Gulf Coast Consultation in Child and Adolescent Psychiatry (G-CAP)

Helping you care for your patients

In Terrebonne, Plaquemines, St Bernard, St Mary, and New Iberia

Tulane's Child Psychiatry G-CAP is a member of the Spirit of Hope Collaborative administered by Catholic Charities with funding from BP

Overview of the project

The G-CAP project includes 4 major components intended to support primary care physicians' ability to assess and manage primary care mental health problems in their pediatric patients and to provide support in identifying those children who need more specialized services.

The four components are
- Warm Line
- Resource guide
- Continuing Medical Education
- Consultation appointments

Warm Line
* 15 hours per week of child psychiatry consultation by phone
* Calls returned within 1 business day
* Consultation for assessment, differential diagnosis and treatment decisions
* Written feedback and detailed recommendations

Resource Guide
* Available on our website www.gcap.tulane.edu
* Assessment tools at your fingertips
* Primary care management of common child psychiatric problems
* Parent resources

Local or web-based continuing education
* Topics tailored to your needs

Consultation appointments
* One-time consultation appointments at Tulane to provide feedback to you about diagnosis and treatment recommendations

Who is on the G-CAP team? G-CAP consultants are all members of the Division of Child and Adolescent Psychiatry at Tulane University School of Medicine

Madeleine Blancher MD FAAP *is a practicing pediatrician with specialty training in child psychiatry*

Mary Margaret Gleason MD FAAP *trained as a triple boarder in pediatrics, psychiatry, and child psychiatry and is on the Tulane faculty. She is the project coordinator.*

Andrea O'Leary MD *also trained as a triple boarder at Tulane and is on the Tulane faculty*

Marilyn Roby MD FAAP *practiced as a pediatrician before returning to train in psychiatry and child psychiatry at Tulane*

Jacqueline Henschke, MD *is a Stanford-trained child and adolescent on the Tulane faculty. She is the project lead consultant.*

Basic Contact Information

Warm Line: The (temporary) warmline number is (504) 988-4653.

Call the warm line during our warmline hours (see below) to talk with a consultant about general or specific mental health treatment questions. We are happy to answer any questions, but expect that the following areas will be the most helpful

- Assessment strategies for emotional or behavioral issues
- Medication choices
- Medication strategies
- Identifying patients in need of referral
- Primary care level behavioral strategies

We will provide a written summary of the question and the recommendations after our phone discussion with you.

Feel free to call and leave a message between the warmline hours. We ask that you leave as much information about the question as possible so we can provide the best possible response when the warmline is open. Helpful information includes

- Your name
- Child's age
- Diagnosis or clinical problem
- Type of question (e.g. medication choice for depression, differentiating between ADHD and bipolar disorder….)

If you prefer, you can fax the question to us using the referral form (p.***) . A consultant will call you back during the next warmline hours. If we do not reach you, we will do our best to provide written feedback and will continue to call during warmline hours. The more information we have about the question, the better that response will be.

During the off hours, you may leave a message or fax a consultation form to us and you will receive a call during the next warmline consultation period. During warmline hours, we will do our best to help you think through urgent issues.

However, please do not use the fax, email, nor off-hours warmline for emergency issues as we cannot provide emergency off-hours support.

Also, please keep in mind that the information we share with you is a consultation only, based upon the information you provide the consultant and does not substitute for your careful medical judgment. We cannot take responsibility for the care of your patients.

Warmline hours

Monday: 9-11 am
Tuesday: 4-7 pm
Wednesday: 8 am-12 pm
Thursday: 9am -5pm

Please let us know if additional evening or weekend hours would be helpful!

Fax: (504) 988 4264

We can accept fax copies of questions or referral information if you prefer fax to the voice mail.

Website: gcap.tulane.edu

Our website includes updated hours, contact information, and the resource guide. Feel free to use liberally!

Email: gccap3@gmail.com

Our email box is on the gmail system and is not HIPAA level secure, so please do not send patient information to the email box. However, we are happy to respond to logistical and scheduling issues over email. Our email will be checked during warmline hours.

Continuing education:

During our initial discussion with you, we will ask you about topics that would be helpful to you. CME topics may be done in person or over the web, depending on availability and preferences.

Consultation appointments

We will have limited numbers of appointments for patients to be seen for a one time consultation appointment at our offices in New Orleans. The goal of these appointments is to assist with assessment and specific treatment recommendations. If you think a patient would benefit from a one time consultation, please discuss with a consultants. These patients will remain your patients, but the consultant will provide detailed written recommendations for next steps in management.

Confidentiality

Because we recognize that we may receive more than one call about a given child, we will ask you for the child's name and birthday to allow us to track the questions and the recommendations we give you. This information will be maintained on a password protected document on an encrypted server and will be accessible only to the consultation team. If you prefer not to provide a name, we can still provide consultation.

Project Costs

There are no costs to you to participate in this program. The program is funded by BP to provide support to oil-spill affected areas and administered by Catholic Charities.

Program Evaluation

The funders need to demonstrate that the financial investment in the mental health of children in oil-spill affected areas was well-spent. Therefore, we will ask you for demographic information about the child about whom you are calling. (You can still call with general questions as well!). This information includes age, zip code, insurance status, and impact of the oil spill on the family.

In addition, we have received approval from Tulane's Institutional Review Board to evaluate the impact of the project on clients served and primary care providers. Participation in this research project is voluntary.

Gulf Coast Consultation in Child and Adolescent Psychiatry

Physician Registration Form

Name:_____

(Your physician identification number (entered by team):_____)

Practice Name:_____ **Practice Address**:_____

Office back line number: _____ **Email address**:_____

Gender: _____ **Age:** _____

Number of years in practice: _____

Residency training: Pediatrics Family Practice Med-Peds Other_____

Any specialty training? No Yes: _____

Board certification: None ABP ABFP other:_____

Number of MDs in practice: _____ **Number NPs in practice:** _____

Approximate percentage of children in your practice who have public insurance:

0 10 20 30 40 50 60 70 80 90 100

Please rate your perception of the Oil Spill has affected your practice

	Substantial increase	Increase	No Change	Decrease	Substantial decrease
Patient Volume	↑↑	↑	-	↓	↓↓
Patient Family Stress	↑↑	↑	-	↓	↓↓
Patient family violence	↑↑	↑	-	↓	↓↓
Patient mental health severity	↑↑	↑	-	↓	↓↓
Patient mental health prevalence	↑↑	↑	-	↓	↓↓
Provider/staff stress	↑↑	↑	-	↓	↓↓

Comments:_____

_____

_____

Please let us know if you have specific requests for continuing education programs or resources you would like from this project. Thanks!

_____

_____

Gulf Coast Consultation in Child and Adolescent Psychiatry

Off hours Consultation Form

Date of consultation: _____

Practice Information:

Pediatric Practice Name: _____

Consulting Physician Name: _____

Pediatric Practice Contact Information:

Backline Phone number or best number to reach you during next warm line session:_____

Fax number:_____

Patient Information (enter any information relevant to your consultation question):

Child/Client Name: _____

Date of Birth or age in years and months : _____

Pertinent Medical History: _____

Current Medications: _____

Allergies: ___ NKDA ___ Other: _____

Is the client/family receiving any therapeutic, community, or social services? Please specify:

_____

_____

Has the family/child been impacted by the BP Oil Spill? (i.e.: job loss, job gain, lifestyle changes, etc.) Please specify:

_____

_____

Consultation Information:

Type of consultation:

☐Diagnostic ☐School issue ☐Resources-community access
☐Medication question ☐Non-patient related mental health question
☐Advice for parent ☐ Other, please specify: _____

Consultation question/request:

_____

_____

_____

_____

Please fax to G-CAP at (504) 988 4264. You will receive a call during the next warmline session. Please check the website for schedule. Please do not fax urgent requests to G-CAP, as we are not an emergency service and cannot respond immediately.

Depression
and
Mood Disorders

Depressive Disorders

Patterns of excessive depressed or irritable moods, with associated neurovegetative symptoms (sleep, appetite, concentration), guilty feelings, suicidality, guilt, and functional impairment or significant distress

Primary reference source: AACAP. Practice parameter for the assessment and treatment of children and adolescents with depressive disorders *J Amer Acad Child Adolescent Psychiatry.* 2007; 46(11): 1506-1523

History:
- From parent and child
- review all symptoms of depressive disorders, including suicidality
- Review domains of impairment (family, peers, academic, extracurricular)
-Assess for recent or chronic stressors

Suggestive of depressive disorder?

Safety assessment
- Suicidal or homicidal thoughts/plans
- Adolescent substance abuse
- Rule out maltreatment and family violence
- Weapons and access to other lethal medicines

As needed:
ER emergency referral for safety
Substance abuse referral
Advise firearm safety

Differential Diagnosis (details below)
- Transient,developmentally appropriate reaction to stressor
- Adjustment disorder with disturbance of mood (or mood and conduct)
- Anxiety disorders
- Externalizing disorders (ADHD, ODD)
- Bipolar disorder
- Substance abuse disorder

Treat primary disorder

Primary Care Universal Interventions
- Psychoeducation about depressive disorders and safety
- Develop plan to address remediable stressors
- Ensure household safety
- Follow closely and provide child and family support

Mild depression, minimal impairment

Refer for therapy (CBT, supportive therapy, or interpersonal therapy)

Symptoms/impairment resolved?

Yes

No

Moderate depression, low/moderate safety risk, age < 12

Refer for specialized depression therapy (CBT, or interpersonal therapy) and monitor closely until referral well established

Symptoms/impairment resolved?

Yes

Severe depressive disorder, high safety risk, adolescent age group

Refer for specialized mental health assessment and treatment

Monitor closely until referral well established

SSRI Trial x 4-6 weeks
Child: fluoxetine,
Adolescent: Fluoextine,sertraline escitalopram

Monitor symptoms with structured measure

Symptoms/impairment resolved?

No

SSRI Trial # 2 x 4-6 weeks (medication not previously used)

Monitor symptoms with structured measure

Symptoms/impairment resolved?

Yes

No

Return to primary care with regular monitoring of mood

Yes

Depressive disorders

Hallmark symptoms: Patterns of excessive depressed or irritable moods, with associated neurovegetative symptoms (sleep, appetite, concentration), guilty feelings, suicidality, guilt, and functional impairment or significant distress

	Major depressive disorder	**Dysthymia**	**Adjustment disorder with depressed mood**
Description	Significant depressive disorder	Chronic, debilitating, but less intense form of depressive disorder	Mood symptoms in response to identified stressor which occurred within 3 months of onset of symptoms
Duration of symptoms	At least 2 weeks duration	At least 1 year of symptoms more days than not (no break greater than 2 months)	Symptoms do not last more than 6 months after the stressor has terminated
Core required symptoms	At least one of the following 1) Depressed or irritable mood 2) Decreased interest in activities that were pleasurable	Depressed or irritable mood	Marked distress that is in excess of what would be expected from exposure to the stressor
Additional symptoms	At least 4 of the following 1) Change in appetite or weight (or failure to gain weight appropriately) 2) Sleep disturbances 3) Observable change in psychomotor activity (increased or decreased) 4) Decreased energy 5) Decreased concentration or decisiveness 6) Increased feelings of guilt or worthlessness 7) Recurrent thoughts of death/dying	1) Change in appetite or weight 2) Sleep disturbances 3) Decreased energy/fatigue 4) Decreased self esteem 5) Poor concentration/difficulty with decisions 6) hopelessness	
Must cause significant Impairment and/or distress?	Yes	Yes	Yes
Exclusionary criteria	Never had a manic episode Not caused by substance use	Never had a manic or hypomanic episode Not caused by substance use	Does not meet criteria for MDD, dysthymia, and is not exclusively in the context of bereavement

APA. *Diagnostic and Statistical manual of mental disorders IV-TR*. 4 ed. Washington, D.C.: American Psychiatric Association; 2000.

Differential Diagnosis of Depressive Disorders

Diagnosis	How the diagnosis can be differentiated from depressive disorders
Normal development	*Sadness or irritability is not pervasive, responds appropriately to comfort or resolution of stressors, and does not cause functional impairment*
ADHD	*Fidgeting ("psychomotor agitation") is present, and mood symptoms may accompany repeated limit setting or consequences, but child shows full range of affect in situations that do not challenge the ADHD behaviors*
Anxiety Disorders (Including generalized anxiety, separation anxiety, specific phobias, obsessive compulsive disorder)	*Anxiety disorders are often co-morbid with depressive disorders, but isolated anxiety disorders do not cause sadness or irritability, although they can cause distress. Children and adolescents are usually able to describe the triggers for their anxiety.*
Bipolar disorder	*Patient has experienced at least 1 episode of mania or hypomania characterized by euphoria/extreme irritability associated with decreased need for sleep, psychomotor agitation, high risk taking behaviors, goal directed activities, grandiosity.*
Eating Disorders	*Although physical symptoms of starvation may mimic depression (weight loss, decreased energy, concentration), patients with an eating disorder without co-morbid depressive symptoms are less likely to endorse depressed mood or identify distress.*
Frustration associated with **Developmental Delays or learning problems**	*Mood symptoms are more likely to be limited to learning domains but not present when the child is participating in a developmentally appropriate activity*
Hypothyroidism	*Weight gain, bradycardia, GI symptoms, thyromegaly may be present. Patients with hypothyroid-drive mood changes are less likely to be suicidal or to be able to identify recent stressors.*
Substance abuse disorder	*May endorse substance use (or gateway drugs). Mood and behavior changes are more erratic (may be "himself" for a few days, then substantial change for period of time), less persistent. Patient may be spending more money or stealing from family. Physical findings related to substance use may be present.*

Assessment Strategies

Universal screening- Pediatric Symptom Checklist or other broad-band screener. Attend to "2"'s on items related to mood symptoms.

Symptom-Specific Structured measures

- Center for Epidemiologic Studies- Depression Scale
  - Scores ≥15 are positive- higher likelihood of depressive disorder

History

- Include history from child and parent
- Review any major life events or stressors including violence exposure and (in adolescent girls) potential pregnancy
- Review changes in functioning in family, school, with peers, or in extracurricular activities including more arguments at home, declines in grades, withdrawal from social activities or other enjoyable activities
- With child alone, explore suicidal and homicidal thoughts and behaviors including
    - Self-injurious behaviors without intent to kill self (e.g. cutting)
    - Passive suicidal ideation- not wanting to be alive
    - Active suicidal ideation- wanting to kill self
    - Active suicidal ideation with plan- wanting to kill self and having developed a plan
    - How close the child has come to acting on the thoughts
    - What has stopped him or her from acting on such thoughts
    - Ability to "contract for safety" – commit to MD and parent that he/she would follow an identified safety plan to alert a responsible adult if thoughts of harming self became more intense
    - Presence of lethal means in home or environment (guns, insulin, other potentially lethal medications)
- Review family history, especially for first degree relatives with mood disorders (depression or bipolar disorder) and household members with mood disorders

Physical Examination/observations

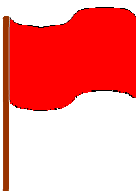
- Physical exam unlikely contributory
- Examine for signs of self injurious behaviors including
    - Cutting- forarms, inner thighs, ankles, underside of breasts, under arms
    - Self-induced vomiting- abrasions on metacarpals
- Signs of substance use (track marks on arms or ankles, nasal septal Thyromegaly

Labs to consider

- Pregnancy test if adolescent girl, especially if considering medication treatment
- TFT's to assess for hypothyroidism

Referrals to consider

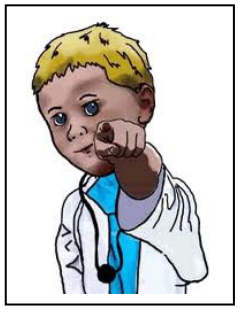
- Cognitive testing or developmental testing (r/o specific learning disability, developmental delay)



Safety issues in Depressive Disorders

- Confirm any firearms or other weapons or lethal means of self-harm in home are secured
- Consider substance abuse and consider urine screen

Primary Care Interventions for DBDs



Prevention

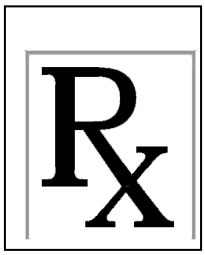
- Mention mood/stress management at every visit
- Monitor high risk children (e.g. those with family histories of depression or bipolar disorder) closely

Prevention and early intervention

- Provide safe “listening” place where child’s negative mood is not perceived as a burden or something to be punished
- Schedule frequent follow-ups if concerned
- Provide handouts on mood management and relaxation skills
- Encourage parental self-care if appropriate

Indicators of need for specialty referral

- No improvement with supportive interventions for mild-moderate depression
- Severe depression
- High risk suicidality (active suicidal ideations with plan)
- Multiple co-morbid conditions beyond generalized anxiety disorder or panic disorder



Evidence based treatments for depression

Program name	**Age Range**	**Brief Overview**
Cognitive Behavioral Therapy	4-adult	Focuses on the thoughts, feelings and behaviors in depression. • Learn to identify feeling states accurately and be aware of them • Identify and learn to analyze negative, automatic thoughts that occur in the context of depression (e.g. “I am a complete failure” when making a small mistake) • Develop coping skills and relaxation skills to fight maladaptive reactions (thoughts and behaviors) to stressors Includes homework exercises and in-session practicing of the skills.
Interpersonal Therapy	12-adult	-Focuses interactions with others and perceptions of those interactions as important factors in the development and perpetuation of depressive symptoms. - Includes in-session role plays of difficult or stressful interactions
Supportive psychotherapy (effective for mild depression only)	all	-Focuses on providing support, coping strategies and providing some reflections to allow the patient to understand interpersonal patterns -less formally structured
Family therapy	all	Focuses on enhancing family interactions that may reduce depression and on identifying problematic interactions that may have triggered/perpetuated depressive symptoms

Adapted from AACAP (2009) ODD: A guide for families from the American Academy of Child and Adolescent Psychiatry. Washington DC. www.aacap.org

Psychopharmacology in depressive disorders

Principles of psychopharmacology in treating Depressive Disorders

- Follow guidelines in parentsmedguide.org physician information
- May be first line treatment for moderate-severe depression, especially in adolescents
- Should be second line treatment for younger children and those with milder depression
- Informed consent includes black box warning re: suicidality as well as risks of mania in children with bipolar disorder that has not yet presented
- Start low go slow
    - Children and adolescents may have higher rates of adverse events than adults
    - Careful monitoring warranted in children with family history of bipolar disorder
    - Generally, start children on ¼ of the adult starting dose and adolescents on ½ of adult starting dose (see table below)
    - Slow titration (increasing dose every 4-6 weeks) is appropriate due to slow onset of action
- Monitor closely with initiation and each dose increase
    - Risk of increased suicidality highest in first 2 months after dose changes
- If no substantial adverse effects, maximize dose before discontinuing an SSRI and starting a new trial
- Avoid multiple serotonerigic medications (especially multiple anti-depressants and or anti-migraine medications) concurrently because of risk of serotonin syndrome (hyperthermia, tachycardia, hypertension, and mental status changes)

First line treatment choice

- Children < 12: fluoxetine has best efficacy:risk ratio. Consider it first line unless very high risk of bipolar disorder or other reason that long half life would be problematic.
- Adolescents: fluoxetine, sertraline, escitalopram have strongest evidence and should be considered first line treatments. Half life, potential for "activation", and family history of response to specific SSRI's should guide recommendation.
- Advise parents that there is approximately a 60% chance of response to first line medication.

Second line treatment

- If treatment is ineffective after 4-6 weeks on a dose expected to be therapeutic (at least one increase after initial starting dose) or if patient develops intolerable adverse effects, select one of the medications among fluoxetine, sertraline, escitalopram for second trial. Of treatment resistant adolescents, would expect 60% to respond to second SSRI.
- Non-SSRI medications, such as the SNRI's (venlafaxine, duloxetine) should be selected only in consultation with a psychiatrist. Venlafaxine has more side effects than an SSRI and does not improve the outcome in treatment resistant depression.
- Serotonin agonists (mirtazapine) are not supported by randomized controlled trials and would not be considered appropriate second line treatment without consultation.

- Buproprion also has not been demonstrated to be effective in randomized clinical trials and generally should not be used as second line treatment except in consultation.
- Tricyclic antidepressants have no efficacy in treating pediatric depression and should not be used.

Length of treatment

- Because of the high risk of relapse in first 6-9 months after a depressive episode, it is recommended that patients continue effective SSRI for at least that period before planned weaning off the medication with close monitoring of symptoms. Weaning may be most safely done during school vacations or other low stress periods.

Monitoring of children and adolescents on SSRI's

- AAP and AACAP have recommended weekly monitoring of suicidality and activation in the first month of treatment and then every two weeks for the second month. Such check-ins may sometimes be performed by phone with patients and families who are assessed to be able to provide reliable information over the phone.
- Emergency planning should be reviewed including phone numbers and appropriate resources for families in area.
- Monitor depressive symptoms with structured measure at least monthly in person.

Medication vs. Therapy: the evidence

- In large study of adolescents with depression (TADS)
    - Adolescents on fluoxetine alone or in combination with CBT showed more rapid response than children receiving CBT alone after 12 weeks of treatment
    - After 9 months of treatment, all 3 groups showed equal response rates (about 80% response)
    - Take home message: children in whom a rapid response to treatment is important (e.g. more severe depression. distress), a combination of therapy and medication or medication alone is recommended
- In children < 12, the data supporting medication is weaker (ONLY found for fluoxetine) and the rates of adverse effects are higher, therefore therapy is preferable
- Children under 6: clinical experience suggests therapy is the appropriate treatment. Because of the complexities of assessing mood disorders in preschoolers, specialty assessment is recommended.

Co-morbid conditions

- Anxiety: follow depression recommendations
- ADHD: treat most impairing disorder first (if equal, start with ADHD because of more rapid response). Then reassess residual symptoms and make decision about appropriate treatment.
- Other disruptive behavior disorders- strongly encourage therapy
- Substance use- refer for specialty treatment. If depression predated the substance abuse, it is appropriate to treat depressive disorder while also addressing substance abuse disorder.
- Eating disorders- SSRIs are unlikely to be effective until not in physiologic starvation state

Summary of Medications used in treatment of depression

Medication (brand name)	Medication class	Usual starting dose (all for children > 6)	Usual titration plan	Maximum pediatric dose	Supported by RCTs?	FDA Approved for depression	Unique characteristics	Common Adverse effects	Potentially dangerous adverse effects
Fluoxetine (Prozac)	SSRI	Child: 5-10 mg Adolescent: 10-20 mg	Increase by 10 mg after 2 weeks and then again after 4 weeks	60 mg (approved in OCD)	Yes	8-18 yo	Long $t_{1/2}$ (4-6 days for fluoxetine, 9 days for active metabolite) May be more activating in first few days	GI distress Head aches Tremor Sleep disturbance Sexual dysfunction Anorexia	Suicidality Mania Serotonin syndrome Abnormal platelet function SIADH Acute angle glaucoma PPHN
Escitalopram (Lexapro)	SSRI	10 mg	Increase after 4 weeks to 20 mg	20 mg	Yes	12-18 yo	Weak CYP450 inhibitor- fewer interactions with other medications than most SSRIs		
Sertraline (Zoloft)	SSRI	Child: 12.5 mg Adol: 12.5-25 mg	May increase by doubling after 2-4 weeks	200 mg (OCD)	Yes	No	May be less activating initially		

Resources for parents:

See parentsmedguide.com.

Brief information about mood disorders for parents: AAP's healthy children.org

Summary of CBT for families: AAP's healthy children

Hamil S (2004) My feeling better workbook: Activities that help kids beat the blues. Available on Amazon.com

Chansky T (2008) Freeing Your Child from Negative Thinking: Powerful, Practical Strategies to Build a Lifetime of Resilience, Flexibility, and Happiness. Da Capo Lifelong Books. Available on Amazon.com

Prescriber reference for black box: parentsmedguide.com.

References for Depressive disorders

AACAP, *Practice Parameter for the Assessment and Treatment of Children and Adolescents With Depressive Disorder.* Journal of the American Academy of Child & Adolescent Psychiatry, 2007. 46(11): p. 1503-1526.

Gunlicks, M. and M.M. Weissman, *Change in Child Psychopathology With Improvement in Parental Depression: A Systematic Review.* Journal of American Academy of Child and Adolescent Psychiatry, 2008. 47(4): p. 379-389.

TADS Study Team, *Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression: Treatment for Adolescents With Depression Study (TADS) Randomized Controlled Trial.* JAMA: Journal of the American Medical Association, 2004. 292(7): p. 807.

Treatment for Adolescents With Depression Study Team., *The Treatment for Adolescents With Depression Study (TADS): Outcomes Over 1 Year of Naturalistic Follow-Up.* Am J Psychiatry, 2009. 166(10): p. 1141-1149.

Vitiello, B., et al., *Long-term outcome of adolescent depression initially resistant to SSRI treatment.* Journal of clinical Psychiatry, 2010. online ahead of print.

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

0 = "Not At All"

1 = "A Little"

2 = "Some"

3 = "A Lot"

However, items 4, 8, 12, and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not At All"

2 = "A Little"

1 = "Some"

0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms.

Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

See also

Tool for Families: Symptoms of Depression in Adolescents, p. 126.

Tool for Families: Common Signs of Depression in Children and Adolescents, p. 147.

REFERENCES

Weissman MM, Orvaschel H, Padian N. 1980. Children's symptom and social functioning self-report scales: Comparison of mothers' and children's reports. *Journal of Nervous Mental Disorders* 168(12):736–740.

Faulstich ME, Carey MP, Ruggiero L, et al. 1986. Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *American Journal of Psychiatry* 143(8):1024–1027.

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	_____	_____	_____	_____
2. I did not feel like eating, I wasn't very hungry.	_____	_____	_____	_____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	_____	_____	_____	_____
4. I felt like I was just as good as other kids.	_____	_____	_____	_____
5. I felt like I couldn't pay attention to what I was doing.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	_____	_____	_____	_____
7. I felt like I was too tired to do things.	_____	_____	_____	_____
8. I felt like something good was going to happen.	_____	_____	_____	_____
9. I felt like things I did before didn't work out right.	_____	_____	_____	_____
10. I felt scared.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	_____	_____	_____	_____
12. I was happy.	_____	_____	_____	_____
13. I was more quiet than usual.	_____	_____	_____	_____
14. I felt lonely, like I didn't have any friends.	_____	_____	_____	_____
15. I felt like kids I know were not friendly or that they didn't want to be with me.	_____	_____	_____	_____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	_____	_____	_____	_____
17. I felt like crying.	_____	_____	_____	_____
18. I felt sad.	_____	_____	_____	_____
19. I felt people didn't like me.	_____	_____	_____	_____
20. It was hard to get started doing things.	_____	_____	_____	_____

Health Issues

Mood Disorders

The mood disorders most likely to be experienced by children with ADHD include dysthymic disorder, major depressive disorder (MDD), and bipolar disorder. Dysthymic disorder can be characterized as a chronic low-grade depression, persistent irritability, and a state of demoralization, often with low self-esteem. Major depressive disorder is a more extreme form of depression that can occur in children with ADHD and even more frequently among adults with ADHD. Dysthymic disorder and MDD typically develop several years after a child is diagnosed with ADHD and, if left untreated, may worsen over time. Bipolar disorder is a severe mood disorder that has only recently been recognized as occurring in children. Unlike adults who experience distinct periods of elation and significant depression, children with bipolar disorder present a more complex disturbance of extreme emotional instability, behavioral difficulties, and social problems. There is significant overlap with symptoms of ADHD, and many children with bipolar disorder also qualify for a diagnosis of ADHD.

What to Look For

Every child feels discouraged or acts irritable once in a while. Children with ADHD, who so often must deal with extra challenges at school and with peers, may exhibit these behaviors more than most. If your child claims to be depressed, however, or seems irritable or sad a large portion of each day, more days than not, she may have a coexisting dysthymic disorder. To be diagnosed with dysthymic disorder, a child must also have at least 2 of the following symptoms:

- Poor appetite or overeating
- Insomnia or excessive sleeping
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness

Before dysthymic disorder can be diagnosed, children must have had these symptoms for a year or longer, although symptoms may have subsided for up to 2 months at a time within that year. The symptoms also must not be caused by another mood disorder, such as MDD or bipolar disorder, a medical condition, substance abuse, or just related to ADHD itself (low self-esteem stemming from poor functioning in school, for example). Finally, the symptoms must be shown to significantly impair your child's social, academic, or other areas of functioning in daily life.

Major depressive disorder is marked by a nearly constant depressed or irritable mood or a marked loss of interest or pleasure in all or nearly all daily activities. In addition to the symptoms listed previously for dysthymic disorder, a child with MDD may cry daily; withdraw from others; become extremely self-critical; talk about dying; or even think about, plan, or carry out a suicide attempt. Unlike the brief outbursts of temper exhibited by a child with ODD who does not get her way, a depressed child's irritability may be nearly constant and not linked to any clear cause. Her inability to concentrate differs from ADHD-type inattention in that it is accompanied by other symptoms of depression, such as loss of appetite or loss of interest in favorite activities. Finally, the depression itself stems from no apparent cause—as opposed to being demoralized as a result of specific obstacles posed by ADHD or becoming depressed in response to parental divorce or any other stressful situation. (In fact, research has shown that the intactness of a child's family and its socioeconomic status have little or no effect on whether a child develops MDD.) While children with ADHD/CD alone are not at higher than normal risk for attempting suicide, children with ADHD/CD who also have an MDD and are involved in substance abuse are more likely to make such an attempt and should be carefully watched.

Talk of suicide (even if you are not sure whether it is serious), a suicide attempt, self-injury, any violent behavior, or severe withdrawal should be considered an emergency that requires the immediate attention of your child's pediatrician, psychologist, or local hospital.

A depressed child may admit to feeling guilty or sad, or she may deny having any problems. It is important to keep in mind the fact that many depressed children refuse to admit to their feelings, and parents often overlook the subtle behaviors that signal a mood disorder. By keeping in close contact with her teacher, bringing your child to each of her treatment reviews with her pediatrician, and including her in all discussions of her treatment as appropriate to her age, you can improve the chances that her pediatrician or mental health professional will detect any signs of developing depression, and that she will have someone to talk to about her feelings.

A child with bipolar disorder and ADHD is prone to explosive outbursts, extreme mood swings (high, low, or mixed mood), and severe behavioral problems. Such a child is often highly impulsive and aggressive, with prolonged outbursts typically "coming out of nowhere" or in response to trivial frustrations. She may have a history of anxiety. She may also have an extremely high energy level and may experience racing thoughts and inflated self-esteem or grandiosity, extreme talkativeness, physical and emotional agitation, overly sexual behavior, and/or a reduced need for sleep. These symptoms can alternate with periods of depression or irritability, during which her behavior resembles that of a child with MDD. A child with ADHD/ bipolar disorder typically has poor social skills. Family relationships are often strained because of the child's extremely unpredictable, aggressive, or defiant behavior. Early on the symptoms may only occur at home, but often begin to occur in other settings as the child gets older. Bipolar disorder is a serious psychiatric disorder that can sometimes include psychotic symptoms (delusions/hallucinations) or self-injurious behavior such as cutting, suicidal thoughts/impulses, and substance abuse. Many children with bipolar disorder have a family history of bipolar disorder, mood disorder, ADHD, and/or substance abuse. Children with ADHD and bipolar disorder are at higher risk than those with ADHD alone for substance abuse and other serious problems during adolescence.

If your child has ADHD with coexisting bipolar disorder, her pediatrician will generally refer her to a child psychiatrist for further assessment, diagnosis, and recommendations for treatment.

Treatment

As with ADHD with anxiety disorders, treatment of ADHD with depression usually involves a broad approach. Treatment approaches may include a combination of cognitive-behavioral therapy, interpersonal therapy (focusing on areas of grief, interpersonal relationships, disputes, life transitions, and personal difficulties), traditional psychotherapy (to help with self-understanding, identification of feelings, improving self-esteem, changing patterns of behavior, interpersonal interactions, and coping with conflicts), as well as family therapy when needed.

Medication management approaches, as with ADHD and other coexisting conditions, include treating the most disabling condition first. If your child's ADHD-related symptoms are causing most of her functioning problems, or the signs of depression are not completely clear, your child's pediatrician is likely to start with stimulant medication to treat the ADHD. In cases when the depressive symptoms turn out to stem from poor functioning due to ADHD and not to a depressive disorder, they may diminish as the ADHD symptoms improve. If the ADHD and depressive symptoms improve, your child's pediatrician will probably maintain stimulant treatment alone. If her ADHD symptoms improve but her depression remains the same, even after a reasonable trial of the type of broad psychotherapeutic approach described previously, her pediatrician may add another medication, most commonly an SSRI—a class of medications including Prozac, Zoloft, Paxil, Luvox, and Celexa. Selective serotonin reuptake inhibitors can make the symptoms of bipolar disorder worse, so a careful evaluation must be completed before starting medication. If this approach is unsuccessful, you may be referred to a developmental/behavioral pediatrician or a psychiatrist, who may try other classes of medications.

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topic landing page

Your Adolescent - Bipolar Mood Disorder

Excerpts from *Your Adolescent* on Bipolar Mood Disorder

Some teenagers are troubled by both depressed and elevated or euphoric moods. The youngster's mood may shift suddenly from one extreme to the other; sometimes there is a rapid cycle between high and low moods. Teens with these severe mood changes may have a *bipolar mood disorder*.

Identifying the Signs
In bipolar disorders, manic episodes usually alternate with periods of depression and relatively normal moods. The manic element of bipolar or *manic-depressive* disorder is signaled by an elevated, expansive, angry, suspicious, or irritable mood lasting at least one week.

During a manic episode, a teenager irrationally distorts his view of himself and has inflated self-esteem. He may talk constantly and rapidly and have difficulty sticking to one idea or subject at a time. He is easily distracted, appears agitated and restless, and sleeps very little. Most alarming, he may engage in reckless and dangerous activities. Bipolar disturbance usually interferes with school functioning or peer and family relations.

During manic episodes, adolescents often experience psychotic symptoms such as hallucinations and delusions. They may report hearing voices or seeing visions. Intense paranoid thinking can result in belligerent or aggressive confrontations. Delusions of grandeur - during which the teen believes he has special powers or importance - can lead to dangerous behavior, such as driving fast and recklessly or jumping off roofs.

Manic teenagers tend to externalize their problems. They perceive themselves to be fine, blaming conditions or people in their environment for their difficulties.

Their behavior and appearance may make them extremely hard to tolerate. Their hygiene may suffer, and they can refuse to eat and sleep. Hyperactive, silly, giggly, or aggressive in their verbal communications, they may use profanities and make sexual comments freely during a manic episode.

In children and younger adolescents, manic episodes are often characterized by irritability and moodiness. By the time a child reaches puberty, distinct signs of euphoria, elation, paranoia, and grandiose delusions may become more apparent. As bipolar disorder is developing or evolving in a teen, sadness, mania, and agitation are often intermixed. With time, the teen may show more evidence of sever depression and mania. Other features of a manic episode may include hyperactivity, talkativeness, and excessive distractibility. When the disorder is milder, the mood disturbance is called *cyclothymic disorder*.

Causes and Consequences
Bipolar disorders tend to occur in families. In addition to the genetic component, parenting can also have a role in the disorder. As a result of their own intense moods and feelings, some parents with mood disorders have difficulty being consistent and effective in their parenting.

How to Respond
Treatment of bipolar disorders (manic-depressive illness) should begin with a full evaluation by a child and adolescent psychiatrist or other qualified professional. Due to the frequent occurrence of psychotic symptoms such as delusions and hallucinations in combination with social withdrawal, poor hygiene, irritability, and temper tantrums, bipolar disorder may be mistaken as schizophrenia in a teenager.

Individual Psychotherapy. Since bipolar disorder is a lifelong condition, it is crucial that the young person learn about the disorder and how to live with it. When identified, symptoms can be successfully treated and controlled. In addition, stressors that might precipitate symptoms can be avoided, reduced, or coped with. When coping skills are learned, these teenagers and their families can lead emotionally rich and productive lives.

Cognitive-Behavioral Therapy. Often effective in treating the ups and downs of bipolar disorder in teens, cognitive therapy focuses on the irrational beliefs and distorted thoughts that are part of the mania or depression. In dealing with periods of depression, the therapy may address the youngster's negative view of self, the world, and the future. Such negative thought patterns may have been formed or reinforced by the family environment. Cognitive therapy focuses on identifying and correcting negative distortions and on helping the teen change his thinking.

Group Therapy. Group therapy for adolescents helps them develop or improve social skills, which can lead to better feelings of mastery and improved self-esteem. Teenagers may find it easier to express feelings in a supportive peer-group environment. Support groups for parents can help them manage specific problem behaviors, use appropriately positive reinforcement, communicate with their teens in an age-appropriate manner, and become better listeners for their adolescent.

Family Therapy. Family therapy can address problems that may worsen or exacerbate bipolar disorder in adolescents: a lack of generational boundaries, severe marital conflict, rigid or chaotic rules, or neglectful or overly involved parent-child relationships. In addition, family sessions may help identify other family members with psychiatric disorders and assist them in getting their own treatment.

Medication. Once other possible causes such as substance abuse, a medication reaction, another medical condition, or another behavioral disorder have been ruled out, a mood-stabilizing medication may be proscribed. Lithium, carbamazepine (Tegretol), or valproic acid (Depakene/Depakote) are commonly prescribed. Before a teenager begins taking a medication, specific target symptoms should be identified in a discussion between the teen, the parents, and the physician. Possible side effects and other aspects of the medication should also be discussed. In some teens, antidepressants may be needed in addition to the mood stabilizer during the depressed phase, and antipsychotics may be used with the mood stabilizer during the manic phase.

Hospitalization. If recognized early, manic-depressive episodes can be treated on an outpatient basis or in a partial hospital program. When there is self-endangering behavior or aggressive behavior toward others, hospitalization may be necessary. Some teens with mania may require hospitalization to ensure their safety.

Click here to order *Your Adolescent* from Harper Collins.

The Use of Medication in Treating Childhood and Adolescent Depression:
Information for Patients and Families

Prepared by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry in consultation with a National Coalition of Concerned Parents, Providers, and Professional Associations

This revision of the original 2005 Parents Medical Guide to the treatment of depression in children and adolescents is a joint project of the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. It has been updated to include important research that has added to our knowledge about effective treatments for child and adolescent depression. Its goal is to help parents and families make informed decisions about getting the best care for a child with depression. For easy use, it is presented in Frequently Asked Questions (FAQ) format.

This updated version was developed by a workgroup of members selected by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. A list of workgroup members and their disclosures of any competing interests can be found at the end of the guide.

FAQ's

How can I advocate effectively for my child who has depression?
Where can I get additional information?
Members of the Parents Medical Guide Workgroup

What is major depression and how is it recognized in children?
Depression is a serious illness that can affect nearly every part of a young person's life and significantly impact his or her family. It can disrupt relationships among family members and friends, harm school performance and limit other educational opportunities. It can lead to other health problems through its effects on eating, sleeping, and physical activity. Because it has so many consequences, it is important that depression is recognized and treated successfully. When it is, most children can get back on track with their lives.

Major depression, or clinical depression, is a mood or "affective" disorder, a category of disorders that includes unipolar depressive disorder, dysthymia and bipolar disorder. Although depression can occur in young children, it is much more common in adolescents. Depression before puberty occurs equally in boys and girls. After puberty, depression is more common in girls.

Depression is not always easy to recognize in children. In children, symptoms of depression are often hidden by other behavioral and physical complaints—examples of which are listed below. Many young people who are depressed will also have a second psychiatric condition at the same time which can complicate diagnosis.

For a diagnosis of depression, at least five of the following symptoms must be present for a period of at least two weeks. These symptoms must also represent a change in behavior and interfere with the child's ability to function at school, at home, or with their friends.

Symptoms of Major Depressive Disorder in Adults	**Signs of Depression Frequently Seen in Youth**
Depressed mood most of the day	Irritable or cranky mood
Decreased interest/enjoyment in once-favorite activities	Boredom, loss of interest in sports, video games; giving up favorite activities
Significant weight loss/gain	Failure to gain weight as normally expected; overeating and weight gain especially in teens
Insomnia or hypersomnia	Changes in sleep patterns; delays in going to or falling asleep; refusal to wake for school; early morning awakening

Psychomotor agitation/retardation	Difficulty sitting still, pacing, or very slowed down with little spontaneous movement
Fatigue or loss of energy	Persistently tired, feels lazy
Low self-esteem; feelings of guilt	Self-critical; blaming oneself for things beyond one's control; "no one likes me, everyone hates me"; feels stupid
Decreased ability to concentrate; indecisive	Decline in performance in school due to decreased motivation and ability to concentrate; frequent absences
Recurrent suicidal ideation or behavior	Frequent thinking and talking about death; writing about death; giving away favorite toys or belongings

Other disorders that fall in the spectrum of mood disorders include dysthymia and bipolar disorder. Dysthymia is a disorder that usually has less severe symptoms than major depression, but it is more chronic and persistent. Instead of shifting into well-defined periods of depression, the child with dysthymia lives in an ongoing joyless and gray world.

Another mood disorder is bipolar disorder. It is very important to recognize and diagnose bipolar disorder because it may first appear as an episode of depression. In bipolar disorder, periods of depression may alternate with periods of mania. During these periods of mania the child will show unnaturally high levels of energy, and/or irritability. If there is a family history of bipolar disorder, it should be discussed with your child's physician as your child may require special treatment considerations. Some children and adolescents may develop mania without a family history of bipolar disorder.

Further information about bipolar disorder in children and adolescents is available on the American Academy of Child and Adolescent Psychiatry website: http://www.aacap.org/cs/root/facts_for_families/bipolar_disorder_in_children_and_teens

What are the treatments for depression?

There are a number of different treatments for depression. These include various forms of psychotherapy, medication, working with the family or a combination of these.

Treatment can also include work with the child's school and/or having the child get involved with peer support or self-help groups.

Your child's physician should develop a comprehensive treatment plan that deals with your specific situation, your child's needs, and the recommended treatment approaches. Your physician should also fully discuss with you and your child the risks and benefits of the treatment plan.

Are antidepressant medications effective for the treatment of child/adolescent depression?

Yes, antidepressant medications can be effective in relieving the symptoms of depression for some children and adolescents. One antidepressant--fluoxetine, or Prozac–a medicine in the category of selective serotonin reuptake inhibitors, or SSRI's, has been approved by the FDA for treating depression in children 8 years of age and older. Escitalopram, or Lexapro has also been approved by the FDA for treating adolescents 12 years of age and older. Your physician may prescribe other antidepressant medications as well. You should know that prescribing an antidepressant that has not been approved by the FDA for use with child and adolescent patients (referred to as off-label use or prescribing) is common and consistent with general clinical practice. Atypical antipsychotics, however, are not approved by the FDA for the treatment of depression in children and adolescents and are not considered appropriate for first-line treatment. As generally used, tricyclic antidepressants (e.g. imipramine, amitriptyline) have not been shown to be effective for pediatric depression and they should not be used as the first treatment.

About 60 percent of children and adolescents will respond to initial treatment with medication. Of those who don't, a significant number will respond to another medication and/or to the addition of a form of psychotherapy called cognitive behavioral therapy (CBT).

An important study--the Treatment for Adolescents with Depression Study (TADS) funded by the National Institute of Mental Health (NIMH), and published in 2004 examined three different treatments for adolescents with moderate to severe depression.

• One treatment used the antidepressant medication fluoxetine, or Prozac.

• Another effective treatment used CBT. CBT helps a patient recognize and change negative patterns of thinking and behavior that are associated with depression.

• The third approach used a combination of medication and CBT.

Each of these treatments was compared to taking a placebo or sugar pill. After 12 weeks of treatment, 71 percent of the patients who received the combination of medication and CBT were much improved. This combined treatment was nearly twice as good in

relieving depression as taking a placebo. About 35% of people who took a placebo showed improvement and 43% of those who received psychotherapy improved. In those who received medication alone, 61% improved. Combined treatment also resulted in better functioning and quality of life. It is the preferred treatment for speedier responses across a broad range of outcomes such as remission and recovery of function. [1,2]

Although all three treatment approaches reduced the frequency of suicidal thinking and behavior, fluoxetine treatment alone was associated with increased suicidal thoughts and behavior when compared to treatment with placebo or psychotherapy alone. However, after three months of treatment, the number of young people experiencing such thoughts and behaviors dropped substantially. There were no completed suicides by any of the adolescents who received one of the three treatments.

This research shows that medication can be an important and valuable treatment for depression in children and adolescents. Importantly, combined treatment may also protect against suicidal thoughts and/or behaviors in patients taking an antidepressant. This effect, however, has not been shown in all the studies that have tested combination treatment against medication treatment alone. [3,4,5]

Are treatments other than medication available for children with depression?
Various forms of psychotherapy, including cognitive behavioral therapy (CBT) and interpersonal therapy (IPT) are helpful for treating mild to moderate forms of depression. CBT tries to help a patient recognize and change negative patterns of thinking and behavior that may contribute to depression. IPT guides the patient to problem solving approaches to damaged interpersonal relationships that can both cause and result from depression.

What is cognitive behavioral therapy (CBT)?
Depressed people think in ways that contribute to their depression and they avoid activities that could reduce their depression. This can make depressive symptoms worse. CBT tries to help patients recognize their negative thoughts and help them to participate in activities that can reduce their symptoms. CBT uses techniques such as problem solving, managing negative emotions, and improving social effectiveness.

CBT has been studied more with depressed adolescents than with depressed children. Several of these studies have shown that CBT is superior to some other forms of psychotherapy in relieving depression. One study that compared treatment with CBT and treatment with medication showed that while medication worked faster, by 16 weeks those treated with CBT were doing just as well as those treated with medication. Most studies have found that for more severe or ongoing depression, the combination of CBT and medication is the fastest and most effective approach.

CBT may be particularly helpful for depressed adolescents who have other psychiatric problems such as anxiety disorders. It may not work as well for those with a history of trauma or abuse. It also does not work as well if the child's parent is currently depressed,

unless that parent is also treated. Older adolescents seem to do better with a treatment approach that is based on the treatment of adults.

CBT has been used with younger children, but mostly to prevent depression or to treat children with milder symptoms. Because CBT is helpful for children with anxiety disorders, it may--with some modifications--also help younger children with depression.

CBT requires specific training. If a therapist presents him or herself as a CBT therapist, parents should ask what type of CBT training the therapist has had.

Will my child's depression pass without treatment?

If depression is untreated, it often lasts from six to nine months, an entire school year for most children. But, if it is not treated it can have serious consequences. It increases the risk for substance abuse, eating disorders, adolescent pregnancy, and suicidal thoughts and behaviors. Children are also likely to have ongoing problems in school, at home, and with their friends. Also, the child runs the risk of developing a chronic and more difficult-to-treat depression. Once a child or adolescent has one period of depression he or she is more likely to get depressed again. For further information, AACAP's Practice Parameters on Depression may be accessed at the website: http://www.aacap.org/galleries/PracticeParameters/Vol%2046%20Nov%202007.pdf

How long should my child continue taking antidepressant medication?

Even when a patient is in remission (having no or minimal depressive symptoms) the same treatment should be continued for another 6 to 9 months. This is to help prevent relapse. This recommendation is based on a National Institute of Mental Health sponsored study of depressed children and adolescents. Patients in this study who improved after 12 weeks of fluoxetine treatment and who continued their treatment relapsed less often than patients who were switched to placebo. (Forty-two percent of the fluoxetine treatment group had a return of depressive symptoms compared to 69% for the placebo group). [(6)] If depressed teens who improved with fluoxetine continued on a combination of fluoxetine plus CBT, even a higher proportion of them remained well compared to those who got fluoxetine alone. [(7)]

Because the risk of relapse remains high even with continued antidepressant treatment, it is very important for patients, families, and doctors to see if depressive symptoms begin again after remission, and to take appropriate steps if they do.

Some young people may need treatment for longer than 6-9 months. Youth who have a family history of mood disorders, severe and complex episodes of depression, a slow and difficult response to treatment, a history of chronic depression, and/or multiple depressive episodes may benefit from continuing treatment for 1-2 years or more. In one study, 38% of depressed adolescents who were in remission, but who continued to receive the SSRI sertraline (Zoloft), for an additional year remained well. None of the adolescents in remission who stopped the medication and received a placebo instead stayed well. [(8)] We don't know yet which patients are most likely to benefit from longer treatment. Your

child's doctor will work with you and your child to determine the best time to stop antidepressant treatment.

What can be done if my child does not improve with medication?
Most young people with depression (about 60 percent) will improve when treated with an SSRI antidepressant. But about 40% of them will not improve when first treated in this way.

The Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) study examined other treatment options for adolescents who do not get better when first treated with an SSRI. Four different treatment groups were studied. One group received a SSRI that was different from the first one they tried, the second group received an antidepressant medication that was not an SSRI (venlafaxine-Effexor), the third group received the different SSRI combined with cognitive behavioral (CBT) therapy, and the fourth group, the non-SSRI medication and CBT. The teenagers who were switched to another medication combined with CBT psychotherapy showed the most improvement. The combined medication-CBT treatment was also more effective than medication-alone treatments. A switch to another SSRI was just as effective as a switch to venlafaxine, but with fewer side effects. [(9)]

These results are encouraging for adolescents who do not initially respond to treatment with an SSRI. Their symptoms may improve if they are switched to another SSRI combined with CBT. There may be less improvement if they are switched to just another antidepressant. Before trying a different treatment, though, it is important to give enough time to see if the initial treatment works, at least 6-8 weeks.

If there is not enough of a positive response to the first treatment, changing medication, adding psychotherapy, or combining both should be considered. For many adolescents, the best treatment will be a combination of individual psychotherapy and medication.

Further information on the Treatment of SSRI-resistant Depression in Adolescents is available on the NIMH website:
http://www.nimh.nih.gov/trials/practical/tordia/treatment-of-ssri-resistant-depression-in-adolescents-tordia.shtml

Do antidepressants increase the risk of suicide?
Suicidal thoughts and behaviors are more common during adolescence than at any other time, but suicide is more common among adults. In any year about 16 percent of high school students think about suicide and about 3-8 percent show suicidal behaviors. Fortunately, very few of them commit suicide. Children and adolescents with depression are much more likely to think about suicide and to attempt it than other children. Although not all suicidal children have depression, untreated depression increases the risk of suicide.

The Food and Drug Administration (FDA) described an increase in reports of suicidal thoughts and/or behaviors in children and adolescents taking antidepressants. But, there were no suicides in the cases they studied. Autopsies of teenagers who have committed suicide show that very few of them had traces of an antidepressant, making the link between antidepressant use and suicide even weaker.

Between 1992 and 2001, there was a large increase in the number of adolescents being prescribed SSRI antidepressants. But, during that time the rate of suicide among American youth ages 10–19 actually dropped by more than 25 percent. This was the first time in nearly 50 years that the suicide rate declined in young people.

What factors other than depression increase the risk of suicide in children and youth?

There are risk factors for suicide besides depression, although depression is the most common diagnosis in adolescents with completed suicide. Often, particularly in boys, completed suicide is associated with depression, conduct disorder, and substance abuse. Sometimes, boys who commit suicide have the latter two without a mood disorder. Anxiety disorders are also common in youth who commit suicide, but almost always in combination with a mood disorder. Depression alone is a bigger contributor to suicide in girls than in boys.

Youth who commit suicide often have difficulty managing their emotions and they commonly make impulsive and risky decisions. Other risk factors for completed suicide include having access to a gun in the house, having made a previous suicide attempt with high suicidal intent and having combinations of a mood disorder along with conduct disorder or substance abuse. [10]

Repeated suicide attempts increase the risk for a completed suicide. Parents should be very alert to repeated attempts. Suicide attempts that are discovered by accident are very serious. They suggest that the young person had a strong wish to die and timed their suicide attempt to decrease the chance of it being discovered.

Another group of teenagers who commit suicide appear to be hard working, careful, and popular. They may do well at their studies and in sports. Often, they appear to be perfectionists. Even though they perform well, they may become very anxious and pessimistic before taking a test or before important events. These young people may be

suffering from an undiagnosed anxiety disorder. They are afraid of doing badly and before a feared event they may go without sleep and seem very preoccupied. Because they seem to perform so well, their death by suicide is often deeply puzzling to their family, teachers, and friends.

Treatment for children and adolescents with depression must include frequent monitoring for suicidal thoughts or behavior, especially during the first 6 weeks of treatment, when suicidal events are most likely to occur. Any child or adolescent who admits to thoughts about suicide or who attempts suicide should receive a comprehensive psychiatric assessment, which should be included in an overall treatment plan. Parents should not be in the position of deciding whether their child's suicidal thoughts or actions pose an imminent danger.

The death of a child by suicide is always a tragedy, but it is important to remember that suicidal thoughts and actions lessen with appropriate treatment. Early recognition and access to effective treatment are essential keys to reducing suicide in children and youth. Since depression is often a major contributor to completed suicide, it is worth considering treating depression with antidepressant medication particularly if combined with cognitive behavioral therapy (CBT), since the combination treatment results in the fastest and most complete response.

Does talking about suicide increase the likelihood that a child will hurt him/herself?
Any expression of suicidal thoughts or feelings by a child or adolescent is a clear signal of distress and should be taken very seriously by health care professionals, parents, family members, teachers, and others.

When a young person talks about suicidal thoughts, there is an opportunity to discuss the need to take special precautions and/or protective measures. Any treatment approach that increases discussion of previously unspoken suicidal thoughts or impulses is helpful. It is much more worrisome and dangerous for a young person with depression to hide the fact that he or she is having suicidal thoughts. The data demonstrate that asking a youth about suicidal ideas does not increase the risk for suicide. Indeed, such questions can help identify adolescents at risk so that appropriate interventions can be implemented. (11)

How can I help monitor my child during treatment?
Since some children and teens may have physical and/or emotional reactions to antidepressants, parents should be attentive to signs of increased anxiety, agitation, panic, aggressiveness, or impulsivity. Your child may experience involuntary restlessness, or an unwarranted elation or energy accompanied by fast, driven speech and unrealistic plans or goals. These reactions are more common at the start of treatment, although they can occur at any point in treatment. If you see these symptoms, consult your doctor immediately. It may be necessary to adjust the dosage, change to a different medication, or to stop using medication.

In a small number of instances, a child or adolescent might have extreme reactions to antidepressants as a result of genetic, allergic, drug interactions, or other unknown factors. Whenever you observe any unexpected symptoms in your child, immediately

contact the child's doctor.

Some children and adolescents may experience weight gain while taking antidepressants and as a result, may want to stop taking their medication. If weight gain becomes a concern, it should be discussed with your child's doctor.

While regular doctor's appointments are important, the frequency of monitoring should be suited to the needs of the child and family. If you and your child's physician do not see evidence of improvement in your child's health within 6-8 weeks, your doctor should reevaluate the treatment plan and consider changes.

Since depression increases the risk for suicide, precautions for suicide prevention should be put in place if a child, or any family member, has depression.

• Lethal means of suicide, such as guns should be removed from the house, and large quantities of dangerous medications, including over-the-counter drugs, should not be left in an accessible location.

• Families should work in consultation with their child's physician or other mental health professional to develop an emergency action plan, called a "safety plan," that is a planned set of actions for you, your child, and your doctor to take if and when your child has increased suicidal thinking. This should include access to a 24-hour number available to deal with crises.

• If your child voices new or more frequent thoughts of wanting to die or to hurt him- or herself, or takes steps to do so, you should implement the safety plan, and contact your child's doctor immediately.

What is a black box warning?

A "black box warning" is a cautionary label placed on some medications. The Food and Drug Administration (FDA) uses it to alert prescribing doctors and patients that special care should be taken using a medication. Black box warnings may apply to patients with particular medical conditions, or to patients within a certain age range.

The FDA decided to attach such a "black box warning" to all antidepressant medications used to treat depression and other disorders such as anxiety and obsessive-compulsive disorder (OCD) in children and adolescents.

In 2007 this warning was extended to young adults 18-24 years of age. This label states that antidepressant medications are "associated with an increased risk of suicidal thinking and/or behavior in a small proportion of children and adolescents, especially during the early phases of treatment."

The FDA did not ban the use of antidepressant medications for youth. The purpose of the warning was to alert physicians and parents to watch children and adolescents to see if their symptoms got worse, or if they showed unusual changes in behavior. The FDA also specifically said that "depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions".

Why did the FDA issue a black box warning?
In 2004, the FDA reviewed 23 clinical trials involving more than 4,300 child and adolescent patients. These patients received any of nine different antidepressant medications. No suicides occurred in any of these studies.

All of the studies the FDA reviewed measured suicidal thinking and behavior by using "Adverse Event Reports." These report the spontaneous sharing of thoughts about suicide or potentially dangerous behavior made by a patient (or reported by the patient's parent). Such "adverse events" were reported by approximately 4 percent of all children and adolescents taking medication, compared with 2 percent of those taking a placebo.

A more recent study found that the risk was even smaller—around 3% in those on medication and 2% in those on placebo. Most of these events were increases in suicidal thoughts. Only a few were actual suicide attempts, and NONE were suicide completions. [12)]

Through careful monitoring, the development of a safety plan, and the combination of medication with psychotherapy, the risks for increased suicidal thoughts can be managed. For moderate to severe depression, there is benefit in the use of medication because of a higher rate of relief, and more complete relief, from depressive symptoms than not using any medication.

Since the FDA issued the black box warning, there has been a decline in antidepressant use, but an increase in completed suicides in adolescents in both the US and the Netherlands. Although it is not yet clear how these trends may be related, this has been the first increase in the adolescent suicide rate reported in over a decade. [(13)]

Can my child continue taking prescribed antidepressant medication?
If your child is being treated with a medication and is doing well, he or she should continue with the treatment for at least 6-9 months under the guidance of the prescribing physician. Research suggests that any increased risk of suicidal thoughts or behaviors is most likely to occur during the first three months of treatment, with some studies showing that the risk is highest in the first 3-6 weeks. Teens especially should know about this possibility, and the patient, parents, and physician should discuss a safety plan – for example, whom the child should immediately contact – if thoughts of suicide occur.

No patient should abruptly stop taking antidepressant medications. Suddenly stopping

medication raises the possibility of negative withdrawal effects such as agitation or increased depression. If you are thinking of changing or stopping your child's antidepressant treatment you should always consult with your child's physician before taking such action.

How can I advocate effectively for my child who has depression?
You have the right to any and all information available about the nature of your child's illness, the treatment options, and the risks and benefits of treatment. Make sure your child receives a comprehensive evaluation. Ask lots of questions about the diagnosis and any proposed course of treatment. If you are not satisfied with the answers or the information you receive, it is perfectly acceptable to seek a second opinion. Help your child or teenager learn about depression, in an age-appropriate way, so he or she can be an active partner in treatment.

It is always important to discuss and develop a personalized treatment approach with your health care provider and to weigh and balance the various risks and benefits of treating your child for depression.

ENDORSERS:
American Academy of Child and Adolescent Psychiatry (www.aacap.org)
American Association of Suicidology (www.suicidology.org)
American Foundation for Suicide Prevention (www.afsp.org)
American Psychiatric Association (www.psych.org)
American Society for Adolescent Psychiatry (www.adolpsych.org)
Child and Adolescent Bipolar Foundation (www.cabf.org)
Depression and Bipolar Support Alliance (www.dbsalliance.org)
Families for Depression Awareness (www.familyaware.org)
National Alliance for the Mentally Ill (www.nami.org)
National Association of Psychiatric Health Systems (www.naphs.org)
Mental Health America (www.mentalhealthamerica.net)
Society for Adolescent Medicine (www.adolescenthealth.org)
Suicide Awareness Voices of Education (www.save.org)
Suicide Prevention Action Network (www.spanusa.org)

Where can I get further information?
You may want to visit the AACAP Resource Center on Depression website, http://www.aacap.org/cs/Depression.ResourceCenter and/or the National Institute of Mental Health website, http://www.nimh.nih.gov/index.shtml

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Disclaimers:
The information contained in this guide is not intended as, and is not, a substitute for professional medical advice. All decisions about clinical care should be made in consultation with a child's treating physician.

No pharmaceutical funding was used in the preparation and maintenance of this guide or the Web site ParentsMedGuide.org.

After reviewing the Medication Guide for Treating Depression, please help us better serve your needs and the needs of others by completing a brief opinion survey. Your feedback on the guide is essential for us to provide accurate and helpful information about child and adolescent depression. Click **HERE** to begin the survey. Thank you!

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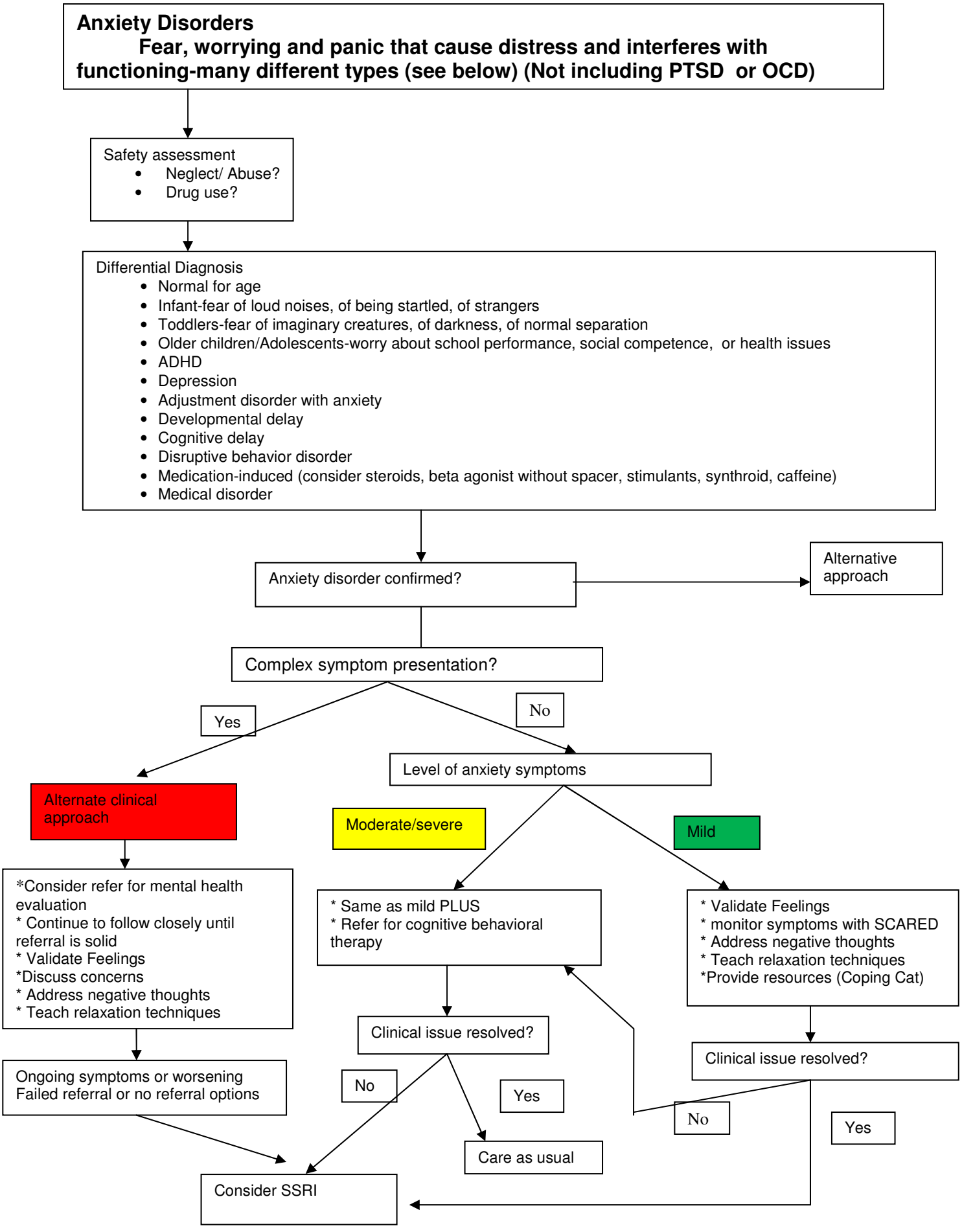
APPENDIX
List of Disclosures

Anxiety Disorders


Anxiety Disorders
Fear, worrying and panic that cause distress and interferes with functioning-many different types (see below) (Not including PTSD or OCD)
Safety assessment
Neglect/ Abuse?
Drug use?
Differential Diagnosis
Normal for age
Infant-fear of loud noises, of being startled, of strangers
Toddlers-fear of imaginary creatures, of darkness, of normal separation
Older children/Adolescents-worry about school performance, social competence, or health issues
ADHD
Depression
Adjustment disorder with anxiety
Developmental delay
Cognitive delay
Disruptive behavior disorder
Medication-induced (consider steroids, beta agonist without spacer, stimulants, synthroid, caffeine)
Medical disorder
Anxiety disorder confirmed?
Alternative approach
Complex symptom presentation?
Yes
No
Alternate clinical approach
Level of anxiety symptoms
Moderate/severe
Mild
*Consider refer for mental health evaluation
* Continue to follow closely until referral is solid
* Validate Feelings
*Discuss concerns
* Address negative thoughts
* Teach relaxation techniques
* Same as mild PLUS
* Refer for cognitive behavioral therapy
* Validate Feelings
* monitor symptoms with SCARED
* Address negative thoughts
* Teach relaxation techniques
*Provide resources (Coping Cat)
Clinical issue resolved?
Clinical issue resolved?
Ongoing symptoms or worsening
Failed referral or no referral options
No
Yes
No
Yes
Care as usual
Consider SSRI

Anxiety disorders in children

How much anxiety is "normal" for a child?

Fears and worries in children can be common and developmentally appropriate. Infants, for example, are easily startled and, later on, develop a transient fear of strangers. Toddlers typically fear darkness, imaginary creatures, and being separated from their caretakers. School-age children tend to worry about injury, death, and natural events such as storms. Pre-adolescents and adolescents typically experience anxiety around school performance, social status, and health issues. Developmentally appropriate fears become problematic if they do not subside with time, or if they are severe enough to impair a child's day-to-day functioning.[1]

Anxiety disorders are the most common type of mental health disorder in children, affecting nearly 13 percent of young people and 40 million American adults. Overall, nearly one quarter of the population will experience an anxiety disorder over the course of their lifetimes.[2]

Although children and adolescents with anxiety are capable of leading healthy successful lives, left undiagnosed, youth with anxiety disorders can fail in school, increase family stress and disruption, and have problems making or keeping friends. To avoid these harmful consequences, early identification and treatment are essential.[1]

What are the signs and symptoms of anxiety?

Children and adolescents with anxiety generally voice a specific worry or fear, which they may not realize is excessive or unreasonable. They can also present with a physical complaint, such as stomachache or headache. Clinicians diagnose specific anxiety disorders by examining the context in which a child's anxiety symptoms occur.

- Children with **Generalized Anxiety Disorder** experience chronic, excessive anxiety about multiple areas of their lives (e.g., family, school, social situations, health, natural disasters).
- Children with **Separation Anxiety** experience excessive fear of being separated from their home or caretakers.
- Children with **Specific Phobia** fear a specific object or situation (e.g., spiders, needles, riding in elevators).
- Children with **Social Phobia** experience anxiety in social settings or performance situations.

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

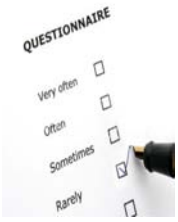
◦ Children with **Panic Disorder** experience unexpected, brief episodes of intense anxiety without an apparent trigger, characterized by multiple physical symptoms (e.g., shortness of breath, increased heart rate, sweating).

◦ Children with **Obsessive-Compulsive Disorder** perform repetitive mental acts or behaviors ("compulsions") to alleviate anxiety caused by disturbing thoughts, impulses, or images ("obsessions").

◦ Children with **Post-Traumatic Stress Disorder** experience anxiety symptoms (e.g. nightmares, feelings of detachment from others, increased startle) following exposure to a traumatic event. [1]

Differential Diagnosis of Anxiety Disorders:

Attention Deficit Hyperactivity Disorder
Child Abuse & Neglect
Hyperthyroidism/ Hypothyroidism/ Thyroiditis
Major Depressive Disorder
Bipolar Disorder
Dysthymia
Oppositional Defiant Disorder
Somatoform Disorder
Pervasive Developmental Disorder
Selective Mutism
Substance Abuse or Dependence
Communication Disorder, Not Otherwise Specified
Learning Disability
Adjustment Disorder
Another Anxiety Disorder



Assessment strategies:

<u>Universal Screening:</u>

- Pediatric Symptom Checklist or other broad-band screener. Attend to "2"'s on items related to aggressive or oppositional behaviors.
- Included in resource book.

- Youth Self Reports (YSR)
  - Provides self-ratings for 20 competence and problem items paralleling those of the Child Behavior Checklist (CBCL)/Ages 6-18.
  - Youths rate themselves for how true each item is now or was within the past six months, using the same three-point response scale as the CBCL/Ages 6-18.
  - Not included in resource book.

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

Symptom specific measure:

- Screen for Child Anxiety Related Emotional Disorders (SCARED)
  - Ages 8-18 years
  - Designed to measure anxiety symptoms from both the child and parent point of view
  - 71-item questionnaire; for each item, the youth or parent both choose the response that best describes how the child has been feeling during the past three months
  - Scores above 33 commonly indicate high anxiety while scores under 33 indicate less severe anxiety
  - Included in resource book

History:

- Include history from child and parent (with symptoms focused on red flags for each specific disorder, listed below)
- Rule out major changes in family or educational setting
- Ask about new exposures
- Explore parenting style, consequences for anxious behaviors
- Explore parental anxiety/depression/other psychopathology, which may contribute to child's coping style

Red flags for anxiety disorders:

- Symptoms are developmentally inappropriate, cause functional impairment, or excessive distress[3]

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

Generalized Anxiety Disorder	Separation Anxiety Disorder	Panic Disorder	Obsessive Compulsive Disorder	Social Phobia	Post-Traumatic Stress Disorder
Symptoms are present for a 6 month period	Symptoms last more than 4 weeks	Symptoms persisting for more than 1 month	Obsession/compulsions take up more than 1 hour a day and interfere with functioning	Symptoms are present for a 6 month period	Acute: symptom duration of more than 1 month, up to 3 months Chronic: symptom duration of more than 3 months
Excessive, unrealistic fears about day-to-day activities "What if" concerns that span far into the future Uncontrollable worry about multiple situations; performance, social, academic, health, financial Unable to unwind, headaches, stomachaches Difficulty concentrating, always thinking of what is next Need for reassurance and approval Fear of criticism, fear of making mistakes Feels that tragedies are preventable by worry, and if disaster happens feel it's their fault Worry that everything is contagious by association; divorce, illness, car accidents	Extreme, excessive distress upon routine separations from home, parents, and/or loved ones Crying, clinging, panic disorganization upon or in anticipation of separation Worry about losing or possible harm befalling parents or family members Fears of getting kidnapped or lost Great difficulty separating at night, may attempt to sleep with parent or sibling Somatic symptoms when separation occurs, or in anticipation of separations Inability to be alone; shadows parents around the house- even to the bathroom Inability to be on a separate floor from parent Disinterest in social activities; preference to be with parent Nightmares about harm, danger, death, separation Great difficulty tolerating disapproval of parent Panics if parent is late for a pick up; needs frequent reassurance about pick up plan	A sudden surge of anxiety that appear out of the blue and peak within 10 minutes Surge of physical symptoms- dizziness, feeling faint, heart racing, tingling in extremities, stomach ache Fear that you are going to have a heart attack or go crazy or lose control in some way; children may fear crying hysterically, throwing up, or losing control of bowels Feeling unreal as if in a movie or detached from one's own body Avoidance of situations for fear of panic attack	Intrusive thoughts, images, impulses that make no sense Child fears that he or she may be going crazy because of strangeness of thoughts Repetitive behaviors; excessive washing, checking, redoing, counting, tapping to relieve anxiety Interference with functioning: child late to school, unable to get dressed for redoing, unable to complete HW due to erasing, rewriting, or rereading	Fears of being humiliated, embarrassed or laughed at in everyday situations Avoids social contact or endures with great distress Avoid eye contact or conversation with others May be terrified of using the telephone, ordering in restaurants eating in cafeteria May be unable to raise hand in class, do book reports or presentations, or ask for help Avoidance of gym class or using public bathrooms Exposure to the feared situation provokes anxiety Anxiety may present as panic symptoms or for younger children temper tantrums, freezing, crying, or shirking from contact	Re-experiencing of the event through flashbacks, nightmares, intrusive thoughts, repetitive play with trauma related themes, intense distress when exposed to reminders of the trauma, a feeling that the trauma is recurring Increased anxieties, especially at night or upon separation Irritable, easily set off Avoidance of thoughts, feelings, reminders associated with the trauma Decreased interest in previously significant activities (sports, friends) Emotional regression (thumb sucking or loss of acquired developmental skills) Detachment from others, restricted emotional affect, anger, aggressive play Sense of foreshortened future Increased physiological arousal; sleep disturbance, increased startle response, irritability, difficulty concentrating, hyper vigilance

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf 3http://www.worrywisekids.org/anxiety/index.html

Physical examination/observations:

Somatic complaints:

- Always assess interactions with you and parents/caregivers
- Stomachaches
- "Lump in the throat"/trouble swallowing
- Nausea

Physical Signs:

- Rapid heart rate
- Sweating
- Diarrhea
- Twitching/muscle soreness
- Shortness of breath
- Headaches
- Irritability
- Sleep problems/fatigue
- Chapped or cracked skin (over washing in OCD)
- Repetitive movements (subtle movements that may indicate ritual behaviors)

Labs to consider:

- Thyroid studies (especially if there is tachycardia, weight loss, or weight gain)
- Urine drug screen
- CBC with differential

Referrals to consider:

- Cognitive testing or developmental testing (to rule out specific learning disabilities or developmental delays)
- Hearing screen (if concerned about deafness or speech & language)
- Functional behavioral assessment: can request through the school or a psychologist (to aid with development of specific behavioral plans at home or school)

Safety issues in anxiety disorders:

- Inquire about suicidal thoughts/ideation
- Ask about bullying at school
- Rule out child abuse/neglect scenarios
- Adolescent substance abuse

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

Primary care interventions for anxiety disorders:

• Have parents practice relaxation techniques at home as recommended by the clinician (Please see relaxation therapy handout).

• Consult with teachers and school psychologists so that the child's special needs can be meet in school.[2]

Specific strategies that can be used at home include:

• Be predictable regarding routines and schedules.

• Provide support and comfort, remembering to encourage all of the child's efforts.

• Never ridicule or criticize the child for becoming anxious. Although there may be no logical danger, these feelings are real to the child.

• While avoiding coercion, it is important not to enable the child in avoiding their fears. This can be accomplished by breaking up large tasks into smaller, more manageable steps.

• Avoid constantly reaffirming to your children that everything will be okay. It is important that they learn that they are capable of reassuring themselves and devise ways to do so.

• Do not attempt to eliminate all anxious situations for your child. Children with anxiety disorders must learn that it is normal to experience some anxiety.

• Create a mutual plan with the child to address their needs, letting the youth set the pace for their recovery. [2]

Indicators for specialty referral:

- Unsafe thoughts or behaviors (suicidal ideation/homicidal ideation with a clear plan to harm themselves or someone else); referral to ER/mental health for safety assessment
- Unresponsive to primary care interventions
- Extreme family distress/parental mental health problems

Treatments used in anxiety disorders:

- Cognitive Behavioral Therapy (CBT) is the most common and empirically-supported treatment for youth anxiety disorders
    - A typical CBT program involves anxiety management skill training and exposure interventions for the child & parent (when appropriate).
    - Anxiety management skill training involves psycho-educational interventions (i.e. providing information about how the body physiologically reacts to anxiety), relaxation exercises (breathing techniques, progressive muscle relaxation) and

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

cognitive skills (identifying thinking errors).
  - Exposure interventions help the child or adolescent systematically confront his or her fears in a planned manner (graded exposures).
  - One evidence based CBT program is Coping Cats. A sixteen session cognitive behavioral therapy for children 8-13 years of age and 14-17 years of age. Coping cats can be obtained at the following website: http://www.workbookpublishing.com/anxiety.html. The coping cat program should be administered by a trained therapist.

- Medications: adapted from AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders (2007)
  - SSRI's (selective serotonin reuptake inhibitors) should be considered for the treatment of youth with anxiety disorders when symptoms are moderate-severe or impairment makes participation in psychotherapy difficult.
  - There is no empirical evidence that a particular SSRI is more effective than another.
  - There are no specific dosing guidelines: start low, monitor for side effects, and increase the dose slowly on the basis of treatment response and tolerability.
  - The safety and efficacy of medications other than SSRI's for the treatment of childhood anxiety disorders have not been established.

Commonly used SSRI's (should be gradually started and gradually tapered)

Medication (Brand Name)	Medication Class	Usual Starting Dose	Usual Titration	Maximum Pediatric Dose	Supported by RTC's?	FDA Approved for Anxiety	Commonly Adverse Side Effects	Potentially Dangerous Side Effects
Fluoxetine (Prozac)	SSRI	Start 5-10mg PO Daily	Increase by 5-10mg q week	20-30mg/day in lower weight patients; 20-80mg in adolescents	Yes	No; Yes for children with Obsessive Compulsive Disorder ages 7 and up	Nausea Headache Insomnia Anxiety Dyspepsia Dizziness Diarrhea	Suicidality Serotonin Syndrome Mania Abnormal bleeding
Sertraline (Zoloft)	SSRI	Start 12.5mg-25mg (lower weight children) or 25-50mg PO Daily	Increase by 12.5-25mg (lower weight children) or 25mg-50mg q week	200mg/day	Yes	No; Yes for children with Obsessive Compulsive Disorder ages 6 and up	Nausea Headache Insomnia Anxiety Dyspepsia Dizziness Diarrhea	Suicidality Serotonin Syndrome Mania Abnormal bleeding
Fluvoxamine (Luvox)	SSRI	Start 25mg po qhs	Increase by 25mg q4-7days	200mg/day	Yes	No; Yes for children with Obsessive Compulsive Disorder	Nausea Headache Insomnia Anxiety Dyspepsia Dizziness Diarrhea	Suicidality Serotonin Syndrome Mania Abnormal bleeding

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

Resources/links:

Websites parents may find helpful:

The Anxious Child – Handout for parents created by the American Academy of Child and Adolescent Psychiatry.
http://www.aacap.org/publications/factsfam/anxious.htm

Bright Futures - Tips for Parenting the Anxious Child —Free handout for parents.
http://www.brightfutures.org/mentalhealth/pdf/families/mc/tips

Freedom from Fear details strategies family members can use when a relative is diagnosed with an anxiety disorder.
http://www.freedomfromfear.org/aanx_factsheet.asp?id=27

Massachusetts General Hospital School Psychiatry Program and MADI Resource Center provides a wealth of information on anxiety disorders, with specific information on symptoms, treatments, and interventions for families, educators and clinicians.
http://www.massgeneral.org/conditions/default.aspx#

Worry Wise Kids lists the red flags that can alert parents to each individual anxiety disorder and details the steps parents can take if they suspect their child suffers from an anxiety disorder and supplies parenting tips for helping anxious youth.
http://www.worrywisekids.org

1http://www.aacap.org/cs/anxiety_disorder_resource_center/anxiety_disorder_faqs
2http://www.childrensmentalhealthmatters.org/Family%20Resource%20Kits/Anxiety%20Families.pdf
3http://www.worrywisekids.org/anxiety/index.html

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

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

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

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)

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

SCORING:

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

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

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

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

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

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

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

SELF-REPORT FOR CHILDHOOD ANXIETY RELATED DISORDERS (SCARED)

<u>CHILD FORM</u> (8 years and older*)

Name:_____ Date: _____

Identification #: _____

Below is a list of items that describe how people feel. For each item that describes you, please circle the **2** if the item is **very true or often true** of you. Circle the **1** if the item is **somewhat or sometimes true** of you. If the item is **not true** of you, please circle the **0**. Please answer all items as well as you can, even if some do not seem to concern you.

0 = Not true or hardly ever true
1 = Somewhat true or sometimes true
2 = Very true or often true

1	When I feel frightened, it is hard to breathe.	0 1 2
2	I get headaches when I am at school.	0 1 2
3	I don't like to be with people I don't know well.	0 1 2
4	I get scared if I sleep away from home.	0 1 2
5	I worry about other people liking me.	0 1 2
6	When I get frightened, I feel like passing out.	0 1 2
7	I am nervous.	0 1 2
8	I follow my mother or father wherever they go.	0 1 2
9	People tell me that I look nervous.	0 1 2
10	I feel nervous with people I don't know well.	0 1 2
11	I get stomach aches at school.	0 1 2
12	When I get frightened, I feel like I am going crazy.	0 1 2
13	I worry about sleeping alone.	0 1 2
14	I worry about being as good as other kids.	0 1 2
15	When I get frightened, I feel like things are not real.	0 1 2
16	I have nightmares about something bad happening to my parents.	0 1 2
17	I worry about going to school.	0 1 2

PLEASE COMPLETE THE NEXT PAGE

0 = Not true or hardly ever true 1 = Somewhat true or sometimes true
2 = Very true or often true

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

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

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

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 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 under stress, so one knows how to do it when stressed.

Breathing Control:

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

Progressive Muscle Relaxation:

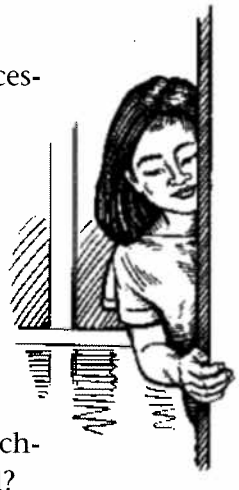
This is particularly helpful for kids who experience body aches along with stress/anxiety. It is easier to have someone guide a child through this the first few times until the technique is learned. Tell kids this is like learning to turn their muscles from uncooked spaghetti into cooked spaghetti.

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

Robert Hilt, MD

Tips for Parenting the Anxious Child

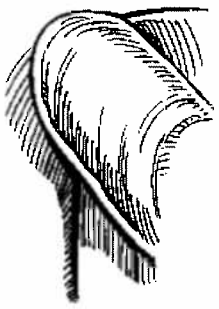
Does your child:



- Worry or feel frightened excessively or without a good reason?
- Have many concerns about academic or social performance?
- Need an excessive amount of reassurance?
- Have physical complaints, such as headaches or stomachaches, when feeling stressed?
- Become embarrassed easily?
- Have difficulty relaxing in groups?

At certain ages all children experience fears. Some children may have more difficulty with anxiety than others. The following suggestions may be useful in addressing your child's anxieties or fears:

- Encourage and reward independent activities.
- Your child may experience physical symptoms when he is stressed; don't overreact to them.
- To help your young child conquer her own fear, ask her to teach a doll or a stuffed animal how to be more confident.
- Explain new situations in advance in a simple, friendly manner. Try role playing to prepare for upcoming situations.
- Help with bedtime fears by buying your child a new and specific stuffed animal, a "special companion," which can help him feel less scared at bedtime.



- Establish clear and regular morning and bedtime routines, and stick with them. Let your child use a night light, if it helps her feel less scared. Children feel more secure with a well-structured and predictable, but not overly rigid, daily routine.
- Assess whether television or video game violence may be contributing to your child's fears. Television and video game violence can make your child scared even if he wants to watch it and says that it does not bother him. For more information on television and video game violence and how it affects children, read Cantor J. 1998. *Mommy, I'm Scared: How TV and Movies Frighten Children and What We Can Do to Protect Them.* New York, NY: Harcourt Brace.
- Be aware that apparent daydreaming and concentration problems at school may be caused by your child's preoccupation with fears and anxiety.
- Ask a librarian to help you choose books to read to your child that address specific fearsome situations.
- Don't get involved in lengthy discussions about fears. Reassure your child that you are doing all you can to keep anything bad from happening. Role play upcoming situations that are likely to cause your child anxiety.
- Be open about and explain stresses on the family (e.g., a parent out of work, an

(continued on next page)

impending move, a sibling experiencing serious problems) to your child in simple terms, and reassure her that the adults in the family will take care of things. Children are sensitive to adult anxiety and may exaggerate situations that are not explained to them.

- Try to avoid extremes (e.g., being too rigid, too permissive, or overprotective).
- Be honest and objective about family problems that might make your child fearful. If the problems are too complex to address within the family (e.g., parental abuse of alcohol, abusive behavior, marital problems or parental illness [mental or physical]), seek counseling.
- Be aware that the object or situation your child identifies as the cause of her fears may be a substitute for something she is hesitant to express (e.g., fear of "monsters" may really be fear of a person; fear of "the dark" may really be fear of the arguing she hears from another room). Consider whether there are "family secrets" your child may be afraid of or not allowed to discuss openly. Seek counseling if you find it too difficult to communicate with your child about her fears.
- Suggest that your child write a story or draw a picture of scary things, and look for clues to help you understand his fears better. An older child might write a letter or keep a journal.
- Preoccupation with death or dying or other morbid subjects may be a sign of depression. If your child is overly concerned with these things, have him evaluated by a health professional.

Source: Adapted, with permission, from Buchanan B, Yarnevich A. 1997. *When Being a Good Parent or Teacher Is Not Enough: Vol. I.* Kansas City, MO: Health Education Consultants. Web site: www.aboutkidsmentalhealth.com.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 47 (Updated November 2004)

THE ANXIOUS CHILD

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age eight months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, (such as fear of the dark, storms, animals, or strangers). Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not discount a child's fears. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children.

Symptoms of separation anxiety include:

- constant thoughts and intense fears about the safety of parents and caretakers
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- being overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Symptoms of phobia include:

- extreme fear about a specific thing or situation (ex. dogs, insects, or needles)
- the fears cause significant distress and interfere with usual activities

Symptoms of social anxiety include:

- fears of meeting or talking to people
- avoidance of social situations
- few friends outside the family

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Other symptoms of anxious children include:

- many worries about things before they happen
- constant worries or concerns about family, school, friends, or activities
- repetitive, unwanted thoughts (obsessions) or actions (compulsions)
- fears of embarrassment or making mistakes
- low self esteem and lack of self-confidence

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child's usual activities, (for example separating from parents, attending school and making friends) parents should consider seeking an evaluation from a qualified mental health professional or a child and adolescent psychiatrist.

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AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

FACTS for FAMILIES

No. 50 (Updated November 2004)

PANIC DISORDER IN CHILDREN AND ADOLESCENTS

Panic disorder is a common and treatable disorder. Children and adolescents with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as a racing heartbeat or feeling short of breath. These periods are called Apanic attacks@ and last minutes to hours. Panic attacks frequently develop without warning. Symptoms of a panic attack include:

- **Intense fearfulness (a sense that something terrible is happening)**
- **Racing or pounding heartbeat**
- **Dizziness or lightheadedness**
- **Shortness of breath or a feeling of being smothered**
- **Trembling or shaking**
- **Sense of unreality**
- **Fear of dying, losing control, or losing your mind**

More than three million Americans will experience panic disorder during their lifetime. Panic disorder often begins during adolescence, although it may start during childhood, and sometimes runs in families.

If not recognized and treated, panic disorder and its complications can be devastating. Panic attacks can interfere with a child's or adolescent's relationships, schoolwork, and normal development. Children and adolescents with panic disorder may begin to feel anxious most of the time, even when they are not having panic attacks. Some begin to avoid situations where they fear a panic attack may occur, or situations where help may not be available. For example, a child may be reluctant to go to school or be separated from his or her parents. In severe cases, the child or adolescent may be afraid to leave home. This pattern of avoiding certain places or situations is called "agoraphobia." Some children and adolescents with panic disorder can develop severe depression and may be at risk of suicidal behavior. As an attempt to decrease anxiety, some adolescents with panic disorder will use alcohol or drugs.

Panic disorder in children can be difficult to diagnose. This can lead to many visits to physicians and multiple medical tests which are expensive and potentially

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Disruptive Behavior Disorders

painful. When properly evaluated and diagnosed, panic disorder usually responds well to treatment. Children and adolescents with symptoms of panic attacks should first be evaluated by their family physician or pediatrician. If no other physical illness or condition is found as a cause for the symptoms, a comprehensive evaluation by a child and adolescent psychiatrist should be obtained.

Several types of treatment are effective. Specific medications may stop panic attacks. Psychotherapy may also help the child and family learn ways to reduce stress or conflict that could otherwise cause a panic attack. With techniques taught in "cognitive behavioral therapy," the child may also learn new ways to control anxiety or panic attacks when they occur. Many children and adolescents with panic disorder respond well to the combination of medication and psychotherapy. With treatment, the panic attacks can usually be stopped. Early treatment can prevent the complications of panic disorder such as agoraphobia, depression and substance abuse.

For more information about panic disorder, visit the National Institute of Mental Health's website at www.nimh.nih.gov or call 1-800-64-PANIC. See also: The Freedom from Fear's website www.freedomfromfear.org or *Facts for Families:* #4 The Depressed Child, #7 Children Who Won't Go to School, #10 Teen Suicide, #47 The Anxious Child, #60 Obsessive Compulsive Disorder in Children and Adolescents, #66 Helping Teenagers with Stress, #70 Posttraumatic Stress Disorder, and *Your Child* (1998 Harper Collins)/*Your Adolescent* (1999 Harper Collins).

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You may also mail in your contribution. Please make checks payable to the AACAP and send to ***Campaign for America's Kids***, P.O. Box 96106, Washington, DC 20090.

The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 7,000 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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Disruptive Behavior Disorders

Child with oppositional patterns and/or aggressive patterns interfering with functioning in home, school, or with peers

History:
- From parent and child
- review symptoms of ODD and CD, with attention to safety concerns
- Ask about parents' discipline practices
- ask about parental depression or mental health

Primary reference source: AACAP. Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. *J Amer Acad Child Adolescent Psychiatry.* 2007;46(1):126-141.

Safety assessment
- Confirm any firearms or other weapons in home are secured
- Adolescent substance abuse
- Rule out maltreatment and family violence
- Homicidal thoughts/plans

As needed:
Advise firearm safety
Substance abuse referral
OCS referral
ER emergency referral for safety

Differential Diagnosis (details below)
- Normal Development
- ADHD
- Adjustment disorder with disturbance of conduct
- Anxiety disorders
- Developmental delay
- Mood disorder
- Punitive parenting/consider maltreatment

Treat primary disorder first

Severe aggression, significant risk to others or risk of educational failure?

Yes

Refer for mental health evaluation , continue to follow at least q month until referral solid

Ongoing symptoms or worsening? No specialty appt?

Yes

Consider psychopharmacological treatment as adjunct to behavioral rx (chart below)

No

Primary Care Interventions
- Explain rationale for safe consequences
- (Specific interventions described below)
- General Principles of interventions for disruptive behavior disorders
  - Reduce positive reinforcement of disruptive behavior
  - Increase reinforcement (praise, token economy) of prosocial and compliant behaviors
  - Ignore annoying or mildly oppositional/provocative behaviors (reduce attention)
  - Punishment for disruptive or unsafe behaviors usually consists of a form of time out, loss of tokens, and/or loss of privileges.
  - Make parental response predictable, contingent and immediate.
- Schedule frequent follow-ups
- Monitor with Vanderbilt or other scale q month

Ongoing symptoms or worsening?

Yes

Disruptive Behavior Disorders

Hallmark symptoms: **Difficulty following rules, trouble with respecting adult authority, and/or aggressive and destructive behaviors.**

Oppositional Defiant Disorder	Conduct Disorder	Disruptive Disorder NOS
A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months	**Repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated**	**Signs of ODD and/or CD which do not meet full criteria but which cause significant functional impairment**
6 month duration	12 month duration	
At least 4 symptoms	At least 3 of following symptoms	
(1) often loses temper (2) often argues with adults (3) often actively defies or refuses to comply with adults' requests or rules (4) often deliberately annoys people (5) often blames others for his or her mistakes or misbehavior (6) is often touchy or easily annoyed by others (7) is often angry and resentful (8) is often spiteful or vindictive	**Aggression to people and animals** (1) often bullies, threatens, or intimidates others (2) often initiates physical fights (3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun) (4) has been physically cruel to people (5) has been physically cruel to animals (6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery) (7) has forced someone into sexual activity	
	Destruction of property (8) has deliberately engaged in fire setting with the intention of causing serious damage (9) has deliberately destroyed others' property (other than by fire setting)	
	Deceitfulness or theft (10) has broken into someone else's house, building, or car (11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others) (12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)	
	Serious violations of rules (13) often stays out at night despite parental prohibitions, beginning before age 13 years (14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period) (15) is often truant from school, beginning before age 13 years	
Out of proportion to age and developmental level		
Must cause functional impairment	Must cause functional impairment	
Not only in the context of mood or psychotic disorder		

APA. *Diagnostic and Statistical manual of mental disorders IV-TR*. 4 ed. Washington, D.C.: American Psychiatric Association; 2000.

Differential Diagnosis of Disruptive Behavior Disorders

Diagnosis	How the diagnosis can be differentiated from DBD
Normal development	*Behaviors are described as problematic but are typical for child's developmental level. Also consider low parental frustration threshold, and a wide range of causes of parental stress, or high parental anxiety.*
ADHD	*Impulsivity and inattention prominent, behaviors do not violate social norms the way CD behaviors do/are associated with remorse when caused by impulsivity*
Adjustment disorder with disturbance of conduct	*Changes in behavior in response to known (or not yet identified) stressor such as important changes in family structure from death, divorce, family conflict, in school setting including new teacher, emotionally unsafe educational or other environment, or changes in home setting. Adjustment disorder should be considered when changes in behavior are sudden or context-specific.*
Anxiety Disorders (Including generalized anxiety, separation anxiety, specific phobias, obsessive compulsive disorder)	*Pervasive or context-specific anxiety can be identified by asking child about internal responses and asking parent about range of anxiety symptoms. Disruptive behaviors may present in young children or those with limited ability to express internal distress or around powerful triggers like driving to school for a child with school avoidance or a child with OCD who is directed not to follow a compulsion.*
Frustration associated with **Developmental Delays**	*Disruptive behaviors in the context of excessive developmental demands- being asked to/trying to do something that is beyond the child's capacity in academic setting, language, or physical development.*
Mood Disorder (Depressive disorder, bipolar disorder)	*Prominent mood symptoms (depression, irritability, euphoria), behavioral difficulties <u>decrease</u> when mood normalizes, "neurovegetative" symptoms such as sleep, appetite, concentration, energy problems present, symptoms interfere with non-authority relationships like friends, siblings*

Assessment Strategies

<u>Universal screening-</u> Pediatric Symptom Checklist or other broad-band screener. Attend to "2"'s on items related to aggressive or oppositional behaviors.

<u>Symptom-Specific Structured measures</u>

- Vanderbilt ADHD Rating Scale (ages 6-12)
  - ODD: items 19-26 (require <u>≥</u>4 for positive score)
  - CD: items 27-40 (require <u>≥</u> 3 for positive score)

<u>History</u>

- Include history from child and parent
- Rule out major changes in family or educational setting
- Ask about new violence exposure
- Explore parenting style, consequences for inappropriate behaviors
- Explore parental depression/other psychopathology, which may contribute to harsh, punitive parenting

- If history of chronic or severe medical problem, consider that parents may see child as vulnerable and that child has not experienced consistent limit setting

Physical Examination/observations

- Physical exam unlikely contributory
- Notice child compliance with parent and staff instructions (and any difference in these patterns)
- Attend to general mood in room (fearful? angry?)

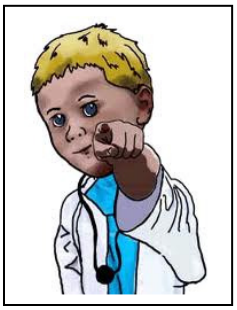
Referrals to consider

- Cognitive testing or developmental testing (r/o specific learning disability, developmental delay)
- Hearing screen (if concerned about deafness)

Safety issues in DBDs

- Confirm any firearms or other weapons in home are secured
- Adolescent substance abuse
- Rule out maltreatment and family violence (parent-> child, parent-> parent, child -> parent)

Primary Care Interventions for DBDs



Prevention

- Start discussing aggression at 1 year visit
- Emphasize the power of enjoying the baby!

Prevention and early intervention

- Acknowledge stresses of parenting
- Explain rationale for recommendations regarding safe consequences
- General Principles of interventions for disruptive behavior disorders
  - Reduce positive reinforcement of disruptive behavior
  - Increase reinforcement (praise, token economy) of prosocial and compliant behaviors
  - Ignore annoying or mildly oppositional/provocative behaviors (reduce attention)
  - Punishment for disruptive or unsafe behaviors usually consists of a form of time out, loss of tokens, and/or loss of privileges.
  - Apply consequences and/or punishment for disruptive behavior.
  - Make parental response predictable, contingent and immediate.
- Schedule frequent follow-ups

Specific intervention strategies: Preschool and School age children

- Consider behavior chart (handout included)
- Prescribe “Time in” (handout included)
- Review safe discipline strategies

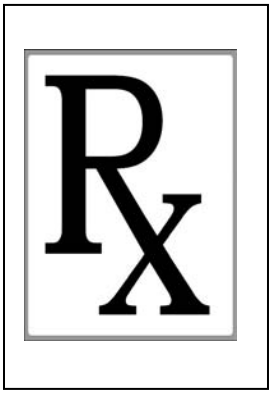
Specific intervention strategies: Adolescents

- Emphasize problem solving skills (handout included)
- Focus on identifying and managing emotional reactions
- Encourage constructive family communication
- Encourage balance of positive reinforcement (motivators) and contingent, safe consequences (punishments)

Indicators of need for specialty referral

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

- Duty to protect: If a patient has a clear plan to harm someone else, clinician should take steps to protect that individual (referral to law enforcement, referral to ER/mental health for safety assessment, or other)



Evidence Based Treatments for ODD/CD and Parent Handouts

Program name	Age Range	Website/resources
Incredible Years Series	0-8	www.IncredibleYears.com
Triple P-Positive Parenting Program	0-13	http://www5.triplep.net
Parent Child Interaction Therapy	0-8	www.pcit.org
Center for Collaborative Problem Solving	0-18	www.explosivechild.com
Functional Family Therapy	10-18	http://www.fftinc.com
The Adolescent Transitions Program	11-13	http://cfc.uoregon.edu/atp.htm

Adapted from AACAP (2009) ODD: A guide for families from the American Academy of Child and Adolescent Psychiatry. Washington DC. www.aacap.org

Specialty treatments used in ODD/CD

Preschoolers

- Parent management training- focuses on increasing positive interactions, shaping child behavior through positive reinforcement, increased attention to positive behaviors, less attention to negative behaviors, clear, safe consequences for unsafe behaviors)

Adolescents

- Individual therapy focused on problem solving
- Family therapy to address maladaptive communication and parenting styles
- Group therapy
- Multi-systemic therapy (MST)- addresses basic needs and provides intensive case management and home based therapy
- Functional Family Therapy (FFT)- addresses problematic family communication and interaction styles

Role of psychopharmacology in treatment of aggressive behaviors

Principles of psychopharmacology in treating DBDs

- Medications for youth with ODD are mostly considered to be adjunctive, palliative, and noncurative.
- Medication should not be the sole intervention in ODD and is not the first line treatment
- Medication trials are most effective after a strong treatment alliance has been established
- Nonresponsiveness to a specific compound should lead to a trial of another class of medication rather than the rapid addition of other medications.
- Treat primary underlying cause of aggression with disorder-specific medications (e.g. stimulants or alpha agnoists for ADHD before atypical antipsychotic agent)
- *(Adapted from from AACAP (2007) Practice Parameter for assessment and treatment of ODD and Pappadopulus (2003) Treatment recommendations for use of antipsychotics for aggressive youths. Full references below).*

Summary of Medications used in treatment of aggression

Medication (brand name)	Medication class	Usual starting dose	Usual titration plan	Maximum pediatric dose	Supported by RCTs?	FDA Approved for aggression	Common Adverse effects	Potentially dangerous adverse effects
Clonidine	Alpha Agonist	.025-.5 mg qhs	Increase by 0.05 mg/day q week	0.3 mg per day divided TID	Yes	Yes	Hypotension, drowsiness, sedation	Hypotension, bradycardiarebound hypertension
Guanfacine (Tenex; Intuniv)	Alpha Agonist	.25-.5 mg qhs	Increase by max 0.5 mg/day every 7 days	3 mg per day divided BID	No	No	Hypotension, drowsiness, sedation (less than clonidine)	Hypotension, rebound hypertension
Methylphenidate (immediate release or extended release formulations)	Stimulant	5-10 mg BID (am and noon) or equiv	Can increase quickly every 3-7 days to effect/adverse effects	60 mg per day	Yes	No (not for aggression)	Decreased appetite,sleep disturbance, emotional dysregulation,	? Association with sudden death, lower seizure threshold
Risperidone	Atypical antipsychotic	0.125-.25 mg q hs	.25-.5mg per 1-2 weeks (minimum 2 week trial)	< 45 kg: 2.5 mg; >45 kg: 3 mg	Yes	Yes (for children with PDD)	Sedation, weight gain, hyperglycemia and hyperlipidemia	Metabolic effects, Extrapyramidal side effects
Lithium	Salt				yes	Yes	Sedation, hypothyrpodism,	Ventricular tachycardia, delirium
Valproate	AED				No	No		Teratogenicity, polycystic ovary

Resources for parents: See AACAP Parent Handout

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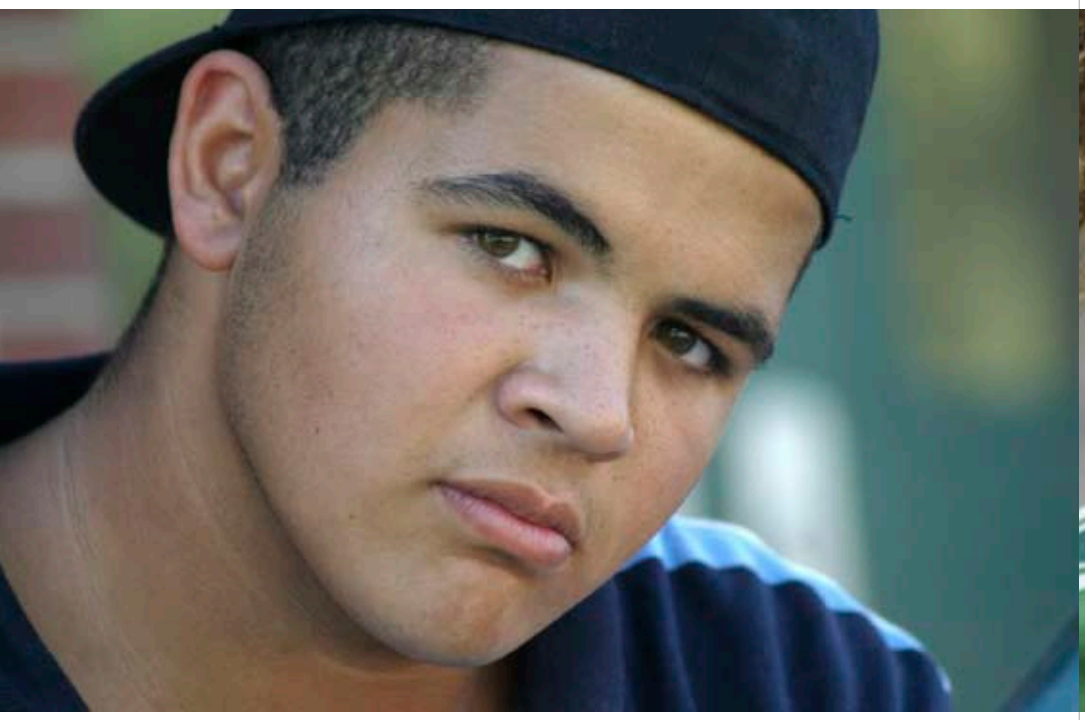
ODD

A Guide for Families by the American Academy of Child and Adolescent Psychiatry



Oppositional Defiant Disorder

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

WWW.AACAP.ORG

eAACAP on aacap.org

Because childhood and adolescent mental illnesses are real, common, and treatable

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Oppositional Defiant Disorder: A Guide for Families is adapted from the American Academy of Child and Adolescent Psychiatry's *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder.* The AACAP *Practice Parameter* was written to aid clinicians, child and adolescent psychiatrists, physicians, and other healthcare professionals in the diagnosis and treatment of children with ODD. This guide was adapted from the AACAP *Practice Parameter* in 2009.

What Is Oppositional Defiant Disorder?

Oppositional defiant disorder (ODD) is one of a group of behavioral disorders called disruptive behavior disorders (DBD). These disorders are called this because children who have these disorders tend to disrupt those around them. ODD is one of the more common mental health disorders found in children and adolescents.

Physicians define ODD as a pattern of disobedient, hostile, and defiant behavior directed toward authority figures. Children and adolescents with ODD often rebel, are stubborn, argue with adults, and refuse to obey. They have angry outbursts and have a hard time controlling their temper.

Even the best-behaved children can be uncooperative and hostile at times, particularly adolescents, but those with ODD show a constant pattern of angry and verbally aggressive behaviors, usually aimed at parents and other authority figures.

The most common behaviors that children and adolescents with ODD show are:

- Defiance
- Spitefulness
- Negativity
- Hostility and verbal aggression

A mental health professional is often called upon if these behaviors create a major disturbance at home, at school, or with peers.

Seeking treatment for children and adolescents suspected of having ODD is critical. This disorder is often accompanied by other serious mental health disorders, and, if left untreated, can develop into conduct disorder (CD), a more serious disruptive behavior disorder. Children with ODD who are not treated also are at an increased risk for substance abuse and delinquency.

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Some parents have trouble seeing defiant behaviors as a symptom of a mental disorder. They may want to wait to start treatment until the child matures to see if he or she will "grow out of it." Also, it is sometimes difficult to distinguish between ODD and normal, independence-seeking behavior that shows up during the "terrible twos" and early teen years.

However, there is evidence to suggest that early intervention and treatment will help a child overcome ODD. Treatment also may prevent its progression into a more a serious mental health concern.

Treatment usually consists of a combination of therapies, including behavioral therapy, parent training, and family therapy. Some children may benefit from medication as well.

With treatment, children and adolescents can overcome the behavioral symptoms of ODD. They can learn techniques to manage their anger and develop new ways of coping with stressful situations. Treatment also can help parents learn better ways to discipline and techniques to reward good behavior.

With treatment, children and adolescents with ODD can overcome their difficult behaviors and lead happier, more fulfilling lives.

How Common Is ODD?

There is a range of estimates for how many children and adolescents have ODD. Evidence suggests that between 1 and 16 percent of children and adolescents have ODD.[1] However, there is not very much information on the prevalence of ODD in preschool children, and estimates cannot be made.[2]

ODD usually appears in late preschool or early school-aged children. In younger children, ODD is more common in boys than girls. However, in school-age children and adolescents the condition occurs about equally in boys and girls.[3]

Although the disorder seems to occur more often in lower socioeconomic groups, ODD affects families of all backgrounds.

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What Causes ODD?

There is no clear-cut cause of ODD. However, most experts believe that a combination of biological, psychological, and social risk factors play a role in the development of the disorder.[4]

Biological Factors

Children and adolescents are more susceptible to developing ODD if they have:

- A parent with a history of attention-deficit/hyperactivity disorder (ADHD), ODD, or CD
- A parent with a mood disorder (such as depression or bipolar disorder)
- A parent who has a problem with drinking or substance abuse
- Impairment in the part of the brain responsible for reasoning, judgment, and impulse control
- A brain-chemical imbalance
- A mother who smoked during pregnancy
- Exposure to toxins
- Poor nutrition

Psychological Factors

- A poor relationship with one or more parent
- A neglectful or absent parent
- A difficulty or inability to form social relationships or process social cues

Social Factors

- Poverty
- Chaotic environment
- Abuse
- Neglect
- Lack of supervision
- Uninvolved parents
- Inconsistent discipline
- Family instability (such as divorce or frequent moves)

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What Are the Symptoms of ODD?

Most children argue with parents and defy authority from time to time, especially when they are tired, hungry, or upset. Some of the behaviors associated with ODD also can arise in children who are undergoing a transition, who are under stress, or who are in the midst of a crisis. This makes the behavioral symptoms of ODD sometimes difficult for parents to distinguish from expectable stress-related behaviors.[5]

Children with ODD show an ongoing pattern of extreme negativity, hostility, and defiance that:

- Is constant
- Lasts at least 6 months
- Is excessive compared with what is usual for the child's age
- Is disruptive to the family and the school
- Is usually directed toward an authority figure (parents, teachers, principal, coach)

The following behavioral symptoms are associated with ODD:

- Frequent temper tantrums
- Excessive arguments with adults
- Actively refusing to comply with requests and rules
- Often questioning rules
- Deliberately annoying and upsetting others
- Often touchy or annoyed by others
- Blaming others for their mistakes
- Frequent outbursts of anger and resentment
- Spiteful attitude and revenge seeking

Typically, children with ODD do not engage in delinquent behavior. Also, children whose behavioral symptoms are specifically related to a mood disorder, such as depression or bipolar disorder, are usually not diagnosed with ODD.

Recently, it has been discovered that girls may show the symptoms of ODD differently than boys. Girls with ODD may show their aggressiveness through words rather than actions and in other indirect ways. For example, girls with ODD are more apt to lie and to be uncooperative while boys are more likely to lose their temper and argue with adults.[6]

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How Is ODD Diagnosed?

While there is no single test that can diagnose ODD, a mental health professional can determine whether a child or adolescent has the disorder by assessing the child's symptoms and behaviors and by using clinical experience to make a diagnosis.

Many parents first call upon the child's primary care physician for an evaluation. This evaluation typically begins by compiling a medical history and performing a physical examination.

Gathering Information

During the evaluation, the child's primary care clinician will look for physical or other mental health issues that may cause problems with behavior. If the doctor cannot find a physical cause for the symptoms, he or she may refer the child to a child and adolescent psychiatrist or a mental health professional who is trained to diagnose and treat mental illnesses in children and adolescents.

A child and adolescent psychiatrist or a qualified mental health professional usually diagnoses ODD.

A mental health professional will gather information from parents, teachers, and daycare providers as well as from the child.

Gathering information from as many people as possible will help the doctor determine how often the behaviors occur and where. It also will help the doctor determine how the behaviors affect the different areas of the child's life.

The mental health professional will determine whether:

- The behavior is severe
- The conflicts are with peers or authority figures
- The behavior is a result of stressful situations within the home
- The child reacts negatively to all authority figures, or only his or her parents or guardians

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Answering these questions will help a mental health professional determine whether the child or adolescent has developed ODD or is responding to a short-lived, stressful situation.

Assessment tools, such as rating scales and questionnaires, may help the child's doctor measure the severity of the behaviors. These tools also may assist in establishing a diagnosis and tracking progress once treatment begins.[7]

In addition to establishing a primary diagnosis, the doctor will look for signs of other conditions that often occur along with ODD, such as ADHD, anxiety, and mood disorders. The doctor also should look for signs that the child has been involved in bullying—as either the victim or perpetrator. Involvement in bullying often is a sign that the child is at risk for aggression and violence.[8]

Establishing a Relationship

Like many mental health disorders, ODD is not always easy to accurately diagnose. Open communication among the mental health professional and the parents and child can help overcome the difficulties diagnosing this disorder. For example, some children see their behaviors as justified and are unmotivated to change. Also, some parents can become defensive when questioned about their parenting style. Having the parent and the child view the mental health professional as an ally can help.[9]

Establishing a good relationship with a mental health professional is important to determining whether the child's behavior is a response to a short-lived situation or transition, ODD, or another serious behavioral condition, such as CD or a mood disorder.

Can ODD Occur with Other Conditions?

Many children who are diagnosed with ODD also have other treatable mental health and learning conditions. Having more than one condition is called having coexisting conditions. Some conditions that coexist with ODD are:

- ADHD
- Anxiety disorders
- Mood disorders (such as depression and bipolar disorder)
- Learning disorders
- Language disorders

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Research indicates that some children develop the behavioral symptoms of ODD as a way to manage anxiety or uncertainty.[10] Anxiety disorders and mood disorders are similar to ODD in that they are often a response to uncertainty and an unstable home and school environment. These similarities make it more likely that ODD and anxiety disorder and a mood disorder (such as depression) will occur together.[11]

Among all conditions that coexist with ODD, ADHD is the most common. Both disorders share common symptoms of disruptive behaviors. However, children and adolescents who have both ODD and ADHD tend to be more aggressive, have more of the negative behavioral symptoms of ODD, and perform less well in school than those who have ODD alone. These children also tend to have more disruption in their families and with their relationships with authority figures than children who do not have ODD.[12]

Doctors have found that ODD can be a precursor to CD. CD is a more serious behavioral disorder that can result in destructive antisocial behavior.

While ODD behaviors may start in early preschool years, CD usually appears when children are older. A child or adolescent who has ADHD as a coexisting condition also seems to be at increased risk of developing CD. In addition, studies show that having CD puts children and adolescents at risk of developing a mood disorder or antisocial personality disorder later in life.[13]

While having ODD and a coexisting condition puts a child at risk for developing other more serious mental health issues, treatments exist that can improve the symptoms of ADHD, anxiety disorders, mood disorders, and learning and language disorders. Also, treating other mental health and learning conditions that occur along with ODD has been shown to decrease the behavioral symptoms of ODD.

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Can ODD Be Prevented?

There is research that shows that early-intervention and school-based programs along with individual therapy can help prevent ODD.[14]

Among preschoolers, the Head Start program has been shown to help children do well in school and prevent delinquency later in life. Head Start is a program of the United States Department of Health and Human Services (US-HHS) that provides education, health, and other services to low-income children and their families. Young children in this program learn social skills and how to resolve conflict and manage anger.[15] A home visit to high-risk children also has been shown to help prevent ODD among preschoolers.[16]

Among adolescents, psychotherapy (talk therapy), social-skills training, vocational training, and help with academics can help reduce disruptive behavior. In addition, school-based programs can be effective in stopping bullying, reducing antisocial behavior, and improving peer relationships.[17]

Parent-management training programs have proven effective in preventing ODD among all age groups. These programs teach parents how to develop a nurturing and secure relationship with their child and how to set boundaries for unacceptable behavior.[18] More information about parent-management training can be found on page nine of this guide.

How Is ODD Treated?

There is no one-size-fits-all treatment for children and adolescents with ODD. The most effective treatment plans are tailored to the needs and behavioral symptoms of each child. Treatment decisions are typically based on a number of different things, including the child's age, the severity of the behaviors, and whether the child has a coexisting mental health condition.[19]

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The goals and circumstances of the parents also are important when forming a treatment plan. In many cases, treatment may last several months or more and requires commitment and follow-through by parents as well as by others involved in the child's care.

Types of Treatment

Treatment usually consists of a combination of:

- **Parent-Management Training Programs and Family Therapy** to teach parents and other family members how to manage the child's behavior. Parents, family members, and other caregivers are taught techniques in positive reinforcement and ways to discipline more effectively.
- **Cognitive Problem-Solving Skills Training** to reduce inappropriate behaviors by teaching the child positive ways of responding to stressful situations. Children with ODD often only know of negative ways of interpreting and responding to real-life situations. Cognitive problem solving skills training teaches them how to see situations and respond appropriately.
- **Social-Skills Programs and School-Based Programs** to teach children and adolescents how to relate more positively to peers and ways to improve their school work. These therapies are most successful when they are conducted in a natural environment, such as at the school or in a social group.
- **Medication** may be necessary to help control some of the more distressing symptoms of ODD as well as the symptoms of coexisting conditions, such as ADHD, anxiety, and mood disorders. However, medication alone is not a treatment for ODD.

Treatments for Each Age Group

For preschool-age children, treatment often concentrates on parent-management training and education. School-age children perform best with a combination of school-based intervention, parent-management training, and individual therapy. For adolescents, individual therapy along with parent-management training has been shown to be the most effective form of treatment.

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In all age groups, individual therapy focusing on problem-solving skills also has been shown to greatly improve the behavior of children and adolescents with ODD. Problem-solving skills training should be specific to the child's behavioral problems, geared to the child's age, and focused on helping the child acquire new problem-solving skills.

More About Parent-Management Training

Studies have shown that intervening with parents is one of the most effective ways to reduce the behavioral symptoms of ODD in all age groups.[20] Parent-management training teaches parents positive ways to manage their child's behavior, discipline techniques, and age-appropriate supervision. It is the treatment of choice to prevent disruptive childhood behavior for many mental health professionals.

This approach embraces the following principles:

- Increased positive parenting practices, such as providing supportive and consistent supervision and discipline
- Decreased negative parenting practices, such as the use of harsh punishment and focus on inappropriate behaviors
- Consistent punishment for disruptive behavior
- Predictable, immediate parental response

Many of the following programs and publications have been noted as positive models by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Health and Human Services (US-HHS):

Programs

Program Name	Age Range	Contact Information
Incredible Years	Up to 8 years	www.IncredibleYears.com
Triple P-Positive Parenting Program	Up to 13 years	http://www5.triplep.net
Parent-Child Interaction Therapy (PCIT)	Up to 8 years	www.pcit.org
Center for Collaborative Problem Solving	Up to 18 years	www.explosivechild.com
The Adolescent Transitions Program (ATP)	11 to 13 years	http://cfc.uoregon.edu/atp.htm

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Publications

Book Name	Age Range	Publication Information
The Defiant Child by Douglas Riley, Ph.D.	Up to 13 years	The Guilford Press
The Explosive Child by R.W. Greene	Up to 13 years	Harper Paperbacks
The Kazdin Method for Parenting the Defiant Child by Allan E. Kazdin, Ph.D.	Up to 18 years	Houghton Mifflin
Parent Management Training by Allan Kazdin	Up to 18 years	Oxford University Press
Multisystematic Treatment of Antisocial Behavior in Children and Adolescents by Scott Henggeler, Sonja Schoenwald, Charles Borduin, and Melisa Rowland	Up to 18 years	The Guilford Press
Helping the Noncompliant Child by Robert McMahon and Rex Forehand	Up to 18 years	The Guilford Press

Medication

Medication alone has not been proven effective in treating ODD. However, medication may be a useful part of a comprehensive treatment plan to help control specific behaviors and to treat coexisting conditions, such as ADHD, anxiety, and mood disorders.

Successful treatment of coexisting conditions often makes ODD treatment more effective. For example, medication used to treat children with ADHD has been shown to lessen behavioral symptoms when ODD and ADHD coexist. When children and adolescents with ODD also have a mood disorder or anxiety, treatment with antidepressants and anti-anxiety medications has been show to help lessen the behavioral symptoms of ODD.[21]

Early Identification and Treatment

Behaviors that go along with ODD are difficult to change. Therefore, early identification and treatment of ODD give children and adolescents the best chance for success.

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How Long Does Treatment Typically Last?

Most treatment plans for children and adolescents with ODD last several months or longer. For those with a more severe ODD, or ODD that does not respond to therapy, treatment can last many years and may include placement in a treatment center.

A residential treatment center only should be considered for families who are not able to provide therapy at home or at school. In-home services are preferable to residential placement and are often sponsored by state and local child welfare agencies.[22]

Does ODD Improve over Time?

For many children, ODD **does** improve over time. Follow-up studies have found that approximately 67 percent of children diagnosed with ODD who received treatment will be symptom-free after three years. However, studies also show that approximately 30 percent of children who were diagnosed with ODD will go on to develop CD.[23]

Other studies show that when the behavioral symptoms of ODD begin in early life (preschool or earlier), the child or adolescent will have less chance of being symptom-free later in life. Also, the risk of developing CD is three times greater for children who were initially diagnosed in preschool.

In addition, preschool children with ODD are more likely to have coexisting conditions, such as ADHD, anxiety disorders, or mood disorders (depression or bipolar disorder) later in life.

In all age groups, approximately 10 percent of children and adolescents diagnosed with ODD will eventually develop a more lasting personality disorder, such as antisocial personality disorder.[24]

However, most children and adolescents will improve over time, especially if they receive treatment. Parents who suspect that their child has a behavioral problem should have their child evaluated. For children who receive treatment, the outlook is very good.

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Which Therapies Have Been Shown Not to Work?

Experts agree that therapies given in a one-time or short-lived fashion, such as boot camps, tough-love camps, or scare tactics, are not effective for children and adolescents with ODD. In fact, these approaches may do more harm than good. Trying to scare or forcibly coerce children and adolescents into behaving may only reinforce aggressive behavior.[25]

Children respond best to treatment that rewards positive behavior and teaches them skills to manage negative behavior.

What Does the Future Hold?

It was once thought that most children would outgrow ODD by adulthood. We now know this is not always true. While some of the symptoms of ODD can go away over time, and many children outgrow the disorder, some children with ODD will continue to experience the consequences of ODD during their later years.

For those who do not receive treatment, ODD can develop into CD, a more serious behavioral disorder. Of those with CD, almost 40 percent will develop antisocial personality disorder in adulthood.[26]

Early diagnosis and treatment can help these individuals learn how to cope with stressful situations and manage their behavioral symptoms.

Psychotherapy, parent-management training, skills training, and family therapy work. Research shows that children and adolescents respond well to therapy for ODD. In fact, for those who receive treatment, many are symptom-free once therapy has concluded and will go on to lead rewarding and happy lives.

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Oppositional Defiant Disorder: A Guide for Families is adapted from the American Academy of Child and Adolescent Psychiatry's *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Oppositional Defiant Disorder.* The AACAP *Practice Parameter* was written to aid clinicians, child and adolescent psychiatrists, physicians, and other healthcare professionals in the diagnosis and treatment of children with ODD. This guide was adapted from the AACAP *Practice Parameter* in 2009.

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This guide is part of the eAACAP Resource Center on oppositional defiant disorder ODD. The resource center includes information on how and when to seek help. The eAACAP ODD Resource Center is available on the American Academy of Child and Adolescent Psychiatry Website at www.aacap.org.

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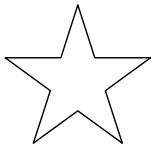
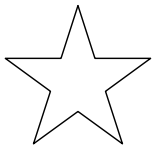
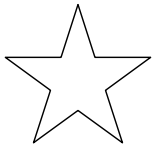


Creating a behavior chart

Behavior charts are based on the well-known fact that children thrive on attention and approval from their parents. Behavior charts are organized ways to make sure that your child knows you are proud of him/her when he/she does the kinds of behaviors you want to see. The more time your child spends on these positive behaviors, the less time your child will have for negative behaviors that you do not want to see. Also, if your child does not get as much attention for the negative behaviors, he/she will be less likely to do those.

1. **Identify the behaviors you would like to see happen more.** These will go in the behavior chart on the left column. If there are more than 1 adults in the home, it is best for everyone to agree on the most important behavior goals.
    a. **Behaviors should be stated in positive terms**- what you WANT to see, not what you do not want to see. *For example: "Sit in your chair for dinner" (NOT: "don't get out of your chair") or "keep your hands to yourself" (NOT: "don't hit").*
    b. **Define goals clearly** so that it is easy to agree at the end of the day that the behavior happened. It is better to make goals very specific in terms of numbers or times of day than to be vague. *For example, "go to bed when you are told" (NOT: "follow directions").*
    c. **Define goals specifically** so that you and your child understand how the goal will be measured. *For example, "say thank you every time someone gives you something", not "be polite").*
    d. **Use single goals** that are specific about the behavior required, not multiple goals merged together. *For example, use two separate goals instead of "brush your teeth and then get into bed".*
    e. **Choose an odd number of goals**. For 3-6 year olds, 3 goals may be appropriate. For older children, 5 goals is manageable. If using 3 goals, 1 should be easy for the child to achieve, to ensure that he/she will be able to experience success, so that then he/she will be motivated to work to achieve the more challenging goals. If using 5 goals, 2 should be behaviors the child can achieve easily.
2. **Make copies of the chart**
3. **Decide what will go in the chart when a child demonstrates the behavior**
    a. Stickers can be purchased for relatively little money at bargain stores.
    b. Some children are excited to be able to draw their own star or smiley face in the chart (only choose this option if the child is likely to draw ONLY in the appropriate box)
    c. Children can also be excited about a big check mark in their favorite color.
4. **Determine what will happen if the child achieves minimum goal in a week**
    a. If using 3 goals, 75% achievement is 16 stars in 1 week
    b. If using 5 goals, 75% achievement is 26 stars in 1 week
    c. Motivator/reinforcer does not need to be expensive, but should be something that the child will enjoy. Reading an extra book at bedtime or other ways of spending time with

parents may be a powerful motivator. Going to a nearby park or having a special treat for dessert may also be useful.

5. **Introduce the idea to your child.**
    a. It is important that your child sees the chart as a way of demonstrating how proud you are of good behavior, not as a punishment.
    b. Give your child any appropriate choices about what to put in the boxes when he/she does a behavior (e.g. smiley faces or check marks or stars) and what he/she is working towards if there are 1-2 choices you would like to offer.
    c. Once your child is excited about being able to earn stars and your approval, he/she can decorate the chart.
6. **Implement the behavior plan**
    a. **Keep the chart in a central place** so that you will not forget about it at the end of the day.
    b. **If bedtime behaviors are a goal**, the behavior should be marked off in the morning. Otherwise, it is usually best to incorporate the behavior review into the pre-bedtime routine.
    c. **If a child does not do the behavior, leave the space blank**. Do not put punishments, sad faces, or other signs of failure in the box. The blank space will be incentive enough to earn the star next time.
    d. **If a child earns a star, celebrate it together,** even if the child only achieves that behavior. The behavior chart focuses on positive behaviors and giving attention to unwanted negative behaviors can actually increase the chance your child will keep doing it.
    e. **Stick with it!** It is not unusual for the negative behaviors to increase for a short time when you start using the behavior chart as a way of testing to see if your child can keep getting your attention for the negative behaviors and to see if you really mean it. They will decrease again after a week or two.
    f. **Once your child is easily achieving most of the stars for a few weeks,** you can change the goals to encourage even more positive behaviors that might have been too hard for him/her at first. For example, if the original goal was to sit in a chair for dinner, but your child is still having trouble at other meals, the goal can be changed to “sit in your chair for all meals”, and the star could only be earned if your child meets that goal.
7. **Special situations**
    a. If your child is likely to try to rip or destroy the chart, place it high on the refrigerator.
    b. You can draw pictures (or cut pictures out of magazines) of the goals if your child cannot read.

_____'s Behavior Chart

Goal	Sunday	Monday	Tues	Wed	Thurs	Fri	Sat

Health Issues

Behavior Therapy: The Specifics of Parent Training

Research confirms that behavioral parent training programs are valuable tools to help parents guide, support, and live more comfortably with their children with ADHD. They are considered by the American Academy of Pediatrics to be a first-line treatment approach for children with ADHD. Following are brief descriptions of some of the topics and techniques that parent training programs introduce through direct instruction, demonstrations, role playing, readings, discussions, and "homework assignments" that parents can use with their own child.

Setting the Stage for Positive Learning: Learning How to Play or "Hang Out" With Your Child

Behavior therapy is not just about a child's behavior, but about improving the relationships between a child and his parents (as well as others) and the interactions within the family. As a parent, you can take the first step toward improved relationships by understanding how discouraging your child's daily experiences can be to him and by countering that negativity with positive messages and support. Your child needs to know that you are not only interested in helping him adjust his behavior, but that you also appreciate him as a person and enjoy just being with him. Feeling that you are there for him, ready to listen, empathize, and help him recover from the many setbacks he encounters will set the stage for the most effective implementation of parent training principles. So before beginning "training" techniques, you must make an effort to befriend your child and show him that you are members of the same team.

Many experts in behavior therapy, including Dr Russell Barkley, suggest that a good way to do this is to make a point of regularly and frequently spending time playing with your younger child, or hanging out with your older one, with no one else present. During this time, your goal is not to teach your child anything or to shape his behavior. It is to let him know that you are interested in him and want to spend time getting to know him better. This can be accomplished by announcing that from now on you will reserve time during several days each week to be with your child (his other parent should do the same) and, during this time, allow him to decide on the activity (any activity that allows the 2 of you to interact is fine—playing with board games or dolls for example, but not watching television or playing organized sports). While you are involved in the activity, allow your child to take the lead. Comment occasionally to show you are paying attention and are involved, and provide positive feedback now and then, but do not try to take over the activity or conversation. The point is to simply be with your child—to let him be the center of your attention and to show you his world. By regularly participating in these activities with your child you are learning to listen and observe while avoiding constantly giving commands or instructions—the first skills necessary to begin reshaping his behavior and changing his relationships within the family. You are also demonstrating in the most effective way possible that your child does not need to engage in negative behaviors to win your attention. Once he learns he has his parents' interest, he can rely on this in trusting them to help him figure out how to get along better and develop more positive relationships with others.

Responding Effectively to Your Child's Behavior

Once you and your child have begun to establish a basis of trust and positive support, it is time to look at the ways you hope to improve your interactions with him at home. Parent interactions can be improved, and improved interactions can set the stage for the successful use of parent training tools and techniques. One of the first principles of parent training is to expand the notion of the word discipline. Many parents assume that the term refers to ways to carry out effective punishment. However, teaching discipline to a child really means teaching self-control—and that is the broad goal of parent training. Fortunately, behavior therapy programs take a more positive approach than just constantly devising punishments for breaking rules. As your child's "teacher-coach-therapist," you will learn how to choose the most effective response to any given situation. In most cases, you will find that you have 3 choices when confronted with a particular behavior in your child: you can praise the behavior, deliberately ignore it, or punish your child for it. Behavior therapy is about deciding correctly which response to choose, following up on that decision, and being consistent about your choices from one event, and one day, to the next.

Of course, it is not always easy to decide whether a behavior deserves to be ignored or punished, and it is not always obvious when and how to provide praise. These and other topics will be discussed in this article. In the meantime, though, it is important to consider how much more powerful and, in most cases, preferable positive reinforcement and ignoring are to punishment, even though in the heat of the moment this may go against your instincts or intuition. It may help to think about how much more likely you are to work hard when your boss recognizes and praises your efforts, and how poorly motivated and resentful you may feel if he frequently criticizes you. In the same way, your child is more likely to respond positively to your actions if you react positively to his, while a negative comment or response on your part is likely to lead to more negative behavior. This is why in behavioral parent training, parents are encouraged to praise their child's behavior whenever possible, and ignore it when necessary, as a strong way of shaping behavior while minimizing the need for punishment.

Giving Clear Commands

The first step in helping your child learn to follow rules, obey your commands, and otherwise manage her own behavior is to make sure that the commands you are giving her are clear. Adults are often accustomed to couching their commands in a variety of "softening" or ambiguous gestures and phrases. Many of us also tend to react too strongly or impulsively to behavior we consider unacceptable. But children with ADHD need to be told what to do in a clear, straightforward, and non-emotional way if they are to learn to control their actions.

You can give effective commands by

- **Minimizing distractions.** Turn off the television or computer game before you address your child, or ask her to turn it off. If you are in a noisy setting, try to move to a quieter place before speaking to her. Most children with ADHD find it difficult to pay attention when surrounded by a lot of competing noise or activity.
- **Establishing good eye contact.** You must fully engage your child's attention by making good eye contact if she is going to hear and follow what you say. At first, you may find it helpful to touch a younger child's arm or hold her hand before addressing her.
- **Clearly stating the command.** You can make commands clear to your child by first stating what therapists call a terminating command—a simple, non-emotional statement of what you want your child to do ("You need to stop pushing your brother."). If the behavior does not stop immediately, you can then follow up with a warning that includes the exact limit and the consequences ("If you push your brother one more time, you'll be in time-out. If you stop immediately the two of you can go on playing.") When stating a command, keep your tone of voice firm and neutral. Refrain from yelling, or looking or sounding angry. It is especially important to monitor your body language because these nonverbal messages are so easy to overlook. State the command as an instruction, not as a question (Not, "Would you please stop teasing your brother?" or "Stop teasing him, OK?" but "You need to stop teasing your brother.").

If you are not sure your child heard the terminating command or warning, ask her to repeat it back to you. Then pay attention to how well she carries out your instructions and respond immediately to her behavior. If she responds as you have asked, follow this up with a positive—praise, thanks, a thumbs-up, or other acknowledgment that she has done well. If her response is not exactly what you had hoped for but is in the right direction, offer her immediate praise for the part of your command that she did carry out. If your child does not start to cooperate according to the limits you have set ("one more time" or "within the next two minutes") invoke the consequences, calmly narrating what is happening as you do so. ("You did not stop pushing your brother, so you are having the five-minute time-out that we just talked about.") Keep in mind that because you have given a warning and a terminating command and spelled out the consequences of disobeying, you have not "put her in" the time-out—she has "chosen" the timeout for herself as an alternative to following your command.

If you make a point of following through on the positive or negative consequences of each command, every time, you should soon find that you will not have to repeat your instructions over and over as you probably did before. Your ultimate goal will be to give a command only once for it to be obeyed. The elimination of constant pleading, nagging, or threatening is a great relief to most parents and goes a long way toward improving your interaction with your child. If you are tempted to "let it slide" when she ignores a command (telling yourself, perhaps, that she does have ADHD, after all), consider how hard it will be to make up for this inconsistency in the future and carry out the promised consequences. If you are going to try to follow up on every command you give, you will need to consider beforehand how important the command you are about to give is. Limiting the number of commands you give will make it easier for you to follow up on each and every one, thus increasing your chances of success.

At first, as you practice giving commands according to these guidelines, you will need to keep things simple. Make sure that all your commands are achievable by your child, and wait until your child has completed one step of your instructions before giving another. If necessary, break a complex command down into smaller steps ("Take off your shoes. Good job! Now take off your socks."). While your child is carrying out your instructions, avoid distracting her. Be sure to follow up on each command, avoid giving commands unless you mean for her to follow them (do not tell her to go to bed until it is really time), and stick to commands that you know can be carried out successfully by your child. It is usually best to give a time limit ("by the third time," "by three minutes") for each command as well, to help her focus on accomplishing it and to help you both

define when it has or has not been accomplished. Keep in mind, however, that children with ADHD often have particular problems with time awareness and time limits. You will need to keep such limits simple, and consider using egg timers or other devices to make these time limits more concrete. By doing so, you can turn commands that have previously ended in failure and frustration ("Go upstairs and clean your room.") to commands that end in success and build on your child's self-esteem ("Put your video game player away by the time this bell goes off in three minutes.").

Shaping Behaviors Gradually: Small Steps in the Right Direction Add Up

Children with ADHD, like all of us, will probably have particular difficulty changing a complex or long-standing set of behaviors. Expecting your child to make a major behavioral change all at once will most likely result in frustration and failure for you both. As mentioned previously, you can support your child's efforts to change a complex set of behaviors by breaking the plan down into smaller, achievable steps, and tackling one at a time. This is called "shaping" your child's behavior. The idea is to break down tasks to the point at which each step is achievable and ends in success and praise for your child instead of failure and frustration. Parent training will help you learn to do this by having you review the targeted outcomes for your child and ways you can help him achieve them. You as parents (or other primary caregivers) can start by writing down what you see as each step toward completing a task or correcting a complex behavior and follow up by creating a plan for working on each step, one at a time. You can incorporate your child in the development of each plan at the level that he can appropriately participate. Even minor goals can be broken down in this way—writing down the steps involved in completing a chore, for example, you might list the steps that your child needs to take in cleaning up his room as

- Puts dirty clothes in a hamper
- Puts books away
- Puts toys in the drawers under his bed
- Pulls up the covers

Then you can start with a single command—"You need to start cleaning up your room by putting the dirty clothes in the hamper." When this is done successfully, you can praise him—"Good job!" If you had just said, "You need to clean your room," and he had put his clothes in the hamper, but not put his books and toys away and pulled up the covers, he would not have been successful and you would have ended up making a negative remark or giving a consequence. At the point that putting his clothes in the hamper when you ask becomes automatic, then, after a few days, you can add the next step—putting the clothes in the hamper and putting his books away, praising him for the successful completion. When this is successful you can add the next task, and so on, until the list is complete. In this way you can "shape his behavior" and at the same time turn what used to be negative interactions into positive ones that build on his self-esteem and competence. You can help your child learn to focus better and accomplish tasks more quickly by timing certain tasks as well and encouraging him to try to break his own speed record again and again. Such small triumphs can mean a great deal to children who have experienced repeated failure or frustration at home or at school. Behavior shaping techniques also heighten your child's awareness of each successful step, helping him to "own" his behavioral successes.

Choosing What to Praise, Ignore, or Punish

The next step in parent training is learning to recognize behaviors that require positive, ignoring, or punishment-type responses. You will be encouraged to do your best to "catch your child being good" and praise her for it whenever possible because this allows for positive interaction and enhances her relationship with you as it strengthens her positive behaviors. Praise should be simple and straightforward ("I like the way you did that."), and not spoiled by negative references ("Great job—why can't you always do it like that?"). In many cases a simple smile, hug, or an arm around your child's shoulders is even more effective than words. Such immediate positive reinforcement is actually a much stronger (and less risky) way to change behavior than larger, long-term rewards, such as the offer of a video game system for maintaining all B's or staying on the honor roll all semester. However, you may still decide to offer your child stickers, points in a token reward system, or other prizes for putting in the effort to help change behaviors you are working on.

"Active ignoring" is one of the most powerful behavioral tools available to parents, but one of the hardest to carry out. Once you give a command, you must follow it through to the end if it is going to be effective and meaningful to your child. Many parents are in the habit of giving frequent corrections all through the day, and then either do not follow through on many of them or dole out so many punishments that they become ineffective and set up a negative relationship with their child. Learning how to actively ignore certain situations can lead to many fewer commands and significantly improve this situation.

In fact, you may be surprised at how effective ignoring a negative behavior can be. This is especially true once your child has grown accustomed to the positive attention she enjoys in your special times together and no longer needs to demand your attention in negative ways. A child who interrupts your phone conversations over and over is, in most cases, only doing it to get your attention. If you respond by saying something like, "Sarah, I'm on the phone—wait until I get off!" you may think you are giving a command to stop the behavior but you are actually rewarding her by giving her the attention she wanted in the first place. If, instead, you ignore her behavior (by not looking at her or responding in words), her attempts to distract you while you are on the phone may escalate at first, while she tries even harder to get the attention that she is used to. This is what behavior therapists call an "extinction burst"—the behavior gets worse before it gets better. However, if you consistently ignore her, she will gradually learn more functional ways to have her needs met. In this way, ignoring works as

a powerful tool for behavior change. A good proportion of behavior problems can be addressed with a combination of praising and ignoring techniques.

As part of a typical parent training program, you will identify the few behaviors that you consider so dangerous (running into the street without looking, for example) or intolerable (hitting other children to hurt them) that they must meet with immediate punishment. Your therapist will teach you how to discuss these behaviors with your child, figure out the punishments that will follow, and figure out possible ways to avoid the same situation in the future. He will help you understand how much more effective punishment can be if it is limited to only your child's most dangerous or intolerable behaviors. When punishment occurs too frequently (as it often does for children with ADHD), its effects are diminished and the child may no longer consistently respond to it. In addition, most parents do not realize that negative attention can be reinforcing, and because of this, negative consequences should be reserved for those few instances when parents feel they must do something immediately (and not just ignore). Any punishment should be preceded, whenever possible, by a terminating and a warning signal. That way your child will always have the opportunity to exert self-control and avoid the punishment.

No matter what your response to your child's behavior, it will be most effective if it takes place immediately. Putting off a discussion until later, or offering a reward at the end of the week for general good behavior, will greatly diminish its effect on a child with ADHD. The response you have chosen to a particular behavior should be as consistent as possible as well. If you responded appropriately to your child's pushing her brother down with punishment yesterday, respond in the same way today. Your parent training therapist will help you decide in advance on the best responses to your child's most frequent behavior issues so you can carry out these actions with confidence.

Using Rewards to Motivate Positive Behavior

Praise is a powerful motivator for all children, but many also especially enjoy and respond to additional, tangible motivators such as reward charts and token economies. Reward charts usually consist of daily calendar sheets listing 4 or 5 achievable chores, behaviors, or other goals on which you and your child have agreed. Before instituting the reward chart with your child, you will have observed your child enough to know that he can successfully complete most of the behaviors listed. The description of each behavior needs to be clear, countable, and unambiguous (for example, "is upstairs brushing his teeth within 5 minutes after being told" or "gets out of bed by the third time he's asked"). You might have 5 items on a chart—4 of which are easily achievable by your child with an additional 1 that you are presently working on. Charts can be reviewed daily, and this becomes a time to let your child know how proud of him you are for working on his chores or behavior. If too many of the items are not achievable and do not end up with stars or stickers, your child will get easily frustrated and negative about participating. Each time your child accomplishes the goal he receives a sticker, a star, or other mark of achievement on the chart. Many younger children are happy enough just to receive the stickers or stars themselves, but some older children may want to accumulate numbers of stars or stickers and redeem them for privileges —such as a trip to a baseball game or to the beach, or modest, prearranged material rewards. These rewards do not need to be new privileges. What you are really doing is putting some of his everyday privileges under his behavioral control, knowing in advance that he will experience success.

Another type of reward system, called a token economy, also involves receiving tokens, stars, stickers, or points for behaving appropriately or complying with commands. Token economies are similar to reward charts in that they can often be helpful when praise alone is not enough to motivate a child to complete tasks or stick to routines. The gains from using a token economy approach can often be seen quickly, but can also fade unless this kind of system is kept up for some time. Each targeted behavior is given a value (3 stickers, 4 points) depending on how difficult a challenge it is for your child. You and your child can then create a list of fun activities or treats that he can "buy" with a prearranged number of stickers or points. Response cost—the withdrawing of rewards or privileges in response to unwanted or problem behavior—can be eventually added onto this system if necessary. In that case, your child's failure to accomplish a targeted behavior on his own or after an agreedon limit results in the same number of stickers or points being deducted from his total. Before response cost is introduced, you need to make sure your child is earning tokens and has "bought into"the token economy plan. Make sure that you see it as motivating and that your child sees it as fun. Otherwise, it will become a frustrating exercise to your child and therefore useless as a strategy.

Reward charts and token economies are good ways to help motivate children to take responsibility for their own behavioral improvement when praise alone has not been effective enough. They also help parents facilitate these gains in structured, positive, consistent, and objective ways. These techniques work especially well when the rewards for compliance are immediate (getting the tokens as soon as possible after complying, and going on the earned and agreed-on trip to the beach within a week). Their effectiveness is also enhanced when your child gets the opportunity to help create the list of goals, assigned value of each behavior, and rewards that follow satisfactory compliance. It is also best to do what you can to keep point deductions to a minimum (by breaking tasks up into reasonable steps and not expecting too much too soon) so that your child does not become too discouraged and give up. Some children do not start to warm up to token economies until they have experienced one or more of the promised "big rewards," so be sure to continue the technique for 1 or more months—as long as your child does not become too frustrated or resistant—before deciding whether it is useful for him. Keeping his goals achievable and the program positive will go a long way toward making this approach successful.

Using Punishment Effectively

No one likes to invoke negative consequences for unacceptable behavior, but doing so calmly and consistently is a necessary part of helping your child learn new ways of functioning. At first it can be difficult to decide when punishment is appropriate because it is easy to attribute much of your child's failure to manage some of her behaviors appropriately to "her ADHD." Refusal to obey, when it does occur along with ADHD, can be greatly reduced with effective parenting techniques.

When parents think about "discipline" and punishment, they often think about spanking (without causing physical injury) as a way to reduce or stop undesirable behavior. Many studies have shown that spanking is, however, a less effective strategy than time-out or removal of privileges for achieving these goals. In addition, spanking models aggressive behavior as a solution to conflict, and can lead to agitated or aggressive behavior, physical injury, or resentment toward parents and deterioration of parent-child relationships. The use of spanking as a strategy for punishment is discouraged by most experts and organizations, including the American Academy of Pediatrics.

Time-outs and loss of privileges are the 2 forms of punishment that have been proven most effective for children with ADHD. They are appropriate tools for responding to the few behaviors you have identified as intolerable. Time-outs, most often used with younger children, involve sending your child to a specified room (with no entertaining distractions and a door that can be closed) or chair (where you can see her) until the end of a preset time—usually about 1 minute per year of the child's age (usually 5–10 minutes). Before instituting time-outs, you must discuss your intention with your child, explaining that they will be the consequence of violating the family's most important rules. Explain that you will always give a terminating command ("Give your brother's toy back.") and a warning ("If you don't give it back within one minute you'll be in time-out.") before you impose a time-out, so that your child will always be able to choose to avoid it by changing her behavior on the spot. Keeping in mind the difficulty with time perception that some children experience, tell your child that you will use a timer to measure the length of the time-out, and demonstrate to her how the timer works.

Once your child understands how time-outs will work, you can begin to implement them when appropriate. When your child displays an unacceptable behavior

- Warn her that a time-out will occur if she does not respond to your warning in a specific amount of time ("Anna, stop pushing your sister. If you haven't stopped by the time I count to three, you will have a time-out.").
- If she does not comply in the specified time, firmly but calmly send her to the time-out setting. Do not give her more time to comply or let her engage you in any distracting interaction.
- Tell her how many minutes the time-out will last, set a timer, and leave her alone—do not start negotiating whether she can get out earlier, or avoid going in. Some experts suggest adding another minute to the time-out each time your child leaves the time-out space or is disruptive, then allowing her out at the end of that time if she is quiet and cooperative.
- When she has completed the time-out process, make a point of praising her next positive behavior so that the negative "punishment" experience is fully ended.

Be prepared for a great deal of resistance the first few times when time-outs occur. Soon, however, your child will learn that you are remaining consistent; that resisting, arguing, or negotiating no longer work; and that it is better to change the original behavior and avoid the time-out altogether. Meanwhile, remember that the goal is for your child to focus on staying out of time-outs rather than getting out of them once she has "chosen" to take the time-out rather than complying with your request to stop an unacceptable behavior. Remember also that "time-out" is time out from "time in"—meaning that the only reason your child will care if she gets a time-out is if she is used to loving, positive, and fun family interactions that will be missed during the time-out period. By supporting your child in these positive ways while sticking to the rules you have created, you can help your child learn to control her behavior and respect your fair and consistent authority.

Loss of privileges, a more appropriate negative consequence for older children and teenagers, consists of invoking a "cost" for intolerable behavior. If your child breaks a family rule or ignores a command after a pre-agreed-on number of warnings, privileges are removed for a time appropriate to the seriousness of the transgression. This technique works best if your child has participated in decisions about exactly which behaviors will merit a loss of privileges and agrees in advance to some prenegotiated penalties. It is also a good idea to try to relate the penalty as closely as possible to the transgression. Your child's failure to complete her homework, for example, may cost her television privileges the next day, while a teenager's failure to return home after curfew may cause her to lose car privileges for the weekend.

If you find that your child continues to strongly resist time-outs or loss of privileges while continuing the negative behaviors, consider the way in which you are implementing these techniques. If you have been giving in to her resistance—allowing her out of the time-out area if she yells and kicks long enough, or letting her negotiate you out of a loss-of-privilege punishment—she will have learned that resistance allows her to have her way. If you have been enforcing the rules sometimes, but not every time, she may not be able to resist testing your responses on every occasion to learn what you will do this time. If you have successfully carried out an effective punishment procedure but neglected to add praise afterward and at other times during the day, your child may have decided she will never be able to succeed and give up trying. These are the reasons why it is so important to remain calm, firm, and consistent while invoking a punishment and to follow up as soon as possible with reassuring praise.

Managing Your Child's Behavior in Public

With proper training and practice, behavior therapy techniques can become relatively simple to implement at home, where a time-out area is clearly identified and it is possible to respond immediately to unacceptable behavior. Parents are often most disturbed by intolerable behavior when it occurs in public, however, because they feel that other adults—who do not know that their child has ADHD and have no idea how much progress he has already made—are negatively judging their child and their parenting skills. In any case, children with ADHD need to learn to manage their behavior wherever they are, so it is important to establish methods for implementing disciplinary techniques outside the home.

The most effective behavior management methods for use in public are the same ones you have developed with your child at home. If he is already familiar with the standard costs for certain types of behavior, you may need only remind him privately before you enter the new environment which 2 or 3 behavior rules he most needs to keep in mind, what rewards will result from his following them, and what the cost will be for breaking these rules. To help him maintain his efforts to comply, praise his positive behaviors occasionally during the outing and let him know you appreciate how hard he is trying to follow the rules—"catch him being good." If he manages to control his behavior throughout the entire period, acknowledge the difficulty of this feat and give him special praise. If you have also offered a reward, then provide it as soon as possible.

If your child refuses or fails to behave acceptably, even after a final warning, you will need to invoke the appropriate negative consequence. Do not delay just because you are among other people—delay will probably just lead to increased misbehavior. You can enforce token economy "fines" or removal of privileges practically anywhere (as long as you keep your conversation private), but you may need to talk with your therapist ahead of time about how you might implement them discreetly yet effectively at the supermarket, your friend's house, church, or wherever you expect to be.

Your child needs your competent handling of rewards and limits as he practices new behavioral rules in public, but he also needs your thoughtful planning if he is to successfully maintain his best self-control in these situations. Planning in advance can make all the difference in his ability to control his restlessness and stay focused.Whenever you take him along on errands, to a restaurant or friend's house, or for a trip—even across town—be sure to pack some activities to keep him happily occupied (activity books, handheld computer games, paper and pen). Once you are in public together, involve him in your activity if possible (helping choose items at the store, helping to make a snack at your friend's house).

Maintaining the Gains From Parent Training

After the sessions are finished, before your behavioral parent training program is complete, you should discuss ways in which you can continue to help your child work toward his targeted outcomes in the months and years to come. You will have learned how to recognize when a desired goal has been reasonably achieved and when and how to formulate new targets with your child, his teacher, and the rest of his treatment team. You should also discuss the ways in which you will need to adapt your parenting techniques to your growing child's new stages of development. While behavioral parent training programs do focus in large part on younger children, you will learn how to move from time-outs to response-cost–type techniques as your child grows and to include him more and more in discussions about behavioral goals, rewards and punishments, and treatment decisions.

Making the Most Out of Parenting Techniques

Clearly, parent training and techniques take a great deal of effort on your part. It is always difficult to change old habits, and altering your parenting approach can be especially challenging because it often springs from family tradition and deep-seated childhood experiences. As you read at the beginning, being able to participate in a formal parent training program is an optimal way to learn, practice, and get feedback on the techniques discussed in this article, but, if this is not possible for any number of reasons, you can also work on these principles with your child's pediatrician or psychologist in a less formal way. While reading this material can give you a general idea of how behavior therapy works, actually participating in parent training or working with professionals in other ways allows you to tailor its methods to your own unique situation, try out some of the techniques under expert guidance, and get regular feedback on what is and is not working and on how to adjust your approach. Without this focused support, you might find success more limited.

Keep in mind, too, that behavior therapies, including parent training, have been shown to be effective only while they are being implemented and maintained. (Your child is not likely to keep up his improved behavior if you drop the effective techniques you have learned.) Even during periods when you see little progress, it is important to remain consistent. During those times when you feel exhausted and discouraged, and wonder what the point is of trying (and most parents of children with ADHD do get to that point once in a while), consider how hard your child must also work to continue trying to maintain his best self-control. By focusing as much as possible on the positive, thinking creatively, and asking for expert help when needed, you can maintain the supportive structure you have created for your child and eventually see measurable improvement.

Last Updated 8/11/2010

Source ADHD: A Complete and Authoritative Guide (Copyright © 2004 American Academy of Pediatrics)

topic landing page

Attention Deficit Hyperactivity Disorder

Principles of Limit Setting

The most important thing to your child is your love and approval. Because of this need for your love, your child will want to respond to and meet your expectations. By keeping your expectations consistent, reasonable, and predictable you can help your child gain control over his or her behavior.

- Reasonable limits make your child feel protected by someone who understands the world better than he does. Knowing the rules helps him relax.
- Most children do not need an abundance of rules. Your child will understand and accept limits better when she helps make the rules through a process of discussion that includes the reasons for the rules (e.g., safety). If you are having to make rules all the time or having to discipline often, consult your primary care health professional.
- When you make a request, get your child's attention, then only ask once. If he does not follow your instructions, take him with you while you complete the task. Praise any cooperation. This is called "One request and then move."
- Although it is best when all caregivers use rules consistently, your child can also adapt to different rules used consistently by different people or in different settings. It is better to expect your child to adapt than to openly clash with others over differences.
- Sometimes rules should be enforced flexibly to meet the needs of a "special occasion" (e.g., staying up later for a special event). This is best done before your child demands such a change to avoid the appearance that you were manipulated. Instead of weakness, this demonstrates a desirable amount of flexibility.

Following through consistently, yet flexibly, on expectations for behavior is a difficult balance for any parent to achieve. The following factors can make this even harder:

- Feeling reluctant to enforce consistent rules or limits because of concerns about causing your child extra stress, or feeling uncomfortable handling your child's anger when a limit is set
- Widely differing expectations for behavior among your child's caregivers
- Stress in other areas of your life
- Too many or too rigid rules
- A history of being exposed to anger in your own life, which can make it more difficult to handle angry responses from your child
- Not having as much fun time together with your child as you would like

If you feel any of these factors are relevant to your family, consider discussing them with your child's primary care health professional or another supportive professional (e.g., religious leader, social worker, counselor).

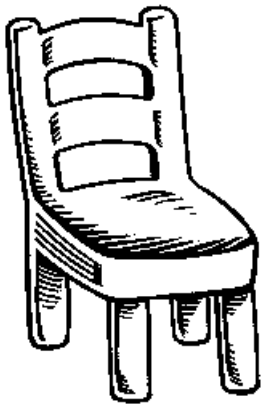
Cite as: Howard BJ. 2002. Principles of limit setting. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

Time Out

Young children respond best to praise for good behavior. However, sometimes they need to have limits set for them or a space to cool off. Time outs let you do this safely and effectively. A time out is a form of discipline that can be used when your child needs to calm down or when your child does something wrong on purpose.

Time out works best when

- You are calm but firm.
- Your child is taught about time out before it is needed.
- Your child understands the purpose of the time out.



When you decide to use a time out

- Warn your child once before initiating a time out.
- Place your child in a boring but safe and nonscary spot (e.g., a nearby chair or step where you can watch her). Toddlers may be placed on the floor or in a playpen.
- Briefly state the rule that was broken or the reason the child needs to take a time out (e.g., "No hitting. Hitting hurts people," or "You are getting a little too excited. Why don't you take a time out.").
- The time out should begin as soon as the child understands the reason for it.
- Time outs should last approximately 1 minute per year of a child's age to a maximum of 10 minutes. Some people find that a timer that ticks and has a bell can help signal the end of the time out. Children ages 6 and older may be able to decide for themselves when they feel calm enough to leave time out. Children ages 10 and older generally benefit more from discussion, logical consequences such as repayment for damages, or removal of privileges (including grounding), than from time out.
- If your child leaves time out before it is over, he or she should be put back without comment and held there with your hands or on your lap.
- After time out, your child should immediately be redirected to an acceptable activity.
- Discussion and/or role playing of the incident and alternatives should take place only after your child is calm again.

If "time outs" lead to increasing struggles or do not work, consult your child's primary care health professional.

Portions of this tool were modeled on: Sege R. 2000. Time-out! In Sege R, ed., *Violence Prevention for Children and Youth: Parent Education Cards* (2nd ed.). Waltham, MA: Massachusetts Medical Society. Copies available from the Massachusetts Medical Society. Phone: (800) 322-2303; e-mail: dph@mms.org.

Cite as: Howard BJ. 2002. Time out. In Jellinek M, Patel BP, Froehle MC, eds., *Bright Futures in Practice: Mental Health—Volume II. Tool Kit.* Arlington, VA: National Center for Education in Maternal and Child Health.

ADHD

Child, parent or teacher concerns for hyperactivity or inattention

Assessment including review of ADHD symptoms, standardized measure (e.g. Vanderbilt) of symptoms per teacher and parent report consideration of differential diagnoses, family and social history

Consider a diagnosis of ADHD with the following symptoms:
Can't sit still/hyperactive
Lack of attention/poor concentration/doesn't seem to listen/daydream
Impulsive/acts without thinking
Behavior problems
Poor academic performance/underachievement

Are the DSM-IV criteria met for ADHD?

Yes → Diagnosis of ADHD

No → Is there evidence of developmental concern or alternative diagnoses?

Differential Diagnosis includes:
Learning/language disorders
Oppositional defiant disorder
Conduct D/o
Anxiety
Depression
Substance abuse

Yes → Address co-morbid conditions

No → Reassess concerns

Diagnosis of ADHD → First line stimulant: select either extended release methylphenidate (mph) or amphetamine formulation (amph) (see chart below). Titrate to effect or limiting adverse effects.

ADHD symptoms fully treated by clinical report and standardized measures?

Yes → Continue stimulant treatment, monitoring q1-2 months with standardized parent and teacher report

No → Trial of other stimulant class (mph or amph)

ADHD symptoms fully treated by clinical report and standardized measures?

Yes → Continue stimulant treatment, monitoring q1-2 months with standardized parent and teacher report

No → Reassess diagnosis, consider atomoxetine, buproprion, or specialty referral → Refer to specialty mental health professional

References :
Reference: Contemporary Pediatrics (2003) Focus on ADHD: Diagnosis, Treatment, Comorbidity; Pp.51-73.
Pliszka, S.R., et al., *The Texas Children's Medication Algorithm Project: Revision of the Algorithm for Pharmacotherapy of Attention-Deficit/Hyperactivity Disorder.* JAACAP, 2006. **45**(6): p. 642-657.

1AACAP, *Practice Parameter for the Use of Stimulant Medications in the Treatment of Children, Adolescents, and Adults.* Journal of the American Academy of Child & Adolescent Psychiatry, 2002. **41**(2S): p. 26S-49s.

ADHD Resource Guide

What are the symptoms of ADHD?

ADHD symptoms usually arise in early childhood. Current diagnostic criteria indicate that the disorder is marked by behaviors that are long lasting and evident for at least six months, with onset before age seven. There are three primary subtypes, each associated with different symptoms.

ADHD - Primarily Inattentive Type:

• Fails to give close attention to details or makes careless mistakes.
• Does not appear to listen.
• Struggles to follow through on instructions.
• Has difficulty with organization.
• Avoids or dislikes tasks requiring sustained mental effort.
• Is easily distracted.
• Is forgetful in daily activities.

ADHD - Primarily Hyperactive/Impulsive Type:

• Fidgets with hands or feet or squirms in chair.
• Has difficulty remaining seated.
• Runs around or climbs excessively.
• Has difficulty engaging in activities quietly.
• Acts as if driven by a motor.
• Talks excessively.
• Blurts out answers before questions have been completed.
• Has difficulty waiting or taking turns.
• Interrupts or intrudes upon others.

ADHD - Combined Type:

• Meets both inattentive and hyperactive/impulsive criteria.

All types

- More frequent or severe than in other children of the same age.
- Create significant difficulty in at least two areas of life, such as home, social settings, school, or work.

Pathophysiology

Findings from neuropsychological studies suggest that the frontal cortex and the circuits linking them to the basal ganglia are critical for executive function and, therefore, to attention and exercising inhibition. Many findings support this view, including those described below.

Executive functions are major tasks of the frontal lobes. Functional MRI of the right mesial prefrontal cortex in persons with ADHD reveals decreased activation (low arousal) during tasks that require motor inhibition. . MRI in people with ADHD also suggests low activity in the right inferior prefrontal cortex and left caudate during a task that involves timing of a motor response. .

Catecholamine controlled dopaminergic and noradrenergic neurotransmission appear to be the main targets for medications used to treat ADHD.

Causes

Genetic factors appear to be play an important role in ADHD. However, many environmental factors have been correlated with ADHD and may increase or decrease risk of ADHD morbidity in predisposed patients.

Epidemiology

Prevalence: 3-7%.

Comorbidity: 50-60% meet *DSM-IV* criteria for at least one of the possible coexisting conditions

- learning disorders
- depression
- anxiety disorder
- oppositional defiant disorder
- substance abuse disorder,
- Conduct disorder.

Gender: Boys:Girls ratio 2-4:1

Course over time: 30-80% of children with ADHD have the disorder as adults. Most experts believe that the rate is well above 50%, with more prominent inattentive symptoms than hyperactive symptoms.

Differential Diagnosis

DSM-IV-TR Diff Dx Differential Diagnosis by the Tables 2011 American Psychiatric Publishing, Inc.	
Attention-Deficit/Hyperactivity Disorder must be differentiated from . . .	**In contrast to Attention-Deficit/Hyperactivity Disorder, the other condition . . .**
Age-appropriate behaviors in active children	• Does not cause clinically significant impairment.
Under-stimulating environments	• Leads to inattention that is related to boredom.
Inattention in Oppositional Defiant Disorder	• Results from unwillingness to conform to others' demands.
Impulsivity in Conduct Disorder	• Is associated with a pattern of antisocial behavior.
Inattention or hyperactivity associated with Pervasive Developmental Disorders	• Has a characteristic symptom presentation with marked defects in social relatedness, serious delays in language, and a restricted range of interests and behaviors.
Inattention or hyperactivity caused by drugs of abuse or medications (e.g., bronchodilator)	• Remits when drug of abuse or medication is discontinued and is diagnosed as Substance-Related Disorder Not Otherwise Specified or Adverse Effects of Medication Not Otherwise Specified.
Symptoms of inattention due to other mental disorders (e.g., Mood or Anxiety Disorders)	• Has the characteristic features of the other mental disorder, and onset is typically after age 7 years. • Attention-Deficit/Hyperactivity Disorder is not diagnosed if inattention occurs exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder, or if it is better accounted for by another mental disorder.
Medical conditions that can mimic ADHD	• Fetal Alcohol Syndrome • Fragile X Syndrome • Hearing Impairment • Medication side effects • Obstructive sleep apnea • Other chronic disease • Substances of abuse • Thyroid disease • Toxins • Vision impairment • Cerebral palsy • Communication disorders • Developmental delays • Learning disabilities • Mental retardation • Neurodevelopmental syndromes • Seizure disorder
Adjustment to stressors	• Abuse • Family stressor/change/dysfunction • Neglect • Parenting dysfunction • Stress in environment (new home, new school)

ADHD Assessment Strategies

Universal screening- Pediatric Symptom Checklist or other broad-band screener. Attend to "2"'s on items related to inattention and/or impulsivity.

Symptom-Specific Structured measures

- Vanderbilt ADHD Rating Scale (ages 6-12)
    - Inattentive type likely if 6 or more "2's" or "3's" on items 1-9
    - Hyperactive type likely if 6 of more "2's" or "3's" on items 10-18
    - Combined type likely if meets both inattentive and hyperactive

ADHD evaluation: The relevant history

Parental concerns
Child's strengths and weaknesses
Duration and onset of symptoms
Goals for evaluation process
Level of impairment
Past approaches to concerns
Specific problems perceived by caregivers

Behavioral history
Ability to separate from caregivers
ADHD symptoms
Psychiatric symptoms
Psychological counseling
Sleep issues (poor quality or quantity, nightmares, snoring)
Suicidal and/or homicidal attempts or thoughts
Temperament (colic, temper tantrums, irregular or picky eating, difficulty keeping a babysitter)

Medical history
Birth history (prematurity, prenatal substance abuse, complications during the pregnancy, labor, or delivery)
Depression
Growth problems
Learning problems
Loss of consciousness/Traumatic Brain Injury
Medications (to include vitamins, herbal supplements, and OTC remedies)
Meningitis or encephalitis
Recurrent headache or abdominal pain
Seasonal allergies
Seizures
Staring spells
Tics

Developmental history
Milestones
Speech, physical, or occupational therapy

Educational history
Conflict with school staff or with classmates
Current academic performance
Disciplinary actions at school (suspensions), consistency of education
Discussions about repeated grades or classes
Earl intervention programs
Individualized educational program
Problems in completed grades
Special education
Strongest and weakest academic areas

Family history
ADHD
Mental illness
Drug and alcohol abuse
Neurologic disorders
Learning or reading difficulties
Birth defects
Legal problems
Physical or sexual abuse
Thyroid disease
Toxic exposures

Personal and social history
Family dysfunction
Living arrangements
Problems with authorities
Social skills
Substance abuse
Work performance

Physical

- Likely normal physical examination although may see symptoms of hyperactivity
- The following should be included at onset of medication use and periodically to assess for medication-related negative effects:
    - Vital signs
        - Height
        - Weight
        - Blood pressure
        - Pulse
    - General appearance
        - Fidgeting
        - Impulse control
        - State of arousal
    - Mental status examination
        - Affect (facial expression)
        - Cognition
        - Thought patterns/organization

Primary Care Management of ADHD

Primary care providers provide most of the ADHD assessment and management in the country. Each provider will have a different level of comfort and experience in treating ADHD beyond the second line treatment.

Principles for pharmacotherapy for ADHD

- First line treatment should be with either a methylphenidate or mixed amphetamine salt formulation. Choice depends on family preference, family history of response to treatment, and provider comfort. Need for non-pill form of the medication should also be considered .
- Mixed amphetamine salts are twice as potent as methylphenidate formulations (5 mg mixed amphetamine salts= 10 mg methylphenidate)
- For school age children, there is no advantage to starting with short acting medicaitons. Extended release will reduce logistical challenges and stigma in school.
- Dose should be increased weekly until optimal effect is reached or side effects are encountered.
- Structured measures for parent and teacher report should be used at each visit until dose established and then regularly after that time.
- Second line treatment should be the alternative stimulant class with same titration approach.
- Beyond second line treatment, reassess diagnosis and non-pharmacolgoical treatment. May consider alpha agonists (especially if significant impulsive symptoms), atomoxetine (especially if co-morbid anxiety or predominantly inattentive symptoms) or buproprion (especially if depression).
- If good effect but decrease appetite
  - Consider weekend medication “holidays”
  - Increased late afternoon/evening caloric intake
  - Avoid appetite stimulants unless multiple other approaches (including medication change) have failed
- If good effect but sleep disturbances
  - Assess and address sleep hygiene
  - Consider shorter acting formulation
  - If already tried other medications, consider alpha agonist at night for sleep
- Concurrent medications
  - Some evidence exists to support use of stimulant + alpha agonists for difficult to treat ADHD
- Does the patient need behavioral therapy?
  - In the Multimodal treatment of ADHD Study (MTA), children with co-morbid anxiety conditions and those from low income families benefitted from the combination of behavioral treatment PLUS stimulants.
- How frequently should they be seen?
  - At least monthly until dose stabilized
  - MTA study showed that children seen at least 9 times per year had substantially better control of ADHD than those seen 6 times per year!
  -

Indicators of need for specialty referral

The timing of consultations depends on the practitioner's degree of knowledge and experience with the evaluation and treatment of ADHD.

Consider brief consultation if

- Refer if the medication is causing side effects or is no longer effective, if there are co-morbidities, or if the medication cannot be adjusted with confidence.

Consider referral for evaluation if:

- Unanswered questions about ADHD or coexistent conditions.
- Concerning family history of a mood or anxiety disorder thought to complicate the differential diagnosis or potential response to treatment
- Substance abuse in patient with ADHD

The 2 major components in the medical care of children with attention deficit hyperactivity disorder (ADHD), previously termed attention deficit disorder (ADD), are behavioral and pharmaceutical therapies.

ADHD MEDICATIONS

Medication	Brand Name	Initial Pediatric Dose	Pediatric Dosage Range and Maximum Dose*	Common Pediatric Dose*	Usual duration of effect	Preparations
Methylphenidate immediate release	Ritalin Methylin methylphenidate	2.5-5 mg TID	0.1-0.8 mg/kg/dose PO qd to 5 times/d; not to exceed 60 mg/d	0.3-0.5 mg/kg/dose PO tid/qid	4	All preparations available as 5-mg, 10-mg, or 20-mg scored tabs; Methylin also available as 2.5-mg, 5-mg, or 10-mg chewable tab and PO solution (5 mg/5 mL and 10 mg/mL)
Methylphenidate sustained-release (SR)	Ritalin LA Metadate CD	10 mg	0.2-1.4 mg/kg/dose PO qd/tid; not to exceed 60 mg/d	0.6-1 mg/kg/dose PO qd/bid	6-8 hours	10-mg, 20-mg, 30-mg, or 40-mg tabs (Metadate also has 50-mg and 60-mg tabs.); can be sprinkled into soft food (Do not cut, crush, or chew.)
Methylphenidate extended release (ER)‡	(Ritalin SR Methylin ER Metadate ER generic S	10	0.2-1.4 mg/kg/dose PO qd/tid; not to exceed 60 mg/d	0.6-1 mg/kg/dose PO qd/bid	7-8 hours	Ritalin SR: 20-mg Spansules (Do not cut, crush, or chew.) Metadate ER: 10, 20 mg (not readily available)
Methylphenidate OROS tablets	Concerta	18 mg	0.3-2 mg/kg PO qd; not to exceed 54 mg/d	0.8-1.6 mg/kg PO qd	8-12 hours	18-mg, 27-mg, 36-mg, and 54-mg tabs (Do not cut, crush, or chew.
Methylphenidate transdermal patch†	Daytrana	Convert from IR or use 10 mg qd	0.3-2 mg/kg released over 9 h; not to exceed one 30-mg patch	10-30 mg released over 9 h	Duration may be titrated. Apply 2 hours before desired effect. Effect lasts ~ 5 hours after removal of patch.	10-mg, 15-mg, 20-mg, 30-mg patches, applied to the hip.
Medication	**Brand name**	**Initial Pediatric**	**Pediatric Dosage Range**	**Common Pediatric Dose**	**Duration of effect**	**Preparations**

		Dose	**and Max dose**			
Dexmethylphenidate IR	Focalin	2.5-5-mg	0.1-0.5 mg/kg/dose PO qd to qid; not to exceed 20 mg/d	0.2-0.3 mg/kg/dose PO bid/tid	4	2.5-mg, 5-mg, or 10-mg scored tabs (Do not cut, crush, or chew.)
Dexmethylphenidate extended release	Focalin XR	5-10-mg	0.2-1 mg/kg/dose PO qd to bid; not to exceed 20 mg/d	0.4-0.6 mg/kg/dose PO qd/bid	Up to 12 hours	5-mg, 10-mg, or 20-mg scored tabs; can be sprinkled into soft food (Do not cut, crush, or chew.)
Dextroamphetamine	Dexedrin Dextrostat	2.5-5 mg	0.1-0.7 mg/kg/dose PO qd/qid; not to exceed 60 mg/d	0.3-0.5 mg/kg/dose PO qd/tid	4	Dexedrine: 5-mg scored tabs; Dextrostat: 5-mg and 10-mg scored tabs
Dextroamphetamine Spansules	Dexedrine CR	5 mg	0.1-0.75 mg/kg/dose PO qd/bid; not to exceed 60 mg/d	0.3-0.6 mg/kg/dose PO qd/bid	10	5-mg, 10-mg, or 15-mg Spansules; can be sprinkled into soft food (Do not cut, crush, or chew.)
Mixed amphetamine salts IR	Addderall Mixed amphetamine salts	2.5-5 mg	0.1-0.7 mg/kg/dose PO qd/qid; not to exceed 40 mg/d	0.3-0.5 mg/kg/dose PO tid/qid	4	5-mg, 7.5-mg, 10-mg, 12.5-mg, 15-mg, 20-mg, or 30-mg scored tabs
Mixed amphetamine salt XR	AdderallXR	5-10 mg	0.2-1.4 mg/kg/dose PO qd/tid Not to exceed 30 mg/d	0.6-1 mg/kg/dose PO qd/bid	10	5-mg, 10-mg, 15-mg, 20-mg, 25-mg, or 30-mg Spansules; can be sprinkled into soft food (Do not cut, crush, or chew.)
Lisdexamfetamine	Vyvanse	30 mg PO qam	30-70 mg PO qam	30-70 mg per day	13	20-mg, 30-mg, 40-mg, 50-mg, 60-mg, or 70-mg caps (Swallow cap whole, sprinkle into soft food, or dissolve contents in glass of water and drink immediately).to be used in patients with high risk of non-po abuse.

Medication	Brand Name	Initial Pediatric Dose	Pediatric Dosage Range and Maximum Dose*	Common Pediatric Dose*	Usual duration of effect	Preparations
Guanfacine	Tenex	0.5 mg qhs	Increase by .5 mg qd up to 3 mg qd Wean off over 2-4 days to avoid rebound HTN	1.5-3 mg per day	8-12 hours	1, 2, 3, 4mg tab Can be broken in half and cut into ¼
Guanfacine ER	Intuniv	1 mg PO qd initially; may adjust dose by increasing increments not exceeding 1 mg/wk	Dosing on mg/kg basis: 0.05-0.08 mg/kg PO qd initially, may adjust dose up to 0.12 mg/kg qd; not to exceed 4 mg/d Discontinuing drug: Taper in decrements not exceeding 1 mg q3-7 days Switching from immediate-release: Discontinue immediate-release tab and titrate with extended-release as described above Do not administer with high-fat meals (increases serum levels)	1-4 mg/d	T ½= 18 hours	1, 2, 3, 4mg tab Do not chew, crush, or split tablets before swallowing
Clonidine	catapres	.05 mg q hs	Increase by 0.05 mg qd up to 0.3 mg qd Wean off over 2-4 days to avoid rebound HTN	.15-.3 mg per day	6 hours	0.1,0.2,0.3, 0.4 mg tab Transdermal patch 0.1, 0.2, 0.3 mg weekly patches
Clonidine ER	Kapvay	0.1 mg PO qhs initially;	Increase dose 0.1 mg/day at weekly intervals Doses 0.2 mg/day or greater should be divided bid	0.1-0.4 mg po qd divided BID	T ½= 12-16 hours	**Dosage forms:** 1,2,3,4 ER Swallow tablet whole; do not crush, chew, or split
Atomoxetine	Strattera	<70 kg: 0.5 mg/kg PO qd initially afternoon); ≥ 70 kg: 40 mg PO qd initiall	not to exceed 1.4 mg/kg/d or 100 mg/d (whichever is less). Increase to 1.2 mg/kg after 3 days of starting dose.	1.2 mg/kg/day		10, 18, 25, 40, 60, 80, 100mg cap

* Maximum pediatric dose suggested by the US Food and Drug Administration (FDA). Although some children benefit greatly from doses greater than these, benefit from use of either the lowest and highest ends of the dose range is uncommon.

†The methylphenidate patch contains a different total methylphenidate dose than the name implies because it is designed to last 12 hours (eg, 10-mg patch [patch size 12.5 cm2] delivers about 10 mg over 9 h [estimated delivery rate is 1.1 mg/h for this particular patch]). Delivery rate varies depending on patch size.

‡Many patients describe their experience with methylphenidate SR preparations as erratic and uncomfortable

**For methylphenidate LA, CD, or ER preparations, convert by using a ratio of 2:1 with immediate-release methylphenidate. For example, Ritalin 10 mg q4h is converted to Ritalin LA 20 mg q8h. For a few patients, effects last only 5-6 hours with the LA preparations, although effects last 3.5-4 hours with the IR form. However, a short effect from one 8-hour preparation does not always mean another 8-hour preparation has the same problem.

Physician Resources

Nichq.org

Parent Resources:

Parentsmedguide.org

Chadd.org

References:

AACAP, *Practice Parameter for the Use of Stimulant Medications in the Treatment of Children, Adolescents, and Adults.* Journal of the American Academy of Child & Adolescent Psychiatry, 2002. 41(2S): p. 26S-49s.

APA, *Diagnostic and Statistical Manual of Mental Disorders IV-TR*. 4 ed. 2000, Washington, D.C.: American Psychiatric Association.

Pliszka, S., *Pharmacologic Treatment of Attention-Deficit/Hyperactivity Disorder: Efficacy, Safety and Mechanisms of Action.* Neuropsychology Review, 2007. 17(1): p. 61.

Daughton, J. and C. Kratchovil, *Stimulants*, in *Pediatric Psychopharmacology*, A. Martin, L. Scahill, and C.J. Kratochvil, Editors. 2011, Oxford: NY. p. 251-262.

Mantauk, S et al. Pediatric ADHD; accessedJanuary 2011 from www.Emedicine.medscape.com; Oct, 2006.

Focus on ADHD: Diagnosis, Treatment, Comorbidity. Contemporary Pediatrics, Dec. 2003. Pp. 51-106

Handouts from NICHQ website: nichq.org in collaboration with AAP and McNeil.

Current Procedural Terminology (CPT) Codes

Initial assessment usually involves time determining the differential diagnosis, a diagnostic plan, and potential treatment options. Therefore, most clinicians will report either an office/outpatient evaluation and management (E/M) code using time as the key factor* or a consultation code for the initial assessment.

Office or Other Outpatient E/M Codes

99201/99202/99203/99204/99205 Use for **new**† patients only; require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

99212/99213/99214/99215 Use for established patients; require 2 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

Office or Other Outpatient Consultation Codes

99241/99242/99243/99244/99245 Use for new **or** established patients; appropriate to report if another physician or other appropriate source (ie, school nurse, psychologist) requests an opinion regarding a child potentially having ADHD. Require 3 of 3 key components or greater than 50 percent of the visit spent in counseling or coordinating care.

NOTE: Use of these codes *requires* the following:

- Written or verbal request for consultation is documented in the patient chart.
- Consultant's opinion as well as any services ordered or performed are documented in the patient chart.
- Consultant's opinion and any services that are performed are prepared in a *written* report, which is sent to the requesting physician or other appropriate source.

Prolonged Physician Services Codes

99354/99355 Use for *outpatient* face-to-face prolonged services.

99358/99359 Use for *non*–face-to-face prolonged services in any setting.

- Used when a physician provides prolonged services beyond the usual service (ie, beyond the typical time).
- An *alternate* to using time as the key factor with the office/outpatient E/M codes **(99201–99215).**
- Time spent does not have to be continuous.
- Codes are "add-on" codes, meaning they are reported separately in addition to the appropriate code for the service provided (eg, office or other outpatient E/M codes, **99201–99215**).
- If the physician spends at least 30 and no more than 74 minutes more than the typical time associated with the reported E/M code, he or she can report **99354** (for face-to-face contact) or **99358** (for non–face-to-face contact). Codes **99355** (each additional 30 minutes of face-to-face prolonged service) and **99359** (each additional 30 minutes of non–face-to-face prolonged service) are used to report each additional 30 minutes of service beyond the first 74 minutes.
- Prolonged service of less than 15 minutes beyond the first hour or less then 15 minutes beyond the final 30 minutes is *not reported separately.*

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*Time can be used as the key factor in determining a level of service when counseling and/or coordinating care constitute more than 50% of the encounter.

†A new patient is defined as one who has not received any professional services from a physician, or another physician of the same specialty who belongs to the same group practice, within the past 3 years (*Principles of CPT Coding* [second edition], American Medical Association, 2001).

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Case Management Services Codes

99361/99362 Use to report a medical conference among the physician and an interdisciplinary team of health professionals to coordinate activities of patient care (patient not present).

99371/99372/99373 Use to report telephone calls made by the physician to patient or parent, for consultation or medical management, or for coordinating medical management with other health care professionals.

Central Nervous System Assessments/Tests Codes

96100 Use to report psychological testing, per hour; includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities (eg, WAIS-R, Rorschach test, MMPI).

96110 Use to report limited developmental testing with interpretation and report (eg, Developmental Screening Test II, Early Language Milestone Screen).

96115 Use to report neurobehavioral status examination with interpretation and report, per hour (eg, Conners Continuous Performance Test, Hawthorne Test).

Other Psychiatric Services or Procedures Codes

90862 Use to report pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (eg, Ritalin check).

90887 Use to report interpretation or explanation of results of psychiatric, other medical examinations or procedures, or other accumulated data to patient's family/guardian(s), or advising them how to assist patient.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and *Diagnostic and Statistical Manual for Primary Care (DSM-PC)* Codes

- *Before ADHD is diagnosed,* do not use "rule out ADHD" as the diagnosis. Use as many diagnosis codes as apply to document the patient's complexity and report the patient's symptoms and/or adverse environmental circumstances.
- *Once a definitive ADHD diagnosis is established,* report the appropriate definitive diagnosis code(s) as the primary code, plus any other symptoms that the patient is exhibiting as secondary diagnoses.
- Counseling diagnosis codes can be used when the patient is present or when counseling the parent/guardian(s) when the patient is not physically present.

ICD-9-CM Codes

293.84 Organic anxiety syndrome
300.00 Anxiety state, unspecified
300.01 Panic disorder
300.02 Generalized anxiety disorder
300.20 Phobia, unspecified
300.23 Social phobia
300.29 Other isolated or simple phobia
300.4 Neurotic depression
307.0 Stammering and stuttering
307.9 Other and unspecified special symptoms or syndromes, not elsewhere classified (NEC)
309.21 Separation anxiety disorder
309.3 Adjustment reaction; with predominant disturbance of conduct
312.00 Undersocialized conduct disorder, aggressive type; unspecified
312.30 Impulse control disorder, unspecified
312.81 Conduct disorder, childhood onset type
312.82 Conduct disorder, adolescent onset type
312.9 Unspecified disturbance of conduct
313.81 Oppositional disorder
313.83 Academic underachievement disorder
314.00 Attention-deficit disorder, without mention of hyperactivity
314.01 Attention-deficit disorder, with mention of hyperactivity
314.1 Hyperkinesis with developmental delay
314.2 Hyperkinetic conduct disorder
314.8 Other specified manifestations of hyperkinetic syndrome
314.9 Unspecified hyperkinetic syndrome
315.00 Reading disorder, unspecified
315.01 Alexia
315.02 Developmental dyslexia
315.09 Specific reading disorder; other
315.1 Specific arithmetical disorder
315.2 Other specific learning difficulties
315.31 Developmental language disorder
315.32 Receptive language disorder (mixed)
315.39 Developmental speech or language disorder; other
315.4 Coordination disorder
315.5 Mixed developmental disorder
315.8 Other specified delay in development
315.9 Unspecified delay in development
781.3 Lack of coordination

ICD-9-CM Codes, continued

NOTE: The *ICD-9-CM* codes below are used to deal with occasions when circumstances other than a disease or injury are recorded as "diagnoses" or "problems." Some carriers may request supporting documentation for the reporting of V codes.

V40.0 Problems with learning
V40.1 Problems with communication (including speech)
V40.3 Mental and behavorial problems; other behavioral problems
V40.9 Unspecified mental or behavioral problem
V60.0 Lack of housing
V60.1 Inadequate housing
V60.2 Inadequate material resources
V60.8 Other specified housing or economic circumstances
V61.20 Counseling for parent-child problem, unspecified
V61.29 Parent-child problems; other
V61.49 Health problems with family; other
V61.8 Health problems within family; other specified family circumstances
V61.9 Health problems within family; unspecified family circumstances
V62.0 Other psychosocial circumstances; unemployment
V62.5 Other psychosocial circumstances; legal circumstances
V62.81 Interpersonal problems, NEC
V62.82 Bereavement, uncomplicated
V62.89 Other psychological or physical stress, NEC; other
V62.9 Unspecified psychosocial circumstance
V65.49 Other specified counseling
V71.02 Observation for suspected mental condition; childhood or adolescent antisocial behavior

DSM-PC Codes

300.01 Panic disorder
300.02 Generalized anxiety disorder
300.23 Social phobia
300.29 Specific phobia
307.0 Stuttering
307.9 Communication disorder, not otherwise specified (NOS)
308.3 Acute stress disorder
309.21 Separation anxiety disorder
309.3 Adjustment disorder with disturbance of conduct
309.81 Posttraumatic stress disorder
312.81 Conduct disorder, childhood onset
312.82 Conduct disorder, adolescent onset
312.9 Disruptive behavior disorder, NOS
313.81 Oppositional-defiant disorder
314.00 Predominantly Inattentive type
314.01 Predominantly Hyperactive-Impulsive type
314.01 Combined type
314.9 Attention-deficit/hyperactivity disorder, NOS
315.0 Reading disorder (developmental reading disorder)
315.1 Mathematics disorder (developmental arithmetic disorder)
315.2 Disorder of written expression (developmental expressive disorder)
315.31 Expressive language disorder
315.32 Mixed receptive-expressive language disorder
315.39 Phonologic disorder
315.4 Developmental coordination disorder
315.9 Learning disorder, NOS
781.3 Developmental coordination problem
V40.0 Learning problem
V40.1 Speech and language problem
V40.2 Anxiety problem
V40.3 Hyperactive/impulsive behavior problem
V40.3 Inattention problem
V40.3 Sadness problem
V62.3 Developmental/cognitive problem
V62.82 Bereavement
V65.4 Aggressive/oppositional variation
V65.4 Developmental/cognitive variation
V65.49 Aggressive/oppositional variation
V65.49 Anxious variation
V65.49 Developmental coordination variation
V65.49 Hyperactive/impulsive variation
V65.49 Inattention variation
V65.49 Learning variation
V65.49 Negative emotional behavior variation
V65.49 Sadness variation
V65.49 Secretive antisocial behaviors variation
V65.49 Speech and language variation
V71.02 Aggressive/oppositional problem
V71.02 Negative emotional behavior problem
V71.02 Secretive antisocial behaviors problem

NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

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

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

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

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

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

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

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

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

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

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

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

Revised - 0303

HL0551

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

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

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

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

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

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

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

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

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

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

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

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

Revised - 0303

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McNeil Consumer & Specialty Pharmaceuticals

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

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

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

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

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

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

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

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

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

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

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

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

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

Revised - 0303

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

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

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

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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

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Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	**ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up

- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Clinical Attention Problem Scale

Please complete once a week

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

Completed by: _____ **Medication:** _____

Below is a list of items that describe pupils. Rate each item that describes the pupil *now* or *within the last week as follows:*

0 = Not true **1 = Somewhat or Sometimes True** **2= Very or Often True**

Morning				Afternoon			
1. Fails to finish things he/she starts	0	1	2	1. Fails to finish things he/she starts	0	1	2
2. Can't concentrate, can't pay attention for long	0	1	2	2. Can't concentrate, can't pay attention for long	0	1	2
3. Can't sit still, restless, or hyperactive	0	1	2	3. Can't sit still, restless, or hyperactive	0	1	2
4. Fidgets	0	1	2	4. Fidgets	0	1	2
5. Daydreams or gets lost in his/her thoughts	0	1	2	5. Daydreams or gets lost in his/her thoughts	0	1	2
6. Impulsive, or acts without thinking	0	1	2	6. Impulsive, or acts without thinking	0	1	2
7. Difficulty following directions	0	1	2	7. Difficulty following directions	0	1	2
8. Talks out of turn	0	1	2	8. Talks out of turn	0	1	2
9. Messy	0	1	2	9. Messy	0	1	2
10. Inattentive, easily distracted	0	1	2	10. Inattentive, easily distracted	0	1	2
11. Talks too much	0	1	2	11. Talks too much	0	1	2
12. Fails to carry out assigned tasks	0	1	2	12. Fails to carry out assigned tasks	0	1	2

Additional Comments:

Clinical Attention Profile Scoring

Name:	Male Female	Record #
Date:	DOB:	Age:

Morning

	Inattention	Overactivity	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			Total
Raw			
Pct			

Afternoon

	Inattention	Overactivity	
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			Total
Raw			
Pct			

Inattention

	All	Boys	Girls
Median	1	2	0
69th %	3	4	2
84th %	6	7	5
93rd %	8	9	7
98th %	11	12	10

Overactivity

	All	Boys	Girls
Median	0	1	0
69th %	1	2	1
84th %	4	4	2
93rd %	6	6	5
98th %	8	8	7

Total Score

	All	Boys	Girls
Median	2	4	1
69th %	6	7	4
84th %	10	11	8
93rd %	14	15	11
98th %	19	20	16

Data from Russell Barkley and Craig Edelbrock

General Tips

1. Rules should be clear and brief. Your child should know exactly what you expect from him or her.
2. Give your child chores. This will give him or her a sense of responsibility and boost self-esteem.
3. Short lists of tasks are excellent to help a child remember.
4. Routines are extremely important for children with ADHD. Set up regular times for meals, homework, TV, getting up, and going to bed. Follow through on the schedule!
5. Identify what your child is good at doing (like art, math, computer skills) and build on it.
6. Tell your child that you love and support him or her unconditionally.
7. Catch your child being good and give immediate positive feedback.

Common Daily Problems

It is very hard to get my child ready for school in the morning.

- Create a consistent and predictable schedule for rising and getting ready in the morning.
- Set up a routine so that your child can predict the order of events. Put this routine in writing or in pictures on a poster for your child. Schedule example:

  Alarm goes off → Brush teeth → Wash face → Get dressed → Eat breakfast → Take medication → Get on school bus

- Reward and praise your child! This will motivate your child to succeed. Even if your child does not succeed in all parts of the "morning routine," use praise to reward your child when he or she is successful. Progress is often made in a series of small steps!
- If your child is on medication, try waking your child up 30 to 45 minutes before the usual wake time and give him or her the medication immediately. Then allow your child to "rest" in bed for the next 30 minutes. This rest period will allow the medication to begin working and your child will be better able to participate in the morning routine.

My child is very irritable in the late afternoon/early evening.

(Common side effect of stimulant medications)

- The late afternoon and evening is often a very stressful time for all children in all families because parents and children have had to "hold it all together" at work and at school.
- If your child is on medication, your child may also be experiencing "rebound"—the time when your child's medication is wearing off and ADHD symptoms may reappear.
- Adjust your child's dosing schedule so that the medication is not wearing off during a time of "high demand" (for example, when homework or chores are usually being done).
- Create a period of "downtime" when your child can do calm activities like listen to music, take a bath, read, etc.
- Alternatively, let your child "blow off extra energy and tension" by doing some physical exercise.
- Talk to you child's doctor about giving your child a smaller dose of medication in the late afternoon. This is called a "stepped down" dose and helps a child transition off of medication in the evening.

My child is losing weight or not eating enough.

(Common side effects of stimulant medication use)

- Encourage breakfast with calorie-dense foods.
- Give the morning dose of medication after your child has already eaten breakfast. Afternoon doses should also be given after lunch.
- Provide your child with nutritious after-school and bedtime snacks that are high in protein and in complex carbohydrates. Examples: Nutrition/protein bars, shakes/drinks made with protein powder, liquid meals.
- Get eating started with any highly preferred food before giving other foods.
- Consider shifting dinner to a time later in the evening when your child's medication has worn off. Alternatively, allow your child to "graze" in the evening on healthy snacks, as he or she may be hungriest right before bed.
- Follow your child's height and weight with careful measurements at your child's doctor's office and talk to your child's doctor.

Homework Tips

- Establish a routine and schedule for homework (a specific time and place.) Don't allow your child to wait until the evening to get started.
- Limit distractions in the home during homework hours (reducing unnecessary noise, activity, and phone calls, and turning off the TV).
- Praise and compliment your child when he or she puts forth good effort and completes tasks. In a supportive, noncritical manner, it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- It is not your responsibility to correct all of your child's errors on homework or make him or her complete and turn in a perfect paper.
- Remind your child to do homework and offer incentives: "When you finish your homework, you can watch TV or play a game."
- If your child struggles with reading, help by reading the material together or reading it to your son or daughter.
- Work a certain amount of time and then stop working on homework.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. Consider hiring a tutor! Often a junior or senior high school student is ideal, depending on the need and age of your child.

Discipline

- Be firm. Set rules and keep to them.
- Make sure your child understands the rules, so he or she does not feel uninformed.
- Use positive reinforcement. Praise and reward your child for good behavior.
- Change or rotate rewards frequently to maintain a high interest level.
- Punish behavior, not the child. If your child misbehaves, try alternatives like allowing natural consequences, withdrawing yourself from the conflict, or giving your child a choice.

Taking Care of Yourself

- Come to terms with your child's challenges and strengths.
- Seek support from family and friends or professional help such as counseling or support groups.
- Help other family members recognize and understand ADHD.

"Common Daily Problems" adapted from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

Homework Tips for Parents

- **Establish a routine and schedule for homework (a specific time and place)** and adhere to the schedule as closely as possible. Don't allow your child to wait until the evening to get started.
- **Limit distractions** in the home during homework hours (eg, reduce unnecessary noise, activity, and phone calls; turn off the TV).
- **Assist your child in dividing assignments into smaller parts** or segments that are more manageable and less overwhelming.
- **Assist your child in getting started on assignments** (eg, read the directions together, do the first items together, observe as your child does the next problem/item on his or her own). Then get up and leave.
- **Monitor and give feedback without doing all the work together.** You want your child to attempt as much as possible independently.
- **Praise and compliment your child when he or she puts forth good effort and completes tasks.** In a supportive, noncritical manner it is appropriate and helpful to assist in pointing out and making some corrections of errors on the homework.
- **It is not your responsibility to correct all of your child's errors on homework** or make him or her complete and turn in a perfect paper.
- **Remind your child to do homework and offer incentives:** "When you finish your homework, you can…"
- **A contract for a larger incentive/reinforcer may be worked out** as part of a plan to motivate your child to persist and follow through with homework. ("If you have no missing or late homework assignments this next week, you will earn. . .").
- **Let the teacher know your child's frustration and tolerance level in the evening.** The teacher needs to be aware of the amount of time it takes your child to complete tasks and what efforts you are making to help at home.
- **Help your child study for tests.** Study together. Quiz your child in a variety of formats.
- **If your child struggles with reading, help by reading the material together** or reading it to your son or daughter.
- **Work a certain amount of time and then stop working on homework.** Don't force your child to spend an excessive and inappropriate amount of time on homework. If you feel your child worked enough for one night, write a note to the teacher attached to the homework.
- It is very common for students with ADHD to fail to turn in their finished work. It is very frustrating to know your child struggled to do the work, but then never gets credit for having done it. Papers seem to mysteriously vanish off the face of the earth! **Supervise to make sure that completed work leaves the home and is in the notebook/backpack.** You may want to arrange with the teacher a system for collecting the work immediately on arrival at school.
- Many parents find it very difficult to help their own child with schoolwork. Find someone who can. **Consider hiring a tutor!** Often a junior or senior high school student is ideal, depending on the needs and age of your child.
- **Make sure your child has the phone number of a study buddy**—at least one responsible classmate to call for clarification of homework assignments.
- Parents, **the biggest struggle is keeping on top of those dreaded long-range homework assignments** (eg, reports, projects). This is something you will need to be vigilant about. Ask for a copy of the project requirements. Post the list at home and go over it together with your child. Write the due date on a master calendar. Then plan how to break down the project into manageable parts, scheduling steps along the way. Get started AT ONCE with going to the library, gathering resources, beginning the reading, and so forth.

Adapted from Rief S. *The ADD/ADHD Book of Lists.* San Francisco, CA: Jossey-Bass Publishers; 2002

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There are 2 main laws protecting students with disabilities—including those with ADHD: 1) the Individuals with Disabilities Education Act of 1997 **(IDEA)** and 2) **Section 504** of the Rehabilitation Act of 1973. IDEA is special education law. Section 504 is a civil rights statute. Both laws guarantee to qualified students a free and appropriate public education (FAPE) and instruction in the least restrictive environment (LRE), which means with their peers who are not disabled and to the maximum extent appropriate to their needs.

Because there are different criteria for eligibility, services/supports available, and procedures and safeguards for implementing the laws, it is important for parents, educators, clinicians, and advocates to be well aware of the variations between IDEA and Section 504 and fully informed about the respective advantages and disadvantages.

Additional Resources

1. *Advocacy Manual: A Parents' How-to Guide for Special Education Services* Learning Disabilities Association of America, 1992. Contact the publisher at 4156 Library Rd, Pittsburgh, PA 15243 or 888/300-6710.
2. *Better IEPs: How to Develop Legally Correct and Educationally Useful Programs* Barbara Bateman and Mary Anne Linden, 3rd edition, 1998. Contact the publisher, Sopris West, at 303/651-2829 or http://www.sopriswest.com.
3. *The Complete IEP Guide: How to Advocate for Your Special Ed Child* Lawrence Siegel, 2nd edition, 2000. Contact the publisher, Nolo, at 510/549-1976 or http://www.nolo.com.
4. *Negotiating the Special Education Maze: A Guide for Parents and Teachers* Winifred Anderson, Stephen Chitwood, and Deidre Hayden; 3rd edition; 1997. Contact the publisher, Woodbine House, at 6510 Bells Mill Rd, Bethesda, MD 20817 or 800/843-7323.
5. Children and Adults With Attention-Deficit/Hyperactivity Disorder http://www.chadd.org
6. Education Resources Information Center http://ericir.syr.edu
7. Internet Resource for Special Children http://www.irsc.org
8. San Diego ADHD Web Page http://www.sandiegoadhd.org
9. National Information Center for Children and Youth with Disabilities http://www.nichcy.org
10. Parent Advocacy Coalition for Educational Rights Center http://www.pacer.org

Glossary of Acronyms

ADHD
Attention-deficit/hyperactivity disorder

BIP
Behavioral Intervention Plan

ED
Emotional disturbance

FAPE
Free and appropriate public education

FBA
Functional Behavioral Assessment

IDEA
Individuals with Disabilities Education Act

IEP
Individualized Education Program

IST
Instructional Support Team

LRE
Least restrictive environment

MDR
Manifestation Determination Review

MDT
Multidisciplinary Team

OHI
Other health impaired

SLD
Specific learning disability

SST
Student Study Team

Revised - 1102

IDEA

Who Is Eligible?

IDEA strongly emphasizes the provision of special education and related services that enable students to access and progress in the general education program. Sometimes students with ADHD qualify for special education and related services under the disability categories of "specific learning disability" (SLD) or "emotional disturbance" (ED). For example, a child who has ADHD who also has coexisting learning disabilities may be eligible under the SLD category. Students with ADHD most commonly are eligible for special education and related services under the IDEA category of "other health impaired" (OHI). Eligibility criteria under this category require that the child has a chronic or acute health problem (eg, ADHD) causing limited alertness to the educational environment (due to heightened alertness to environmental stimuli) that results in an adverse effect on the child's educational performance to the degree that special education is needed.

Note: *The adverse effect on educational performance is not limited to academics, but can include impairments in other aspects of school functioning, such as behavior, as well.*

How Does a Parent Access Services Under IDEA?

- **Parents or school personnel may refer a child** by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- Within a limited time frame, **the school's multidisciplinary evaluation team, addressing all areas of the child's difficulties, develops an assessment plan.**
- After parents or guardians consent to the assessment plan, **the child receives a comprehensive evaluation** by the multidisciplinary team of school professionals.
- After the evaluation, **an Individualized Education Program (IEP) meeting is scheduled** with the team, including parents, teacher(s), special education providers, the school psychologist and/or educational evaluator, a school system representative, and the student (as appropriate).
- Based on the results of the evaluation, as well as other input provided by parents and/or other team members, **the team decides whether the child meets eligibility criteria** for special education under one of the categories defined by IDEA.
- **An IEP is developed and written for qualifying students through a collaborative team effort.** It is tailored and designed to address the educational needs of the student.
- The **IEP goes into effect** once the parents sign it and agree to the plan.
- The IEP must address the following:
  - Present levels of educational performance, including how the child's disability affects his or her involvement and progress in the general curriculum
  - Delineation of all special education and related services, modifications (if any), and supports to be provided to the child or on behalf of the child
  - Annual goals and measurable, short-term objectives/benchmarks
  - The extent (if any) to which the child will not participate with children in the regular class and other school activities
  - Modifications (if any) in the administration of statewide and district-wide tests the child will need to participate in those assessments
  - Dates and places specifying when, where, and how often services will be provided, and by whom

What Happens After the IEP Is Written?

1. Services are provided. These include all programs, supplemental aids, program modifications, and accommodations that are spelled out in the IEP.
2. Progress is measured and reported to parents. Parents are informed of progress toward IEP goals during the year, and an annual IEP review meeting is required.
3. Students are reevaluated every 3 years (triennial evaluation) or sooner if deemed necessary by the team or on parent/teacher request.

Adapted from Rief S. *The ADD/ADHD Book of Lists.* San Francisco, CA: Jossey-Bass Publishers; 2002, and from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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Section 504

Who Is Eligible?

Students with ADHD also may be protected under Section 504 of the Rehabilitation Act of 1973 (even if they do not meet eligibility criteria under IDEA for special education). To determine eligibility under Section 504 (ie, the impact of the disability on learning), the school is required to do an assessment. This typically is a much less extensive evaluation than that conducted for the IEP process. Section 504 is a federal civil rights statute that:

- Protects the rights of people with disabilities from discrimination by any agencies receiving federal funding (including all public schools)
- Applies to students with a record of (or who are regarded as having) a physical or mental impairment that substantially limits one or more major life function (which includes learning)
- Is intended to provide students with disabilities equal access to education and commensurate opportunities to learn as their peers who are not disabled

How Does a Parent Access Services Under Section 504?

- **Parents or school personnel may refer a child** by requesting an evaluation to determine eligibility for special education and related services. It is best to put this request in writing.
- **If the school determines that the child's ADHD *does* significantly limit his or her learning,** the child would be eligible for a 504 plan designating:
  - –Reasonable accommodations in the educational program
  - –Related aids and services, if deemed necessary (eg, counseling, assistive technology)

What Happens After the 504 Plan Is Written?

The implementation of a 504 plan typically falls under the responsibility of general education, not special education. A few sample classroom accommodations may include:

- Tailoring homework assignments
- Extended time for testing
- Preferential seating
- Supplementing verbal instructions with visual instructions
- Organizational assistance
- Using behavioral management techniques
- Modifying test delivery

What Do Section 504 and IDEA Have in Common?

Both:

- Require school districts to provide free and appropriate public education (FAPE) in the least restrictive environment (LRE)
- Provide a variety of supports (adaptations/accommodations/modifications) to enable the student to participate and learn in the general education program
- Provide an opportunity for the student to participate in extracurricular and nonacademic activities
- Require nondiscriminatory evaluation by the school district
- Include due process procedures if a family is dissatisfied with a school's decision

Which One Is Right for My Child—a 504 Plan or an IEP?

This is a decision that the team (parents and school personnel) must make considering eligibility criteria and the specific needs of the individual student. For students with ADHD who have more significant school difficulties:

IDEA usually is preferable because:

- It provides for a more extensive evaluation.
- Specific goals and short-term objectives are a key component of the plan and regularly monitored for progress.
- There is a much wider range of program options, services, and supports available.
- It provides funding for programs/services (Section 504 is non-funded).
- It provides more protections (procedural safeguards, monitoring, regulations) with regard to evaluation, frequency of review, parent participation, disciplinary actions, and other factors.

A 504 plan would be preferable for:

- Students who have milder impairments and don't need special education. A 504 plan is a faster, easier procedure for obtaining accommodations and supports.
- Students whose educational needs can be addressed through adjustments, modifications, and accommodations in the general curriculum/classroom.

Adapted from Rief S. *The ADD/ADHD Book of Lists.* San Francisco, CA: Jossey-Bass Publishers; 2002, and from material developed by Laurel K. Leslie, MD, San Diego ADHD Project.

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Sample Letter #1:
Request for Assessment for Educational Services Under Section 504

(Date)

School Site Principal's Name
School Name
Address

RE: **(Student's Name and Grade)**

Dear **(Principal's Name)*:**

I am the parent of **(Student's Name),** who is in Mr/Ms **(Teacher's Name)'s** class. **(Student's Name)** has been experiencing school problems for some time now. We have been working with the teacher(s) to modify **(his/her)** regular education program but **(we have not seen any improvement** or **the problems have been getting worse).** Therefore, I wish to request an assessment of my child for appropriate educational services and interventions according to the provisions of Section 504 of the Rehabilitation Act.

I look forward to working with you as soon as possible to develop an assessment plan to begin the evaluation process. I request copies of the assessment results 1 week prior to the meeting.

Thank you for your assistance. I can be reached by phone at **(Area Code and Phone Number).**
The best time to reach me is **(times/days).**

Sincerely,

(Sign Your Name)
(Print Your Name)
(Address)
(Telephone Number)

Adapted from San Diego Learning Disabilities Association.
http://ldasandiego.org/

Note: Remember to keep a copy for your files.
*If the principal does not respond, contact the district 504 coordinator. It is recommended that you either write a letter or document your phone conversation. If you do not get a response, you have the right to file a compliance complaint.

Sample Letter #2:
Request for Assessment for Special Education

(Date)

School Site Principal's Name:
School Name
Address

RE: **(Student's Name and Grade)**

Dear **(Principal's Name)*:**

I am the parent of **(Student's name)** who is in Mr/Ms **(Teacher's Name)'s** class. **(Student's Name)** has been experiencing school problems for some time now. These problems include:_____

_____

We have been working with the teacher(s) to modify **(his/her)** regular education program but **(we have not seen any improvement** or **the problems have been getting worse).** Therefore, I wish to request an assessment of my child for possible special education services according to the provisions of IDEA.

I look forward to working with you within the next 15 days to develop an assessment to begin the evaluation process. Please ensure that I receive copies of the assessment results 1 week prior to the IEP meeting. Thank you for your assistance. I can be reached by phone at **(Area Code and Phone Number).** The best time to reach me is **(times/days).**

Sincerely,

Sign your name
Print your name
Street Address
City, State, ZIP

Doctor's Signature
License Number
Practice Address
City, State, ZIP

Adapted from San Diego Learning Disabilities Association.
http://ldasandiego.org/

Medication Management Information

Stimulant medication and dosage: Based on the patient's daily schedule and response to medication. Measure at baseline and periodically monitor: Height, weight, blood pressure, pulse, sleep, appetite, mood, tics, family goals, and side effects.

Stimulant Medications - Immediate Release

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects*
Mixed salts of amphetamine (Dextroamphetamine/ Levoamphetamine)	• Adderall Tablets *(scored)*:5 mg (blue), 10 mg (blue), 20 mg (pink), and 30 mg (pink)	Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg **Do not use in patients with Cardiac disease**	About 4–6 hours depending on dose
Dextroamphetamine	• Dexedrine Tablet: 5 mg (orange) •Dextrostat Tablet *(scored)*:5 mg (yellow) and 10 mg (yellow)	Tablet: Start with 5 mg 1–2 times per day and increase by 5 mg each week until good control achieved. Maximum Recommended Daily Dose: 40 mg	Tablet: 4–5 hours
Methylphenidate	• Ritalin Tablets *(scored)*:5, 10, and 20 mg •Methylin Tablets *(scored)*:5, 10, and 20 mg •Focalin Tablets: 2.5, 5, and 10 mg	Start with 5 mg (2.5 mg for Focalin) 1–2 times per day and increase by 5 mg each week until good control is achieved. May need third reduced dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	3–4 hours

Stimulant Medications Sustained Release, continued on side 2

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects*
Mixed salts of amphetamine (Dextroamphetamine/ Levoamphetamine)	• Adderall XR Capsule *(can be sprinkled)*: 10 mg (blue/blue), 20 mg (orange/orange), and 30 mg (natural/orange)	Start at 10 mg in the morning and increase by 10 mg each week until good control is achieved. Maximum Recommended Daily Dose: 40 mg **Do not use in patients with Cardiac disease**	8–12 hours
Dextroamphetamine	• Dexedrine Spansule Spansule *(can be sprinkled)*:5, 10, and 15 mg (orange/black)	Start at 5 mg in the morning and increase by 5 mg each week until good control is achieved. Maximum Recommended Daily Dose: 45 mg	8–10 hours
Methylphenidate	• Concerta Capsule *(noncrushable)*: 18, 27, 36, and 54 mg	Start at 18 mg each morning and increase by 18 mg each week until good control is achieved. Maximum Recommended Daily Dose: 72 mg	8–12 hours
	• Ritalin SR Tablet: 20 mg SR (white) • Ritalin LA Capsule *(can be sprinkled)*: 20, 30, and 40 mg	Start at 20 mg in the morning and increase by 20 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	4–8 hours

*These are estimates, as duration may vary with individual child.

Stimulant Medications Sustained Release, continued

Active Ingredient	Drug Name	Dosing	Duration of Behavioral Effects
Methylphenidate (cont.)	•Metadate ER Tablet: 10 and 20 mg extended release •Methylin ER Tablet: 10 and 20 mg extended releases	Start at 10 mg each morning and increase by 10 mg each week until good control is achieved. May need second dose or regular methylphenidate dose in the afternoon. Maximum Recommended Daily Dose: 60 mg	4–8 hours
	•Metadate CD Capsule: 10, 20, and 30 mg extended release *(can be sprinkled)*:.	Start at 10 mg each morning and increase by 10mg mg each week until good control is achieved Maximum Recommended Daily Dose: 60 mg	4–8 hours

Contraindications and Side Effects

Active Ingredient	Contraindications *(Stimulants can be used in children with epilepsy.)*
Mixed salts of amphetamine	MAO Inhibitors within 14 days Glaucoma, Cardiovascular disease, Hyperthyroidism Moderate to severe hypertension
Dextroamphetamine	MAO Inhibitors within 14 days Glaucoma
Methylphenidate	MAO Inhibitors within 14 days Glaucoma Preexisting severe gastrointestinal narrowing Caution should be used when prescribing concomitantly with anticoagulants, anticonvulsants, phenylbutazone, and tricyclic antidepressants
Common Side Effects: • Decreased appetite • Sleep problems • Transient headache • Transient stomachache • Behavioral rebound	
Infrequent Side Effects: • Weight loss • Increased heart rate, blood pressure • Dizziness • Growth suppression • Hallucinations/mania • Exacerbation of tics and Tourette syndrome (rare)	
Possible Strategies for Common Side Effects: (If one stimulant is not working or produces too many adverse side effects, try another stimulant before using a different class of medications.) Decreased Appetite Behavioral Rebound Irritability/Dysphoria • Dose after meals • Try sustained-release stimulant • Decrease dose • Frequent snacks medication • Try another stimulant medication • Drug holidays • Add reduced dose in late afternoon • Consider coexisting conditions, especially depression Sleep Problems Exacerbation of Tics (rare) Psychosis/Euphoria/Mania/Severe • Bedtime routine • Observe Depression • Reduce or eliminate afternoon dose • Reduce dose • Stop treatment with stimulants • Move dosing regimen to earlier time • Try another stimulant or class of • Referral to mental health specialist • Restrict or eliminate caffeine medications	

Non Stimulant Medications

Active Ingredient	Drug Name	Dosing
Atomoxetine HCL	Strattera Capsule: 10mg, 18mg, 25mg, 40 mg, 60mg	Start as a single daily dose, based on weight, 0.5mg/kg/day for the first week then increase up to a max 1.4 mg/kg/day all given in 1 daily dose.

*These are estimates, as duration may vary with individual child. Note: Drugs listed on this handout do not appear in any order of importance.

ADHD

Parents Medication Guide

Attention-Deficit/Hyperactivity Disorder

Prepared by:

American Academy
of Child and Adolescent
Psychiatry and

American Psychiatric
Association

Table of Contents

Introduction

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurobehavioral condition characterized by excessive restlessness, inattention, distraction, and impulsivity. It is usually first identified when children are school-aged, although it also can be diagnosed in people of all age groups. In an average classroom of 30 children, research suggests that at least one will have ADHD.[1]

High activity levels and short attention spans are a normal part of childhood for many children, but for those with ADHD, hyperactivity and inattentiveness are excessive and interfere with daily functioning. Some children with ADHD only have problems with attention; other children only have issues with hyperactivity and impulsivity; some children have problems with both. Over time, children with ADHD tend to shed some of the overactivity and impulsivity, but they often continue to have significant problems with inattention, distraction, and organization.

ADHD can interfere with a child's ability to perform in school and capacity to develop and maintain social (peer) relationships. ADHD can increase a child's risk of dropping out of school or having disciplinary problems. ADHD also is associated with an increased risk of having problems with hazardous driving, cigarette smoking, and substance abuse.

Effective treatments are available to help manage the inattention, hyperactivity, and impulsiveness symptoms of ADHD and can improve a person's ability to function at home, at school, and in other places.

This medication guide is intended to help parents, patients, and family members better understand the treatments used to care for children with ADHD.

Before treatment can begin, however, each child must have a careful review of his or her medical history, and a physical examination should be conducted. ADHD symptoms should be assessed by a health care professional qualified to evaluate children with ADHD. The professional treating your child for ADHD should be trained to diagnose and treat ADHD. They also should have a thorough understanding of normal child development (such as pediatricians, developmental pediatricians, child and adolescent psychiatrists, and pediatric neurologists). Treatment may include medication, behavioral therapy, or a combination of the two.

As a parent or guardian of a child or teenager diagnosed with ADHD, you may be aware of the debate surrounding the medication used to treat this condition. Recently, the U.S. Food and Drug Administration (FDA) reviewed several research studies involving children and adolescents who were prescribed medication for ADHD and concluded that these medications are effective and that the risks associated with these medications are known and can be managed.

While the FDA found that these medications are generally safe and effective, many children and teenagers who take medication for ADHD experience side effects at one time or another. Some of these side effects can be significant and should be closely monitored.

Recently, the FDA directed the makers of ADHD medication to develop medication guides to better inform patients and their families about the known potential side effects associated with these medicines—common and rare. These guides will be provided along with the ADHD medication when it is dispensed from the pharmacy. Parents and guardians of children being treated with ADHD medication should read the medication guides and talk to their child's doctor if they have any questions or concerns.[2]

For more information about the FDA's medication guides, please **click here**.*

Causes, Symptoms & Choosing Treatment

What is ADHD?

ADHD is a neurobehavioral condition with symptoms that include excessive restlessness, poor attention, and impulsive acts. Estimates show that between 3 and 7 percent of school-aged children and about 4 percent of adults have ADHD.[3]

No single biological cause for ADHD has been found. But most research points to genes inherited from parents as the leading contributor to ADHD. For example, studies clearly show that ADHD runs in families—seventy-six percent of children with ADHD have a relative with the condition.[4] Scientists are currently looking for which genes, or combinations of genes, influence how ADHD affects the behavior of those with the condition.

Being born prematurely, maternal smoking or extreme stress during pregnancy, being exposed to alcohol in the womb, and traumatic brain injury also may contribute to the development of ADHD.

Potential Consequences when ADHD is Left Untreated

- Increased risk for school failure and dropout
- Behavior and discipline problems
- Social difficulties and family strife
- Accidental injury
- Alcohol and drug abuse
- Depression and other mental-health disorders
- Employment problems
- Driving accidents
- Unplanned pregnancy
- Delinquency, criminality, and arrest

*http://www.fda.gov/cder/drug/infopage/ADHD/default.htm

How do I find out if my child has ADHD?

Because there is no brain imaging scan or blood test to diagnose ADHD, it is important that a health care professional specifically trained to diagnose and treat ADHD evaluate your child's behavior. Clinicians, such as pediatricians and child and adolescent psychiatrists, will be able to tell whether your child's behaviors are symptoms of ADHD or if he or she is just unusually active or immature.

Most cases of ADHD are first diagnosed in the early school years. Children who are diagnosed with ADHD have symptoms that impair their ability to function as well as other children the same age. These symptoms must last at least 6 months before a child can be diagnosed with ADHD.

There are three subtypes of ADHD: primarily inattentive, primarily hyperactive/impulsive, and that with significant symptoms of both (called combined subtype).

Boys diagnosed with ADHD outnumber girls with the condition by about three to one. Some doctors think that just as many girls have ADHD as boys, but they are not diagnosed as often because they are less disruptive and because their symptoms may not become unmanageable until they are older. For instance, girls sometimes show their ADHD in less troublemaking ways, such as being inattentive. Now that more health care professionals are aware of the unique ways ADHD affects girls and boys, more girls are being diagnosed and receiving treatment.[5]

"Before I was diagnosed, a lot of my time was spent coping with my ADHD symptoms."

—an adult with ADHD

Some parents worry because more children are being diagnosed with ADHD now than in the past. Research indicates that the increase is largely due to enhanced awareness and improved detection of the condition—including diagnosing children who may have less severe forms of ADHD. Now that more people know about ADHD and its symptoms, younger children, adolescents, girls, and adults with this condition are more likely to be identified and treated.

Despite the rise in ADHD diagnoses and the fear that some children are still being incorrectly identified as having ADHD, underdiagnosis remains a problem. There are still many children with ADHD (almost half) who are not diagnosed and do not receive treatment.[6]

What types of treatments are effective?

To help families make important decisions about treatment, the National Institute of Mental Health (NIMH) conducted the most in-depth study ever carried out for evaluating ADHD treatments. This study is called the Multimodal Treatment Study of Children with ADHD (or the MTA). Data from this study showed that methylphenidate (a commonly used stimulant medication for ADHD) is effective in treating the symptoms of ADHD, either alone or in

combination with behavioral therapy. It also found that treatment that includes medication is more effective for the symptoms of ADHD (such as hyperactivity) than behavioral therapy alone. This is especially true when the medication's dosage is closely monitored and personalized for each child.[7]

The MTA study, along with dozens of other large-scale studies that have assessed the safety and effectiveness of ADHD medications, provides evidence that medication plays an important role in the treatment of children, adolescents, and adults with ADHD.

This research demonstrates that for most young people with ADHD, medication dramatically reduces hyperactivity, improves attention, and increases the ability to get along with others.

While medicine alone is a proven treatment for ADHD, the MTA study found that combining behavioral treatment with medicine was useful in helping families, teachers, and children learn ways to manage and modify the behaviors that cause problems at home and at school. In addition, some children receiving combined treatment were able to take lower doses of medicine.

Behavioral treatments in the MTA study included three approaches:

- **Parent Training:** Helps parents learn about ADHD and ways to manage ADHD behaviors.
- **Child-Focused Treatment:** Helps children and teens with ADHD learn to develop social, academic, and problem-solving skills.
- **School-Based Interventions:** Help teachers meet children's educational needs by teaching them skills to manage the children's ADHD behaviors in the classroom (such as rewards, consequences, and daily report cards sent to parents).

Children with ADHD who have other mental-health conditions, such as depression and anxiety, were especially helped by having individual and family treatment as part of their treatment plan.

Most Common ADHD Medications

Trade Name	Generic Name
Adderall	mixed amphetamine salts
Adderall XR	mixed amphetamine salts
Concerta	methylphenidate
Daytrana	methylphenidate (patch)
Dexedrine	dextroamphetamine
Dexedrine Spansule	dextroamphetamine
Dextrostat	dextroamphetamine
Focalin	dexmethylphenidate
Focalin XR	dexmethylphenidate
Metadate	methylphenidate
Metadate CD	methylphenidate
Methylin	methylphenidate hydrochloride (liquid & chewable tablets)
Ritalin	methylphenidate
Ritalin LA	methylphenidate
Ritalin SR	methylphenidate
Strattera	atomoxetine
Vyvanse	lisdexamfetamine

Over time, this list will grow. Researchers are continuing to develop new medications for ADHD.

The FDA directed pharmaceutical companies to develop medication guides for each of these medications. These guides can be accessed by **clicking here**.*

* http://www.fda.gov/cder/drug/infopage/ADHD/default.htm

Will medication cure my child?

Medication is a highly effective way to treat the symptoms of ADHD, but it only works when it is taken as prescribed. Unlike antibiotics and similar medications that are taken for short periods of time to treat infections and other ailments,

there is no ADHD medication that will cure this condition. Fortunately, the majority of children with ADHD can improve significantly with a combination of medication and behavioral treatment.[8]

Research is ongoing to learn more about the way ADHD affects brain function and how to best treat the condition. Other research is looking at the long-term outcomes for people with ADHD.

Choices in Medication

What types of medication are available?

ADHD medications are grouped into two major categories: stimulant and non-stimulant.

Stimulant medications, such as methylphenidate and amphetamines, are highly effective treatments for ADHD and have been available for decades. Amphetamines have been prescribed for more than 70 years; methylphenidate for more than 50 years, and both types of medication have been very well studied. Evidence shows that stimulants are quite safe when prescribed to healthy patients and used under medical supervision.

The only FDA-approved non-stimulant medication, atomoxetine (Strattera), also has been shown to be an effective treatment for ADHD. Some parents prefer the non-stimulant atomoxetine (Strattera) because of their concerns about stimulant medication. Also, atomoxetine (Strattera) may be a good alternative for children who do not respond well to stimulant medication or have other conditions along with their ADHD.

Deciding which ADHD medication is right for your child takes time, because doctors often need to try more than one medication to find the one that works best.

Some ADHD medications might not be right for your child because of their side effects. Both stimulant and non-stimulant medications have side effects. A medication's side effects usually can be managed by adjusting the dose, changing the time it is administered, or switching medications.

Parents can help their child's doctor find the correct medication and dosage by keeping a medication diary or log book to track how well their child is doing and what side effects he or she may be experiencing.

If your child does not do well on any of the usual treatments for ADHD, some medications that have not been approved by the FDA for the treatment of ADHD may be helpful. However, these medications are usually only prescribed after first-line ADHD medications and behavioral treatment have already been tried.[9]

Finding the correct ADHD medication and dose takes time. If your child's symptoms are not better after being on a full therapeutic dose of a particular ADHD medication for a week or more, the prescribing doctor may consider trying another medication or adjusting the dose.

Taking ADHD Medication

How is ADHD medication taken?

Stimulant Medications: Stimulant medication comes in short-acting and long-acting forms. Short-acting stimulants are generally taken two to three times a day and last 4 to 5 hours per dose. Long-acting stimulants are usually taken once a day and last between 7 and 12 hours. Sometimes doctors will prescribe a combination of long-acting and short-acting stimulant medication, but this approach has not been systematically studied.

"As soon as I started taking stimulant medication, it was as if a light came on in the room."

—an adult with ADHD

For those children who have difficulty swallowing pills, a patch applied to the skin, liquid medications, chewable pills, and capsules that can be opened and sprinkled on food also are available.

Most doctors start children at a low dosage of stimulant medication and increase the amount every 1 to 3 weeks until the ADHD symptoms are under control. It can take several months to find the correct dose of stimulant medication.

Non-Stimulant Medications: The non-stimulant medication atomoxetine (Strattera) is usually taken as a single daily dose in the morning or as two divided doses in the morning and late afternoon or early evening. Most doctors prescribe a lower dose initially and then gradually increase the dosage as the patient adjusts to the medication. It can take several weeks to build up to the correct dosage and several additional weeks to see the full effects.

There are other non-stimulant medications that are sometimes used for the treatment of ADHD, such as tricyclic antidepressants, guanfacine, clonidine, and bupropion (Wellbutrin). However, these drugs are not approved by the FDA for the treatment of ADHD.

It is important not to miss doses of *any* ADHD medication. Missing a single dose can leave your child without the beneficial effects of the medication, and the ADHD symptoms may return.

Can over-the-counter or prescription medication interfere with ADHD medication?

Yes, some over-the-counter medications can interfere with your child's ADHD medications. For example, Benadryl (diphenhydramine) can cause agitation in some children with ADHD. Therefore, it is important to tell your child's

doctor about all of the over-the-counter (OTC) and prescription medications, herbal supplements, and vitamins your child is taking. Your child's prescribing doctor will let you know which medicines are okay to take while on ADHD medication, or you can ask the pharmacist about drug interactions before purchasing a non-prescription medication, supplement, or vitamin.

How do I know the medication is working?

With stimulant medication, parents and teachers should see some beneficial effects within 30 to 90 minutes—depending on the dose and formulation used. However, if the dose of stimulant medication is too low, your child's symptoms may not be affected at all.

Some beneficial effects of the non-stimulant medication atomoxetine (Strattera) might be noticed within the first week of taking medication. However, it can take several weeks for the non-stimulant medication atomoxetine (Strattera) to reach its full effect—even if the dosage is correct.

"My child is happier now she's on medication."

—a parent of a child with ADHD

When ADHD medication is working, many of the ADHD symptoms go away. It is not uncommon, though, for some symptoms to linger. Behavioral treatments may help with the remaining symptoms.

While it may take time to find an effective medication and dosage, ADHD medications do work. In fact, up to 90 percent of children with ADHD will find at least one medication or a combination of medications that works well for them.[10]

Are there times when my child can take a break from medication?

In the past, doctors often recommended that children take a break from their ADHD medication after school, on weekends, and during the summer. Now, many doctors recommend that children stay on their ADHD medication full-time to get the benefits at home and at play. This can be especially true for teens who may benefit from ADHD medication outside of school to help make decisions about cigarette smoking, substance use, and risky behavior, as well as help with completing their homework and paying attention while driving.[11] However, some breaks from medication or reducing the medication's dose may be considered for less demanding times or if your child has troublesome side effects.

How will ADHD medication make my child feel?

For most children, ADHD medication will make them feel calmer and more able to focus and concentrate. Some of these changes may go unnoticed by your child—although parents and teachers should notice positive behavioral changes if the medication is working properly. ADHD medication should not

change a child's basic personality even though it may make them less hyperactive and more attentive. Sometimes children report feeling a little unusual when they first start taking ADHD medication, but these feelings are usually minor and often go away with time. Also, some children taking non-stimulant atomoxetine (Strattera) medication report feeling more irritable than usual. Their irritability may improve with time, or changing the dose or medication also may help. If you notice a personality change (such as a "zombie"-like personality) or if your child is continually irritable while taking medication, talk with your child's doctor.

When is it okay to stop taking ADHD medication?

Many children diagnosed with ADHD will continue to have problems with one or more symptoms of this condition later in life. In these cases, ADHD medication can be taken into adulthood to help control their symptoms.

For many others, the symptoms of ADHD lessen over time as they begin to "outgrow" ADHD or learn to compensate for their behavioral symptoms. The symptom most apt to lessen over time is hyperactivity.

Some signs that your child may be ready to reduce or stop ADHD medication are: 1) your child has been symptom-free for more than a year while on medication, 2) your child is doing better and better, but the dosage has stayed the same, 3) your child's behavior is appropriate despite missing a dose or two, or 4) your child has developed a newfound ability to concentrate.[9]

The choice to stop taking ADHD medication should be discussed with the prescribing doctor, teachers, family members, and your child. You may find that your child needs extra support from teachers and family members to reinforce good behavior once the medication is stopped. You also will need to monitor your child's behavior once he or she is off the medication to make sure any lingering symptoms are attended to.

How do I explain ADHD medication to my child?

It is important that your child understands what ADHD medication is, why it is being prescribed, and how it can be helpful. This is especially true for older children and adolescents who may have concerns about being "different" because they are taking medicine. You may want to compare taking ADHD medications to wearing eyeglasses. Wearing glasses helps you see better just as ADHD medication gives you better control over behavior so that it is easier to focus, pay attention, learn, and behave.

Stimulant Medication & Addiction

Is there a risk my child may become addicted to stimulant medication?

Some parents worry that stimulant medication may make their child susceptible to addiction. This is a common misconception about ADHD medication. According to the National Institute on Drug Abuse (NIDA), children who take medication to treat their ADHD are less likely to have problems with substance abuse than children with ADHD who don't receive treatment.[12]

If taken appropriately, ADHD stimulant medications are not addictive.

While few people who are prescribed ADHD medications abuse their medication, giving or selling stimulant medication to others remains a concern. Because of the known risk of abuse with these types of medications, the Drug Enforcement Administration (DEA) has classified stimulants as medications that require stricter control. These are referred to as Schedule II or controlled medications.

The children and adolescents who misuse stimulant medication often do so to "get high" or to improve school performance ("cram all night"). To ensure these medications are used correctly, parents and guardians should make sure they are kept in a secure place, and their use should be monitored. Parents also must inform the child's doctor if medication is missing or being taken inappropriately. If misuse is a concern, medication should be dispensed by a parent. If medication is taken during school hours, most school jurisdictions require that the medication be given by school personnel.

Side Effects & ADHD Medication

What are the most common side effects?

Most children treated with ADHD medication have some side effects. Some of the most common and predictable side effects from stimulant medication are reduced appetite, weight loss, problems sleeping, headaches, stomach pain, and irritability. These side effects usually get better within the first couple of months of treatment.

The non-stimulant atomoxetine (Strattera) also can cause nausea, reduced appetite, and weight loss. Some children complain of drowsiness or mild irritability during the day while taking this medication; however, these side effects usually go away after the first month of treatment.

Side effects usually are not dangerous, but they should *all* be reported to your child's doctor—especially if they cause discomfort or interfere with your child's everyday activities. Side effects often can be reduced by switching medications, using another form of the medication, adjusting the dose, or changing the time the medication is taken.

What are the rare or serious side effects?

Heart-related problems, hallucinations and agitation, suicidal thoughts, and liver problems are some of the rare and serious side effects people on ADHD medication may be at risk of developing.

Be sure to tell the doctor if your child has a history of heart problems or symptoms, such as fainting, dizziness, or irregular heart rate. Also, inform the doctor if there is a family history of major heart problems or sudden death.

The FDA recommends that parents who are considering ADHD medication for their child work with the prescribing doctor to develop a treatment plan that includes a careful review of health history and regular medical exams. **In particular, you should tell the doctor about any heart or mental-health problems your child experiences while on ADHD medication and if there is a family history of these problems.**[2]

Heart-Related Problems: There have been rare reports of serious heart-related problems, such as sudden death, heart attack, and stroke, in patients taking ADHD medication. The FDA investigated these reports and found that many involved patients who had undiagnosed heart defects. The FDA concluded it was not possible to determine whether or not the hidden heart defect, the medication, or a combination of the two caused the heart-related problems in the reports. *It appears that there is no increased risk of sudden death, heart attack, or stroke for children taking ADHD medication if the child is healthy and has no current heart problems.* However, the FDA added a warning label to ADHD medication cautioning doctors about prescribing them for people who have heart defects.[13] Some children with heart defects may be able to take stimulants, but only under close supervision of their physician.

Hallucinations and Agitation: The FDA also investigated a small number of reports of visual hallucinations, psychosis, and aggressive outbursts in patients taking ADHD medication. Another FDA review of medications used to treat ADHD showed a slightly increased risk (about 1 per 1,000) for hearing voices, becoming suspicious for no reason, or becoming manic in patients who did not have these symptoms prior to starting medication.[2]

Voicing Suicidal Thoughts: The non-stimulant medication atomoxetine (Strattera) is associated with a rare, but potentially serious, side effect. There is a slightly increased risk (about 4 per 1,000) of voicing suicidal thoughts and feelings while taking the non-stimulant ADHD medication atomoxetine (Strattera). While this risk is very low, monitor your child's mental welfare carefully by asking them about their thoughts and feelings when they are on this medication—especially during the first few months after starting medication or when your child's dose is increased or decreased.[14]

Pre-Existing Mental-Health Conditions: Patients with pre-existing psychosis, bipolar disorder, or a history of drug abuse should be carefully monitored when using ADHD medication. Evidence shows that some ADHD medications may worsen pre-existing psychosis and bipolar disorder. Some children with these conditions, however, can benefit from ADHD medication but may need other

When to Call the Doctor Immediately

- If your child is feeling faint or dizzy; complains of unusual heartbeats (such as rapid or skipped beats), chest pains, or shortness of breath; becomes agitated; begins having hallucinations; seems depressed; or voices suicidal thoughts
- If your child complains of itching, right upper belly pain, or unexplained flu-like symptoms or if he or she has dark urine or yellow eyes or skin

treatment as well. Also, patients with a history of drug abuse may be at increased risk of a relapse or misusing their medication if taking stimulant medication. The role of stimulants in the treatment of adolescents with ADHD and substance abuse problems remains unclear.

Liver Problems: There have been rare cases reported of the non-stimulant atomoxetine (Strattera) causing potentially serious liver problems. Signs to watch for are itching, right upper belly pain, dark urine, yellow skin or eyes, and unexplained flu-like symptoms.

To find out more about the FDA's warnings regarding cardiac risk and psychiatric side effects of ADHD medications, **click here**.[†]

Do I need to monitor my child's appetite, weight, and height?

Parents are in the best position to monitor their child's well-being—including mental and physical health.

As with any disorder, treatments and medication may have side effects. Some of the things that are important to watch when your child is on ADHD medication include changes in appetite and weight. Your child's growth rate also should be monitored.

Monitoring weight and height is primarily the doctor's responsibility, but it is helpful for parents to pay attention as well. The effect of ADHD treatment on growth has been studied for many years. Recent research shows that stimulant medication may be associated with a small reduction in growth (primarily weight related), at least during the first 1 to 3 years of treatment. However, most studies show that any reduction in growth rate is often temporary and unrelated to the child's ultimate height.

[†]http://www.fda.gov/bbs/topics/NEWS/2007/NEW01568.html

If there is a change in your child's appetite or weight, you should contact your child's doctor. You, your child's doctor, and your child (if your child is involved in making decisions about treatment) can talk about changing eating habits to keep his or her weight within the normal range, as well as possible changes in dosing or medications.

How can I best manage some of the common side effects my child may experience?

There are several things you can do to decrease problems caused by the most common side effects associated with ADHD medication.

Decreased Appetite: Some solutions for a decreased appetite include administering medication after breakfast so your child will be hungry for the morning meal, feeding your child large meals in the evening when the medication is beginning to wear off, or having food available when the child is hungry. It also is prudent to feed children taking ADHD medication a balanced diet with high-caloric foods and drinks, as appropriate, to overcome any loss in weight. If your child's reduced appetite continues for a long period of time, you may want to ask the prescribing doctor if it would be okay to stop or reduce the dose of the medication in the summertime or on the weekends.

Sleep Problems: Regardless of the cause of your child's sleep problems, setting up a healthy bedtime routine should help them get to sleep. This can include bathing, brushing teeth, reading, or being read to. These activities should be designed to relax your child. Also, try to avoid stimulating and distracting electronics, such as radios, computers, and televisions, before bedtime.

If your child is taking a stimulant medication and a bedtime routine does not help the sleep problems, talk with your doctor about administering the medication earlier in the day. For children taking a long-acting stimulant medication, you can ask about changing to a shorter-acting medication (8 hours instead of 12 hours, for example). If your child is already taking short-acting medication, you can talk to the doctor about reducing the dose or stopping the medication in the afternoon to help your child get to sleep. Or, in certain instances, a medication may be used to help with sleep.

Drowsiness: If your child is taking the non-stimulant atomoxetine (Strattera) and becomes sleepy in the daytime, your child's doctor may recommend giving the medication at bedtime instead of in the morning, dividing the dose and administering the medication twice a day, or lowering the dose to reduce drowsiness.

Behavioral Rebound: Some children taking stimulant medication may seem more irritable and have an increase in ADHD symptoms in the afternoon or evening. This is called "rebounding" by some doctors and may be caused by the medication wearing off. To remedy this, your child's doctor may recommend trying a medication that lasts longer or taking a small dose of immediate-release stimulant later in the day.[9]

Other Side Effects: If you have questions or concerns about these or other side effects, contact your child's doctor.

School & the Child with ADHD

How can the school help my child with ADHD?

Schools can work with families and doctors to help children with ADHD in school. Open communication between parents and school staff can be the key to a child's success. Teachers often are the first to notice ADHD-like behaviors and can provide parents, guardians, and doctors with information that may help with diagnosis and treatment. Also, teachers and parents can work together to solve problems and plan ways to support a child's learning at home as well as at school. For example, teachers will often use specific instructional and behavioral strategies in the classroom to help students with ADHD.

Students whose ADHD impairs their ability to learn may qualify for special education under the Individuals with Disabilities Act (IDEA) or for a Section 504[15] plan under the Rehabilitation Act of 1973. Special education and 504 plans provide assistance to students with disabilities and are designed to meet their unique learning and behavioral needs. Children with ADHD are eligible for special education in the "Other Health Impairment" disability category under IDEA. Children who do not qualify for special education may still be eligible for a 504 plan.

Public schools are required to evaluate students and provide free appropriate public education (FAPE)[16] to all students with disabilities. Families also can request that their child be tested to help decide if he or she can qualify for educational services. However, parents and guardians must give written permission before a school can provide testing or services to a child. Testing and services are confidential and are provided through the public school system at no cost to the family.

"Finding out that our child had ADHD answered a lot of questions about why she wasn't performing better at school."

—a parent of a child with ADHD

Some children may need to take their ADHD medication during school hours. If authorized by a parent or guardian, school staff can give a child prescription medicine. Parents and guardians should contact the school principal, nurse, or counselor if their child needs to take medicine while at school.

Federal law states that schools cannot make decisions about medicine for a child or require students to take medicine to attend school.

How does ADHD affect my child's ability to form friendships?

Children with ADHD often have difficulty with social relationships, which may cause conflict with family members or lead to rejection by other children their age. A lack of social skills combined with hyperactive, impulsive, and inattentive behavior may cause children with ADHD to act in ways that others think are mean, bossy, rude, thoughtless, or weird. In addition, children with ADHD, like children with other disabilities, are more frequently the targets of bullies.

Medicine for ADHD can have positive effects on social behavior and improve the way that a child relates to others. For example, they may be more able to wait their turn in games or conversations or less likely to blurt out comments without thinking. Parents can help foster good friendships for their children by letting teachers, school counselors, and coaches know about problems that might develop, arranging one-on-one play dates, and encouraging participation in school activities and peer-group programs.

"ADHD always made me feel different from the other kids at school."

—an adult with ADHD

Does my child need treatment when not in school?

The symptoms of ADHD are usually with your child—at school and at play as well as at home. Most doctors recommend that children stay on ADHD medication most of the waking day, especially if ADHD symptoms cause distress in situations outside of school. Not taking ADHD medication may put your child at risk. Younger children are at risk for injuries and for having social issues when they are not taking their ADHD medication, and adolescents are more at risk for motor vehicle accidents and other risky behaviors.

It is possible that your child's doctor may direct you to give your child a break from medication during certain times, such as when they are out of school, to help manage side effects. It is important for you and your child to be aware that the symptoms of ADHD are likely to resurface once your child is off of medication.

Disorders that Can Accompany ADHD

What are some of the more common disorders that can accompany ADHD?

Research shows that two-thirds of children diagnosed with ADHD have at least one additional mental-health or learning disorder.

To ensure an accurate diagnosis, your child's doctor will look for other conditions that show the same types of symptoms as ADHD. The doctor may find that your child has ADHD, another condition, or ADHD *and* another condition. Having more than one condition is called having coexisting (also called comorbid) conditions.

Coexisting conditions can make diagnosing and treating ADHD more difficult. They also create more challenges for a child to overcome, so it is important to identify and treat these other conditions.

Disorders that Commonly Accompany ADHD

- Oppositional defiant disorder
- Conduct disorder
- Learning and language disabilities
- Anxiety disorders
- Depressive disorders
- Bipolar disorder
- Tourette's Disorder

Some of the more common coexisting conditions are oppositional defiant disorder, learning and language disabilities, and anxiety and depressive disorders.

Studies have shown that half or more children with ADHD also have oppositional defiant disorder. Children with oppositional defiant disorder often are defiant of authority and have a tendency to intentionally bother others. Some children with ADHD who exhibit more significant behavioral problems are diagnosed with conduct disorder. Conduct disorder is a serious psychiatric disorder in which the child is aggressive to people and animals, is destructive to property, and frequently violates society's rules. Children with coexisting conduct disorder are at much higher risk for getting into trouble with the law than children who have only ADHD. Your child's doctor may recommend counseling if your child has either oppositional defiant disorder or conduct disorder.

Twenty-five to 35 percent of children with ADHD will have a coexisting language or learning problem. Children with these coexisting conditions often benefit from scholastic and language therapies, as well as extra help at school.

Additionally, 33 percent of children with ADHD also have a problem with anxiety or mood disorders (such as depression). Children with these problems may benefit from additional treatment as well, possibly including talk therapy, medication, or both.

One of the more serious coexisting conditions that can occur with ADHD is bipolar disorder. Some signs that suggest your child has bipolar disorder are overly happy mood, grandiosity (believing that they are much more talented than they really are), racing thoughts, and less need for sleep. On the other hand, many children with bipolar disorder as a coexisting condition appear highly irritable and overly sensitive and reactive and are often described as"an emotional roller coaster."

When ADHD medication fails to improve a child's symptoms, it may be a sign of a coexisting condition.

Only a qualified mental-health clinician can determine whether your child's behaviors are caused by ADHD, another condition, or a combination of the two. A thorough assessment and accurate diagnosis are essential to choosing the right treatments, including which medication might benefit your child the most and which medication might make certain disorders worse.[9]

Can ADHD medication cause bipolar disorder?

No. ADHD medication does not cause bipolar disorder. However, ADHD medications can make pre-existing manic symptoms worse. And, in rare instances, they also may cause manic episodes or behavior. If your child becomes manic or overly irritable while taking ADHD medication, contact your child's doctor immediately.

Can my child take ADHD medication if there is a coexisting condition?

If your child's doctor determines that your child has one or more coexisting conditions, a treatment plan should be developed to address each coexisting condition as well as the ADHD.

Many children with ADHD and coexisting conditions take medication to help treat their ADHD. For example, children with ADHD and anxiety or disruptive behavior disorders have as good a response to stimulants as do patients who do not have these coexisting conditions.[9]

Proceed with medication cautiously if your child is diagnosed with bipolar disorder as a coexisting condition. There have been rare reports that stimulants worsen bipolar disorder. If your child suddenly becomes aggressive or depressed, or if he or she voices suicidal thoughts after starting an ADHD medication, contact your child's doctor immediately.

Additional monitoring also is advised when treating youth with stimulant medications who have coexisting substance abuse disorders.

Psychosocial Treatments

What psychosocial or behavioral treatments can be useful?

Psychosocial (or behavioral) treatment alone, such as social skills training or individual therapies, has not been shown to be as effective as medicine for the core symptoms of ADHD. However, behavioral treatment on its own may be recommended as an initial treatment if the symptoms of ADHD are mild, the diagnosis of ADHD is uncertain, or the family prefers this type of treatment.

Whether or not your child is on medication, behavioral treatment can help manage ADHD symptoms and lessen their impact on your child. One study showed that you may be able to lower your child's medication dosage if behavioral therapy is working well. Many parents find that the best way to learn how to use these techniques is to work with a therapist who has experience in behavior issues. Most doctors recommend that parents and guardians attend parenting classes, particularly those focused on managing children with ADHD.

Teachers also can benefit from using behavioral training techniques. They can set up programs similar to those at home, giving rewards for good behaviors and consequences for unwanted behaviors to help children learn boundaries and how to deal with choices in the school setting.

Home and School Strategies for Your Child

- Have the same routine every day.
- Organize everyday items.
- Use organizers for homework.
- Keep rules consistent and balanced.

Unproven Treatments

Do alternative treatments for ADHD, such as special diets or herbal supplements, really work?

Parents often hear reports of "miracle cures" for ADHD on the television, in magazines, or in advertisements. Before considering *any* treatment for ADHD, find out whether the source of this information is unbiased and whether the claims are valid, and discuss it with your child's doctor. Also keep in mind that there is no known cure for ADHD at this time.

Some of the more prevalent unproven treatments for ADHD are special diets, herbal supplements, homeopathic treatments, vision therapy, chiropractic adjustments, yeast infection treatments, anti–motion-sickness medication, metronome training, auditory stimulation, applied kinesiology (realigning bones in the skull), and brain wave biofeedback.[17]

While it would be wonderful if these treatments worked, rigorous scientific research has not found these alternatives to be effective managing the symptoms of ADHD—and they are definitely not "cures."

Always tell your child's doctor about any alternative therapies, supplements, or over-the-counter medications that your child is using. They may interact with prescribed medications and hinder your child's progress or compromise your child's safety.

If you plan to try this type of treatment, it is helpful to use the same measures you would use to tell if one of the FDA-approved medications is working. These include behavior rating scales and specific target goals that you set up in consultation with your child's doctor.

What Does the Future Hold?

It was once thought that most children would outgrow ADHD by their teenage years. We now know this is not true. While some of the symptoms of ADHD can diminish over time,[10] and some children may outgrow the disorder, most children with ADHD will continue to experience some ADHD symptoms during their later years.[9]

For some people, ADHD is a lifelong condition. Almost 50 percent of children with ADHD still have symptoms that require treatment in adulthood.[9] Early diagnosis can help these individuals learn how to manage their symptoms and succeed in life.

"Once I started ADHD medication, I had the perspective to look back on my life and see why some things I tried had failed."

—an adult with ADHD

For More Information about ADHD

National Organizations

American Academy of Child and Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
1-202-966-7300
http://www.aacap.org

American Academy of Family Physicians (AAFP)
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2672
1-800-274-2237
http://www.aafp.org

American Academy of Pediatrics (AAP)
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1098
1-847-434-4000
http://www.aap.org

American Psychiatric Association (APA)
1000 Wilson Boulevard, Suite 1825
Arlington, VA 22209
1-703-907-7300
http://www.psych.org

Attention Deficit Disorder Resources
223 Tacoma Avenue, South, #100
Tacoma, WA 98402
1-253-759-5085
http://www.addresources.org

Centers for Disease Control and Prevention (CDC)
1600 Clifton Road
Atlanta, GA 30333
1-404-639-3311
http://www.cdc.gov

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD)
8181 Professional Place, Suite 150
Landover, MD 20785
1-800-233-4050
http://www.chadd.org

Federation of Families for Children's Mental Health
9605 Medical Center Drive, Suite 280
Rockville, MD
1-240-403-1901
http://www.ffcmh.org

LD OnLine
WETA Public Television
2775 South Quincy Street
Arlington, VA 22206
http://www.ldonline.org

National Association of State Directors of Special Education, Inc. (NASDSE)
IDEA Partnership
1800 Diagonal Road, Suite 320
Alexandria, VA 22314
1-877-IDEA-info
http://www.ideapartnership.org

National Dissemination Center for Children with Disabilities (NICHCY)
P.O. Box 1492
Washington, DC 20013
1-800-695-0285
http://www.nichcy.org

National Institute of Mental Health (NIMH)
6001 Executive Boulevard
Bethesda, MD 20892
1-866-615-6464
http://www.nimh.nih.gov

Public Information and Communications Branch
National Institute of Mental Health (NIMH)
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
1-866-615-6464
http://www.nimh.nih.gov

National Resource Center on AD/HD
8181 Professional Place, Suite 150
Landover, MD 20785
1-800-233-4050
http://www.help4adhd.org

Parent Advocacy Coalition for Educational Rights (PACER Center)
8161 Normandale Boulevard
Minneapolis, MN 55437
1-888-248-0822
http://www.pacer.org

Fact Sheets about ADHD in English

Children Who Can't Pay Attention
http://www.aacap.org/page.ww?section=Facts%20for%20Families&name=Children%20Who%20Can't%20Pay%20Attention/ADHD

What We Know
http://www.help4adhd.org/en/about/wwk

The Disorder Named ADHD
http://www.help4adhd.org/documents/WWK1.pdf

Parenting a Child with AD/HD
http://www.help4adhd.org/documents/WWK2.pdf

Managing Medication for Children and Adolescents with AD/HD
http://www.help4adhd.org/documents/WWK3.pdf
http://www.help4adhd.org/documents/WWK3s.pdf (short version)

Educational Rights for Children with AD/HD
http://www.help4adhd.org/documents/WWK4.pdf

AD/HD and Co-Existing Disorders
http://www.help4adhd.org/documents/WWK5.pdf

AD/HD and Coexisting Conditions: Tics and Tourette Syndrome
http://www.help4adhd.org/documents/WWK5a1.pdf

AD/HD and Coexisting Conditions: Disruptive Behavior Disorders
http://www.help4adhd.org/documents/WWK5b3.pdf

AD/HD and Coexisting Conditions: Depression
http://www.help4adhd.org/documents/WWK5c.pdf

Complementary and Alternative Treatments
http://www.help4adhd.org/documents/WWK6.pdf

Deciding on a Treatment for AD/HD (short version)
http://www.help4adhd.org/documents/WWK6s.pdf

Psychosocial Treatment for Children and Adolescents with AD/HD
http://www.help4adhd.org/documents/WWK7.pdf

Behavioral Treatment for Children and Teenagers with AD/HD
http://www.help4adhd.org/documents/WWK7s.pdf

AD/HD Predominantly Inattentive Type
http://www.help4adhd.org/documents/WWK8.pdf

Medication Diversion
http://www.help4adhd.org/en/living/parenting/diversion

Fact Sheets about ADHD in Spanish

Hoja de Datos de CHADD
Spanish-Language Fact Sheets
http://www.help4adhd.org/espanol.cfm

El Trastorno Llamado TDA/H
http://209.126.179.236/fs/sfs1.htm

Criando a un niño con el Trastorno por Déficit de Atención e Hiperactividad
http://209.126.179.236/fs/sfs2.htm

Manejo médico de los niños y adultos con el TDA/H
http://209.126.179.236/fs/sfs3.htm

Derechos educacionales de los niños con el TDA/H
http://209.126.179.236/fs/sfs4.htm

TDA/H y Trastornos Coexistentes
http://209.126.179.236/fs/sfs5.htm

Evaluando las Intervenciones Complementarias y/o Controvertibles
http://209.126.179.236/fs/sfs6.htm

Educational Rights for Children with Attention-Deficit/Hyperactivity Disorder: A Primer for Parents (1996)—free bilingual booklet
http://www.help4adhd.org/pr060106.cfm

Recommended Reading for Children

Learning To Slow Down & Pay Attention: A Book for Kids About ADHD (2004)
Kathleen G. Nadeau, Ellen B. Dixon, and Charles Beyl

Jumpin' Johnny Get Back to Work! A Child's Guide to ADHD/Hyperactivity (1991)
Michael Gordon

The Survival Guide for Kids with ADD or ADHD (2006)
John F. Taylor

Joey Pigza Loses Control (2005)
Jack Gantos

50 Activities and Games for Kids with ADHD (2000)
Patricia O. Quinn (Editor)

The Girls' Guide To AD/HD: Don't Lose This Book! (2004)
Beth Walker

Recommended Reading for Adults

Taking Charge of ADHD: The Complete, Authoritative Guide for Parents
(revised edition) (2000)
Russell Barkley

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

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

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

A Bird's-Eye View of Life with ADD and ADHD: Advice from Young Survivors (2003)
Chris Dendy and Alex Dendy

Making the System Work for Your Child with ADHD (2004)
Peter Jensen

Practical Suggestions for AD/HD (2003)
Clare Jones

Kids in the Syndrome Mix of ADHD, LD, Asperger's, Tourette's, Bipolar, and More! The One-Stop Guide for Parents, Teachers, and Other Professionals (2005)
Martin Kutscher, Tony Attwood, and Robert Wolff

Help4ADD@High School (1998)
Kathleen Nadeau

Putting on the Brakes: Young People's Guide to Understanding Attention Deficit Hyperactivity Disorder (2001)
Patricia Quinn and Judith Stern

The ADHD Book of Lists: A Practical Guide for Helping Children and Teens with Attention Deficit Disorders (2003)
Sandra Rief

Suicide and Emergency Room Experiences

Parenting Children with ADHD: 10 Lessons That Medicine Cannot Teach (APA Lifetools) (paperback) (2004)
Vincent J. Monastra, Ph.D.

Straight Talk About Psychiatric Medications for Kids (revised edition) (paperback) (2004)
Timothy E. Wilens, M.D.

The Gift of ADHD: How to Transform Your Child's Problems into Strengths (paperback) (2005)
Lara Honos-Webb

Twelve Effective Ways to Help Your ADD/ADHD Child: Drug-Free Alternatives for Attention-Deficit Disorders (paperback) (2000)
Laura J. Stevens

Thom Hartmann's Complete Guide to ADHD: Help for Your Family at Home, School and Work (paperback) (2000)
Thom Hartmann, Lucy Jo Palladino (Foreword), and Peter Jaksa (Afterword)

ADD & ADHD Answer Book: The Top 275 Questions Parents Ask (paperback) (2005)
Susan Ashley

Contributors

American Academy of Child and Adolescent Psychiatry (AACAP)

American Psychiatric Association (APA)

Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)

Child and Adolescent Bipolar Foundation

Federation of Families for Children's Mental Health

Mental Health America

National Alliance on Mental Illness (NAMI)

National Institute of Mental Health (NIMH)

Endnotes

[1] Available at: http://www.nimh.nih.gov/publicat/adhd.cfm#intro. Accessed 4/12/07.

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[3] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV-TR). Washington, DC: American Psychiatric Association, 2004.

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[11] U.S. Department of Transportation National Highway Traffic Safety Administration, Study shows that young adults diagnosed with severe attention deficit hyperactivity disorder as children have more driving risks. *Traffic Tech* 1996;131.

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[13] Available at: http://www.fda.gov/medwatch/safety/2006/safety06.htm#Dexedrine. Accessed 2/12/07.

[14] Available at: http://www.fda.gov/bbs/topics/NEWS/2005/NEW01237.html. Accessed 2/12/07.

[15] Available at: http://www.hhs.gov/ocr/504.html. Accessed 4/29/07.

[16] Available at: http://www.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html. Accessed 4/29/07.

[17] Available at: http://www.aap.org/healthtopics/adhd.cfm. Accessed 4/12/07.

After reviewing the ADHD Parents Medication Guide, please help us better serve your needs and the needs of others by completing a brief opinion survey. Your feedback on the guide is essential for us to provide accurate and helpful information about child and adolescent ADHD.

Click **HERE** to begin the survey.

Thank you!

TeenScreen® National Center for Mental Health Checkups at Columbia University

Youth Suicide and Prevention

Youth Suicide and Attempts

■ Suicide is the third leading cause of death among 10-24 year olds.[1]

■ Between 1999 and 2007, a total of 38,988 young people aged 10-24 died by suicide, translating to nearly 4,400 deaths in this age group every year.[2]

■ Approximately 149,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at U.S. Emergency Departments each year.[3]

There are an estimated 100–200 suicide attempts for each completed suicide among young people.[4]

■ Data from the 2007 Centers for Disease Control and Prevention Youth Risk Behavior Survey revealed that in the previous year:

- 15% of responding US high school students had serious thoughts of killing themselves,
- 11% made a suicide plan,
- 7% attempted suicide, and
- 2% made a suicide attempt that required medical attention.

■ It is estimated that 13.2 million people were directly affected by a suicide within the previous year.[5]

Demographic Variations in Risk

■ **Age:** Older adolescents (≥16 years) are more at risk for suicide than younger adolescents. This increased risk is attributed to greater prevalence of psychopathology, especially depression and substance abuse.[6]

■ **Gender:** More than four times as many male youth (ages 15-19) die by suicide[7], however girls attempt suicide two to three times more often than boys.[8, 9]

■ **Geographic location:** Data from 2000- 2006 indicates that suicide rates are highest in the western and northwestern regions of the U.S.[10]

■ **At-Risk Populations:** The following populations have been demonstrated to have elevated rates of suicide or suicide attempts among young people:

- American Indian and Alaska Native youth,
- Latina youth,
- lesbian, gay, bisexual and transgender youth,
- young people from disadvantaged socio-economic backgrounds, and
- youth in the juvenile justice and child welfare systems.[11,12]

Risk Factors

■ **Depression:** Up to 60% of adolescent suicide victims have a depressive disorder at the time of their death.[13,14]

■ **Drug and Alcohol Use:** Substance use disorders are associated with up to 6.2 times greater than average risk of suicide attempts, according to data from the National Comorbidity Survey.[15]

■ **Prior Attempts:** A prior suicide attempt is one of the strongest predictors of completed suicide. Between 25 and 50 percent of teenage suicide victims are known to have made a previous suicide attempt.[16]

■ **History of Trauma or Abuse:** Exposure to sexual and/or physical abuse as a child leads to a significant increase in the occurrence of suicidal ideation and behavior between the ages of 16 and 25.[17]

■ **Bullying:** Students who are involved in bullying behavior, whether as a victim or a bully, are at significantly higher risk for depression, serious suicidal ideation (SSI), and suicide attempts.[18]

■ **Exposure to Suicide:** A single adolescent suicide increases the risk of additional suicides within a community and may serve as a catalyst for the development of a suicide cluster, a phenomenon which accounts for 1-5% of teenage suicides.[19] Having an immediate family member commit suicide has been found to increase the risk of suicide by a factor of three or more.[20,21]

An Opportunity for Intervention

■ The vast majority of adolescent suicide victims have a psychiatric disorder (90%), and 63 percent exhibit symptoms identifiable by screening for at least a year before their death, leaving an opportunity for intervention and prevention.[22]

Low Recognition of Warning Signs

■ Adolescents with suicidal ideation are less likely to seek help than their peers; studies of high school students have repeatedly shown that higher levels of suicidal ideation are significantly correlated with lower intentions to seek help.[23]

■ As many as 83% of adolescents seen in primary care settings who had attempted suicide were not recognized as suicidal or a danger to themselves by their primary care physician, even when examined in the months prior to their suicide attempt.[24]

■ Studies have found that fewer than 25% of parents of children with self-injurious behaviors are aware of the problem.[25]

Improving Prevention Practices

■ In *The Case for Routine Mental Health Screening,* the American Academy of Pediatrics' Task Force on Mental Health states that a review of the evidence supports the conclusion that screening with a validated tool is useful in identifying youth with mental health problems in a variety of settings.

A 2007 study in *Pediatrics* resolved that "the best way to assess for suicidal ideation is by directly asking or screening via self-report."[26]

Mental Health Screening Endorsed as a Suicide Prevention Measure

■ In 2003, the President's New Freedom Commission on Mental Health recommended mental health screening as a means to improve early intervention and prevent complications of mental illness, such as suicide.

■ *National Strategy for Suicide Prevention*

A joint effort of the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control and Prevention, the National Institutes of Health, the Health Resource and Services Administration, and the Indian Health Service:

The *National Strategy for Suicide Prevention* calls for screening for depression, substance abuse and suicide risk as a measurable performance indicator for health plans and as a minimum standard of care in all federally supported primary care settings, such as Medicaid, Medicare, the Children's Health Insurance Program (CHIP).

■ The U.S. Preventive Services Task Force (USPSTF) recommends annual depression screening for all 12-18 year olds. This recommendation was based on the task force's findings that:

Adolescent depression is associated with serious long-term morbidities and risk of suicide; screening questionnaires can effectively identify depression in adolescents; and effective treatments are available.

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Teen Suicide

Fact Sheet

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EPIDEMIOLOGY

Suicide rates are obtained from official death-certificate data, which are usually published one to two years after the death. ***Suicide statistics for your area*** can be found on the following Web site: http://wonder.cdc.gov/mortsql.html.

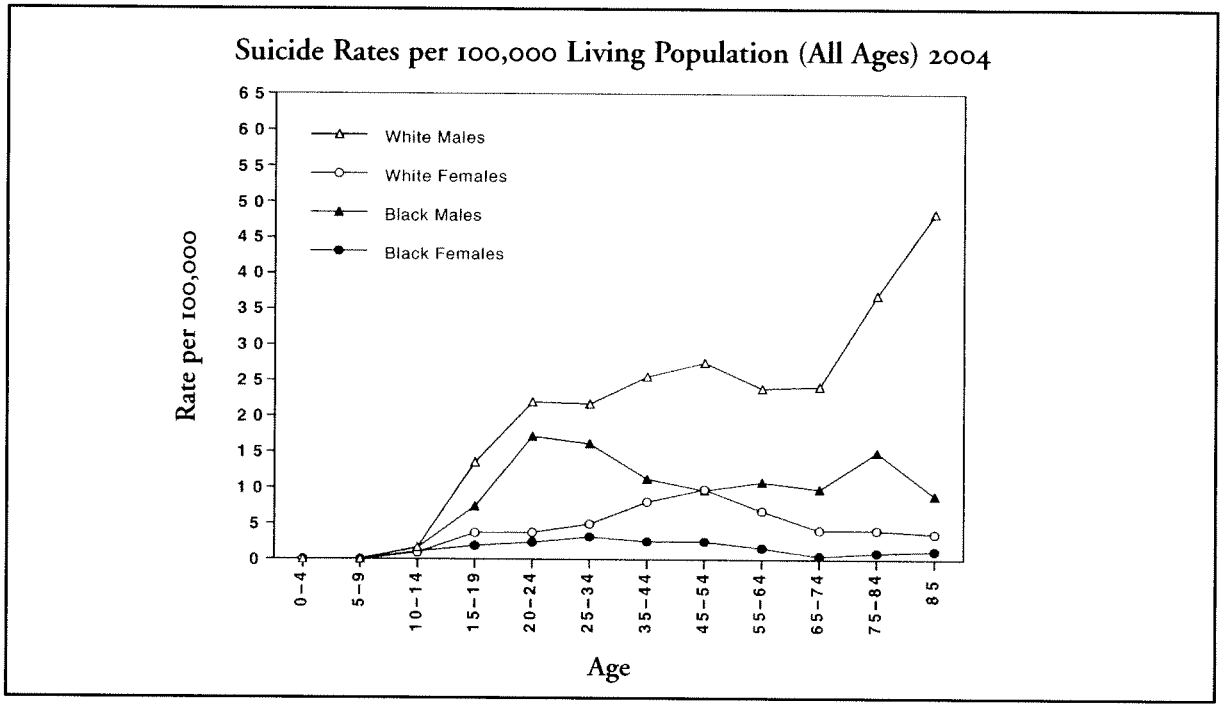
TABLE I

U.S. YOUTH SUICIDE RATES IN 2004

Ages	# of Males	# of Females	% of All Deaths	% of All Suicides	Males	Females	Total
10-14	185	98	7.2%	0.872%	1.71	0.95	1.34
15-19	1,345	355	12.4%	5.241%	12.65	3.52	8.20
20-24	2,251	365	13.3%	8.064%	20.84	3.59	12.47

- Each of the 10- to 14-, 15- to 19-, and 20- to 24-year-old age groups represent approximately 7 percent of the U.S. population. But .87 percent of all suicides occur in the 10- to 14-year-old age group,
- 5.2 percent of all suicides occur in the 15- to 19-year-old age group, and
- 8.1 percent of all suicides occur in the 20- to 24-year-old age group.

FIGURE I



Source: CDC, National Center for Injury Prevention and Control, Office of Statistics and Programming (2006). Web-based Injury Statistics Query and Reporting System (WISQARS). Available at <http://www.cdc.gov/ncipc/wisqars>. Accessed December 18, 2006.

AGE

The suicide rate is higher in males and shows more variation with age in males. Before puberty, suicide is equally rare in both genders, but, in males, it increases through the teen years, reaching a level in the early 20s that is maintained until middle age, when, from age 55, it again increases steadily (see Figure 2). The female suicide rate changes little during the lifetime. Suicide before puberty is very rare in all countries, including the U.S. Around 90 percent of suicides in the 10- to 14-year-old age group occur among 12- to 14-year-olds. This might be because of unknown biological processes or because conditions such as depression or the complications of substance and alcohol abuse, both of which are strong risk factors for suicide, are rare before puberty, but become more common through adolescence.

GENDER

- In the U.S., suicide is slightly less than twice as common in males than in females among 10- to 14-year-olds, almost four times more common in 15- to 19-year-olds, and just under six times more common in 20- to 24-year-olds. Gender differences remain high, and, by late middle age, almost all suicides occur among men.

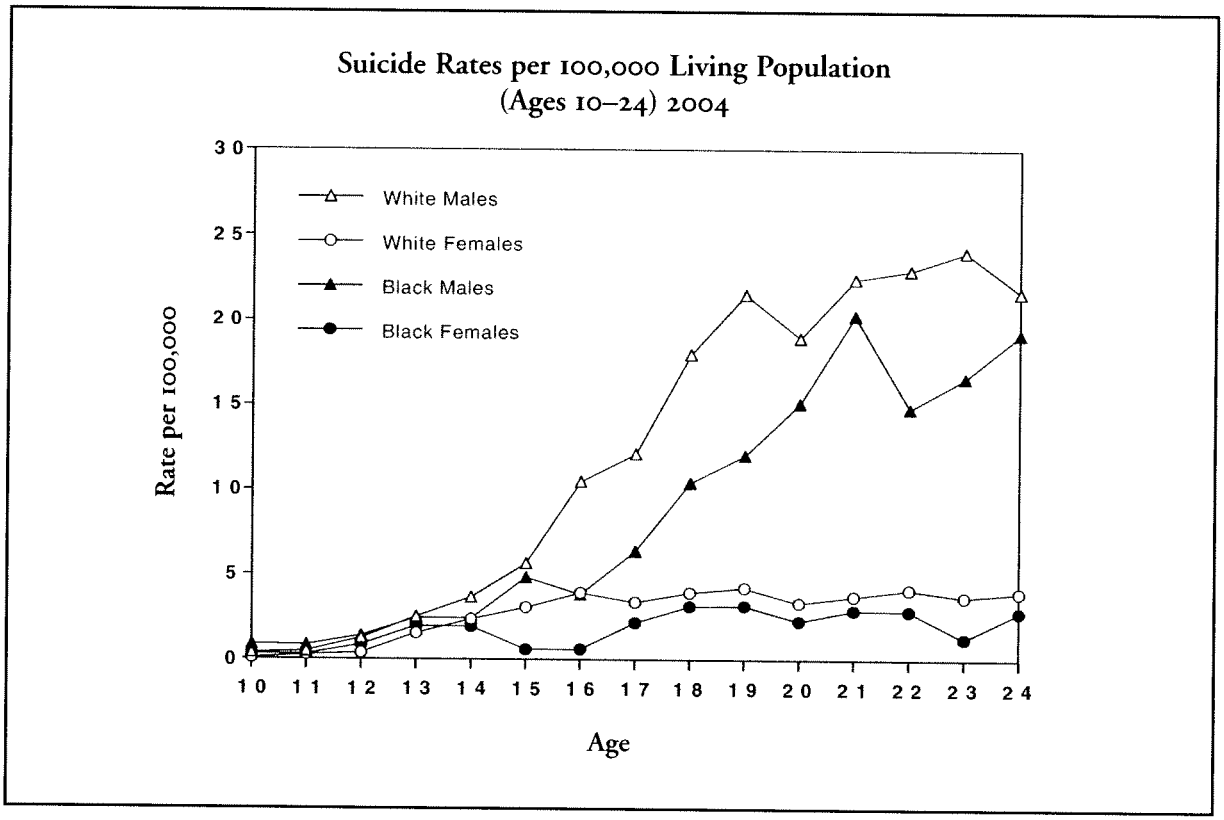
Possible reasons for gender differences are:

- Suicide is often associated with aggressive behavior, which is more common in males.
- Suicide is associated with low levels of serotonin, which is generally lower in males.
- Methods. Regardless of culture, suicidality in women is most often expressed by ingestion whether of prescription medication, OTC analgeics, caustics, herbicides or insecticides. If the ingestion acts slowly and is treatable, intended suicides may become attempts. In Asian countries, ingestions of rapidly lethal herbicides/insecticides are associated with suicide being more common in females than males.

ETHNCITY AND CULTURE

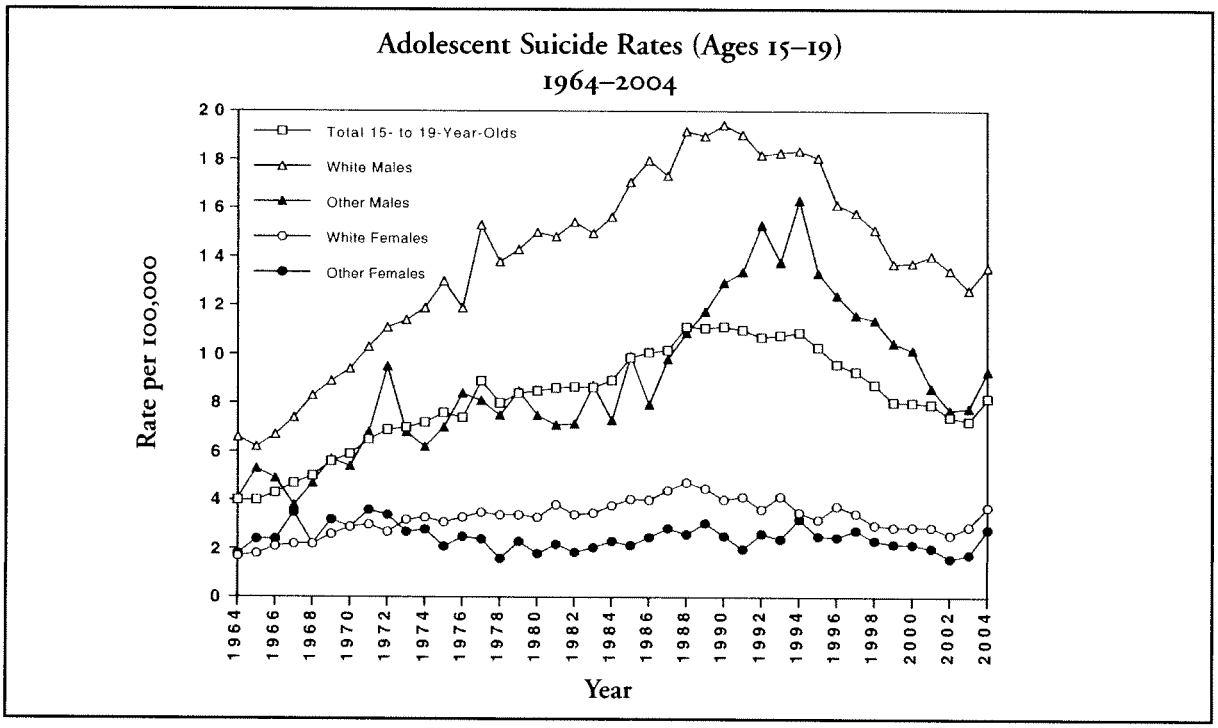
- The U.S. is an ideal setting to examine ethnic and cultural influences within a given country. Since 1980, the first year that detailed racial information was collected, American Indians/Alaska natives have consistently had the highest adolescent suicide rates, followed by whites, but within the groups there are big regional differences. Asians/Pacific Islanders and blacks have the lowest rates at all ages.

FIGURE 2



Source: CDC, National Center for Injury Prevention and Control, Office of Statistics and Programming (2006). Web-based Injury Statistics Query and Reporting System (WISQARS). Available at <http://www.cdc.gov/ncipc/wisqars>. Accessed December 18, 2006.

FIGURE 3



The "other" groups include all nonwhites.

Sources: National Center for Health Statistics, Division of Vital Statistics, Mortality Statistics Branch, years 1964–1978. Supplied upon written request to NCHS, 6525 Belcrest Road, Hyattsville, MD 20782-2003, (310) 458-4636; National Center for Health Statistics, Division of Vital Statistics (unpublished, 2000). Deaths rates for 72 selected causes, by five-year age groups, race, and sex: United States, 1979–1998. Worktable GMWK 291 Trend B, plate 1 of 2, pages 485–490; CDC, National Center for Injury Prevention and Control, Office of Statistics and Programming (2006). Web-based Injury Statistics Query and Reporting System (WISQARS). Available at <http://www.cdc.gov/ncipc/wisqars>. Accessed December 18, 2006.

Since 1990, the first year in which a majority of states have recorded Hispanic-origin data, Hispanic adolescent males have consistently had lower suicide rates than non-Hispanics, though the rates for females have been nearly the same.

- Alcohol use is a major factor in the determination of national differences (Wasserman et al.).
- The difference between black and white suicide rates are greatest in those over thirty. Differences between black and white youth have narowed since the 1980s, suggesting that a longstanding "protective effect" is losing its effect. Selective underreporting of suicide among minorities in the U.S. occurs to a minor degree and does not by itself explain the magnitude of the difference (Mohler & Earls 2001). In 2004, black-white differences among 15- to 24-year-olds were greatest in Southern states and least in Midwestern and Northeastern states.

Possible explanations for ethnic rate differences include:

- Cultures/religions that regard suicide in a very negative light might discourage depressed believers from committing suicide.
- African Americans are more likely to hold fundamentalist beliefs, i.e., an emphasis on scripture and on a "personal God." This might result in greater social-support and might reduce feelings of personal guilt and responsibility that are characteristic of the depressive state.
- Note: Some cultures encourage suicide under special circumstances, e.g., among the Apache Indians and the Seppuku tradition in Japan. However, cultural sanction for suicide applies only to small subgroups.

GEOGRAPHY

In the United States in 2004, suicide rates among 15- to 24-year-olds were lowest in the Northeastern states and highest in the West. Alaska had the highest suicide rate, followed by New Mexico and Montana.

THE CHANGING SUICIDE RATE (SEE FIGURE 3)

The teen suicide rate in boys tripled between the mid-1960s and the late 1980s. However, starting in 1994, the youth suicide rate fell by 30 percent or more in most groups. In 2003, the suicide rate for white teens was at its lowest level in 27 years and it is of great concern that in 2004 - a year that saw a great decline in the prescription of antidepressants - it increased.

- The decline in the suicide rate varied by ethnicity. It started first among whites but in other ethnicities followed 4-6 years later.
- There has been little change in the much-lower suicide rates of ***white and other female teens.***

Possible explanations for the decline in the teen suicide rate.

Not supported:

- Use of drugs and alcohol is a known risk factor for suicide, but use rates increased during the period of declining suicide (CDC 2006) and so this is an unlikely explanation.
- Increased availability of suicide-awareness programs. There is no evidence that suicide-awareness programs increase help-seeking among depressed or suicidal teens. The AAS maintains a registry of suicide-prevention programs—mainly suicide-awareness programs—which remained constant during this period.
- Increased availability of psychotherapies. The use of psychotherapy by adolescents has not increased (Olfson et al. 2002), and, with the exception of dialectical-behavior therapy (DBT) (see Treatment) in adults, controlled psychotherapy studies have failed to show a reduction in attempts. Regretably, there are very few practitioners of DBT generally, and even fewer for adolescents. So, this, too, is unlikely to explain the decline.

Some support:

- The Brady Bill took effect in 1994 and may have hastened reduced gun availability.
- Psychoeducation and destigmatization of depression accompanying intense marketing of antidepressants.
- Continuous improvement in quality of emergency room care.
- Antidepressants. A substantial increase in the prescribing of medication, specifically antidepressants, for the general teenage population (Olfson et al. 2002) took place during this period. Although treatment of depression with SSRI antidepressants seems to result in an increase in suicide attempts and threats (Hammad 2004), there is no evidence of a similar effect on completed suicides, and SSRI's are rarely present at the autopsy of a teen suicide. Until controlled trials that are specifically designed to look at this question have been conducted many professionals will withold judgement on this queston.

THE SUICIDE ACT

METHODS

- In the United States, firearms are the most common method used to commit suicide by all age, gender, and ethnic groups.
- In 2006, overdoses accounted for only 3.2 percent of teenage male suicides, but accounted for 14.6 percent of teenage female suicides.
- Hanging, relative to other methods, is more common in early adolescence than in later years.
- Suicide rates by firearm have decreased since 1994, while rates by hanging have increased. While these changes are not equivalanet, limiting access to guns might be pushing suicidal teens to substitute the more accessible method of suffocation.

PRECIPITANTS

- Suicide often occurs shortly after a stress event (Gould et al. 1996), most commonly a disciplinary crisis or interpersonal loss (e.g., breakup with boyfriend or girlfriend, recent separation of parents, suspension from school, or appearance in juvenile court).
- Attempts to reconstruct the mental state of teen suicides from psychological-autopsy research suggest that high levels of anxiety or anger are commonly present just prior to death.

WHAT LEADS TO SUICIDE (RISK FACTORS)

PSYCHIATRIC DIAGNOSES

(See Table 2)

- Psychiatric studies in very different countries have shown that a psychiatric diagnosis is present in about 90 percent of suicides before and at the time of the death.
- Alcohol abuse is present in approximately two thirds of 18- to 19-year-old males, but are not common in younger (< 14 years) male or female suicides (Shaffer et al. 1996).
- A history of depression alone or in combination with aggressive behavior and/or substance abuse or anxiety is found in over half of all suicides.
- Fewer than 10 percent of teenage suicides have schizophrenia or manic depression. Although these conditions have a high suicide rate, they are relatively infrequent in the general population.

TABLE 2

Psychiatric Diagnoses in Child and Adolescent Suicides (Percentages)

Study	Marttunen et al. 1991			Shaffer et al. 1996			Brent et al. 1999		
Country	Finland			USA			USA		
Area	National			Greater New York			Western Pennsylvania		
Period	1987–1988			1984–1986			1984–1994		
N	53			120			140		
Age	13–19			< 20			13–19		
% Girls	17%			21%			15%		
Control Group	None			Matched Community			Matched Community		
Diagnostic System	DSM-IIIR			DSM-III			DSM-IIIR		
Diagnosis (%)	Males %	Females %	All %	Males %	Females %	All %	Males %	Females %	All %
Any Diagnosis	93	100	94	90	92	91	82	81	82
Any Mood Disorder	48	67	51	60	68	61	43	71	47
Substance Abuse	27	44	30	42	12	35	35	24	34
Conduct/Antisocial/ Disruptive Disorder	18	11	17	54	36	50	35	10	31
Any Anxiety Disorder	2	11	4	27	28	27	13	24	14
Schizophrenia	5	11	6	3	4	3	not measured	not measured	not measured
Past Suicide Attempt	27	67	34	28	50	33	37	62	41

Sources: Marttunen et al. (1991), Archives of General Psychiatry *48(9):834–839; Martunnen et al. (1995),* Journal of the American Academy of Child and Adolescent Psychiatry *31(4):649–654; Shaffer et al. (1996a),* Archives of General Psychiatry *53:339–348; Brent et al. (1999),* Journal of the American Academy of Child and Adolescent Psychiatry *38(12):1497–1505.*

CLINICAL FEATURES

- Between 25 and 50 percent of teenage suicide victims are known to have made a previous suicide attempt.
- Statements indicitave of hopelessness were present in about half of all suicides. However, hopelessness is a common feature of depression with or without suicidality.
- Aggressive/impulsive behavior is common in both sexes.
- About half of teenagers who committed suicide had had previous contact with a mental health professional.

- 15 to 20 percent had seen a mental health professional between one and three months prior to death (Shaffer et al. 1996).

SOCIO-ENVIRONMENTAL

- The ***socioeconomic background*** of suicides is generally similar to that of the general population, except among blacks. Black teen suicides tend to have a higher ses than the general black population (Gould et al. 1996).
- Suicides are less likely to ***attend college*** than same-age, same-sex general population. The rate of suicide in college students is somewhat lower than in 18-21 year olds in the general population. But this age is a period of significant suicide risk, and many students do commit suicide.
- ***Firearm availability*** might contribute to some suicides, but it is not clear that handgun control would have a major effect on the youth suicide rate. Very few (about 5 percent) suicides are committed with handguns, and the rate of suicide in the United States, where firearms are readily available, is lower than the rate in many countries where access to firearms is very limited. In countries that have implemented strict firearm controls the fall in suicides by firearm has been transient as other methods became used instead.
- Early ***sexual and physical abuse*** lead to many types of psychopathology, including suicide ideation and attempts. The effect on ideation and attempts is modest, but there is a statistically significant "dose-response" effect, so that abuse characterized by penetration gives a greater risk for suicide ideation and attempt behavior than other forms of sexual abuse (Ferguson et al. 1996).
- ***Religious beliefs*** might have a protective effect on suicidality and depression (Miller & Gur 2000) and have been offered as an explanation for the lower black suicide rates, especially in older cohorts (Nelleman et al. 1998). In adult populations, an association has been found between religious orthodoxy and lower suicidality.

NEUROCHEMICAL ABNORMALITIES

Findings in adult and older adolescent suicides and suicide attempts include:

- Abnormally low levels of the serotonin (5HT) metabolites 5-HIAA and HVA in cerebrospinal fluid. This suggests an underavailability of serotonin, a neurotransmitter that is sedating and that plays a key role in behavioral control.
- Reduced concentration of presynaptic serotonin binding sites in the ventral prefrontal cortex. This is the part of the brain that plays a key role in behavioral control. Dysfunction in this area could lead to impulsive, excitable, intense behavioral responses to stress.
- Increased postsynaptic 5HT receptor density in the ventral prefrontal cortex. This could be the brain's way of trying to compensate for the underavailability of serotonin in the area.

FAMILIES

- Family dysfunction is common in youth with a psychiatric disorder, and when suicidal teens are compared to teens with the same diorder but who are not suicidal family factors such as divorces, living in a one parent families, marital dysharmony, and parent/child friction do not distinguish between those with or without suicide except that:
- *Suicide victims communicate less often and less fully with their parents than control teens.*
- Having a close family member (sibling, parent, aunt, uncle, or grandparent) who committed suicide increases the risk of suicide twofold. Familial suicide could be a result of imitation or genetics. If it is a genetic influence, we do not know if it is the predisposition to a specific mental illness that is inherited.

SUICIDE CONTAGION

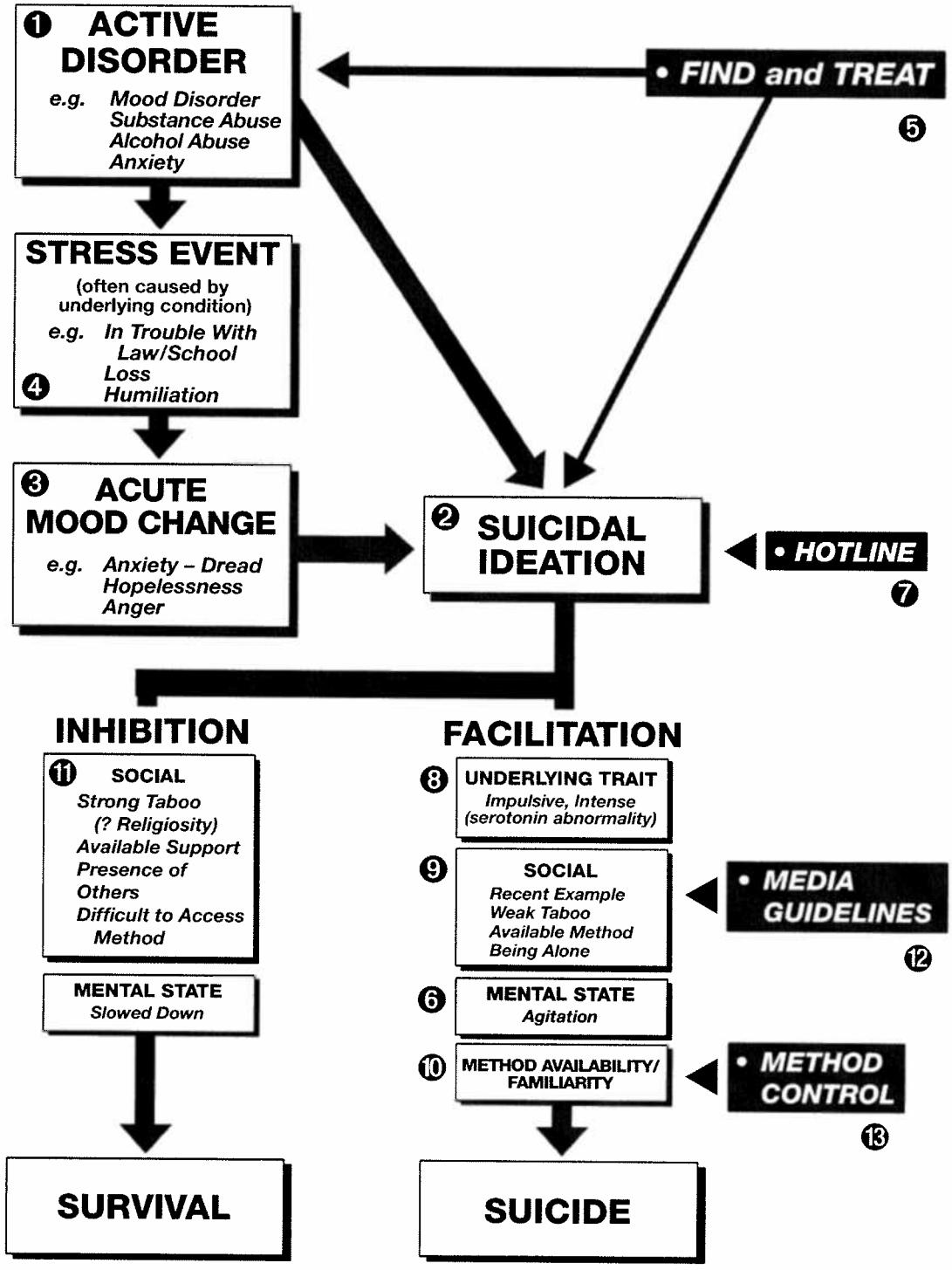
Suicide contagion, sometimes referred to as imitative or copy-cat suicide, is supported by the following evidence:

- After a film or news story on suicide, suicide rates tend to go up for a brief period of time, with higher rates of suicide by the same method as the published suicide.
- Following the implementation of suicide guidelines, or during newspaper strikes, suicide rates tend to go down for a period of time.
- There are accounts of specific suicides that were committed shortly after seeing or reading about a suicide.
- Suicide clusters occur in high schools and communities. Typically, these result in the death of three to seven teenagers over a period of three to nine months. Clusters appear more likely to occur after an initial public suicide.

SEXUAL ORIENTATION

Gay, lesbian, and bisexual youth have higher rates of suicidal ideation and suicide attempts. Research has not yet determined whether risk is elevated for completed suicide. Reasons underlying increased risk of suicide attempts in gay, lesbian, and bisexual youth are under investigation.

HOW DO SUICIDES OCCUR AND HOW CAN THEY BE PREVENTED?



PERINATAL HAZARD

Salk et al. (1985) first noted an excess of ***obstetric complications*** among suicides. This was then confirmed by other investigators in the U.S. and Europe.

- Mothers of the eventual suicides received less prenatal care and were more likely to smoke cigarettes and drink alcohol during pregnancy.
- The reasons for this have not been confirmed, but the excess of suicide could, therefore, be due to cns consequences of birth complications, exposure to some teratogen during pregnancy, the heritability of psychopathology, the effects of inappropriate parenting by deviant mothers, etc.

A SEQUENTIAL MODEL OF SUICIDE

The preceding flow chart proposes a "model" indicating where the most important risk factors operate. It provides a strategic map of locations where interventions might be useful.

An active ***mental disorder*** (1), most commonly a mood disorder, often in males with co-occurring substance abuse or disruptive disorder, is present in about 90 percent of adolescent suicides at the time of death and, along with ***suicidal ideation*** (2) (see below), can conveniently be regarded as the closest thing we have to a ***necessary*** risk condition. Even though relatively few psychiatrically disturbed youths will commit suicide, aggressive case-finding and the development and provision of effective treatment for affected youth could be expected to reduce the suicide rate.

The ***cognitive set*** (3) of hopelessness seems to predispose to suicidal ideation. Hopelessness is often a product of depression and could be expected to be reduced with treatment of psychiatric disorder. However, hopelessness, long regarded by cognitive theorists as predisposing to depression, has in several studies appeared to operate as a risk factor for suicide independent of depression. Thus, the treatment of hopelessness by appropriate psychotherapy could be considered a reasonable preventive intervention.

Adverse ***stress events*** (4), most often a disciplinary crisis, interpersonal loss, or a perceived humiliation, often occur in close proximity to a suicide. Such events are common during adolescence and are only weak independent predictors of suicide. Their high frequency makes them an inappropriate focus for intervention. However, in many instances, these events might be a consequence of an adolescent's underlying mental disorder, which, in a vicious cycle, might also deprive the teen of parent, peer, or teacher support and in other ways impede his or her ability to cope with or seek solutions to stresses. Case-finding (5) and treatment of psychiatric disorder could also be an effective preventive activity at this level.

External stress events are probably linked to suicide through the induction of a ***negative mood*** (6). Suicide hot lines (7) were originally designed to operate at this point in the process of burgeoning suicidality. Interventions that alert the teen to dangerous internal mental states and provide skills for dealing with these directly or by obtaining external help, whether from a professional or a help line, could operate here.

An underlying disorder, recent stress, and inadequate support, coupled with hopelessness or preoccupation with suicide, will thus set the stage for suicide. We must assume that many teens experience this confluence of risk factors, yet few commit suicide. It is probably at this point that specific enhancers and inhibitors operate.

Enhancement might be mediated by a biological or toxic (i.e., drug- or alcohol-induced) predisposition to impulsivity or emotional volatility (8), by high social value being placed on suicide (as by the victim's familiarity with peers or public figures whose suicide, related by the media, carries a sense of importance or romance) (9), by the availability of a lethal method (10), by social isolation, or by the absence of any ***inhibiting*** factors.

Inhibiting (11) factors might include societal or religious taboos, the presence of social support, and difficulty in accessing a method.

Preventive interventions operating at this final stage would, therefore, include media guidelines (12) to promote responsible reporting of suicide and to minimize contagion, promotion of strong taboo against suicide in society, and the removal of lethal medications and weapons (13) from the homes of suicidal youth. Nearly all of these would involve nonmedical, societal, or political interventions.

There remain some factors, in particular a ***family history*** of suicidal behavior, that appear to operate as salient risk factors even when controlling for psychopathology, but that are difficult to place in this model: family history, which could operate at a number of points, including modeling; an association with adverse early experiences; a genetic disposition towards another risk factor, such as a type of psychiatric disorder; a violent, impulsive temperament; or some combination of these.

On the basis of an analysis of this kind, the best bet for suicide prevention would seem to be the effective identification and treatment of associated psychiatric disorders. These operate to promote suicide at many points of the process, and our ability to intervene effectively with these is probably greater than our ability to bring about the societal or political changes that are needed to alter the end-stage determinants of suicide.

TABLE 3: DEPRESSED FEELINGS AND SUICIDE IDEATION AND ATTEMPTS IN 2003

Percentage of High-School Students Who Felt Sad or Hopeless,*† Who Seriously Considered Attempting Suicide,† Who Made a Suicide Plan,† Who Actually Attempted Suicide*† and Whose Suicide Attempt Required Medical Attention,* by Sex, Race/Ethnicity, and Grade — United States, Youth Risk Behavior Study, 2005, N=13,917 —

	Felt sad or hopeless*†			Seriously considered attempting suicide†			Made a suicide plan†			Attempted suicide†§			Suicide attempt required medical attention†		
Category	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Race/Ethnicity															
White¶	**33.4** (±2.4)**	18.4 (±1.9)	25.8 (±1.7)	**21.5** (±1.8)	12.4 (±1.3)	16.9 (±1.2)	**15.4** (±1.5)	9.7 (±1.5)	12.5 (±1.2)	**9.3** (±1.5)	5.2 (±1.3)	7.3 (±1.0)	2.7 (±0.7)	1.5 (±0.5)	2.1 (±0.5)
Black¶	**36.9** (±3.4)	19.5 (±2.9)	28.4 (±2.5)	**17.1** (±2.2)	7.0 (±1.8)	12.2 (±1.5)	**13.5** (±2.0)	5.5 (±1.6)	9.6 (±1.2)	**9.8** (±2.4)	5.2 (±2.8)	7.6 (±2.1)	2.6 (±1.0)	1.4 (±1.1)	2.0 (±0.8)
Hispanic	**46.7** (±3.0)	**26.0** (±3.2)	**36.2** (±2.4)	**24.2** (±3.2)	11.9 (±2.1)	17.9 (±1.8)	**18.5** (±2.8)	10.7 (±2.6)	14.5 (±1.5)	**14.9** (±2.2)	**7.8** (±2.4)	**11.3** (±1.5)	**3.7** (±1.3)	**2.8** (±1.3)	**3.2** (±1.0)
Grade															
9	38.5 (±3.1)	19.9 (±2.6)	29.0 (±2.2)	23.9 (±2.6)	12.2 (±2.7)	17.9 (±2.1)	17.6 (±2.2)	10.2 (±2.2)	13.9 (±1.6)	14.1 (±1.8)	6.8 (±2.5)	10.4 (±1.7)	4.0 (±1.2)	2.1 (±1.2)	3.0 (±0.8)
10	37.0 (±2.6)	21.3 (±2.7)	28.9 (±2.1)	23.0 (±2.0)	11.9 (±2.0)	17.3 (±1.6)	18.1 (±2.0)	10.3 (±1.6)	14.1 (±1.4)	10.8 (±1.7)	7.6 (±2.1)	9.1 (±1.3)	2.4 (±0.7)	2.2 (±1.0)	2.3 (±0.7)
11	38.0 (±3.1)	19.4 (±2.8)	28.8 (±2.4)	21.6 (±3.0)	11.9 (±1.9)	16.8 (±1.8)	16.3 (±2.5)	9.5 (±2.2)	12.9 (±1.7)	11.0 (±2.6)	4.5 (±1.5)	7.8 (±1.5)	2.9 (±1.1)	1.4 (±0.8)	2.2 (±0.8)
12††	32.6 (±3.5)	20.2 (±2.8)	26.4 (±2.4)	18.0 (±2.7)	11.6 (±2.1)	14.8 (±1.7)	12.0 (±2.2)	9.0 (±2.4)	10.5 (±1.8)	6.5 (±1.6)	4.3 (±1.5)	5.4 (±1.2)	2.2 (±0.7)	1.0 (±0.6)	1.6 (±0.5)
Total	**36.7** (±1.9)	**20.4** (±1.3)	**28.5** (±1.2)	**21.8** (±1.3)	**12.0** (±1.0)	**16.9** (±0.9)	**16.2** (±1.2)	**9.9** (±1.2)	**13.0** (±0.9)	**10.8** (±1.1)	**6.0** (±1.2)	**8.4** (±0.9)	**2.9** (±0.6)	**1.8** (±0.5)	**2.3** (±0.4)

* Almost every day for ≥ 2 weeks in a row.
§ One or more times.
** 95-percent confidence interval.
† During the 12 months preceding the survey.
¶ Non-Hispanic.

†† The lower rate of these problems in twelfth grade might reflect an aging process, but is also likely to reflect the selective departure from school of more troubled teens.

SUICIDE ATTEMPTS

EPIDEMIOLOGY

- Beginning in 1991, biennial changes in the suicide-attempt and suicidal-ideation rates have been assessed in the Youth Risk Behavior Survey (YRBS). Our most representative information comes from this survey, and, unlike mortality data, the yrbs presents a direct comparison of white, black, and Hispanic youth.
- High-school-age girls have higher rates of feeling sad or hopeless, seriously considering suicide, making a suicidal plan, attempting suicide, and making a suicide attempt that requires medical attention than boys (YRBS 2001, 2005; see Table 3).
- In 2005, 8.4 percent of U.S. high-school students reported having made a suicide attempt in the past 12 months, and 6 percent of male U.S. high-school students reported an attempt in the past 12 months. The female-to-male attempted suicide ratio is 1.8:1.
- In most countries, suicide attempts are more common among females than among males.
- In the U.S., Hispanic teens, as compared to whites or blacks, have the highest attempt rates (YRBS 2006).
- Teen suicide attempt rates are higher when asked using anonymous self-reports than in face-to-face interviews (Safer 1997).
- Most teen suicide attempters seen in an emergency room or clinic have cut themselves or have taken an overdose.
- Suicide attempts are made relatively infrequently by prepubertal children and they increase in prevalence through adolescence, reaching a peak at around age sixteen, after which they decline (Kessler et al. 1999).

MANAGEMENT

The goal of the first evaluation is to determine whether an adolescent needs continued observation or can be safely discharged home. Factors indicating hospitalization for further evaluation and supervision include:

- *Gender:* All males over age 12.
- *Mental State:* Evidence of significant depression, evidence of psychosis, feelings of hopelessness, or a recent history of social withdrawal and uncommunicativeness.

  Teens who declare that they still wish to die should be retained.

  An intoxicated teen should be retained in the emergency room until sober.
- *Nature of the Attempt:* Hospitalization is indicated if the attempter employed a potentially lethal method other than ingestion or superficial cuts to the skin.
- A *past history* of suicide attempt and/or an established history of volatile unpredictable behavior.
- *Home Background:* The absence of a caring or responsible setting to which to discharge the patient is an added consideration if any of the other listed factors are dubious.

EVALUATION OF THE ATTEMPT

The contingencies surrounding the suicide attempt should be evaluated to help determine the potential risk of a re-attempt. Evaluations of the attempt should consider the following:

- The method used, including its lethality and/or the teen's perception of its lethality.
- Precipitants of the attempt, including external triggers (e.g., arguments with family members or friends, school problems, etc.) and internal triggers (e.g., re-experienced symptoms, negative automatic thoughts, etc.).
- Degree of intent (i.e., How much did the teen wish to die?).
- Degree of planning involved in making the attempt (e.g., Was the attempt planned ahead of time or was it impulsive?).
- Was the attempt made when the teen was alone or when others were present or in close proximity?
- Did the teen make threats or give warnings prior to the attempt?
- Was the attempt timed so that intervention would be possible?
- Disclosure of the attempt (i.e., Did the teen tell someone after making the attempt?).
- The teen's reaction to the attempt (i.e., Is the teen happy to have recovered or is he/she is sorry the attempt was not successful?).
- Frequency and duration of suicidal ideation preceding and following the attempt.

DISCHARGE

It might be reasonable to discharge the patient if the teen's physical condition permits and if none of the above criteria are met. Discharge should take place only after the following actions have been taken:

- The *salient features* in the teen's history (e.g., details of the method used, the absence of other recent attempts, no evidence of disturbed behavior prior to the attempt, etc.) must be corroborated by the teen's usual caretaker.
- No suicide attempter should be discharged from an emergency room or a doctor's office without a history being taken from a parent or caretaker.
- The caretaker must agree to undertake to immediately remove and/or *secure any firearms* or potentially dangerous medications present in the home.

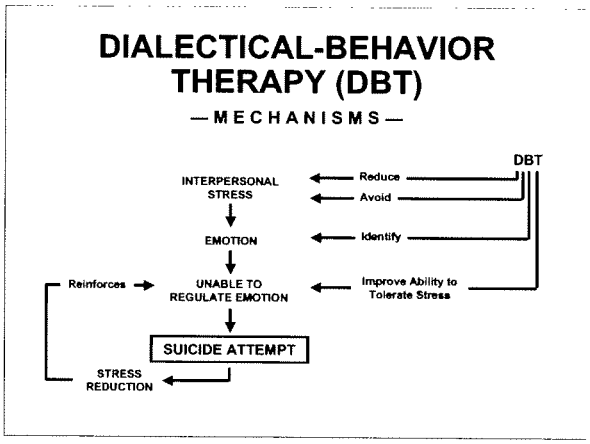
High Risk For Suicide

- Both Genders
  - Persistent wish to die
  - Taking precautions against discovery
- Among Males (at much higher risk than females)
  - Previous Suicide Attempts
  - Age 16 or Over
  - Associated Mood Disorder
  - Associated Substance Abuse
- Among Females
  - Mood Disorders
- Immediate Risk Predicted by Agitation and MDD

- Concrete and precise arrangements must be made for a ***follow-up appointment.*** It is not sufficient to instruct the teen or family to call the office tomorrow to make an appointment.
- The teen must be given a ***telephone number*** to call in the event that they again feel like committing suicide.

TREATMENT

- Psycho-education. Parents, peers, etc., need to be informed about features that may herald a period of great vulnerability, e.g., increased agitation and irritability after getting into trouble, etc. Parents need to be counseled on how to reduce expressed emotion in the presence of the youth.
- There are few controlled studies among either adolescents or adults to inform on optimal treatment approach.
- It is customary to use a problem-oriented approach that puts little focus on suicidality alone, but addresses the teen's diagnosis, the circumstances that led to the attempt, the family situation, and the psychiatric status of the parents.
- ***Cognitive-behavior therapy (CBT)*** has been tested in several randomized controlled trials. It aims to help the patient identify negative feeling states, correct irrational ideas, and become aware of the options that are open to him or her. For example, if suicide is seen as the "only solution" to a "hopeless" problem, the therapist will help patients weigh up their reasons for living and dying, teach alternative problem-solving solutions, and, through the use of role-playing, rehearse strategies that can be used when a crisis situation next arises.
- ***Dialectical-behavior therapy (DBT)*** (Linehan 1993) is a form of therapy that balances the need for changing certain behaviors with acceptance of other characteristics of the self, avoidance or improved management of interpersonal conflicts, and reducing the impact of painful situations. It emphasizes self-observation and regulation of affect to prevent impulsive responses to distress.
- ***Medication:*** There is as yet no well-designed study



to show whether psychoactive drugs can impact on ***adolescent*** suicidality. However, SSRI antidepressants have been shown to reduce suicidal preoccupations in both depressed and nondepressed suicidal adults (Letizia 1996; Verkes 1999). Lithium prophylaris significantly reduces the likelihood of suicidality in adults with bipolar illness. Clozapine reduces suicidality in adults with schizophrenia. As noted above, SSRIs reduce depressive symptoms in adolescents.

- Involving parents and other ***family*** members in ***treatment*** is recommended to reduce parent-child conflict and improve family communications and conflict-resolution skills. Improved family relations often reduce the teen's feelings of hopelessness and anger.

PREVENTION

POSSIBLE PREVENTION STRATEGIES

1. Crisis Services (Hot Lines)

Practical Advantages:

- Provides some level of service at times when other services are unavailable.
- Offers confidentiality and anonymity to clients.
- Provides information about other treatment resources.
- Provides a safe, nonjudgmental environment enabling clients to articulate complex feelings.
- Offers added benefit of allowing callers to freely initiate and terminate contact.

Efficacy: Although evidence for their efficacy is sparce, recent evidence indicates that youth who use hot lines are helped by them. Uncontrolled study of telephone crisis counseling yielded significant decreases in suicidality and significant improvements in the mental state of youth during the course of the call.

Lack of Efficacy:

- Few adolescents use hot lines.
- Negative attitudes are stronger toward hot lines than they are toward other sources of help.

Recent Updated Services: Efforts are underway to standardize and increase the quality of the risk assessments and interventions provided by hot lines, under the auspices of the National Suicide Prevention Lifeline (1-800-273-TALK), funded by the Substance Abuse and Mental Health Services Adminstration (SAMHSA).

2. Educational Approaches

There has been a considerable increase in the provision of suicide-prevention programs for United States high-school students. Most programs provide curricula directly to high-school students.

Goals are to:

- Increase awareness of the problem.
- Provide knowledge about the behavioral characteristics ("warning signs") of teens at risk for suicide.
- Describe available treatment or counseling resources.

However:

- Few programs subscribe to a model of suicide as a product of mental illness. Most assume that suicide follows from common environmental stresses and that all teenagers share a potential vulnerability to suicide.
- Programs do not effectively increase knowledge, alter unwanted attitudes to suicide, or increase help-seeking behavior.
- They are unselective, and their audiences are predominantly not at risk for suicide.
- Problematic to expose the majority group, most of whom would not hope to obtain benefits from discussions about suicide.
- The stress model could help to reduce protective taboos.

Suicide-Awareness Voices Education (www.save.org): Using QPR (question, persuade, and refer), trained volunteer staff teach school communities how to recognize symptoms of clinical depression, the warning signs of suicide, and how to get help. Implemented in school settings.

Yellow Ribbon (www.yellowribbon.org): A community-based model that promotes help-seeking behavior through education and gatekeeper training. Implemented in school settings, the program includes the following components:

- Increasing public awareness of suicide prevention.
- Training gatekeepers.
- Facilitating help-seeking behavior with "Ask for Help" cards that include a toll-free number.

The Jed Foundation (www.jedfoundation.org): Takes place on university campuses and primarily involves an Internet-based intervention system. U-Lifeline allows college students to assess their mental health status and locate community resources.

Lifelines: AFSP and SPRC list this curriculum-based intervention as a "promising evidence-based program." Four 45-minute lessons comprise this school-based program and include:

- Help-seeking, school-resources, and suicide-attitudes education.
- Role playing and exercises to identify suicidal peers.
- Modeling of appropriate and inappropriate responses to suicidal peers.
- Policies for responding to at-risk youth, suicide attempts, and completions.

3. Case-Finding

- Systematically screen teens to identify those who have made previous attempts, are currently suicidal, are currently depressed, or suffer from substance or alcohol abuse. Sensitive surveys that

identify most teens at risk can be conducted that respect confidentiality.

- However, there will be many false positives, and these are costly.
- The President's New Freedom Commission (2003), the Children's Mental Health Screening and Prevention Act (2005), and the Garrett Lee Smith Memorial Act (2004) support youth-suicide-prevention programs and recommend increased screening for suicidality.
- Results from a randomized controlled trial (Gould 2005) investigating the potential harm of screening for suicide in troubled youth indicate no evidence of iatrogenic effects. Results suggest that students exposed to suicide questions were no more likely to report suicidal ideation after the survey than unexposed students. Furthermore, high-risk students in the experimental group were neither more suicidal nor more distressed than their control-group counterparts.

Columbia University TeenScreen (www.teenscreen.org): AFSP and SPRC list this national mental health and suicide screening program as a "promising evidence-based program." Screening takes place primarily in school settings, but also in juvenile justice facilities, shelters, and doctor's offices.

The program involves the following stages:

- Voluntary parental consent and student assent.
- Screening using the Columbia Suicide Screen (CSS) and immediate scoring by trained staff.
- A debriefing interview for those who score "negative" on the questionnaire and a clinical interview with a mental health professional for those score "positive" on the questionnaire.
- If further evaluation is recommended as a result of the clinical interview, parents are contacted by a case manager and offered assistance connecting with local service providers.
- Hit and miss rates using the CSS as compared to the DISC are:

	ANY IDEATION OR ATTEMPT OR A DSM-IIIR MOOD, ANXIETY OR SUBSTANCE-USE DISORDER WITH IMPAIRMENT (N = 172)		ANY IDEATION OR ATTEMPT AND A DSM-IIIR MOOD, ANXIETY, OR SUBSTANCE-USE DISORDER WITH DISORDER (N = 51)	
	HIT	MISS	HIT	MISS
EMPIRICALLY DERIVED ALGORITHM (2004 PAPER)	39%	61%	65%	35%
CTS ALGORITHM	65%	35%	82%	18%

- The rate at which the CSS over identifies youth is:

	ANY IDEATION OR ATTEMPT OR A DSM-IIIR MOOD, ANXIETY OR SUBSTANCE-USE DISORDER WITH IMPAIRMENT (N = 172)		ANY IDEATION OR ATTEMPT AND A DSM-IIIR MOOD, ANXIETY, OR SUBSTANCE-USE DISORDER WITH DISORDER (N = 51)	
	PPV	OVER IDENTIFY	PPV	OVER-IDENTIFY
EMPIRICALLY DERIVED ALGORITHM (N = 80)	81%	19%	41%	59%
CTS ALGORITHM (N = 186)	60%	40%	23%	77%

- The proportion of those positive on the CSS for substance abuse, depression, and anxiety only versus those with a previous suicide attempts is:

	PRIOR ATTEMPT WITH OR WITHOUT DIAGNOSIS	ANY DX (NO ATTEMPT)	IDEATION ONLY	NOTHING
EMPIRICALLY DERIVED ALGORITHM (N = 80)	27 (33.8%)	27 (33.8%)	11 (13.8%)	15 (18.8%)
CTS ALGORITHM (N = 186)	37 (19.9%)	53 (28.5%)	21 (11.3%)	75 (40.3%)

SOS: Signs of Suicide (www.mentalhealthscreening.org/highschool): The AFSP and SPRC list this program as a "promising evidenced-based program." It combines an educational curriculum to raise awareness of suicide and its related issues with the Columbia Depression Scale (CDS) screening form. Implemented in school settings, the program involves the following stages:

- A 50-minute classroom presentation featuring a 25-minute video, a teacher-led discussion, and the screening questionnaire.
- Students self-score form.
- Students are taught to self-refer and peer-refer if they indicate a mental health problem.

A recent paper by Hallfors et al. (2006) examines an instrument and screening method significantly different than TeenScreen.

The study found that a substantial number of the children identified by their screen were judged not to have a serious disorder and that the screening procedure was burdensome to school teachers. The authors concluded by suggesting that screening be abandoned.

A comparison of the Hallfors screening study and the TeenScreen program illustrates how this study is not comparable to TeenScreen:

Hallfors Study

- 1- to 4-week follow-up, and at one school no follow-up, of identified youth.

- Follow-up evaluations conducted by school staff, interfering with the youth's mental health confidentiality.
- One depression-related question and no anxiety related questions on screening form.
- Analyses do not reveal diagnostic profile of screened teens, so it is unknown what diagnoses were found and then deemed insignificant (by non-clinicians) in those screened positive.
- Recommendation not to undertake further screening drawn largely from opinions of academic counselors who may have lacked the skills to make important clinical decisions.

TeenScreen Program

- Immediate clinical evaluation required for identified youth.
- Clinical evaluations conducted by qualified mental health professionals.
- Three questions about depression plus anxiety related questions on screening form.
- Screening program and records kept separate from academic records and staff.

Screening as a mental health check-up also identifies youth who may not be actively suicidal, but at risk for other debilitating mental health problems that may influence suicidal ideation and attempt. Research shows that 90 percent of suicide completers have a diagnosable mental illness at the time of death. (Shaffer 1996)

Children who suffer from mental health problems such as depression, anxiety, suicidal behavior, substance, and alcohol use and abuse do not perform well academically compared to their non-mentally ill peers (U.S. Dep of Ed 2001;Reinherz et al. 1993).

Over half of the adolescents in the United States who fail to complete their secondary education have a diagnosable psychiatric disorder (Stoep et al. 2003).

A 21-year longitudinal study found that anxiety disorders were associated with drug use and dependence, suicidal behavior and a reduced likelihood of attending college (Woodward et al. 2001).

Conversely, research indicates that pressure from maladaptive perfectionistic strivings and an excessive investment in accomplishments, such as academics, may contribute to an elevated risk of depression and anxiety (Luthar & Becker 2002).

4. Professional Education

Training medical professionals in the appropriate use of antidepressant and mood-stabilizing drugs has been found to reduce the suicide rate, at least among female adults.

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What to expect during an emergency psychiatric evaluation

This handout was made as a general guideline for parents and children; please note that individual hospitals and emergency rooms have varying policies.

Why is my child being sent for an emergency psychiatric evaluation?

Physicians refer children and families to the emergency room for a psychiatric evaluation when they have concerns about safety for the child/adolescent. Those safety concerns are usually around issues such as self-harm or suicide, a child or adolescent that has expressed a desire to hurt someone else, or a child/adolescent that has become so impaired by their illness that they cannot function. At the emergency room your child will be evaluated by hospital staff and physicians to determine if they are able to go home or need a higher level of care in an inpatient psychiatric hospital.

Who will see my child/adolescent during the evaluation process?

You and your child will encounter various hospital staff and physicians during the evaluation process. Initially you will be registered into the emergency room where demographic information will be taken. You will be asked for information such as you and your child's address, date of birth, social security numbers, contact information, and up to date insurance information. Most hospitals ask to make copies of your insurance card and any identification you may have. You will then be seen by a triage nurse that will take your child's vital signs and a brief history about why you are coming to the hospital. You may be seen next by the emergency room physician who will ask for information about why your child is at the emergency room for this evaluation, medical history, current medications, additional social information, and perform a physical exam. The emergency room physician may order any laboratory exams or tests they feel are appropriate. Since a physical exam will be performed your child may be asked to change into a hospital gown.

After being evaluated by an emergency physician, a psychiatric consultation will be called and you and your child will be interviewed by a psychiatrist and a determination will be made about going home versus going to an inpatient psychiatric hospital. You will be asked by several different hospital staff and physicians for similar information. This is done to make sure important information is not missed.

What happens if the decision is made to send my child to an inpatient psychiatric hospital?

Once it is determined that your child needs to be in an inpatient psychiatric facility, a Physician Emergency Certificate (PEC) is issued. Once this document is issued your child cannot leave the emergency room. The PEC allows for up to a 72 hour hold from the date and time it is issued. After it is issued an inpatient psychiatric bed, appropriate for your child's age and gender, will be located. Hospital staff will attempt to locate a bed close to the hospital, but if there is none available an available bed in Louisiana will be found. It is possible that your child will go to an inpatient psychiatric hospital anywhere in the state of Louisiana.

How long could the evaluation process take?

It can take anywhere from a few hours to 24 hours, and in some instances it could take a few days to find an available bed at an inpatient psychiatric hospital. You will be asked to stay with your child during this time period. If you are unable to stay or need to leave the hospital for any reason (to get food or clothes for your child's inpatient hospital stay) please give the staff contact numbers where they can reach you immediately.

Who should I speak with if I have concerns about the evaluation process?

Ask to speak with your nurse, the charge nurse, nursing supervisor, or attending physician if you have any concerns about the evaluation.