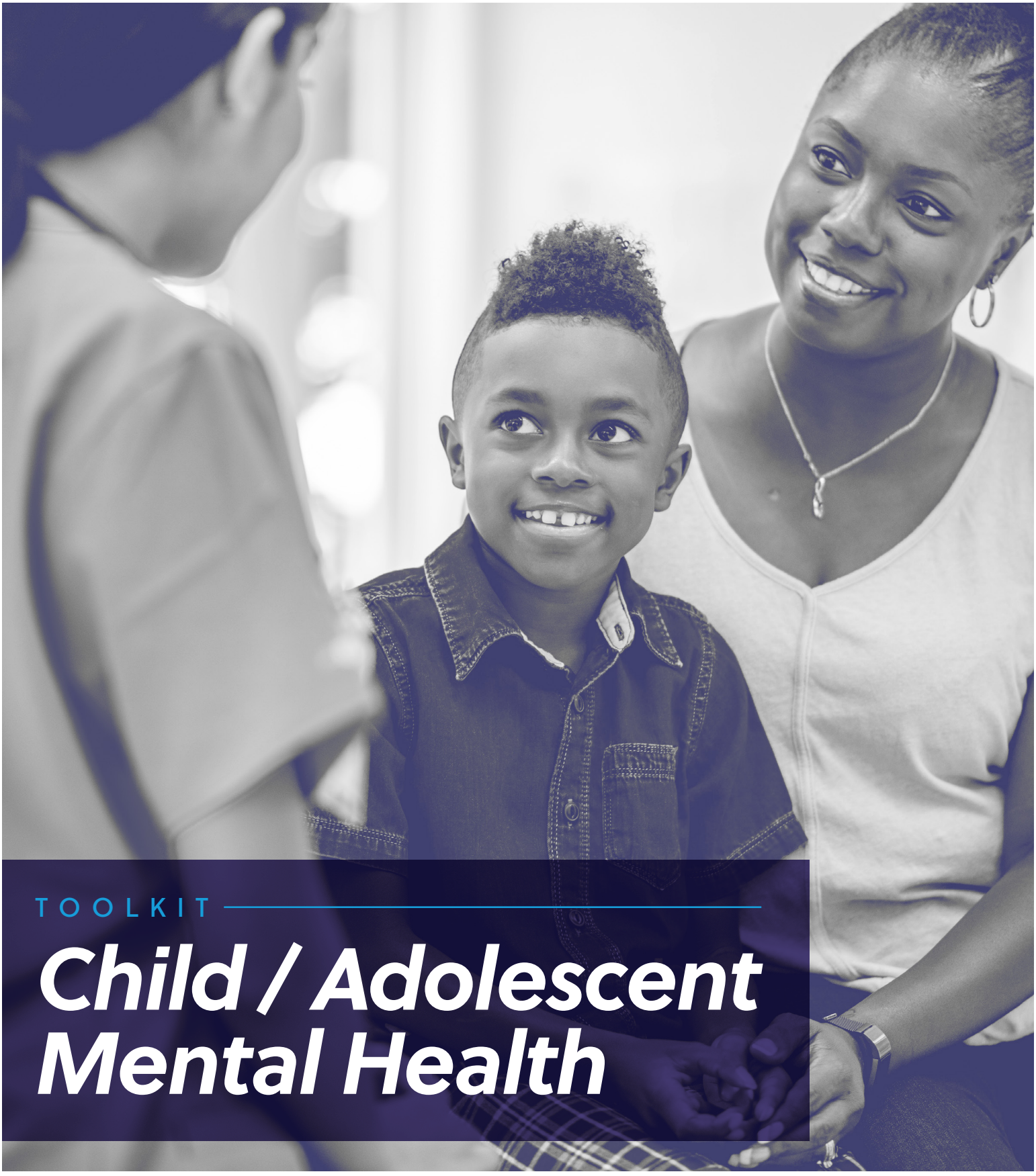
ProjectTEACH

FAMILIES THRIVE WITH GOOD MENTAL HEALTH



TOOLKIT

Child / Adolescent Mental Health

Overview

This collection of "Quick Check" guides is an evidence-based toolkit for real-time point of care use during the assessment and treatment of child and adolescent mental health problems in pediatric primary care. Like a pilot or surgeon's checklist, these guides are reminders and assume that the user is familiar with the management of mental health concerns. For more detailed information, follow the embedded links to "read more." We hope you find the Quick Checks Toolkit useful for teaching and day-to-day practice.

When you see the icon  refer to the medication card for more information.

Should you need further support, Project TEACH provides the following services:

- Phone consultation Monday-Friday, 9:00 am-5:00 pm (1-855-227-7272)
- Child and adolescent mental health training, both live and on our website, ProjectTeachNY.com
- Assistance finding community resources and connecting patients and families.

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ADHD: Assessment

ADHD is a neurodevelopmental disorder characterized by difficulties being able to stop, look, listen, think, plan, and do (e.g. executive functioning).

PRESENTING PROBLEM(S)

- Focus and attention
- Hyperactivity and Impulsivity
- Combined symptoms

HPI: COLDER

Characteristics – What do you see at home, hear from school? What is your greatest concern?

Onset – At what age were symptoms first noticed?

Location – Are the problems seen in multiple activities (i.e. school, home, sports, community)? Or just one setting (less likely to be ADHD)?

Duration – How long have these symptoms been present? Have they been present on a consistent basis (typical ADHD) or variable over months/years (less likely to be ADHD)?

Evoking – What settings or activities make it worse? Reading, doing chores, certain times of day, when tired or hungry?

Relieving – What makes it better? Are there strategies and accommodations that decrease symptoms and impairment?

DIAGNOSTIC CRITERIA

Six or more symptoms from one or both categories below for age 6-16. Five or more symptoms from one or both categories below for age17 and older. Symptoms must: be present most or all the time, be evident for over six months, occur in two or more settings and have onset before age 12 (even if diagnosis is later)

Inattentive

- careless
- inattentive
- poor follow through
- avoids tasks that require attention
- disorganized
- easily distracted
- loses things
- forgetful
- doesn't listen when spoken to

Hyperactive

- squirms and fidgets
- can't stay seated
- runs/climbs
- on the go/driven
- talks excessively
- can't play quietly
- blurts out answers
- can't wait for turn
- intrusive/interrupts

COMMON COMORBIDITY

- Oppositional Defiant Disorder; Conduct disorder
- Learning disorders
- Anxiety and Mood disorders
- Neurodevelopmental disorders
- Substance Use disorders (adolescents)

SEVERITY

Assess functional impairment (**SHHIP**):

School performance, behavior and relationships

Home behavior, relationships with parents, siblings, extended family

Health impact on sleep, eating, worsening comorbid illnesses

Internal distress, self-esteem, mood or anxiety impact

Peer relationships in neighborhood, school, with cousins.

PHYSICAL EXAM AND LABS

- Routine history and physical
- Individual and family cardiac history
- No further laboratory testing unless the history and/or exam indicates a need

FAMILY

Genetics: Family history of ADHD common, Learning Disabilities, other MH diagnoses

Environment: Family beliefs about ADHD/treatment, parenting skills and practices, household stressors and Adverse Childhood Experiences

TOOLS

- Pediatric Symptom Checklist-17 (PSC) Self-Report and Parent
- Vanderbilt Behavioral Checklist (Parent and Teacher report) for assessment and for following clinical progress
- PHQ-9 (screen for possible comorbid depression)
- SCARED (screen for possible comorbid anxiety) Self-Report (ages 8-18+) and Parent Report (ages 4-18+)
- CATS (screen for possible trauma)

TREATMENT HISTORY

- Previous counseling or therapy? What kind and how long? How helpful?
- Medications tried, doses, response and adverse side effects
- Dietary adjustments, supplements, other alternative interventions
- School accommodations or interventions (Behavior Plan, counseling, 504 Accommodation Plan, IEP, etc.)

ADHD Management

ADHD management is often a combination of psychosocial, medication and school interventions, prioritized by the child's age.

PRESCHOOL AGED CHILDREN

1. **Prioritize Psychosocial treatment:**
   - Parent education and guidance
   - Parent behavior management training (e.g. Parent-Child Interaction Therapy)
2. **Medications:** Consider medications if psychosocial treatment fails, is unavailable, or if symptoms and impairment are severe. There is more evidence to support the use of stimulants in preschoolers but trying an alpha agonist is a common practice.

SCHOOL AGED CHILDREN

1. **Medications:** (1) Stimulant (2) Non-stimulant
2. **Psychosocial treatment:**
   - Parent education and guidance
   - Parent behavior management training
   - Social skills and organization/executive function skills coaching for child/teen
3. **School:** Consider accommodations or interventions (Behavior Plan, 504 Plan, IEP, etc.).

MANAGEMENT OF COMMON COMORBIDITIES

1. **Anxiety/Depression:**
   (a) Stimulant and exposure-based CBT psychotherapy
   (b) For severe anxiety, consider an SSRI trial
2. **Oppositional Defiant Disorder:**
   (a) Parent behavior management training and maximize dose of stimulant medication
   (b) Consider augmentation with alpha agonist
3. **Adolescent Substance Use:** Educate and monitor for substance including stimulant abuse and diversion.
4. **Tics:** Stimulants may improve, worsen, or have little impact on tics; tics are not a contraindication. Consider alpha-2 agonists if tics are problematic.

MEDICATIONS

- Short acting and extended-release preparations of both methylphenidate and amphetamines are effective.
- Start preschoolers and young children with immediate release MPH preparations.
- If you follow rating scales closely and adjust the doses until there is "no room for improvement," you can achieve double the remission rate!
- With an inadequate response or a dose-limiting side effect, consider trying the other stimulant family or augmentation with an alpha agonist.
- Atomoxetine or Viloxazine can be effective alternatives when there is a high risk of diversion or abuse of stimulants or if the family prefers not using stimulants.

Pearls of Medication:

- Stimulant medications take effect immediately and can be adjusted quickly whereas non-stimulants require several weeks to take full effect and require daily compliance.
- Amphetamine medicines can increase irritability if your patient is irritable at baseline.
- Although their effect size is smaller than stimulants, alpha agonists can be helpful to augment core ADHD symptoms and for sleep onset difficulties.
- Complex cases with comorbid diagnoses require evidence-based psychotherapy and other interventions as well as adequate medications.

MONITORING PROGRESS & SIDE EFFECTS

Medication

- Stimulants: Follow-up within 30 days of initiating. Once very stable, follow-up at least every 3-6 months. Review prescription requests and refills for possible abuse and diversion.
- Alpha-adrenergic: Educate family and monitor for sedation, hypotension, bradycardia and rebound hypertension. Guanfacine and clonidine should be ramped up gradually and require tapering to discontinue.
- Monitor prescription refills for possible abuse and diversion.

Monitor Severity:

- Assess residual ADHD symptoms with follow up Vanderbilts (Parent and Teacher report).
- Assess distress and degree of impairment (**SHHIP**): **S**chool performance, **H**ome dynamics, **H**ealth Impact, **I**nternal distress, and **P**eer relationships.

Consider Assessment for Possible Comorbidities

- Learning Disabilities (Psycho-educational Assessment at school)
- Substance Use (CRAFFT)
- Anxiety (SCARED Self-Report (ages 8-18+) and Parent Report (ages 4-18+)
- Depression (PHQ-9)
- Trauma (CATS)

Aggression Assessment

Aggression is a symptom and not a psychiatric diagnosis. Assessment and management of underlying diagnoses is the best strategy. Direct targeting of aggression is sometimes necessary to maintain the safety of the child and others.

PRESENTING PROBLEM

- Aggressive behavior can be verbal or physical directed toward property, self or others.

HPI: COLDER

Characteristics – Current nature of aggressive behavior.
Subtypes: Emotional meltdown, impulsive outbursts, anxious hyperarousal
Target: Verbal aggression, physical aggression towards property, others or self

Onset – Perinatal and developmental history, first concern with aggression

Locations – Situations associated with aggression

Duration – Frequency, severity and duration of aggressive (red zone) episodes

Evoking – Situations, people, activities that trigger aggression. Caregiver or teacher unintentionally rewarding aggression.

Relieving – People or interventions that de-escalate aggression?

AGGRESSION SUBTYPES

- Impulsive Aggression: Unprovoked, brief, rapid, thoughtless, inability to delay reward/recognize consequences; out of proportion and out of the blue
- Affective Storm (hot) Aggression: Exaggerated response to affectively provoked or charged (i.e. difficulty modulating arousal), reactive. "Hot blooded" aggression. Extended duration (30+ minutes)
- Anxious/Hyperarousal-based Aggression: Overstimulation, overwhelmed, response to excess anxiety; lash out with relief of tension
- Cognitive/Disorganized Aggression: Distorted perceptions, impaired reasoning, delusions, paranoia
- Predatory (Cold): Premeditated, consciously executed, instrumentally motivated, "cold blooded"

AGGRESSION SEVERITY

- Assess distress and degree of impairment (**SHHIP**): **S**chool performance, **H**ome dynamics, **H**ealth Impact, **I**nternal distress, and **P**eer relationships.
- Use rating scales to assess severity:
  - Modified Overt Aggression Scale (MOAS) profile
  - Nisonger Behavior Rating Form (BRF) score
  - Vanderbilt Scales (Parent and Teacher report)

COMMON COMORBIDITY

- Acute Stress Reaction and Adjustment Disorders
- Anxiety and Panic Disorders
- Attention Deficit Hyperactivity Disorder
- Autism Spectrum Disorder
- Bipolar Disorder
- Conduct Disorder
- Disruptive Mood Dysregulation Disorder
- Genetic, Toxic, Metabolic and Autoimmune Disorders
- Intellectual Disability
- Oppositional Defiant Disorder
- Post Traumatic Stress Disorder
- Schizophrenia and other Psychotic Disorders
- Substance Use Disorders and Intoxication

PHYSICAL EXAM AND LABS

- Targeted physical exam and labs relevant to findings

FAMILY

Genetics: Inherited temperamental traits, psychiatric disorder risk

Environment: Unsafe neighborhood, witness to/victim of aggression at home

TOOLS

- Treatment of Maladaptive Aggression in Youth (T-MAY)
- MOAS, Nisonger BRF

TREATMENT HISTORY

- Psychosocial treatments:
  - Individual, Family and group therapy, Care Management, Multisystem Therapy (MST), Functional Family Therapy (FFT)
- School interventions:
  - 504 Accommodation Plan, Behavioral Support Plan, Individualized Educational Program, Behavior Intervention Plan
- Medication trials:
  - Medication, doses, length of trials, adverse side effects

Aggression Management

Management of Aggression starts with the safety of the patient and those around them. Then comes the assessment and management of underlying contributing diagnoses. Lastly, there are the interventions targeting aggression directly.

1. **Assessment of safety** of patient and others

2. Assessment of **underlying diagnoses** and treatment

- **ADHD:** Maximize stimulant or alpha agonists to fully treat impulsive aggression. Focus on improving parent/child and school behavior management interventions.
- **Trauma:** Use trauma focused therapies (TF-CBT) for the child and family.
- **Mood and Anxiety Disorders:** Evidence-based therapy (Cognitive Behavioral Therapy (CBT), Dialectic Behavioral Therapy (DBT), Supportive Parenting for Anxious Childhood Emotions (SPACE Program). Consider evidence-based medication (SSRI, SNRI)
- **Developmental disorders:**
  - Improve communication therapies.
  - Intensive behavioral supports (functional analysis and ABA).
  - Review and suggest appropriate educational program.
  - Medications: Risperidone and Aripiprazole Consider a time-limited trial for serious agitation and aggression in ASD/ID or non-ID/ASD children (T-May). Educate family, monitor metabolic labs and extra-pyramidal side effects and try to decrease or discontinue every six months.
- **Sleep Disorders:** Focus on sleep hygiene, consider melatonin or clonidine trial.

3. **Build a "village"** of therapeutic allies in the community including therapists, schools, other health care providers

- Parent-child therapies focus predominantly on behavioral management and effective parenting styles:
  - Parent-Child Interaction Therapy (PCIT),
  - Triple P (Positive Parenting Program),
  - Other parent management programs (some available online for families)
- Behavioral management programs:
  - Applied Behavioral Analysis (ABA), available for children diagnosed with Autism Spectrum Disorder.
  - School-based behavioral support or intervention plan.
  - If OPWDD qualified, inquire about behavioral and family support services.
- Systemic family, school and community interventions:
  - Parental, marital and family therapies as needed.
  - Multisystemic Therapy (MST)
  - Functional Family Therapy (FFT)
- Individual child therapies:
  - CBT or DBT useful for associated mood, anxiety or trauma issues.
  - Mindfulness and calming techniques for children with motivation for self-control.

4. **Medication management** with consultation.

- Treat the underlying disorder or comorbidity.
- With serious safety issues, limited therapeutic resources or chronic severe impairment, medication options might include:
  - Stimulants or alpha agonist agents
  - Antipsychotic agents
  - Others such as lithium or anticonvulsants
- Monitor progress:
  - Repeat MOAS, Vanderbilts.
- Monitor side effects:
  - Review compliance, follow appropriate labs and vital signs, discuss the timeline for considering decrease or discontinue antipsychotics for aggression at every follow up.

Call Project TEACH for consultation at any step along the way.

855-227-7272 **projectteachny.org** ProjectTEACH FAMILIES THRIVE WITH GOOD MENTAL HEALTH

Anxiety Assessment

Anxiety disorders have biological, psychological and social aspects (BPS) that contribute to the presenting symptoms and impairment and often change over time.

PRESENTING PROBLEM

- **Physical/somatic:** Headache, stomachache, shallow rapid breathing, nausea
- **Fearful thinking and/or emotional distress:** Automatic negative thoughts, rumination, agitation, outbursts
- **Avoidance:** Refuses separations (sleeps with parent, school refusal, no sleepovers) and/or avoids social settings (cafeteria, hallways, shopping, playgrounds, sports)

HPI: COLDER

Characteristics – What does it feel like in your body? What thoughts come to mind? Has it changed your life?

Onset – When did you first feel this? When did it first restrict/interfere with your life?

Location – Where in your body do you feel it? What settings make it worse or better?

Duration – How long does it last? Is it getting better, worse or the same?

Evoking – What makes it worse? Separations? Social situations? School work, peers or adults?

Relieving – What or who makes it better? What have you tried so far?

DSM 5 ANXIETY DISORDER SUBTYPES

- Young Children: Separation Anxiety Disorder, Selective Mutism
- Older Children and Teens: Generalized Anxiety Disorder, Social Anxiety Disorder, Phobias, Panic Disorder

SEVERITY

Assess functional impairment (**SHHIP**):

School performance, behavior and relationships

Home behavior, relationships with parents, siblings, extended family

Health impact on sleep, eating, worsening comorbid illnesses

Internal distress, self-esteem, mood or anxiety impact

Peer relationships in neighborhood, at school, with cousins.

COMMON COMORBIDITY

- Substance abuse and self-medication
- PTSD
- Depression

PHYSICAL EXAM AND LABS

- Routine history and physical.
- Labs as indicated for potential medical issues that may contribute to mental health condition (thyroid tests for anxiety when thyroid signs/symptoms suggest).
- Pursue reasonable medical causes and determine when "enough is enough".

FAMILY

Genetics: Family history of anxiety disorders, panic, agoraphobia, depression and bipolar disorder (other mental health diagnoses).

Environment: Family beliefs about accommodating anxiety, parenting skills and practices, household stressors and Adverse Childhood Experiences.

TOOLS

- SCARED Self-Report (ages 8-18+) and Parent Report (ages 4-18+)
- GAD-7 (12+) self and parent reports; follows only generalized anxiety symptoms
- PHQ-9 (12+) for possible comorbid depression

TREATMENT HISTORY

Prior counseling or therapy:

- What kind and how long. Use of graduated sustained exposure
- Medications tried, doses, response, and adverse side effects
- Diet/supplements, alternative interventions

School accommodations or interventions:

- Behavior Plan, 504 Plan, counseling, IEP, re-entry after long absence.

Anxiety Management

Anxiety relief is a goal, but the management of anxiety-driven avoidance is critical to reducing impairment. Parents and children/teens must be engaged for treatment to succeed.

MILD

- Education for child and family (Self-directed programs e.g. BRAVE, Camp Cope-a-lot).
- Promote wellness: healthy diet, good sleep hygiene, regular exercise and age-appropriate socialization.
- Encourage parents to "nudge" child to face fears to build mental muscles and resilience: Supportive Parenting for Anxious Childhood Emotions (SPACE) Program.
- Mindfulness activities: yoga, meditation, relaxation
- Mindfulness Apps: Headspace, Calm Kids, Mindshift 12+, Stop, Breathe and Think

MODERATE

- Use all interventions for Mild Anxiety and add Evidence-based Psychotherapy:
  - Exposure-based Cognitive Behavioral Therapy (e.g. Coping Cat)
  - Parent Training for Childhood Anxiety (e.g. SPACE Program)
- School: Collaborate with schools for support without over-accommodation and reinforce attendance.

SEVERE

- Use all interventions for Mild Anxiety plus Psychotherapy and add Medication.
- SSRI as first line: Sertraline, Fluoxetine or Escitalopram
- SNRI as second line: Duloxetine, Venlafaxine
- Increase family teamwork and discourage avoidance.
- Increase collaboration with school for re-entry if needed, accommodations and possible 504 Plan or IEP.
- Monitor distress and degree of impairment (SHHIP): School performance, Home dynamics, Health, Internal distress, Peer relationships.

MEDICATIONS

1. Perform brief reassuring box warning for suicidality
2. Explain common side effects of GI upset, behavior activation, insomnia.
3. Explain uncommon side effects of serotonin syndrome, hypomania or mania

- Initiate at ½ lowest treatment dose for 7-10 days and then increase to lowest treatment dose for 4-6 weeks.
- If not near total remission, increase to moderate treatment dose for 4-6 weeks.
- If not near total remission, increase to maximum treatment dose for 4-8 weeks.
- Call Project TEACH for advice on cross-tapering to an alternative SSRI or SNRI, which depends on half-life of both medications.
- Neither PRN Benadryl or hydroxyzine are very effective and can distract from using CBT strategies.
- PRN benzodiazepines do not outperform placebo for chronic anxiety in children and teens and have dependency risk. They can be useful for medical and dental procedures.

MONITORING PROGRESS & SIDE EFFECTS

- **Medication**
  - Take time initially to reassure patient and parents about box warning and other potential side effects to build trust,
  - Schedule follow-up in 2-3 weeks for problem-solving and reassurance to increase compliance with trial,
- **Monitor Symptom Severity**
  - SCARED Self-Report (ages 8-18+) and Parent Report (ages 4-18+)
  - GAD-7; self report (age 13+)
- **Monitor change in Impairment (SHHIP):**
  - School performance, behavior and relationships
  - Home behavior, relationships with parents, siblings, extended family
  - Health impact on sleep, eating, worsening comorbid illnesses
  - Internal distress, self-esteem, mood or anxiety impact
  - Peer relationships in neighborhood, at school, with cousins.
- **Monitor for Comorbidities**
  - Depression (PHQ-9)
  - Suicidality (ASQ) or Columbia Suicide Severity Rating Scale (CSSRS)
  - Substance Use (CRAFFT)

Depression Assessment

Major Depressive Disorder (MDD) affects mood, general wellbeing and thinking. Depression can distort one's ability to provide an accurate history, therefore gathering collateral information is imperative.

PRESENTING PROBLEM

- Depressed mood
- Irritability
- Lack of joy/pleasure

HPI: COLDER

Risk Factors:

- Personal or family history of depression, anxiety, trauma, suicidality, substance use
- LGBTQA+ status

Characteristics – Can you describe how you feel physically and emotionally? How do you feel about you and your future? Are you less involved and interested in things?

Onset – When did you start feeling this way? Was it sudden or gradual? Anything that triggered it?

Location – Where in your body do you feel it most? In which situations, around whom, do you feel it most?

Duration – Did you have similar episodes in the past? Is it persistent? Getting better or worse?

Evoking – Are there situations or people who seem to make it worse?

Relieving – Are there situations or people who make it better?

DSM 5 DIAGNOSTIC CRITERIA (PHQ-9)

- **For at least two weeks, must have (one or both):**
  1. Depressed mood or irritable mood in children and teens
  2. Diminished interest or pleasure in all, or almost all, activities
- **PLUS - Four (or more) of the following symptoms:**
  3. Appetite and weight changes
  4. Sleep pattern disruption
  5. Psychomotor agitation or retardation
  6. Fatigue or loss of energy
  7. Feelings of worthlessness or excessive or inappropriate guilt
  8. Diminished ability to think or concentrate, or indecisiveness
  9. Recurrent thoughts of death, suicidal ideation or plan, or suicide attempt

SEVERITY

- Assess impairment (**SHHIP**):

  School performance, behavior and relationships
  Home behavior, relationships with parents, siblings, extended family
  Health impact on sleep, eating, worsening comorbid illnesses
  Internal distress, self-esteem, mood or anxiety impact
  Peer relationships in neighborhood, at school, with cousins
- Screen for suicidality: Ask Suicidal Screening Questions (ASQ) or Columbia Suicide Severity Rating Scale (CSSRS)
- Review adequacy of adult supervision and access to lethal means: guns, other weapons, medications, driving.

COMMON COMORBIDITY

- Anxiety disorders
- Substance abuse
- OCD
- PTSD

PHYSICAL EXAM AND LABS

- Routine history and physical including examining forearms and thighs for self-injury
- Order labs only as indicated for potential medical reasons that may contribute to condition (thyroid tests).

TOOLS

- Center for Epidemiological Studies – Depression Scale for Children (CES-DC) 6-17 self-report
- Patient Health Questionnaire-9 Teens (PHQ-9)
- Columbia Depression Scale (CDS) Self-Report 11+ and Parent Report
- ASQ
- CSSRS

TREATMENT HISTORY

- Prior counseling or therapy: What kind and how long?
- Use of exposure, face fears?
- Medications trials, maximum dose, length of time, response, adverse side effects
- Diet/supplements, alternative interventions
- School accommodations or interventions (Behavior Plan, counseling, 504 Accommodation Plan, IEP, etc.)

Depression Management

Establish a trusting alliance, explain confidentiality and assess the immediate safety of the child and others. Once safety is addressed, severity of symptoms and impairment determine the recommended treatment.

MILD

- Educate child and family about depression
- Help set lifestyle goals (behavioral activation):
  - Eat a healthy diet
  - Get adequate sleep
  - Exercise regularly
  - Engage socially with family and friends
- Engage in mindfulness:
  - Activities: Yoga, meditation, relaxation
  - Apps: Headspace, Calm Kids, Mindshift 12+, etc.
- Collaborate with schools for support

MODERATE

- Use all interventions for Mild Depression, ***Plus (1 or 2):***
  1. Evidence-based Psychotherapy (55% efficacy)
     - Cognitive Behavioral Therapy (CBT)
     - Interpersonal Therapy (IPT)

     OR
  2. Medication: SSRI medication (60% efficacy)
     Selective Serotonin Reuptake Inhibitors (SSRI):
     - Fluoxetine
     - Escitalopram
     - Sertraline
- Seek support in schools: Behavior Plan, counseling, 504 Accommodation Plan, IEP, etc.

SEVERE

- Use all interventions for Mild Depression, ***Plus (1 and 2):***
  1. Evidence-based Psychotherapy (55% efficacy)
     - Cognitive Behavioral Therapy (CBT)
     - Interpersonal Therapy (IPT)

     AND
  2. Medication: SSRI medication (60% efficacy)
     Selective Serotonin Reuptake Inhibitors (SSRI):
     - Fluoxetine
     - Escitalopram
     - Sertraline
- Seek support in school: Behavior Plan, counseling, 504 Accommodation Plan, IEP, etc.

MEDICATION

Selective Serotonin Reuptake Inhibitors (SSRI) are first Line. Fluoxetine and Escitalopram are FDA approved.

1. Perform brief reassuring box warning for suicidality.
2. Explain common side effects of GI upset, behavior activation, insomnia.
3. Explain uncommon side effects of serotonin syndrome, hypomania or mania
   - Initiate at ½ lowest treatment dose for 7-10 days and then increase to lowest treatment dose for 4-6 weeks.
   - If not near total remission, increase to moderate treatment dose for 4-6 weeks.
   - If not near total remission, increase to maximum treatment dose for 4-8 weeks.
   - Call Project TEACH for advice on cross-tapering to an alternative SSRI or SNRI, which depends on half-life of both medications.
   - Increase to maximum recommended dose or rate-limiting side effect, seeking full remission
   - With good "partial' response, call Project Teach to discuss augmentation with bupropion or aripiprazole.
   - After two adequate SSRI trials, consider Duloxetine or Venlafaxine or call Project Teach to discuss treatment resistance strategies

MONITORING PROGRESS & SIDE EFFECTS

- Medication
  - Regular follow up improves compliance, 2-4 weeks initially, 3 months when stable.
  - Review common side effects on medication card.
- Symptoms Severity
  - CES-DC (6-17 self report)
  - PHQ-9 (12+ self report)
  - CDS Self-Report 11+ and parent report
- Monitor change in Impairment (**SHHIP**):
  - **S**chool performance, behavior and relationships
  - **H**ome behavior, relationships with parents, siblings, extended family
  - **H**ealth impact on sleep, eating, worsening comorbid illnesses
  - **I**nternal distress, self-esteem, mood or anxiety impact
  - **P**eer relationships in neighborhood, at school, with cousins
- Monitor for Comorbidities
  - Suicidality (ASQ or CSSRS)
  - Substance Use (CRAFFT)
  - Self-injury
  - Hypomania or mania (Young Mania Scale)

Eating Disorder Assessment

An Eating Disorder can be mild or life-threatening. Assessment requires collecting information from several sources and building a multi-specialty team of providers.

PRESENTING PROBLEM

- Weight loss, food refusal and under eating
- Feeling fat, fear of gaining weight
- Rigid avoidance of certain foods
- Binge eating, self-induced vomiting, excessive exercise
- Fear of eating, swallowing and/or vomiting

HPI: COLDER

Characteristics – Is child refusing/reluctant to eat? Are they restricting? How intense is food avoidance? Have they lost weight? Realistic body image?

Onset – When did it start? Was there a triggering event?

Location – Does child eat with family? In the cafeteria at school? In front of others?

Duration – How ingrained are the patterns? Is it stable or escalating?

Evoking – Do stressors make it worse? Tests? Athletic wear? Swimming in gym?

Relieving – What makes it better? What has been tried? By child? By family?

DSM 5: EATING DISORDER SUBTYPES

- **Anorexia Nervosa** – refusal to eat, significant weight loss, feeling fat even when underweight
- **Bulimia Nervosa** – recurrent binge eating, inappropriate compensatory behavior to lose weight
- **Avoidant/Restrictive Food Intake Disorder (ARFID)** – lack of interest in food, fear of eating/swallowing, failure to gain weight, or actual weight loss

SEVERITY

Many people with EDOs perform well except for the impact on their health (**SHHIP**).

- **S**chool - Academics, peer and teacher relationships
- **H**ealth Impact - Weight, vital signs, constipation, exhaustion, menstruation, sleep and mood
- **H**ome – Distress, conflict, concerns of Family
- **I**nternal Distress – anxiety, depression, preoccupation
- **P**eer Relationships and social functioning

COMMON COMORBIDITY

- Depression
- Anxiety Disorders
- Post Traumatic Stress Disorder
- Obsessive Compulsive Disorder

PHYSICAL EXAM AND LABS

Insight and judgement about physical changes can be distorted.

- Vital Signs: Height, weight, BMI, pulse, postural signs, pulse history on smart watch
- Labs: CBC with diff, electrolytes, Mg and Phos, amylase, Thyroid and liver function tests, U/A with specific gravity
- Consider ECG, especially with bradycardia

FAMILY

Genetics – Family history of eating disorders, OCD, anxiety or depression

Environment – Family attitude about food and eating, excessive exercising, being under or overweight, perfectionism and parent attitude about being a central part of treatment

TOOLS

- Eating Attitude Test (EAT)
- Rating scales for comorbid diagnosis:
  - Depression (CDS, PHQ-9A)
  - Anxiety (SCARED Self-Report (ages 8-18+) and Parent Report (ages 4-18+), GAD-7)
  - PTSD (CATS)
  - OCD (YBOCS)

TREATMENT HISTORY

- Psychotherapy treatment: Family-Based Treatment (FBT) individual, group.
- Treatment settings: inpatient, partial hospital (PHP), intensive outpatient (IOP), outpatient
- Medical refeeding: oral supplementation, feeding tube, gastric tube
- Medication trials: name of medication, maximum dose, length of time, response, adverse side effects
- Diet/supplements, alternative interventions
- School accommodations or interventions (Behavior Plan, counseling, 504 Accommodation Plan, IEP, etc.)

Eating Disorder Management

Family-based Treatment (FBT) has the strongest evidence base. Interventions are more effective when the child is young and symptoms are mild. Entrenched patterns are hard to change, especially at a low weight.

MILD

Some symptoms **without** significant weight loss.

- Monitor weight and vital signs, menses, eating disorder symptoms and behavior.
- Counsel regarding nutrition (consider Registered Dietitian referral), family-wide eating and exercise attitudes and psychological health, socialization, adequate sleep, less perfectionism.
- Link with therapist experienced in eating disorders meeting every 1-2 weeks.
- For younger patients, family therapy is a very important modality.

MODERATE

Many eating disorder symptoms and **weight loss** not yet impacting health.

In addition to all items above, monitor medically every 2-4 weeks:

- Weight and vital signs, menses, eating disordered symptoms, behavior.
- Set clear physiological limits and indications for higher levels of care.
- Collaborate closely with Nutritionist/Registered Dietitian
- Assess and treat psychiatric comorbidity – CDS, PHQ-9A, SCARED, GAD-7, YBOCS
- Link with eating disorders program (outpatient or intensive outpatient)
  - Individual, family and group therapy

SEVERE

Many eating disorder symptoms with significant **weight loss** plus **physiologic instability**.

In addition to items for Mild and Moderate EDO interventions consider:

- Higher levels of care: Intensive Outpatient (IOP), Partial Hospitalization
- Inpatient Hospitalization
  - Pediatric inpatient unit with psychiatry consult
  - General Adolescent Psychiatry Unit with Adolescent Medicine consult
  - Specialty eating disorder unit or residential program

MEDICATIONS

- Treatment of pre-existing or comorbid anxiety, depression and OCD can help stabilize eating disorder symptoms.
- Medication does not work well when patient is in starvation mode.
- Food and weight restoration is the primary intervention for low-weight patients

MONITORING PROGRESS & SIDE EFFECTS

Physiological improvements are critical: perform blind weights, postural vital signs, monitor menses, heart rhythm and pulse

- Repeat Eating Attitude Test (EAT)
- Follow rating scales for comorbid depression, anxiety, PTSD and OCD

EATING DISORDER PROGRAMS IN NYS

- Call Project TEACH (855-227-7272) for consultation and referrals.
- New York State offers Comprehensive Care Centers for Eating Disorders (CCCED) to help connect your patients to specialized services. As of December 2025:
  - Metro Region CCCED - Coordinated care access for children, adolescent and adult patients at:
    - Columbia University Medical Center/The New York State Psychiatric Institute
    - Weill Cornell Medical Center/New York Presbyterian Hospital Westchester Division
    - Cohen Children's Medical Center

    For additional information, call 646-774-8066
  - CCCED of Western New York for children, adolescents and young adults:
    - Golisano Children's Hospital, Department of Adolescent Medicine: Eating Disorder Program

    For additional information, call 585-275-2964.
  - CCCED of Northeastern New York:
    - Collaborative program between Albany Med Health System and HPA Livewell.

    For additional information, call 518-262-3125.
- IOP Children's Psychiatry Clinic

Management of School Refusal

The goal is to **get the child back in school as soon as possible**. Immediate full-time attendance is preferred, but a gradual return coordinated with the school can work.

Treatment Principles and Interventions

COLLABORATION IS KEY!

Teamwork including the family, school, child, Primary Care and Mental Health Clinicians can achieve sustained attendance.

- Resist writing a letter for Home Instruction (tutoring) or make it very time-limited with a re-entry plan. Extensive Home Instruction can worsen absenteeism and make the return more difficult.

PSYCHOTHERAPY

- Educate parents and kids about the risks of school absenteeism and the importance of returning to school.
- Explore the root cause of non-attendance: Leaving home/parent vs. trouble on the bus vs. conflict or bullying with peers vs. academic struggles vs. low energy and motivation (School Refusal Assessment Scale (SRAS-R)). Focus on problem solving instead of avoidance.
- Reinforce courage, bravery, and gradual exposure. "You can do this!!"
- Repair and protect sleep hygiene.
- Refer for Exposure-based Cognitive Behavioral Therapy (CBT) for underlying anxiety or depression.
- Build strengths and skills for managing anxiety instead of "rescuing" child. This may provoke initial anger and/or distress from the child but hold the line and it will get better!

FAMILY

- Talk positively about school and drive past, use playing fields/playground during school breaks and summer.
- Prepare kids with school clothes, lunch box, sneakers, etc. at the end of summer and after breaks.

SCHOOL

- Create a re-entry plan with a stepwise return and a main contact person to coordinate and communicate.
- For support during school, use school resources (social worker, guidance counselor, nurse) instead of family. Limit texts and calls home.
- The child should attend school unless they have a measurable fever, vomiting or diarrhea. The school nurse can assess other physical symptoms and facilitate a return to class or call home.
- Check-in/check-out with favored adults at school and supportive counseling at school can help with connecting.
- Creative drop-off strategies:
  - Have a friend accompany the student on the bus and entering school.
  - Temporarily have extended family or family friends take the student to school.
  - Have school support person greet student at the door and support transition.

MEDICATIONS

- Treat contributing anxiety and/or depression with adequate doses of antidepressants.
- As-needed (prn) medication during the school day often detracts from the use of coping skills.
- Consider time-limited use of melatonin or an alpha agonist to reset and maintain sleep hygiene.

MONITOR

- Monitor input from parents, child and school.
- Monitor attendance closely for regression.
- Encourage participation in school-based extracurricular activities.
- Use follow-up rating scales for anxiety (SCARED Self-Report (ages 8-18+) and Parent Report (ages 4-18+)) and depression (PHQ-9) / CDS).
- Monitor but don't over focus on somatic symptoms (headache, stomach ache).

Trauma Informed Care (TIC)

Providers should follow the 4 Rs of Trauma Informed Care (TIC):

1 - Realize how common trauma is | 2 - Recognize signs & symptoms | 3 - Respond with policies/procedures | 4 - Resist re-traumitization

6 GUIDING PRINCIPLES (SAMHSA)

1. Establish physical and emotional safety of patient and staff. (report any ongoing risk to Child Protective Services as required.)
2. Be trustworthy and transparent.
3. Seek peer support.
4. Create collaboration and mutuality.
5. Empower voice and choice.
6. Consider cultural, historical and gender issues.

THE 2 MOST COMMON PATTERNS

- A single or series of Potential Traumatic Events (PTEs) Such events could include: severe threats, physical violence, accidents, sudden death of a significant other, traumatic loss and/or abuse.
- Repetitive trauma, chronic toxic stress and/or adverse childhood experiences

SIGNS AND SYMPTOMS

These symptoms can vary widely:

- Functional regression (sleep, tantrums, toileting, eating behaviors, baby talk)
- Anxiety, hyperarousal, avoidance, and re-experiencing (nightmares and flashbacks)
- Self-destructive, violent or dissociative behavior
- Negative self-concept, shame, guilt, difficulty with relationships

ASSESSMENT

- Ask, "Has anything really bad or scary happened to you (or your child)?"
- Look for the 3 E's: Exposure, Experience and Effects
- Screening tools include:

  - Pediatric ACES and Related Life Experiences (PEARLS) (parent and youth) to assess adverse experiences

  - Benevolent Childhood Experiences (BCEs) to access protective factors

  - PTSD rating scales: Child and Adolescent Trauma Scale (CATS) or Child PTSD Symptom Scale (CPSS) to assess the following: PTE i.e. severe threat without physical violence, severe accident, sudden death of significant person, severe abuse and/or neglect

TRAUMA RELATED DISORDERS:

- Acute Stress Disorder – within 30 days of exposure to trauma. Symptoms include: re-experiencing, regression, anxious and depressed mood.
- Post-Traumatic Stress Disorder (PTSD) – Greater than 30 days after exposure to trauma. Symptoms include intrusive re-experiencing, functional regression, hyper-arousal, sleep disruption. Dissociative subtype includes: depersonalization, derealization, amnesia and identity disturbance.
- Adjustment Disorders – Up to 6 months of emotional or behavioral symptoms that interfere with function.
- Reactive Attachment Disorder (RAD) – young child is inhibited or emotionally withdrawn; rarely seeks comfort from adults following longstanding social neglect or deprivation.
- Disinhibited Social Engagement Disorder (DSED)– young child actively approaches unfamiliar adults following chronic neglect and disrupted attachments.
- Major Psychiatric Disorders - including depression, anxiety, substance use and eating disorders.

PHYSICAL SYMPTOMS

Common medical signs of trauma exposure include: hypertension, tachycardia, digestive symptoms, unexplained pain and headaches.

SEVERITY (SHHIP)

- School - academics, teacher relationships
- Health - sleep, appetite
- Home - conflict, support
- Internal Stress - anxiety, depression
- Peer relationships

STRENGTHS

- Positive relationships, thoughts, self-regulation skills
- Engagement in school and community
- Ability to cooperate with treatment plan

Quick Links

MEDICATION CARDS

ADHD Medication Card

Antidepressant Medication Card

Antipsychotic Medication Card

TOOLS

- Ask Suicide Screening Questions (ASQ)
- Benevolent Childhood Experiences (BCEs)
- Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT)
- Center for Epidemiological Studies – Depression Scale for Children (CES-DC) 6-17 self-report
- Child PTSD Symptom Scale (CPSS)
- Columbia Depression Scale (CDS)
  - Teen and Parent report
- Columbia Suicide Severity Rating Scale (CSSRS)
- Eating Attitude Test (EAT)
- Generalized Anxiety Disorder (GAD-7)
- Modified Overt Aggression Scale (MOAS)
- Pediatric ACES and Related Life Experiences (PEARLS)
  - Self-Report
  - Parent Form
- Pediatric Symptom Checklist-17 (PSC)
  - Self-Report
  - Parent Form
- Patient Health Questionnaire-9 (PHQ-9)
  - Teens Self-Report 12+
- SCARED
  - Self-Report (ages 8-18+)
  - Parent Report (ages 4-18+)
- Treatment of Maladaptive Aggression in Youth (T-MAY)
- Vanderbilt Behavioral Checklist
  - Parent Form
  - Teacher report
- Yale-Brown Obsessive-Compulsive Scale (YBOCS)

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