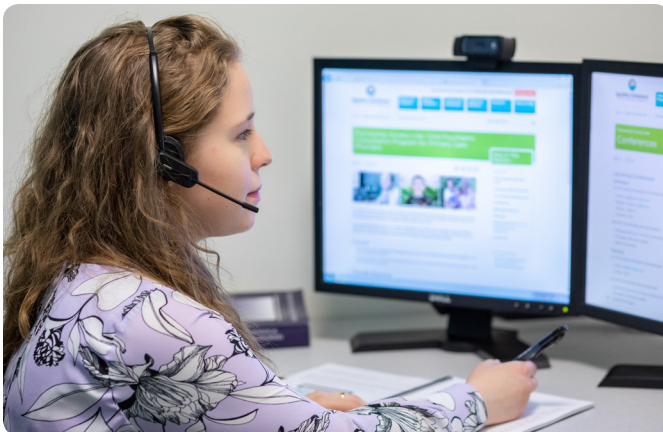


Seattle Children's

# Primary Care Principles for Child Mental Health

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

Version 7.2 — 2019



866-599-7257  
Monday – Friday,  
8 a.m. to 5 p.m.



**PARTNERSHIP ACCESS LINE**

Child Psychiatric Consultation  
for Primary Care Providers

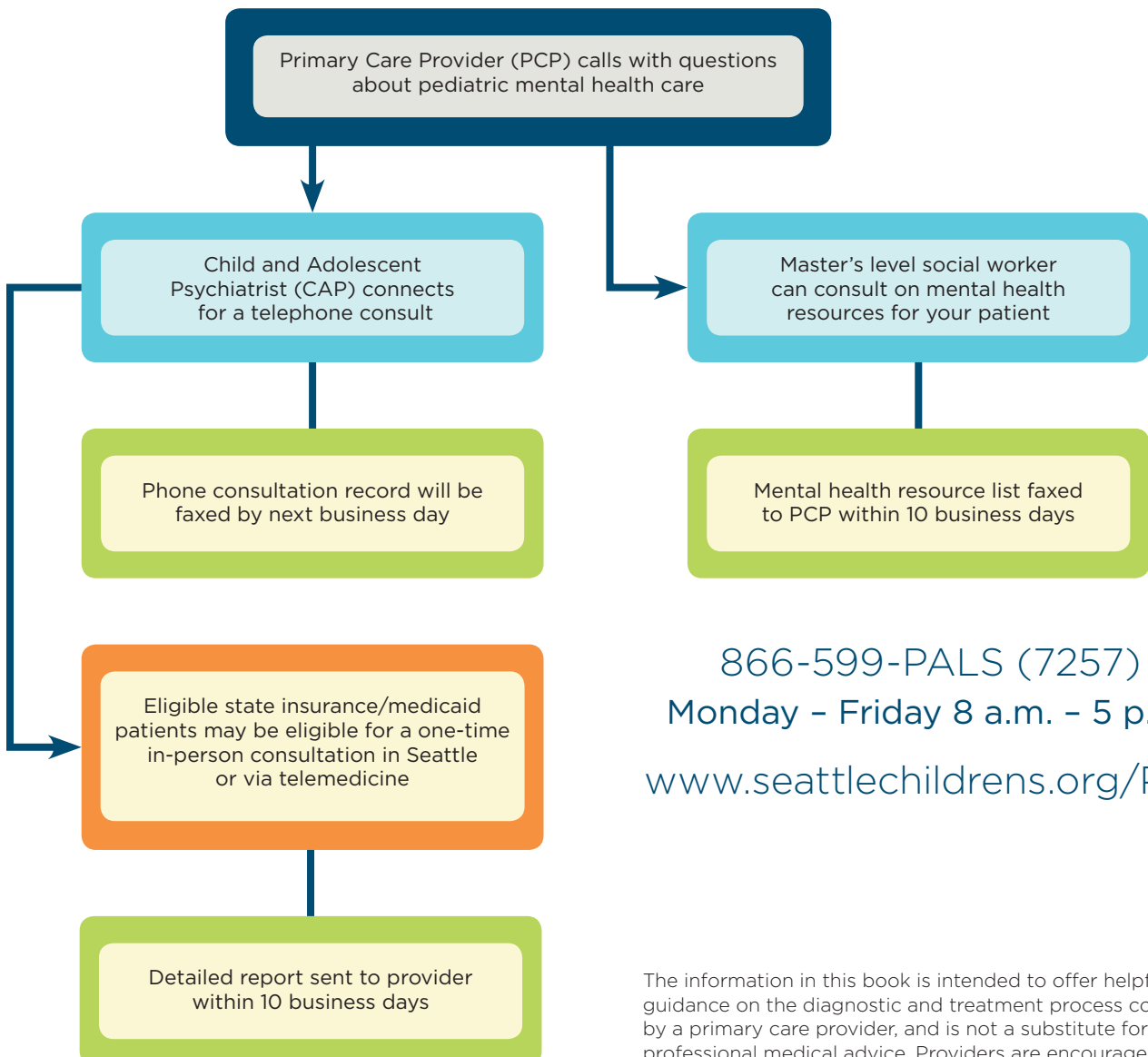
# Partnership Access Line:

## Child Psychiatric Consultation Program for Primary Care Providers

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

- At the time of the call our program coordinator will ask for basic patient information
- HIPAA, section **45 CFR 164.506**; no additional release of patient information is required to consult by phone.

PAL is funded by the Washington State Legislature and by Washington's Health Care Authority.



866-599-PALS (7257)

Monday – Friday 8 a.m. – 5 p.m.

[www.seattlechildrens.org/PAL](http://www.seattlechildrens.org/PAL)

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

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

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# Peer Review

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

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

General peer review has included:

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

Section specific peer review has included:

***ADHD:***

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

***Anxiety:***

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

***Autism:***

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

***Bipolar:***

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

***Depression:***

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

***Disruptive Behavior and Aggression:***

Terry Lee, MD, Acting Assistant Professor, U. of Washington

***Eating Disorder:***

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

***Substance Use Disorder:***

Laura Richardson, MD, MPH, Professor of Pediatrics; Adolescent Medicine

# Care Guide Methods

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

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

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

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

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



# How This Care Guide Can Help You

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

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

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

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

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

## Contained inside:

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

# Washington Quick Provider Resources

## General Information

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

## Accessing a Mental/Behavioral Health Therapist

- Find a therapist  
<http://therapists.psychologytoday.com>  
[www.helppro.com](http://www.helppro.com)
- For those with Medicaid, contact your Apple Health Plan or your local Behavioral Health Organization (BHO):  
[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/child-and-youth-behavioral-health](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/child-and-youth-behavioral-health)

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

## Family Support Organizations

- DSHS Resources for Parents  
[www.dshs.wa.gov/ca/advancing-child-welfare/getting-help](http://www.dshs.wa.gov/ca/advancing-child-welfare/getting-help)
- Department of Children, Youth, and Families  
[www.dcyf.wa.gov](http://www.dcyf.wa.gov)
- Parent Trust  
[www.parenttrust.org](http://www.parenttrust.org)
- Parent to Parent  
[www.p2pusa.org](http://www.p2pusa.org)

## Developmental Disabilities Resources

- Developmental Disabilities Administration  
[www.dshs.wa.gov/dda](http://www.dshs.wa.gov/dda)
- To apply for DD Services please request an application from your local office. Office locator:  
[www.dshs.wa.gov/DDA/dda/find-an-office](http://www.dshs.wa.gov/DDA/dda/find-an-office)

## Juvenile Justice Services

- Juvenile Rehabilitation  
[www.dshs.wa.gov/ra/juvenile-rehabilitation](http://www.dshs.wa.gov/ra/juvenile-rehabilitation)
- Office of Juvenile Justice and Delinquency Prevention  
[www.ojjdp.gov](http://www.ojjdp.gov)

## Military Family Resources

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

## Crisis Services

- START text – 741741  
[www.crisistextline.org](http://www.crisistextline.org)
- Crisis/Acute Mental Health Care  
[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/acute-mental-health-care-inpatient](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/acute-mental-health-care-inpatient)
- County Crisis Lines  
[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines)  
\*Please note — anyone can call their local county crisis line regardless of their insurance coverage.
- US National Suicide Hotlines  
1-800-SUICIDE — 1-800-273-TALK  
[www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)
- Teenlink — A confidential teen-answered help line and computer chat service  
1-866-833-6546  
<http://866teenlink.org>

## Substance Abuse Services

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



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# Medicaid Guide to Services

## Public Mental Health Overview

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

- Contracts with the Behavioral Health Organizations (BHOs)
- Contracts with Healthy Options Managed Care Organizations (MCO)
- Individual Care Provider Agreements with professionals who will accept payment on a fee-for-service basis for people who are eligible for Medicaid, but who are not enrolled with a Healthy Options MCO or eligible for care through the Behavioral Health Organizations.

## Behavioral Health Organizations (BHO)

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

## Summary of the BHO Access to Care Standards

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

- The individual is determined to have a mental illness. The diagnosis must be included as a covered diagnosis in the Access to Care Standards. Most major disorders are covered. Of note, Autism Spectrum Disorders, Tic and Tourette Disorders, and Gender Identity Disorders are not covered. For information on covered diagnoses please visit: [www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/access-care-standards-acs-and-icd-information](http://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/access-care-standards-acs-and-icd-information).

- The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness.
- The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- The individual is expected to benefit from the intervention.
- The individual’s unmet need would not be more appropriately met by any other formal or informal system or support.
- Children under the age of six may not readily fit diagnostic criteria. For them eligibility is determined on the basis of functional impairment related to the symptoms of an emotional disorder.

## Functional Criteria: Children’s Global Assessment Scale (C-GAS)

There must be demonstrated functional impairment including a C-GAS score of less than 60, and requiring assistance to meet the need in at least one life domain for Brief Services (up to 6 months, or low intensity for 12 months). For Community Support services (up to 12 months) there must be a C-GAS score of less than 50 and requiring assistance to meet the need in at least one life domain. C-GAS is generally not considered valid for children under the age of six; therefore these children are exempt from such scoring. A “DC:0-3” rating score may be substituted for that evaluation. Functional impairment for very young children is further described in the published Access to Care Standards.



# Medicaid Guide to Services, cont.

## Life domains for the Access to Care Standards include:

- Health & self-care, including the ability to access medical, dental and mental health care to include access to psychiatric medications
- Cultural factors
- Home & family life safety & stability
- Work, school, daycare, pre-school or other daily activities
- Ability to use community resources to fulfill needs

## Requesting Services from the BHO System

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

Crisis mental health services are provided upon request, 24-hours a day, 7 days a week and are available to anyone who needs them regardless of ability to pay. All BHOs publish a toll free crisis number in local phone books and can be found online at: [www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines)

## To refer someone for crisis intervention services, you or the family should call the appropriate crisis line listed on the following pages.

BHOs ensure an intake evaluation is made available within 10 business days of the request for routine mental health services (unless an intake evaluation has already been provided in the last 12 months) that establishes Medical necessity based upon the Access to Care Standards. This is true no matter how the request for services is made.

Requests for BHO services may be made to a BHO or to a BHO contracted provider via:

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

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

# Behavioral Health Organizations

| BHO Name  | Counties Served   | Address & Phone Number  | Ombudsman Services                       | Crisis Lines  |
|---|---|---|--|---|
| Greater Columbia BHO<br><a href="http://www.gcbh.org">www.gcbh.org</a>  | Asotin<br>Benton<br>Columbia<br>Franklin<br>Garfield<br>Kittitas<br>Klickitat<br>Walla Walla<br>Whitman<br>Yakima | 101 N Edison St<br>Kennewick, WA 99336<br>509-735-8681<br>800-795-9296  | 509-783-7333<br>800-257-0660             | Asotin: 888-475-5665<br>Benton: 800-783-0544<br>Columbia: 866-382-1164<br>Franklin: 800-783-0544<br>Garfield: 888-475-5665<br>Kittitas: 800-572-8122<br>509-925-4168<br>Klickitat: 800-572-8122<br>509-773-5801<br>Walla Walla: 509-524-2999<br>Whitman: 866-871-6385<br>Yakima: 800-572-8122<br>509-575-4200 |
| Great Rivers BHO<br><a href="http://www.grbho.org">www.grbho.org</a>  | Cowlitz<br>Grays Harbor<br>Lewis<br>Pacific<br>Wahkiakum  | 57 W Main St<br>Suite 260<br>Chehalis, WA 98532<br>800-392-6298   | 855-851-1038                             | Cowlitz: 360-425-6064<br>Grays Harbor: 800-685-6556<br>Lewis: 800-559-6696<br>Pacific: 800-884-2298<br>Wahkiakum: 800-635-5989  |
| King County BHO<br><a href="http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse">www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse</a> | King  | 401 Fifth Ave<br>Suite 500<br>Seattle, WA 98104<br>800-790-8049   | 206-477-0630<br>800-790-8049 #3          | 866-427-4747<br>Children's Crisis Outreach Response System (CCORS) – King County's enhanced child crisis service is available to any child with any type of insurance while they are within the King County border. CCORS is available by calling the Crisis Clinic: 206-461-3222                             |
| North Sound BHO<br><a href="http://northsoundbho.org">http://northsoundbho.org</a>  | Island<br>San Juan<br>Skagit<br>Snohomish<br>Whatcom  | 301 Valley Mall Way<br>Suite 110<br>Mount Vernon, WA 98273<br>360-416-7013<br>800-684-3555<br>Access to Care line: 888-693-7200 | 888-336-6164<br>360-416-7004<br>#1 or #2 | 800-584-3578  |
| OptumHealth – Pierce County BHO<br><a href="http://www.optumpiercebho.com">www.optumpiercebho.com</a>   | Pierce  | 3315 S 23 <sup>rd</sup> St, Suite 310<br>Tacoma, WA 98405<br>253-292-4200<br>866-673-6256                                       | 253-302-5311<br>800-531-0508             | 800-576-7764  |



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# Behavioral Health Organizations

| BHO Name  | Counties Served   | Address & Phone Number   | Ombudsman Services  | Crisis Lines   |
|---|---|--|---|--|
| Salish BHO<br><a href="http://www.salishbho.org">www.salishbho.org</a>  | Clallam<br>Jefferson<br>Kitsap  | 614 Division St, MS-23<br>Port Orchard, WA 98366<br>360-337-7050<br>800-525-5637               | 360-692-1582<br>888-377-8174  | Clallam:<br>East County: 360-452-4500<br>800-843-4793<br>West County: 800-843-4793<br>Jefferson:<br>East County: 360-385-0321<br>877-410-4803<br>West County: 800-843-4793<br>Kitsap: 360-479-3033<br>800-843-4793 |
| Spokane County Regional BHO<br><a href="http://www.spokanecounty.org/mentalhealth">www.spokanecounty.org/mentalhealth</a> | Adams<br>Ferry<br>Lincoln<br>Okanogan<br>Pend Oreille<br>Spokane<br>Stevens | 312 W 8 <sup>th</sup> Ave<br>Fourth Floor<br>Spokane, WA 99204<br>509-477-5722<br>800-273-5864 | Spokane County:<br>509-477-4666<br><br>All except<br>Spokane County:<br>800-346-4529<br>509-766-2568 #314 | All Counties:<br>509-838-4428  |
| Thurston-Mason BHO<br><a href="http://tmbho.org">http://tmbho.org</a>   | Mason<br>Thurston   | 412 Lilly Road NE<br>Olympia, WA 98506<br>360-867-2602<br>800-658-4105                         | 360-867-2556<br>800-658-4105  | Mason: 800-270-0041<br>360-754-1338<br>Thurston: 800-270-0041<br>360-754-1338  |

Future updates to these BHO listings can be found at:

[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/child-and-youth-behavioral-health](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/child-and-youth-behavioral-health)

| Integrated Physical and Behavioral Health Care   | Counties Served            | Access   | Ombudsman Services | Crisis Lines |
|--|----------------------------|--|--------------------|--------------|
| Chelan, Douglas, and Grant Counties<br><a href="http://wa.beacon-healthoptions.com/about-us/north-central-washington-services">http://wa.beacon-healthoptions.com/about-us/north-central-washington-services</a> | Chelan<br>Douglas<br>Grant | Contact your Apple Health plan directly to request treatment. For more information call Apple Health Customer Service at 1-800-562-3022. | 844-636-2038       | 800-852-2923 |
| Clark and Skamania Counties<br><a href="http://wa.beacon-healthoptions.com/about-us/services">http://wa.beacon-healthoptions.com/about-us/services</a>   | Clark<br>Skamania          | Contact your Apple Health plan directly to request treatment. For more information call Apple Health Customer Service at 1-800-562-3022. | 866-666-5070       | 800-626-8137 |

# Healthy Options

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

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

For an updated list of currently contracted Healthy Options providers visit HCA online at: [www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/apple-health-managed-care#contact-your-apple-health-plan](http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/apple-health-managed-care#contact-your-apple-health-plan)

**Not all Healthy Options plans serve all counties.**

To obtain more information about Healthy Options and all other managed care programs, visit HCA online at: [www.hca.wa.gov/assets/free-or-low-cost/service\\_area\\_map.pdf](http://www.hca.wa.gov/assets/free-or-low-cost/service_area_map.pdf)

**Fee-For-Service**

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

# Additional Tools from HCA

## **Patient Review and Coordination (PRC) Program**

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

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

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

## **CHET (Child Health & Education Tracking) screening tools for foster care**

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

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

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



# Adolescent Substance Abuse Treatment and Prevention



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

To learn more about BHO substance abuse services, visit:

[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/substance-use-treatment](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/substance-use-treatment)

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

## **Washington Recovery Help Line – 24 Hour Help for Substance Abuse: 1-866-789-1511**

[www.warecoveryhelpline.org](http://www.warecoveryhelpline.org)

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## **Directory of Certified Behavioral Health Services in Washington State**

[www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf](http://www.hca.wa.gov/assets/free-or-low-cost/directory-certified-behavioral-health-agencies.pdf)

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## **Reduce Under Age Drinking**

Find resources parents can use to prevent underage drinking and marijuana use at Start Talking Now, the Washington Healthy Youth (WHY) website: [www.starttalkingnow.org](http://www.starttalkingnow.org)

# Washington Second Opinion Review

## Fact Sheet: ADHD Medications

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

### ADHD Medication Review Guidelines

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

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

|                    | Methylphenidate | Dexmethylphenidate | Amphetamines    | Atomoxetine     | Clonidine XR or Guanfacine XR |
|--------------------|-----------------|--------------------|-----------------|-----------------|-------------------------------|
| Methylphenidate    |                 | Review required    | Review required | Review required |                               |
| Dexmethylphenidate | Review required |                    | Review required | Review required |                               |
| Amphetamines       | Review required | Review required    |                 | Review required |                               |
| Atomoxetine        | Review required | Review required    | Review required |                 | Review required               |

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

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

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

# Washington Second Opinion Review

## Fact Sheet: Antipsychotics

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

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

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

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

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

### Antipsychotic Medications for Foster Care and Adoption Support Clients

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

## Fact Sheet: Psychiatric Polypharmacy

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

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

# Washington Second Opinion Review

## Fact Sheet: Antidepressants

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

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

## Generics First for New Starts of Psychiatric Medications

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

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

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

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

**Who:** Seattle Children's Medication Review Program, PO Box 5371, M/S S-232C, Seattle, WA 98145

**Phone:** 206-987-2702, Fax: 206-985-3109

# Mental Health Assessment Principles

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

Robert Hilt, MD



# What Can You Do For Multiple Problems?

- **Establish what seems to be the leading problem and focus your attention on that.** For instance if a child is having screaming tantrums, hitting other children, is sleeping poorly and sometimes appears anxious, one may decide the leading problem is unsafe externalizing behavior. In that case, review the steps of our disruptive behavior and aggression decision tree. The child's sleep problems and intermittent anxiety can be explored further at a future appointment.
- **Get collateral information.** Particularly if the caregiver does not know the child's full history, other information sources including school, former physicians or therapists, other relatives, and foster care case managers will likely be able to give you information that clarifies what should be done. Respect the fact that it takes time to gather this additional information, which can be done by phone calls, record requests, or by sending out questionnaires or rating scales. Remember our first assessment principle; you don't have to figure this all out in one visit.
- **Use checklists for preliminary behavior/mental health screening.** These will help you narrow down what area to investigate and can quantify the likelihood of finding different types of diagnoses.  
Options include:
  - PSC-17 (free, included in this guide)
  - SDQ (Strength and Difficulties Questionnaire, 25 questions, 5 subscales, good psychometrics, multiple languages available, free for individual providers to download and use, free online scoring.) You must go to the developer's website to obtain: [www.sdqinfo.org](http://www.sdqinfo.org)
  - CBCL (Child Behavior Checklist, school age version has 113 core questions plus 2 other pages to describe child functioning, widely used, very good psychometrics, translated versions available.) Requires scoring software and requires purchase from the developer: [www.aseba.org](http://www.aseba.org)
  - BASC-2 (Behavior Assessment Scale for Children, second edition, all multiple choice, 134-160 items for parent report on school age child, commonly used, very good psychometrics, scoring software recommended). Requires purchase from the developer: [www.pearsonclinical.com/education/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html](http://www.pearsonclinical.com/education/products/100000658/behavior-assessment-system-for-children-second-edition-basc-2.html)
- **Discuss the scenario with a specialist.** PAL psychiatrists would like to talk about any tricky situations with you, and are available Monday through Friday, 8am to 5pm.
- **If you suspect a specific problem, a disorder specific rating scale can help you learn how likely or severe that diagnosis might be.** Disorder specific scales like the Vanderbilt scale for ADHD will not make the diagnosis for you — a diagnosis must be based on your overall clinical impression. When children have severe mental health symptoms, referral to a mental health clinic is appropriate. Very high rating scale scores might similarly indicate that referral to specialty care is appropriate.
- **A good therapist can help you refine your diagnosis over time.** If you identify the child has a general problem for which a therapist referral is appropriate (such as having some sort of mood disorder), then the therapist can provide further specialized assessment (such as diagnosing Major Depression).
- **If you choose to prescribe a medication when the diagnosis is still uncertain, be very clear what the target symptom is you are treating, and monitor that symptom closely.** If that target symptom does not improve, then that medicine needs to be stopped. It is **very** important to not simply stack medicines one upon another without demonstrating a clear benefit to the child.

Robert Hilt, MD

# Evidence Based Mental Health Care

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

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

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

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

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



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

## **Peer reviewed care guidelines from a professional association**

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

American Academy of Child and Adolescent Psychiatry, Practice Parameters  
[www.aacap.org/AACAP/Resources\\_for\\_Primary\\_Care/Practice\\_Parameters\\_and\\_Resource\\_Centers/Home.aspx](http://www.aacap.org/AACAP/Resources_for_Primary_Care/Practice_Parameters_and_Resource_Centers/Home.aspx)

## **Peer reviewed care guidelines from a state sponsored workgroup**

Partnership Access Line (PAL) in Washington  
[www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

Medication Project from Texas  
[www.dfps.state.tx.us/Child\\_Protection/Medical\\_Services/documents/reports/2016-03\\_Psychotropic\\_Medication\\_Utilization\\_Parameters\\_for\\_Foster\\_Children.pdf](http://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf)

## **Federal agency publications**

National Institute of Mental Health  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

Substance Abuse & Mental Health Service Administration  
[www.samhsa.gov](http://www.samhsa.gov)

## **Collaborative guidance from respected organizations**

American Academy of Adolescent and Child Psychiatry (AACAP) and American Psychological Association (APA)  
[www.parentsmedguide.org](http://www.parentsmedguide.org)

National Alliance for the Mentally Ill  
[www.nami.org](http://www.nami.org)

PracticeWise from the AAP  
[www.aap.org/en-us/Documents/CRPsychosocialInterventions.pdf](http://www.aap.org/en-us/Documents/CRPsychosocialInterventions.pdf)

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

Pub Med provides free Medline searches  
[www.ncbi.nlm.nih.gov/pubmed](http://www.ncbi.nlm.nih.gov/pubmed)

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

Robert Hilt, MD



# Developmental Screenings

# Developmental Screening Tools and Rating Scales

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

## Validated scales with a per-use fee:

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

## Validated scales that are free to use:

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

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

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

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



## Early Childhood Screening Assessment (ECSA)

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

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

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

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

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

# Pediatric Symptom Checklist

## PSC-17 Description

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

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

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

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

### **PSC-17 Scoring:**

PSC-17 Internalizing score positive if  $\geq 5$

PSC-17 Externalizing score positive if  $\geq 7$

PSC-17 Attention score positive if  $\geq 7$

PSC-17 Total score positive if  $\geq 15$

"Attention" diagnoses can include: ADHD, ADD

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

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

# Pediatric Symptom Checklist-17 (PSC-17)

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

Name of Child:.....

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

## Scoring:

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

## Suggested Screen Cutoff:

PSC-17 - I  $\geq$  5

PSC-17 - A  $\geq$  7

PSC-17 - E  $\geq$  7

Total Score  $\geq$  15

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

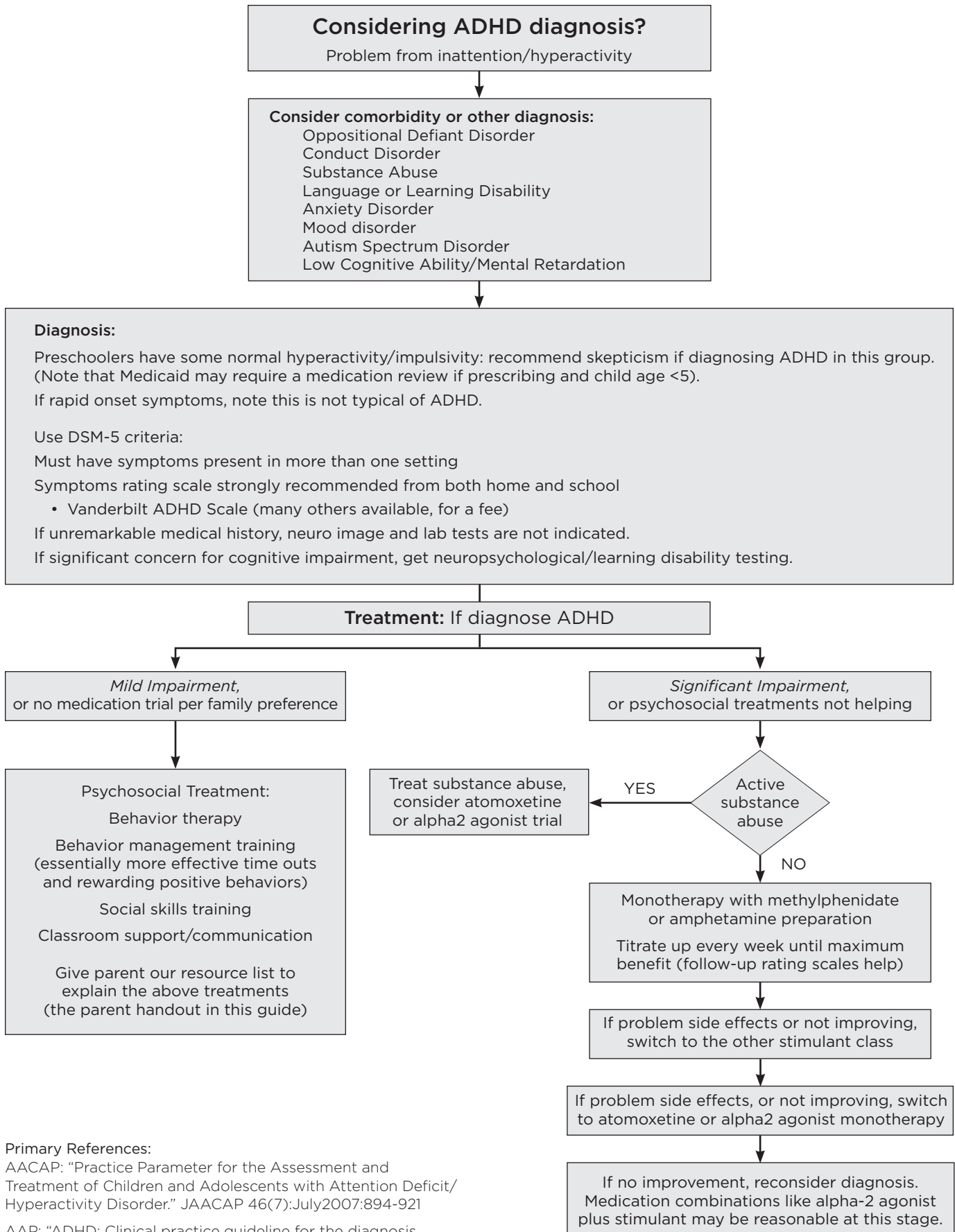
PSC-17 may be freely reproduced.

Created by W Gardner and K Kelleher (1999), and based on PSC by M Jellinek et al. (1988)

Formatted by R Hilt, inspired by Columbus Children's Research Institute formatting of PSC-17



# ADHD



# Vanderbilt ADHD Teacher Rating Scale

Child's Name .....

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

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

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

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



# Vanderbilt ADHD Teacher Rating Scale

Child's Name .....

Today's Date.....

| Symptoms  | Never | Occasionally | Often | Very Often |
|---|-------|--------------|-------|------------|
| 29. Is fearful, anxious, or worried   | 0     | 1            | 2     | 3          |
| 30. Is self-conscious or easily embarrassed                                   | 0     | 1            | 2     | 3          |
| 31. Is afraid to try new things for fear of making mistakes                   | 0     | 1            | 2     | 3          |
| 32. Feels worthless or inferior   | 0     | 1            | 2     | 3          |
| 33. Blames self for problems, feels guilty                                    | 0     | 1            | 2     | 3          |
| 34. Feels lonely, unwanted, or unloved; complains that "no one loves him/her" | 0     | 1            | 2     | 3          |
| 35. Is sad, unhappy, or depressed   | 0     | 1            | 2     | 3          |

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

**Comments:**

## For Office Use Only

### SYMPTOMS:

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

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

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

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

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

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

Child's Name .....

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

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

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

| Symptoms   | Never | Occasionally | Often | Very Often |
|--|-------|--------------|-------|------------|
| 1. Does not pay attention to details or makes careless mistakes, such as in homework   | 0     | 1            | 2     | 3          |
| 2. Has difficulty sustaining attention to tasks or activities  | 0     | 1            | 2     | 3          |
| 3. Does not seem to listen when spoken to directly   | 0     | 1            | 2     | 3          |
| 4. Does not follow through on instruction and fails to finish schoolwork (not due to oppositional behavior or failure to understand) | 0     | 1            | 2     | 3          |
| 5. Has difficulty organizing tasks and activities  | 0     | 1            | 2     | 3          |
| 6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort   | 0     | 1            | 2     | 3          |
| 7. Loses things necessary for tasks or activities (school assignments, pencils, or books)  | 0     | 1            | 2     | 3          |
| 8. Is easily distracted by extraneous stimuli  | 0     | 1            | 2     | 3          |
| 9. Is forgetful in daily activities  | 0     | 1            | 2     | 3          |
| 10. Fidgets with hands or feet or squirms in seat  | 0     | 1            | 2     | 3          |
| 11. Leaves seat when remaining in seated is expected   | 0     | 1            | 2     | 3          |
| 12. Runs about or climbs excessively when remaining seated is expected   | 0     | 1            | 2     | 3          |
| 13. Has difficulty playing or engaging in leisure activities quietly   | 0     | 1            | 2     | 3          |
| 14. Is "on the go" or often acts as if "driven by a motor"   | 0     | 1            | 2     | 3          |
| 15. Talks too much   | 0     | 1            | 2     | 3          |
| 16. Blurts out answers before questions have been completed  | 0     | 1            | 2     | 3          |
| 17. Has difficulty waiting his or her turn   | 0     | 1            | 2     | 3          |
| 18. Interrupts or intrudes in on others (butts into conversations or games)  | 0     | 1            | 2     | 3          |
| 19. Argues with adults   | 0     | 1            | 2     | 3          |
| 20. Loses temper   | 0     | 1            | 2     | 3          |
| 21. Actively defies or refuses to comply with adults' requests or rules  | 0     | 1            | 2     | 3          |
| 22. Deliberately annoys people   | 0     | 1            | 2     | 3          |
| 23. Blames others for his or her mistakes or misbehavior   | 0     | 1            | 2     | 3          |
| 24. Is touchy or easily annoyed by others  | 0     | 1            | 2     | 3          |
| 25. Is angry or resentful  | 0     | 1            | 2     | 3          |
| 26. Is spiteful and vindictive   | 0     | 1            | 2     | 3          |
| 27. Bullies, threatens, or intimidates others  | 0     | 1            | 2     | 3          |
| 28. Initiates physical fights  | 0     | 1            | 2     | 3          |
| 29. Lies to obtain goods for favors or to avoid obligations ("cons" others)  | 0     | 1            | 2     | 3          |
| 30. Is truant from school (skips school) without permission  | 0     | 1            | 2     | 3          |
| 31. Is physically cruel to people  | 0     | 1            | 2     | 3          |

# Vanderbilt ADHD Parent Rating Scale

Child's Name .....

Today's Date.....

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

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

## For Office Use Only

## Comments:

### SYMPTOMS:

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

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

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

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

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

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

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

# Scoring the Vanderbilt ADHD Scales

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

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

## Parent Version

### Predominantly Inattentive Subtype

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

### Predominantly Hyperactive/Impulsive Subtype

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

### Combined Subtype

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

### Oppositional-defiant disorder

Requires 4 or more counted behaviors on items 19 through 26.

### Conduct disorder

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

### Anxiety or depression

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

## Teacher Version

### Predominantly Inattentive Subtype

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

### Predominantly Hyperactive/Impulsive Subtype

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

### Combined subtype

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

### Oppositional defiant and conduct disorders

Requires 3 or more counted behaviors from questions 19 through 28.

### Anxiety or depression

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

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

# ADHD Stimulant Medications

## Short Acting Stimulants

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

## Extended Release Stimulants

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

# ADHD Non-Stimulant Medications

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

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

## Relative Effect Size of ADHD Medication Choices

Effect size of all stimulants ~1.0

Effect size of atomoxetine ~0.7

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

## Stimulant Relative Potencies:

Methylphenidate 10mg ≈ dexamethylphenidate 5mg

Methylphenidate 10mg ≈ dextroamphetamine 5mg

## \*ADHD Medication Monitoring:

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

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

# ADHD Resources

## Information for Families

### Books families may find helpful:

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

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

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

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

### Books children may find helpful:

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

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

### Websites families may find helpful:

Parents Med Guide

[www.parentsmedguide.org](http://www.parentsmedguide.org) (quality information about medications for ADHD)

Children and Adults with ADHD

[www.chadd.org](http://www.chadd.org) (support groups, information resource)

Teach ADHD

<http://teachadhd.com> (teaching advice for ADHD kids)

### “Behavior Management Training” and “Behavior Therapy”:

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

The principle elements of these treatments are:

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



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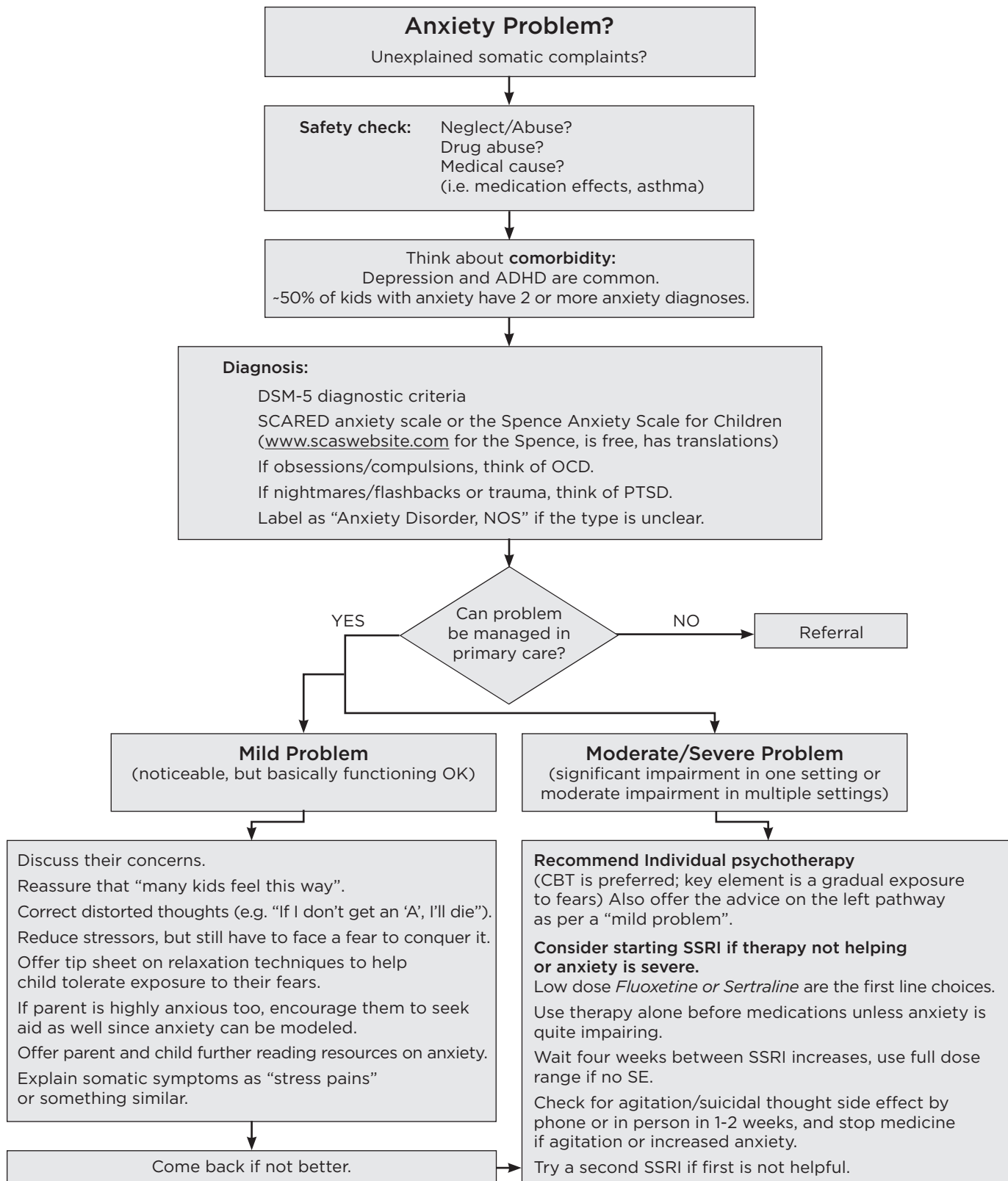
Child Psychiatric Consultation  
for Primary Care Providers

This resource page is  
now available in Spanish at  
[www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)





# Anxiety



#### Primary References:

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

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

# Relaxation Therapy Tip Sheet

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

## Breathing Control

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

## Progressive Muscle Relaxation

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

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

Robert Hilt, MD

# PTSD: Treating A Unique Anxiety Disorder

## Identifying Post-Traumatic Stress Disorder (PTSD)

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

## Treatment

**Psychotherapy or counseling** is the first-line treatment

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

## Medications

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

Rebecca Barclay, MD and Robert Hilt, MD

## Reference:

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

## Rating Scale:

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

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

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

## Directions:

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

|  | 0<br>Not True<br>or Hardly<br>Ever True | 1<br>Somewhat<br>True or<br>Sometimes True | 2<br>Very True<br>or Often<br>True |
|--|---|--|------------------------------------|
| I have scary dreams about a very bad thing that once happened to me.                                       | <input type="checkbox"/>                | <input type="checkbox"/>                   | <input type="checkbox"/>           |
| I try not to think about a very bad thing that once happened to me.  | <input type="checkbox"/>                | <input type="checkbox"/>                   | <input type="checkbox"/>           |
| I get scared when I think back on a very bad thing that once happened to me.                               | <input type="checkbox"/>                | <input type="checkbox"/>                   | <input type="checkbox"/>           |
| I keep thinking about a very bad thing that once happened to me, even when I don't want to think about it. | <input type="checkbox"/>                | <input type="checkbox"/>                   | <input type="checkbox"/>           |

Score .....

# Screen for Child Anxiety Related Disorders (SCARED)

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

## Directions:

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

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

# Screen for Child Anxiety Related Disorders (SCARED)

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

\* 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.



# Screen for Child Anxiety Related Disorders (SCARED)

Name .....

Today's Date .....

## Directions:

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

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

# Screen for Child Anxiety Related Disorders (SCARED)

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

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

# SCARED Rating Scale Scoring Aid

| Question | Panic<br>Somatic | Generalized<br>Anxiety | Separation    | Social        | School<br>Attendance |
|----------|------------------|------------------------|---------------|---------------|----------------------|
| 1        |                  |                        |               |               |                      |
| 2        |                  |                        |               |               |                      |
| 3        |                  |                        |               |               |                      |
| 4        |                  |                        |               |               |                      |
| 5        |                  |                        |               |               |                      |
| 6        |                  |                        |               |               |                      |
| 7        |                  |                        |               |               |                      |
| 8        |                  |                        |               |               |                      |
| 9        |                  |                        |               |               |                      |
| 10       |                  |                        |               |               |                      |
| 11       |                  |                        |               |               |                      |
| 12       |                  |                        |               |               |                      |
| 13       |                  |                        |               |               |                      |
| 14       |                  |                        |               |               |                      |
| 15       |                  |                        |               |               |                      |
| 16       |                  |                        |               |               |                      |
| 17       |                  |                        |               |               |                      |
| 18       |                  |                        |               |               |                      |
| 19       |                  |                        |               |               |                      |
| 20       |                  |                        |               |               |                      |
| 21       |                  |                        |               |               |                      |
| 22       |                  |                        |               |               |                      |
| 23       |                  |                        |               |               |                      |
| 24       |                  |                        |               |               |                      |
| 25       |                  |                        |               |               |                      |
| 26       |                  |                        |               |               |                      |
| 27       |                  |                        |               |               |                      |
| 28       |                  |                        |               |               |                      |
| 29       |                  |                        |               |               |                      |
| 30       |                  |                        |               |               |                      |
| 31       |                  |                        |               |               |                      |
| 32       |                  |                        |               |               |                      |
| 33       |                  |                        |               |               |                      |
| 34       |                  |                        |               |               |                      |
| 35       |                  |                        |               |               |                      |
| 36       |                  |                        |               |               |                      |
| 37       |                  |                        |               |               |                      |
| 38       |                  |                        |               |               |                      |
| 39       |                  |                        |               |               |                      |
| 40       |                  |                        |               |               |                      |
| 41       |                  |                        |               |               |                      |
| Total    | Cutoff<br>= 7    | Cutoff<br>= 9          | Cutoff<br>= 5 | Cutoff<br>= 8 | Cutoff<br>= 3        |

0 = not true or hardly true

1 = somewhat true or sometimes true

2 = very true or often true

## SCORING

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

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

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

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

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

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

Total anxiety  $\geq 25$

# Anxiety Medications

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

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

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

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

Successful medication trials should continue for 6-12 months.

# Anxiety Resources

## Information for Families

### Books parents may find helpful:

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

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

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

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

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

### Books children may find helpful:

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

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

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

### Recording children may find helpful:

I Can Relax (2012), by Donna Pincus

### Websites parents may find helpful:

Anxiety Disorders Association of America

[www.adaa.org](http://www.adaa.org)

Children's Center for OCD and Anxiety

[www.worrywisekids.org](http://www.worrywisekids.org)

Child Anxiety Network

[www.childanxiety.net/Anxiety\\_Disorders.htm](http://www.childanxiety.net/Anxiety_Disorders.htm)

American Academy of Child and Adolescent Psychiatry

[www.aacap.org/aacap/families\\_and\\_youth/resource\\_centers/Anxiety\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/families_and_youth/resource_centers/Anxiety_Disorder_Resource_Center/Home.aspx)

National Institute of Mental Health

[www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml](http://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](http://www.aftertheinjury.org)



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## PARTNERSHIP ACCESS LINE

Child Psychiatric Consultation  
for Primary Care Providers

This resource page is  
now available in Spanish at  
[www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)



# Autism Spectrum Disorders

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

## Considering an Autism Spectrum Disorder?

### Any Early Red Flags?

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

### Consider a comorbidity or other diagnoses:

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

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

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

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

M-CHAT (Modified Checklist of Autism in Toddlers) for age 16-30 months.

Found at <http://mchatscreen.com>

CAST (Childhood Autism Spectrum Test) for age 4-11 years, and AQ (Autism Quotient) for age 12-15 years.

Found at [www.autismresearchcentre.com/arc\\_tests](http://www.autismresearchcentre.com/arc_tests)

### Treatment:

#### Refer to further evaluation, Early Intervention and education:

If birth to 3 years old, contact the Family Health Hotline (800-322-2588) or the Washington State Early Learning Program at (<https://del.wa.gov>). They assist with evaluation and treatment of any developmental concerns.

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

#### Individually evaluate/address any deficits in the following areas (might consider a formal autism evaluation):

Speech and language deficits: consider referral to speech/language therapist

Social skills deficits: consider social skills groups or a speech/language therapist

Sensory sensitivities/motor abnormalities that impact function: consider referral to occupational or physical therapy

Maladaptive behavior that affects function: consider referral to a behavioral therapist, psychologist, or psychiatrist

#### Medical Evaluation:

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

### Primary References:

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

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



# Treatments for Autism and Difficulties Associated with Autism

## **Treatment for Autism:**

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

## **Speech and Language Therapy:**

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

## **Social Skills Training:**

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

## **Occupational and Physical Therapy:**

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

## **Medical Assessment:**

- Consider medical, neurological, psychiatric, medication-induced, and trauma-related causes of maladaptive behaviors, especially if there are sudden changes in function. Rule out pain (head or ear aches, constipation) as a trigger for any new behaviors, particularly since

children with autism are not typically very good at communicating distress and may exhibit maladaptive behavior when medically distressed.

## **Behavior Therapy:**

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

## **Psychotropic Medications:**

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

## **Co-morbid Psychiatric Disorders:**

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

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

# Treating Maladaptive Behavior for the Developmentally Disabled Using Functional Analysis

## ***Identify the behavior***

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

## ***Analyze and make hypotheses about the function of the behavior***

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

## ***Modify the environment by changing provoking and reinforcing factors***

- Enhance communication—consider using an alternative communication system, such as a picture-exchange communication system (PECS) for non-verbal children.
- Use simple, concrete sentences and questions with child. Remain calm.
- Increase structure — provide schedule of day's events, use routines, anticipate transitions. Consider social stories to practice routines, especially to prepare for new situations. Teach the child how to ask for help and how to tell adults when they need a break.

- Modify demands — match the task to their IQ, developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

## ***Consult with a behavioral specialist to facilitate process and support family***

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

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

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

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

# Applied Behavioral Analysis (ABA) Tip Sheet

## What is ABA?

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

## What behaviors or skill deficits can be addressed with ABA?

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

## How do I help my patient and families access ABA?

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

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

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

- a) a referral from a health care professional or caregiver for testing and comprehensive evaluation at a Center of Excellence ([www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/autism-and-applied-behavioral-analysis](http://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/autism-and-applied-behavioral-analysis))
- b) the writing of an order for ABA services (usually in the form of a letter or embedded in encounter documentation)
- c) assessment by a qualified board certified behavior analyst (BCBA) and development of a treatment plan
- d) and then submission of plan for authorization by HCA. Re-authorization is typically required by BCBA at a 3-6 month interval.

## What if my patient is covered by private insurance?

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

David Camenisch, MD MPH

# Psychiatric Medication Considerations for Children with Autism

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

## Some medications to consider include:

**Risperidone:** FDA approved for children 5-16 years of age with irritability, aggression, self-injury, and quick mood swings associated with autism. Use if behavioral therapy is yielding inadequate results on severe symptoms. Can have many adverse effects including weight gain, dystonia, sedation, neuroleptic malignant syndrome, tardive dyskinesia and both cholesterol and glucose elevations. Suggest start at 0.25-0.5mg/day, usual effective dosage is less than 2mg/day. Requires glucose, lipid panel, and AIMS monitoring (see page 58).

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

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

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

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# Autism Resources

## Information for Families

### Books families may find helpful:

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

### Websites families may find helpful:

- Autism Speaks  
[www.autismspeaks.org](http://www.autismspeaks.org)  
(advocacy, diagnostic, treatment and support resources)
- Autism Center — University of Washington  
<http://depts.washington.edu/uwautism>  
(advocacy, diagnostic, treatment and support resources)
- ARC Washington State — Parent to Parent (peer mentorship program) [http://arcwa.org/getsupport/parent\\_to\\_parent\\_p2p\\_programs](http://arcwa.org/getsupport/parent_to_parent_p2p_programs)

## Resources for Teaching Social Skills

### All Ages:

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

### Preschool-Kindergarten:

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

### Elementary Grades (1st through 4th):

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

### Secondary Grades and Adolescents:

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

### Board Games and Online Games:

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

### Picture Exchange Communication System (PECS) resource:

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

This resource page is now available in Spanish at [www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)



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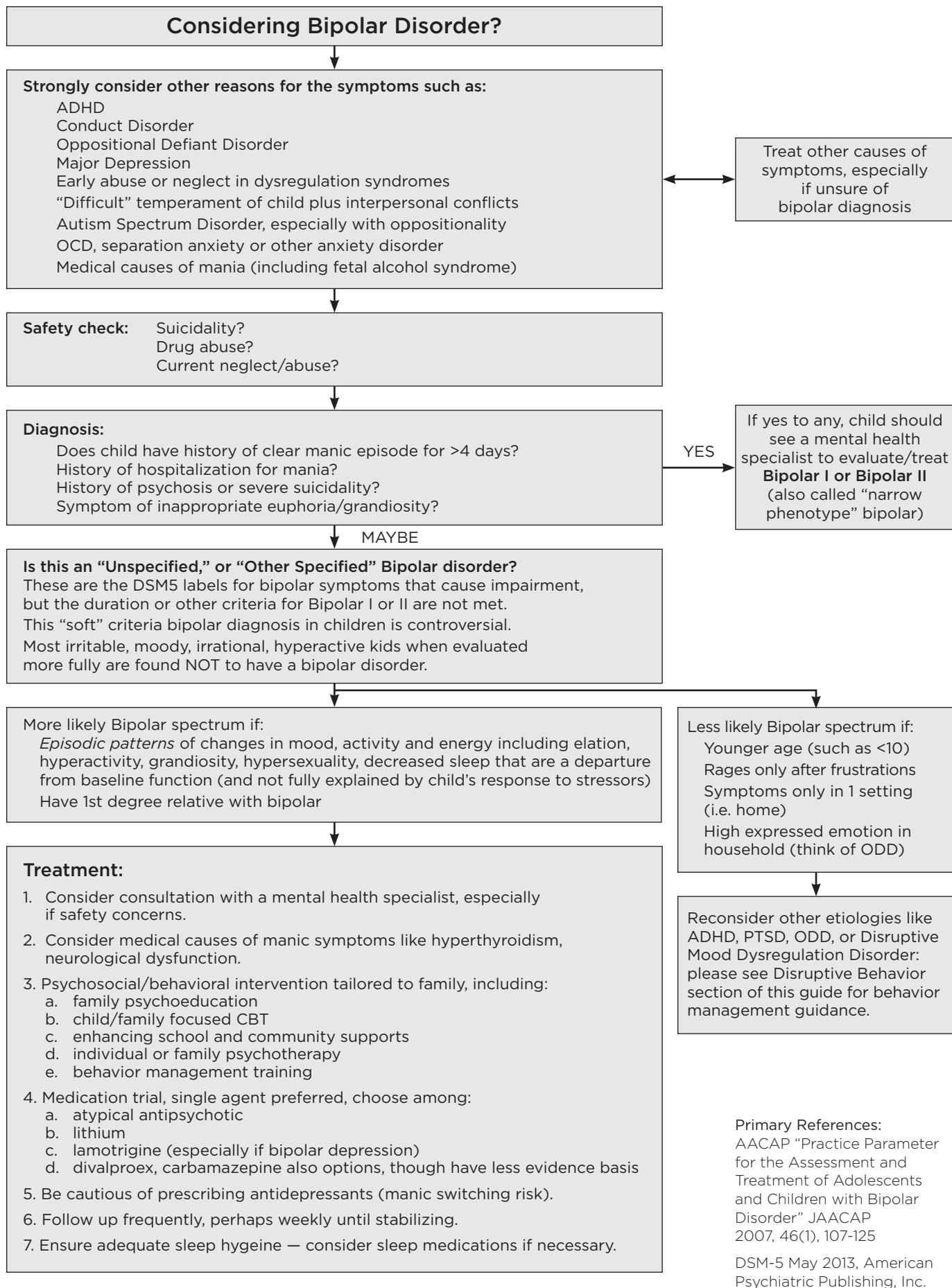
# Bipolar Disorder

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

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

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







# Bipolar Disorder Medications

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

## Atypical Antipsychotics

| Drug Name               | Dosage Form                       | Usual Starting Dose | Sedation | Weight Gain | EPS (stiff muscles) | Bipolar (+) child RCT evidence? | FDA bipolar approved? | Editorial Comments   |
|-------------------------|-----------------------------------|---------------------|----------|-------------|---------------------|---------------------------------|-----------------------|--|
| Risperidone (Risperdal) | 0.25, 0.5, 1, 2, 3, 4mg<br>1mg/ml | 0.25mg QHS          | +        | +           | +                   | Yes                             | Yes (Age >10)         | Generic forms. More dystonia risk than rest  |
| Aripiprazole (Abilify)  | 2, 5, 10, 15, 25, 30mg<br>1mg/ml  | 2mg QD              | +        | +           | +/-                 | Yes                             | Yes (Age >10)         | Generic forms. Long 1/2 life, can take weeks to build effect, more weight gain than for adults |
| Quetiapine (Seroquel)   | 25, 50, 100, 200, 300, 400mg      | 25mg BID            | ++       | +           | +/-                 | Yes                             | Yes (Age >10)         | Generic forms. Pills larger, could be hard for kids to swallow.                                |
| Ziprasidone (Geodon)    | 20, 40, 60, 80mg                  | 20mg BID            | +        | +           | +/-                 | Yes                             | Yes (Age >10)         | Generic forms. Greater risk of QT lengthen, EKG check  |
| Olanzapine (Zyprexa)    | 2.5, 5, 7.5, 10, 15, 20mg         | 2.5 mg QHS          | ++       | ++          | +/-                 | Yes                             | Yes (Age >10)         | Generic forms. Greatest risk of weight gain, increased cholesterol                             |
| Asenapine (Saphris)     | Sublingual<br>2.5, 5, 10mg        | 2.5 mg SL BID       | ++       | +/-         | +/-                 | Yes                             | Yes (Age >10)         | Oral paresthesias, must dissolve in mouth  |
| Lurasidone (Latuda)     | 20, 40, 60, 80, 120mg             | 20 mg QD            | +        | +           | +/-                 | Yes                             | Yes (Age >10)         | Take with food   |

### Monitoring for all atypical antipsychotics:

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

# Bipolar Disorder Medications

## Other Medication Options

| Drug Name     | Bipolar (+) RCT evidence in kids | FDA bipolar approved children? | Monitoring   | Editorial Comments   |
|---------------|----------------------------------|--------------------------------|--|--|
| Lithium       | Yes                              | Yes (7 and older)              | Baseline EKG, BUN/creat, TSH, CBC.<br>Lithium level after 5 days.<br>Q3month Lithium level.<br>Q6mo TSH,BUN/creatinine | Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal |
| Valproate     | No                               | No                             | CBC, LFT at baseline, in 3 month, then Q6month.<br>VPA level checks needed   | Weight gain, sedation, rare severe toxicity of liver, ↓platelets ↓WBC, risk of polycystic ovarian syndrome                                     |
| Carbamazepine | No                               | No                             | CBC, LFT at baseline, then every 3-6 months.<br>CBZ level checks needed  | Aplasia and rash risk.<br>Oxcarbazepine bipolar trial with kids had negative results   |
| Lamotrigine   | No                               | No                             | CBC, LFT at baseline, in 2 -4 weeks, then Q6 month.<br>Monitor for rash  | Stevens-Johnson rash risk requires slow titration, adult studies support use for bipolar depression  |

# ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

**INSTRUCTIONS:** COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

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

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

2 = MILD 3 = MODERATE 4 = SEVERE

## EXAMINATION PROCEDURE

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

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.</li> <li>2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW?</li> <li>3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE, HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.</li> <li>4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION)</li> <li>5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.)</li> <li>6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE.</li> </ol> | <ol style="list-style-type: none"> <li>7. ASK PATIENT TO PROTRUDE TONGUE. OBSERVE ABNORMALITIES OF TONGUE MOVEMENT,) DO THIS TWICE.</li> <li>*8. ASK PATIENT TO TAP THUMB. WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)</li> <li>9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.)</li> <li>10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.)</li> <li>*11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS, AND MOUTH.)</li> <li>*12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE.</li> </ol> <p>** ACTIVATED MOVEMENTS</p> |
|---|---|

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

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

☐ EXAMINATION COMPLETED

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

REVISED 03/20/97

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

# Bipolar Disorder Resources

## Information for Families

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

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

### Books families may find helpful:

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

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

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

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

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

### Websites families may find helpful:

American Academy of Child and Adolescent Psychiatry, Practice Parameter on Bipolar Disorder.  
This contains a very detailed review of treatments.

[www.aacap.org/App\\_Themes/AACAP/docs/practice\\_parameters/JAACAP\\_Bipolar\\_2007.pdf](http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/JAACAP_Bipolar_2007.pdf)

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

[www.aacap.org/aacap/families\\_and\\_youth/resource\\_centers/bipolar\\_disorder\\_resource\\_center/home.aspx](http://www.aacap.org/aacap/families_and_youth/resource_centers/bipolar_disorder_resource_center/home.aspx)

National Institute of Mental Health, bipolar disorder section

[www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml](http://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml)

National Alliance for the Mentally Ill

[www.nami.org](http://www.nami.org)

Depression and Bipolar Support Alliance

[www.dbsalliance.org](http://www.dbsalliance.org)

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

[www.parentsmedguide.org](http://www.parentsmedguide.org)

This resource page is  
now available in Spanish at  
[www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

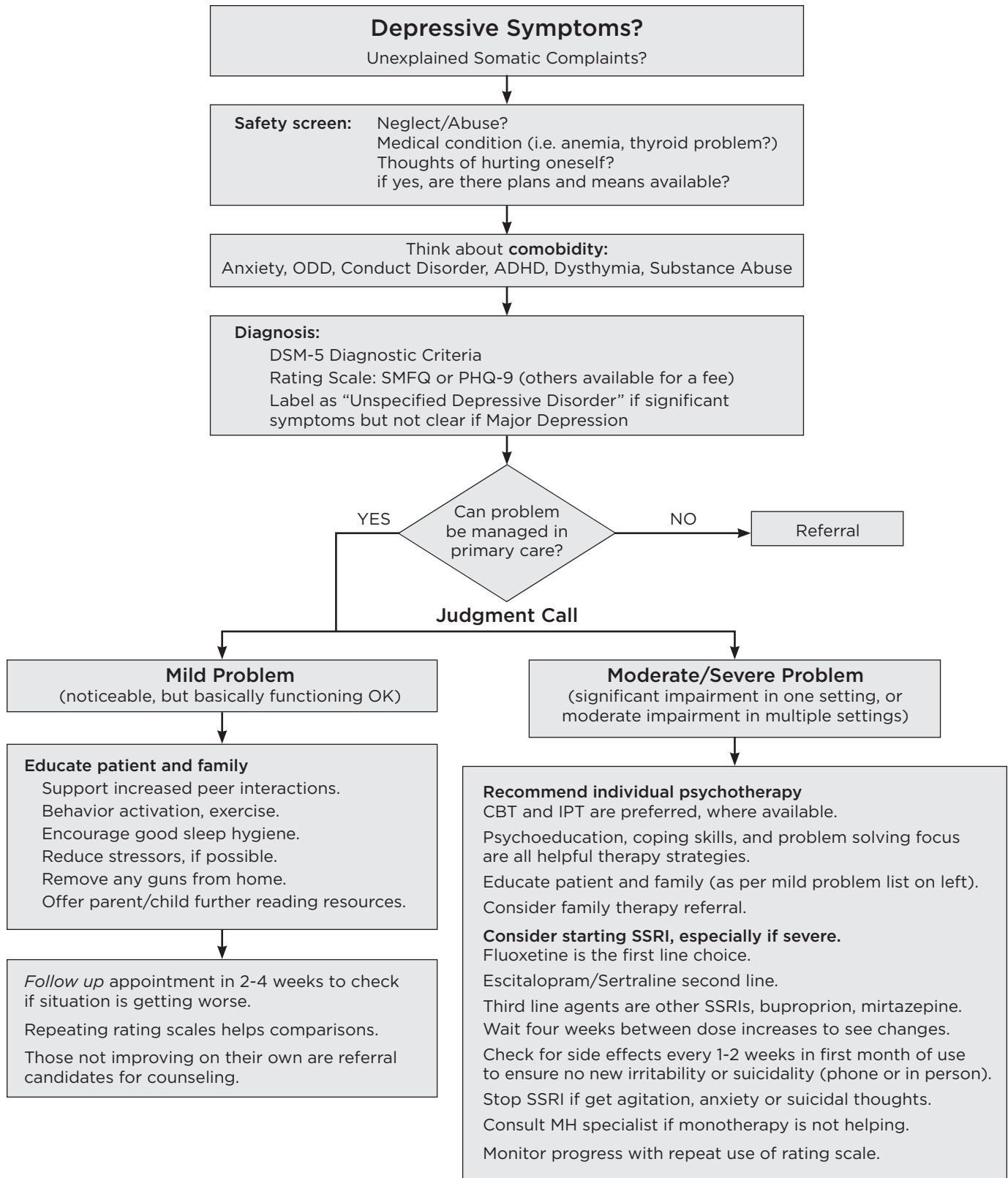


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for Primary Care Providers



# Depression



#### Primary References:

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

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

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

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

# Short Mood and Feelings Questionnaire

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

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

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

If it was only sometimes true, check SOMETIMES.

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

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

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# Short Mood and Feelings Questionnaire

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

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

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

If it was only sometimes true, check SOMETIMES.

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

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

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# Scoring the SMFQ

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

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

## Scoring:

Assign a numerical value to each answer as follows:

Not true = 0

Sometimes = 1

True = 2

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

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

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

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

# Patient Health Questionnaire (PHQ-9)

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

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

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

|  |                            |
|--|----------------------------|
| 10. If you checked off <i>any</i> problems, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people. | Not difficult at all ..... |
|  | Somewhat difficult .....   |
|  | Very difficult .....       |
|  | Extremely difficult .....  |

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# Scoring the PHQ-9

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

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

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

Any immediate plans for suicide require an emergent response.

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

A depression diagnosis requires a functional impairment to be present.

## **Add up the total number from items 1-9**

Estimated depression severity:

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

\* As recommended by Macarthur Foundation and Pfizer, Inc.

# Depression Medications

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

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

Successful medication trials should continue for 6 to 12 months

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

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

# Crisis Prevention Plan Aid

## A parent's guide to creating a crisis prevention plan

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

Steps for creating your own Crisis Prevention Plan:

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

Christina Clark, MD

# Crisis Prevention Plan

## My triggers are:

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

## My early warning signs are:

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

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

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

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

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

## If I am unable to help myself I can call:

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

- Your County Crisis Line Phone Number: .....  
(you can look it up here:  
[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines))
- Text HOME to 741741 or visit: <https://www.crisistextline.org>
- Teen Link Hotline: 1-866-833-6546 or <http://866teenlink.org>
- The National Suicide Hotline: 1-800-784-2433

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

# General Home Safety Recommendations After a Child Crisis Event

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

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

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

- If you believe that you, your child, or another person is no longer safe as a result of your child’s behavior, call 911 to have your child transported to the emergency department closest to your home
- Consider calling your local county crisis hotline, which are listed at:  
[www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines](http://www.hca.wa.gov/health-care-services-and-supports/behavioral-health-recovery/mental-health-crisis-lines)
- Consider calling the national suicide hotline:  
1-800-784-2433

This resource page is now available in Spanish at [www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

# Depression Resources

## Information for Families

### Books families may find helpful:

The Childhood Depression Sourcebook (1998), by Jeffery Miller

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

The Explosive Child (2001), by Ross Greene

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

### Books children may find helpful:

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

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

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

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

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

### Crisis Hotlines:

National Crisis Hotline  
1-800-784-2433

National Suicide Prevention Lifeline  
1-800-273-8255

START text - 741741  
[www.crisistextline.org](http://www.crisistextline.org)

### Websites families may find helpful:

Guide to depression medications from APA and AACAP professional societies  
[www.parentsmedguide.org](http://www.parentsmedguide.org)

National Institute of Mental Health  
[www.nimh.nih.gov/health/topics/depression/index.shtml](http://www.nimh.nih.gov/health/topics/depression/index.shtml)

National Alliance for Mental Illness  
[www.nami.org/Find-Support/Teens-and-Young-Adults](http://www.nami.org/Find-Support/Teens-and-Young-Adults)

American Foundation for Suicide Prevention  
[www.afsp.org](http://www.afsp.org)

American Academy of Child and Adolescent Psychiatry  
[www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Depression\\_Resource\\_Center/Home.aspx](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/](http://www.dartmouthcoopproject.org/teen-mental-health-2/)

This resource page is  
now available in Spanish at  
[www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

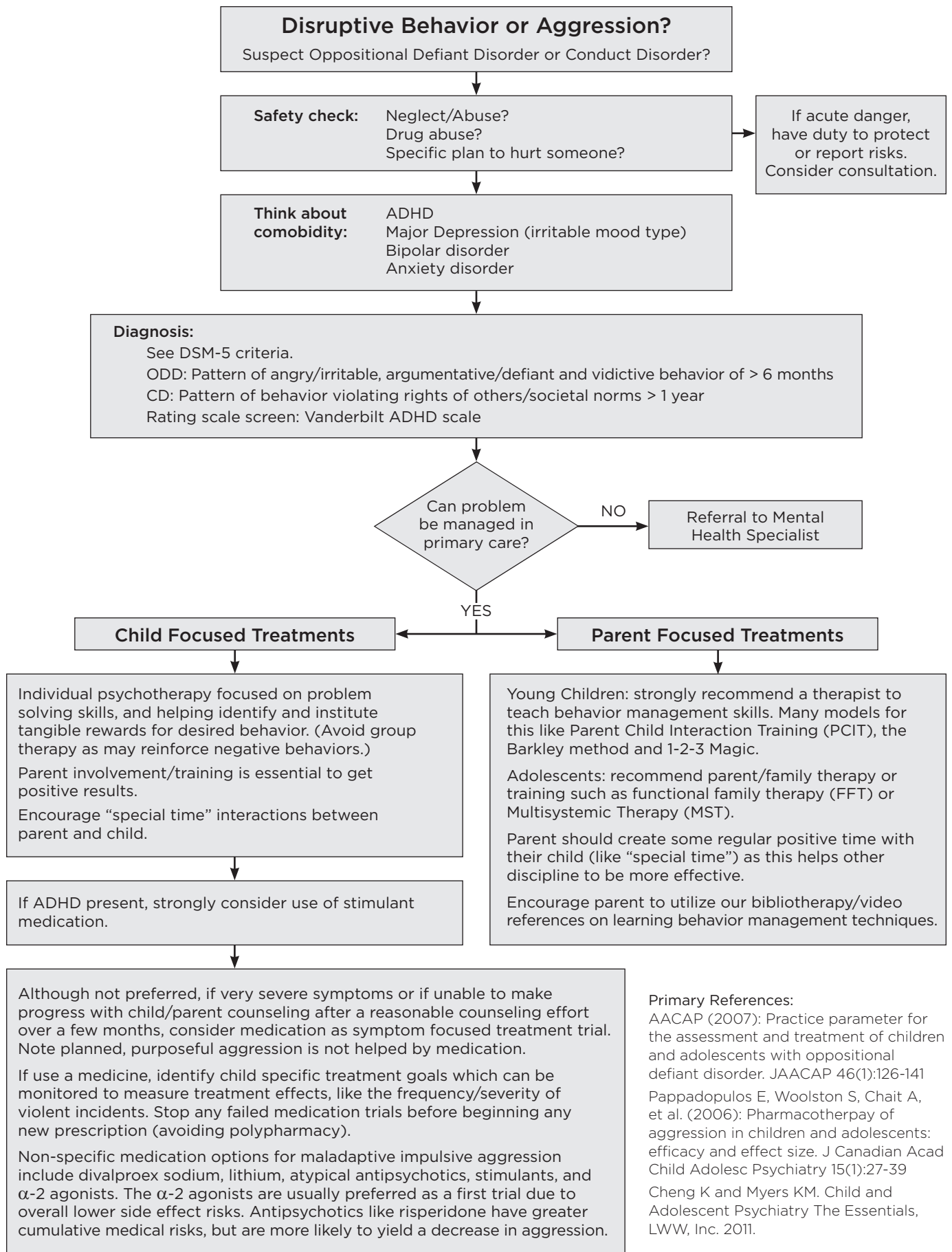


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for Primary Care Providers





# Disruptive Behavior and Aggression



# Non-Specific Medications for Disruptive Behavior and Aggression

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

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

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

\*Pappadopoulos E et al., J Cdn. Acad. Child Adol. Psych. (2006)

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

## Other Medication Options

| Drug Name             | Description                 | (+) RCT evidence in kids** | Monitoring  | Editorial Comments   |
|-----------------------|-----------------------------|----------------------------|---|--|
| Lithium               | A salt, is renally excreted | Yes                        | Baseline EKG, BUN/creat, TSH, CBC. Lithium level after 5 days. Q3month Li. Q6mo TSH,BUN/crt | Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal |
| Valproate             | Anti-seizure                | Yes                        | CBC, LFT at baseline, in 3 month, then Q6month. VPA level checks needed                     | Sedating, weight gain, rare severe toxicity of liver, ↓platelets   |
| Carbamazepine         | Anti-seizure                | No                         | CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed                        | Aplasia and rash risk. Note a negative result trial with kids and oxcarbazepine & bipolar disorder   |
| Clonidine, Guanfacine | α-2 agonists                | Yes                        | Pulse, BP   | Orthostasis, sedation sign of excess dose, avoid high doses, rebound hypertension if quick stop  |

\*\*Pappadopoulos E et al. (2006) and lit. review

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

## ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

**INSTRUCTIONS:** COMPLETE EXAMINATION PROCEDURE BEFORE MAKING RATINGS.

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

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

2 = MILD 3 = MODERATE 4 = SEVERE

### EXAMINATION PROCEDURE

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

- |   |   |
|---|---|
| <ol style="list-style-type: none"> <li>1. ASK PATIENT WHETHER THERE IS ANYTHING IN HIS/HER MOUTH (I.E., GUM, CANDY, ETC.) AND IF THERE IS, TO REMOVE IT.</li> <li>2. ASK PATIENT ABOUT THE CURRENT CONDITION OF HIS/HER TEETH. ASK PATIENT IF HE/SHE WEARS DENTURES. DO TEETH/DENTURES BOTHER PATIENT NOW?</li> <li>3. ASK PATIENT WHETHER HE/SHE NOTICES ANY MOVEMENTS IN MOUTH, FACE, HANDS, OR FEET. IF YES, ASK TO DESCRIBE AND TO WHAT EXTENT THEY CURRENTLY BOTHER PATIENT OR INTERFERE WITH HIS/HER ACTIVITIES.</li> <li>4. HAVE PATIENT SIT IN CHAIR WITH HANDS ON KNEES LEGS SLIGHTLY APART AND FEET FLAT ON FLOOR. (LOOK AT ENTIRE BODY FOR MOVEMENTS WHILE IN THIS POSITION)</li> <li>5. ASK PATIENT TO SIT WITH HANDS HANGING UNSUPPORTED. IF MALE, BETWEEN LEGS; IF FEMALE AND WEARING A DRESS, HANGING OVER KNEES (OBSERVE HANDS AND OTHER BODY AREAS.)</li> <li>6. ASK PATIENT TO OPEN MOUTH. (OBSERVE TONGUE AT REST WITHIN MOUTH,) DO THIS TWICE.</li> </ol> | <ol style="list-style-type: none"> <li>7. ASK PATIENT TO PROTRUDE TONGUE. OBSERVE ABNORMALITIES OF TONGUE MOVEMENT.) DO THIS TWICE.</li> <li>*8. ASK PATIENT TO TAP THUMB. WITH EACH FINGER, AS RAPIDLY AS POSSIBLE FOR 10-15 SECONDS; SEPARATELY WITH RIGHT HAND, THEN WITH LEFT HAND. (OBSERVE FACIAL AND LEG MOVEMENTS.)</li> <li>9. FLEX AND EXTEND PATIENT'S LEFT AND RIGHT ARMS (ONE AT A TIME). (NOTE ANY RIGIDITY AND RATE ON DOTES.)</li> <li>10. ASK PATIENT TO STAND UP. (OBSERVE IN PROFILE. OBSERVE ALL BODY AREAS AGAIN. HIPS INCLUDED.)</li> <li>*11. ASK PATIENT TO EXTEND BOTH ARMS OUTSTRETCHED IN FRONT WITH PALMS DOWN. (OBSERVE TRUNK, LEGS. AND MOUTH.)</li> <li>*12. HAVE PATIENT WALK A FEW PACES, TURN, AND WALK BACK TO CHAIR. (OBSERVE HANDS AND GAIT) DO THIS TWICE.</li> <li>** ACTIVATED MOVEMENTS</li> </ol> |
|---|---|

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

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

☐ EXAMINATION COMPLETED

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

REVISED 03/20/97

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

# Time Out

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

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

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

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

Robert Hilt, MD

This resource page is now available in Spanish at [www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

# Special Time

## Also known as “Child Directed Play”

*A strength based approach to overall child behavior problems.*

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

How to do special time:

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

Robert Hilt, MD

This resource page is now available in Spanish at [www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)

# Treating Disruptive Behavior and Aggression Using Functional Analysis

## Identify the behavior

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

## Analyze and make hypotheses about the function of the behavior

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

## Modify the environment by changing provoking and reinforcing factors.

- Enhance communication — could try naming the thoughts or feelings that you believe the child may be having, like “I see that you want to eat right now.”
- Use simple, concrete sentences and questions with child.
- Remain calm since your emotional reaction may reinforce an undesired behavior.
- Increase structure — provide schedule of day’s events, use routines, anticipate transitions. Describe an upcoming routine to prepare for new situations. Teach child how to ask for help and how to tell adults when they need a break.

- Modify demands — match the task to their developmental stage & language ability. Limit time for tasks, schedule fun activities after less preferred ones.
- Allow child access to a time-limited escape to a calm, quiet place if overwhelmed.
- Reinforce positive behavior with attention and praise, find out what child finds rewarding (special activity, food, favorite toy, a gold star, etc.)
- Avoid reinforcing maladaptive behavior with attention or other gains.
- Schedule special, non task-driven, time for child and parents together that is honored and not conditional on other behaviors.

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

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

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

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

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

# Bullying: Advice for the Primary Care Clinician

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

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

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

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

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

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

For a bullying bystander, action steps to recommend include:

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

## Working directly with the bully:

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

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

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

Parents and school officials can **learn more** about how to stop bullying at [www.stopbullying.gov](http://www.stopbullying.gov)

Rebecca Barclay, MD and Robert Hilt, MD

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



# Disruptive Behavior and Aggression Resources

## Information for Families

### Books parents may find helpful:

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

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

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

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

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

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

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

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

### Videos parents may find helpful:

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

Managing the Defiant Child, by Russell Barkley, PhD

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

Raising an Emotionally Intelligent Child, by John Gottman, PhD

### Websites families may find helpful:

American Academy of Child Psychiatry Oppositional Defiant Disorder resource center

[www.aacap.org/AACAP/Families\\_and\\_Youth/Resource\\_Centers/Oppositional\\_Defiant\\_Disorder\\_Resource\\_Center/Home.aspx](http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/Oppositional_Defiant_Disorder_Resource_Center/Home.aspx)

Oppositional Defiant Disorder information from Mayo Clinic

<http://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/basics/definition/con-20024559>

The Incredible Years training programs

[www.incredibleyears.com](http://www.incredibleyears.com)

Lives in the Balance

[www.livesinthebalance.org](http://www.livesinthebalance.org)



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Child Psychiatric Consultation  
for Primary Care Providers

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# Sleep Hygiene for Young Children

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

Robert Hilt, MD

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

# Sleep Hygiene for Teens

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

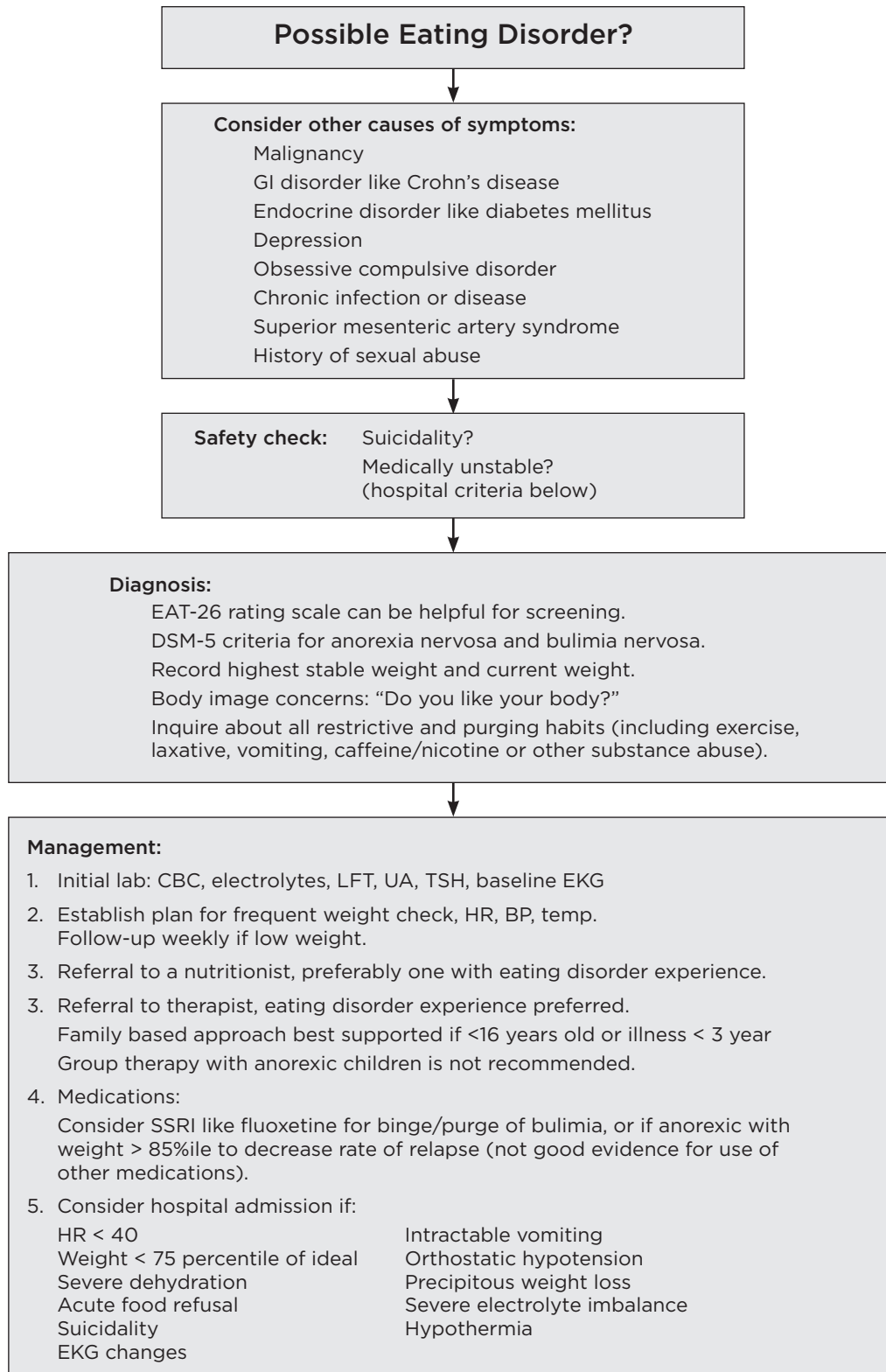
Robert Hilt, MD

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

This resource page is now available in Spanish at [www.seattlechildrens.org/pal](http://www.seattlechildrens.org/pal)



# Eating Disorder



#### Primary References:

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

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

# Eating Attitudes Test<sup>®</sup> (EAT-26)

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

## Part A: Complete the following questions:

- 1) Birth Date      Month: ..... Day: ..... Year: ..... 2) Gender: ☐ Male   ☐ Female  
 3) Height      Feet: ..... Inches: .....  
 4) Current Weight (lbs.): ..... 5) Highest Weight (excluding pregnancy): .....  
 6) Lowest Adult Weight: ..... 7) Ideal Weight: .....

| Part B: Please check a response for each of the following statements:  | Always                       | Usually                     | Often                    | Sometimes                   | Rarely                   | Never                     |
|--|------------------------------|-----------------------------|--------------------------|-----------------------------|--------------------------|---------------------------|
| 1. Am terrified about being overweight.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 2. Avoid eating when I am hungry.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 3. Find myself preoccupied with food.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 4. Have gone on eating binges where I feel that I may not be able to stop.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 5. Cut my food into small pieces.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 6. Aware of the calorie content of foods that I eat.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 7. Particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)                               | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 8. Feel that others would prefer if I ate more.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 9. Vomit after I have eaten.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 10. Feel extremely guilty after eating.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 11. Am preoccupied with a desire to be thinner.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 12. Think about burning up calories when I exercise.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 13. Other people think that I am too thin.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 14. Am preoccupied with the thought of having fat on my body.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 15. Take longer than others to eat my meals.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 16. Avoid foods with sugar in them.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 17. Eat diet foods.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 18. Feel that food controls my life.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 19. Display self-control around food.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 20. Feel that others pressure me to eat.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 21. Give too much time and thought to food.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 22. Feel uncomfortable after eating sweets.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 23. Engage in dieting behavior.  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 24. Like my stomach to be empty.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 25. Have the impulse to vomit after meals.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| 26. Enjoy trying new rich foods.   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| <b>Part C: Behavioral Questions.</b><br>In the past 6 months have you:   | <b>Never</b>                 | <b>Once a month or less</b> | <b>2-3 times a month</b> | <b>Once a week</b>          | <b>2-6 times a week</b>  | <b>Once a day or more</b> |
| A. Gone on eating binges where you feel that you may not be able to stop?  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| B. Ever made yourself sick (vomited) to control your weight or shape?  | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| C. Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?                               | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| D. Exercised more than 60 minutes a day to lose or to control your weight?   | <input type="checkbox"/>     | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>    | <input type="checkbox"/> | <input type="checkbox"/>  |
| E. Lost 20 pounds or more in the past 6 months   | <input type="checkbox"/> Yes |                             |                          | <input type="checkbox"/> No |                          |                           |
| • Defined as eating much more than most people would under the same circumstances and feeling that eating is out of control. |                              |                             |                          |                             |                          |                           |

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

# Scoring the Eating Attitudes Test<sup>®</sup> (EAT-26)

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

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

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

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

## EAT-26 Score

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

### Scoring for Questions 1-25:

|           |   |   |
|-----------|---|---|
| Always    | = | 3 |
| Usually   | = | 2 |
| Often     | = | 1 |
| Sometimes | = | 0 |
| Rarely    | = | 0 |
| Never     | = | 0 |

### Scoring for Question 26:

|           |   |   |
|-----------|---|---|
| Always    | = | 0 |
| Usually   | = | 0 |
| Often     | = | 0 |
| Sometimes | = | 1 |
| Rarely    | = | 2 |
| Never     | = | 3 |

# Eating Disorder Resources

## Information for Families

### Books families may find helpful:

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

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

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

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

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

### Books youth may find helpful:

Eating Disorders (2003), by Trudi Strain Trueit

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

### Websites families may find helpful:

National Eating Disorders Association, provides information and referrals  
[www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)

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

Academy for Eating Disorders, professional organization  
[www.aedweb.org](http://www.aedweb.org)

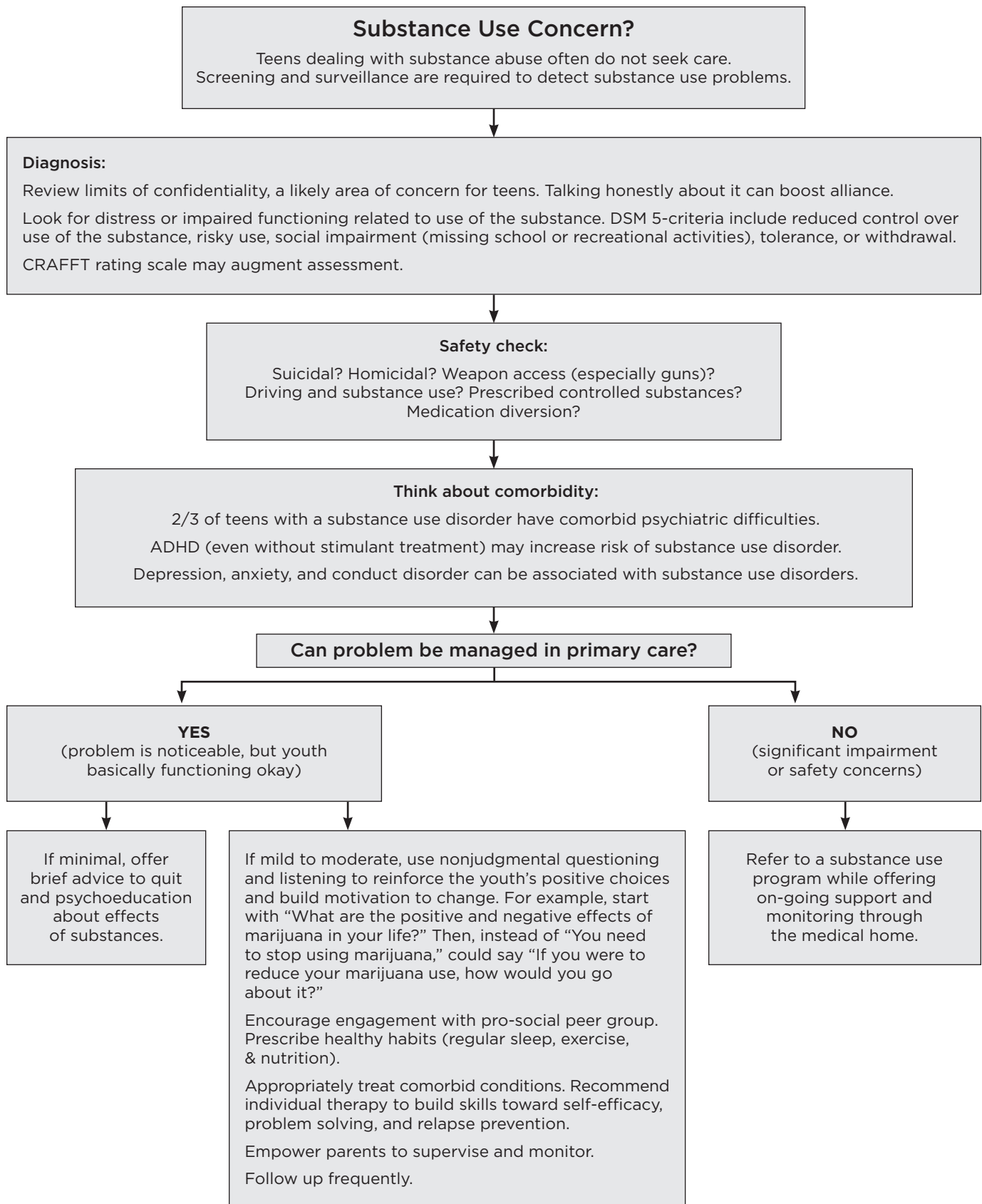
Recovery support site  
<http://something-fishy.org>

Seattle Children's, Eating Disorder Booklist and Resources  
[www.seattlechildrens.org/pdf/PE456.pdf](http://www.seattlechildrens.org/pdf/PE456.pdf)





# Substance Use



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

# The CRAFFT Questionnaire (version 2.0)

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

## Part A

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

- |   |   |
|---|---|
| 1. Drink more than a few sips of beer, wine, or any drink containing <b>alcohol</b> ?<br>Say "0" if none.   | <input style="width: 100px; height: 20px;" type="text"/><br># of days |
| 2. Use any <b>marijuana</b> (pot, weed, hash, or in foods) or " <b>synthetic marijuana</b> " (like "K2" or "Spice")? Say "0" if none.                                   | <input style="width: 100px; height: 20px;" type="text"/><br># of days |
| 3. Use <b>anything else to get high</b> (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff or "huff")? Say "0" if none. | <input style="width: 100px; height: 20px;" type="text"/><br># of days |

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

YES ☐



Ask CAR question only, then stop

NO ☐



Ask all six CRAFFT\* questions below

## Part B

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

**\*Two or more YES answers suggest a serious problem and need for further assessment.  
See next page for further instructions** →

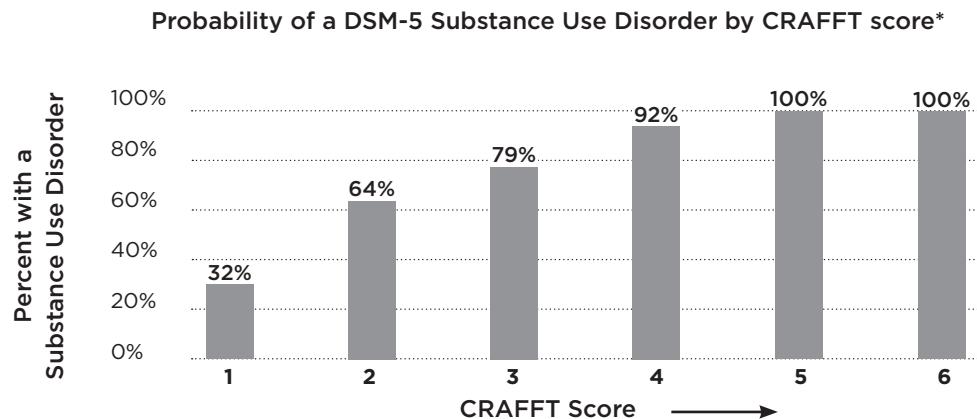
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For more information and versions in other languages, see [www.ceasar.org](http://www.ceasar.org).

For additional information, contact [CeASAR@childrens.harvard.edu](mailto:CeASAR@childrens.harvard.edu)

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



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

2. Use these talking points for brief counseling.



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



2. **RECOMMEND** not to use  
*"As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can:*
  - 1) *Harm your developing brain;*
  - 2) *Interfere with learning and memory, and*
  - 3) *Put you in embarrassing or dangerous situations."*



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



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



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

3. Give patient Contract for Life. Available at [www.ceasar-boston.org/CRAFFT/screenCRAFFT.php](http://www.ceasar-boston.org/CRAFFT/screenCRAFFT.php)

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**NOTICE TO CLINIC STAFF AND MEDICAL RECORDS:**

The information on this page is protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient.

# Substance Abuse Resources

## Information for Families

### Websites families may find helpful:

A Parent's Guide to Preventing Underage Marijuana Use

[www.seattlechildrens.org/pdf/parents-guide-preventing-underage-marijuana-use.pdf](http://www.seattlechildrens.org/pdf/parents-guide-preventing-underage-marijuana-use.pdf)

Partnership for Drug-Free Kids

<https://drugfree.org>

Parent-Teen Driving Agreement

[www.healthychildren.org/English/ages-stages/teen/safety/pages/Teen-Driving-Agreement.aspx](http://www.healthychildren.org/English/ages-stages/teen/safety/pages/Teen-Driving-Agreement.aspx)

Drugs: What You Should Know

[www.seattlechildrens.org/kids-health/teens/drugs-and-alcohol/drugs/drugs--what-you-should-know](http://www.seattlechildrens.org/kids-health/teens/drugs-and-alcohol/drugs/drugs--what-you-should-know)

Washington Recovery Helpline (866-789-1511)

[www.warecoveryhelpline.org](http://www.warecoveryhelpline.org)

Start Talking Now

[www.starttalkingnow.org](http://www.starttalkingnow.org)

National Institute on Drug Abuse for Parents

<https://teens.drugabuse.gov/parents>

### Websites youth may find helpful:

The Cool Spot

[www.thecoolspot.gov](http://www.thecoolspot.gov)

### Books families may find helpful:

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

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



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