Disclaimer: The information in this book is intended to offer helpful guidance for diagnosis and treatment via a primary care provider, and is not a substitute for specific professional medical advice. There was no pharmaceutical industry or commercial financial interests involved in funding the preparation and creation of this booklet.

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Dr. Robert Hilt and the Seattle Children’s Partnership Access Line. Please see their website and care guide for further great information. (http://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/)

Dr. Anthony Guerrero, University of Hawaii Dept of Psychiatry Chair & Child and Adolescent Psychiatry Fellowship Associate Program Director
Dr. Daniel Alicata, University of Hawaii Child and Adolescent Psychiatry Program Director
Dr. Deb Goebert, University of Hawaii Dept of Psychiatry Research Faculty
Dr. Roshni Koli, University of Hawaii Dept of Psychiatry Faculty
Dr. Lee Buenconsejo-Lum, University of Hawaii Residency Programs Designated Institutional Official and Dept of Family Medicine Faculty
University of Hawaii Child and Adolescent Psychiatry Fellows: Dr. Trisa Danz, Dr. Wai Jenn Lim, Dr. Andrew Smith, Dr. Sarah Johnson
Queens Family Treatment Center Social workers: Andrea Chun & Justin Oliver
Kapiolani Social workers/Staff: Candyce Kaaiai, Melissa Willke, Cindy Mekdara, Yvette Smith, Kathy Hanson, Kelly Devine, Lynette Miki, Kathleen Han
Department of Health Developmental Disabilities Division: Dr. Okamoto & Laine Tokumoto
**How to access a provider:**
Use a web search engine to find the "customer service" line for the insurance carrier of your child. They should be able to direct you to providers in your network for your specific insurance plan. Most insurance companies will have a coordinator or hotline that will help connect patients with mental health providers.

**How to access CAMHD (Child and Adolescent Mental Health Division):**
To see if you qualify for Hawaii Quest, call the Enrollment Call Center at:
Oahu: 587-3521
Neighbor Island: 1-800-316-8005

For Hearing Impaired:
Oahu: 692-7182
Neighbor Island: 1-800-603-1201

If you do qualify for Hawaii Quest, call your nearest Family Guidance Center (below) to see if you qualify for services.

![Family Guidance Centers](image)

Also, talk to a Counselor, Student Services Coordinator or Principal at your child’s school, because you may be able to get help through there if your child has an existing Individualized Educational Program.

**Support for Emotional and Behavioral Development (SEBD) Form:** To start services with CAMHD, you will need to sign this consent form ([http://helpyourkeiki.com/wp-content/uploads/2014/07/SEBD-referral-form.pdf](http://helpyourkeiki.com/wp-content/uploads/2014/07/SEBD-referral-form.pdf)). This form allows your child to receive a mental health evaluation to determine if he or she has a diagnosis. Based on the information from this assessment, your child may fit the criteria of the youth served at CAMHD, which would then qualify him or her to receive treatment.
Developmental Disabilities Division (DDD) services

Criteria for referral for intellectual disability

- Diagnosis by a licensed professional recognized by the division. Diagnosis incorporates the use of an IQ test. The results are 2 or more standard deviations below the mean.
- Results in substantial functional limitations in 3 or more of the following areas:
  - Self care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self direction
  - Capacity for independent living
  - Economic self sufficiency.
- Present before the age of 18yo.

Criteria for referral for developmental disability

- Diagnosis that meets definition of an eligible condition for a severe and chronic disability. The diagnosis is attributable to a mental or physical impairment or combination of both. (e.g. of eligible conditions include autism spectrum, mental illness, emotional disorders, substance abuse, learning disabilities, ADHD)
- Manifested before the age of 22.
- Is likely to continue indefinitely.
- Results in substantial functional limitations in 3 or more of the following areas:
  - Self care
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self direction
  - Capacity for independent living
  - Economic self sufficiency.
- Reflects the persons need for a combination and sequence of special, interdisciplinary or generic care, treatment or other services which are life long or of an extended duration and are individually planned and coordinated.

How to apply to services: Parents should schedule an appointment after gathering medical documentation at 733-1689.
General Hawaii Resources

211 Aloha United Way (http://auw211.org/) – database of resources and support lines.


Legal Aid society of Hawaii (http://www.legalaidhawaii.org/) - Legal advice and assistance for low income families: Oahu 536-4302, neighbor islands 1-800-499-4302

Child and Family Service.org (www.childandfamilyservice.org) – Programs for at-risk children and families

Good Beginnings (www.goodbeginnings.org) -

Hawaii Children’s Trust Fund (www.Hawaiichildrenstrustfund.org) –

808 Youth (http://www.808youth.com/) - Youth Services Database

Evidence Based Services of Committee of Hawaii (http://helpyourkeiki.com/find-help/hawaii-quest-medicaid/) – Information, general guidance and how to Access CAMHD services

Hale Kipa (https://www.halekipa.org/) – youth programs, shelter. Oahu 589-1829

Child Section of the Center for the Center of Cognitive Behavioral Therapy and, Department of Psychology at the University of Hawaii Manoa. Includes 3 clinics: stress and anxiety, ADHD, and psychoeducational testing. For private assessments. Call 956-9559

Teen Link Hawaii (http://teenlinkhawaii.org/) – youth programs for various concerns

The Bus (http://www.thebus.org/) – Oahu bus system. 848-5555

Teen Alert Program (http://www.tap808.org/) - Dating violence prevention and intervention 531-3771

Employment/Job training
  - Alu Like, Inc 535-6750
  - Hawaii Job Corps 536-0695
  - Helemano Plantation 622-3929
  - Hawaii Vocational Rehab 586-4824

Koku Life app (available for smart phones) – regularly updated, helpful community resources in Hawaii. Includes suicide prevention resources, safety planning tool, mental health screening tools, resources for specialized populations, and local directory.
Crisis Intervention and Prevention

Safety Concerns/ Crisis

- Acute agitation
- Bizarre, unusual, or reckless behavior
- Suicidal or homicidal ideation

Things to consider in rating urgency of ER evaluation...

Does the individual have a plan?
Does the individual express intent?
How long has the patient felt this way for?
Does the individual have access to the means of his/her plan?
What is the lethality of his/her plan?
Is he/she currently intoxicated?

Mild Concern

Close follow up via:
- Referral to mental health provider (therapist, psychologist, psychiatrist)
- Weekly check-ins and spacing out as needed
- Consideration of crisis plan for parents and patient to reference should condition worsen

Moderate to Severe Concern

Immediate evaluation via:
- ACCESS LINE (808-832-3100) for guidance and Crisis Mobile Outreach evaluation
- 9-1-1 for Police or Emergency Medical Services assistance, or
- Visit the nearest Emergency Room

National Suicide hotline: 1-800-784-2433
Teen Link hotline: 1-866-833-6546
Oahu Crisis Line: 808-832-3100
Neighbor Island Crisis Line: 1-800-753-6879
Hawaii Crisis Support Text Line: Text “ALOHA” to 741741

Hawaii Child and Adolescent Psych Resources for Primary Care | 5
**Crisis Prevention Plans** are intended to help children and adolescents with the help of their caregivers prevent minor problems from escalating into larger crises by trying to logically think through:

1) **triggers** or causes of distress, including **early warning signs** “My triggers are...” “My early warning signs are...”
2) options and **coping skills** for decreasing the distress “When this happens, I can...”
3) **other supports** or interventions should primary options or coping skills be inadequate “When this fails/ If I am unable to manage myself, my parents/ caregivers can...”

**Additional considerations for parents:**

1) maintain regular routines in low-stress environment
2) encourage regular school attendance unless otherwise directed by your provider
3) maintain control and possession of medications and administer them to your child as directed
4) secure any objects that your child can use for self-harm so that they are locked up and/or that your child is unaware of the location (including location of keys or combinations of locks used to secure items). This includes medications of all family members and any over the counter medications.

**State Resources**

Child Welfare/Protective Services: Oahu 832-5300, state wide 1-800-494-3991

Domestic Violence Hotline: 808-841-0822

Domestic violence Drop In Centers: Pu’uhonua crisis counseling/Ohi’a Shelter 526-2200

Domestic Violence Action Center: Oahu 531-3771, neighbor island 1-800-690-6200

Sex Abuse Treatment Center: Oahu 24 Hour hotline 524-7273

Sex Assault Crisis Hotline: Kauai 245-4144; Big Island 935-0677
Attention Deficit Hyperactivity Disorder (ADHD)

Considering ADHD diagnosis?
Problem from inattention/hyperactivity

Consider comorbidity or other diagnosis:
- Oppositional Defiant Disorder
- Conduct Disorder
- Substance Abuse
- Language or Learning Disability
- Anxiety Disorder
- Mood disorder
- Autism Spectrum Disorder
- Low Cognitive Ability/Mental Retardation

Diagnosis:
Preschoolers have some normal hyperactivity/impulsivity; recommend skepticism if diagnosing ADHD in this group.
(Note that Medicaid may require a medication review if prescribing and child age <5)
If rapid onset symptoms, note this is not typical of ADHD

Use DSM-5 criteria:
Must have symptoms present in more than one setting
Symptoms rating scale strongly recommended from both home and school
- Vanderbilt ADHD Scale (many others available, for a fee)
If unremarkable medical history, neuro image and lab tests are not indicated
If significant concern for cognitive impairment, get neuropsychological/learning disability testing

Treatment: If diagnose ADHD

Mild Impairment,
or no medication trial per family preference

Psychosocial Treatment:
- Behavior therapy
- Behavior management training (essentially more effective time outs and rewarding positive behaviors)
- Social skills training
- Classroom support/communication
Give parent our resource list to explain the above treatments
(the parent handout in this guide)

Significant impairment,
or psychosocial treatments not helping

Treat substance abuse, consider atomoxetine or alpha2 agonist trial

YES
Active substance abuse

NO

Monotherapy with methylphenidate or amphetamine preparation
Titrate up every week until maximum benefit (follow-up rating scales help)

If problem side effects or not improving, switch to the other stimulant class

If problem side effects, or not improving, switch to atomoxetine or alpha2 agonist monotherapy

If no improvement, reconsider diagnosis. Medication combinations like alpha-2 agonist plus stimulant may be reasonable at this stage.

Primary References:
AACAP: “Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder.” JAACAP 46(7): July 2007:894-921

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.28
Screening tools:

Vanderbilt scales (parent fills out the parent version and teachers fill out the teacher version) found at http://www.nichq.org/childrens-health/adhd/resources/vanderbilt-assessment-scales

### ADHD Stimulant Medications

**Short Acting Stimulants**

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

**Extended Release Stimulants**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Duration</th>
<th>Dosages</th>
<th>Stimulant Class</th>
<th>Usual Starting Dose</th>
<th>FDA Max Daily Dose</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerta</td>
<td>10-12 hours</td>
<td>16, 27, 36, 54 mg</td>
<td>Methyl.</td>
<td>10mg QAM</td>
<td>72mg</td>
<td>Generic available, Osmotic pump capsule</td>
</tr>
<tr>
<td>Adderall XR</td>
<td>8-12 hours</td>
<td>5, 10, 15, 20, 25, 30 mg</td>
<td>Dextro.</td>
<td>5mg QD</td>
<td>30mg</td>
<td>Generic available, beads in capsule can be sprinkled</td>
</tr>
<tr>
<td>Metadate CD (30% IR)</td>
<td>-8 hours</td>
<td>10, 20, 30, 40, 50, 60 mg capsules</td>
<td>Methyl.</td>
<td>10mg QAM</td>
<td>60mg</td>
<td>Generic available, beads in capsule can be sprinkled</td>
</tr>
<tr>
<td>Ritalin LA (50% IR)</td>
<td>-8 hours</td>
<td>10, 20, 30, 40 mg capsules</td>
<td>Methyl.</td>
<td>10mg QAM</td>
<td>60mg</td>
<td>Generic available, beads in capsule can be sprinkled</td>
</tr>
<tr>
<td>Focalin XR</td>
<td>10-12 hours</td>
<td>5 to 40mg in 5 mg steps</td>
<td>Methyl.</td>
<td>5mg QAM</td>
<td>30mg</td>
<td>Beads in capsule can be sprinkled</td>
</tr>
<tr>
<td>Daytrana patch</td>
<td>Until 3-5 hours after patch removal</td>
<td>10, 15, 20, 30 mg Max 30mg/9hr</td>
<td>Methyl.</td>
<td>10mg QAM</td>
<td>30mg</td>
<td>Rash can be a problem, slow AM startup, has an allergy risk, peeling off patch a problem with young kids</td>
</tr>
<tr>
<td>Lisdexamfetamine (Vyvanse)</td>
<td>-10 hours</td>
<td>20, 30, 40 50, 60, 70mg</td>
<td>Dextro.</td>
<td>30mg QD</td>
<td>70mg</td>
<td>Conversion ratio from dextroamphetamine is not established</td>
</tr>
<tr>
<td>Dextroamphetamine ER</td>
<td>8-10 hours</td>
<td>5, 10, 15 mg</td>
<td>Dextro.</td>
<td>5mg QAM</td>
<td>40mg</td>
<td>Beads in capsule can be sprinkled</td>
</tr>
<tr>
<td>Quillichew ER</td>
<td>6-8 hours</td>
<td>20, 30, 40 mg</td>
<td>Methyl.</td>
<td>20mg QAM</td>
<td>60mg</td>
<td>Chewable cherry-flavored tablets</td>
</tr>
</tbody>
</table>

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.34
ADHD Non-Stimulant Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Duration</th>
<th>Dosages</th>
<th>Usual Starting Dose</th>
<th>FDA Max Daily Dose</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atomoxetine (Strattera)</td>
<td>All day</td>
<td>10, 18, 25, 40 60, 80, 100mg</td>
<td>0.5mg/kg/day (1 to 1.2 mg/kg/d usual full dosage)</td>
<td>Lesser of 1.4mg/kg/day or 100mg (HCA limit is 120mg/day)</td>
<td>Usually lower effectiveness has GI side effects, takes weeks to see full benefit</td>
</tr>
<tr>
<td>Clonidine (Catapres)</td>
<td>12 hour 1/2 life</td>
<td>0.1, 0.2, 0.3mg</td>
<td>0.05mg QHS if &lt;45kg, otherwise 0.1mg QHS Caution if &lt;5 yr.</td>
<td>(Not per FDA) 27-40kg 0.2mg 40-45kg 0.3mg &gt;45kg 0.4mg</td>
<td>Often given to help sleep, also treats tics, can have rebound BP effects</td>
</tr>
<tr>
<td>Clonidine XR (Kapvay)</td>
<td>12-16 hours</td>
<td>0.1, 0.2 mg</td>
<td>0.1mg QHS</td>
<td>0.4mg daily</td>
<td>Lower peak blood level, then acts like regular clonidine (similar 1/2 life), Still is sedating, Approved for combo with stimulants</td>
</tr>
<tr>
<td>Guanfacine (Tenex)</td>
<td>14 hour 1/2 life</td>
<td>1, 2 mg</td>
<td>0.5mg QHS if &lt;45kg, otherwise 1mg QHS Caution if &lt;5 yr.</td>
<td>(Not per FDA) 27-40kg 2mg 40-45kg 3mg &gt;45kg 4mg</td>
<td>Often given to help sleep, also treats tics, can have rebound BP effects</td>
</tr>
<tr>
<td>Guanfacine XR (Intuniv)</td>
<td>16 hour 1/2 life</td>
<td>1, 2, 3, 4 mg</td>
<td>1mg QD if over 6 years old (full dosage 0.05 to 0.12mg/kg)</td>
<td>4mg daily</td>
<td>Lower peak blood level, then acts like regular Tenex (similar 1/2 life), Still is sedating, Approved for combo with stimulants</td>
</tr>
</tbody>
</table>

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

Relative Effect Size of ADHD Medication Choices

- Effect size of all stimulants -1.0
- Effect size of atomoxetine -0.7
- Effect size of guanfacine -0.65 (using Cohen's d-statistic)

Stimulant Relative Potencies:
- Methylphenidate 10mg = dexamethasone 5mg
- Methylphenidate 10mg = dextroamphetamine 5mg

Therapy to consider: Behavior Management Training or Behavior Therapies. Generally lasts 10-20 sessions with a qualified therapist. These treatments while helpful can be less effective than medications, though when used together may help with some difficulties more than just medications alone. Key points of this therapy includes reviewing information about ADHD, learning to attend to both misbehavior and when child complies, establishing a token economy, using timeouts effectively, managing noncompliant behavior in public settings, using a daily school report card, anticipating future misconduct.
Helpful Websites for Families and schools

- Parents Med Guide: www.parentsmedguide.org (information about medications for ADHD)
- Children and Adults with ADHD: www.chadd.org (support groups, information resources)
- Teach ADHD: http://teachadhd.com (teaching advice for ADHD kids)

Hawaii Resources

The ADHD Center of Hawai’i (http://www.ldcenterofhawaii.com/)
Anxiety

Anxiety Problem?
Unexplained somatic complaints?

Safety check: Neglect/Abuse?
Drug abuse?
Medical cause?
(i.e. medication effects, asthma)

Think about comorbidity:
Depression and ADHD are common.
-50% of kids with anxiety have 2 or more anxiety diagnoses

Diagnosis:
DSM-5 diagnostic criteria
SCARED anxiety scale or the Spence Anxiety Scale for Children
(www.scaswebsite.com for the Spence, is free, has translations)
If obsessions/compulsions, think of OCD
If nightmares/flashbacks or trauma, think of PTSD
Label as “Anxiety Disorder, NOS” if the type is unclear

Can problem be managed in primary care?

YES

Mild Problem
(noticeable, but basically functioning OK)

Discuss their concerns
Reassure that “many kids feel this way”
Correct distorted thoughts (e.g., “if I don’t get an ‘A’, I’ll die”)
Reduce stressors, but still have to face a fear to conquer it
Offer tip sheet on relaxation techniques to help child tolerate exposure to their fears
If parent is highly anxious too, encourage them to seek aid as well since anxiety can be modeled
Offer parent and child further reading resources on anxiety
Explain somatic symptoms as “stress pains” or something similar

Come back if not better

Moderate/Severe Problem
(significant impairment in one setting or moderate impairment in multiple settings)

Recommend Individual psychotherapy
(CBT is preferred; key element is a gradual exposure to fears) Also offer the advice on the left pathway as per a “mild problem”
Consider starting SSRI if therapy not helping or anxiety is severe
Low dose Fluoxetine or Sertraline are the first line choices
Use therapy alone before medications unless anxiety is quite impairing
Wait four weeks between SSRI increases, use full dose range if no SE
Check for agitation/suicidal thought side effect by phone or in person in 1-2 weeks, and stop medicine if agitation or increased anxiety
Try a second SSRI if first is not help

Referral

NO

Primary References:
Arlington, VA: National Center for Education in Maternal and Child Health: 203-211
AACAP: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders, JAACAP; 46(2): 267-283
**Screening tools:**
SCARED (two forms to be completed, one by the parent and one by the child).
http://www.midss.org/content/screen-child-anxiety-related-disorders-scared

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### Anxiety Medications

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage Form</th>
<th>Usual starting dose for adolescents</th>
<th>Increase increment (after 4 weeks)</th>
<th>RCT anxiety treatment benefit in kids</th>
<th>FDA anxiety approved for children?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine (Prozac)</td>
<td>10, 20, 40mg 20mg/5ml</td>
<td>5-10 mg/day (60mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>Yes (For OCD &gt;7yr)</td>
<td>Long 1/2 life, no SE from a missed dose</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
<td>25, 50, 100mg 20mg/ml</td>
<td>25 mg/day (200mg max)*</td>
<td>25-50mg**</td>
<td>Yes</td>
<td>Yes (For OCD &gt;6yr)</td>
<td>May be prone to SE from weaning off</td>
</tr>
</tbody>
</table>

Sertraline and Fluoxetine are both first line medications for child anxiety disorders, per the evidence base.

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Usual starting dose for adolescents</th>
<th>Increase increment</th>
<th>RCT anxiety treatment benefit in kids</th>
<th>FDA anxiety approved for children?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluvoxamine (Luvox)</td>
<td>25, 50, 100mg</td>
<td>25 mg/day (300mg max)*</td>
<td>50 mg**</td>
<td>Yes</td>
<td>Yes (For OCD &gt;8yr)</td>
<td>Often more side effect than other SSRIs, has many drug interactions</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
<td>10, 20, 30, and 40 mg 10mg/5ml 12.5, 25, 37.5mg CR forms</td>
<td>5-10 mg/day (60mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>No</td>
<td>Not preferred if child also has depression. Can have short 1/2 life</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
<td>10, 20, 40 mg 10mg/5ml</td>
<td>5-10 mg/day (40mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>No</td>
<td>Very few drug interactions</td>
</tr>
<tr>
<td>Escitalopram (Lexapro)</td>
<td>5, 10, 20mg 5mg/5ml</td>
<td>2.5 to 5 mg/day (20mg max)*</td>
<td>5-10mg**</td>
<td>No</td>
<td>No</td>
<td>Active isomer of citalopram</td>
</tr>
</tbody>
</table>

* Recommend decrease maximum dosage by at least 1/3 for pre-pubertal children
** Recommend using the lower dose increase increments for younger children.

Successful medication trials should continue for 6-12 months.

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Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.47
Helpful websites:
American Academy of Child & Adolescent Psychiatry
http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx
Anxiety Disorders Association of America
www.adaa.org
Child Anxiety Network
http://www.childanxiety.net/
Children’s Center for OCD and Anxiety
www.worrywisekids.org
National Institute of Mental Health

Technology based resources:
- Example apps include “Virtual Hope Box” app, Headspace for Kids (does require subscription after trial but aimed towards kids)
- Search for additional apps with keywords: “Meditation” “Mindfulness”
- Search for YouTube videos with keywords: “Progressive Muscle Relaxation” “Deep Breathing” “nature sounds”

Special considerations: Suspecting PTSD
- Assess for safety and ensure child is safe.
- Ask for details from the child, or consider asking the details of the caregiver.
- Look for symptoms such as 1) intrusive thoughts, nightmares; 2) avoidance of reminders; 3) mood or cognition changes; 4) hypervigilance/ hyperarousal
- There is no compelling evidence for medications to address PTSD in children; first line is Trauma-focused cognitive behavioral therapy (TF-CBT); though clonidine and prazosin can be helpful off-label use for nightmares
- Helpful website: After the Injury (www.aftertheinjury.org)
Autism Spectrum Disorder (ASD)

Considering an Autism Spectrum Disorder?

<table>
<thead>
<tr>
<th>Any Early Red Flags?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not smiling in response to being smiled at, or making eye contact</td>
</tr>
<tr>
<td>Does not develop shared attention with others</td>
</tr>
<tr>
<td>Does not respond to own name by 1 year of age</td>
</tr>
<tr>
<td>Poor social communication or lack of interest in other children</td>
</tr>
</tbody>
</table>

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

Diagnosis: Use DSM-5 diagnostic criteria which include presence or early developmental history of:
1. Impairments in Social Communication and Social Interaction — three domains of impairment in this area should include A) deficits in social-emotional reciprocity, B) deficits in nonverbal communication for social interaction, and C) deficits in developing, maintaining, and understanding relationships.
2. Restrictive, repetitive, patterns of behavior, interests or activities — including at least two of the following domains of A) stereotyped/repetitive movements, use of objects or speech, B) insistence on sameness, inflexible routines, ritualized patterns of behavior, C) highly restricted, fixated interests of abnormal intensity or focus, D) hyper or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment.

May augment one's assessment with an age-appropriate screening tool:
- M-CHAT (Modified Checklist of Autism in Toddlers) for age 16-30 months.
  Found at www2.gsu.edu/~psdrl/Diana_L_Robins_PhD.html
- CAST (Childhood Autism Spectrum Test) for age 4-11 years, and AQ (Autism Quotient) for age 12-15 years.
  Found at www.autismresearchcentre.com/arc_tests

Treatment:
Refer to further evaluation, Early intervention and education:

Please see the section for early intervention services specific to the state of Hawaii below in the resources section. Descriptions are provided for each, detailing the appropriate age range for each resource listed.

Edited by Rachel Sy-Layug, DO & Jillian Yoshimoto, DO

Individually evaluate/address any deficits in the following areas (might consider a formal autism evaluation):
- Speech and language deficits: consider referral to speech/language therapist
- Social skills deficits: consider social skills groups or a speech/language therapist
- Sensory sensitivities/motor abnormalities that impact function: consider referral to occupational or physical therapy
- Maladaptive behavior that affects function: consider referral to a behavioral therapist, psychologist, or psychiatrist

Medical Evaluation:
2. Consider epilepsy if comorbid intellectual or global developmental delay, or decline in functioning.
3. Do genetic, metabolic, or other studies as indicated by presentation. Consider Fragile X testing.
4. Monitor closely for treatable medical problems like ear infections and constipation which can worsen symptoms.
5. Consider co-morbid psychiatric conditions (like ADHD, anxiety or depression) which can worsen functioning.

Primary References:
**Screening tools**

- MCHAT (Modified Checklist of Autism in Toddlers) for ages 16-30 months found at [http://mchatscreen.com/](http://mchatscreen.com/).
- CAST (Childhood Autism Spectrum Test) for ages 4-11 years or AQ (Autism Quotient) for ages 12-15 years both found at [https://www.autismresearchcentre.com/arc_tests](https://www.autismresearchcentre.com/arc_tests)

**Medication considerations:** There are no medications that can improve the core symptoms of autism. Medication can be used for co-morbid conditions (like ADHD, anxiety or depression) or for autism related irritability and aggression. Risperidone and Aripiprazole are FDA approved.

Therapy to consider: Applied Behavioral Analysis (ABA), a therapy that helps children improve communication and social skills, as well as decrease a range of problematic behaviors. This is achieved through focusing on understanding behavior as a part of the child’s environment and then modifying the behavior to achieve a range of goals. It can be very labor intensive and expensive.

**Helpful websites for families**

- Autism Speaks: [www.autismspeaks.org](http://www.autismspeaks.org) (advocacy, diagnostic, treatment and support resources)

**Hawaii Resources**

- Early Head Start (Parent education/child development activities for children 6weeks to 3years of low income families) – Oahu 842-5996, Big Island 961-0570, Maui 242-0900
- Head Start (Info on free preschool program for ages 3-5yo of low income families.) – Oahu 847-2400, Kalihi 842-5996, Big Island 961-0570, Kauai 245-5914, Maui 249-2988, Molokai 553-5472/553-3727
- Hawaii Home Visiting Network (Intake, screening, home visiting and early intervention services for children up to 36 months.) – Oahu 681-1555, East Hawaii 961-3877
- Pulama I Na Keaki (home based and small group education for families of Hawaiian children prenatal to 5 years) – Oahu 535-1317, West Hawaii 331-2818, Maui 242-9774
- HKISS (Dept of Health information for parents of children with special needs from birth to 3years) – Oahu 594-0066, Neighbor Islands 1-800-235-5477
- Learning Disability Association of Hawaii: Oahu 536-9684,
- Ekolu Eha Ike Pono (Free developmental, socioemotional, hearing, vision screenings for children 3-4 years) 696-5361
- Special Parent Information Network: (for families of children with special needs) Oahu 586-8126, Neighbor Islands (call the islands number then dial 68126) Big Islands 974-4000, Kauai 274-3141, Maui 984-2400, Lanai/Molokai 1-800-468-4644
Bipolar Disorder

Considering Bipolar Disorder?

Strongly consider other reasons for the symptoms such as:
- ADHD
- Conduct Disorder
- Oppositional Defiant Disorder
- Major Depression
- Early abuse or neglect in dysregulation syndromes
- “Difficult” temperament of child plus interpersonal conflicts
- Autism Spectrum Disorder, especially with oppositionality
- OCD, separation anxiety or other anxiety disorder
- Medical causes of mania (including fetal alcohol syndrome)

Safety check: Suicidality?
- Drug abuse?
- Current neglect/abuse?

Diagnosis:
- Does child have history of clear manic episode for >4 days?
- History of hospitalization for mania?
- History of psychosis or severe suicidality?
- Symptom of inappropriate euphoria/grandiosity?

Is this an "Unspecified," or "Other Specified" Bipolar disorder?
These are the DSM-5 labels for bipolar symptoms that cause impairment, but the duration or other criteria for Bipolar I or II are not met.
This “soft” criteria bipolar diagnosis in children is controversial.
Most irritable, moody, irrational, hyperactive kids when evaluated more fully are found NOT to have a bipolar disorder.

More likely Bipolar spectrum if:
- Episodic patterns of changes in mood, activity and energy including elation, hyperactivity, grandiosity, hypersexuality, decreased sleep that are a departure from baseline function (and not fully explained by child’s response to stressors)
- Have 1st degree relative with bipolar

Less likely Bipolar spectrum if:
- Younger age (such as <10)
- Rages only after frustrations
- Symptoms only in 1 setting (i.e., home)
- High expressed emotion in household (think of ODD)

Treatment:
1. Consider consultation with a mental health specialist, especially if safety concerns
2. Consider medical causes of manic symptoms like hypothyroidism, neurological dysfunction
3. Psychosocial/behavioral intervention tailored to family, including:
   a. family psychoeducation
   b. child/family focused CBT
   c. enhancing school and community supports
   d. Individual or family psychotherapy
   e. behavior management training
4. Medication trial, single agent preferred, choose among:
   a. atypical antipsychotic
   b. lithium
   c. lamotrigine (especially if bipolar depression)
   d. divalproex, carbamazepine also options, though have less evidence basis
5. Be cautious of prescribing antidepressants (manic switching risk)
6. Follow up frequently, perhaps weekly until stabilizing
7. Ensure adequate sleep hygiene — consider sleep medications if necessary

Treat other causes of symptoms, especially if unsure of bipolar diagnosis

If yes to any, child should see a mental health specialist to evaluate/treat
Bipolar I or Bipolar II
(also called "narrow phenotype" bipolar)

If yes to any, child should see a mental health specialist to evaluate/treat
Bipolar I or Bipolar II
(also called "narrow phenotype" bipolar)

Primary References:
AACAP “Practice Parameter for the Assessment and Treatment of Adolescents and Children with Bipolar Disorder” JAAACAP 2007, 46(3), 107-125
Screening tools:

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**Bipolar Disorder Medications**

Evidence base on bipolar medications is for narrow phenotype, or classic Bipolar I or II. Broad phenotype, or Bipolar No Elsewhere Classified has not been well researched in children.

### Atypical Antipsychotics

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage Form</th>
<th>Usual Starting Dose</th>
<th>Sedation</th>
<th>Weight Gain</th>
<th>EPS (stiff muscles)</th>
<th>Bipolar (+) child RCT evidence?</th>
<th>FDA bipolar approved?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risperidone</td>
<td>0.25, 0.5, 1, 2, 3, 4mg 1mg/ml</td>
<td>0.25mg QHS</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>Yes</td>
<td>Yes (Age &gt;10)</td>
<td>Generic forms, More dystonia risk than rest</td>
</tr>
<tr>
<td>Aripiprazole</td>
<td>2, 5, 10, 15, 25, 30mg 1mg/ml</td>
<td>2mg QD</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>Yes</td>
<td>Yes (Age &gt;10)</td>
<td>Generic forms, Long 1/2 life, can take weeks to build effect, more weight gain than for adults</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>25, 50, 100, 200, 300, 400mg</td>
<td>25mg BiD</td>
<td>++</td>
<td>+</td>
<td>+/-</td>
<td>Yes</td>
<td>Yes (Age &gt;10)</td>
<td>Generic forms, Pills larger, could be hard for kids to swallow.</td>
</tr>
<tr>
<td>Ziprasidone</td>
<td>20, 40, 60, 80mg</td>
<td>20mg BiD</td>
<td>+</td>
<td>+</td>
<td>+/-</td>
<td>No</td>
<td>No</td>
<td>Generic forms, Greater risk of QT lengthen, EKG check</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5, 5, 7.5, 10, 15, 20mg</td>
<td>2.5 mg QHS</td>
<td>++</td>
<td>++</td>
<td>+/-</td>
<td>Yes</td>
<td>Yes (Age &gt;13)</td>
<td>Generic forms, Greatest risk of weight gain, increased cholesterol</td>
</tr>
<tr>
<td>Asenapine</td>
<td>Sublingual 2.5, 5, 10mg</td>
<td>2.5 mg SL BiD</td>
<td>++</td>
<td>+/-</td>
<td>+/-</td>
<td>Yes</td>
<td>Yes (Age &gt;10)</td>
<td>Oral paresthesia, must dissolve in mouth</td>
</tr>
</tbody>
</table>

### Monitoring for all atypical antipsychotics:

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

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.58
### Helpful websites:

American Academy of Child & Adolescent Psychiatry  

National Institute of Mental Health  

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**Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.59**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Bipolar (+) RCT evidence in kids</th>
<th>FDA bipolar approved children?</th>
<th>Monitoring</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>Yes</td>
<td>Yes (over age 12)</td>
<td>Baseline EKG, BUN/creat, TSH, CBC. Lithium level after 5 days. Q3month Lithium level. Q6mo TSH,BUN/creatinine</td>
<td>Sedating, weight gain, renal and thyroid toxicity. If dehydration can get acute toxicity. Reduces suicide risk though an overdose can be fatal</td>
</tr>
<tr>
<td>Valproate</td>
<td>No</td>
<td>No</td>
<td>CBC, LFT at baseline, in 3 month, then Q6month. VPA level checks needed</td>
<td>Weight gain, sedation, rare severe toxicity of liver, platelets ↓ WBC, risk of polycystic ovarian syndrome</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>No</td>
<td>No</td>
<td>CBC, LFT at baseline, then every 3-6 months. CBZ level checks needed</td>
<td>Aplasia and rash risk. Oxcarbazepine bipolar trial with kids had negative results</td>
</tr>
<tr>
<td>Lamotrigine</td>
<td>No</td>
<td>No</td>
<td>CBC, LFT at baseline, in 2-4 weeks, then Q6 month. Monitor for rash</td>
<td>Stevens-Johnson rash risk requires slow titration, adult studies support use for bipolar depression</td>
</tr>
</tbody>
</table>
Depression

Depressive Symptoms?
Unexplained Somatic Complaints?

Safety screen:
Neglect/Abuse?
Medical condition (i.e. anemia, thyroid problem?)
Thoughts of hurting oneself?
If yes, are there plans and means available?

Think about comorbidity:
Anxiety, ODD, Conduct Disorder, ADHD, Dysthymia, Substance abuse

Diagnosis:
DSM-5 Diagnostic Criteria
Rating Scale: SFMQ or PHQ-9 (others available for a fee)
Label as “Depression, NOS” if significant symptoms but not clear if Major Depression

Can problem be managed in primary care?

YES

Mild Problem
(noticeable, but basically functioning OK)

- Educate patient and family
  - Support increased peer interactions
  - Behavior activation, exercise
  - Encourage good sleep hygiene
  - Reduce stressors, if possible
  - Remove any guns from home
  - Offer parent/child further reading resources

- Follow up appointment in 2-4 weeks to check if situation is getting worse
- Repeating rating scales helps comparisons
- Those not improving on their own are referral candidates for counseling

NO

Referral

Moderate/Severe Problem
(significant impairment in one setting, or moderate impairment in multiple settings)

- Recommend individual psychotherapy
  - CBT and IPT are preferred, where available
  - Psychoeducation, coping skills, and problem solving focus are all helpful therapy strategies
  - Educate patient and family (as per mild problem list on left)
  - Consider family therapy referral
  - Consider starting SSRI, especially if severe
    - Fluoxetine is the first line choice
    - Escitalopram/Sertraline second line
    - Third line agents are other SSRIs, bupropion, mirtazapine
    - Wait four weeks between dose increases to see changes
    - Check for side effects every 1-2 weeks in first month of use to ensure no new irritability or suicidality (phone or in person)
    - Stop SSRI if get agitation, anxiety or suicidal thoughts
    - Consult MH specialist if monotherapy is not helping
    - Monitor progress with repeat use of rating scale

Primary References:
Arlington, VA: National Center for Education in Maternal and Child Health: 203-211
Zuckerbrodt R ed: “Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit.”
Columbia University: Center for the Advancement of Children’s Mental Health

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.63
Screening tools:
- CES-DC (Center for Epidemiological Studies Depression Scale for Children) found at https://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf
- PHQ-9 (Patient Health Questionnaire) found at http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

## Depression Medications

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosage Form</th>
<th>Usual starting dose for adolescent</th>
<th>Increase increment (after -4 weeks)</th>
<th>RCT evidence in kids</th>
<th>FDA depression approved for children?</th>
<th>Editorial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine</td>
<td>10, 20, 40mg 20mg/5ml</td>
<td>10 mg/day (60mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>Yes (over age 8)</td>
<td>Long 1/2 life, no side effect from a missed dose</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25, 50, 100mg 20mg/ml</td>
<td>25 mg/day (200mg max)*</td>
<td>25-50mg**</td>
<td>Yes</td>
<td>No</td>
<td>May be prone to side effects when stopping</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>5, 10, 20mg 5mg/5ml</td>
<td>5 mg/day (20mg max)*</td>
<td>5-10mg**</td>
<td>Yes</td>
<td>Yes (for adolescents)</td>
<td>The active isomer of citalopram.</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10, 20, 40mg 10mg/ml</td>
<td>10 mg/day (40mg max)*</td>
<td>10-20mg**</td>
<td>Yes</td>
<td>No</td>
<td>Few drug interactions</td>
</tr>
<tr>
<td>Bupropion</td>
<td>75, 100mg 100, 150, 200mg SR forms</td>
<td>75 mg/day (later dose this BID) (400mg max)*</td>
<td>75-100mg**</td>
<td>No</td>
<td>No</td>
<td>Can have more agitation risk. Avoid if eat d/o. Also has use for ADHD treatment.</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>15, 30, 45mg</td>
<td>15 mg/day (45mg max)*</td>
<td>15mg**</td>
<td>No</td>
<td>No</td>
<td>Sedating, increases appetite</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>25, 37.5, 50, 75, 100mg</td>
<td>37.5 mg/day (225mg max)*</td>
<td>37.5 to 75mg**</td>
<td>No</td>
<td>No</td>
<td>Only recommended for older adolescents. Withdrawal symptoms can be severe.</td>
</tr>
</tbody>
</table>

Starting doses in children less than 13 may need to be lowered using liquid forms
Successful medication trials should continue for 6 to 12 months
* Recommend decrease maximum dosage by around 1/3 for pre-pubertal children
** Recommend using the lower dose increase increments for younger children.

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.69

**Therapy to consider:** Many therapy options including cognitive behavioral therapy (CBT), interpersonal therapy (IPT), psychodynamic/play therapy, supportive therapy.
Helpful websites for families

- Parents Med Guide: www.parentsmedguide.org (information about depression medication)
- National institute of Mental Health:
  [https://www.nimh.nih.gov/health/topics/depression/index.shtml](https://www.nimh.nih.gov/health/topics/depression/index.shtml) (general depression information)
- American Academy of Child and Adolescent Psychiatry:
- Teen Self-Help Cognitive Behavior Therapy (CBT) guidance:
  [www.dartmouthcoopproject.org/teen-mental-health-2/](http://www.dartmouthcoopproject.org/teen-mental-health-2/)
Disruptive Behavior

Disruptive Behavior or Aggression?
Suspect Oppositional Defiant Disorder or Conduct Disorder?

Safety check:
- Neglect/Abuse?
- Drug abuse?
- Specific plan to hurt someone?

If acute danger, have duty to protect or report risks; Consider consultation

Think about comorbidity:
- ADHD
- Major Depression (irritable mood type)
- Bipolar disorder
- Anxiety disorder

Diagnosis:
See DSM-5 criteria
ODD: Pattern of angry/irritable, argumentative/defiant and vindictive behavior of > 6 months
CD: Pattern of behavior violating rights of others/societal norms > 1 year
Rating scale screen: Vanderbilt ADHD scale

Can problem be managed in primary care?

NO Referral to Mental Health Specialist

YES

Child Focused Treatments
Individual psychotherapy focused on problem solving skills, and helping identify and institute tangible rewards for desired behavior. (Avoid group therapy as may reinforce negative behaviors.)
Parent involvement/training is essential to get positive results.
Encourage "special time" interactions between parent and child.

If ADHD present, strongly consider use of stimulant medication.

Although not preferred; if very severe symptoms or if unable to make progress with child/parent counseling after a reasonable counseling effort over a few months, consider medication as symptom focused treatment trial. Note planned, purposeful aggression is not helped by medication.

If use medicine, identify child specific treatment goals which can be monitored to measure treatment effects, like the frequency/severity of violent incidents. Stop any failed medication trials before beginning any new prescription (avoiding polypharmacy).

Non-specific medication options for maladaptive impulsive aggression include divalproex sodium, lithium, atypical antipsychotics, stimulants, and α-2 agonists. The α-2 agonists are usually preferred as a first trial due to overall lower side effect risks. Antipsychotics like risperidone have greater cumulative medical risks, but are more likely to yield a decrease in aggression.

Parent Focused Treatments
Young children: strongly recommend a therapist to teach behavior management skills. Many models for this like Parent Child Interaction Training (PCIT), the Barkley method and I-2-3 Magic.
Adolescents: recommend parent/family therapy or training such as functional family therapy (FFT) or Multisystemic Therapy (MST).
Parent should create some regular positive time with their child (like "special time") as this helps other discipline to be more effective.
Encourage parent to utilize our bibliotherapy/video references on learning behavior management techniques.

Primary References:
Screening tools:
No screening tools.

Non-Specific Medications for Disruptive Behavior and Aggression

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

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

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

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

Other Medication Options

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

**Pappadopolous E et al. (2006) and lit. review

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

Hilt, R. Seattle Children’s Hospital Partnership Access Line Washington Care Guide 2017, pg.81

Hawaii Child and Adolescent Psych Resources for Primary Care | 23
Helpful websites:
American Academy of Child & Adolescent Psychiatry
Anxiety Disorders Association of America
http://www.mayoclinic.org/diseases-conditions/oppositional-defiant-disorder/basics/definition/con-20024559

Bibliography: * 1-2-3 Magic * Calmer, Easier, Happier Parenting * The Incredible Years

Behavioral Therapies to Consider:
Time Out: specific time away from attention, rewards, or other reinforcement by utilizing dull, boring placement for a set amount of time after an undesired behavior.
  1) Should start immediately after an undesired behavior
  2) Set consistent limits, and if a warning is used before, follow through with that warning. Stick to the time frame and use a timer if necessary.
  3) Focus on only 1-2 behaviors at a time
  4) Do not engage with the child during this time (this includes arguing, lecturing, etc.)

Special Time: regular times established for the parent and child to share in a positive experience with one another
  1) Should be done regularly, at least several times per week.
  2) Parent picks the time keeping in mind siblings should all receive equal time, even if this means shorter though consistent time. (can also use timer here if appropriate)
  3) Occurs regardless of how day went and involve 1:1 attention without interruption
  4) Child picks the activity

Functional Behavioral Analysis:
  1) Identify the behavior: what they do, the timing and frequency, any provoking factors, the duration
  2) Hypothesize what may be driving the behavior: inability to communicate effectively, achieving a goal/ benefit, there is no function (could this be independent)
  3) Attempt to change provoking and reinforcing factors
    a) enhance communication via simple concrete sentences and questions
    b) naming thoughts/ feelings/ behaviors
    c) remaining calm and allowing child time to cool down as needed too
    d) increase structure; match demands to the child’s development stage and ability
    e) reinforce positive behavior with attention, praise, and rewards; avoid reinforcing negative behavior with attention
Substance Use Disorder

What to consider when evaluating for a substance use disorder

- What drugs are they using? (examples: marijuana, alcohol, cocaine, meth, heroin, hallucinogens, prescription meds, OTC medication – cough medicine). How long have they been using the drug? How often?
- Assess for safety:
  - Have you operated a car, truck or other vehicle while intoxicated? Been in a dangerous situation because of the drugs or alcohol?
  - Have you had to use your body or other getting into a dangerous situation in order to obtain the drug? (screening for risk of a child trafficking situation)

Screening tools:

- CRAFFT (a teen screening tool) found at http://www.ceasar-boston.org/CRAFFT/screenCRAFFT.php
- DAST – 10 or 20 found at http://www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

Helpful websites for families

- Teen drug abuse: http://www.teen-drug-abuse.org/ (information on teen drug use)
- National Institute on Drug Abuse for teens: https://teens.drugabuse.gov/ (information on teen drug use for teens, parents and teachers)

Hawaii Resources

- Coalition for a Drug Free Hawaii: Oahu 545-3228, Neighbor Islands 1-800-845-1946
- Hina Mauka (substance use treatment program): Oahu 236-2600, Neighbor Islands 1-888-HINAMAUKA
- Teencare: Kaneohe 216-1415, Waianae 382-6099, Waipahu 677-6711
- Substance Abuse Treatment
  - Malama Family Recovery Services: 668-2277
  - Women’s Way: 732-2802 ext 4952
  - Molokai (Hale Ho’okupa’a): 553-3231
- Alcoholics Anonymous – (http://alcoholicsanonymous.com/aa-meetings/hawaii/) or (http://oahucentraloffice.com/meeting-schedule-by-day/) 946-1438
- Narcotics Anonymous – (http://na-hawaii.org/) 734-4357