Principles of Practice* on page 6.

Level 3

If depression is severe, or there is continued poor response to psychosocial treatment alone, consider combination treatment with fluoxetine and concurrent psychosocial treatment.

- Fluoxetine — 4 to 5 years old
  - Maximum dose: 5 mg/day
  - Discontinuation trial after 6 months of any effective medication treatment with gradual downward taper.
  - **Monitor for behavioral disinhibition and suicidality.** Behavioral disinhibition is defined as impulsive, sensation seeking behaviors and lack of self-regulation.

Not Recommended:

- The use of medication without psychosocial treatment.
- Use of tricyclic antidepressants (TCAs) or paroxetine.

Note: In preschool children, MDD is very rare (point prevalence is thought to be 0.5%).

Major Depressive Disorder (MDD) in Children and Adolescents Ages 6 to 17 Years Old

Level 0

Assessment

- Screening using multi-informant, validated rating scales that include depression and screening for comorbidity (other psychiatric and medical conditions):
  - Center for Epidemiological Studies Depression Scale for Children Patient Health Questionnaire (CES-DC)
  - Patient Health Questionnaire-9 (PHQ-9)
  - Pediatric Symptom Checklist (PSC)

  Note: The above scales are available at ***http://medicaidmentalhealth.org/.***
- Specific screen for harm to self or others and access to firearms, knives/sharps, and other lethal means such as alcohol, prescription and non-prescription medications.
- Evaluate sleep hygiene, diet, and exercise.
- Address environmental stressors such as abuse, bullying, conflict, functioning at school, peer relationships, and caregiver depression.
- Specific screen for harm to self/others.
- **Establish a safety plan:**
  - Removal of firearms, knives/sharps, and other lethal means such as alcohol, prescription and non-prescription medications.
  - **Develop an emergency action plan:**
    - Provide adolescents with mutually agreeable and available emergency numbers and contacts.
    - Engage a concerned third party familiar with the adolescent.
- Positive screen: DSM-5 - based interview evaluation.
- Consider medical reason for depression (e.g., hypothyroidism, B12/folate deficiency, anemia, malnutrition (with or without eating disorder), chronic disorder (diabetes, asthma, inflammatory bowel disease, juvenile rheumatoid disease, infectious mononucleosis, etc.).
- Rule out iatrogenic etiology of depression (i.e., medication side effects/interactions).
- Evaluate past psychiatric and medical history, previous treatment, family conflict and current depression of family and caregivers, bullying, abuse, peer conflict, school issues and substance abuse.
- Consider and rule out presence of bipolar depression. Pointers: Prior (hypo)mania, family history of bipolar disorder, atypical depression with reverse neurovegetative signs, seasonal affective component, brief and recurrent episodes, and melancholic depression in prepubertal child.

Major Depressive Disorder (MDD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 0 (continued)

- Track outcomes using empirically validated tools. Refer to DSM-5 Severity Measure for Depression, Child Age 11–17 available and Child Depression Inventory (CDI) available at ***http://www.medicaidmentalhealth.org/***.

  Note: The Child Depression Inventory is not available in the public domain.

Always monitor for:

- Emergence or exacerbation of suicidality and balance the risk–benefit profile of antidepressants during the acute treatment phase.
- Behavioral activation (eg. difficulty falling asleep, increased motor activity, increased talkativeness)
- Adverse events
- Treatment adherence
- Treatment or inherently emergent comorbidity
- Potential development of (hypo)mania

Level 1

Initial treatment plan

- Active support: 6 week trial (if mild symptoms).
  - Components of active support must include psychosocial interventions and psychoeducation and may include: Self-help materials, active listening/relationship building, school involvement, mood monitoring, pleasant activities, cognitive restructuring, family conflict reduction, sleep hygiene, and exercise.

Major Depressive Disorder (MDD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 2

Reassess diagnosis first (e.g., bipolar disorder), rule out psychostimulant or substance abuse related psychosis. Targeted treatments if symptoms are moderate to severe, impairment continues, and/or no response to active support. Start with cognitive behavioral therapy (CBT), Interpersonal therapy (IPT), depression-specific behavioral family therapy.

- **2a.** Fluoxetine or combination of CBT or IPT psychotherapy with fluoxetine (COMB).
- **2b.** May consider use of escitalopram for age 12 and above.

Qualifiers:

- Mild: Psychosocial interventions only.
- Moderate/Severe: COMB.
- Psychosis: SSRIs (fluoxetine, escitalopram) plus antipsychotic.
- Comorbidity: COMB, treat comorbidity.
- Suicidality: intensify surveillance and follow-up; COMB if on antidepressant only or remove antidepressant if otherwise ineffective; if chronic, consider lithium augmentation.

Level 3

Inadequate response

- If no clinical response to the medication utilized in Level 2, switch to another medication listed above.

Level 4

Poor or non-response

- Refer to mental health specialist.
- Re-assess diagnosis (bipolar disorder, substance use disorder, anxiety disorders, PTSD), rule out medical condition (e.g., hypothyroidism), or medication side effects.
- Increase psychosocial intervention and medication dose if tolerated.
- Augment with alternate psychosocial intervention (either CBT or IPT).
- Consider change in level of care (treatment setting and interventions based on severity of illness).
- For milder form and/or seasonal affective symptoms with light sensitivity, consider bright light therapy.

Major Depressive Disorder (MDD) in Children and Adolescents Ages 6 to 17 Years Old *(continued)*

Level 5

If poor or non-response to Level 4 interventions

- Switch previously used SSRIs to sertraline, citalopram, bupropion or venlafaxine, especially in those who do not have access to psychotherapy or have not responded to non-pharmacological interventions.
- Consider augmentation of SSRI with bupropion, thyroxine, lithium, buspirone, mirtazapine, aripiprazole, quetiapine, or risperidone (adult data only).
- If psychotic/severe: ECT (for adolescents).

Notes:

- Factors favoring maintenance treatment (at any Level):
  - Partial response
  - Prior relapse
  - Suicidality
  - Comorbidity risk for relapse
  - Environmental risk for relapse
  - Family history of relapsing/recurrent major depression
  - Lack of return to full premorbid functioning
- Maintenance treatment: 9 to 12 months.
- After maintenance treatment: If stable, at level of premorbid functioning, and no anticipated increase in stressors, consider discontinuation trial over 3 to 4 months.

Note on pharmacogenomic testing: The current evidence does not support pharmacogenomic testing in routine psychiatric clinical practice.

For a full list of references, visit ***http://medicaidmentalhealth.org/.***

ADDITIONAL PSYCHOTHERAPEUTIC MEDICATION TREATMENT GUIDELINES

These medication guidelines are adapted from the Primary Care Principles for Child Mental Health, Version 7.1 and are used with permission.

Drug Name	Young Child (4 – 6 Years)	Child (6 – 12 Years)	Adolescent	Editorial Comments
***Fluoxetine (Prozac)**				
Dosage form: 10, 20, 40 mg 20 mg/5ml	Starting Dose: 1-2 mg/day Maximum Dose: 5-10 mg/day (limited data)	Starting Dose: 2.5-5 mg/day Maximum Dose: 20-40 mg/day	Starting Dose: 10 mg/day Maximum Dose: 60 mg/day	Long ½ life, no SE from a missed dose
***Sertraline (Zoloft)**				
Dosage form: 25, 50, 100 mg 20 mg/ml	Starting Dose: 5-10 mg/day Maximum Dose: 50-75 mg/day (limited data)	Starting Dose: 10-12.5 mg/day Maximum Dose: 100-150 mg/day	Starting Dose: 25 mg/day Maximum Dose: 200 mg/day	May be prone to SE from weaning off
Escitalopram (Lexapro)				
Dosage form: 5, 10, 50 mg 5 mg/5ml	Starting Dose: 1-2 mg/day Maximum Dose: 5 -10 mg (limited data)	Starting Dose: 2.5 mg/day Maximum Dose: 10-20 mg/day	Starting Dose: 5 mg/day Maximum Dose: 20 mg/day	Active isomer of citalopram
Citalopram (Celexa)				
Dosage form: 10, 20, 40 mg 10 mg/5ml	No data	Starting Dose: 5 mg/day Maximum Dose: 20-40 mg/day	Starting Dose: 10 mg/day Maximum Dose: 40 mg/day (check EKG above 40 mg for QTc prolongation)	Very few drug interactions

Bupropion (Wellbutrin)				
Dosage form: 75, 100 mg SR: 100, 150, 200 mg XL: 150, 300 mg			Starting dose: 75 mg/day (later dose this BID) Maximum dose: 400 mg	Can have more agitation risk. Avoid if eat d/o.
Mirtazapine (Remeron)				
Dosage form: 15, 30, 45 mg			Starting dose: 15 mg/day Maximum dose: 45 mg/day	Sedating, increases appetite
***Venlafaxine (Effexor)**				
Dosage form: 25, 37.5, 50, 75, 100 mg ER: 37.5, 75, 150 mg	No data	Starting Dose: 37.5 mg/day Maximum Dose: 75-112.5 mg/day (25-39 kg)	Starting Dose: 37.5 mg/day Maximum Dose: 150 mg/day (40-49 kg) 225 mg/day (>50 kg)	Only recommended for older adolescents. Withdrawal symptoms can be severe.

**Indicates placebo-controlled studies in children 6 to 17 years with anxiety disorders.*

Adapted from Hilt, R. Primary Care Principles for Child Mental Health, Version 7.1., accessed at: http://seattlechildrens.org/PAL

COMORBIDITIES AND OTHER RISK FACTORS

There is wide variation in estimates of comorbidities among children and adolescents with depressive disorder. It is estimated that 30-80% of children / adolescents with depressive disorder also suffer from an anxiety disorder. In addition, 10-80% may suffer from a comorbid disruptive disorder or somatoform disorder.

It is important to note that 20-30% of children / adolescents with depressive disorder may also suffer from substance abuse, and this should be assessed accordingly.

Source: Bright Futures in Practice: Mental Health – Volume I, Practice Guide. Available at https://www.brightfutures.org/mentalhealth/pdf/index.html

DMDD

DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) (5.1.1.1.3.1)

DESCRIPTION

Disruptive mood dysregulation disorder (DMDD) is a new diagnosis appearing in the DSM-5. DMDD is a childhood condition of extreme irritability, anger, and frequent, intense temper outbursts that interfere with children's ability to function at home, in school, or with their friends. Children with DMDD demonstrate low frustration tolerance and exhibit difficulties with emotional regulation, distress tolerance, and behavioral self-control. DMDD symptoms typically begin before the age of 10, but the diagnosis is not given to children under 6 or adolescents over. Children with DMDD are also at increased risk of developing depression or anxiety disorders in adulthood.

SYMPTOMS

The core feature of disruptive mood dysregulation disorder is chronic, severe persistent irritability. This severe irritability has two prominent clinical manifestations, the first of which is frequent temper outbursts. These outbursts typically occur in response to frustration and can be verbal or behavioral (the latter in the form of aggression against property, self, or others). They must occur frequently (i.e., on average, three or more times per week) (Criterion C) over at least 1 year in at least two settings (Criteria E and F), such as in the home and at school, and they must be developmentally inappropriate (Criterion B). The second manifestation of severe irritability consists of chronic, persistently irritable or angry mood that is present between the severe temper outbursts. This irritable or angry mood must be characteristic of the child, being present most of the day, nearly every day, and noticeable by others in the child's environment (Criterion D).

DSM-5 DIAGNOSTIC CRITERIA

Disruptive Mood Dysregulation Disorder

A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
B. The temper outbursts are inconsistent with developmental level.
C. The temper outbursts occur, on average, three or more times per week.
D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).

E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.
F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
H. By history or observation, the age at onset of Criteria A–E is before 10 years.
I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
J. Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
K. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).
L. Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention deficit / hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.
M. The symptoms are not attributable to the physiological effects of a substance or another medical or neurological condition.

Source: American Psychiatric Association. (2013). Disruptive Mood Dysregulation Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Suicide Risk

In general, evidence documenting suicidal behavior and aggression, as well as other severe functional consequences, in disruptive mood dysregulation disorder should be noted when evaluating children with chronic irritability.

Prevalence

Disruptive mood dysregulation disorder is common among children presenting to pediatric mental health clinics. Prevalence estimates of the disorder in the community are unclear. Based on rates of chronic and severe persistent irritability, which is the core feature of the disorder, the overall 6-month to 1-year period-prevalence of disruptive mood dysregulation disorder among children and adolescents probably falls in the 2%–5% range (Brotman et al. 2006) However, rates are expected to be higher in males and school-age children than in females and adolescents. Children presenting with features of disruptive mood dysregulation disorder are predominantly male (Leibenluft, 2011). This difference in prevalence between males and females differentiates disruptive mood dysregulation disorder from bipolar disorder, in which there is an equal gender prevalence.

Source: Brotman, M, Schmajuk, M., Rich, B, et al. (2006). Prevalence, Clinical Correlated, and Longitudinal Course of Severe Mood Dysregulation in Children. Biological Psychiatry, 60(9): 991-997.

Source: Leibenluft, E. (2011).Severe Mood Dysregulation, Irritability and the Diagnostic Boundaries of Bipolar Disorder in Youths. The American Journal of Psychiatry, 168(2): 129-142

SCREENING, ASSESSMENT, DIAGNOSIS, TREATMENT AND MANAGEMENT OF DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) (5.1.1.1.3.2)

Sources: AACAP (2007): Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. JAACAP 46(1):126-141 and FL medication guidelines; AAP Bright Futures Bright Futures in Practice: Mental Health–Volume I, Practice Guide (Jellinek M, Patel BP, Froehle MC, eds. 2002. *Bright Futures in Practice: Mental Health–Volume I. Practice Guide.* Arlington,VA: National Center for Education in Maternal and Child Health.

DISRUPTIVE MOOD DISORDER DECISION TREE

Family, caregiver or school concern; Positive screen

Assessment / Diagnosis:

- Review DSM-V criteria
- Assess for common co-morbidities (ADHD, anxiety, other mood disorder, substance abuse)
- Consider referral for psychological assessment
- Rule out use of substances
- Directly address suicidal ideation and other risk for self-harm
- Assess other safety concerns (sibling, peer and family safety)

Assess severity and associated risk issues

Mild concern / Diagnosis unclear / low safety risk:

1. Psychoeducation for family
2. Regular screening / symptom monitoring
3. Assist family with coping skills for disruptive behaviors (e.g. *Mental Health Toolkit, How to Handle Anger*)
4. Continue to screen for self-harm risk and other mood or anxiety disorder
5. Help child identify uncomfortable emotions and develop coping skills

Manage and monitor in primary care; refer based on worsening or increase in

Mild-Moderate severity / some safety risk indication:

1. Implement all "mild" level interventions
2. Combined child-parent therapy
3. Encourage Parents to reinforce positive behaviors and avoid negative punishment
4. Assess for suicidal ideation and other suicide risk
5. Consider appropriateness of medications (see guidelines)

Manage in primary care if comfortable and adequately resourced, or refer to specialty care

Moderate – severe; clear mood disorder / safety risk:

1. Refer to specialist for parent-child psychotherapy
2. Directly address suicidal ideation and risk and family safety
3. Monitor for treatment response and adjust / augment treatment as needed
4. Monitor for development of mood disorder, substance use or other co-morbidities
5. Consider multimodal treatment that engages family, school and / or other supports
6. Consider engagement (with parent permission) of other social service agencies as

Refer to specialty care and continue monitoring follow up

VALIDATED SCREENING TOOLS: OVERVIEW, ITEMS AND SCORING INSTRUCTIONS (5.1.1.1.3.3)

Currently there are no available screening or assessment tools available specifically for DMDD because it is a new diagnosis. Differential diagnoses should be considered when evaluating whether a patient meets the criteria for DMDD. The presenting behaviors cannot occur exclusively during an episode of major depressive disorder and cannot be better explained by another mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]). Additionally, DMDD cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention deficit / hyperactivity disorder, conduct disorder, and substance use disorders.

EVIDENCE BASED TREATMENTS (5.1.1.1.3.4; 5.1.1.2.4.1)

FLORIDA MEDICAID DRUG THERAPY MANAGEMENT GUIDELINES

The Florida Medicaid Drug Therapy Management Program for Behavioral Health states that as Disruptive Mood Dysregulation Disorder is still such a new diagnosis, there has not been sufficient time to build a body of evidence based drug treatments and that in these instances; the physician's clinical judgement is paramount. Although it does not go into specifics regarding the use of these drugs, on the overview of Disruptive Mood Dysregulation Disorder on the National Institute of Mental Health website, there is mention of the use of stimulants, antidepressants, and atypical antipsychotics for treating the irritability that often accompanies DMDD.

Source: Florida Medicaid Drug Therapy Management Program for Behavioral Health Psychotherapeutic Medication Treatment Guidelines. Available at: http://www.medicaidmentalhealth.org

Source: NIMH Mental Health Information: Disruptive Mood Dysregulation Disorder. Available at: https://www.nimh.nih.gov/health/topics/disruptive-mood-dysregulation-disorder-dmdd/disruptive-mood-dysregulation-disorder.shtml

Disruptive Mood Dysregulation Disorder (DMDD) in Children and Adolescents Ages 6 to 17 Years Old: Recommendations

Note: Disruptive Mood Dysregulation Disorder (DMDD) is a new diagnosis in DSM-5 characterized by irritability and explosive outbursts. Due to an increase in the use of this diagnosis since its introduction to the DSM-5, the expert panel determined it appropriate to provide recommendations on the diagnosis and treatment of this condition.

Due to the current lack of evidence-based specific and suitable pharmacological treatment options for Disruptive Mood Dysregulation Disorder, clinical judgment is paramount in the choice of medications, dose, length of treatment, and measurement of treatment response. Medications are only part of the treatment plan and are provided in combination with psychosocial interventions which may include parent training, anger management, social skills, care managers, in-home services, psychiatric hospitalization, residential treatment and other supports determined on a case by case basis.

Level 0

Comprehensive assessment:

- Systematic interview covering other psychiatric conditions in which irritability may be a presenting symptom:
  - ADHD
  - ODD and/or conduct disorder
  - Bipolar disorder (mania)
  - Depressive disorders
  - Anxiety disorders (including obsessive-compulsive disorder)
  - PTSD and trauma related conditions
  - Autism Spectrum Disorder
  - Intermittent explosive disorder
  - Psychosis
  - Drug/alcohol use/abuse
- Family history of psychopathology including depressive disorders, anxiety disorders and bipolar disorder (with specific assessment for mania).
- Information from collateral sources (eg. teachers, caregivers) to establish duration of symptoms.

Use rating scales to assess for psychiatric conditions as noted above. Refer to relevant sections in these *Practice Guidelines*.

- Assess for other medical conditions or medications that may be contributing to symptoms.
  - If other medical conditions are present, make appropriate referrals to primary care or specialists to ensure conditions are treated adequately.
  - If symptoms are medication-induced, consider tapering or stopping the offending agent.
- Assess for psychosocial stressors (eg. conflict at home, classroom situation, bullying) that may be contributing to the child's symptoms (i.e. irritability, anger, temper outbursts disproportionate to the situation and more severe than the typical reaction of same-aged peers).

Disruptive Mood Dysregulation Disorder (DMDD) in Children and Adolescents Ages 6 to 17 Years Old: Recommendations *(continued)*

Level 0 *(continued)*

- Assess for and rule out other DSM-5 diagnoses as noted above (eg. ADHD, ODD, bipolar disorder, etc.).
- Assess and document the severity of symptoms (frequency, intensity, number and duration of outbursts and irritability) using rating scales.
  - *Recommended rating scales for irritability:*
    - Affective Reactivity Index (quick assessment, focuses on frequency of irritability only)
    - Child Behavior Checklist (comprehensive scale that includes irritability sub-scale)
    - Aberrant Behavior Checklist (used in children with developmental disorders, has irritability sub-scale).

      Note: The Child Behavior Checklist and Aberrant Behavior Checklist are not available in the public domain.
  - *Recommended scales for aggression and outbursts:*
    - Overt Aggression Scale-Modified (measures nature and severity of aggression)
    - Irritability Inventory (assesses triggers, behaviors, duration of outbursts and how the child feels after the outburst).

      Note: The Irritability Inventory has not been widely used, and it is not available on the public domain.

For available clinical rating scales, refer to ***http://www.medicaidmentalhealth.org/.***

- Assess and document degree of impairment, which is based on the severity, frequency, and duration of outbursts.

Note: Once other medical and psychiatric conditions have been assessed or/ruled out, and treatment has been optimized for known conditions (medical, psychiatric) in which irritability and aggression may be presenting symptoms and for which there are evidence based treatments, if DSM-5 criteria are met for Disruptive Mood Dysregulation Disorder, that diagnosis may be made.

Level 1

The core symptoms of Disruptive Mood Dysregulation Disorder are irritability, anger, aggression, and temper outbursts (verbal or behavioral/physical) that are disproportionate to the situation and significantly more severe than the typical reaction of same-aged peers. Irritability and aggression are distinct symptoms. Irritability is defined as becoming extremely angry with what most would feel is minor provocation (Copeland, et al., 2015). Aggression refers to hostile, injurious, or destructive behaviors.

- **1a.** Address psychosocial stressors that are directly contributing to or worsening the child's symptoms (eg. irritability, anger, aggression, temper outbursts).
- **1b.** Address the severity of the child's symptoms.
  - If symptoms are mild, implement psychosocial interventions (eg. targeted case management, crisis intervention programs, parent training).
  - If symptoms are moderate to severe (eg. child is removed from school, has been seen in emergency room or psychiatrically hospitalized), psychosocial interventions alone are unlikely to suffice. Consider interventions in Level 2.

Disruptive Mood Dysregulation Disorder (DMDD) in Children and Adolescents Ages 6 to 17 Years Old: Recommendations *(continued)*

→	**Level 2** Currently, limited scientific evidence exists for the use of medications for Disruptive Mood Dysregulation Disorder. If irritability and outbursts continue to cause impairment after co-morbid disorders have been treated optimally, re-assess the diagnosis. If symptoms persist, may consider use of treatments targeted toward aggression including atypical antipsychotics, mood stabilizers, alpha agonists, or antidepressants in conjunction with psychotherapeutic and psychosocial interventions. Refer to Table 9 on pg. 28 for dosing recommendations for aggression.
Not Recommended: Use of medications alone.	

For a full list of references, visit ***http://medicaidmentalhealth.org/.***

EVIDENCE BASED THERAPEUTIC INTERVENTIONS

Psychological treatments should be considered first, with medication added later if necessary, or psychological treatments can be provided along with medication from the beginning. Pediatricians should work closely with the parent and child to determine the best treatment option for the child. Effective psychological treatments can be in the form of psychotherapy, and parent-training.

COGNITIVE BEHAVIORAL THERAPY (CBT)

- Some evidence that Cognitive Behavioral Therapy (CBT) may be effective in treating severe mood dysregulation, a symptom of DMDD.
- Techniques include stabilizing the child's daily routines, increasing family supports, and monitoring affect / emotions.
- Treatment outcomes have yielded a reduction of physical aggression, improved self-esteem, enhanced ability to self-recognize negative emotions (e.g., anger), and an increased ability to identify the connection between one's mood and exhibited behavior

ADLERIAN PLAY THERAPY (ADPT)

- May reduce disruptive behaviors, a symptom of DMDD (e.g., rule breaking, aggression, attention seeking) in a classroom setting.
- Integrates directive and non-directive play techniques that encourage children to rehearse changing perceptions, attitudes, and behaviors through language and/or metaphors.
- Techniques are grounded in the basic principles of Adlerian Therapy (e.g., early recollections, birth order, social interests)

CHILD PARENT RELATIONSHIP THERAPY (CPRT)

- Based upon the premise that a secure parent-child relationship is the essential factor for children's well-being.
- Play-based treatment program for young children between 3 and 8 years who have behavioral, emotional, social, and attachment disorders and for their parents.

- Aims to fully involve parents in the therapeutic process through group sessions in which parents learn skills to respond more effectively to their children's emotional and behavioral needs.
- Children are expected to learn that they can count on their parents to reliably and consistently meet their needs for love, acceptance, safety, and security.

PARENT TRAINING

- Aims to help parents interact with a child in a way that will reduce aggression and irritable behavior and improve the parent-child relationship.
- Teaches parents more effective ways to respond to irritable behavior,
- Focuses on the importance of predictability, being consistent with children, and rewarding positive behavior.

Source: NIMH Mental Health Information: Disruptive Mood Dysregulation Disorder. Available at: https://www.nimh.nih.gov/health/topics/disruptive-mood-dysregulation-disorder-dmdd/disruptive-mood-dysregulation-disorder.shtml

Source: Substance Abuse and Mental Health Services Administration: National Registry of Evidence-based Programs and Practices (NREPP). Available at: https://www.samhsa.gov/nrepp

RESOURCES FOR FAMILIES

RESOURCES FOR ATTENTION DEFECIT HYPERACTIVITY DISORDER (ADHD) (5.1.1.3.5)

Positive Coping Strategies and Behavior Modification Techniques

Every Day Coping Strategies	
➢ Start each day with a fresh start ➢ Set clear and realistic expectations for each of your children-each child has their own uniqueness. ➢ Set realistic expectations for yourself. ➢ Focus on the behavior you want to improve. ➢ Choose appropriate consequences for your child's age. ➢ Give specific, one-step directions or commands. ➢ Be consistent. ➢ Be patient. ➢ Be fair. ➢ Stay calm. ➢ Give Praise.	
Behavior Modification Techniques	
Time Out/ **Time In**	**The Basics of Time Outs** ➢ Goal is to teach how to behave not punish. ➢ Focus on the behavior. ➢ Provide clear explanation of behavioral expectations and consequences. ➢ Have a designated space for time out that is quiet and non-distracting. ➢ Keep it brief-one minute per year of age. ➢ Use a timer-it will help you and your child track time. Time starts when the child calms down. ➢ Provide an immediate and consistent response. ➢ Stay calm. ➢ Give praise for behavior change.
Positive Reinforcement and Negative Consequences	**The Basics of Positive Reinforcement** ➢ Set clear and realistic expectations. ➢ Praise positive behavioral change. ➢ Give immediate privilege/reward after positive behavioral change. ➢ Take away privilege/reward for negative, problem, or unwanted behavior.
Reward System/Token Economy	**The Basics of Reward Systems/Token Economy** ➢ Set clear and realistic expectations ➢ Focus on positive behaviors or task achievement

	➢ Know what makes your child behave-privileges, prizes, stickers, stars, money etc. ➢ Change rewards/tokens not rules. ➢ Set realistic and achievable goals for the number of times a positive behavior must be displayed to earn reward/token. ➢ Chart progress in a public place in the home like the refrigerator. ➢ Earned rewards are never lost. ➢ Be consistent with rewards/tokens. ➢ Give praise for behavior change. ➢ Once behavior is mastered wean off rewards/tokens.

Adapted from: Evidence-based best practices for the management of Attention-Deficit/Hyperactivity Disorder (ADHD) in Pediatric Primary Care in South Carolina (2011). Retrieved from: http://www.sccp.sc.edu/sites/default/files/15006-ADHD%20SCORxE%20SUM.pdf

ADHD Resources for Parents, Caregivers and Teachers: Books and Guides

- ADHD: What Every Parent Needs to Know, 2nd edition by Michael I. Reiff (2011)
- Raising Boys with ADHD: Secrets for Parenting Healthy, Happy Sons by Mary Anne Richey and James W. Forgan (2012)
- Taking Charge of ADHD, Third Edition: The Complete, Authoritative Guide for Parent by Russell A. Barkley (2013)
- Parenting Children with ADHD: 10 Lessons That Medicine Cannot Teach by Vincent Monastra (2014)
- Focused: ADHD & ADD Parenting Strategies for Children with Attention Deficit Disorder by Blythe N. Grossberg (2015)
- Mindful Parenting for ADHD: A Guide to Cultivating Calm, Reducing Stress, and Helping Children Thrive by Mark Bertin, MD and Ari Tuckman PsyD (2015)
- Managing ADHD in School: The Best Evidence-Based Methods for Teachers by Russell Barkley (2016)
- Parenting ADHD Now!: Easy Intervention Strategies to Empower Kids with ADHD by Elaine Taylor-Klaus and Diane Dempster (2016)
- Super ADHD by Rachel Knight (2017)

ADHD Resource Websites

American Academy of Pediatrics	https://www.aap.org
Bright Futures	https://www.brightfutures.org/mentalhealth/pdf/bridges/adhd.pdf
National Institute of Mental Health	https://www.nimh.nih.gov/health/topics/attention- deficit-hyperactivity- disorder-adhd/index.shtml
CHADD: The National Resource for ADHD	http://www.chadd.org/
Healthy Children (English)	https://www.healthychildren.org/English/health-issues/conditions/adhd/Pages/default.aspx
Healthy Children (Spanish)	https://www.healthychildren.org/spanish/health-issues/conditions/adhd/paginas/default.aspx
National Alliance on Mental Illness (NAMI)	https://nami.org/Learn-More/Mental-Health-Conditions/ADHD
ADHD Parent Medication Guide	https://www.aacap.org/App_Themes/AACAP/docs/resource_centers/resources/med_guides/adhd_parents_medication_guide_english.pdf
Teach ADHD	http://www.teachadhd.ca/Pages/default.aspx

RESOURCES FOR ANXIETY (5.1.1.3.5)

Anxiety Resources for Children: Books and Recordings

- What To Do When You Worry Too Much (Huebner, 2005)
- What To Do When You Are Scared and Worried (Crist, 2004)
- What To Do When Your Brain Gets Stuck: A Kid's Guide to Overcoming OCD (Huebner, 2007)
- A Boy and a Bear: The Children's Relaxation Book (Lite, 2003)
- What To Do When You Dread Your Bed: A Kid's Guide to Overcoming Problems with Sleep (Huebner, 2008)
- I Can Relax (Pincus, 2012) – *recording*

Anxiety Resources for Adolescents: Books, Workbooks and Smartphone Apps

- My Anxious Mind: A Teen's Guide to Managing Anxiety and Panic (Tompkins and Martinez, 2009)
- Riding the Wave Workbook for Adolescents with Panic Disorder (Pincus, Ehrenreich and Spiegel, 2008)
- Smartphone applications for youth and their parents that provide access to tools taught in CBT sessions (eg. Mayo Clinic Anxiety Coach)

Anxiety Resources for Parents and Caregivers: Books, Workbooks and Online Resources

- Helping Your Anxious Child (Rapee, Wignall, Spense, Cobham and Lyneham, 2008)
- Keys to Parenting Your Anxious Child (Manassis, 2008)
- Freeing Your Child from Anxiety (Chansky, 2014)
- Worried No More: Help and Hope for Anxious Children (Wagner, 2005)
- Talking Back to OCD (March, 2006)
- Freeing Your Child from Obsessive-Compulsive Disorder (Chansky, 2001)
- Helping Your Child with Selective Mutism (McHolm, Cunningham, Vanier and Rapee, 2005)

- The Selective Mutism Treatment Guide: Manuals for Parents, Teachers and Therapists (Perdnick, 2012)
- When Children Refuse School: A CBT Approach Parent Workbook (Kearney and Albano, 2007)
- Parent training, educational materials and resources at https://www.anxietybc.com/ and http://www.copingcatparents.com/

Anxiety Resource Websites

American Academy of Child and Adolescent Psychiatry (AACAP), Facts for Families	http://www.aacap.org
Anxiety and Depression Association of America (ADAA)	https://www.adaa.org/
Selective Mutism Group-Child Anxiety Network	http://www.selectivemutism.org/
Association for Behavioral and Cognitive Therapies	http://www.abct.org/Home/
Computer-based CBT treatments (cCBT) for youth with anxiety disorders: The BRAVE Program, BRAVE-Online and Camp Cope-A-Lot	http://www.brave-online.com/
Children's Center for OCD and Anxiety	www.worrywisekids.org
Child Anxiety Network	www.childanxiety.net/Anxiety_Disorders.htm
National Institute of Mental Health	www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml
Anxiety BC Youth (an online CBT tools website for teens)	http://youth.anxietybc.com
After the Injury (from Children's Hospital of Philadelphia)	www.aftertheinjury.org

Resources obtained from: (1) *Florida's 2016-17 Medicaid Guidelines for Treatment of Anxiety Disorder. Available at http://medicaidmentalhealth.org/.* ***(2)*** *Seattle Children's Primary Care Principles for Child Mental Health. Available at http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/*

RESOURCES FOR AUTISM SPECTRUM DISORDER (ASD) (5.1.1.3.5)

Autism Resources for Parents, Caregivers, and Teachers: Books and Guides

- Look at My Eyes: Autism Spectrum Disorders: Autism and PDD-NOS by Melanie Fowler (2011)
- What I Wish I'd Known about Raising a Child with Autism: A Mom and a Psychologist Offer Heartfelt Guidance for the First Five Years by Bobbi Sheahan and Kathy DeOrnellas (2011)
- Crazy Love: A Traumedy about Life with Autism by Sharie Walter (2011)
- Ten Things Every Child with Autism Wishes You Knew: Updated and Expanded Edition by Ellen Notbohm and Veronica Zysk (2013)
- Autism in the Family: Caring and Coping Together by Robert A. Naseef, Ph.D. (2013)
- We Said, They Said: 50 Things Parents and Teachers of Students with Autism Want Each Other to Know by Cassie Zupke (2013)
- A Parent's Guide to High-Functioning Autism Spectrum Disorder, Second Edition: How to Meet the Challenges and Help Your Child Thrive by Sally Ozonoff, Geraldine Dawson and James McPartland (2014)
- The Parent's Autism Sourcebook: A Comprehensive Guide to Screenings, Treatments, Services, and Organizations by Kim Mack Rosenberg and Tony Lyons (2015)
- Uniquely Human: A Different Way of Seeing Autism by Barry M. Prizant (2016)

Autism Resource Websites

Autism Society	http://www.autism-society.org/
Autism Society of Florida	http://www.autismfl.com/
Florida Department of Education (FDOE) ASD Website	http://www.fldoe.org/academics/exceptional-student-edu/ese-eligibility/autism-spectrum-disorder-asd.stml
USF CARD Autism Support Materials	http://card-usf.fmhi.usf.edu/resources/materials/asd.html
Centers for Disease Control (CDC)	https://www.cdc.gov/ncbddd/autism/index.html
Autism NOW: The National Autism Resource and Information Center	http://autismnow.org/
FSU Autism Institute	http://med.fsu.edu/index.cfm?page=autismInstitute.home
FSU Center for Autism and Related Disabilities (CARD)	http://www.fsucard.com

RESOURCES FOR BIPOLARD DISORDER (5.1.1.3.5)

Bipolar Resources Families: Books and Workbooks

There is currently a professional debate about how bipolar disorder in children is defined, with some authors using "bipolar, unspecified type" as a label for any very irritable child. Therefore, families should start their learning about bipolar disorder overall with the following which provide high quality information and support.

- An Unquiet Mind (Jamison, 1995)
- Bipolar Disorder for Dummies (Fink & Craynak, 2005)
- The Bipolar Workbook: Tools for controlling your mood swings (Basco, 2006)
- Your Child Does Not Have Bipolar Disorder (Kaplan, 2011)
- The Bipolar Teen: What You Can Do to Help Your Child and Your Family (Miklowitz & George, 2007)

Bipolar Disorder Resource Websites

American Academy of Child and Adolescent Psychiatry Bipolar Disorder Resource Center	http://www.aacap.org/aacap/families_and_youth/resource_centers/bipolar_disorder_resource_center/home.aspx
National Institute of Mental Health	www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml
National Alliance for the Mentally Ill	www.nami.org

Resources obtained from: ***(1)*** *Florida's 2016-17 Medicaid Guidelines for Treatment of Anxiety Disorder. Available at http://medicaidmentalhealth.org/.* ***(2)*** *Seattle Children's Primary Care Principles for Child Mental Health. Available at http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/*

RESOURCES FOR DEPRESSION (5.1.1.3.5)

Depression Resources for Children: Books and Workbooks

- Taking Depression to School (Khalsa, 2002)
- Where's Your Smile, Crocodile? (Freedman, 2001)
- My Feeling Better Workbook: Help for Kids Who Are Sad and Depressed (Hamil, 2008)

Depression Resources for Adolescents: Books

- Feeling Good: The New Mood Therapy (Burns, 1999)
- When Nothing Matters Anymore: A Survival Guide for Depressed Teens (Cobain & Verdick, 2007)

Depression Resource Websites

National Institute of Mental Health	www.nimh.nih.gov/health/topics/depression/index.shtml
National Alliance for Mental Illness	https://www.nami.org/Find-Support/Teens-and-Young-Adults
American Foundation for Suicide Prevention	www.afsp.org
American Academy of Child and Adolescent Psychiatry	http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Depression_Resource_Center/Home.aspx
Teen Self-Help Cognitive Behavior Therapy (CBT) guidance	www.dartmouthcoopproject.org/teen-mental-health-2/
Youth Suicide Prevention Program	www.yspp.org

Crisis Hotlines

National Crisis Hotline, 1-800-784-2433

National Suicide Prevention Lifeline, 1-800-273-8255

Resources obtained from: (1) *Florida's 2016-17 Medicaid Guidelines for Treatment of Anxiety Disorder. Available at http://medicaidmentalhealth.org/.* ***(2)*** *Seattle Children's Primary Care Principles for Child Mental Health. Available at http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/resources/*

RESOURCES FOR DISRUPTIVE MOOD DYSREGULATION DISORDER (DMDD) (5.1.1.3.5)

DMDD Resources for Parents, Caregivers, and Teachers: Books

- The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children by Ross W. Greene, Ph.D. (2014)
- Lost at School: Why Our Kids with Behavioral Challenges are Falling Through the Cracks and How We Can Help Them by Ross W. Greene, Ph.D. (2014)
- Parenting a Child Who Has Intense Emotions: Dialectical Behavior Therapy Skills to Help Your Child Regulate Emotional Outbursts and Aggressive Behaviors by Pat Harvey and Jeanine Penzo (2009)
- Disruptive Mood Dysregulation Disorder (DMDD), ADHD and the Bipolar Child Under DSM-5: A Concise Guide for Parents and Professionals by Todd Finnerty (2013)

DMSS Resource Websites

American Academy of Child and Adolescent Psychiatry-DMDD	http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/Facts_for_Families_Pages/Disruptive_Mood_Dysregulation_Disorder_DMDD_110.aspx
America Academy of Child and Adolescent Psychiatry Family Resources	http://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx
National Institute of Mental Health	https://www.nimh.nih.gov/health/topics/disruptive-mood-dysregulation-disorder-dmdd/disruptive-mood-dysregulation-disorder.shtml
Child Mind Institute	https://childmind.org/guide/guide-to-disruptive-mood-dysregulation-disorder/
Bright Futures Pediatric Symptom Checklist (PSC-35)	https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf

Vanderbilt Diagnostic Rating Scale	https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales
Federation of Families For Children's Mental Health	https://www.ffcmh.org/

Behavioral Resources for Bullying for Parents, Caregivers, and Teachers: Books

- Bullying Prevention: Creating a Positive School Climate and Developing Social Competence by Pamela Orpinas, PhD and Arthur Horne, Ph.D. (2006).
- The Bully, the Bullied, and the Bystander: From Preschool to High School--How Parents and Teachers Can Help Break the Cycle by Barbara Coloroso (2009).
- Bullied: What Every Parent, Teacher, and Kid Needs to Know About Ending the Cycle of Fear by Carrie Goldman (2013).
- 8 Keys to End Bullying: Strategies for Parents & Schools (8 Keys to Mental Health) by Signe Whitson and Babette Rothschild (2014).

Behavioral Resources for Bullying for Children and Adolescents: Books and Workbooks

- Stand Up for Yourself & Your Friends: Dealing with Bullies & Bossiness and Finding a Better Way Patti Kelley Criswell and Angela Martini (2016).
- The Bullying Workbook for Teens: Activities to Help You Deal with Social Aggression and Cyberbullying by Raychelle Cassada Lohmann and Julia V. Taylor PhD (2013)

Behavioral Modification Tips for Parents

Every Day Coping Strategies
➢ Start each day with a fresh start ➢ Set clear and realistic expectations for each of your children-each child has their own uniqueness. ➢ Set realistic expectations for yourself. ➢ Focus on the behavior you want to improve. ➢ Choose appropriate consequences for your child's age. ➢ Give specific, one-step directions or commands.

- Be consistent.
- Be patient.
- Be fair.
- Stay calm.
- Give praise.

Behavior Modification Techniques	
Time Out/ **Time In**	**The Basics of Time Outs** ➢ Goal is to teach how to behave not punish. ➢ Focus on the behavior. ➢ Provide clear explanation of behavioral expectations and consequences. ➢ Have a designated space for time out that is quiet and non-distracting. ➢ Keep it brief-one minute per year of age. ➢ Use a timer-it will help you and your child track time. Time starts when the child calms down. ➢ Provide an immediate and consistent response. ➢ Stay calm. ➢ Give praise for behavior change.
Positive Reinforcement and Negative Consequences	**The Basics of Positive Reinforcement** ➢ Set clear and realistic expectations. ➢ Praise positive behavioral change. ➢ Give immediate privilege/reward after positive behavioral change. ➢ Take away privilege/reward for negative, problem, or unwanted behavior.

Reward System/Token Economy	**The Basics of Reward Systems/Token Economy** ➢ Set clear and realistic expectations ➢ Focus on positive behaviors or task achievement ➢ Know what makes your child behave-privileges, prizes, stickers, stars, money etc. ➢ Change rewards/tokens not rules. ➢ Set realistic and achievable goals for the number of times a positive behavior must be displayed to earn reward/token. ➢ Chart progress in a public place in the home like the refrigerator. ➢ Earned rewards are never lost. ➢ Be consistent with rewards/tokens. ➢ Give praise for behavior change. ➢ Once behavior is mastered wean off rewards/tokens.
Behavior Modification Techniques, continued	
Sleep Hygiene	**The Basics of Sleep Hygiene** Regular adequate sleep leads to improved attention, memory, behavior, learning, mental and physical health, emotional regulation, and quality of life. ➢ Establish a consistent bedtime routine for young children. ➢ Turn off all screens 30 minutes before bedtime. ➢ Keep the sleep schedule consistent. Do not allow it to vary more than an hour of weekends from weekday schedule. ➢ Age Appropriate Sleep Recommendations (regularly, in a 24 hour period) o Infants age 4-12 months need 12-16 hours of sleep (including naps) o Children age 1-2 years need 11-14 hours of sleep (including naps)

	o Children age 3-5 years need 10-13 hours of sleep (including naps) o Children age 6-12 years need 9-12 hours of sleep o Adolescents age 13-18 need 8-10 hours of sleep
Child Directed Play	**Child Directed Play** Child Directed Play (CDP) is one-on-one parent/child interaction in short duration (10-15 minutes) regularly scheduled increments that allows the child to lead and play in any way that they chose (that is safe). ➢ Recommended for children ages 2-10 ➢ Used to enhance child's sense of self-regulation, self-confidence and appropriate control. ➢ Provides an opportunity for your child to have your attention without negative behaviors. ➢ Improves child's sense of confidence and security in their relationship with you. How to do CDP: ➢ Join your child on the floor. ➢ Describe your child's play, i.e. "There goes the train through the tunnel." ➢ Imitate your child's activities. ➢ Repeat, with more detail, what your child says using a statement rather than a question. ➢ Identify specific behaviors that you want to encourage and praise those behaviors specifically. For example, rather than a blanket statement of "geat job," you might say, "You are being very careful with stacking those blocks." ➢ Avoid giving commands about play or toys. ➢ Remember to allow your child to lead. Don't interject your ideas about play.

Source: Paruthi S, Brooks LJ, D'Ambrosio C, Hall WA, Kotagal S, Lloyd RM, Malow BA, Maski K, Nichols C, Quan SF, Rosen CL, Troester MM, Wise MS. Recommended amount of sleep for pediatric populations: a consensus statement of the American Academy of Sleep Medicine. J Clin Sleep Med 2016;12(6):785-786.

Source: Seattle Children's. Growth and Development: Child Directed Play. Retrieved from: http://www.seattlechildrens.org/safety-wellness/growth-development/child-directed-play/

Source: Evidence-based best practices for the management of Attention-Deficit/Hyperactivity Disorder (ADHD) in Pediatric Primary Care in South Carolina (2011). Retrieved from: http://www.sccp.sc.edu/sites/default/files/15006-ADHD%20SCORxE%20SUM.pdf

APPENDIX A

ADHD DIFFERENTIAL DIAGNOSIS DESCRIPTIONS

OPPOSITIONAL DEFIANT DISORDER

- May resist work or school tasks that require self-application because they resist conforming to others' demands.
- Behavior is characterized by negativity, hostility, and defiance.
- Symptoms must be differentiated from aversion to school or mentally demanding tasks due to difficulty in sustaining mental effort, forgetting instructions, and impulsivity in individuals with ADHD..
- Individuals with ADHD may develop secondary oppositional attitudes toward such tasks and devalue their importance.

INTERMITTENT EXPLOSIVE DISORDER

- High levels of impulsive behavior
- Show serious aggression toward others, which is not characteristic of ADHD.
- Do not experience problems with sustaining attention as seen in ADHD.
- Rare in childhood.
- May be diagnosed in the presence of ADHD.

OTHER NEURODEVELOPMENTAL DISORDERS

- Distinguish increased motoric activity that may occur in ADHD from the repetitive motor behavior that characterizes stereotypic movement disorder and some cases of autism spectrum disorder.
- In stereotypic movement disorder, the motoric behavior is generally fixed and repetitive (e.g., body rocking, self-biting), whereas the fidgetiness and restlessness in ADHD are typically generalized and not characterized by repetitive stereotypic movements.
- In Tourette’s disorder, frequent multiple tics can be mistaken for the generalized fidgetiness of ADHD. Prolonged observation may be needed to differentiate fidgetiness from bouts of multiple tics.

SPECIFIC LEARNING DISORDER

- Children with specific learning disorder may appear inattentive because of frustration, lack of interest, or limited ability.
- Inattention is not impairing outside of academic work.

AUTISM SPECTRUM DISORDER

- Exhibits inattention, social dysfunction, and difficult-to-manage behavior.
- Exhibits social disengagement, isolation, and indifference to facial and tonal communication.
- Display tantrums because of an inability to tolerate a change from their expected course of events as opposed to impulsivity or poor self-control.

REACTIVE ATTACHMENT DISORDER

- Children with reactive attachment disorder may show social disinhibition, but not the full ADHD symptom cluster, and display other features such as a lack of enduring relationships that are not characteristic of ADHD.

ANXIETY DISORDERS

- Inattention and/or restlessness due to worry and rumination.

DEPRESSIVE DISORDERS

- Inability to concentrate becomes prominent only during a depressive episode.

BIPOLAR DISORDER

- Episodic increased activity, poor concentration, and increased impulsivity (occurring several days at a time.
- Increased impulsivity or inattention is accompanied by elevated mood, grandiosity, and other specific bipolar features lasting 4 or more days.

- Bipolar disorder is rare in preadolescents, even when severe irritability and anger are prominent.

DISRUPTIVE MOOD DYSREGULATION DISORDER

- Pervasive irritability, and intolerance of frustration.
- Impulsiveness and disorganized attention are not essential features.
- Most children and adolescents with this disorder have symptoms that also meet criteria for ADHD, which is diagnosed separately.

SUBSTANCE USE DISORDERS

- Attention deficit / hyperactivity disorder (ADHD) and substance use disorders are inextricably intertwined.
- Differentiating ADHD from substance use disorders may be problematic if the first presentation of ADHD symptoms follows the onset of abuse or frequent use.
- Clear evidence of ADHD before substance misuse from informants or previous records may be essential for differential diagnosis.

PERSONALITY DISORDERS

- These disorders tend to share the features of disorganization, social intrusiveness, emotional dysregulation, and cognitive dysregulation.
- ADHD is not characterized by fear of abandonment, self-injury, extreme ambivalence, or other features of personality disorder.
- Extended clinical observation, informant interview, or detailed history to distinguish impulsive, socially intrusive, or inappropriate behavior from narcissistic, aggressive, or domineering behavior is required to make this differential diagnosis.

PSYCHOTIC DISORDERS

- ADHD is not diagnosed if the symptoms of inattention and hyperactivity occur exclusively during the course of a psychotic disorder.

MEDICATION-INDUCED SYMPTOMS OF ADHD

- Symptoms of inattention, hyperactivity, or impulsivity attributable to the use of medication (e.g., bronchodilators, isoniazid, neuroleptics [resulting in akathisia], thyroid replacement medication) are diagnosed as other specified or unspecified other (or unknown) substance-related disorders.

Source: American Psychiatric Association. (2013). Attention Deficit/Hyperactivity Disorder. In Diagnostic and statistical manual of mental disorders (5th ed.) https://doi.org/10.1176/appi.books.9780890425596.dsm01

ADDITIONAL ADHD SCREENING TOOLS

ADHD RATING SCALE IV

The ADHD Rating Scale-IV is completed independently by the parent and scored by a clinician. The scale consists of 2 subscales: inattention (9 items) and hyperactivity-impulsivity (9 items). **If 3 or more items are skipped, the clinician should use extreme caution in interpreting the scale. Results from this rating scale alone should not be used to make a diagnosis.**

http://pcptoolkit.beaconhealthoptions.com/wp-content/uploads/2016/01/cms-quality-child_adhd_rating_scale_screener.pdf

SWAN (STRENGTHS AND NEEDS OF ADHD SYMPTOMS AND NORMAL BEHAVIOR SCALE)

This screening tool elicits strengths and weaknesses in the domains of attention and impulsivity-hyperactivity in children 6-18 years old. There is an 18-item and 30-item version. It takes approximately 10 minutes to score.

https://ecom.amerihealth.com/ah/pdfs/providers/resources/worksheets/prevhealth_swan.pdf

APPENDIX B

ADDITIONAL SCREENING TOOLS FOR ANXIETY DISORDERS

THE SEVERITY MEASURE FOR GENERALIZED ANXIETY DISORDER–CHILD AGE 11-17

The Severity Measure for Generalized Anxiety Disorder–Child Age 11-17 is a 10-item measure that assesses the severity of generalized anxiety disorder in children and adolescents. The measure was designed to be completed by the child upon receiving a diagnosis of generalized anxiety disorder (or clinically significant generalized anxiety disorder symptoms) and thereafter, prior to follow-up visits with the clinician.

This measure is available to clinicians and researchers free online at: https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Severity-Measure-For-Generalized-Anxiety-Disorder-Child-Age-11-to-17.pdf

APPENDIX C

ADDITIONAL SCREENING TOOLS FOR DEPRESSION

SHORT MOOD AND FEELINGS QUESTIONNAIRE, CHILD VERSION

The Short Mood and Feelings Questionnaire was developed by researchers at Duke University and is a short self-report tool for children ages 6 and older to assess depression symptoms. It can be completed either by the child on themselves using the Child Self Report version or the parent on the child using the Parent Report on Child version.

The Child Self Report tool has a sensitivity of 60% and a specificity of 85% for major depression at a cut off score of 8 or higher. Although sensitivity and specificity of statistics of the parent version is not reported in literature, repeated administration of the parent version over time can still be useful for symptom tracking.

These tools are available for free online at: http://devepi.duhs.duke.edu/mfq.html

Permission to publish these tools are granted with appropriate citation of the authors: Adrian Angold and Elizabeth J. Costello, 1987; Developmental Epidemiology Program; Duke University.

Source: Angold A, Costello EJ, Messer SC. "Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents." International Journal of Methods in Psychiatric Research (1995), 5:237-249.

SHORT MOOD AND FEELINGS QUESTIONNAIRE, CHILD VERSION

This form is about how you might have been feeling or acting recently. For each question, please check how much you have felt or acted this way *in the past two weeks.*

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

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

SHORT MOOD AND FEELINGS QUESTIONNAIRE, PARENT VERSION

This form is about how your child might have been feeling or acting recently. For each question, please check how much she or he has felt or acted this way *in the past two weeks.*

If a sentence was true about you most of the time, check TRUE.

If it was only sometimes true, check SOMETIMES.

If a sentence was not true about you, check NOT TRUE.

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

Scoring the SMFQ

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

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

Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

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

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