MOC Part 2 - Identifying and Caring for Children with Developmental, Behavioral, and Mental Health Disorders

Beth Bloom Emrick, MD

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- I have no financial disclosures
  - I served on the expert panel for the WV ADHD and Comorbid Concerns (WV ACC) Guidelines
- I will mention off-label uses of medication

Objectives

1. Recognize signs and symptoms of common developmental, behavioral, and mental health disorders.
2. Identify appropriate screening tools for developmental and mental health disorders.
3. Understand treatment of common developmental, behavioral, and mental health disorders.

ADHD

CLINICAL PRACTICE GUIDELINE

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

Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

Mark L. Wolraich, MD, FAAP,[a] Joseph F. Hagan, Jr, MD, FAAP,[b,c] Carla Allan, PhD,[d,e] Eugenia Chan, MD, MPH, FAAP,[f,g] Dale Davison, MSpEd, PCC,[h,i] Marian Earls, MD, MTS, FAAP,[j,k] Steven W. Evans, PhD,[l,m] Susan K. Flinn, MA,[n] Tanya Froehlich, MD, MS, FAAP,[o,p] Jennifer Frost, MD, FAAFP,[q,r] Joseph R. Holbrook, PhD, MPH,[s] Christoph Ulrich Lehmann, MD, FAAP,[t] Herschel Robert Lessin, MD, FAAP,[u] Kymika Okechukwu, MPA,[v] Karen L. Pierce, MD, DFAACAP,[w,x] Jonathan D. Winner, MD, FAAP,[y] William Zurhellen, MD, FAAP,[z] SUBCOMMITTEE ON CHILDREN AND ADOLESCENTS WITH ATTENTION-DEFICIT/HYPERACTIVE DISORDER

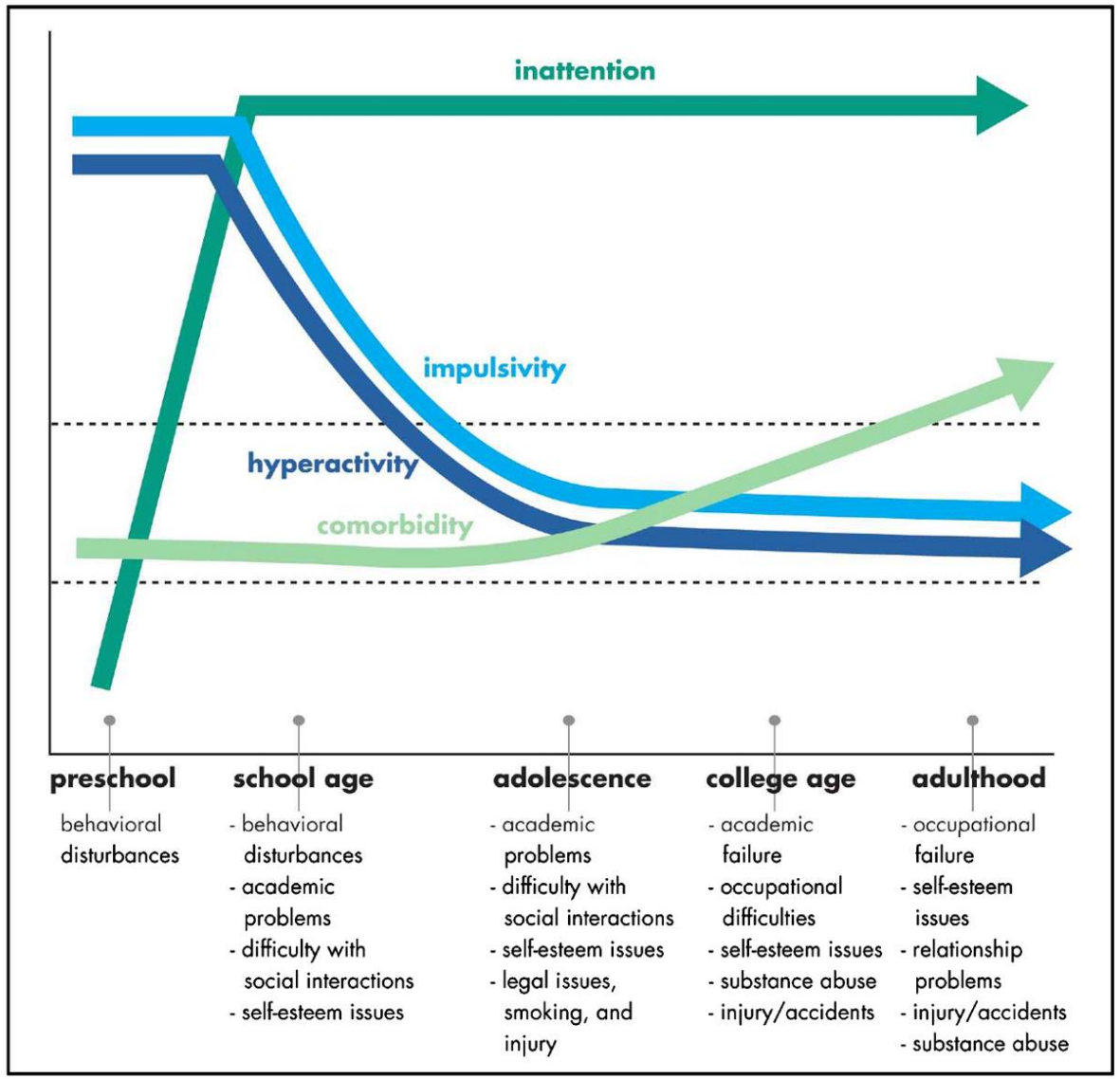
What is it?

- Update to the 2011 Guideline
- Recommendations for
  - Evaluation
  - Diagnosis
  - Treatment
- Children age 4-18 years

ADHD

- Worldwide prevalence of 7.2%
- 2016 US Survey – 9.4% of children 2-17 years ever diagnosed
  - 8.4% have a current diagnosis
  - Includes 2.4% of 2-5 year olds
- ⅔ taking medication
- ½ received behavioral treatment in last year
- ¼ had never received treatment

Impact of Development on ADHD



The Guideline

Key Action Statement 1

- **Pediatrician or Primary Care Clinician (PCC)** initiate an evaluation for ADHD for any child or adolescent 4 years to the 18th birthday who presents with
  - Academic or behavioral problems
  - Inattention
  - Hyperactivity
  - Impulsivity
- NOTE: Insufficient evidence to recommend diagnosis/treatment <4 years – if substantial impairment, PCC should consider referral for parent training in behavior management

Key Action Statement 2

- PCC should determine that the DSM-5 criteria have been met
  - Symptoms in more than one setting
    - Parents
    - Teachers
    - Other school personnel
  - Rule out any alternative cause

- NOTE: Neuropsych testing has not been found to improve diagnostic accuracy, but may benefit in clarifying the learning strengths/weaknesses

Special Circumstance – Preschool-Aged Children

- DSM-5 can identify young children with ADHD
- DSM-5-based rating scales were normed for ages 5-18 years
- BUT any DSM-IV scale can be used – minimal changes

- Parent training in behavior management is the preferred first treatment – *even if diagnosis is not yet verified*

Special Circumstance – Adolescents

- Multiple teachers
- Parents may have less opportunity to observe
- Some problems less likely to be observed
- Adolescents may minimize their symptoms

- Get info from multiple sources

Special Circumstance - Adolescents

- Must have symptoms prior to age 12
- Consider whether a mimicking or comorbid condition is present
  - Anxiety
  - Depression
  - Substance use

Key Action Statement 3

- In evaluation for ADHD, must screen for comorbid conditions
  - Emotional/Behavioral
    - Anxiety
    - Depression
    - ODD
    - Conduct disorder
  - Developmental disorders
    - Learning/language disorders
    - ASD
  - Physical conditions
    - Tics
    - Sleep apnea

Key Action Statement 4

- ADHD is a chronic condition
- Manage as children with special healthcare needs
- Use chronic care and medical home model
  - Might be especially beneficial for *parents* who have ADHD
    - Might need extra support in following a consistent schedule for medications, appointments, etc.

Key Action Statement 4

- Impairments persist into adulthood
  - Increased risk for early death, suicide
  - Increased substance use disorders
  - Lower educational achievement
  - Increased rate of incarceration
- Treatment discontinuation associated with
  - MVA
  - Criminality
  - Violent reoffending
  - Depression
  - Interpersonal issues
  - Other injuries

Key Action Statement 5a (preschool children)

- 1st line:
  - PTBM
  - Behavioral classroom interventions
  - *If available*
- Methylphenidate may be considered if no significant improvement
- If evidence-based behavior management *not* available, weigh risk of medication vs. harm of delaying treatment

Key Action Statement 5b (school age – 6-11 years)

- Prescribe FDA-approved medication for ADHD

AND

- PTBM and/or behavioral classroom intervention (preferably both)

- Evidence best for stimulant medications, less strong for atomoxetine and alpha-agonists

Key Action Statement 5b (adolescents – 12-17 years)

- Prescribe FDA-approved medication for ADHD

AND

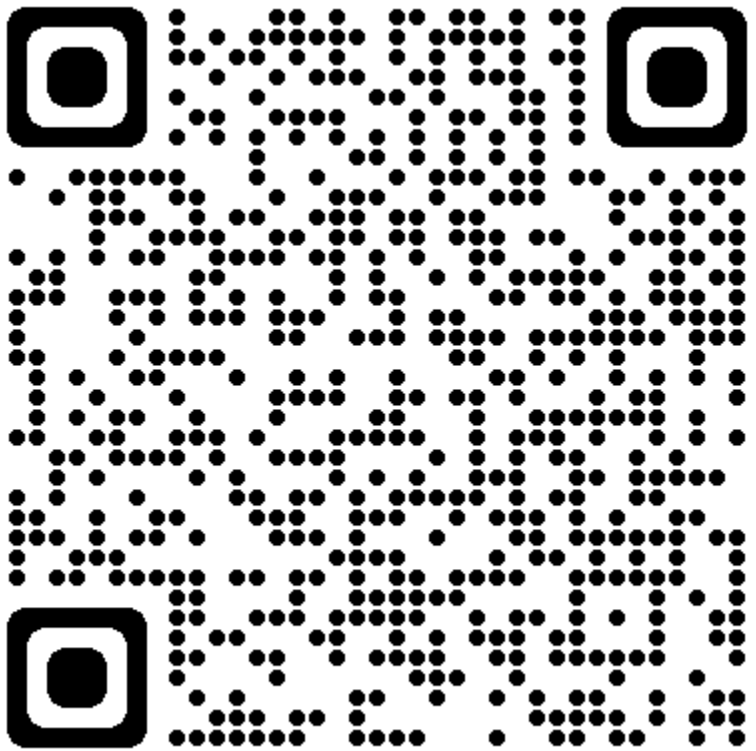
- PTBM and/or behavioral classroom intervention (preferably both)

- Begin planning for transition to adult care

Which medication?

- Preschool-aged may have increased mood lability and dysphoria with stimulants
- School-aged – best evidence for stimulants
  - Atomoxetine, ER-guanfacine, ER-Clonidine
- Response to methylphenidate vs. amphetamine is idiosyncratic
- ADHD subtype does not predict response to medication
- Not yet enough evidence to support pharmacogenetic testing

ADHD Medication Guide



ADHD Medication Guide*

Revised: December 1, 2023

Amphetamine Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

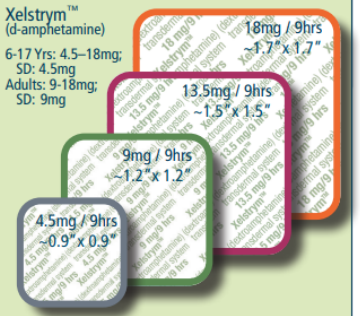
Dyanavel® XR (d- & l-amphetamine sulfate)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg		5mg		10mg		15mg		20mg	
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6 Yrs–Adults: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL	
Mydayis®‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	G 12.5mg		G 25mg		G 37.5mg		G 50mg		
Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 13–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg		
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5-30mg; SD: 20mg (biphasic – 50/50)		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg		
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G♦ 5mg	G 10mg	G♦ 15mg					

Amphetamine Pro-Drug Formulations – Long Acting, Oral** (Medications in this section are shown at actual size)

Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg	G 70mg		
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–70mg; SD: 30mg	G 10mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg			

Amphetamine Formulations – Long Acting, Transdermal

Xelstrym™ (d-amphetamine)
6-17 Yrs: 4.5–18mg; SD: 4.5mg
Adults: 9-18mg; SD: 9mg



(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)

Amphetamine Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg		G 10mg					
Evekeo® ODT (d- & l- amphetamine sulfate)	6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	5mg		10mg		15mg	20mg		
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–16 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		G 15mg	G 20mg	G 30mg	
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg	
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL							

Non-Stimulants** (Medications in this section are shown at actual size)

Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1-4mg; SD: 1mg 13–17 Yrs: 1-7mg; SD: 1mg Weight-based dosing: SD: 0.05-0.08 mg/kg/day; may increase to 0.12 mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg					
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg							
Strattera®† (atomoxetine)	≤70kg: 0.5mg/kg x ≥3days, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) >70 kg: 40mg x ≥3days, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg		
Qelbree®‡ (viloxazine)	6–11 Yrs: 100-400mg; SD: 100mg 12–17 Yrs: 200-400mg; SD: 200mg Adults: 200-600mg; SD: 200mg	100mg	200mg	300mg	+	400mg	+			

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ADHD Medication Guide*

Revised: December 1, 2023

Methylphenidate Formulations – Long Acting, Oral** (Capsules and tablets in this section are shown at actual size)

Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	G 27mg	G 36mg	G 54mg	Relexxii® (bioequivalent to corresponding Concerta dosing)		G 45mg	G 63mg	G 72mg
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 5–40mg; SD: 5mg (biphasic – 50/50)	G 5mg		G 10mg	G 15mg	G 20mg	G 25mg	G 30mg	G 35mg	G 40mg
Cotempla XR-ODT®¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg	8.6mg		17.3mg	25.9mg	34.6mg		51.8mg		
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg (biphasic – 40/60)	G 10mg	G 15mg	G 20mg	G 30mg	G 40mg	G 50mg	G 60mg		
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg	10mg 2mL — 1 Bottle: 300mg 60mL		20mg 4mL — 1 Bottle: 600mg 120mL	30mg 6mL — 1 Bottle: 900mg 180mL	40mg 8mL — 2 Bottles: 600mg 120mL	50mg 10mL — 2 Bottles: 750mg 150mL	60mg 12mL — 2 Bottles: 900mg 180mL		
QuilliChew ER®§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg (biphasic – 30/70)			20mg	30mg	40mg				
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg (biphasic – 50/50)	G 10mg		G 20mg	G 30mg	G 40mg		G♦ 60mg		
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg (biphasic – 30/70)	G♦ 10mg		G♦ 20mg	G♦ 30mg	G♦ 40mg	G♦ 50mg	G♦ 60mg		
Metadate® ER†	6 Yrs-Adult: 20–60mg; SD: 20mg	G♦ 10mg		G♦ 20mg						

Methylphenidate Pro-Drug Formulations - Long Acting, Oral** (Medications in this section are shown at actual size)

Azstarys®? (dexmethylphenidate + serdexmethylphenidate)	6-12 Yrs: 26.1/5.2 – 52.3/10.4; SD: 39.2/7.8 mg; 13 Yrs – Adult: 39.2/7.8 – 52.3/10.4; SD: 39.2/7.8mg	26.1mg SDX / 5.2mg d-MPH	39.2mg SDX/ 7.8mg d-MPH	52.3mg SDX/ 10.4mg d-MPH		

Methylphenidate Formulations – Long Acting/Delayed Onset, Oral** (Medications in this section are shown at actual size)

Jornay PM®‡	6 Yrs–Adults: 20–100mg (dosed in the evening); SD: 20mg	20mg	40mg	60mg	80mg	100mg

Methylphenidate Formulations – Short Acting, Oral** (Medications in this section are shown at actual size)

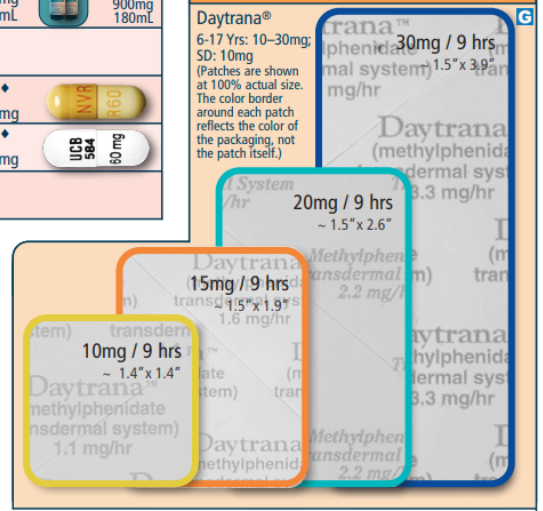
Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	G 5mg	G 10mg	
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg	G 10mg	G 20mg	
Methylin Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID	G♦ 2.5mg	G♦ 5mg	G♦ 10mg		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL	G 10mg/5mL		

Methylphenidate Formulations - Long Acting, Transdermal

Daytrana®

6-17 Yrs: 10–30mg; SD: 10mg

(Patches are shown at 100% actual size. The color border around each patch reflects the color of the packaging, not the patch itself.)



Administration Key:

¶ Orally disintegrating tablet † Must be swallowed whole § Chewable

¥ Can be mixed with yogurt, orange juice, or water

‡ Can open capsule and sprinkle medication on apple sauce

? Can open capsule and sprinkle medication into water or onto apple sauce

¥ Can open capsule and mix with apple sauce or yogurt

G Indicates a generic formulation is also available; generic products are not shown

G Indicates a generic (but NOT a branded) formulation is available

- View the latest version of the ADHD Medication Guide at www.ADHDMedicationGuide.com

♦**Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Adhansia XR; Adzenys ER (liquid); Cylert (pemoline); Dexedrine Spansules (5mg, 15mg); Dexedrine tablets; DextroStat tablets; LiquADD solution; Metadate CD capsules; Metadate ER tablet (10mg); Methylin Chewable tablets; Ritalin LA capsule (60mg); Ritalin SR tablets (20mg).

****Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication. **Please note:** medications have been arranged on the ADHD Medication Guide for ease of display and visual comparison; dosing comparability cannot be assumed.

- Updated versions of the ADHD Medication Guide can be viewed at: www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be ordered on-line from the ADD Warehouse
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

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Conversion of Medications

WV ACC Guidelines

Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Conversion Aid* — Appendix 2.8

Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Conversion Aid*				
Current Medication	**Current Total Daily Dose (mg/day)**	**Conversion Factor**	**New Medication**	**Total Daily Dose (mg/day)**
Amphetamine Salts				
Mixed Amphetamine Salts Immediate-Release (IR)/ Extended-Release (ER)	20 mg	1	**Mixed Amphetamine Salts IR/ER**	20 mg (may divide IR dose in 1 to 3 equally divided doses)
	20 mg	2	**Methylphenidate HCl IR/ER**	40 mg* (may divide IR dose in 1 to 3 equally divided doses)
*Alternatively, consider switching amphetamines to methylphenidate at the same dose and titrating up				
Mixed Amphetamine Salts IR/ER	20 mg	2.5	**Vyvanse** (lisdexamfetamine dimesylate)	50 mg
Mixed Amphetamine Salts IR/ER	20 mg	0.625	**Adzenys XR-ODT, Adzenys ER (amphetamine) ODT-XR tablet and ER oral suspension**	12.5 mg
Adzenys XR-ODT, **Adzenys ER** (amphetamine) **ODT-XR tablet and ER oral suspension**	12.5 mg	1.6	**Mixed Amphetamine Salts IR/ER**	20 mg (may divide IR dose in 1 to 3 equally divided doses)
Lisdexamfetamine				
Vyvanse (lisdexamfetamine dimesylate)	10 mg	~0.77	**Methylphenidate HCl IR/ER**	7.7 mg* (may divide IR dose in 1 to 3 equally divided doses)
Vyvanse (lisdexamfetamine dimesylate)	50 mg	0.4 - 0.6	**Mixed Amphetamine Salts IR/ER**	25 mg* (may divide IR dose in 1 to 3 equally divided doses)

Attention-Deficit/Hyperactivity Disorder (ADHD) Medication Conversion Aid*				
Current Medication	**Current Total Daily Dose (mg/day)**	**Conversion Factor**	**New Medication**	**Total Daily Dose (mg/day)**
Methylphenidate and Derivatives				
Aptensio XR (methylphenidate HCl) capsule	10 mg	1	**Methylphenidate HCl IR/ER**	10 mg (may divide IR products in 1 to 3 equally divided doses)
Dexmethylphenidate HCl IR/ER	10 mg	2	**Methylphenidate HCl IR/ER**	20 mg (may divide IR products in 1 to 3 equally divided doses)
		1	**Dexmethylphenidate HCl IR/ER**	10 mg (may divide IR products in 1 to 3 equally divided doses)
Methylphenidate HCl IR	15 mg (may divide IR dose in 1 to 3 equally divided doses)	~0.67	**Daytrana** (methylphenidate transdermal) patch	10 mg/ 9 hr wear time
Daytrana (methylphenidate transdermal) patch	10 mg/ 9 hr wear time	1.5	**Methylphenidate HCl IR**	15 mg (may divide IR dose in 1 to 3 equally divided doses)
Methylphenidate HCl IR/ER	20 mg	0.5	*The conversion of methylphenidate to dextroamphetamine/amphetamine is done at approximately ½ the dose of methylphenidate. However, it may be reasonable for children who are already receiving ≥ 20 mg/day methylphenidate to convert to dextroamphetamine-amphetamine at a starting dose of 10 mg once per day and titrate based on response.	
		1.3	**Vyvanse** (lisdexamfetamine dimesylate)	26 mg* (available in 20 mg, 30 mg)
Concerta (methylphenidate osmotic release) ER tablets	18 mg	~0.56	**Daytrana** (methylphenidate transdermal) patch	10 mg/ 9 hr wear time
Daytrana (methylphenidate transdermal) patch	10 mg/ 9 hr wear time	1.8	**Concerta** (methylphenidate osmotic release) ER tablets	18 mg

The recommendation for the following medications is to start with the initial dose and titrate when switching due to pharmacokinetics and salt form differences*

Adhansia XR
Adzenys XR-ODT
(if switching to another product other than Adderall XR)
Azstarys
Dyanavel XR
Evekeo ODT
Jornay PM
Mydayis
QuilliChew ER
Quillivant XR

School Programming and Supports

504 PLAN

INDIVIDUALIZED EDUCATION PROGRAM (OHI) – ONLY IF SEVERITY IMPAIRS THE CHILD'S ABILITY TO LEARN

School Programming and Supports

- Interventions that help student *independently* meet age-appropriate academic/behavioral expectations
  - Daily report cards
  - Point systems
  - Academic remediation
- Provide changes to student's program so ADHD no longer results in failure – accommodations
  - Extended time
  - Reduced homework
  - Ability to keep study materials
  - Provision of teacher's notes to student

Key Action Statement 6

- Titrate dose of medication to achieve maximum benefit with tolerable side effects
- MTA – 70% responded to methylphenidate after systematic trial of 4 different doses
  - Those in community care had less response, but also lower medication doses
- Titration can be quick – 7 day basis
- Make families aware that there will be trials and titration

Key Action Statement 7

- PCC should initiate treatment or refer patients for treatment of comorbid conditions

Barriers to High-Quality Care for Children and Adolescents with ADHD

- Limited access to care
  - Inadequate DBP/Mental Health training in clinical training programs
    - Focus on inpatient/ICU
    - Not enough training in setting up medical home
  - Shortage of consultant specialists and referral resources
    - 8300 Child psychiatrists
    - 662 DBP
    - Additional training increases education time and cost, but little return on investment in terms of compensation
    - Geographically skewed distribution of specialists
      - 44% of counties in the US do not have a pediatrician!

Suggested Strategies for Limited Access to Care

- Devote more time in pediatric and FM residency curricula to developmental, behavioral, learning, and mental health issues
- Teach skills to function within a medical home setting
- Affordable CME to help PCC get more comfortable treating ADHD
- Develop collaborative care models
- Incentives for additional training – load forgiveness

Barrier – Inadequate Payment for Needed Services and Payer Coverage Limitations for Needed Medications

- Payment is not guaranteed despite diagnostic and procedure codes
- Restrictions to medication therapy
  - Prior approval – reviewers not familiar with pediatrics
  - Narrow formularies
    - Favor 1 ADHD medication when another may be more appropriate
  - Frequent formulary changes
    - Generic preference
- Mental health services reimbursed lower than physical health
- Care coordination services not covered

Strategies to Address Payment and Medication Limits

- Policy changes
  - Review payment systems to reflect time and cognitive effort
  - Compensate needed services
  - New payment models
  - Require that reviewers have pediatric expertise
  - Advocate for better monitoring by FDA of ADHD medication generic formulations

Question 1

Which of the following is NOT true when diagnosing ADHD?

A. Impairments must be seen in more than one setting
B. Neuropsych testing improves diagnostic accuracy
C. The Primary Care Clinician can initiate evaluation in children with symptoms of hyperactivity, inattention, or school difficulty
D. Rating scales based on DSM-5 are available for children ages 5-18 years

Question 2

Which of the following is true when treating ADHD in preschool-aged children?

A. Amphetamine-dextroamphetamine is the preferred medication treatment when medication is warranted
B. Parent training in behavior management is the first-line treatment
C. Parent training in behavior management should not be initiated until the diagnosis is confirmed
D. Preschool-aged children cannot be diagnosed with ADHD

Question 3

Which of the following makes diagnosis of ADHD more challenging in adolescents?

A. Adolescents tend to exaggerate their symptoms
B. Mimicking and comorbid conditions must be considered
C. Parents have more opportunity to observe their behavior
D. Symptoms must have been present before age 7 years

Question 4

Accommodations in the classroom that could be useful for a student with ADHD include . . .

A. Reduced homework
B. Ability to keep study materials
C. Provision of teacher's notes to student
D. All of the above

Question 5

Which of the following is true when choosing a medication to treat a school-aged child with ADHD?

A. ADHD subtype does not predict response to medication
B. Methylphenidate is more effective than amphetamine derivatives
C. Nonstimulant medications are the first-line treatment
D. Pharmacogenetic testing can predict which medication will have the best response

GUIDELINES

Society for Developmental and Behavioral Pediatrics Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Complex Attention-Deficit/Hyperactivity Disorder

Barbaresi, William J. MD (Guideline Panel Chair)[*]; Campbell, Lisa MD[†]; Diekroger, Elizabeth A. MD[‡]; Froehlich, Tanya E. MD[§]; Liu, Yi Hui MD, MPH[‖]; O'Malley, Eva[¶]; Pelham, William E. Jr PhD, ABPP[**]; Power, Thomas J. PhD, ABPP[††]; Zinner, Samuel H. MD[‡‡]; Chan, Eugenia MD, MPH[*]

Author Information

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Autism Spectrum Disorder

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Identification, Evaluation, and Management of Children With Autism Spectrum Disorder

Susan L. Hyman, MD, FAAP,[a] Susan E. Levy, MD, MPH, FAAP,[b] Scott M. Myers, MD, FAAP,[c] COUNCIL ON CHILDREN WITH DISABILITIES, SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

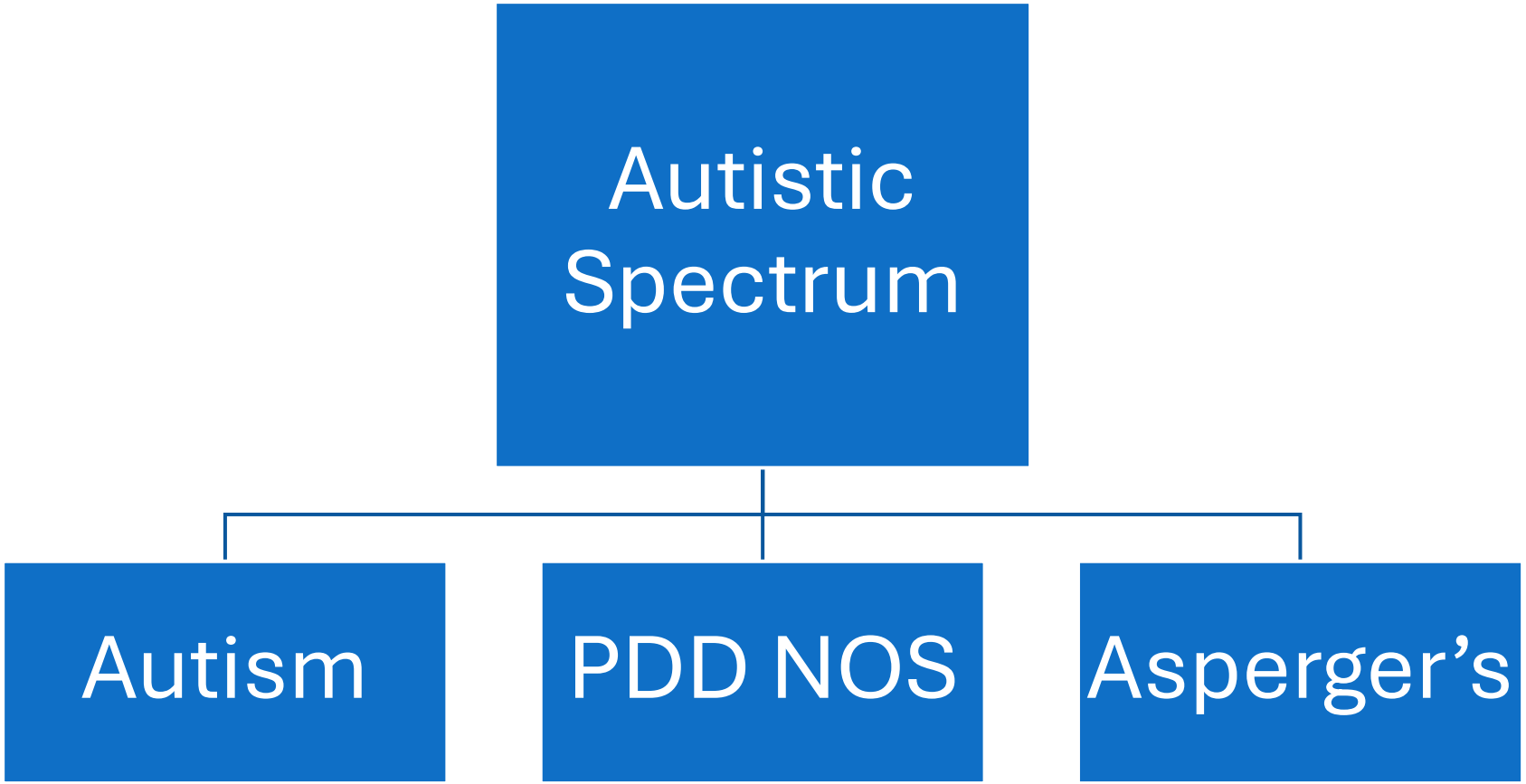
Autism Spectrum Disorder

- Neurodevelopmental disorder characterized by social and communication impairment and restricted or repetitive behaviors
- Direct and indirect costs of caring for individuals with ASD in the US in 2015 were estimated to be $268 billion
- Lifetime cost of education, health, and other service needs for an individual with ASD ranges from $1.4 to $2.4 million dollars

The Clinical Report

- In the 12 year since the previous clinical report . . .
  - Prevalence rates of ASD in children increased
  - Understanding of risk factors expanded
  - More awareness of co-occurring medical conditions
  - Improved understanding of genetic etiology
  - Growth of evidence-based interventions
  - The DSM-5 changed the diagnostic criteria in 2013

DSM-IV Autism



DSM-5 Autism Spectrum Disorder

Role of Primary Care

- Critical access to child in the medical home
  - Identify symptoms of ASD early in childhood
  - Support the family through the process of diagnosis and intervention
  - Address etiologic evaluations
  - Help the family understand how to interpret the evidence supporting interventions so they can engage in shared decision making
  - Manage co-occurring medical conditions

- In this report, they hoped to help guide primary care clinicians in providing a medical home for patients with ASD

Prevalence of ASD

- Prevalence is reported more than incidence
- Difficult to determine incidence
  - Heterogeneity in the symptoms and severity
  - Diagnosed at different ages
  - What is reported is the age *at recognition* of the symptoms, not the onset

Identified Prevalence of Autism Spectrum Disorder

ADDM Network 2000-2020 Combining Data from All Sites

Surveillance Year	Birth Year	Number of ADDM Sites Reporting	Combined Prevalence per 1,000 Children (Range Across ADDM Sites)	This is about 1 in X children
2020	2012	11	27.6 (23.1-44.9)	1 in 36
2018	2010	11	23.0 (16.5-38.9)	1 in 44
2016	2008	11	18.5 (18.0-19.1)	1 in 54
2014	2006	11	16.8 (13.1-29.3)	1 in 59
2012	2004	11	14.5 (8.2-24.6)	1 in 69
2010	2002	11	14.7 (5.7-21.9)	1 in 68
2008	2000	14	11.3 (4.8-21.2)	1 in 88
2006	1998	11	9.0 (4.2-12.1)	1 in 110
2004	1996	8	8.0 (4.6-9.8)	1 in 125
2002	1994	14	6.6 (3.3-10.6)	1 in 150
2000	1992	6	6.7 (4.5-9.9)	1 in 150

“Why is Autism Increasing?”

“Why is Autism Increasing?” (aka “If it’s not the vaccines, then what is it?”)

- Broadening of the criteria over time as the DSM is revised
- The more inclusive definition of pervasive developmental disorder in DSM-IV (1994)
- Increased public awareness of ASD and its symptoms
- Recommendations for universal screening for ASD in primary care (2007)
- Increased availability of early intervention and school-based services
- Diagnostic substitution
- True increase associated with other biological risk factors

Clinical Symptoms

- Research into the neurobiology and genetics is ongoing
- Diagnosis still based on clinical symptoms

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history; **must have all 3 symptoms in this domain**

Deficits	Examples
1. Social-emotional reciprocity	• Abnormal social approach and failure of normal back-and-forth conversation • reduced sharing of interests, emotions, or affect • failure to initiate or respond to social interactions
2. Nonverbal communicative behaviors used for social interaction	• Poorly integrated verbal and nonverbal communication • abnormalities in eye contact and body language or deficits in understanding and use of gestures • total lack of facial expressions and nonverbal communication
3. Developing, maintaining, and understanding relationships	• Difficulties adjusting behavior to suit various social contexts • Difficulties in sharing imaginative play or in making friends • Absence of interest in peers

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least 2 of the following, currently or by history; must have 2 of the 4 symptoms

Deficits	Examples
1. Stereotyped or repetitive motor movements, use of objects, or speech	Simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior	Extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day
3. Highly restricted, fixated interests that are abnormal in intensity or focus	Strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment	Apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement

Co-occurring Symptoms and Conditions

- Sleep disorders
- Seizures
- ADHD
- Anxiety
- Mood disorders
- Food refusal
- Self injury
- Aggression

Prognosis

- Difficult to predict developmental trajectory
- More difficult to recognize mild symptoms in children under 3 years
- As children continue to develop, communication and social skills may improve
- Repetitive behaviors change over time
- IQ and language ability in childhood predict outcome in adulthood
- QOL in high functioning adults was associated more with family and community supports than their ASD symptoms

JAMA Pediatrics | Original Investigation

Persistence of Autism Spectrum Disorder From Early Childhood Through School Age

Elizabeth Harstad, MD, MPH; Ellen Hanson, PhD; Stephanie J. Brewster, MS, CGC; Rafael DePillis, BS; Anna L. Milliken, BA; Gabriella Aberbach, MSc; Georgios Sideridis, PhD; William J. Barbaresi, MD

- 37.1% did not continue to meet criteria
  - Initial diagnosis mean age 24.6 months
  - Research assessment age 74.3 months
- All of the children with nonpersistent ASD had IQ >70

Red Flag Symptoms

	Symptom
By 12 months	• Does not respond to name
By 14 months	• Does not point at objects to show interest
By 18 months	• Does not pretend play
General	• Avoids eye contact and may want to be alone • Has trouble understanding other people's feelings or talking about their own feelings • Has delayed speech and language skills • Repeats words or phrases over and over (echolalia) • Gives unrelated answers to questions • Gets upset by minor changes • Has obsessive interests • Makes repetitive movements like flapping hands, rocking, or spinning in circles • Has unusual reactions to the way things sound, smell, taste, look, or feel

Screening

- AAP recommends screening all children
  - Developmental surveillance at all visits
  - Standardized autism-specific screening tests at 18-24 months
- Identify children at risk for ASD based on symptoms

- “Primary care providers are tasked with identifying all children who would benefit from early intervention, not just children at risk for ASD.”

Screening Tools for ASD

- M-CHAT-R/F
  - Most commonly used
  - Caregiver-completed questionnaire
  - Ages 16 to 30 months
  - 20 questions
    - ≥8 – high risk, refer immediately
    - 3-7 – follow up interview for the items scored positive
      - If they continue to score 3-7 items positive, 47% risk of having ASD diagnosed, 95% chance of being identified from another delay that would benefit from intervention

Barriers to Identifying Risk for ASD

- Milder symptoms and/or average or higher IQ may not be identified early
- Underdiagnosis in girls due to lesser intensity of symptoms and fewer externalizing behaviors
- Coexisting conditions may impede recognition of symptoms

A definitive diagnosis is not necessary to institute services for documented delays that would be served through early intervention or school services.

Making the Diagnosis

- Most children will need to see a specialist, but general pediatricians comfortable with applying the DSM-5 criteria can make an initial diagnosis
  - Facilitates start of services
- To meet criteria, symptoms must impair function
- There are no laboratory tests that can help make the diagnosis!

Structured Observations for Evaluation

- Not required to make a diagnosis – “support application of the DSM-5 criteria”
- Autism Diagnostic Observation Schedule (ADOS-2)
  - Structured interview or play session
  - Modules for different ages

- Childhood Autism Rating Scale (CARS)
  - 15-point scale completed by clinician based on history and observation

Evaluation of Co-occurring Developmental Concerns

- Cognitive testing
- Language Testing
- Adaptive Function Testing
- Motor Assessment
- Hearing
- Vision
- Sensory*

Autism Diagnosis in Primary Care

Why diagnose ASD in the medical home?

- Reducing wait times
- Improving continuity of care
- Reducing disparities in access to diagnostic services
- Assisting family in better understanding their child’s strengths and needs for support

If you need something to listen to on the drive home . . .

Listen to the Science Behind Child Health.

Listen to the weekly AAP podcast ***Pediatrics On Call*** with hosts Drs. Joanna Parga-Belinkie (@jopargalinkiemd) and David Hill (@davidlhillmd) and the experts who help advance our mission to provide optimal health for infants, children, adolescents, and young adults.

Pediatrics On Call

NEW EPISODES

VIEW ALL EPISODES

EPISODE 197

Diagnosing Autism in the Medical Home, How Moving Affects Access to Social Services

Katharine Zuckerman, MD, MPH, FAAP, offers advice from a new tip sheet about diagnosing autism in the medical home. Hosts David Hill, MD, FAAP, and Joanna Parga-Belinkie, MD, FAAP, also speak with Kathryn Leifheit, PhD, MSPH, about her research into how moving affects families' access to social services.

LISTEN NOW

Question 6

What is the next best step when a child fails 5 items on the M-CHAT-R/F?

A. Administer the follow up interview for the failed items
B. Make a diagnosis of Autism Spectrum Disorder
C. Refer for diagnostic evaluation
D. Refer for early intervention and diagnostic evaluation

Question 7

What is the next best step when a child fails more than 8 items on the M-CHAT-R/F?

A. Administer the follow up interview for the failed items
B. Make a diagnosis of Autism Spectrum Disorder
C. Refer for diagnostic evaluation
D. Refer for early intervention and diagnostic evaluation

Question 8

Why is the prevalence of autism increasing?

A. Increased availability of early intervention and school-based symptoms
B. Increased public awareness of symptoms
C. Recommendations for universal screening in primary care
D. All of the above

Question 9

Which of the following is true about the DSM-5 criteria for ASD?

A. All of the social-communication deficits to meet criteria for ASD
B. All of the restricted, repetitive behaviors criteria to meet criteria for ASD
C. Sensory issues are not included in the criteria
D. ASD cannot be diagnosed in combination with ADHD

Question 10

Which of the following is true of diagnosing ASD?

A. Autism Diagnostic Observation Schedule (ADOS-2) testing is required for diagnosis
B. Structures evaluations can be used to support application of the DSM-5 criteria
C. Intervention should be delayed until an official diagnosis is made
D. Only a Developmental-Behavioral Pediatrician or child psychologist can diagnose ASD

Anxiety

AACAP OFFICIAL ACTION

Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders

Heather J. Walter, MD, MPH, Oscar G. Bukstein, MD, MPH, A. Reese Abright, MD,
Helene Keable, MD, Ujjwal Ramtekkar, MD, MPE, MBA,
Jane Ripperger-Suhler, MD, Carol Rockhill, MD, PhD, MPH

Anxiety

- 7% of youths worldwide at any given time
- 20-30% lifetime prevalence

Diagnosis	Lifetime Prevalence, Youth 13-18 years
Specific phobia	20%
Social anxiety	9%
Separation anxiety	8%
Generalized anxiety Panic Agoraphobia	2% each

Age of onset

- Median age of anxiety disorders about 11 years
- Each anxiety disorder often onsets during a specific developmental phase
  - Separation anxiety – preschool/early school-age
  - Specific phobias – school age
  - Social anxiety – later school age and early adolescence
  - Generalized anxiety, panic, and agoraphobia – later adolescence and adulthood

Sequelae

- Impairments in multiple adult outcomes if untreated
  - Social
  - Educational
  - Occupational
  - Health
  - Mental health
- 9% of adolescents with anxiety have suicidal ideation
  - 6% made attempts

Identification

Evidence Assessment The USPSTF concludes with moderate certainty that screening for anxiety in children and adolescents aged 8 to 18 years has a moderate net benefit. The USPSTF concludes that the evidence is insufficient on screening for anxiety in children 7 years or younger.

The Anxiety Disorders

- Separation anxiety – *developmentally inappropriate*, excessive worry or distress associated with separation from a primary caregiver or major attachment figure
- Selective mutism – absence of speech in certain social situations despite the presence of speech in other situations (usually at home).
- Specific phobia – excessive fear or worry about a specific object or situation
- Social anxiety – excessive fear or worry about being negatively evaluated by others in social situations
- Panic (ie, abrupt surge of intense fear or discomfort) – recurrent unexpected panic attacks with physical and cognitive manifestations

The Anxiety Disorders

- Agoraphobia – excessive fear or worry about being in situations (eg, crowds, enclosed spaces) in which the individual may be unable to escape or get help should panic-like or other overwhelming or embarrassing symptoms occur.
- Generalized anxiety – excessive, uncontrollable worries regarding numerous everyday situations or activities.
- Substance/ medication-induced anxiety and anxiety due to another medical condition – anxiety occurring in the context of substance/medication use or a physical illness.

Symptom Rating Scales

- Generalized Anxiety Disorder (GAD-7)
  - Ages 11 to adult
  - 7 questions plus one about impairment
- Screen for Child Anxiety Related Disorders (SCARED)
  - Parent and child versions
  - Ages 8-18 years
  - 41 questions
  - 5 domains: GAD, separation anxiety, social anxiety, panic or somatic symptoms, and school avoidance

Differential Diagnosis

- Medical conditions
- Medications
- Licit and illicit substances
- Mental conditions
  - ADHD – distractibility, restlessness
  - Depression – distractibility, somatic complaints
  - Bipolar disorder – distractibility, restlessness, irritability, insomnia
  - Obsessive-compulsive disorder – intrusive thoughts, avoidance, reassurance seeking
  - Psychotic disorders – restlessness, agitation, social withdrawal, distractibilty
  - ASD – social withdrawal, social skills deficits, distractibility
  - Learning disorders – worry about school performance

Treatment Recommendations

1. AACAP recommends (1C) that cognitive-behavioral therapy (CBT) be offered to patients 6 to 18 years old with social anxiety, generalized anxiety, separation anxiety, specific phobia, or panic disorder.
2. AACAP recommends (1B) that selective serotonergic reuptake inhibitors (SSRIs) be offered to patients 6 to 18 years old with social anxiety, generalized anxiety, separation anxiety, or panic disorder.

SSRIs

- What to expect
  - Statistically significant improvement within 2 weeks
  - Clinically significant improvement by week 6
  - Maximal improvement by week 12 or later
- Generally well tolerated; most adverse effects emerge early in treatment (first few weeks)
  - Dry mouth, diarrhea, heartburn, headache, somnolence, insomnia, dizziness, vivid dreams, changes in appetite, weight loss or gain, fatigue, nervousness, tremor, bruxism, and diaphoresis
  - Potentially serious – suicidal thinking and behavior, activation/agitation, hypomania, mania, sexual dysfunction, seizures, serotonin syndrome

SSRIs and Suicidal Ideation

- All SSRIs have a black box warning for suicidal thinking and behavior through age 24 years
- Pooled absolute rates for suicidal ideation:
  - 1% for youth treated with SSRI
  - 0.2% for youths treated with placebo
- Number needed to harm – 143
- Number needed to treat to achieve response – 3

Serotonin Syndrome

Signs and symptoms include:

- Agitation or restlessness
- Insomnia
- Confusion
- Rapid heart rate and high blood pressure
- Dilated pupils
- Loss of muscle coordination or twitching muscles
- High blood pressure
- Muscle rigidity
- Heavy sweating
- Diarrhea
- Headache
- Shivering
- Goose bumps

Severe serotonin syndrome can be life-threatening. Signs include:

- High fever
- Tremor
- Seizures
- Irregular heartbeat
- Unconsciousness

3. AACAP suggests (2C) that combination treatment (CBT and an SSRI) could be offered preferentially over CBT alone or an SSRI alone to patients 6 to 18 years old with social anxiety, generalized anxiety, separation anxiety, or panic disorder.
4. AACAP suggests (2C) that serotonin norepinephrine reuptake inhibitors (SNRIs) could be offered to patients 6 to 18 years old with social anxiety, generalized anxiety, separation anxiety, or panic disorder.

Question 11

At what age do children typically display separation anxiety?

A. Preschool
B. School age
C. Later school age
D. Adolescence

Question 12

Which symptom rating scale would be more likely to identify symptoms of social anxiety?

A. Generalized Anxiety Disorder 7-item
B. Mood and Feelings Questionnaire
C. Preschool Feelings Checklist
D. Screen for Child Anxiety Related Disorders

Question 13

Which of the following is recommended by AACAP for treatment of generalized anxiety in children?

A. Cognitive-behavioral therapy
B. Dialectical behavioral therapy
C. Interpersonal psychotherapy
D. Play therapy

Question 14

Which class of medications is recommended by AACAP for treatment of anxiety?

A. Antihistamines
B. Atypical antipsychotics
C. Benzodiazepines
D. Selective Serotonergic reuptake inhibitors?

Question 15

Which of the following is true of SSRIs?

A. Statistically significant improvement is seen within 48 hours
B. Maximal improvement is seen by week 2
C. Adverse effects occur late in treatment
D. Black box warning is for suicidal thinking and behavior through age 24 years

Question 16

Which of the following symptoms could indicate severe serotonin syndrome?

A. High fever
B. Tremor
C. Seizures
D. All of the above

DEPRESSION

Prevalence

- At any given time, nearly 3% of youth worldwide
- Major Depressive Disorder
  - Lifetime prevalence in US – 11%
  - Past-year prevalence in US – 7.5%
- Dysthymia
  - Lifetime prevalence – 1.8%
  - Past-year prevalence – 1.3%
- Nearly 30% reported suicidality in the past year; >10% reported an attempt

Depression - DSM-5

- ≥5 symptoms in a 2 week period and represent a change from previous functioning (must have #1 or #2)
  1. Depressed mood most of the day, nearly very day, as indicated by subjective report (feels sad, empty, hopeless) or observation made by others (appears tearful)
     - NOTE: in children, can be irritable mood
  2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (subjective account or observation)

Depression – DSM-5

3. Significant weight loss when not dieting or weight gain (change of ≤5% of body weight in a month) or decrease or increase in appetite nearly every day
   - NOTE: In children, failure to make expected weight gain
4. Insomnia or hypersomnia
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 (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

Depression – DSM-5

- Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The episode is not attributable to the physiological effects of a substance or to another medical condition
- Not better explained by another disorder
- There has never been a manic episode or hypomanic episode

Focused Symptom Rating Scales

- Patient Health Questionnaire (PHQ)-9 Modified for Teens
  - Ages 12-18 years
  - 9 questions
- Mood and Feelings Questionnaire
  - Ages 6-19 years
  - 6 versions
    - Child self-report, parent-report, adult-self report
    - Long (33 questions) and short (9 questions) version of each
- Preschool Feelings Checklist
  - Preschoolers – ages 3.0-5.6 years
  - 20 questions, parent report

Treatment

1. AACAP suggests (2I) that cognitive-behavioral therapy and interpersonal therapy could be offered to adolescents and children with major depressive disorder or persistent depressive disorder.

Treatment

2. AACAP suggests (2I) that selective serotonin reuptake inhibitor medication (except paroxetine), preferably fluoxetine, could be offered to adolescents and children with major depressive disorder.
3. AACAP suggests (2I) that combination treatment (cognitive-behavioral therapy plus fluoxetine) could be offered to adolescents and children with major depressive disorder.

Question 17

What symptom may be seen in children with depression in place of depressed mood?

A. Agitation
B. Anhedonia
C. Irritable mood
D. Dysthymia

Question 18

Which depression symptom rating scale would be appropriate for use in an 8-year-old?

A. Child Behavior Checklist
B. Mood and Feelings Questionnaire
C. Patient Health Questionnaire (PHQ-9) Modified for Teens
D. Preschool Feelings Checklist

Question 19

What is the preferred SSRI for treatment of major depressive disorder in adolescents and children?

A. Citalopram
B. Fluoxetine
C. Sertraline
D. Paroxetine

Question 20

Which SSRI is not recommended for treatment of depression in adolescents and children with major depression?

A. Citalopram
B. Fluoxetine
C. Sertraline
D. Paroxetine

SUICIDE

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Suicide and Suicide Risk in Adolescents

Liwei L. Hua, MD, PhD,[a] Janet Lee, MD, FAAP,[b] Maria H. Rahmandar, MD, FAAP,[c] Eric J. Sigel, MD, FAAP,[d]
COMMITTEE ON ADOLESCENCE; COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION

Addressing Suicide Risk

- Goal: promote protective factors and minimize risk factors
- Questions to consider:
  - Do you feel connected to your family?
  - Do you feel supported by your family?
  - Do you have a supportive friend group?
  - How would your good friends describe you?
  - Are you religious or spiritual?
  - What do you think you're good at?
  - What are you proud of?
  - Are you part of any school groups?
  - For parents: What are your child's strengths?

When to Screen

- Evolving
  - AAP recommends screening ALL youth ages 12 years and older at least annually
  - 2022 US Preventive Services Task Force – insufficient evidence for routine screening for suicide risk in primary care
  - Joint Commission requires screening for anyone 12 years and over admitted for a primarily mental health concern
    - Many hospitals have made this unviersal

How to Screen

- PHQ-9 Modified for Adolescents has 4 extra questions, including
  - “Has there been a time in the past month when you have had serious thoughts about ending your life?”
  - “Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?
- HOWEVER – not validated as a suicide risk screening tool
- AAP discourages use of PHQ-9 Modified for Adolescents as a suicide screening tool
- It can be used with the Ask Suicide Screening Questions (ASQ) to screen for both depression and suicide risk

Ask Suicide Screening Questions (ASQ)

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past weeks, have you been having thoughts of killing yourself?
4. Have you ever tried to kill yourself?

(If yes to any of the questions 1–4, then ask question 5.)

5. Are you having thoughts of killing yourself now?

Managing Positive Suicide Risk Screens: Using a Brief Suicide Safety Assessment

- Used in positive screens to determine disposition – is there need for more comprehensive mental health evaluation?
- “Ideally, practices have access to a behavioral health specialist who can administer the BSSA.”
- 2 freely-available BSSAs
  - ASQ BSSA
  - Columbia Suicide Severity Rating Scale

Safety Planning

- Can be effective as a brief intervention for reduction of suicide risk
- Patient works with a healthcare provider to create a list of personalized coping strategies, including
  - Warning signs of impending SI or behavior
  - Reliable coping strategies one can engage in oneself
  - People and places that can provide distractions if internal coping strategies are not sufficient
  - Trusted people who can help when necessary
  - Professional support resources
  - Information on limiting access to lethal means of suicide

Safety Planning is NOT the same as no-harm or no-suicide contracts

- Contracts are not recommended
  - Lack of data to support efficacy
  - Patients may feel they are coercive and not disclose SI because they fear they would disappoint their provider
  - Do not include coping mechanisms

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Place:** _____ 4. **Place:** _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. **Name:** _____ **Contact:** _____
2. **Name:** _____ **Contact:** _____
3. **Name:** _____ **Contact:** _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

2. **Clinician/Agency Name:** _____ **Phone:** _____

Emergency Contact : _____

3. **Local Emergency Department:** _____

Emergency Department Address: _____

Emergency Department Phone : _____

4. **Suicide Prevention Lifeline Phone:** 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Assessment for Access to Lethal Means

- Assess for lethal means, especially firearms, during preventive care visits and provide counseling to decrease or eliminate access
  - Firearms
  - Medications
  - Illicit substances
  - Knives, ropes, and other lethal means
- If firearms are present, discuss ways to temporarily store them outside the home

Guidance for Pediatricians and Pediatric Health Care Providers

- Be mindful of individual, relationship, and community/ societal factors, including history of trauma or other adversity, when assessing suicide risk in patients.
- Screen for suicide risk as part of well-child visits starting at 12 years of age and during higher-risk situations, such as any presentation of a behavioral or mental health concern or for youth with additional risk factors.
- Be aware that screening only for depression is not sufficient to identify suicide risk.
- Screen for suicide risk during ED visits and medical hospitalizations.
- Screen for substance use disorders, because substance use is often associated with depression and self-treatment and is a risk factor for suicidal thoughts and behaviors.
- If suicide screen is positive, conduct a BSSA and subsequent safety planning and/or referrals as appropriate.
- For all adolescent health supervision visits, and especially visits with adolescents who have suicidal thoughts, assess for access to lethal means, with counseling on safe firearm and medication storage.
- Removal of firearms and medications from the home entirely should also be assessed, especially if an adolescent is having SI.

Guidance for Pediatricians and Pediatric Health Care Providers

- Include the family in suicide prevention and treatment efforts, when possible, because family-based interventions have been shown to be effective in preventing future suicide attempts in youth.
- During health supervision visits and visits addressing mental health concerns, counsel families around sleep hygiene, community engagement, and connectedness, because these factors can help to promote emotional wellness and may be protective against suicidal thoughts.
- Treat depression with a referral to a psychotherapist and with antidepressant medication, when indicated, because depression increases the risk of suicide.
- When indicated and available, refer to a child and adolescent psychiatrist or other mental health provider.
- Be aware of use of language when speaking with youth and families about suicide. Attempt to replace questionable terminologies with sensitive terminologies as follows:
  - Use “die by suicide” instead of “commit suicide.”
  - Use “death by suicide” instead of “successful suicide.”
  - Use “suicide attempt” instead of “failed suicide attempt.”

Question 21

When does the AAP recommend screening for suicide risk?

A. All youth ages 12 and older at least annually
B. All youth 12 years and over admitted for a primarily mental health concern
C. All youth 12 years and older when presenting to clinic with a mental health complaint
D. AAP found insufficient evidence to recommend routine screening for suicide risk in primary care

Question 22

Which of the following can be used to screen for suicide risk?

A. Ask Suicide Screening Questions
B. Behavior Assessment System for Children
C. Mood and Feelings Questionnaire
D. PHQ-9 Modified for Adolescents

Question 23

If a patient has a positive screen on the Ask Suicide Screening Questions, what is the next best step?

A. Administer a Brief Suicide Safety Assessment
B. Admit for psychiatric evaluation
C. Arrange for nonurgent mental health follow up
D. No follow up is necessary

Question 24

Which of the following coping strategies may be listed during safety planning for a patient with suicide risk?

A. Warning signs of impending SI or behavior
B. Professional support resources
C. Information on limiting access to lethal means of suicide
D. All of the above

Question 25

Which of the following is a sensitive term that is recommended when speaking with youth and families about suicide?

A. Commit suicide
B. Die by suicide
C. Successful suicide
D. Failed suicide attempt